Massachusetts MDS Section S Manual

Section S items S0170 and S0171, S1210, S6230, S6232, S6234, S6236, and S2360 are required in Massachusetts for all OBRA comprehensive and non comprehensive assessments. Section S items S0172 and S0173 are required for all OBRA comprehensive assessments.

S0170 – Advanced Directives

Intent:
To record who has responsibility for participating in decisions about the resident's health care and treatment, and to record the existence of legal directives regarding treatment options for the resident, whether made by the resident or a legal proxy.

Definitions:

- **Guardian**: Someone who has been appointed after a court hearing and is authorized to make decisions for the resident, including giving and withholding consent for medical treatment. Once appointed, only another court hearing may revoke the decision-making authority of the guardian. This includes temporary, limited, or full guardianship.
- **DPOA-HC (Durable Power of Attorney – Health Care):** Documentation that someone other than the resident is legally responsible for health care decisions if the resident becomes unable to make decisions. This document may also provide guidelines for the agent or proxy decision-maker, and may include instructions concerning the resident's wishes for care.
- **Living Will**: A document written by the resident describing their wishes about which actions should or should not be taken for their health in the event that they are no longer able to make decisions.
- **Do Not Resuscitate**: Documentation not to have cardiopulmonary resuscitation (CPR) performed if the heart stops or breathing ceases.
- **Do Not Hospitalize**: Documentation that specifies that the resident should not be sent to the hospital even after developing a medical condition that usually requires hospitalization.
- **Do Not Intubate**: Documentation not to have a breathing tube inserted through the mouth or nose in the event of respiratory or cardiac failure.
- **Feeding Restrictions**: Documentation not to feed the resident by artificial means (e.g., tube, intravenous nutrition) if the resident is unable to be nourished by oral means.

- **Other Treatment Restrictions**: Documentation of restrictions other than those noted above. Examples include (but not limited to) blood transfusions, medications, and invasive procedures.

Process:
Review the resident's medical record for documentation of the resident's advance directives. Documentation must be available in the record for a directive to be considered current and binding.

Coding:

- **S0170A-Z: For those items with supporting documentation in the medical record, check all that apply**: For items S0170A – S0170H, check all options that apply to the patient. If no options apply, check item S0170Z.

S0171 – Health Care Proxy

Intent:
To record who has responsibility for making decisions regarding the resident's health care and treatment.

Definitions:

- **Health Care Proxy**: Legal document in Massachusetts which allows a person (the resident) to name someone (an agent) to make health care decisions on their behalf if the resident becomes unable to make or communicate those decisions.
- **Invoked**: For the purposes of this section, invoked means to put into effect, or activated.

Process:

- **S0171-A**: Review the resident's record for a copy of the resident's current health care proxy.
- **S0171-B**: Review the resident's record for documentation that the decision to invoke the health care proxy has been determined by the resident's attending Physician. The agent's authority becomes effective if the attending Physician determines in writing that the resident lacks the capacity to make or to communicate health care decisions.

Coding:

- **S0171-A: Does resident have a health care proxy?:** If a copy of the resident's current health care proxy is available in the medical record, code '1' (yes). If not, code '0' (no).

- **S0171-B: Has health care proxy been invoked?:** If at the time of completion of this MDS record, there is documentation that the resident's health care proxy is invoked, code '1' (yes). If not, code '0' (no).

S0172 – S0173 Goals of Care

Intent:
The intent of this section is to ascertain whether a discussion has taken place with the resident or legal health care representative regarding the resident's personal goals of care.

Definitions:

- **Goals of Care**: A resident's personal goals or choices for the provision of health care such as comfort, curing illness, and/or management of symptoms.
- **Referring Provider**: The resident's attending healthcare clinician in the prior health care delivery setting.
- **Hospital**: This includes hospitals such as acute care, psychiatric, rehab, and/or long-term acute care (LTAC).
- **Previous Nursing Home**: A nursing facility that the resident previously resided at.
- **Home without Home Health Services**: A personal residence where the resident was not receiving care from a Medicare certified Home Health Agency.
- **Home with Home Health Services**: A personal residence where the resident was receiving care from a Medicare certified Home Health Agency.
- **PCP Office**: Office of the resident's primary care physician.
- **Other**: Any referring facility not included in the above choices.

Process S0172*:*
Review the resident's medical record for documentation of a discussion of goals of care from a referring provider at the time of admission.

Coding:
S0172A: On admission, was documentation received by the facility from the referring provider that a discussion of Goals of Care with the Resident or Legal healthcare representative occurred?

Code '1' (yes) if you received documentation of a discussion on goals of care from the referring provider. This question is not asking for specifics on the resident's goals of care, only the documentation of a discussion.

Code '0' (no) if you did not receive such documentation. Code '9' (N/A) if this is not an admission OBRA MDS.

- **S0172B-G: If you answered 'yes' to question S0172A, in which setting(s) did the discussion take place? (Check all that apply)**:
  - If you answered 'yes' to S0172A, check all settings that apply.
  - If you answered 'no' to S0172A, skip to S0173.

Process S0173:

- Review the resident's medical record for documentation that a discussion of goals of care occurred since the last comprehensive OBRA assessment was completed.

***Coding:* S0173:**

- **S0173: Is there documentation in the medical record that a discussion of Goals of Care occurred with the Resident or Legal healthcare representative since the last comprehensive OBRA assessment was completed?**
  Code '1' (yes) if there is documentation in the medical record that a discussion of Goals of Care with the Resident or Legal healthcare representative occurred since the last comprehensive OBRA assessment was completed. Code '0' (no) if there is no such documentation. Code '9' (N/A) if this is an admission OBRA MDS.

S2360 The Utilization of Non-Pharmacological Resident Centered Care Program Techniques

Intent:
The intent of this section is to ascertain if any non-pharmacological Resident centered care program techniques are currently in use for the resident.

S2060: Resident Centered Care

Process:
Review the resident's medical record to determine if any non-pharmacological Resident centered care program techniques are currently in use for the resident.

Definitions:

- **Habilitation therapy**: Habilitation therapy (HT) is designed to help people with Alzheimer's disease improve functional abilities that are hindered by the progression of dementia..[1]

- **Hand in Hand**: a training program developed by CMS for Nursing Homes that emphasizes person-centered care of persons with dementia and the prevention of abuse.[2]
- **Consistent Assignment**: residents see the same caregivers (registered nurse, licensed practical nurse or certified nursing assistant) almost every time they are on duty. Many residents are more comfortable with caregivers who know and understand their personal preferences and needs. Consistent assignment is primary assignment.[3]

Coding S2060

For this resident, are any of the non-pharmacological resident centered care techniques supported by the programs listed below included in the individualized resident centered care approach? Check all items that apply.

☐ **Habilitation therapy**

☐ **Hand in Hand**

☐ **Other**

☐ **Consistent Assignment**

☐ **None of the above**

- If you answered yes to question S6230, for programs listed above, check all options that apply to the resident. If no options apply, check "none of the above".
- If you answered "no" to question S6230, leave this section blank.

[1] https://nhqualitycampaign.org/wp-content/uploads/2020/09/Habilitation_Therapy_a_New_Starscape2.edit_.pdf
[2] http://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/SurveyCertificationGenInfo/Downloads/Survey-and-Cert-Letter-12-44.pdf
[3] http://www.nhqualitycampaign.org/files/factsheets/Consumer%20Fact%20Sheet%20-%20Consistent%20Assignment.pdf

S6300, S6301, S6302, SXXX4 Medications for Opioid Use Disorder and Accompanying Treatments

Intent:
The intent of this section is to ascertain whether the resident is receiving medication for opioid use disorder and accompanying treatments. Residents who are receiving medication for opioid use disorder should also have a standing order for naloxone to be used to reverse an opioid overdose and receive counselling services.

S6300: Is resident currently receiving any medications for opioid use disorder?

Process S6300

- Review the resident's medical record to determine if the resident is currently receiving medication(s) for opioid use disorder.

Coding S6300

Is resident currently receiving any medications for opioid use disorder?

- Code 0 (no) if the resident is not receiving any medications for opioid use disorder.
    - If you answered 'no' to S6300, code questions S6301 and S6302 as Not Applicable
- Code 1 (yes) if the resident is currently receiving Methadone
- Code 2 (yes) if the resident is currently receiving Buprenorphine AKA Suboxone
- Code 3 (yes) if the resident is currently receiving Naltrexone
- Code 9 (yes) if the resident is currently receiving Medication(s) for Opioid Use Disorder other than Methadone, Buprenorphine, or Naltrexone

S6301: Does this resident have a standing order for Naloxone in their medication list?

Process S6301

- Review the resident's medical record to determine if the resident has an active order for Naloxone to reverse an opioid overdose.

Coding S6301

Does this resident have a standing order for Naloxone in their medication list?

- Code 0 (no) if the resident does not have a standing order for Naloxone documented in the medical record.
- Code 1 (yes) if the resident does have a standing order for Naloxone documented in the medical record.
- Code 9 (not applicable) if this question does not apply

S6302: Was Buprenorphine prescribed at this facility or by an outside provider?

Process S6302

- Review the resident's medical record to determine if the prescriber for Buprenorphine was at the facility or outside of the facility. Only answer this question if the resident is receiving Buprenorphine AKA Suboxone.

Coding S6302

Was Buprenorphine prescribed at this facility or by an outside provider?

- Code 1 if the resident was prescribed Buprenorphine by a prescriber at the facility.
- Code 2 if the resident was prescribed Buprenorphine by a prescriber outside of the facility.

S6303A-D: Is the resident currently receiving counseling for opioid use disorder?

Process S6303A-D

- Review the resident's medical record to determine if the resident is currently receiving counseling and where that counseling is taking place.

Coding S6303A-D

Is the resident currently receiving counseling for opioid use disorder? Check all items that apply.

☐ **Onsite**

☐ **At another location**

☐**Virtually (telehealth)**

S6304 – S6305 Psychotropic Medications

Intent:
The intent of this section is to ascertain whether the resident is receiving any psychotropic medications.

Process S6304
Review the resident's medical record to determine if the resident is receiving any psychotropic medications, including standing orders or PRN. A full list of psychotropic medications can be found here: https://www.mass.gov/doc/circular-letter-17-2-699-revised-informed-consent-for-use-of-psychotropic-medications-in-ltcfs/download

Coding S6304A-I

Is the resident currently on any psychotropic medications? Check all items that apply.

☐**Antidepressants**

☐**Anxiolytics/Sedatives/Hypnotics**

☐ **Antipsychotics**

☐ **Stimulants**

☐ **Chemical Dependency Adjuncts**

☐ **Monoamine Oxidase Inhibitors**

☐ **Mood stabilizers**

☐ **Miscellaneous Drugs (see Circular Letter 17-2-699)**

☐**Other**

Process S6305
Review the resident's medical record to determine if the resident is receiving any psychotropic medications PRN. If they are receiving PRN psychotropic medications, note the most recent date that medications were received.

Coding S6305A

Does this resident have an active order for PRN psychotropics?

- Code 0 (no) if the resident does not have an active order for PRN psychotropics documented in the medical record.
    - If you answered 'no' to S6305A, skip question S6305B
- Code 1 (yes) if the resident does have an active order for PRN psychotropics documented in the medical record.

Coding S6305B

When was the last date that this resident received PRN psychotropics?

- Enter the date as YYYYMMDD