

Quality of Life and the MDS

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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 improve resident care and Quality of Life
- Understand the timeline for implementation of MDS 3.0

2

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

3

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

4

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

5

The Minimum Data Set (MDS)

- *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

6

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

7

Types and Timing of Assessments RAI User’s Manual, Chapter 2

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

8

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

9

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

10

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

11

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

12

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

13

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)

14

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

15

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

16

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

17

Section K Oral/Nutritional Status

18

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

19

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

20

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

21

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: Compare the weight in the current observation period to:
 - 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

22

Section K

K3 – Weight Changes

- Calculating weight changes
 - Do not round weights. Obtain actual weights for the 30-day and 180-day time periods from chart
 - Multiply resident's weight from 30 days ago by the proportion ($5\% = 0.05$). If resident has gained or lost more than this 5%, code accordingly at K3a or K3b
 - Multiply resident's weight from 180 days ago by the proportion ($10\% = 0.10$). If resident has gained or lost more than this 10%, code accordingly at K3a or K3b
 - Do not round percentages up or down

23

Section K

K3 – Weight Changes (continued)

- Do not wait until Quarterly MDS assessment to assess weight status
 - Weigh at least monthly
 - Assess meal intakes 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

24

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

25

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

26

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

27

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

28

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)

29

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

30

Section N Activity Pursuit Patterns

31

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

32

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

33

Section N

- 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

34

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

35

Section N

- 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

36

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

37

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

38

Resources

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

39