

News Currents

In Brief

SNFs Take \$990 Million Hit In 2009 Budget

Plan Includes Freeze In Market Basket

President Bush recently unveiled a \$3.1 trillion budget proposal that would drain more than \$990 million from Medicare skilled nursing facility (SNF) funding in fiscal year 2009 if enacted by Congress. The proposal, released on Feb. 4, includes a zero market basket update for three years (2009 to 2011), followed by a negative 0.65 percent cut in 2012 and 2013, in addition to a four-year phase-out of Medicare allowable bad debt reimbursement.

Total savings from the bad debt reimbursement phase-out would reach nearly \$8.5 billion over five years across all settings, the Office of Management and Budget (OMB) estimates, while SNFs would face annual cuts of nearly \$200 million if all reimbursement for bad debt were eliminated, according to the American Health Care Association (AHCA).

This figure, AHCA says, could climb as high as \$400 million if more states fail to pay copayments for dually eligible nursing facility patients. However, it must be enacted by Congress in order to take effect.

The five-year impact of the SNF market basket cuts would amount to more than 9 percent (\$17 billion) of all Medicare cuts over five years (\$180 billion), according to OMB.

Another significant item under the

president's plan is a proposal to revive the Survey & Certification Revisit User Fee program under the Centers for Medicare & Medicaid Services (CMS). The fees, however, cannot be imposed until authorizing legislation is enacted by Congress, in which case, SNFs requiring a revisit survey based on a deficiency citation during initial certification, recertification, or a substantiated complaint survey could be charged a fee for the event.

Although AHCA's preliminary analysis of the budget indicates no direct Medicaid funding cuts for long term care, several relevant programs are slated for

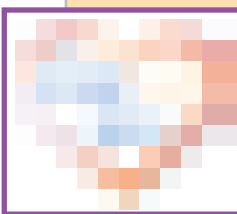
cutbacks.

Under the proposal, the option for states to increase the long term care equity limit for Medicaid eligibility, from \$500,000 to \$750,000, would be eliminated and held at \$500,000. Beginning in 2011, however, this limit would be subject to the Consumer Price Index.

AHCA rebuffed the president's proposal as "unreasonable from the standpoint of seniors' Medicare-financed nursing facility care and unrealistic in the face of worsening economic conditions in states across the nation—which will surely squeeze state Medicaid budgets."

National Nursing Home Week Announced

The American Health Care Association (AHCA) recently announced the theme of its 2008 National Nursing Home Week observance: "Love is Ageless." Established by AHCA in 1967, National Nursing Home Week will be celebrated nationwide beginning Mother's Day, May 11, 2008, and continuing through May 17.



This event is an opportunity for the profession and individual nursing facilities to bring into focus the residents

who mean so much to the community and their families, says AHCA, as well as caregivers who give so much of themselves to help those less able to do so.

AHCA will produce a National Nursing Home Week kit consisting of an event planning guide, promotional products for the observance, a presidential proclamation, and other useful items for nursing facility staff.

—Meg LaPorte

In a statement, AHCA President and Chief Executive Officer Bruce Yarwood decried the plan, describing it as "the most unreasonable and unrealistic of President Bush's entire tenure in the White House."

"Through both the elimination of patients' badly needed Medicare market basket update and through what amounts to a back-door attempt to cut Medicare funding through regulation, the president's budget represents a double-whammy hit on funding vital to ensure the continued provision of quality care," he said.

—Meg LaPorte

Reform Calls For Shared Responsibility

Funding Plan Would Relieve Overburdened Programs

Long term care financing would be restructured and bolstered by new streams of private funding under a reform plan proposed by the American Health Care Association (AHCA), the National Center for Assisted Living, and the Alliance for Quality Nursing Home Care.

The organizations have designed a funding model aimed at relieving overburdened public programs and ensuring that the nation's long term care infrastructure is prepared to meet the financing and service needs of aging baby boomers. The enormous generation is expected to drive health care costs up sharply for the next 50 years, heaping financial pressure on already strained public long term care programs. "A strong, viable solution is needed," the groups said in their joint proposal.

The centerpiece of the plan is a fed-



Yarwood addresses news conference.

erally funded catastrophic long term care program that would be open to all Medicare beneficiaries who chose to

participate. The program would offer a wide array of benefits: cash for community-based services, direct payment of nursing or assisted living facility care, or enrollment in a Medicare Advantage plan that offers long term care services.

To qualify, beneficiaries would have to finance front-end long term care costs through a private insurance plan, pre-tax savings account, or reverse mortgage. Beneficiaries with average incomes would have to plan coverage for \$100,000 worth of benefits. Wealthier beneficiaries would have to meet a higher threshold, while those with few assets and incomes below 150 percent of the federal poverty level would be exempt from the so-called "personal responsibility requirement."

The federal catastrophic program would not be tapped until an individual's private benefits were exhausted.

Stock Check

PROVIDERS	Symbol	Where Traded	% Current Price 1/31/08	Adjusted P/E Ratio	Change From 1/1/08	52-Week Range High	52-Week Range Low	PROVIDERS	Symbol	Where Traded	% Current Price 1/31/08	Adjusted P/E Ratio	Change From 1/1/08	52-Week Range High	52-Week Range Low
Skilled Nursing								REITS							
Advocat	AVCA	NASDAQ	\$11.74	7.1	7%	\$17.69	\$9.25	Care Investment Trust*	CRE	NYSE	\$10.79	6.3%	0%	\$14.80	\$9.40
Ensign Group	ENSG	NASDAQ	\$9.81	7.7	-32%	\$16.65	\$9.62	Health Care Property Investors	HCP	NYSE	\$30.37	5.9%	-13%	\$42.11	\$25.11
Kindred Healthcare	KND	NYSE	\$27.54	11.4	10%	\$28.74	\$17.35	Health Care REIT	HCN	NYSE	\$42.82	6.2%	-4%	\$48.55	\$35.08
National HealthCare	NHC	AMEX	\$50.11	6.8	-3%	\$57.50	\$46.75	Healthcare Realty Trust	HR	NYSE	\$25.83	6.0%	2%	\$44.19	\$18.00
Skilled Healthcare Group	SKH	NASDAQ	\$13.90	9.6	-5%	\$16.81	\$12.98	LTC Properties	LTC	NYSE	\$26.04	6.0%	4%	\$29.25	\$19.02
Sun Healthcare Group	SUNH	NASDAQ	\$17.23	10.3	0%	\$18.78	\$11.86	National Health Investors	NHI	NYSE	\$29.56	6.8%	6%	\$35.54	\$27.00
Assisted/Independent Living								Nationwide Health Properties							
Assisted Living Concepts	ALC	NYSE	\$6.59	10.4	-12%	\$13.18	\$6.00	NHP	NYSE	\$31.56	5.6%	1%	\$35.01	\$22.63	
Brookdale Senior Living	BKD	NYSE	\$22.28	12.6	-22%	\$49.94	\$20.46	Omega Healthcare	OHI	NYSE	\$16.35	7.1%	2%	\$19.17	\$12.00
Capital Senior Living	CSU	NYSE	\$7.66	11.3	-23%	\$12.22	\$6.32	Senior Housing Properties Trust	SNH	NYSE	\$22.39	6.3%	-1%	\$26.83	\$16.22
Emeritus Assisted Living	ESC	AMEX	\$22.15	16.8	-12%	\$39.40	\$19.99	Universal Health Realty	UHT	NYSE	\$36.05	6.4%	2%	\$42.05	\$28.23
Five Star Quality Care	FVE	AMEX	\$7.60	9.4	-8%	\$12.46	\$6.07	Ventas	VTR	NYSE	\$44.20	4.3%	-2%	\$47.97	\$26.50
Sunrise Senior Living	SRZ	NYSE	\$28.71	N/A	-6%	\$42.97	\$24.64								

Quotes courtesy of www.seniorcareinvestor.com, Norwalk, CT (203) 846-6800

*Care Investment Trust went public on June 22, 2007, selling 15 million shares at a price of \$15.00 per share. The 2007 percentage change is based on the IPO price, and the initial dividend of \$0.17 per share was paid to shareholders of record on Nov. 15, 2007.

The reforms would create a long term care system that offered “more comprehensive coverage, broader consumer options, and responsible use of government resources,” said Bruce Yarwood, president and chief executive officer of AHCA.

Dan Mendelson, president of Avalere Health, a Washington, D.C.-based research firm that worked with the groups to develop the funding model, said in a statement that the hybrid approach “accomplishes two critical tasks.” It offers protection “against the crush of paying for long term care” and draws “new funding streams into a system that is currently unsustainable.”

Mendelson said the successful implementation of Medicare’s prescription drug benefit has demonstrated the viability of a “carefully crafted” public-private partnership, in which consumers take some responsibility.

At a press briefing where the proposal was unveiled, Mendelson added that two-thirds of seniors are currently unable to pay for more than one year of nursing facility care, and 90 percent of people over age 55 have no protection for long term care expenses, which can exceed \$70,000 a year.

While the proposal would shift financing away from Medicaid, states would continue to make maintenance-of-effort contributions to the federal program, based on the amount they would otherwise have to pay for long term care services delivered to dually eligible beneficiaries.

Individuals who declined to accept and meet their personal responsibility requirement would be unable to participate in the federal catastrophic program. Instead, they would be limited to a stripped-down benefit plan and a requirement to spend down to the poverty level in the event that they

ever needed to access government-sponsored long term care services.

In addition to overhauling long term care financing, the groups’ proposal would revamp Medicare reimbursement for post-acute care services. The plan calls for development of a uniform assessment tool that would be used across settings to make discharge decisions, identify the best site for a patient’s care, create a care plan, develop quality indicators, and calculate payment. A site-neutral prospective payment system for post-acute care would also be developed.

Reimbursement would be based on an individual’s needs, clinical condition, and characteristics.

AHCA’s Yarwood said he hoped the proposal would stimulate debate on the presidential campaign trail and draw national attention to the “little-appreciated crisis” in long term care.

—Lynn Wagner

LTC Staff Should Be In Top Tier For Pandemic Vaccine: AHCA

Direct care staff in long term care facilities should be at the head of the line for pandemic influenza vaccine in the event of an outbreak, the American Health Care Association (AHCA) said in comments on a draft version of Department of Health and Human Services (HHS) guidance for distributing the nation’s scarce vaccine supply.

The guidance puts long term care staff in the top tier of recipients, but only allows 25 percent of facility staff into that high-priority category.

AHCA is urging HHS to ensure that all direct care and support staff in long term care settings—including nursing facilities, assisted living communities, and homes for people with developmental disabilities—are given priority status.

Healthy staff would be critical to maintaining the long term care infra-

structure and preventing widespread illness and death in those settings, said Janice Zalen, AHCA’s senior director of special programs, in a Jan. 18 letter to John Agwunobi, assistant secretary for health at HHS.

“More than 90 percent of all deaths from influenza occur in the elderly, with residents of long term care facilities particularly at risk,” Zalen said. Furthermore, nursing facilities would be designated as surge sites for hospitals. To keep long term care facilities operating and able to care for their own residents, as well as incoming hospital patients, it would be essential to maintain a healthy workforce, Zalen said.

“Twenty-five percent of our direct care staff would not even begin to allow us to maintain a proper work-

force and long term care infrastructure,” said AHCA President and Chief Executive Officer Bruce Yarwood, in another letter submitted to HHS on the vaccine guidance.

Citing recent public comments made by Ben Schwartz, MD, from the Centers for Disease Control and Prevention, that the mortality rate for the elderly population in an influenza pandemic is likely to be 11 times higher than the general population, Yarwood said, “the need for vaccinating more of our workers becomes even clearer.” Staff must be vaccinated “both as a protection to the residents and so that there is a full workforce to take care of what could be a very, very ill population,” Yarwood said.



Assisted Living Tackles Medication

Comprehensive Recommendations Formulated

Medication use among residents of assisted living facilities has reached critical mass, according to the nearly 80 assisted living providers, advocates, consumers, researchers, and policy experts who gathered recently in Washington, D.C., for a day-long symposium on the issue.

Recent research shows that assisted living residents now utilize medications at nearly the same rate as nursing facility residents—a fact that is not surprising given the rising acuity level within the sector. The critical nature of this revelation, coupled with the fact that regulatory oversight of assisted living varies from state to state, prompted the Center for Excellence in Assisted Living (CEAL) to sponsor the Jan. 31 symposium.

David Kyllo, executive director of the National Center for Assisted Living (NCAL) and current CEAL chair, laid the groundwork for lively discussion of the issues by noting the results of a recent informal poll that revealed some of the most pressing challenges assisted living facilities face with regard to medication management: difficulty reaching physicians and nurse practitioners (NPs), timely delivery of medications, and appropriately trained staff.

Also playing an active role in the discussions was NCAL Chair Howard Groff, president of Tealwood Care Centers, Bloomington, Minn., who moderated a panel discussion on dis-

pensing, administration, and prescribing of medications.

The results of a separate medication management research study, conducted by Susan Reinhard, MSN, director of the AARP Public Policy Institute, revealed that more than 77 percent of the residents needed assistance with

In addition, the average error among all of the facilities was nearly 30 percent, although none of the errors were highly likely to cause severe harm, said Reinhard. Indeed, the majority of errors (71.3 percent) entailed administering the medications at the wrong time.

As Reinhard pointed out, however, passing medications in the facility-mandated time frame revealed a larger issue of a deficiency in person-centered care delivery. “The prescriber doesn’t care what time the resident receives the medication; it’s usually the facility that makes that decision,” she said. “This doesn’t make sense from a person-centered point of view.”

Reinhard also observed that the presence of physicians and NPs on site made a difference in the appropriateness of medications, resident assessments, problem solving, and overall health management of the residents.

NCAL board members Deb Choma, RN, and Pat Giorgio provided their perspectives on a panel discussion that focused on the training of medication assistants. When asked to identify the most important components of training for such

aides, the panelists emphasized proper charting and documentation, medical terminology, and pharmacology, as well as the value of recognizing staff as an integral part of the medication team.

Choma, who is a nurse administrator and trainer, noted that she provides ➤



Top: CEAL Chair Kyllo (l.) with CEAL’s Karen Love and RN Josh Allen. Bottom: NCAL Chair Howard Groff.

medication. According to Reinhard, the study, which entailed the observation of medication administration processes within 15 facilities in four states, showed that the residents took an average of 13 total medications, with an average of 10 taken routinely and three PRN (as needed).

trainees with a “cheat sheet” containing medical and pharmacological terminology. “I also ask pharmacists to come in for an in-service with staff.”

Giorgio, president of Evergreen Estates in Cedar Rapids, Iowa, suggested that mistakes be used as learning opportunities. “In addition, staff should be trained to learn what’s normal and what’s not normal—so they know when they need to call for help.”

Much of the participants’ discussion centered on person-centered medication management—individualizing the administration and prescribing of medications to fit the lifestyle and health care needs of the residents.

Brandy Toivonen, a medication aide and memory care coordinator with Springridge Court in Wilsonville, Ore., noted that she strives hard for person-centered care in her community. “It boils down to really knowing the resident and discussing it with the family before admission,” she said.

Breaking down the key components of medication management, the group then hammered out proposals that address family and staff education, improved communication between physicians and staff, more rigorous training of medication assistants, and the identification of systems that foster reduced errors, preservation of func-

tionality, and access and availability. Additional recommendations included more consistent utilization of consultant pharmacists, streamlining pharmacies that serve facilities, standardization, and the introduction of a value proposition.

Recommendations aimed at improving and fostering evidence-based prescribing included educating residents and families about what information they should bring to their physicians, such as medications, the medication administration record, over-the-counter medications, and all replicable documents.

—Meg LaPorte

Hearing Mulls Polling Accessibility For Elderly Voters

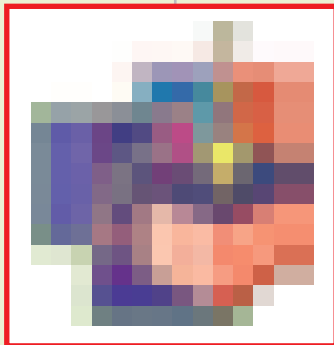
The fear of disenfranchising elderly citizens and those with disabilities from voting in the 2008 presidential election prompted some recent congressional activity, including a call by U.S. Sen. Herb Kohl

(D-Wis.) for a Government Accountability Office (GAO) investigation.

“If we do not remove the barriers that prevent elderly and disabled citizens from exercising their right to vote, then we are—for all intents and

purposes—disenfranchising them,” said Kohl during a recent hearing on older voters and the various barriers they face in exercising their right to vote.

Although the hearing focused specifically on states participating in the recent Super Tuesday (Feb. 5) primaries, it covered issues of poll accessibility, voting within long term care settings, and ongoing concerns that the voter identification law currently pending before the Supreme Court could disproportionately disenfranchise seniors.



“Older individuals as a whole represent a politically active group, particularly during primary elections, which typically attract a lower level of voter turnout,” said a statement from the

senator’s office, which noted that 45 percent of the Republican vote and 36 percent of the Democratic vote in the Nevada primary were comprised of those 60 years of age and older.

“There is no reason for states to fall down on the job of voter accessibility,” said

Kohl. “We know that innovative mechanisms exist to allow older and disabled Americans to vote regardless of their physical abilities.”

Sens. Kohl and Dianne Feinstein (D-Calif.) asked the Election Assistance Commission to conduct research on voting within long term care settings and develop voluntary guidelines to help states facilitate voting.

According to Kohl’s statement, of the 24 states that held primaries on Super Tuesday, only eight facilitate voting in long term care settings either

by setting up public polling locations on the premises, sending election officials into the center to assist seniors, or helping nursing facility administrators obtain absentee ballots in advance.

The other 16 states currently make no accommodations for voters living in a long term care setting, and long term care administrators are offered no direction from election officials as to how they should assist their residents with voting.

During the 2000 elections, GAO found that only 16 percent of polling sites surveyed nationwide were fully accessible to people with disabilities. “This has a real impact on older voters, because in spite of their tendency to be more engaged politically, older voters with a disability are 39 to 48 percent less likely to vote than their peers without a disability,” Kohl said.

Witnesses before the hearing addressed the committee about challenges with voter accessibility at the polls, the pros and cons of absentee balloting, laws currently in place to safeguard older voters and those with disabilities, and the need for stronger enforcement.

—Meg LaPorte

DD Provider Touts Remote Caregiving

AHCA Cites Need To Protect Funding For The Frail

Citing pervasive problems in disability services, including high turnover rates, low wages, worker shortages, and increased demand, Ralph Gronefeld Jr., president and chief executive officer of ResCare, Louisville, Ky., recently testified before a congressional subcommittee about wages and career opportunities for direct care workers who care for people with developmental and intellectual disabilities.

During a recent hearing on Medicaid's role in helping families of individuals with disabilities, Gronefeld asked the U.S. House of Representatives Energy and Commerce Committee Subcommittee on Health to "consider legislation to develop incentives, such as training programs and career advancement opportunities, which would enable

more people to enter this field," as well as changes to Department of Labor workforce rules.

Such pervasive problems are adversely affecting families and individuals receiving services and the people who provide those services, he said.

He suggested that the increasing costs of Medicaid services can be addressed by looking at the more than 200 different waiver programs currently in place in more than 50 states and finding the ones that provide the best outcomes for the least cost.

Gronefeld also touted the company's recent study of remote caregiving services. "We found that individuals who receive remote caregiving services show a greater satisfaction with the added independence they experience," he told the panel.

"In addition, savings can be realized

that would enable us to serve many more people for the same amount of money. The changes I'm suggesting today can ensure the safety, security, and independence for those we serve; simplify the system; standardize best practices; and attract committed dedicated caregivers."

The American Health Care Association (AHCA) weighed in on the hearing with a written statement affirming the importance of consumer choice in disability services. "We applaud ensuring choice in long term care and appreciate that it is recognized in [proposed legislation]; however, we have specific concerns with the legislation," said Bruce Yarwood, AHCA president and chief executive officer.

"We believe that in order to protect the care and preferences of all Americans, we must partner to develop solutions that protect funding for all Medicaid programs; ensure choice of a broad range of settings, including nursing facilities and intermediate care facilities; and do not inappropriately limit state options."

Yarwood's statement emphasized the importance of consumer choice in long term care, "particularly preferences regarding whether care and services are provided within one's home, community, or a long term care facility. We firmly back efforts in which care is available in the most appropriate, least-restrictive setting for an individual's needs and preferences," he said.

"Therefore, we wish to ensure that critical funding will not be diverted from optional Medicaid programs and that choice is not limited for individuals with profound and severe mental retardation, who may require a higher level of specialized care."

—Meg LaPorte

By The Numbers



Results are ranked by average scores and correlations with workplace recommendation.

Source: 2006 National Survey of Nursing Home Workforce Satisfaction by My InnerView Inc.

Ice Storm Tests Emergency Plan

Staff Step Up To Protect Residents During Move

Assisted living residences in Kansas were able to test their emergency preparedness plans when ice storms hit, cutting off the power supply and causing a few residences to evacuate.

In Topeka and Manhattan, Kan., two Midwest Health assisted living residences were on standby for the call to begin the evacuation from Vice President of Operations Joe Perkin. While Perkin was working the phones obtaining up-to-date weather information, the power to the Manhattan building went out.

The staff swung into action, notifying family members to see if they wanted to pick up residents and planning the evacuation of the remaining residents.

While Midwest Health emergency preparedness plans were working, Perkin struggled to get an answer from the power company about when power would be restored.

Perkin made the decision to evacuate. The Manhattan, Kan., assisted living residence did not have a generator. Evacuation meant relocating the residents to a nearby sister skilled nursing facility, which had a generator.

The residence's staff had full knowledge of the emergency plan procedures, and extra staff were on hand to help. They went through checklists of things to do, which included collecting a couple days' worth of each resident's clothing, extra medication, and administrative and medical records.

Perkin says they contacted the county's local emergency preparedness office, and it delivered extra cots to Midwest's facility.

Midwest Health owns its own buses with wheelchair ramps, and the drivers were onsite after being notified by the company. As residents boarded the



buses, employees made sure they were kept warm with extra blankets and coats. Staff accompanied them on the bus ride to make sure their trip was as

comfortable as possible. By 8 p.m., the residents were settled into their temporary quarters. After getting the residents situated in Manhattan, Perkin received the call that the power in the assisted living center was back on.

No residents were harmed during the evacuation or on the return trip. "The main thing that came out of this experience for me was how wonderfully our staff responded," Perkins says. "They were there within a moment's notice and stayed until everything was done."

—Kathleen Lourde

4,000 SNFs Targeted For Improvement

A list of 4,000 nursing facilities identified as "targeted for improvement" was released publicly and posted on the Centers for Medicare & Medicaid Services (CMS) Web site on Feb. 5, 2008, leading to widespread negative media coverage and confusion about how the list was compiled. CMS claims that the list, which is more than 90 pages in length and includes the name and location of each facility, was published as part of a patient safety initiative that requires quality improvement organizations to "offer help to specific nursing homes and hospitals that have not recently performed well on important quality measures."

The facilities on the list were identified using the following publicly reported measures and formulas:

- *High-risk pressure ulcers*: facilities with at least two of the most recent three quarters of data showing results of 14 or more percentage points away from the goal of 6 percent.

- *Physical restraints*: facilities with at least two of the most recent three

quarters of data showing results of 8 or more percentage points away from the goal of 3 percent.

Responding to concerns about negative publicity surrounding the list, Barry Straube, CMS acting chief medical officer, noted that the measures "are just two of several...that have been reported on nursing homes...publicly for a number of years." He further contended that the agency "is not targeting them as bad facilities," adding that "many, if not most, are exceedingly good facilities—the list should not be construed as bad nursing homes," he said.

In related news, CMS at press time announced the release of a list of more than 128 facilities that the agency described as demonstrating "failure to maintain compliance." Although a shorter list was first released last November as part of CMS' Special Focus Facilities initiative, the most recent iteration is a comprehensive and updated version, the agency says.

—Meg LaPorte

MDS 3.0 Completion Involves Patient Interviews

The latest draft of the minimum data set (MDS) 3.0 incorporates direct interviews with residents to assess their cognition, mood, preferences for daily routines and activities,

and pain. According to the Centers for Medicare & Medicaid Services (CMS), the interviews comprise the most significant advance in the MDS revision, giving residents a voice in their own assessment process and reflecting the essence of what it means to provide

resident-centered care. “Respect for the individual resident is fundamental to high-quality care and resident quality of life,” the agency said. “One of the best ways of conveying this respect is to directly ask the resident about how he or she feels and about his or her preferences.”

Each of the interviews has an alternate staff-driven assessment, as a contingency for residents who are unable to participate in the interview format. Staff are instructed, however, to first attempt a direct resident interview.

In a section on mood, the interviewer walks residents through a list of nine possible mood disorders, ranging from “little interest or pleasure in doing things,” to “thoughts that you would be better off dead, or hurting yourself in some way.” The assessor asks whether the resident has experienced each symptom over the past two weeks and if so with what frequency.

Similarly, the section on daily routines and activities asks residents to rate the importance of certain routines, such as making clothing choices, choosing whether to take a shower or bath, having snacks available between meals, and having the option to stay up past 8:00 p.m. at night.

The interview also addresses the importance of specific activities, including having a variety of reading material, listening to music, having pets around, going outdoors, and doing things with groups of people. If a resident is unable to respond, this interview shifts to a family member or significant other.

A fourth interview asks residents if they are experiencing pain, the frequency and intensity of pain, and its effect on their ability to function.

In addition to the interviews, MDS 3.0 changes include revised and updated clinical content in many areas to create “more valid measures of the condition,” CMS said.

—Lynn Wagner