

CMS ACKNOWLEDGEMENTS 2010 EDITION

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American Health Care Association
American Health Information Management Association
American Hospital Association
American Medical Directors Association
American Nurses Association
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Questions regarding information presented in this Manual should be directed to your State's RAI Coordinator. Please continue to check our web site for more information at www.cms.gov/NursingHomeQualityInits/25_NHQIMDS30.asp.

CHAPTER 1: RESIDENT ASSESSMENT INSTRUMENT (RAI)

1.1 Overview

The purpose of this manual is to offer clear guidance about how to use the Resident Assessment Instrument (RAI) correctly and effectively to help provide appropriate care. Providing care to residents with post-hospital and long-term care needs is complex and challenging work. Clinical competence, observational, interviewing and critical thinking skills, and assessment expertise from all disciplines are required to develop individualized care plans. The RAI helps nursing home staff gather definitive information on a resident's strengths and needs, which must be addressed in an individualized care plan. It also assists staff with evaluating goal achievement and revising care plans accordingly by enabling the nursing home to track changes in the resident's status. As the process of problem identification is integrated with sound clinical interventions, the care plan becomes each resident's unique path toward achieving or maintaining his or her highest practical level of well-being.

The RAI helps nursing home staff look at residents holistically—as individuals for whom quality of life and quality of care are mutually significant and necessary. Interdisciplinary use of the RAI promotes this emphasis on quality of care and quality of life. Nursing homes have found that involving disciplines such as dietary, social work, physical therapy, occupational therapy, speech language pathology, pharmacy, and activities in the RAI process has fostered a more holistic approach to resident care and strengthened team communication. This interdisciplinary process also helps to support the spheres of influence on the resident's experience of care, including: workplace practices, the nursing home's cultural and physical environment, staff satisfaction, clinical and care practice delivery, shared leadership, family and community relationships, and Federal/State/local government regulations.

Persons generally enter a nursing home because of problems with functional status caused by physical deterioration, cognitive decline, the onset or exacerbation of an acute illness or condition, or other related factors. Sometimes, the individual's ability to manage independently has been limited to the extent that skilled nursing, medical treatment, and/or rehabilitation is needed for the resident to maintain and/or restore function or to live safely from day to day. While we recognize that there are often unavoidable declines, particularly in the last stages of life, all necessary resources and disciplines must be used to ensure that residents achieve the highest level of functioning possible (quality of care) and maintain their sense of individuality (quality of life). This is true for both long-term residents and residents in a rehabilitative program anticipating return to their previous environment or another environment of their choice.

1.2 Content of the RAI for Nursing Homes

The RAI consists of three basic components: The Minimum Data Set (MDS) Version 3.0, the Care Area Assessment (CAA) process and the RAI utilization guidelines. The utilization of the three components of the RAI yields information about a resident's functional status, strengths, weaknesses, and preferences, as well as offering guidance on further assessment once problems have been identified. Each component flows naturally into the next as follows:

- **Minimum Data Set.** A core set of screening, clinical, and functional status elements, including common definitions and coding categories, which forms the foundation of a comprehensive assessment for all residents of nursing homes certified to participate in Medicare or Medicaid. The items in the MDS standardize communication about resident problems and conditions within nursing homes, between nursing homes, and between nursing homes and outside agencies. The required subsets of data items for each MDS assessment and tracking document (e.g., admission, quarterly, annual, significant change, discharge, entry, etc) can be found in Appendix H.
- **Care Area Assessment Process.** This process is designed to assist the assessor to systematically interpret the information recorded on the MDS. Once a care area has been triggered, nursing home providers use current, evidence-based clinical resources to conduct an assessment of the potential problem and determine whether or not to care plan for it. The CAA process helps the clinician to focus on key issues identified during the assessment process so that decisions as to whether and how to intervene can be explored with the resident. The CAA process is explained in detail in Chapter 4. Specific components of the CAA process include:
 - **Care Area Triggers (CATs)** are specific resident responses for one or a combination of MDS elements. The triggers identify residents who have or are at risk for developing specific functional problems and require further assessment.
 - **CAA Resources** are a list of resources that may be helpful in performing the assessment of a triggered care area. These resources are included in Appendix C and represent neither an all-inclusive list nor government endorsement.
 - **CAA Summary (Section V of the MDS 3.0)** provides a location for documentation of the care area(s) that have triggered from the MDS and the decisions made during the CAA process regarding whether or not to proceed to care planning.
- **Utilization Guidelines.** The Utilization Guidelines provide instructions for when and how to use the RAI. These include instructions for completion of the RAI as well as structured frameworks for synthesizing MDS and other clinical information (available from http://cms.gov/manuals/Downloads/som107ap_pp_guidelines_ltcf.pdf).

1.3 Completion of the RAI

Over time, the various uses of the MDS have expanded. While its primary purpose as an assessment tool is used to identify resident care problems that are addressed in an individualized care plan, data collected from MDS assessments is also used for the Medicare reimbursement system, many State Medicaid reimbursement systems, and monitoring the quality of care provided to nursing home residents. The MDS instrument has also been adapted for the hospital swing bed program. Swing bed providers are required to complete the MDS for reimbursement under the Skilled Nursing Facility Prospective Payment System (SNF PPS).

- **Medicare and Medicaid Payment Systems.** The MDS contains items that reflect the acuity level of the resident, including diagnoses, treatments, and an evaluation of the resident's functional status. The MDS is used as a data collection tool to classify Medicare residents into RUGs. The RUG classification system is used in the PPS for skilled nursing facilities, hospital swing bed programs, and in many State Medicaid case mix payment systems to group residents into similar resource usage categories for the

purposes of reimbursement. More detailed information on the SNF PPS is provided in Chapters 2 and 6. Please refer to the Medicare Internet-Only Manuals (www.cms.gov/Manuals/IOM/list.asp) for comprehensive information on SNF PPS, including but not limited to SNF coverage, SNF policies, and claims processing.

- **Monitoring the Quality of Care.** MDS assessment data are also used to monitor the quality of care in the nation's nursing homes. MDS-based quality indicators (QIs) and quality measures (QMs) were developed by researchers to assist: (1) State Survey and Certification staff in identifying potential care problems in a nursing home; (2) nursing home providers with quality improvement activities/efforts; (3) nursing home consumers in understanding the quality of care provided by a nursing home; and (4) CMS with long-term quality monitoring and program planning. CMS continuously evaluates the usefulness of the QI/QMs which may be modified in the future to enhance their effectiveness.
- **Consumer Access to Nursing Home Information.** Consumers are also able to access information about every Medicare- and Medicaid-certified nursing home in the country. The Nursing Home Compare tool (www.medicare.gov/nhcompare/home.asp) provides public access to nursing home characteristics, staffing and quality of care measures for certified nursing homes.

As such, while nursing homes have flexibility in completion of the RAI, some aspects of the process are dictated by regulation. Federal regulations at 42 CFR 483.20 (b)(1)(xviii), (g), and (h) require that (1) the assessment accurately reflects the resident's status, (2) a registered nurse conducts or coordinates each assessment with the appropriate participation of health professionals, and (3) the assessment process includes direct observation, as well as communication with the resident and direct care staff on all shifts. However, nursing homes are left to determine (1) who should participate in the assessment process, (2) how the assessment process is completed, and (3) how the assessment information is documented while remaining in compliance with the requirements of the Federal regulations and the instructions contained within this manual.

Given the requirements of participation of appropriate health professionals and direct care staff, completion of the RAI is best accomplished by an interdisciplinary team (IDT) that includes nursing home staff with varied clinical backgrounds, including nursing staff and the resident's physician. Such a team brings their combined experience and knowledge to the table in providing an understanding of the strengths, needs and preferences of a resident to ensure the best possible quality of care and quality of life. It is important to note that even nursing homes that have been granted a RN waiver under 42 CFR 483.30 (c) or (d) must provide a RN to conduct or coordinate the assessment.

In addition, an accurate assessment requires collecting information from multiple sources, some of which are mandated by regulations. Those sources must include the resident and direct care staff on all shifts, and should also include the resident's medical record, physician, and family, guardian, or significant other as appropriate or acceptable. It is important to note here that information obtained should cover the same observation period as specified by the MDS items on the assessment, and should be validated for accuracy (what the resident's actual status was during that observation period) by the IDT completing the assessment. As such, nursing homes

are responsible for ensuring that all participants in the assessment process have the requisite knowledge to complete an accurate assessment.

While CMS does not impose specific documentation procedures on nursing homes in completing the RAI, documentation that contributes to identification and communication of a resident's problems, needs, and strengths, that monitors their condition on an on-going basis, and that records treatment and response to treatment, is a matter of good clinical practice and an expectation of trained and licensed health care professionals. Good clinical practice is an expectation of CMS. As such, it is important to note that completion of the MDS does not remove a nursing home's responsibility to document a more detailed assessment of particular issues relevant for a resident. In addition, documentation must substantiate a resident's need for Part A SNF-level services and the response to those services for the Medicare PPS.

1.4 Problem Identification Using the RAI

Clinicians are generally taught a problem identification process as part of their professional education. For example, the nursing profession's problem identification model is called the nursing process, which consists of assessment, diagnosis, planning, implementation, and evaluation. All good problem identification models have similar steps to those of the nursing process.

The RAI simply provides a structured, standardized approach for applying a problem identification process in nursing homes. The RAI should not be, nor was it ever meant to be, an additional burden for nursing home staff.

The completion of the RAI can be conceptualized using the nursing process as follows:

- a. **Assessment**—Taking stock of all observations, information, and knowledge about a resident from all available sources (e.g., medical records, the resident, resident's family, and/or guardian or other legally authorized representative).
- b. **Decision Making**—Determining with the resident (resident's family and/or guardian or other legally authorized representative), the resident's physician and the interdisciplinary team, the severity, functional impact, and scope of a resident's problems. Decision making should be guided by a review of the assessment information and the CAA decision-making process. Understanding the causes and relationships between a resident's problems and discovering the "whats" and "whys" of resident's problems; finding out who the resident is and putting the needs, interests, and lifestyle choices of the resident at the center of care.
- c. **Care Planning**—Establishing a course of action with input from the resident (resident's family and/or guardian or other legally authorized representative), resident's physician and interdisciplinary team that moves a resident toward resident-specific goals utilizing individual resident strengths and interdisciplinary expertise; crafting the "how" of resident care.
- d. **Identification of Outcomes**—Determining the expected outcomes forms the basis for evaluating resident-specific goals and interventions to help residents achieve those goals. This also assists the interdisciplinary team in determining who needs to be involved to support the expected resident outcomes. Outcomes identification reinforces individualized care tenets by promoting residents' participation in the process.

- e. **Implementation**—Putting that course of action (specific interventions derived through interdisciplinary individualized care planning) into motion by staff knowledgeable about the resident's care goals and approaches; carrying out the “how” and “when” of resident care.
- f. **Evaluation**—Critically reviewing individualized care plan goals, interventions and implementation in terms of achieved resident outcomes and assessing the need to modify the care plan (i.e., change interventions) to adjust to changes in the resident's status, goals, or improvement or decline.

The following pathway illustrates a problem identification process flowing from MDS (and other assessments), to the CAA decision-making process, to care plan development, to care plan implementation, and finally to evaluation. This manual will feature this pathway throughout the chapter discussions.



If you look at the RAI process as solution oriented and dynamic, it becomes a richly practical means of helping nursing home staff gather and analyze information in order to improve a resident's quality of care and quality of life. The RAI offers a clear path toward using all members of the interdisciplinary team in a proactive process. There is absolutely no reason to insert the RAI process as an added task or view it as another “layer” of labor.

The key to understanding the RAI process and successfully using it is believing that its structure is designed to enhance resident care and promote the quality of a resident's life. This occurs not only because it follows an interdisciplinary problem-solving model, but also because staff (across all shifts), residents and families (and/or guardian or other legally authorized representative) are all involved in its “hands on” approach. The result is a process that flows smoothly and allows for good communication and tracking of resident care. In short, it works.

Since the RAI has been implemented, nursing home staff who have applied the RAI process in the manner we have discussed have discovered that it works in the following ways:

- **Residents Respond to Individualized Care.** While we will discuss other positive responses to the RAI below, there is none more persuasive or powerful than good resident outcomes both in terms of a resident's quality of care and quality of life. Nursing home providers have found that when care plans reflect careful consideration of individual problems and causes, linked with input from residents, residents' families (and/or guardian or other legally authorized representative), an interdisciplinary team, and appropriate resident-specific approaches to care, residents have experienced goal achievement and either the level of functioning has improved or has deteriorated at a slower rate. Nursing home staff report that, as individualized attention increases, resident satisfaction with quality of life also increases.
- **Staff Communication Has Become More Effective.** When staff members are involved in a resident's ongoing assessment and have input into the determination and development of a resident's care plan, the commitment to and the understanding of that care plan is enhanced. All levels of staff, including nursing assistants, have a stake in the

process. Knowledge gained from careful examination of possible causes and solutions of resident problems (i.e., from using the CATs) challenges staff to hone the professional skills of their discipline as well as focus on the individuality of the resident and holistically consider how that individuality must be accommodated in the care plan.

- **Resident and Family Involvement in Care Has Increased.** There has been a dramatic increase in the frequency and nature of resident and family involvement in the care planning process. Input has been provided on individual resident goals, needs, interests, strengths, problems, preferences, and lifestyle choices. When considering all of this information, staff members have a much better picture of the resident, and residents and families have a better understanding of the goals and processes of care.
- **Increased Clarity of Documentation.** When the approaches to achieving a specific goal are understood and distinct, the need for voluminous documentation diminishes. Likewise, when staff members are communicating effectively among themselves with respect to resident care, repetitive documentation is not necessary and contradictory notes do not occur. In addition, new staff, consultants, or others who review records have found that the increased clarity of the information documented about a resident makes tracking care and outcomes easier to accomplish.

The purpose of this manual is to offer clear guidance, through instruction and example, for the effective use of the RAI, and thereby help nursing home staff achieve the benefits listed above.

In keeping with objectives set forth in the Institute of Medicine (IOM) study completed in 1986 (Committee on Nursing Home Regulation, IOM) that made recommendations to improve the quality of care in nursing homes, the RAI provides each resident with a standardized, comprehensive and reproducible assessment. This tool assesses a resident's ability to perform daily life functions, identifies significant impairments in a resident's functional capacity, and provides opportunities for direct resident interview. In essence, with an accurate RAI completed periodically, caregivers have a genuine and consistent recorded "look" at the resident and can attend to that resident's needs with realistic goals in hand.

Furthermore, with the consistent application of item definitions, the RAI ensures standardized communication both within the nursing home and between facilities (e.g., other long-term care facilities or hospitals). Basically, when everyone is speaking the same language, the opportunity for misunderstanding or error is diminished considerably.

1.5 MDS 3.0

In response to changes in nursing home care, resident characteristics, advances in resident assessment methods, and provider and consumer concerns about the performance of the MDS 2.0, the Centers for Medicare & Medicaid Services (CMS) contracted with the RAND Corporation and Harvard University to draft revisions and nationally test the MDS Version 3.0. Following is a synopsis of the goals and key findings as reported in the *Development & Validation of a Revised Nursing Home Assessment Tool: MDS 3.0* final report (Saliba and Buchanan, 2008).

Goals

The goals of the MDS 3.0 revision are to introduce advances in assessment measures, increase the clinical relevance of items, improve the accuracy and validity of the tool, increase user satisfaction, and increase the resident's voice by introducing more resident interview items. Providers, consumers, and other technical experts in nursing home care requested that MDS 3.0 revisions focus on improving the tool's clinical utility, clarity, and accuracy. CMS also wanted to increase the usability of the instrument while maintaining the ability to use MDS data for quality indicators, quality measures, and payment (resource utilization groups [RUGs] classification).

In addition to improving the content and structure of the MDS, the RAND/Harvard team also aimed to improve user satisfaction. User attitudes are key determinants of quality improvement implementation. Negative user attitudes toward the MDS are often cited as a reason that nursing homes have not fully implemented the information from the MDS into targeted care planning.

Methods

To address many of the issues and challenges previously identified and to provide an empirical foundation for examining revisions to the MDS before they were implemented, the RAND/Harvard team engaged in a careful iterative process that incorporated provider and consumer input, expert consultation, scientific advances in clinical knowledge about screening and assessment, CMS experience, and intensive item development and testing by a national Veterans Health Administration (VHA) consortium. This process allowed the final national testing of MDS 3.0 to include well-developed and tested items.

The national validation and evaluation of the MDS 3.0 included 71 community nursing homes (3,822 residents) and 19 VHA nursing homes (764 residents), regionally distributed throughout the United States. The evaluation was designed to test and analyze inter-rater agreement (reliability) between gold-standard (research) nurses and between nursing home and gold-standard nurses, validity of key sections, response rates for interview items, anonymous feedback on changes from participating nurses, and time to complete the MDS assessment. In addition, the national test design allowed comparison of item distributions between MDS 3.0 and MDS 2.0 and thus facilitated mapping into payment cells (Saliba and Buchanan, 2008).

Key Findings for MDS 3.0

- Improved Resident Input
- Improved Accuracy and Reliability
- Increased Efficiency
- Improved Staff Satisfaction and Perception of Clinical Utility

Improvements incorporated in MDS 3.0 produce a more efficient assessment instrument: better quality information was obtained in less time. Such gains should improve identification of resident needs and enhance resident-focused care planning. In addition, inclusion of items recognized in other care settings is likely to enhance communication among providers. These significant gains reflect the cumulative effect of changes across the tool, including:

- use of more valid items,
- direct inclusion of resident reports, and
- improved clarity of retained items.

1.6 Components of the MDS

The MDS is completed for all residents in Medicare- or Medicaid-certified nursing homes. The mandated assessment schedule is discussed in Chapter 2. States may also establish additional MDS requirements. For specific information on State requirements, please contact your State RAI Coordinator (see Appendix B).

1.7 Layout of the RAI Manual

The layout of the RAI manual is as follows:

- Chapter 1: Resident Assessment Manual
- Chapter 2: Instructions and Schedule for Completing the Mandated Clinical and Medicare Assessments
- Chapter 3: Item-by-Item Guide to the MDS 3.0
- Chapter 4: Care Area Assessment (CAA) Process and Care Planning
- Chapter 5: Submission and Correction of the MDS Assessments
- Chapter 6: Medicare Skilled Nursing Home Prospective Payment System (SNF PPS)

APPENDICES

- Appendix A: Glossary and Common Acronyms
- Appendix B: State Agency and CMS Regional Office RAI/MDS Contacts
- Appendix C: Care Area Assessment (CAA) Resources
- Appendix D: Interviewing Techniques
- Appendix E: Cognitive Performance Scale (CPS) Scoring Rules
- Appendix F: MDS 3.0 Draft Matrix
- Appendix G: References
- Appendix H: Forms

Section	Title	Intent
A	Identification Information	Obtain key information to uniquely identify each resident, nursing home, and reasons for assessment.
B	Hearing, Speech, and Vision	Document the resident's ability to hear, understand, and communicate with others and whether the resident experiences visual, hearing or speech limitations and/or difficulties.
C	Cognitive Patterns	Determine the resident's attention, orientation, and ability to register and recall information.
D	Mood	Identify signs and symptoms of mood distress.
E	Behavior	Identify behavioral symptoms that may cause distress or are potentially harmful to the resident, or may be distressing or disruptive to facility residents, staff members or the environment.
F	Preferences for Customary Routine and Activities	Obtain information regarding the resident's preferences for his or her daily routine and activities.
G	Functional Status	Assess the need for assistance with activities of daily living (ADLs), altered gait and balance, and decreased range of motion.
H	Bladder and Bowel	Gather information on the use of bowel and bladder appliances, the use of and response to urinary toileting programs, urinary and bowel continence, bowel training programs, and bowel patterns.
I	Active Disease Diagnosis	Code diseases that have a relationship to the resident's current functional, cognitive, mood or behavior status, medical treatments, nursing monitoring, or risk of death.
J	Health Conditions	Document health conditions that impact the resident's functional status and quality of life.
K	Swallowing/Nutritional Status	Assess conditions that could affect the resident's ability to maintain adequate nutrition and hydration.
L	Oral/Dental Status	Record any oral or dental problems present.
M	Skin Conditions	Document the risk, presence, appearance, and change of pressure ulcers as well as other skin ulcers, wounds or lesions. Also includes treatment categories related to skin injury or avoiding injury.
N	Medications	Record the number of days that any type of injection, insulin, and/or select medications was received by the resident.
O	Special Treatments and Procedures	Identify any special treatments, procedures, and programs that the resident received during the specified time periods.
P	Restraints	Record the frequency that the resident was restrained by any of the listed devices at any time during the day or night.
Q	Participation in Assessment and Goal Setting	Record the participation of the resident, family and/or significant others in the assessment, and to understand the resident's overall goals.
V	Care Area Assessment (CAA) Summary	Document triggered care areas, whether or not a care plan has been developed for each triggered area, and the location of care area assessment documentation.
X	Correction Request	Indicate whether an MDS record is a new record to be added to the QIES ASAP system or a request to modify or inactivate a record already present in the QIES ASAP database.
Z	Assessment Administration	Provide billing information and signatures of persons completing the assessment.

1.7 Protecting the Privacy of the MDS Data

MDS assessment data is personal information about nursing facility residents that facilities are required to collect and keep confidential in accordance with federal law. The 42 CFR Part 483.20 requires Medicare and Medicaid certified nursing facility providers to collect the resident assessment data that comprises the MDS. This data is considered part of the resident's medical record and is protected from improper disclosure by Medicare and Medicaid certified facilities under the Conditions of Participation (COP). By regulation at CFR 483.75(1)(2)(3) and 483.75(1)(2)(4)(i)(ii)(iii), release of information from the resident's clinical record is permissible only when required by:

1. transfer to another health care institution,
2. law (both State and Federal), and/or
3. the resident.

Otherwise, providers cannot release MDS data in individual level format or in the aggregate. Nursing facility providers are also required under CFR 483.20 to transmit MDS data to a Federal data repository. Any personal data maintained and retrieved by the Federal government is subject to the requirements of the Privacy Act of 1974. The Privacy Act specifically protects the confidentiality of personal identifiable information and safeguards against its misuse. Information regarding The Privacy Act can be found at <http://www1.cms.gov/PrivacyActof1974>.

The Privacy Act requires by regulation that all individuals whose data are collected and maintained in a federal database must receive notice. Therefore, residents in nursing facilities must be informed that the MDS data is being collected and submitted to the national system, QIES Assessment Submission and Processing and the State MDS database. The notice shown on page 1- 14 of this section meets the requirements of the Privacy Act of 1974 for nursing facilities. The form is a notice and not a consent to release or use MDS data for health care information. Each resident or family member must be given the notice containing submission information at the time of admission. It is important to remember that resident consent is not required to complete and submit MDS assessments that are required under OBRA or for Medicare payment purposes.

Contractual Agreements

Providers, who are part of a chain, may release data to their corporate office or parent company but not to other providers within their chain organization. The parent company is required to "act" in the same manner as the facility and is permitted to use data only to the extent the facility is permitted to do so (as described in the 42 CFR at 483.10(e)(3)).

In the case where a facility submits MDS data to CMS through a contractor or through its corporate office, the contractor or corporate office has the same rights and restrictions as the facility does under the Federal and State regulations with respect to maintaining resident data, keeping such data confidential, and making disclosures of such data. This means that a contractor may maintain a database, but must abide by the same rules and regulations as the facility. Moreover, the fact that there may have been a change of ownership of a facility that has been transferring data through a contractor should not alter the contractor's rights and responsibilities;

presumably, the new owner has assumed existing contractual rights and obligations, including those under the contract for submitting MDS information. All contractual agreements, regardless of their type, involving the MDS data should not violate the requirements of participation in the Medicare and/or Medicaid program, the Privacy Act of 1974 or any applicable State laws.

NURSING FACILITIES PRIVACY ACT STATEMENT – HEALTH CARE RECORDS	
<p><i>THIS FORM PROVIDES YOU THE ADVICE REQUIRED BY THE PRIVACY ACT OF 1974. THIS FORM IS NOT A CONSENT FORM TO RELEASE OR USE HEALTH CARE INFORMATION PERTAINING TO YOU.</i></p>	
<p>1. AUTHORITY FOR COLLECTION OF INFORMATION, INCLUDING SOCIAL SECURITY NUMBER AND WHETHER DISCLOSURE IS MANDATORY OR VOLUNTARY.</p> <p>Sections 1819(f), 1919(f), 1819(b)(3)(A), 1919(b)(3)(A), and 1864 of the Social Security Act. Medicare and Medicaid participating long-term care facilities are required to conduct comprehensive, accurate, standardized and reproducible assessments of each resident's functional capacity and health status. To implement this requirement, the facility must obtain information from every resident. This information also is used by the Federal Centers for Medicare & Medicaid Services (CMS) to ensure that the facility meets quality standards and provides appropriate care to all residents. For this purpose, as of June 22, 1998, all such facilities are required to establish a database of resident assessment information, and to electronically transmit this information to the HCFA contractor in the State government, which in turn transmits the information to HCFA.</p> <p>Because the law requires disclosure of this information to Federal and State sources as discussed above, a resident does not have the right to refuse consent to these disclosures.</p> <p>These data are protected under the requirements of the Federal Privacy Act of 1974 and the MDS Long-Term Care System of Records.</p>	
<p>2. PRINCIPAL PURPOSES FOR WHICH INFORMATION IS INTENDED TO BE USED</p> <p>The information will be used to track changes in health and functional status over time for purposes of evaluating and improving the quality of care provided by nursing facilities that participate in Medicare or Medicaid. Submission of MDS information may also be necessary for the nursing facilities to receive reimbursement for Medicare services.</p>	
<p>3. ROUTINE USES</p> <p>The primary use of this information is to aid in the administration of the survey and certification of Medicare/Medicaid long-term care facilities and to improve the effectiveness and quality of care given in those facilities. This system will also support regulatory, reimbursement, policy, and research functions. This system will collect the minimum amount of personal data needed to accomplish its Stated purpose.</p> <p>The information collected will be entered into the Long-Term Care Minimum Data Set (LTC MDS) system of records, System No. 09-70-0528, published in the Federal Register at Vol. 72, no. 52/Monday, March 19, 2007. Information from this system may be disclosed, under specific circumstances (routine uses), which include: (1) To support agency contractors, consultants or grantees who have been engaged by the agency to assist in accomplishment of a CMS function; (2) assist another Federal or state agency to fulfill a requirement of a Federal statute that implements a health benefits program funded in whole or in part with Federal funds; (3) assist Quality Improvement Organizations to perform Title XI or Title XVIII functions; (4) assist insurance companies, underwriters, third party administrators, employers, group health plans for purposes of coordination of benefits with the Medicare Program; (6) the Federal Department of Justice, court, or adjudicatory body in litigation; (7) to support a national accrediting organization to enable them to target potential or identified problems with accredited facilities; (8) assist a CMS contractor in the administration of a CMS-administered health benefits program; (9) to assist another Federal agency that administers or that has the authority to investigate potential fraud, waste or abuse in a health benefits program funded in whole or part by Federal funds.</p>	
<p>4. EFFECT ON INDIVIDUAL OF NOT PROVIDING INFORMATION</p> <p>The information contained in the Long-Term Care Minimum Data Set is generally necessary for the facility to provide appropriate and effective care to each resident. If a resident fails to provide such information, for example on medical history, inappropriate and potentially harmful care may result. Moreover, payment for such services by third parties, including Medicare and Medicaid, may not be available unless the facility has sufficient information to identify the individual and support a claim for payment.</p>	
<p>_____</p> <p><i>Signature of Resident or Sponsor</i></p>	<p>_____</p> <p><i>Date</i></p>