



Wyoming
Department
of Health



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Mountain-Pacific
Quality Health

Need to Know: Significant Change and Discharge Assessments

Jane Belt, RN, MS, RAC-MT, RAC-MTA, QCP
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Learning Objectives

- Determine completion requirements for completing significant change assessments
- Delineate types of discharge assessments
- Review survey deficiencies related to significant change and discharge assessments

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OBRA Significant Change in Status

A0310. Type of Assessment

Enter Code

0

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A. Federal OBRA Reason for Assessment (required by day 14)

- 01. Admission assessment
- 02. Quarterly review assessment
- 03. Annual assessment
- 04. Significant change in status assessment
- 05. Significant correction to prior comprehensive assessment
- 06. Significant correction to prior quarterly assessment
- 99. None of the above


• SCSA
• A0310A = 04

Comprehensive Item Set (NC)
— Includes CAAs

RAI Manual p. 2-22 – 2-29

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Significant Change in Status

- **Required** when the IDT determines a resident meets the significant change guidelines for either major improvement or decline
- Can be performed any time after the completion of an Admission assessment
- Completion dates (MDS/CAAs/care plan) depend on date the IDT determination was made that significant change had occurred

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"Significant Change"

Major decline or improvement in resident's status:

Will not normally resolve itself without intervention by staff or by implementing standard disease-related clinical interventions, the decline is not considered "self-limiting";

Impacts **more than one area** of the resident's health status; and

Requires interdisciplinary review and/or revision of the care plan

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TIP!

Managing SCSAs

- If it is not clear that a resident's status change meets the SCSA guidelines, the IDT can take up to 14 days to make the determination
- If condition does not return to the resident's baseline status in 14 days, then a significant change determination needs to be started
- Once the IDT determines the resident has met the significant change guidelines, the initial identification of the significant change should be documented in the medical record

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Delving into the Definition

- “Self-limiting” = when the condition will normally resolve itself without further intervention or by staff implementing standard disease-related clinical interventions. If the condition has not resolved within 2 weeks, staff should begin a SCSA
- Use clinical judgment – resident gets the flu with vomiting and diarrhea and experiences 5% weight loss in first week. Monitor, provide fluids, nutrition as tolerated, and if the resident starts to regain weight – no SCSA would be required

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Significant Change in Status Assessment

Appropriate when:

- Determination that a significant change in a resident's condition from his/her baseline has occurred by comparison of resident's current status to the most recent OBRA assessment
- Condition is not expected to return to baseline within two weeks
- Resident who is terminal enrolls in a hospice program
- Resident receiving hospice services decides to discontinue services (revokes hospice)
- Resident changes hospice providers

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Significant Change in Status Assessment

Another consideration:

- A SCSA would **not** be appropriate in situations where the resident has stabilized but is expected to be discharged in the immediate future. The nursing home has engaged in discharge planning with the resident and family, and a comprehensive reassessment is not necessary to facilitate discharge planning

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SCSA

- **Terminal residents:**
 - SCSA not required if decline is expected course of the terminal disease process
 - If a terminally ill resident experiences a new onset of symptoms or a condition that is not part of the expected course of deterioration, and the criteria are met for a SCSA, a SCSA is required

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SCSA and Hospice Election

- An SCSA is required to be performed when a terminally ill resident **enrolls in a hospice program** (Medicare-certified or State-licensed hospice provider) **or changes hospice providers** and remains a resident of the nursing facility
 - Must be completed regardless of whether an assessment was recently conducted on the resident
 - Purpose is to ensure a coordinated care plan between the hospice and the nursing home
 - ARD must be within 14 days from the effective date of hospice

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SCSA and Hospice Election

- If resident is admitted on hospice benefit, the facility should complete the Admission Assessment and capture hospice (O0100K)
 - Completing an Admission Assessment followed by an SCSA is not required unless the resident elects hospice AFTER the ARD of the Admission Assessment
- When the hospice election occurs after the Admission Assessment ARD but prior to its completion, facilities may choose to adjust the ARD to the date of hospice election and complete only the Admission Assessment
 - In such situations, an SCSA is not required (p. 2-23)

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SCSA and Hospice Discontinues

- If resident is admitted on hospice benefit but decides to discontinue it *prior* to the ARD of the Admission Assessment, the facility should complete the Admission Assessment, checking the Hospice Care item, O0100K
- Completing an Admission Assessment followed by a SCSA is not required
- When hospice revocation occurs after the Admission Assessment ARD, but prior to its completion, facilities may choose to adjust the ARD to the date of hospice revocation so that only the Admission Assessment is required
- In such situations, an SCSA is not required (page 2-24)

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SCSA and Hospice Discontinues

- An SCSA is required to be performed when a resident receiving hospice services *discontinues* those services (revoking of hospice services)
 - The ARD must be within 14 days of one of the following:
 - The effective date of the hospice revocation
 - The expiration date of the certification of terminal illness
 - The date of the physician's or medical director's order stating resident is no longer terminally ill (pages 2-23 and 2-24)

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SCSA

- If there is only one change, staff may still decide that the resident would benefit from an SCSA
- Nursing home staff must document the rationale, in the resident's medical record, for completing the SCSA that does not meet the criteria for completion

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SCSA Timing

- ARD must be less than or equal to 14 days after the determination date (date + 14 calendar days)
- MDS completion date (Z0500B) no later than 14 days from the determination date (determination date + 14 calendar days)
- CAAs completion date (V0200B2) same as MDS, could be earlier than MDS – not later
- Care plan completion (V0200C2) no later than 7 calendar days after the CAA completion date (V0200B2 + 7 days)

OBRA-Required Assessment Summary – RAI pgs. 2-16-2-18

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Take Advantage of CAA Guidance and SCSA

- Review all triggered care areas compared to the resident's previous status
- If the CAA process indicates no change in a care area, then the prior documentation for the particular care area may be carried forward
- The nursing home should specify where the supporting documentation can be located in the medical record

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Need to Refer for Level II PASRR?

- Preadmission Screening and Resident Review (PASRR)
 - Identifies individuals with mental illness, intellectual disability, or a condition related to intellectual disability that may require special services
- When a significant change in status assessment is being completed for a resident known or suspected to have one of the following:

<ol style="list-style-type: none"> 1. Mental illness 2. Intellectual disability 3. Condition related to intellectual disability 	}	<p>A referral to the state mental health or intellectual disability/DD authority for a possible Level II PASRR evaluation must promptly occur</p>
--	---	---

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Significant Change in Status Assessment

Significant change differs from a significant error because it reflects an actual significant change in the resident's health status and NOT incorrect coding of the MDS

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SCSA Guideline Examples

- **Decline** in two or more of the following:
 - Resident's decision-making ability has changed
 - Presence of a resident mood item not previously reported by the resident or staff and/or an increase in symptom frequency (PHQ-9®)
 - Increase in the number of areas where behavioral symptoms are coded as being present and/or the frequency of a symptom increases for items
 - Changes in frequency or severity of behavioral symptoms of dementia that indicate progression of the disease process since the last assessment

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SCSA Guideline Examples

- **Decline (cont.):**
 - Any decline in an ADL physical functioning area (at least 1) where a resident is newly coded as 3, 4 or 8 (Extensive assistance, Total dependence, Activity did not occur) since last assessment in Section G and does not reflect normal fluctuations in that individual's functioning
 - Incontinence pattern changes or there was placement of an indwelling catheter
 - Emergence of an unplanned weight loss problem (5% change in 30 days or 10% change in 180 days)

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SCSA Guideline Examples

• Decline (cont.):

- Emergence of a new pressure ulcer at Stage 2 or higher, a new unstageable pressure ulcer/injury, a new deep tissue injury or worsening in pressure ulcer status
- Begins to use restraint of any type when it was not used before
- Emergence of a condition/disease in which a resident is judged to be unstable

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SCSA Guideline Examples

• Improvement in two or more of the following:

- Any improvement in ADL physical functioning areas (at least 1) where a resident is newly coded as Independent, Supervision or Limited assistance since last assessment and does not reflect normal fluctuations in that individual's functioning
- Decrease in the number of areas where behavioral symptoms are coded as being present and/or frequency of a symptom decreases
- Resident's decision-making improves
- Resident's incontinence pattern improves

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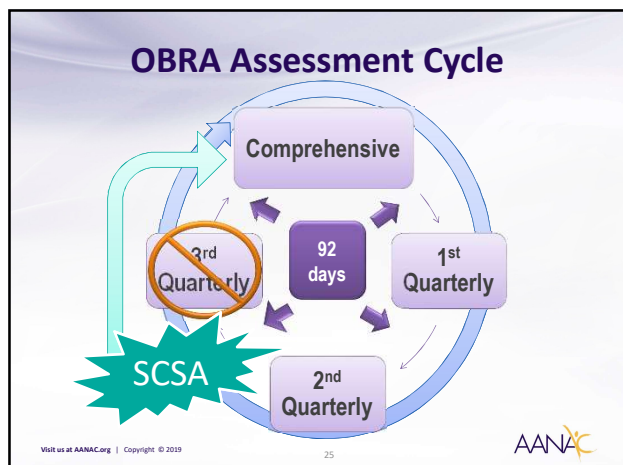
SCSA Impact on Assessment Cycle

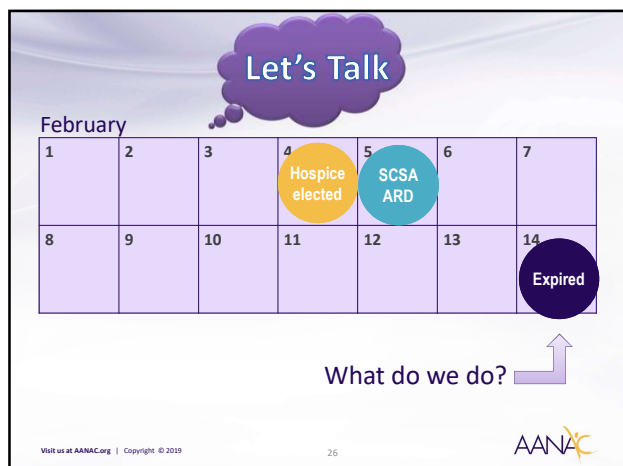
- Completion of a Significant Change in Status Assessment will reset the OBRA cycle
 - Next OBRA assessment due is a Quarterly within 92 days of SCSA ARD
 - Next comprehensive OBRA assessment due is an Annual within 366 days of SCSA ARD

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Think About

- Resident readmitted to nursing home from the hospital
- The IDT determined that the resident had experienced a significant change in their health status
- The ARD was set and the SCSA was completed within the 14 day window
- On day 16, the resident elected the hospice benefit
- What do you do?

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OBRA Discharge Assessments

- Must be completed any time:
 - Resident is discharged to a private residence, or
 - Admitted to acute hospital, or
 - Hospital observation stay exceeds 24 hours
 - Resident is transferred from a Medicare- and/or Medicaid-certified bed to a noncertified bed
- Applies:
 - *Regardless* of facility's policy for opening and closing of records
 - *Regardless* of bed-hold status
 - **May be combined with other assessments**

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Discharge Assessments

- **Not** required when the resident:
 - Is on temporary home visit of at least one night
 - Is on therapeutic leave of at least one night
 - Is in a hospital observational stay of < 24 hours and is not admitted to the hospital
- ARD must equal the discharge date (A2000)

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OBRA Discharge Assessments

Return Not Anticipated

- A0301F = 10
- Must be completed when resident discharged and **not** expected to return within 30 days
- If does return, Entry record (A1700) coded as 1 = Admission
- If payer is Medicare Part A, PPS schedule starts with 5-day (can be combined with Admission)
- Completion (Z0500B) within 14 days after discharge date (A2000 + 14 calendar days)

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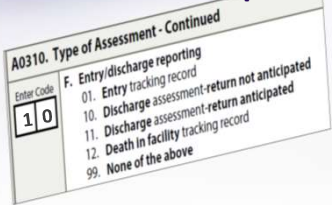
30

Return Anticipated

- A0310F = 11
- Must be completed when resident discharged and expected to return within 30 days
- If discharged to hospital, complete DRA unless it is known that he/she will not return within 30 days
- When returns, Entry record (A1700) coded as 2 = reentry and would be completed every time readmitted
- Complete (Z0500B) within 14 days after discharge date (A2000 + 14 days)




OBRA Discharge Assessment - Return Not Anticipated (RNA)



- **OBRA Discharge Item Set (ND)**
 - Subset of items from Comprehensive
 - Used when resident is discharged to:
 - Home, lower level of care, another nursing home
 - Does not include CAAs

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Discharge Return Not Anticipated Impact on Assessment Cycle

Resident discharges return not anticipated:

Annual

→

Quarterly

→

DC-
RNA


→

STOP

The assessment cycle ends for this resident

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Discharge Return Not Anticipated Impact on Assessment Cycle

Resident discharges return not anticipated and admits again at later date

Annual

→

Quarterly

→

DC-
RNA

→

STOP

Admission

→

Quarterly

→


Quarterly

→

Restart with admission type entry record, followed by a new Admission assessment

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OBRA Discharge Assessment-Return Anticipated

A0310. Type of Assessment - Continued

Enter Code	F. Entry/discharge reporting
11	01. Entry tracking record
	10. Discharge assessment-return not anticipated
	11. Discharge assessment-return anticipated
	12. Death in facility tracking record
	99. None of the above

- **OBRA Discharge Item Set (ND)**
 - Subset of items from comprehensive
 - Does not include CAAs
 - Discharge to inpatient hospital admission
 - Respite stay when resident comes in and out on relatively frequent basis and reentry can be expected within 30 days

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Discharge Return Anticipated Impact on Assessment Cycle

Resident discharges **return anticipated** and returns within 30 days

```

graph LR
    A[Annual] --> B[Quarterly]
    B --> C[DC-RA]
    C --> D{SCSA?}
    D -- No --> E[Quarterly]
    E --> F[Quarterly]
    F --> G[Annual]
    G --> A
    D -- Yes --> H[SCSA]
    H --> I[Quarterly]
    I --> J[Quarterly]
    J --> K[Quarterly]
    K --> C
  
```

- Evaluate for a SCSA on return, if **No**, continue current OBRA Cycle
- In determining if a resident returned to the facility within 30 days, the day of discharge is not counted in the 30 days

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Discharge Return Anticipated Impact on Assessment Cycle

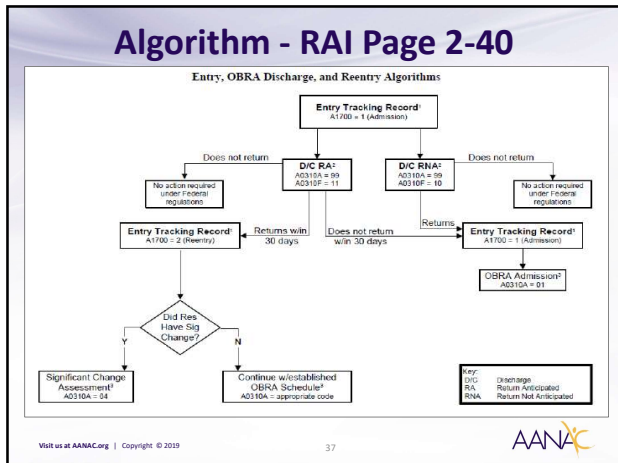
Resident discharges **return anticipated** and returns within 30 days

```

graph LR
    A[Annual] --> B[Quarterly]
    B --> C[DC-RA]
    C --> D{SCSA?}
    D -- Yes --> E[SCSA]
    E --> F[Quarterly]
    F --> G[Quarterly]
    G --> H[Quarterly]
    H --> C
    D -- No --> I[Quarterly]
    I --> J[Quarterly]
    J --> K[Annual]
    K --> A
  
```

- Evaluate for a SCSA on return
- If yes, the SCSA will reset the cycle

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Discharge Assessments: Unplanned

- **Unplanned discharges (A0310G):**
 - Stand-alone Discharge Assessment
 - Scripted Mood and Pain interviews not required
 - Complete staff assessment of mental status: ST memory (C0700), LT memory (C0800), and C1000 (cognitive skills for daily decision making)
 - If combining unplanned discharge combined with other assessments which require interviews (e.g., 14-day and unplanned discharge)
 - If the resident was interviewable, but the interview was not attempted for any reason (including left unexpectedly), item C0100 is coded “yes” then dash the rest as per the RAI manual instructions. Do not proceed to the staff assessment

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A0310. Type of Assessment

A0310G. Definition of unplanned discharge

Transfer to acute care hospital or ER to stabilize a condition or determine if an acute care admission is required based on ER evaluation

or Resident unexpectedly leaves the facility against medical advice

or Resident unexpectedly decides to go home or to another setting

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Discharge and Reentry FAQ

Q: What happens if the resident returns after a discharge return not anticipated?

A: You must complete a new Admission Assessment and begin a new schedule

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Discharge and Reentry FAQ

Q: If a resident is transported to the ER and is gone overnight (less than 24 hours) but is not admitted to the hospital, what assessment(s) should be completed?

A: No additional assessments are required since the resident is still in an admitted status in the nursing home

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Discharge and Reentry FAQ

Q: What should I do if I learn that a resident who was discharged return anticipated to the hospital goes to a different facility when he is discharged from the hospital?

A: Once you learn that a resident has in fact been admitted to another facility or has expired and will not be returning to your facility, there is no federal requirement to inactivate the resident's record nor to complete another Discharge Assessment. Contact State Agency/State RAI coordinator for specific state requirements

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CMS 2567

Citations in the Nation with Severity Level D and Above

	Total	D	E	F
F637 Significant Change	455	411	37	7

E. Change in status for 3 out of 15 sampled residents:

- Cognition, ADLs, ROM, and bowel and bladder continence
- Cognition, a urinary catheter, and significant weight loss
- ADLs, bowel and bladder continence, and weight loss

F. Change in mental and physical condition for 1 of 26 residents:

- Multiple physical and verbal behaviors; decline in ADLs, falls with injuries (laceration on head, black eye). Nurse acknowledged changes, but said resident was private pay, was going home soon, but then did not go

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D. Based on interview and record review, the facility failed to develop an MDS for a significant change in status for one of 18 sampled residents. Findings: during an interview with the MDS nurse, it was found that the resident discharged to the hospital on [DATE] and returned to the facility on [DATE]. Resident's MDS Discharge assessment dated [DATE], indicated an unplanned discharge to the acute hospital with a return anticipated.

MDS Admission assessment indicated Resident had these changes and a decline in function: communication - no speech, sometimes understood and sometimes understands; cognition - severely impaired (never/rarely made decisions); functional status – ext. assist with eating, dependent with locomotion on and off unit; bowel - always incontinent; nutritional status - weight = 162#(12.4% weight loss in the last 3 months and 8.9 % in the last 30 days), on feeding tube. The MDS nurse confirmed the findings. She stated a significant change in status MDS assessment should have been done

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