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MDS 3.0: IMPLICATIONS FOR SOCIAL WORKERS IN NURSING HOMES AND COMMUNITY-BASED SETTINGS

Introduction

The Minimum Data Set (MDS) is a standardized assessment tool used in Medicare- and Medicaid-certified nursing facilities and skilled nursing facilities. Swing bed providers—that is, small, rural hospitals that are certified by the Centers for Medicare & Medicaid Services (CMS) to provide either acute or SNF care—also use the MDS, as do nursing homes within the Veterans Health Administration. The MDS launched in 1991 and was updated (MDS 2.0) in 1995. As of October 1, 2010, all providers completing the MDS 2.0 must begin using a new version of the MDS.

The MDS 3.0 reflects multiple changes in the resident assessment process and presents important implications for social work practice in both nursing homes and community-based settings. In particular, the implementation of the MDS 3.0 underscores the importance of the professional social work role in assessment and care planning for nursing home residents. Furthermore, it highlights the role of community-based social workers in helping nursing home residents transition to community-based settings.

Development and Goals of the MDS 3.0

CMS contracted with the RAND Corporation (a nonprofit research organization) and Harvard to evaluate, revise, and test the MDS. A national trial of the MDS 3.0 (Saliba & Buchanan, 2008), involving about 4,500 residents in almost 100 nursing homes across the United States, demonstrated the following results:

- Enhanced resident voice. By incorporating direct interview items in the MDS, CMS seeks to increase resident (and, if appropriate, family) participation in the assessment process. Interview questions are focused but include a range of choices and response formats. A majority of residents, representing the full range of cognitive of abilities, successfully completed the direct interview items in the national trial. For situations in which residents are unable to participate meaningfully in interviews, however, staff may use observational versions of the same instruments to assess residents. The Resident Assessment Instrument (RAI) and accompanying manual offer guidance as to whether a resident or staff interview should be conducted; interviewing techniques; coding instructions; and scoring interpretations.

- Improved accuracy and reliability. The MDS 3.0 includes more valid assessment measures, clearer instructions, definitions of commonly misunderstood terms, and language consistent with other health care settings. Direct resident interview increases accuracy, especially for domains such as mood, cognition, pain, and preferences.

- Increased efficiency. In the national trial, the average user completed the MDS 3.0 in almost half the time required to complete to MDS 2.0 (62 versus 112 minutes). The tool has also been reformatted for ease of use, and certain questions have been deleted.

- Increased staff satisfaction. Nursing home staff participating in the national trial indicated the MDS 3.0 was more clinically relevant, accurate, and clear. Feedback about the direct interview items was also positive.

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Psychosocial Content Within the MDS 3.0

Certain sections within the MDS address residents' psychosocial status and, consequently, are particularly germane to social work.

Section C: Cognitive Patterns

The MDS 3.0 begins with the Brief Interview for Mental Status (BIMS), a direct resident interview that correlates highly with the Modified Mini-Mental Status (3MS) exam. Following completion of either the BIMS or the staff assessment for mental status, MDS 3.0 prompts staff to complete a brief standardized assessment for signs and symptoms of delirium.

Section D: Mood

The MDS 3.0 uses a 9-item resident mood interview, the Patient Health Questionnaire (PHQ-9©) (or, alternately, an observational version), that screens for symptoms of depression congruent with diagnostic criteria in the current *Diagnostic and Statistical Manual of Mental Disorders* (*DSM-IV-TR*) (American Psychiatric Association, 2000). The revised look-back period of 14 days is consistent with the minimum period for symptoms indicative of depressive episode in the *DSM-IV-TR*.

Section F: Preferences for Customary Routine and Activities

The revised MDS uses a research-based resident interview to assess the resident's preferences for routine and activities while she or he is in the nursing home. If the resident is unable to complete the interview, the MDS 3.0 directs staff to interview a family member or significant other about the resident's customary routine and activities. If neither interview is completed, staff evaluates the resident's preferences for activities and daily routine.

Section Q: Participation in Assessment and Goal Setting

In this section, nursing home staff interviews each resident (or the resident's significant other, guardian, or legally authorized representative) regarding her or his wishes and expectations related to discharge. Furthermore, the new Section Q prompts staff to follow through, in a systematic manner, to ensure that residents' goals for discharge to the community are addressed.

To fulfill the new Section Q requirements, each state must formally designate one or more local contact agencies (LCAs). Options for LCAs include Aging and Disability Resource Centers (ADRCs), Area Agencies on Aging (AAAs), Centers for Independent Living (CILs), Developmental Disabilities Administration (DDA), Money Follows the Person (MFP) programs, and Mental Health Administration (MHA). The LCA will follow up with each resident referred to discuss options. Nursing home and LCA staff have joint responsibility for collaboration and coordination related to resident discharge and transition planning activities.

It is worth noting that MDS 3.0 Section J, which addresses health conditions, also includes a resident interview to assess pain.

Implications for Social Work

The advent of the MDS 3.0 presents important considerations for the social work profession.

Increased emphasis on person-centered care

One of CMS's primary goals in revising the MDS is to help move the field toward person-centered care, thereby enhancing both quality of care and quality of life for nursing home residents (CMS, 2009; Saliba & Buchanan, 2008). The incorporation of direct resident interviews and enhanced content addressing discharge and transition planning reflect this goal. With its ecological framework (Gitterman & Germain, 2008), strengths perspective, ethical grounding in advocacy and self-determination (NASW, 2008), and expertise in interviewing and psychosocial assessment, the social work profession is well prepared to lead nursing homes in the shift toward resident-centered care (Krugh, 2003).

Need for additional social work involvement in MDS testing

Social workers participated in the development and testing of the MDS 3.0 in multiple ways. They had the opportunity to offer written comments on the draft MDS 3.0 in April 2003 and to participate by phone or in person at a town hall meeting in June 2003. A master's-level social worker served as CMS's project officer for MDS 3.0 national testing; others provided technical and content expertise in various advisory panels (Saliba & Buchanan, 2008). An interdisciplinary team, which included a social worker, developed and pilot tested revisions to MDS 3.0 prior to national testing (Saliba, personal communication, June 29, 2010). The extent of social work involvement in the national trial is unknown, however. For the national test, RNs were trained and served as both facility-based data collectors and research comparison professionals (Saliba & Buchanan), in keeping with the federal requirement for RNs to coordinate the resident assessment process.[1] Participating facility nurses had the option of training other members of the interdisciplinary team (IDT) to collect resident data for the trial. Review of time sheets revealed that some facilities elected to have different IDT members complete various sections; however, data regarding the extent of social work

participation in the trial are not available (Saliba, personal communication).

Consistent social work participation in the national trial would have provided valuable information about the psychosocial sections of the MDS 3.0. Future research demonstrating the nursing home social work role in completing the MDS 3.0 may help make the case for enhanced social work involvement in future revisions to the MDS and for the social work role in nursing homes.

Need for professional social work services in nursing homes

NASW's policy statement on long-term care (2009b) calls for access to "qualified, professional social work services" throughout the long-term care spectrum (p. 226). The *NASW Standards for Social Work Services in Long-Term Care Facilities* (2003) define the educational preparation for a social worker as a bachelor's or advanced degree in social work. In contrast, federal regulations define a *qualified* social worker as someone with either "a bachelor's degree in social work or a bachelor's degree in a human services field including but not limited to sociology, special education, rehabilitation counseling, and psychology" (42CFR483.15). Some state requirements are even weaker than federal regulations (Bern-Klug, 2008). Such regulations represent a growing trend toward the deprofessionalization of social work; increasingly, persons providing social services lack social work values, knowledge, and skills (NASW, 2009a).

Although such deprofessionalization is a long-standing problem in nursing home social work,[2] it assumes new urgency with the introduction of MDS 3.0. All BSWs and MSWs, regardless of specialization, receive training in interviewing and psychosocial assessment, care planning, and intervention. As such, degreed social workers possess the knowledge and skills to conduct resident interviews (although they may require training to learn how to use PHQ-9 or other tools required in MDS 3.0) and to determine when residents' responses warrant additional evaluation and services. On the other hand, social service staff members who lack social work education may not be adequately prepared to identify and address psychosocial issues (Bern-Klug et al., 2009).

Need for increased social work staffing in nursing homes

Practitioners, researchers, and policy-makers have raised the question of caseload manageability for nursing home social service staff long before MDS 3.0. An investigation by the Office of the Inspector General (OIG) found that more than one-third of nursing home residents with identified psychosocial needs had inadequate care plans, and almost half of those with care plans did not receive all planned services (Department of Health and Human Services [DHHS], 2003). Moreover, although almost all facilities reviewed complied with or exceeded federal staffing regulations, 45% of social services staff reported that barriers such as lack of time, burdensome paperwork, and insufficient staffing decreased their ability to provide comprehensive psychosocial services (DHHS).[3]

The national trial showed MDS 3.0 took much less time to complete than MDS 2.0 (Saliba & Buchanan, 2008). However, some social workers in the field believe the new psychosocial requirements will increase their workload and affect the quality of psychosocial services—a perception verbalized in professionally facilitated focus groups of nursing home administrators and social services staff (Connolly, Downes, Fogler, & Reuter, 2010). With the incorporation of resident interviews and more reliable, valid assessment measures, MDS 3.0 may identify more depression and other psychosocial needs in nursing home residents.[4] Responding to those needs, whether through direct intervention or external referral for clinical mental health services, is generally the responsibility of nursing home social workers.[5] Preparing for and implementing the Section Q transition-planning requirements may also require additional social work staff time.

Need for stronger linkages between nursing homes and community-based organizations

Facilitating transitions for long-term residents requires a robust network of relationships and resources. Nursing home social workers and community-based social workers may need to develop new relationships or strengthen existing ones. Shared social work values of advocacy and self-determination can aid social workers from different settings in working through potential differences in perception regarding residents' ability to live in the community. Although mistrust may exist between some nursing homes and community organizations, social workers across settings can affirm, to colleagues and clients alike, the value of the entire long-term care continuum. Consistent, well-planned communication among all parties will be essential to prevent role ambiguity and lack of care coordination. Ombudsmen, many of whom are social workers, will continue to play an important role in advocating for residents' rights and choices.

Comprehensive long-term services and supports are essential to the safety and well-being of individuals who transition from a nursing home to the community. Such services and supports include, but are not limited to, accessible, affordable housing and transportation; home modifications and durable medical equipment; psychosocial resources, including mental and behavioral health services; assistance with personal care and instrumental activities of

daily living; medical care; and financial assistance. Three states participating in a pilot test of Section Q faced difficulties in transitions because of gaps in addiction, mental health, and housing services; limited operating hours for home health agencies; and funding cuts affecting in-home supply services, living accommodations deposits, and personal care services (Milne, 2010). States participating in the MFP Rebalancing Demonstration may use MFP grant funds for transition planning and implementation; as of June 2010, however, only 30 states currently participate in the program. Moreover, MFP only serves people with Medicaid. Individuals who do not qualify for Medicaid may receive information regarding resources and eligibility from AAAs, ADRCs, and CILs, but funding from those sources for transition planning and implementation may be limited.

Many nursing home residents may also need one or more family caregivers to help coordinate or provide care and services in the community. Family caregivers, fearing resource shortages and increased caregiving burden, may be concerned about residents moving back into the community. Both nursing home and community-based social workers can play a role in developing sustainable transition plans by mediating family discussions and helping family caregivers assess their own needs and resources.

Conclusion

The introduction of the revised MDS presents both opportunities and challenges to social workers in nursing homes and community-based settings. The shift toward person-centered care complements social work values and training, underscoring the need for professional social work services in nursing homes. By taking a leadership role in resident interviews and care planning addressing cognition, mood, activities and preferences, and transition planning, professional social workers may strengthen their role on the interdisciplinary team—and in subsequent revisions to the MDS. At the same time, the additional time anticipated to meet MDS 3.0 requirements could bring to the fore the question of appropriate staffing ratios for nursing home social services. Social workers in both nursing homes and community-based settings will play critical roles in helping nursing home residents who wish to return to the community in making those transitions.

Resources

CMS information

MDS 3.0 home page: www.cms.gov/NursingHomeQualityInits/25_NHQIMDS30.asp#TopOfPage

April 2010 Section Q conference materials: http://taformfp.com/training.aspx?id=1910

Other MDS 3.0 training opportunities

NASW-approved continuing education programs: www.socialworkers.org/ce

American Association of Homes and Services for the Aging: www.aahsa.org

American Health Care Association: www.ahca.org

Transition planning and implementation resources

Administration on Aging: www.aoa.gov

Aging and Disability Resource Centers: www.aoa.gov/AoARoot/AoA_Programs/HCLTC/ADRC/index.aspx

Area Agencies on Aging: www.eldercare.gov

Assistive technology—nationally funded programs: http://resna.org/resnaresources/at-act-programs

Centers for Independent Living (for individuals with disabilities)—state directory: www.ilru.org/html/publications/directory/index.html

Clearinghouse for Home and Community-Based Services: www.hcbs.org

Money Follows the Person: www.cms.gov/CommunityServices/20_MFP.asp and http://taformfp.com

National Association of State Medicaid Directors: www.nasmd.org

National Council on Aging Benefits CheckUp: www.benefitscheckup.org

National Transitions of Care Coalition: www.ntocc.org

State Health Insurance and Assistance Programs (for Medicare beneficiaries): www.cms.gov/partnerships/10_SHIPS.asp

Consumer advocacy organizations

National Association of State Long-Term Care Ombudsman Programs: www.nasop.org

National Long-Term Care Ombudsman Resource Center: www.ltcombudsman.org

The National Consumer Voice for Quality Long-Term Care: www.theconsumervoice.org

Social work resources

NASW Code of Ethics: www.socialworkers.org/pubs/code/default.asp

NASW Standards for Social Work Services in Long-Term Care Facilities: www.socialworkers.org/practice/standards/NASWLongTermStandards.pdf

Resource Page for Nursing Home Social Workers: www.uiowa.edu/~socialwk/NursingHomeResource/index.html

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1 Federal regulation stipulates that registered nurses (RNs) "conduct or coordinate each assessment *with the appropriate participation of health professionals* [italics added]" (42CFR483.20(h)).

2 See, for example, Bern-Klug et al.'s 2009 article describing the qualifications of nursing home social service directors (as reported in a national survey) and Simons's 2006 study of the relationship between social service director qualifications and psychosocial deficiencies incurred in nursing homes.

3 See also studies by Bonifas (2008) and Zhang, Gammonley, Paek, and Frahm (2008), which demonstrate a relationship between high caseload size and the likelihood of a deficiency in medically related social services, and Bern-Klug, Kramer, Sharr, and Cruz's 2010 study of nursing home social service directors' perceptions of manageable caseloads.

4 According to Saliba and Buchanan (2008), "Staff and family observations of depressed mood and pain significantly *underestimate* the presence of these treatable conditions" (p. 4).

5 Although clinical social workers are qualified to provide mental health services, nursing home social work staff with clinical licenses may not have the time or flexibility to carry out this role. The exclusion of clinical social workers from Medicare Part A billing presents a significant barrier to mental health services in skilled nursing facilities. NASW continues to advocate for legislation (*Clinical Social Work Medicare Equity Act*, S. 687) to address this problem.