The 4-part presentation of the Minimum Data Set (MDS) 3.0 by Saliba and colleagues\(^1\)\(^-\)\(^4\) redifines how we think about residents in the nursing home and how we document their needs. The MDS 3.0 brings significant improvements to the previous version, and harmoniously makes an attempt to be all things to all people. It is a monumental effort. It is a document to record care needs, identify diagnoses, and marshal resources when there is a change in conditions. It provides survey oversight and opportunities for quality improvement. It serves as a mechanism for reimbursement in many states. It does all of these things using the “patient’s own voice.” It is mindful of the time constraints and training of those providing direct care in the nursing home, and never loses sight of the compliance process.

Nursing home reform took its current evolutionary shape in 1986 with an Institute of Medicine report entitled “Improving the Quality of Care in Nursing Homes.”\(^5\) Dr. Sidney Katz was the lead author, and when John Morley asked for an editorial, I told him someone more “officious” than I should write this piece. Unfortunately, Dr. Katz died at age 84 in 2008, but he certainly would have been proud of what has transpired. Every Institute of Medicine committee would like their report to have a grand impact. The 1986 report was a commissioned work and led to the Omnibus Budget Reconciliation Act of 1987 (OBRA ‘87). That piece of legislation laid the foundation for the MDS and Dr. Saliba and her colleagues have channeled those principles more effectively in the current rendition of the MDS.

Their story is well laid out in the pages that comprise these 4 publications.\(^1\)\(^-\)\(^4\) It is testament to how well this project was designed and executed. Listening to the patient took a central role and even when John Morley asked for an editorial, I told him someone more “officious” than I should write this piece. Unfortunately, Dr. Katz died at age 84 in 2008, but he certainly would have been proud of what has transpired. Every Institute of Medicine committee would like their report to have a grand impact. The 1986 report was a commissioned work and led to the Omnibus Budget Reconciliation Act of 1987 (OBRA ‘87). That piece of legislation laid the foundation for the MDS and Dr. Saliba and her colleagues have channeled those principles more effectively in the current rendition of the MDS.

Their story is well laid out in the pages that comprise these 4 publications.\(^1\)\(^-\)\(^4\) It is testament to how well this project was designed and executed. Listening to the patient took a central role and even worked for the resident with advanced dementia. Despite the time constraints imposed on nursing, they were still able to create a document that is engaging and easy to use. If early reports are to be believed, this patient-centered approach is well received and allows for better care at the bedside. Surveyors still get the information they require and the research community gets a wealth of data that is more structured to analyze the processes of care in today’s nursing home.

The MDS 3.0 is a remarkable piece of work for all of these reasons. The authors laid out the problems they faced, defined their processes, field tested their assumptions, and created something useful. Whole sections were redone. The first 2 articles lay out the foundation,\(^1,2\) whereas parts 3 and 4 highlight some of the innovations.\(^3,4\) The Brief Interview of Mental Status (BIMS),\(^2\) featured in part 3, was created explicitly for MDS 3.0. It was tested in the field and found to be an effective tool. It replaced an observational measure that required computational scoring and served no purpose beyond a base evaluation and a change of mental status.

Part 3 provides an in-depth review of cognition.\(^3\) The Cognitive Performance Scale was never the language geriatricians spoke and was rarely useful in studying dementia in a nursing home population. The BIMS has face validity and is the first screening test deployed to study a large population of at-risk patients. It is an off-the-shelf product that will gain traction in the research and scientific community to better understand Alzheimer’s disease in the nursing home. It came as a pleasant surprise to see the BIMS also listed as an appendix. It is frustrating to review the virtues of a new measure and then never find it published in what would be considered an original article. It is also maddening to learn about a valuable screening tool and then realize it has a copyright and will cost if used regularly. The BIMS, just like the Patient Health Questionnaire-9 (PHQ-9), is given freely and without any strings attached.

Perhaps the hallmark of the MDS 3.0 is the inclusion of the PHQ-9.\(^4\) This depression scale is also off-the-shelf and replaces other mood questions of limited usefulness, albeit, it may have been adequate for purposes of the State Operations Manual. The PHQ-9 is simple, reliable, and the scores are easily understood. When depression improves, scores go down. When depression worsens, scores increase. It is also in the “patient’s voice” and has been used in other settings for more than a decade. The MDS 3.0 team describes their study of the PHQ-9 in the nursing home, tests its reliability, and finds it to be better across the age and disease spectrum than the questionnaire it replaces. Their study also proves it to be efficacious in populations with dementia and gives voice to surrogate caregivers. It also comes with no fees attached.

In the next few years, we will learn far more about dementia and depression in the nursing home as geriatricians mine the data in MDS 3.0. The authors stayed very close to their responsibilities in laying the foundation for MDS 3.0. I believe they have created a far more important foundation with underpinnings that will advance some sorely needed research in the nursing home. The data set provided by MDS 3.0 will be used by the next generation of investigators (both governmental and academic) to understand the needs of our residents. And what better way to understand these needs than “in their own voice.” The MDS 3.0 will improve patient-centered care in the nursing home for our residents. The immediate benefit is care at the bedside; however, long term it will give investigators a better opportunity to effectively study the nursing home resident. The MDS 3.0 will add to our knowledge base, and that is exciting.
References