Objectives

- Identify the five functions of the MDS
- Describe the assessment and care planning process utilized by the nursing home
- Utilize the Nursing Home Quality Measures Reports in identifying potential patient problems
- Identify strategies for hospice staff to assist nursing home partners

What is the Minimum Data Set (MDS)?

The Most Important Document in the Nursing Home!!
Improvements in the MDS 3.0

- Gives the Resident a Voice
- Increases Clinical Relevance
- Increases Accuracy
- Increases Clarity
- Reduces time to complete

MDS 3.0 Impacts

1. Assessment
2. Care Planning
3. Quality Indicators/Quality Measures
4. Reimbursement

Assessment
Nursing Assessment

- Standardized form
- Mandated by federal government
- Completed on all residents if the nursing home is Medicare/Medicaid certified
- Completed within 14 days of admission
- Electronically submitted to the government

Resident Interviews

- Four interviews: Cognitive Patterns, Mood, Daily and Activity Preferences, Pain Assessment
- 85% - 90% of residents were able to participate in the interviews
- If the resident is unable to participate, there is a skip pattern for staff assessment
- CMS has produced a video to assist in teaching interview techniques
- Using audio amplifiers and cue cards enhanced participation by residents who were thought to be unable to participate

Brief Interview for Mental Status (BIMS)

- Staff interview required unless resident is rarely/never understood
- Asks the resident to repeat and later in the interview, recall three words: sock, blue, and bed
- Asks questions to determine whether the resident knows the year, month, and day of the week
Mood Interview

- Staff asks nine questions to determine if a symptom is present and how frequently the resident experiences these symptoms.
- Some of the questions that have relevance to hospice include:
  - Little interest or pleasure in doing things
  - Feeling down, depressed, or hopeless
  - Feeling bad about yourself - or that you are a failure or have let yourself or your family down
  - Thoughts that you would be better off dead, or of hurting yourself in some way

Preferences for Customary Routine and Activities: Daily Preferences

While you are in the facility, how important is it to you to:

- choose between a tub bath, shower, bed bath, or sponge bath?
- choose your own bedtime?
- have your family or a close friend involved in discussions about your care?

If resident is not able to respond, staff should interview family member or significant other.

Preferences for Customary Routine and Activities: Activity Preference

While you are in the facility, how important is it to you to:

- listen to music you like?
- be around animals such as pets?
- keep up with the news?
- go outside to get fresh air when the weather is good?
- participate in religious services or practices?
Functional Status

- Assesses activities of daily living (ADL) assistance
- There are four ADLs which impact the reimbursement (RUG IV) rate: bed mobility, transfer, eating, toilet use
- Comparing the status on the quarterly assessments could assist in the documentation of decline.

Functional Status (cont)

- The activity is coded based upon the resident’s performance over all shifts and the level of support provided by the staff
- Assistance provided by family, visitors, private duty nursing, or hospice staff cannot be counted

Pain Assessment

- Asks the question as to whether the resident is on a scheduled pain medication regimen and whether they received a PRN medication during the reference date
- Asks whether resident received non-medication intervention for pain
- Requires interviewing the residents to assess their level of pain
- Pain is assessed using either a numeric rating scale (0 – 10) or verbal descriptor scale (mild, moderate, severe, very severe, horrible)
Identification of Hospice Patients

- A1800 (07) Tracks whether resident is a hospice patient upon admission to the facility
- A2100 (07) Tracks whether resident is discharged from the nursing facility on hospice
- O100 (k) Hospice care

CMS will now have the ability to identify the characteristics of residents receiving hospice care in the nursing home

Definitions and Requirements

- J1400 Prognosis - Does the resident have a condition or chronic disease that may result in a life expectancy of less than 6 months?

  Requires a physicians written statement of 6 month prognosis

- If a resident elects hospice in the middle of an assessment period, it is mandatory that a Significant Change in Status Assessment (SCSA) is completed

- Hospice is defined in all items as a provider that is Medicare certified or licensed by the state

Participation in Assessment and Goal Setting

- Questions ask whether the resident, family or significant other, or guardian participated in the assessment

- Questions resident’s overall goals and whether there is an expectation that they will remain in the facility or be discharged to the community

- If resident wants to return to the community, it asks questions to determine if staff have followed through with appropriate referrals to other local community agencies

- CMS is focusing on the development of community based services such as, Money Follows the Person, CLASS, Community Health Centers
Care Planning

Development of Care Plan

- The MDS contains Care Area Triggers (CATs)
- CATs are connected to Care Area Assessments (CAAs)
- RAPs (Resident Assessment Protocols) have been replaced with CAAs
- CAAs must be assessed to determine whether or not they require care planning
- No particular format is required, but tools utilized in the assessment must be current, evidence-based, or expert-endorsed
- CAAs can be combined

Care Area Assessments (CAAs) Replace Resident Assessment Protocols (RAPs)

- Delirium
- Cognitive Loss/Dementia
- Visual Function
- Communication
- ADL Functional/Rehabilitation Potential
- Urinary Incontinence and Indwelling Catheter
- Psychosocial Well-being
- Mood State
- Behavioral Symptom
- Activities
- Falls
- Nutritional Status
- Feeding Tubes
- Dehydration/Fluid Maintenance
- Dental Care
- Pressure Ulcer
- Psychotropic Drug Use
- Physical Restraints
- Pain
- Return to Community
Time Frame

- For the long stay resident, facility still has 14 days to complete the MDS, and 7 days to complete the care plan
- Comprehensive assessments are required annually and when a significant change in the resident’s condition occurs, such as admission/discharge to hospice
- There is no requirement for CAAs with quarterly assessments

Quality Measures

Quality Improvement Tool

- Based on responses to MDS questions
- Assist nursing home in identifying potential problems in the care of residents
- Some may occur in terminally ill residents and cannot be avoided
Casper Quality Reports

- Assists nursing home staff in:
  - identifying potential problem areas in the home
  - Identifying problems specific to a resident
- Utilized by surveyors in preparing for survey to:
  - identify potential problems with care
  - select residents for chart review
Calculation of Quality Measure Scores

- Risk adjustment refines raw QM scores to better reflect the prevalence of problems that nursing homes should be able to address.
- Residents whose outcomes are not under staff control (e.g., present on admission) or the outcome may be unavoidable (e.g., the resident has end-stage disease or is comatose) are excluded.
- All of the QMs have exclusions, except vaccination QMs.
- The only QM score that is risk adjusted for hospice residents is “need for help with activities of daily living has increased.”

Nursing Home Compare

- Locates nursing homes by name, zip code, state & city.
- Provides nursing home specific Quality Measures and compares them to state and national percentages…updated quarterly.
- Some of the Quality Measures reported on Nursing Home Compare are different from the Casper Report.
- www.medicare.gov/NursingHomeCompare

Reimbursement
Staff Time and Resource Intensity Verification (STRIVE) Study

In 2005, CMS initiated a national nursing home staff time measurement study, STRIVE. Based on this analysis, CMS developed the RUG-IV classification system that incorporates the MDS 3.0 items. Study showed that services furnished only during the prior hospital stay do not translate into greater staff resource use after admission to the SNF. Therefore, the 14 day look-back has been eliminated.

RUG IV Conditions

Added

- Parkinson’s, COPD & SOB while lying flat, respiratory failure, and oxygen, isolation for active infectious disease

Removed

- Aphasia, dehydration, internal bleeding, suctioning, physician visits and orders

Moved

- Coma, septicemia, Diabetes Mellitus and orders and injections, tube feeding, foot/wound infection and tx, dialysis
- IV feeding, wounds and tx, IV meds

RUG IV, 8 Classifications, 66 Groups

Medicare

- Rehabilitation Plus Extensive Services (9)
- Rehabilitation (14)
- Extensive Services (3)
- Special Care High (8)
- Special Care Low (8)
- Clinically Complex (10)

Medicaid

- Behavioral Symptoms and Cognitive Performance (4)
- Reduced Physical Function (10)
SNF PPS Requirements

- Enrolled in Medicare and available days
- 3-day qualifying hospital stay
- Admission within 30 days (deferred treatment exception)
- Need and receive medically necessary skilled care on a daily basis—nursing or rehabilitation
- RUG assignment does not mean skilled care criteria are met
- Condition treated during hospital stay or arose while receiving SNF care

Payment for Medicare Skilled Nursing Home Benefit

- Requires frequent submission of a new MDS for reimbursement under Prospective Payment System (PPS) at day 5, 14, 30, 60, and 90.
- Payment levels may change during 100-day Skilled Nursing Benefit Period.
- All-Inclusive Rate

Potential Payment for Medicaid

- Remaining levels can be utilized by Medicaid
- State is receiving MDS information
- If it is cost-effective for Medicare, it should be cost effective for Medicaid
- Most States average the individual resident rates quarterly to determine the rate
Don’t Mess with MDS!!

- Need training to complete MDS correctly
- Accuracy of reports is dependent upon accuracy of data input
- Members of the nursing home team may complete sections, but MDS is ultimately signed by an RN
- Identify the MDS Coordinators in the nursing home and help make their job easier

Hospice Can Help

- Communicate with the MDS Coordinator to ensure that they receive tracking information on admission and discharge if the patient is on hospice
- Notify the MDS Coordinator when a patient resides in the nursing home elects hospice
- Coordinate and collaborate with MDS Coordinator or other designated staff in completion of the care plan
- Individualize care plans to include resident preferences
Hospice Can Help

- Ensure that there is a copy of the hospice election statement in the nursing home medical record
- Ensure there is a signed copy of physician cert/re-certs in the nursing home medical record
- Assist nursing home staff in assessment of psychosocial issues surrounding mood and discharge planning
- Include patient/family in treatment decisions
- Assist in pain and symptom management

Questions & Answers