Learning Objectives

- Describe why the MDS matters to hospital and nursing home clinicians
- Identify key components of longitudinal care
- Detail the granular elements of an effective discharge plan between care settings

Why Care Coordination Matters?

- Strong transitional care practices seek to ensure coordination and continuity of care as patients transfer between different venues
- IOM has called for greater integration of care delivery across settings
- Why the challenge is greater:
  - Aging population – greater complexity
  - Proliferation of care venues
  - Providers increasingly define practice by location
Why Care Coordination Matters?

- Hospitals focus on patient acute disease processes and episodes
- Nursing homes focus on resident functional abilities and quality of life
- Home and Community based services focus on customer/consumer directed care and quality of life


Challenge: The Spectrum of Care is Vast... as are the Barriers to Care Coordination

Acuity of Illness
- Acute Care Facility
- Emergency Department
- Physician Office
- Outpatient Testing/Pharmacy/OSE

Intensity of Care
- Living at Home
- Home Health
- Hospice
- Nursing Facility
Why Care Coordination Matters?

- Electronic Health Records and technology adoption is radically changing how we care for patients
OVERVIEW OF THE MDS
Connecting the MDS to quality outcomes

RAI and MDS Background
• Omnibus Budget Reconciliation Act of 1987 (OBRA ‘87)
  – Dramatically changed the way Nursing Facilities approached resident care, radically modifying nursing home regulations and the survey process
  – Established requirement for a nationwide, comprehensive, standardized, reproducible assessment of each resident’s functional status.

Minimum Data Set (MDS)
• Federally mandated tool that drives:
  – Resident care
  – Medicare Skilled Nursing Facility Prospective Payment System (SNF PPS)
  – Medicaid case-mix payment systems
  – Regulatory oversight and facility quality improvement activities through the Quality Measures (QMs)
  – Consumer oversight through Quality Measures (QMs)
Resident Assessment Instrument

- Assessment process is like the nursing process
  - Developed as a tool to improve care by improving assessment and care planning
  - Aimed at regulatory mandate: Provide necessary care and services to attain or maintain the highest practicable well-being for each resident

Accuracy of Assessments

Interdisciplinary Process

- "Accuracy of Assessment" means that the "appropriate, qualified health professional" correctly documents resident’s status
- Assessment must be conducted by "staff that are qualified to assess relevant care areas" and knowledgeable about the resident
- Assessments must be conducted "with the appropriate participation of health professionals"

Highlights of the MDS 3.0

Section B – Hearing, Speech and Vision
  - Skip if comatose
  - Assess hearing, speech, and vision
  - Assess for communication difficulties
Highlights of the MDS 3.0

Section C – Cognitive Patterns
- Brief interview for Mental Status (BIMS) – assessor is told not to attempt test if resident is rarely/never understood or if comatose as determined in Section B
  • Scripted interview with complete directions
- If unable to interview the resident, staff members assess mental status
- Signs and symptoms of delirium adapted from the Confusion Assessment Method (CAM)

Highlights of the MDS 3.0

Section D – Mood
- Resident Mood Interview uses the Patient Health Questionnaire (PHQ-9)
- If the resident is rarely/never understood, staff assessment or PHQ-9-OV (observational version) is conducted
- Used in RUG IV calculations

PHQ-9 and PHQ-9-OV

Section D – Mood
- Both tools require computation of a total severity score for depression
- Scale:
  • 0-4 none
  • 5-9 mild
  • 10-14 moderate
  • 15-19 moderately severe
  • 20-27 severe (20-30 for PHQ-9-OV)
Highlights of the MDS 3.0

Section E - Behavior
- Assesses for any psychosis including hallucinations and delusions
- Requires information on behavioral symptoms, both presence and frequency
- Assesses impact of the behavioral symptoms on the resident and others
- Assesses for "rejection" of care
- Requires determination of wandering, both presence and frequency

Highlights of the MDS 3.0

Section F – Preferences for Customary Routine and Activities
- Daily Preferences / Choices
  - Clothing
  - Taking care of your personal possessions
  - How you are bathed
  - Snacking between meals
  - Your bedtime
  - Family involved in discussions about you
  - Your phone privacy
  - Locking your possessions

Highlights of the MDS 3.0

Section F – Preferences for Customary Routine and Activities
- Interview for Activity Preferences
  - Having reading materials
  - Listening to music
  - Being around animals
  - Keeping up with the news
  - Being with groups of people
  - Doing your favorite activities
  - Going outdoors
  - Participating in religious services
Highlights of the MDS 3.0

Section G – Functional Status
- ADL’s – coding includes both self-performance and staff support
- Self-performance codes = Complete independence through total dependence
- Balance during transitions and walking focuses on residents at risk for falls
- Code resident’s ability to sit-to-stand, walk, turn around, move to and from the toilet, and surface-to-surface transfer

Highlights of the MDS 3.0

Section H – Bladder and Bowel
- Requires information from the clinician about attempts to conduct a resident-specific urinary toileting program trial, the resident’s response, and if the program is continued
- Requires information about a bowel toileting program
- How this is answered (with supporting documentation) has survey implications

Highlights of the MDS 3.0

Section I – Active Disease Diagnosis
- Diagnosis listed by body systems
- Additional spaces are provided to write in diseases not specified on the listed items
- This section requires a physician documented diagnosis every 60 days and active diagnosis in the last 7 days
Highlights of the MDS 3.0

Section J – Health Conditions
- Pain assessment collects data about scheduled pain medication regimen and non-medication interventions
- Includes a resident interview for all residents unless comatose or rarely/never understood
- Look-back period is five days
- Assesses for pain effect on resident function as well as frequency and intensity of the pain

Highlights of the MDS 3.0

Section J – Health Conditions
- Falls assessment includes pre-admission history as well as falls since admission
- Falls assessment also requires data about the number of falls with no injury, minor injury, and major injury since admission or since prior assessment
- Residents with two or more falls are at much greater risk for future falls

Highlights of the MDS 3.0

Section K – Swallowing/Nutritional
- The practice for rounding height and weight measurements follows the standard practice of rounding numbers
  - 0.1 to 0.4 = round down
  - 0.5 and > = round up
- Addresses unplanned weight loss/gain, swallowing problems, and specialized nutritional approaches
Highlights of the MDS 3.0

Section L – Oral/Dental Status
- Addresses dentures, edentulous, mouth tissue, natural teeth, gums, mouth or facial pain, discomfort or difficulty chewing
- Provides choice of “unable to examine” the resident’s mouth

Highlights of the MDS 3.0

Section M – Skin Conditions
- Assesses for pressure ulcer risk and asks if a formal assessment tool is used
- Separates pressure ulcers from venous/arterial and diabetic foot ulcers
- Assesses for pressure ulcers present on admission
- Eliminates reverse staging of pressure ulcers

Highlights of the MDS 3.0

Section N - Medications
- Questions regarding insulin injections and orders for insulin
- Drug classifications include anticoagulants, antibiotics, diuretics, and many psychoactive medications
Highlights of the MDS 3.0

Section O - Special Treatments and Procedures
– Treatments and programs are completed based upon two scenarios
  • Occurred while NOT a resident
  • Occurred while a resident
– Section O also collects dates regarding
  • Influenza and pneumococcal vaccinations
  • Therapies in past 7 days
  • Restorative nursing care in past 7 days
  • Number of physician exams and order changes in past 14 days

Highlights of the MDS 3.0

Section P - Restraints
– Divides restraint usage between:
  • Those used in bed versus
  • Those used in a chair or while out of bed

Highlights of the MDS 3.0

Section Q - Participation and Goal Setting
– Focuses on resident’s overall expectations, goals, discharge planning
– Requires the assessor to ask the resident “Do you want to talk to someone about the possibility of returning to the community?”
– Also asks if a referral has been made to the local contact agency
Care Area Assessments

1. Delirium
2. Cognitive Loss/Dementia
3. Visual Function
4. Communication
5. ADL Function / Rehabilitation Potential
6. Urinary Incontinence and Indwelling Catheter
7. Psychosocial Well-Being
8. Mood State
9. Behavior Symptoms
10. Activities
11. Falls
12. Nutritional Status
13. Feeding Tube
14. Dehydration / Fluid Maintenance
15. Dental Care
16. Pressure Ulcer
17. Psychotropic Drug Use
18. Physical Restraints
19. Pain
20. Return to Community Referral

Anatomy of the RAI

Minimum Data Set (MDS)
Screening tool to identify possible problems

Care Area Triggers (CATs)
Clues to possible problems, needs, strengths

Care Area Assessments (CAAs)
Further, in-depth assessment to identify details of the possible problems, needs, strengths & to draw conclusions about root causes

CAA Summary
Documentation of triggered CAAs, location of documentation to support care planning decision

Care Plan

CAA Review and Documentation

- IDT conducts a thorough assessment of the resident using care area specific resources for each of the triggered CAAs

- IDT documents its findings to include:
  - Description of the problem
  - Causes/contributing factors
  - Complications and risk factors related to the CAA
  - Referral(s) to other discipline(s)
  - Decision regarding need for a care plan addressing the specific CAA
Current and Evidence-Based

- Appendix C of the RAI Manual page C-84

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5-Star Ratings
Quality Measures

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Quality Measures – Star Rating
9 of 18 on Nursing Home Compare site

7 long-stay
- ADL decline
- High-risk residents with pressure ulcers
- Indwelling catheter
- Physically restrained
- UTI
- Self-report moderate to severe pain
- Fall with major injury

2 short-stay
- New or worsened pressure ulcers
- Self-report moderate to severe pain
COMPONENTS OF LONGITUDINAL CARE
Coordination of discharges and transfers

Care Across Settings
• Transfer summary is for receiving team, not medical records department
• Discharge diagnoses should also include functional, cognitive, behavioral, and affective disorders
• Discharge meds should be more than a list (include diagnosis)

Care Across Settings
• D/C instructions should include signs, symptoms, and red flags; also, who to call
• Explicitly list follow-up studies and appointments
• Social history: names and contact information for caregivers, surrogate decision makers

Care Across Settings

- Include functional status at baseline and at time of transfer
- If you have seen the forest (not just the trees), say so: overall goals of care, preferred intensity of care, advance directives

Transitional Across Settings

Coordination that should occur!
- Basic Demographics and Patient Information
- Assessment and current problem list (CAA analysis plus other problems and risk areas)
- Planning of Care - goals and interventions
- Monitoring progress across settings
- Transfer documents
- NOMNC and ABN Appeal process

Transition Tools and Resources

- Project BOOST – Better Outcomes by Optimizing Safe Transitions
- Project RED – Better Outcomes by Optimizing Safe Transitions
- INTERACT - Interventions to Reduce Acute Care Transitions
Transition Tools and Resources

- BOOST
- Project RED
- The Care Transitions Program -
  http://www.caretransitions.org/

Transition Tools and Resources

- POLST
  http://www.polst.org/
- Bridge Model -
  http://www.caretransitions.org/
- Transition Care Model -
  http://www-transitionalcare.info/index.html
- INTERACT:
  http://www.aoa.gov/aging_statistics/docs/AoA_ACA_Slides_032712.pdf
Review of Learning Objectives

- Describe why the MDS matters to hospital and nursing home clinicians
- Identify key components of longitudinal care
- Detail the granular elements of an effective discharge plan between care settings

Good ideas are not adopted automatically. They must be driven into practice with courageous impatience. Once implemented, they can be easily overturned or subverted through apathy or lack of follow-up, so a continuous effort is required.

Admiral Hyman G. Rickover

Teamwork
Additional Resources

- CMS MDS 3.0 Information Site
- CMS Website – PPS
  www.cms.hhs.gov/SNFPPS/01_overview.asp
- Nursing Home Compare
  www.medicare.gov/NHCompare

JUDI KULUS
jkulus@aanac.org
Direct: 952-200-7456