Quality of Life and the MDS

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How the MDS impacts Quality of Life

- Appendix PP: CMS “Guidance to Surveyors of Long Term Care Facilities”
  - Regulations and F-Tags address assessment of individual care plan interventions and on-going assessment of resident
- Revisions to CMS Transmittal 48, Issued June 12, 2009
  - Addresses many components of Quality of Life issues
  - “Promote care in a manner and environment that maintains or enhances each resident’s dignity and respect in full recognition of his/her individuality”
  - Self Determination and Participation
  - Accommodation of Individual Needs
- Many items captured in MDS Section AC and then throughout the clinical assessment items

Objectives

- Understand the RAI process of coding, assessing, and care planning in MDS sections
- Understand how the MDS impacts Quality of Life
- Understand the timing for completing the various assessments required
- Understand appropriate coding for Section “K” and “N” to improves resident care and Quality of Life
- Understand the timeline for implementation of MDS 3.0

The Minimum Data Set (MDS)

- SECTION A – Identification and Background Information
- SECTIONS B-Q – Clinical Assessment
  - These are the primary sections that impact Quality of Care and QIs, QMs, and RUGs items
  - SECTION R – Signature and Completion Date
- SECTION S – State Section – Not utilized by every state
The Minimum Data Set (MDS)

- **SECTION T – Supplement**
  - Required for all Medicare assessments
  - Required by some states for all assessments
- **SECTION U – Medications**
  - Not used by CMS, may be required by state
- **SECTION V – Resident Assessment Protocol Summary**
  - Must be completed with each federally required comprehensive Assessment
- **SECTION W – Supplemental Items**
  - Implemented October 2005 to document National Provider Identifier and to provide data to track rates of influenza and pneumococcal vaccinations

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**Types and Timing of Assessments**

- **Types of Assessments**
  - Comprehensive: Full assessment form + RAPs + care planning
    - Admission
    - Annual
    - Significant Change
    - Significant Correction of prior Full

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**The Minimum Data Set (MDS)**

- Discharge and Reentry Tracking forms – Track resident’s movements from and to the SNF
  - Discharged Prior to Completing Initial Assessment
  - Discharged Return Not Anticipated
  - Discharged Return Anticipated
  - Determines MDS requirements upon resident’s readmission

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**Types of MDS Forms**

- “Full” Assessment Form
  - Sections A – R and plus any state-required sections
  - Section T required for PPS assessments
- Quarterly Assessment Form
  - Subset of Full Assessment Form items
  - Each state must designate the form to be used in the state and may require additional items
Admission Assessment

• Admission assessment is performed **one time only**, upon initial admission to the facility
  – Exception: When resident returns after being
  – Discharged-Return Not Anticipated
  – This is true regardless of:
  – How long the resident is out of the facility
  – Whether or not bed was held
  – Whether or not medical record was closed

Annual Assessment

• Must be completed at least once every 366 days
• Any comprehensive assessment can meet this requirement
  – Annual assessment
  – Significant Change in Status assessment
  – Significant Correction of a prior Full assessment

Annual Assessment Timeline

• R2b, MDS completion, must be on or after the latest date AA9 and no later than 14 days after ARD (A3a)
• VB2, RAP completion, must be on or after R2b and no later than 14 days after ARD (A3a)
• VB4, care plan completion, must be on or after VB2 but no later than 7 days after the date at VB2

Timing

• R2b RN signature certifies completion of the MDS assessment process, must be on or after
  – latest date in AA9 and no later than 14 days after ARD (A3a)
• VB1 RN signature completing the RAP process
• VB3 Signature of person stating completion/review of care planning decisions.
  – Must be completed within 7 days of VB2 (date)
  – Any member of the care planning team can
SCSA

- Required when resident has a significant change as defined by the regulations
  - Has an impact on more than one area of the resident's health status
  - Significant change in status = decline or improvement in resident's status that:
    - Will not normally resolve itself without intervention by staff or by implementing standard disease-related clinical interventions
    - Requires interdisciplinary review or revision of the care plan, or both
- Not appropriate if initial Admission assessment has never been completed
  - Comprehensive MDS form is used with RAPs and Care Plan items
  - Must be completed within 14 days of documented changes

Quarterly Assessment

- Quarterly forms are designated by states
  - The 2-page minimum-required MDS Quarterly form
  - Optional version for RUG-III Quarterly form
  - Optional version for RUG-III 1997 update Quarterly form
  - MDS Medicare PPS Assessment Form (MPAF)
  - Comprehensive assessment always can take place of
- R2b, Quarterly completion, no later than 92 days after the R2b of the last assessment
- R2b no later than 14 days after the ARD (A3a)
- R2b on or after the latest AA9 date and no later than 14 days after the ARD (A3a)

Discharge Tracking Forms

- Must be completed when resident
  - Dies
  - Is admitted to another health care facility
  - Is discharged home or to lower level of care
- Requirements apply
  - Regardless of facility’s policy for discharge or bed holds
  - Regardless of facility’s policy for opening and closing of records
  - Regardless of how long the resident is out of the facility
- Not required when the resident
  - Is on temporary visit home or other social or therapeutic leave
  - Is in a hospital observational stay of < 24 hours and is not admitted to the hospital
- Discharge and Reentry Flow Chart
  - RAI User’s Manual, p. 2-26

Discharge Tracking Forms

- Three separate codes to choose from:
  - A8a = 8: Discharged-Prior to Completing Initial Assessment
    - Required any time resident is discharged before the initial Admission assessment is completed regardless of reason for discharge
  - A8a = 6: Discharged-Return Not Anticipated
    - Resident is discharged and not expected to return to the facility
  - A8a = 7: Discharged-Return Anticipated

AA9 Must be completed within 7 days following discharge
Reentry Tracking Form
A8a = 9
- Completed upon return only when Discharged-Return Anticipated tracking form was completed at time of discharge
- Not appropriate following discharge with Return Not Anticipated
- Not appropriate following Discharged-Prior to Completing Initial Assessment

Section K
Oral/Nutritional Status

Section K

- Recognition of the interrelationships of functional status, nutrition, hydration, and depression is essential to accurate coding and successful intervention
- Must be an interdisciplinary assessment: “The appropriate health professionals should conduct the assessment even though each of them might not actually encode the data into the MDS”
- All items have a seven day look back from the ARD

Section K
K1 – Oral Problems
- Identifies problems that might contribute to nutritional problems and weight loss
  - Code chewing and swallowing problems even when interventions have been successful in resolving the problem
    - Dietary modifications such as thickened liquids for swallowing problem
    - Compensatory techniques such as double swallow for swallowing problem
    - Dentures and/or mechanical soft diet for chewing problem
    - Tube feeding or IV nutrition for dysphagia
Section K

K2 – Height and Weight
- Measure height in inches at least annually
  - Round height upward to nearest whole inch
  - Measure using consistent technique (shoes off, etc.)
  - For bedbound resident, measure along entire length of trunk and legs, running tape measure along bended hip, thigh, bended knee, lower leg
  - If resident unable to stand to obtain current height or is missing limbs, use another means of determining height per current standards of clinical practice

Section K

K3 – Weight Changes
- Weight loss or gain based on change of 5% or more in last 30 days, or 10% or more in last 180 days
- Compares two snapshots in time:
  - The weight taken in the 30-day period prior to the 30-day period ending in the current observation period, and to
  - The weight reflected in the observation period of the MDS completed 6 months prior

K3 – Weight Changes (continued)
- Do not wait until Quarterly MDS assessment to assess weight status
  - Weigh at least monthly
  - Assess meal intake at least weekly
  - Assess fluid I&O periodically to ensure proper hydration status (fluid overload causes weight gain)
- Do not wait for the 30 or 180-day timeframe if the resident is losing/gaining a significant amount of weight
  - Change of 5% in one month, 7½% in 3 months, 10% in 6 months → thorough assessment
Section K
K4 – Nutritional Problems
• Intent: To identify specific problems, conditions, and risk factors for functional decline that affect or could affect resident’s health or functional status
  – K4a: Complaints about the taste
  – K4b: Regular or repetitive complaints of hunger
  – K4c: Leaves 25% or more of food uneaten at most meals

Section K
K5 – Nutritional approaches
• 7-day observation period
• K5a - Parenteral/IV includes only fluids administered for nutrition or hydration
  – IV fluids or hyperal, including TPN, administered continuously or intermittently
  – IV fluids running at KVO (Keep Vein Open)
  – IV fluids administered via heparin locks
  – IV fluids contained in piggybacks
  – IV fluids used to reconstitute medications for IV administration

Section K
• K5a – Parenteral/IV does NOT include:
  – IV medications
  – IV fluids administered as a routine part of an operative or diagnostic procedure or recovery room stay
  – IV fluids administered solely as flushes
  – Parenteral/IV fluids administered during chemotherapy or dialysis

Section K
• K5c, Mechanically Altered Diet, and K5e, Therapeutic Diet
  – Mechanically altered refers to texture; therapeutic refers to nutritional content
    • Mechanically altered is not automatically therapeutic unless it meets the definition
  – Do not code enteral feeding formulas as mechanically altered
  – Code enteral feeding formulas as therapeutic diets only when they meet the definition
Section K

K6 – Parenteral or Enteral Intake

• Intent: To record the proportion of calories received, and the average fluid intake, through parenteral or tube feeding in last 7 days
  – Complete this section only if K5a, parenteral/IV and/or K5b, feeding tube, is checked
• K6a – Calorie intake
  – If resident has IV and/or tube feeding and took nothing by mouth or only sips of fluids, then K6a=4. 76% to 100% by parenteral or enteral route
  – Dietitian will need to do a calorie count if resident had more oral intake than that (see p. 3-156 of RAI Manual)

Section K

K6 – Parenteral or Enteral Intake (continued)

• K6b – Average fluid intake
  – Calculate the actual amount of fluid received
    • Include free water in tube feeding and IV piggybacks
    • Do NOT include heparin flush solutions
  – Calculate over the last 7 days even if the resident was not in the facility for all of the 7 days**
  – Calculate over the last 7 days even if the resident did not receive fluids on all 7 days**
  **Divide the week’s total fluid intake via IV/tube feeding by 7 days in all cases

Section N

Activity Pursuit Patterns

N1 – Time Awake

• Identifies periods of a typical day in the last 7 days when the resident was awake all or most of the time
  – Defined as no more than a total of a one hour nap during any of the periods
  – Resident who naps a lot may be bored or depressed
  – Resident who is awake most of the time should be encouraged to be mentally, physically, socially active
• Accurate assessment of past and current activity interests and abilities is the foundation for building an activity program
## Section N

- **N2 – Average Time Involved in Activities**
  - Refers to proportion of available time resident was actually involved in activity pursuits
    - Consider free time when the resident was awake and
    - Was not involved in receiving nursing care or treatments
    - Was not engaged in ADL activities (including eating)
    - Pursuing independent activities (watering plants, reading, writing letters, watching soap operas)
    - Social contacts with family, residents, staff, volunteers
    - Recreational pursuits in a group, one-on-one, or an individual basis
    - Involved in Therapeutic Recreation

- **N3 – Preferred Activity Settings**
  - Do not limit preference list to areas to which the resident now has access
  - Identify areas in which the resident is most at ease
  - Build the activity program based on these preferences

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## Section N

- **N4 – General Activity Preferences (adapted to resident’s current abilities)**
  - Choices should not be limited by whether the activity is currently available to the resident or by whether the resident currently engages in the activity
  - Identify preferences and incorporate them into the plan of care as appropriate to resident’s capabilities
  - Resident may be facing a future that cannot include some of her/his favorite activities due to change in functional status

- **N5 – Prefers change in daily routine**
  - To determine if resident has interest in pursuing activities not offered or not made available to the resident
  - Includes situations in which an activity is provided but resident would like other choices within the activity
  - Ask resident, discuss with close family or friend, and observe throughout the day
Section N
N5 – Prefers change in daily routine
(continued)
• Need for change in the program can be signaled in many ways
  – Outright refusal to participate
  – Declining to participate because of fatigue or other vague reasons
  – Restlessness, agitation during activities
• Depression can play a role here – be alert to the need to assist resident in adaptation to her/his changed situation

MDS 3.0
• To make the MDS more clinically relevant while still achieving the federal payment mandates and quality initiatives
• To improve ease of use and efficiency
• To integrate selected standard scales
• To listen to the resident’s voice
• To provide consistency in look back
• To retain/improve some MDS 2.0 items and wording
• To retain items for RUGs and Quality Indicators/Measures

Resources
• Provider Instructions for Making Automated Corrections
  http://www.qso.com/download/mds/PrMn1002.pdf
• MDS Automation and Transmission Manuals
  http://www.qso.com/mds/download.html
• Special Long Term Care Open Door Forum on MDS 3.0 materials
  http://www.cms.hhs.gov/OpenDoorForums/05_ODF_SpecialODF.asp