

Enhancing Person-Centered Care through MDS 3.0 Assessment Accuracy

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RAI User's Manual

- * The information in this program refers to publicly available information as of the date of the presentation (September 19, 2013).
- * For the most accurate and up-to-date information regarding the Resident Assessment Instrument (RAI), including the Minimum Data Set, Version 3.0 (MDS 3.0), please refer to the CMS RAI User's Manual Web page at the following link:

<http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/NursingHomeQualityInits/MDS30RAIManual.html>

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Program Objectives

Upon completion of the program, the participant will be able to:

- * Explain the antipsychotic quality measures (QMs)
- * Articulate how to code Section I: Active Diagnoses, No410: Medications Received, and Section Q: Participation in Assessment and Goal Setting on the MDS 3.0
- * Describe the required elements of Care Area Assessment (CAA) documentation
- * Discuss the role of Wyoming's Aging and Disability Resource Center in helping to ensure residents have an opportunity to receive long term care in the least restrictive setting possible

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Antipsychotic Medication Quality Measures (QMs)

- * Two QMs – one long stay and one short stay
- * The long stay is used to track progress in the National Partnership To Improve Dementia Care
- * CMS Nursing Home Quality Measures Resources
 - * <http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/NursingHomeQualityInits/NHQIQualityMeasures.html>

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Key Definitions for the QMs Long Stay and Short Stay



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Key Definitions for the QMs Target Assessment (Short-Stay)

- * Qualifying Reason for Assessment (RFA):
 - * A0310A = [01, 02, 03, 04, 05, 06] or
 - * A0310B = [01, 02, 03, 04, 05, 06] or
 - * A0310F = [10, 11]
- * The target date is no more than 120 days before the end of the episode

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Key Definitions for the QMs Target Assessment (Long-Stay)

- * Qualifying Reason for Assessment (RFA):
 - * A0310A = [01, 02, 03, 04, 05, 06] or
 - * A0310B = [01, 02, 03, 04, 05, 06] or
 - * A0310F = [10, 11]
- * The target date is no more than 120 days before the end of the episode

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Key Definitions for the QMs Initial Assessment (Short-Stay)

- * First assessment following the Admission Entry Record at the start of the episode
- * Qualifying Reason for Assessment (RFA):
 - * A0310A = [01] or
 - * A0310B = [01, 06] or
 - * A0310F = [10, 11]

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Key Definitions for the QMs Look-Back Scan (Short-Stay)

- * Qualifying Reason for Assessment (RFA):
 - * A0310A = [01, 02, 03, 04, 05, 06] or
 - * A0310B = [01, 02, 03, 04, 05, 06] or
 - * A0310F = [10, 11]
- * Methodology uses all assessments within the selected episode (e.g., up to all 100 days)

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Percent of Short-Stay Residents Who Newly Received an Antipsychotic Medication

Numerator

- * Short-stay residents for whom one or more assessments in a look-back scan (not including the initial assessment) indicates that antipsychotic medication was received
 - * For assessments with target dates on or before 03/31/2012: N0400A = [1]
 - * For assessments with target dates on or after 04/01/2012: N0410A = [1,2,3,4,5,6,7]

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Percent of Short-Stay Residents Who Newly Received an Antipsychotic Medication

Denominator

- * All short-stay residents who do not have exclusions and who meet all of the following conditions:
 - * The resident has a target assessment, and
 - * The resident has an initial assessment, and
 - * The target assessment is not the same as the initial assessment

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Percent of Short-Stay Residents Who Newly Received an Antipsychotic Medication

Exclusions

- * Any of the following related conditions are present on any assessment in a look-back scan:
 - * Schizophrenia (I6000 = [1])
 - * Tourette's Syndrome (I5350 = [1])
 - * Huntington's Disease (I5250 = [1])
- * Antipsychotic medication use on the initial assessment
- * Missing data

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Short Stay Antipsychotic QM An Example of the Denominator

- * 100 Short Stay residents
 - * 4 were on antipsychotic medications on their initial assessment
 - * 2 have Schizophrenia
 - * 1 has Tourette's Syndrome
 - * 1 has Huntington's Disease
 - * 4 residents only have one MDS
 - * 1 resident has two MDSs but No410A is dashed on both
- * Denominator = 87 residents

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Percent of Long-Stay Residents Who Received An Antipsychotic Medication

Numerator

- * Long-stay residents with a selected target assessment where the following condition is true: antipsychotic medications received. This condition is defined as follows:
 - * For assessments with target dates on or before 03/31/2012: No400A = [1]
 - * For assessments with target dates on or after 04/01/2012: No410A=[1,2,3,4,5,6,7]

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Percent of Long-Stay Residents Who Received An Antipsychotic Medication

Denominator

- * All long-stay residents with a selected target assessment, except those with exclusions

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Percent of Long-Stay Residents Who Received An Antipsychotic Medication

Exclusions

- * Missing data
- * Any of the following related conditions are present on the target assessment (unless otherwise indicated):
 - * Schizophrenia (I6000 = [1])
 - * Tourette's Syndrome (I5350 = [1])
 - * Tourette's Syndrome (I5350 = [1]) on the prior assessment if this item is not active on the target assessment and if a prior assessment is available
 - * Huntington's Disease (I5250 = [1])

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Section I: Active Diagnoses

- * There are two look-back periods for this section:
 - * Diagnosis identification (Step 1) is a 60-day look-back period
 - * Determining diagnosis status (Step 2) is a 7-day look-back period (except for Item I2300 UTI, which does not use the active 7-day look-back period)

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Step One - Identify Diagnoses

- * Has the physician (or nurse practitioner, physician assistant, or clinical nurse specialist, if allowable under state licensure laws) documented the diagnosis in the last 60 days?

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Step Two - Determine Whether Diagnoses are Active

- * Does the diagnosis have a direct relationship to the resident's current functional status, cognitive status, mood or behavior status, medical treatments, nursing monitoring, or risk of death during the 7-day look-back period?

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Section I: Active Diagnoses

- * Check off each active disease in I0100 – I6500
- * If none apply, check I7900, None of the above active diagnoses with the last 7 days
- * If a disease or condition is not specifically listed, enter the diagnosis and ICD code in item I8000, Additional active diagnosis

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No410: Medications Received

Steps for Assessment

- * Review the resident's medical record for documentation that any of these medications were received by the resident during the 7-day look-back period (or since admission/entry or reentry if less than 7 days)
- * Review documentation from other health care settings where the resident may have received any of these medications while a resident of the nursing home

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No410: Medications Received

- * No410A, Antipsychotic
- * No410B, Antianxiety
- * No410C, Antidepressant
- * No410D, Hypnotic
- * No410E, Anticoagulant (e.g., warfarin, heparin, or low- molecular weight heparin)
- * No410F, Antibiotic
- * No410G, Diuretic

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No410: Medications Received

- * **Key Point:** Code medications in Item No410 according to the medication's therapeutic category and/or pharmacological classification, not how it is used

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Your Antipsychotic QMs are High... Now What???

- * Confirm the MDS 3.0 is correct
- * Understand the status of the resident and the circumstances leading to their antipsychotic use
- * Evaluate patterns of antipsychotic use within the facility
- * Review care protocols

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Your Antipsychotic QMs are High... Now What???

- * Do care protocols include:
 - * Recognition and assessment?
 - * Cause identification and diagnosis?
 - * Development of care plan?
 - * Individualized approaches and treatment?
 - * Monitoring, follow-up and oversight?
 - * Quality assessment and assurance (QAA)?

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BODIES Mnemonic

- * B—What behaviors did you see?
- * O—How often did the behaviors occur?
- * D—What was the duration of the behaviors?
- * I—How intense were the behaviors?
- * E—How effective was treatment, if given?
- * S—What made the behaviors start/stop?

Source: Snow, L.; Rapp, M.P.; Kunik, M. (2005)
Pain management in persons with dementia.
 Geriatrics. P. 22- 25

Your Antipsychotic QMs are High... Now What???

- * Are care protocols followed?
- * If not, why?
 - * Does the staff know the protocol?
 - * Is resident specific information (including care approaches) available to the staff?
 - * Are the care plans implemented as written?
 - * Is staff education in dementia care provided?

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The screenshot shows the website <http://www.nhqualitycampaign.org/>. The page layout includes a header with the title 'Advancing Excellence' and a navigation bar. The main content area is divided into several sections: 'UPDATES BY STATE' with a map of the United States, 'LIVE UPDATES' with a 'Get Adobe Reader' button, 'REGISTER TODAY!' with buttons for 'Nursing Homes', 'Consumers', and 'Nursing Home Staff', 'NEWS' with a link to 'Improving Care for Our Seniors - NHQ Video', and 'FOR PARTICIPANTS' with buttons for 'ENROLL NOW!', 'FIND PARTICIPANTS', 'SUBMIT DATA', and 'CONTACT US'. A large blue arrow points to the 'CMS PARTNERSHIP TO IMPROVE DEMENTIA CARE' link in the 'FOR PARTICIPANTS' section. The footer of the website displays the URL <http://www.nhqualitycampaign.org/>.

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Section Q: Participation in Assessment and Goal Setting

- * Two focuses in Section Q:
 - * Record the participation and expectations of the resident, family members, or significant other(s) in the assessment
 - * Understand the resident's overall goals

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Q0100: Participation in Assessment

Q0100. Participation in Assessment

Enter Code <input type="checkbox"/>	A. Resident participated in assessment 0. No 1. Yes
Enter Code <input type="checkbox"/>	B. Family or significant other participated in assessment 0. No 1. Yes 9. No family or significant other available
Enter Code <input type="checkbox"/>	C. Guardian or legally authorized representative participated in assessment 0. No 1. Yes 9. No guardian or legally authorized representative available

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Q0300: Resident's Overall Expectation

Q0300. Resident's Overall Expectation	
Complete only if A0310E = 1	
Enter Code <input style="width: 30px; height: 20px;" type="checkbox"/>	A. Select one for resident's overall goal established during assessment process <ol style="list-style-type: none"> 1. Expects to be discharged to the community 2. Expects to remain in this facility 3. Expects to be discharged to another facility/institution 9. Unknown or uncertain
Enter Code <input style="width: 30px; height: 20px;" type="checkbox"/>	B. Indicate information source for Q0300A <ol style="list-style-type: none"> 1. Resident 2. If not resident, then family or significant other 3. If not resident, family, or significant other, then guardian or legally authorized representative 9. Unknown or uncertain

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Q0400: Discharge Plan

* Is active discharge planning already occurring for the resident to return to the community?

- * 0. No
- * 1. Yes ... Skip to Q0600, Referral

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Q0490: Resident's Preference to Avoid Being Asked Question Q0500B

- * Does the resident's clinical record document a request that this question be asked only on comprehensive assessments?
- * 0. No
- * 1. Yes... Skip to Q0600, Referral
- * 8. Information not available

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Q0500: Return to Community

- * Ask the resident (or family or significant other or guardian or legally authorized representative if resident is unable to understand or respond): "Do you want to talk to someone about the possibility of leaving this facility and returning to live and receive services in the community?"
- * 0. No
- * 1. Yes
- * 9. Unknown or uncertain

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Q0500: Return to Community

- * A “yes” to item Q0500B will trigger follow-up care planning and contact with the designated local contact agency within approximately 10 business days
- * The SNF/NF should not assume that the resident cannot transition out of the SNF/NF due to their level of care needs
- * If the level of cognitive impairment is such that the resident does not understand Q0500, a family member, significant other guardian and/or legally appointed decision-maker for that individual could be asked the question

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Q0550: Resident's Preference to Avoid Being Asked Question Q0500B Again

- * Q0550A, Does the resident, (or family or significant other or guardian, if resident is unable to respond) want to be asked about returning to the community on all assessments (rather than being asked yearly only on comprehensive assessments)?
 - * Code 0, No
 - * Code 1, Yes
 - * Code 9, Information not available

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Q0550: Resident's Preference to Avoid Being Asked Question Q0500B Again

- * Q0550B, Indicate information source for Q0550A
 - * Code 1, Resident
 - * Code 2, If not resident, then family or significant other
 - * Code 3, If not resident, family or significant other, then guardian or legally authorized representative
 - * Code 8, No information source available

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Q0600: Referral

- * Has a referral been made to the Local Contact Agency? (Document reasons in resident's clinical record)
 - * 0. No - referral not needed
 - * 1. No - referral is or may be needed (For more information see Appendix C, Care Area Assessment Resources #20)
 - * 2. Yes - referral made

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Qo600: Referral

- * Close collaboration between the nursing facility and the local contact agency is needed to evaluate the resident's medical needs, finances and available community transition resources
- * When Qo600 is answered 1, No, a care area trigger requires a return to community care area assessment (CAA) and CAA 20 provides a step-by-step process for the facility to use in order to provide the resident an opportunity to discuss returning to the community

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CAA #20 Return to Community Referral

Triggering condition

- * Referral is or may be needed but has not been made to local contact agency as indicated by: Qo600 = 1

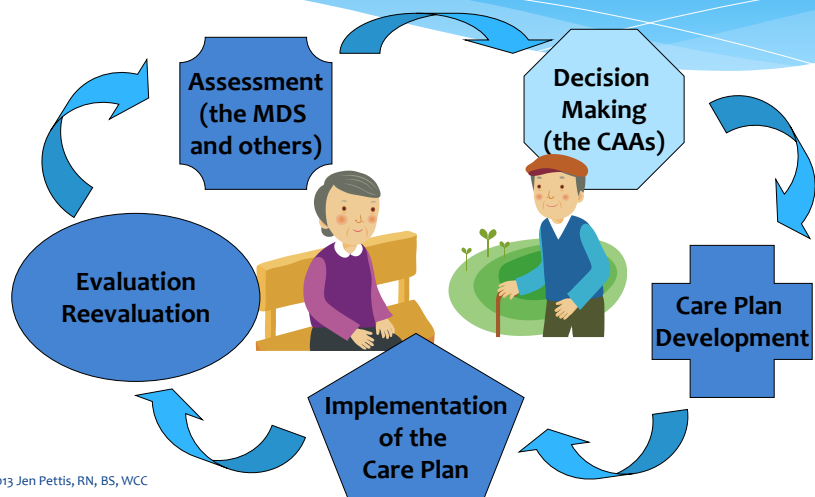
Goal of care planning

- * To initiate and maintain collaboration between the nursing facility and the local contact agency (LCA) to support the individual's expressed interest in being transitioned to community living

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Bridging the MDS to the Care Plan: The Care Area Assessments (CAAs)



Relevant Documentation for Each Triggered CAA Describes:

- * The nature of the issue or condition
- * Causes and contributing factors
- * Complications and risk factors
- * Factors that must be considered in developing individualized care plan interventions, including referrals
- * The resource(s) or assessment tool(s) used and conclusions that arose from performing the CAA
- * Completion of Section V of the MDS

Wyoming Aging and Disability Resource Center (WyADRC)

WyADRC's Mission

“To provide a comprehensive and coordinated system of information and assistance for older Wyoming residents and adults with disabilities.”

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NURSING HOMES, MDS 3.0 and the WyADRC



ADRC Program Resources – National Trends & WyADRC

By engaging in critical pathways to long term services and supports, such as hospital discharge planners, physicians or other health professionals, or long term supports providers, through options counseling, ADRCs convey the range of alternative services and settings available so individuals can both plan ahead and make informed decisions about current needs.



The ADRC initiative is part of a nationwide effort to restructure services and supports for older adults, all persons with disabilities, family members and care providers. It complements long term care system change activities designed to enhance access by older adults and people with disabilities of all ages to community living, personal choice and independence.

Cathie L. Hughes, M.A., M.C.J.
Founder & CEO – SW-WRAP
Program Director, WyADRC

Connecting People to Resources
Bridging Social Supports & Health Care Systems

NURSING HOMES, MDS 3.0 and the WyADRC



Xerox-Wyoming Study – Presentation August 13,2013

- ✓ 24% of Nursing Facilities reported that there were no barriers to transitional services

- ✓ 76% of the Nursing facilities identified that they faced transitional services barriers

✓Barriers: Housing

Lack of ALFs, Limited # of ALFs willing to accept waivers, Lack of affordable housing, low-income housing wait lists

✓Barriers: LTSS Supply

Lack of available Home Health & Hospice Services;
Lack of Adult Day Care Services, lack of Alzheimer's & Gero-Psych Services, Lack of Family Supports

✓Access Barriers

Failure to meet Medicaid eligibility, wait lists for waiver services, travel distances between service providers and clients

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Xerox-Wyoming Study – Presentation August 13,2013

✓ Why Q Referrals are not made for Transition Services:

- Not Familiar with referral process (43.48%)
- Referrals made via phone to the local Project Out Representative (39.13%)
- Instructed by "State" to call Local Project Out Representative (4.35%)
- Done at the Facility Level (4.35%)
- No reason given (4.35%)
- No resident voiced a desire to go home, referral not needed (4.35%)



✓ Reasons Cited for Return to Facility

- Non compliance with treatment plan
- Lack of caregiver support
- The aging process
- Alcoholism
- Physical and mental health challenges
- Physical decline

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NURSING HOMES, MDS 3.0 and the WyADRC



WyADRC works with Wyoming Department of Health and nursing facilities throughout the state to provide options counseling and care transitions support to consumers, their families and caregivers.

MDS CARE PLAN DEVELOPMENT RESOURCES

WyADRC Option Counselors 1-877-435-7851

SW-WRAP/WyADRC Statewide Resource Database
www.swwrap.com or www.wyomingadrc.org

FIND HELP LINK (<http://www.swwrap.com/index.php/component/cpx/?Itemid=118>)

Set up your own resource group or groups to quickly access your most frequently used resources!

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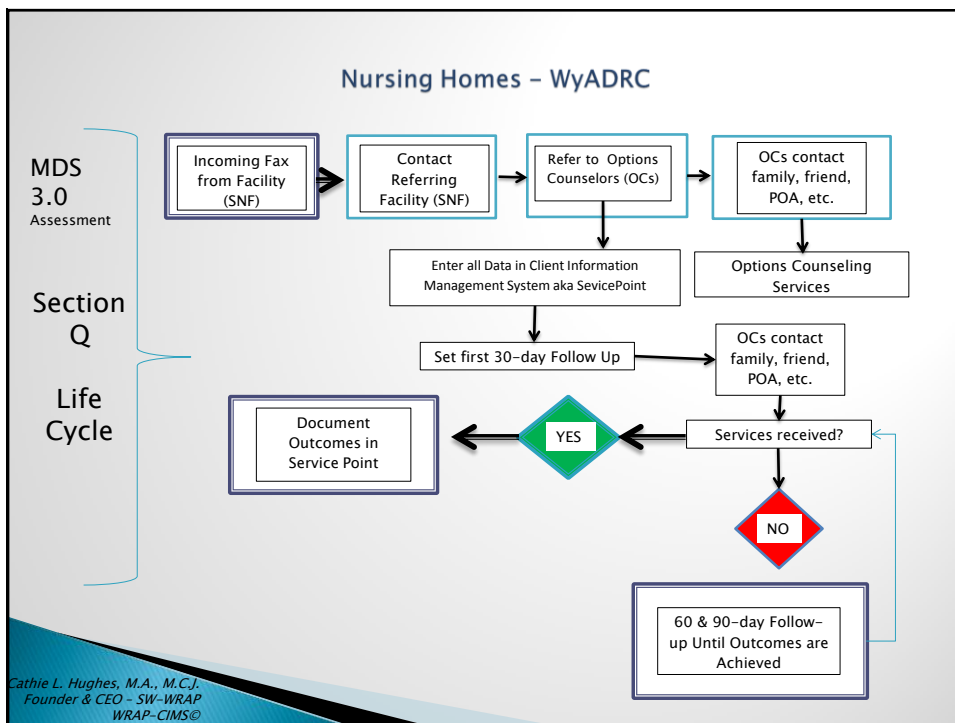
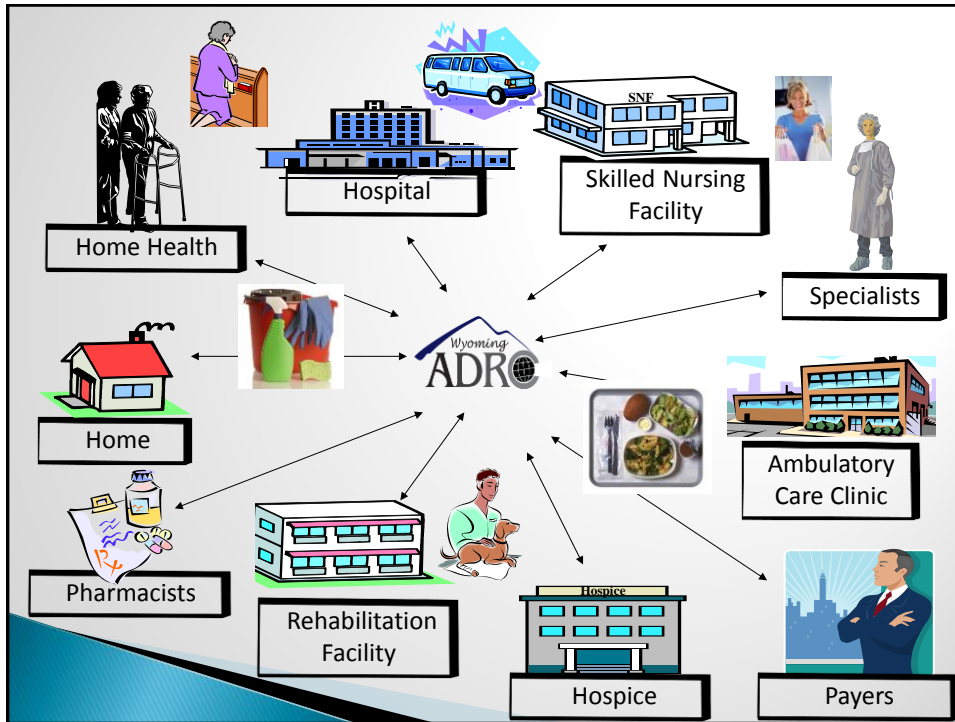


Identified Partners for the Integrating Care for Populations and Communities Learning Action
 Networks (LANs) – Mountain-Pacific QIO

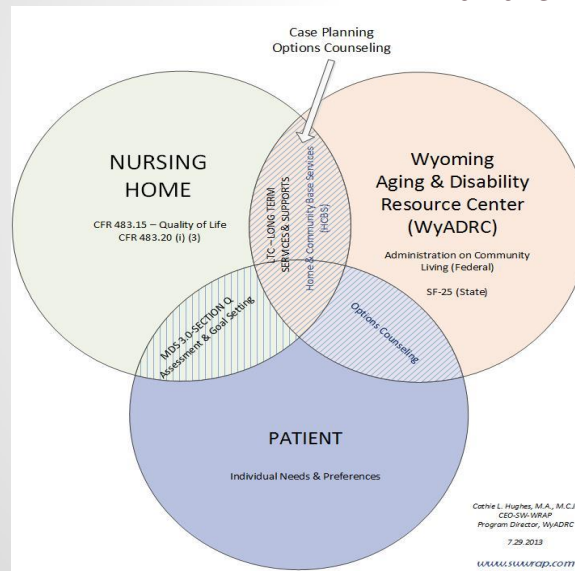
- | | |
|--|---------------------------------|
| ✓ Hospitals, SNFs | ✓ Hospice / Home Health |
| ✓ PCPs & Staff, Hospitalists | ✓ Pharmacists |
| ✓ Nurses, Case Managers,
Discharge Planners | ✓ Community Service Providers |
| ✓ PT, OT and Speech Therapists | ✓ Beneficiaries/Support Systems |
| | ✓ Caregivers |
| | ✓ Others |

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MDS 3.0 Collaboration & Services Coordination with the WyADRC



SW-WRAP / WyADRC

Nursing Homes, Section Q Referrals, and the WyADRC



For More Information, Contact the WyADRC @ 307-875-2196 or
Cathie Hughes @ ceo@swwrap.com

*Cathie L. Hughes, M.A., M.C.J.
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Questions?



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