

# Education *access*

**IHCA**  
ILLINOIS HEALTH CARE ASSOCIATION

**ICAL**  
ILLINOIS CENTER FOR ASSISTED LIVING

**The Center**  
for Developmental  
Disabilities Advocacy and  
Community Supports

## MDS 3.0

### What's Coming in October!

#### Date

**August 21, 2018**

*Web Seminar*

10—11 a.m.

#### Session Overview

All MDS nurses expect updates and changes every October 1. This year is no exception. While there are many wording changes in the manual, there are significant changes to section items themselves. In addition, data will begin being collected for the Drug Regimen Review quality measure that will affect payment for FY 2020. Join us for this web seminar for an in-depth look at the upcoming changes and plan how to adapt.

At the conclusion of this session participants should be able to:

- Identify and be able to manage recent changes to MDS 3.0
- Explain the new quality measure Drug Regimen Review
- Verbalize a plan for ongoing compliance

#### Speaker

***Caryn Adams, RN, MSN, RAC-CT, DNS-CT, HCS-O, AHIMA Certified ICD-10 CM/PCS Trainer***, is a manager in Wipfli LLP's health care senior living practice and has more than 25 years' experience in the health care profession. Her vast experience lends a deep understanding of the challenges faced by her clients. Caryn is dedicated to providing exceptional client service to assist long term care and senior living providers in achieving their strategic goals.

# MDS 3.0: What's Coming in October!



Participant	Email Address
	<b>Each participant MUST have a unique email address</b>

Contact Person: \_\_\_\_\_

Email address: \_\_\_\_\_

Facility: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

Payment:

- \_\_\_ Member of IHCA or LTCNA (first registrant).....\$60 per person
- \_\_\_ Member of IHCA or LTCNA (additional registrants wanting CEs).....\$15 per person
- \_\_\_ Non-member.....\$100 per person

**Grand Total** \_\_\_\_\_

Check enclosed

Charge to:    Visa                       MasterCard                       American Express                       Discover

# \_\_\_\_\_ Expiration Date: \_\_\_\_\_

Security Code: \_\_\_\_\_ (3 digits REQUIRED)    Signature: \_\_\_\_\_

Name on the credit card: \_\_\_\_\_

Credit Card Billing Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

**Return with payment to:**                      **OR**                      [Click here to register online](#)  
**Illinois Health Care Association**  
**1029 S. Fourth Street**  
**Springfield, IL 62703**  
**Fax: 217.528.0452**

AMOUNT	CK#/ CC	MEMBER STATUS	DATE