

2018 RAI User's Manual and MDS Coding Updates



Delaware Health and Social Services

MDS Coding for Beginners
Tuesday, October 2, 2018

Judi Kulus, MSN, MAT, RN, RAC-MT, NHA
VP of Curriculum Development

Visit us at AANAC.org | Copyright © 2017



Objectives

- Describe the RAI/MDS Foundation and Process
- Review coding instructions for selected items on the MDS Item Set
- Discuss the requirements for OBRA and PPS Scheduling
- Outline how to develop effective CAAs and Care Plans

Visit us at AANAC.org | Copyright © 2017

2



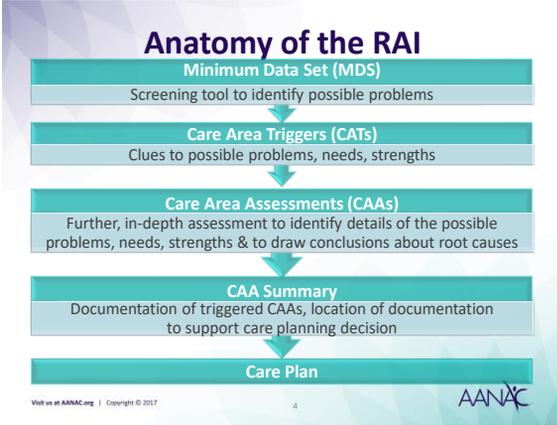
The Resident Assessment Instrument (RAI) Process

Based on the Long-Term Care Facility
Resident Assessment Instrument
3.0 User's Manual
Version 1.16
October 2018

Visit us at AANAC.org | Copyright © 2017

3





The Minimum Data Set (MDS)

- Federally mandated tool that drives:
 - Resident care
 - Medicare reimbursement, incentives, and possible payment reductions
 - Medicaid reimbursement in many states
 - Regulatory oversight and facility quality improvement activities through the Quality Measures (QMs)
 - Consumer oversight through Quality Measures (QMs)

Visit us at AANAC.org | Copyright © 2017

Accuracy of Assessments

- MDS must accurately reflect the resident's status as of the Assessment Reference Date (ARD) (42 CFR 483.20(g), F641)
- ARD is also referred to as item A2300
- Accuracy is essential to
 - Develop appropriate care plans
 - Result in QMs that adequately reflect resident care
 - Receive appropriate reimbursement
 - Avoid appearance of fraud or abuse

Visit us at AANAC.org | Copyright © 2017

Accuracy of Assessments

- *RAI User's Manual* is the definitive resource for MDS coding instructions
 - Always use it when completing MDS items
 - Keep in mind the clarifications, issues of note, and other pertinent information needed to understand how to code each item
 - Ensure you have the most current version
 - CMS posts updates on its website
 - AANAC posts them STAT for members in the "LTC Today" section of the AANAC home page

Visit us at AANAC.org | Copyright © 2017

7



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"

Visit us at AANAC.org | Copyright © 2017

8



Accuracy of Assessments

- Accuracy achieved by understanding intent of MDS questions and use of the assessments
 - MDS is a **functional** assessment only
 - Example: G0400 – Functional limitation in ROM. Record limitation *that interferes with daily functioning* or places the resident at risk
 - Looking at **resource utilization** often is very different from standard nursing assessment
 - N0300 asks about number of days resident received injections. Clinicians do not typically question the number of days – more concerned with the medication

Visit us at AANAC.org | Copyright © 2017

9



Data Collection and Coding Decisions

- Collect information
 - From all sources permitted by the instructions
 - For the time frame of the look-back period only
 - **Look-back is seven days unless rules state otherwise**
 - Anything that happened before or after look-back period does not go on the MDS
- Apply the item-specific rules from the *RAI User's Manual* to the data collected

Visit us at AANAC.org | Copyright © 2017

10



Supporting Documentation

- Any reviewer or auditor of the medical record should be able to come to the same coding decision by reading the chart*

*Exception: the interviews conducted and documented directly on the form would not be expected to be documented in the medical record

Visit us at AANAC.org | Copyright © 2017

11



Section A

Identification Information

Intent

To obtain key information to uniquely identify each resident, the home in which he or she resides, and the reasons for assessment

Visit us at AANAC.org | Copyright © 2017

12



A0310: Type of Assessment

- Identifies reason(s) for completing the assessment or tracking record
 - OBRA clinical assessments (A0310A)
 - PPS payment assessments (A0310B)
 - Other Medicare-Required Assessments (A0310C)
 - Swing-Bed clinical change assessment (A0310D)
 - Is this assessment the first assessment (A0310E)



Visit us at AANAC.org | Copyright © 2017

13



A0310: Type of Assessment (cont.)

- Type of discharge (*complete only if A0310F = 10 or 11*) (A0310G)
 - Planned or unplanned
 - “Unplanned” is a shorter OBRA Discharge assessment
 - Excludes Brief Interview for Mental Status (BIMS), Mood and Pain interviews, and Mood and Pain staff assessments
 - DOES include staff assessment for mental status

Visit us at AANAC.org | Copyright © 2017

14



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

Visit us at AANAC.org | Copyright © 2017

15



A0310. Type of Assessment (cont.)

– Is this a SNF PPS Part A Discharge Assessment? (A0310H)

- Used to calculate current and future Quality Measures mandated for the SNF Quality Reporting Program
- Required when a resident's SNF's Medicare Part A stay ends, and the resident remains in the facility; **or**
- May be combined with an OBRA Discharge if the Part A stay ends the same day or the day before the resident's Discharge Date (A2000). When combined:

MORE AHEAD

STAY TUNED

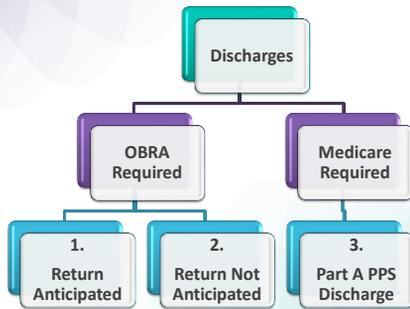
- ARD must be the same as the Discharge Date
- OBRA Discharge item set will be used

Visit us at AANAC.org | Copyright © 2017

16



Three Types of Discharges



Visit us at AANAC.org | Copyright © 2017

17



A1500: PASRR

Preadmission Screening and Resident Review (PASRR) screening is required for **all** residents (regardless of the individual's payment source) just prior to or upon admission to a nursing home or a unit that is **Medicaid** certified unless:

- Admitted directly from hospital **and**
- Physician certifies stay to be less than 30 days **and**
- NH care required for same condition for which individual was hospitalized

Visit us at AANAC.org | Copyright © 2017

18



A1500: PASRR

- PASRR (Level I screening) identifies individuals with mental illness, intellectual/developmental disability (“mental retardation” per regulation), or related condition that may require special services
- Item only completed on comprehensive assessments (A0310A = 01, 03, 04, 05) and asks whether Level II screening is needed
- **Code 1, Yes**, only if a PASRR Level II screen was done **and** determined the resident **has condition**
 - Also identify condition in A1510
- If facility or unit is **not Medicaid** certified, **code 9**
 - Otherwise, **code 0, No**

Visit us at AANAC.org | Copyright © 2017

19



A2300: Assessment Reference Date (ARD)

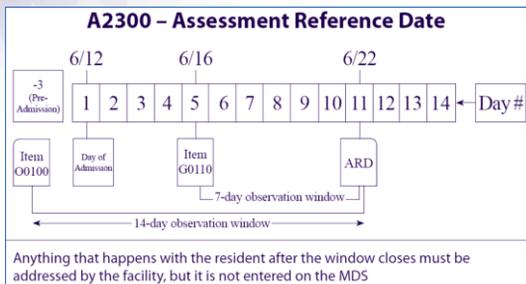
- Establishes a common assessment or **observation period** or **look-back period** for all staff participating in the resident’s assessment
 - Consecutive calendar days looking back from ARD
 - The ARD determines the care and services that will be captured on the MDS
 - Last day of the observation period: the end point in time for observation for all items with a look-back period for the particular assessment
- Acceptable time frame for the ARD depends on regulatory time frames for the assessment type
- Observation period not extended if resident is out of facility for a portion of the assessment period

Visit us at AANAC.org | Copyright © 2017

20



Assessment Reference Date (ARD)



Visit us at AANAC.org | Copyright © 2017

21



A2400: Medicare Stay

- Relates to the **most recent Part A stay** that occurred after the most recent admission or readmission after a discharge of either type
 - On or after A1600 Entry Date
- NOT for Medicare Advantage HMO plan stays
- Identifies when resident's Part A stay begins and ends
- **A2400A** coded **yes** if resident has **had MCR Part A stay** since the most recent admission/reentry. If Part A coverage is still in progress, enter dashes in A2400C
- **A2400B** code the **first day of the Medicare stay**

Visit us at AANAC.org | Copyright © 2017

22



A2400: Medicare Stay

- **A2400C:** End of Medicare Stay – code the last day of this MCR stay
- End Date is coded by whichever occurs *first*:
 - Day Part A benefit exhausts (day 100)
 - Last covered day as recorded as effective date on Notice of Medicare Non-Coverage (NOMNC)
 - Last paid day of Part A when payer source changes to another payer
 - Date resident was discharged from the facility (see A2000, Discharge Date)
- If Medicare stay ongoing – no end date – enter dashes

Visit us at AANAC.org | Copyright © 2017

23



MDS 3.0

Scripted Interviews

BIMS, PHQ-9®, Activities/Preferences, Pain

Visit us at AANAC.org | Copyright © 2017

24



The Scripted Interviews

BIMS, PHQ-9®, Activities/Preferences, Pain

- Proper preparation critical for each interview
 - Ensure a private, quiet environment
 - Use resident’s preferred language (arrange for interpreter, if needed)
 - Be sure resident can hear you and see you and has access to preferred method for communication
 - If resident appears unable to communicate, offer alternatives, such as writing, pointing, American sign language, or cue cards
 - Attempt to conduct interview with all residents using appropriate look-back period; the interviews are NOT contingent upon B0700

Visit us at AANAC.org | Copyright © 2017

25



The Scripted Interviews

- Interview techniques that can be used if resident having difficulty:
 - Unfolding = general question asked and then narrowing the response options by asking which is closer to accurate for the resident
 - Disentangling – breaking a list into its parts and asks about each component
 - Echoing = summarizing the resident’s answer and what response depicts what the resident said
 - Probing = ask neutral questions, such as “Tell me more” or “Tell me what you mean”

Visit us at AANAC.org | Copyright © 2017

26



The Scripted Interviews (cont.)

- If the resident interview was **not conducted within look-back period** (preferably the day before or on the ARD), the gateway items are coded “1,” YES but a dash (“-”) must be entered in the resident interview items **AND** the Staff Assessment would **not** be completed
- If the resident did **not complete** the interview the items C0600, D0500, F0700, J0700 ask if **STAFF** should complete assessment. When?
 - Interview attempted but not completed by resident
 - Resident unable to participate in interview
 - Resident refused to participate

Visit us at AANAC.org | Copyright © 2017

27



Special Situations for Scripted Interviews

- When coding stand-alone OMRAs (COT, EOT, or SOT), the interview items may be coded using the responses provided by the resident on a previous assessment ONLY if the DATE of the interview responses from the previous assessment (as documented in Z0400) were obtained no more than 14 days prior to the DATE of completion for the interview items on the unscheduled assessment (as documented in Z0400)

Visit us at AANAC.org | Copyright © 2017

28



Special Situations for Scripted Interviews

- If completing a stand-alone, unscheduled PPS assessment, the resident interview may be conducted up to two calendar days after the ARD. This flexibility period can be used even if the resident discharges from the facility during that period

Visit us at AANAC.org | Copyright © 2017

29



Special Situations for Scripted Interviews

- If the resident is discharged unexpectedly before an interview was completed:
 - Stand-alone OBRA Discharge assessment
 - Scripted Mood and Pain interview sections not required
 - Only section C, Staff Assessment of Mental Status is to be completed
 - Other assessment types (PPS, Quarterly, etc.)
 - Use information available at time of discharge
 - Dash items only if information is not available
 - Staff may be interviewed after the discharge (up to 2 days)

Visit us at AANAC.org | Copyright © 2017

30



For All Interviews

- Stick to script and cues
- Same if interpreter used

- Each interview has its own definition of an incomplete interview to determine when the assessor must conduct the staff assessment
- Single-point-in-time interview documented directly on the MDS
- Other documentation, interviews, and observations during look-back period are not taken into account interviews, but are relevant to care planning

Visit us at AANAC.org | Copyright © 2017

31



What to Know About the Brief Interview for Mental Status (BIMS)

- BIMS required to be completed only once for a particular assessment
- **10/1/18: BIMS has same completion time frame as other interviews – (preferably the day before or on the day of the ARD)**
- First standardized cognition test used in MDS
 - Relies on direct interview with the resident
 - Scripted language tested with this population is provided and must be followed as noted on MDS
 - Observe for **delirium** during BIMS; take immediate action if present

Visit us at AANAC.org | Copyright © 2017

32



C0500: BIMS Summary Score₃

- Assuming the resident can hear and is not delirious, the following distributions are suggested:

13–15	Cognitively Intact
08–12	Moderate Impairment
00–07	Severe impairment

- BIMS does not diagnose
 - Tool for physician and physician extenders
 - Comparison of current to previous BIMS

Visit us at AANAC.org | Copyright © 2017

33



Staff Assessment for Mental Status

- C0700. Short-Term Memory OK
 - Ask about activity just completed (5 minutes ago) or ask to repeat three words after five minutes
- C0800. Long-Term Memory OK
 - Ask about significant past events – married, children, ask about mementos in room
- C0900. Memory/Recall Ability
 - Season, room location, staff names and faces, what kind of place living in
- C1000: Cognitive Skills for Daily Decision Making
 - Decisions, directions, using environmental cues; knowing need to use walker; seeking information to plan the day
 - Determine the quality of the decisions in the context of the resident's own lifestyle, culture, and values; exercising right to decline treatment should not be captured as impaired decision making

Visit us at AANAC.org | Copyright © 2017

34



Signs and Symptoms of Delirium (C1310) from CAM®

Code these items in C1310 after completing the BIMS or staff assessment

Delirium: Mental disturbance characterized by new or acutely worsening confusion, disordered expression of thoughts, change in level of consciousness, or hallucinations

Prompt detection is essential in order to identify and treat or eliminate the cause

Visit us at AANAC.org | Copyright © 2017

35



C1310A: Acute Mental Status Change

- Compare resident's status during 7-day look-back period to his/her baseline
- Interview staff, family, others who had contact with resident during look-back period
- Review medical record
- Observe behavior during cognitive testing (BIMS or staff assessment)
- If C1310A = **yes**, may indicate delirium or other serious medical complications
 - May cause decline or death if not treated promptly
- Capture C1310B–D (even if response to 1310A is **no**)

Visit us at AANAC.org | Copyright © 2017

36



D0300: Total Severity Score

- Score does not diagnose mood disorders but can be important tool for physicians and physician extenders
- Can be used to track changes in severity over time:



Visit us at AANAC.org | Copyright © 2017

40



D0350: Safety Notification

- If resident reported thoughts of being better off dead or of hurting self in some way (D0200I) (that is, column 1. coded = 1), appropriate facility clinical staff and physician or other primary care provider must be notified. This documents that follow-up
- Leave blank if D0200I is not coded 1, Yes

Visit us at AANAC.org | Copyright © 2017

41



SECTION E BEHAVIOR

Visit us at AANAC.org | Copyright © 2017

42



Introduction

- Capture behavior that actually occurred during 7-day look-back period
 - Coding behaviors is based on the presence of the behavior and not on medical diagnoses
- Code regardless of what staff or others believe the cause or intent of the behavior to be
- If the behavior occurred during the look-back period, code it regardless of how long it has been present
- If behavior occurred and it meets the definition, it **must** be coded

Visit us at AANAC.org | Copyright © 2017

43



E0800: Rejection of Care

The intent of this item is to identify potential behavioral problems, not situations in which care has been rejected based on a choice that is consistent with the resident's preferences or goals for health and well-being or a choice made on behalf of the resident by a family member or other proxy decision-maker.

(RAI User's Manual, Chapter 3, page E-15)

Visit us at AANAC.org | Copyright © 2017

44



E0800: Rejection of Care

- Residents with decision-making capacity have the legal right to decline care, services, and treatment
 - They have a right to make their choice, even when the choice might not seem logical to others
- When a resident who lacks decision-making capacity rejects care, services, or treatment, if the rejection is consistent with that individual's values, culture, lifestyle, or goals for health care, it should not be identified as a problem or coded as rejecting care

Visit us at AANAC.org | Copyright © 2017

45



E0800: Rejection of Care - Example

A resident who recently returned to the nursing home after surgery for a hip fracture is offered physical therapy and declines. She states that she wants to walk again but is afraid of falling. This occurred on four days during the look-back period

Coding: E0800 would be **coded 2 (yes)**, behavior of this type **occurred 4–6 days**, but less than daily.

Visit us at AANAC.org | Copyright © 2017

46



SECTION G FUNCTIONAL STATUS

Intent

Items in this section assess the need for assistance with activities of daily living (ADLs), altered gait and balance, and decreased range of motion. In addition, on admission, resident and staff opinions regarding functional rehabilitation

Visit us at AANAC.org | Copyright © 2017

47



MDS Coding

Must be **based on observations:**

Of **each episode** of the ADL activity that occurred

Of **all disciplines**, including direct care staff

Over a **24-hour period** each day

For **entire assessment period**

Visit us at AANAC.org | Copyright © 2017

48



MDS Coding

- Code based on level of assistance when using any special adaptive devices the resident normally uses, such as walker, dressing stick, etc.
- Include resident performance and assistance by facility staff, including contract rehab or nursing agency staff
- Do not include assistance provided by others, such as family or other visitors, hospice staff, nursing/CNA students

Visit us at AANAC.org | Copyright © 2017

49



MDS Coding

- Information contained in the **clinical record must support MDS coding**
 - Documentation that furnishes a picture of the resident’s care needs and response to treatment is accepted standard of practice, is part of good resident care and staff care planning

Visit us at AANAC.org | Copyright © 2017

50



ADL Activity Definitions

A. Bed Mobility

How resident moves to and from a lying position, turns side to side, and positions body while in bed or alternate sleep furniture

B. Transfer

How resident moves between surfaces, including to or from: bed, chair, wheelchair, standing position. Excludes to/from bath and toilet

C. Walk in room

How resident walks between locations in his/her room

Visit us at AANAC.org | Copyright © 2017

51



ADL Activity Definitions

D. Walk in corridor

How resident walks in corridor on unit

E. Locomotion on unit

How resident moves between locations in his/her room and adjacent corridor on the same floor. If in wheelchair, self-sufficiency once in the chair

F. Locomotion off unit

How resident moves to and returns from off-unit locations (areas set aside for dining, activities, or treatments). If the facility has only one floor, how the resident moves to and from distant areas on the floor. If in wheelchair, self-sufficiency once in the chair

Visit us at AANAC.org | Copyright © 2017

52



ADL Activity Definitions

G. Dressing

How the resident puts on, fastens, and takes off all items of clothing, including donning/removing a prosthesis or TED hose. Dressing includes putting on and changing pajamas and housedress

H. Eating

How the resident eats and drinks, regardless of skill. Do not include eating/drinking during medication pass. Includes intake of nourishment by other means (tube feeding, total parenteral nutrition, IV fluids administered for nutrition or hydration)

Visit us at AANAC.org | Copyright © 2017

53



ADL Activity Definitions

I. Toilet Use

How the resident uses the toilet room, commode, bedpan, or urinal; transfers on/off toilet; cleanses self after elimination; changes pad; manages ostomy or catheter; and adjusts clothes. Do not include emptying of bedpan, urinal, bedside commode, catheter bag, or ostomy bag

J. Personal Hygiene

How the resident maintains personal hygiene, including combing hair, brushing teeth, shaving, applying makeup, and washing/drying face, hands. Excludes baths and showers

Visit us at AANAC.org | Copyright © 2017

54



G0110(1): ADL Self-Performance

Scales are used to record **actual level of involvement**

- Do not record resident’s capacity
- Do not record type and level of assistance the resident “should” receive

Visit us at AANAC.org | Copyright © 2017

55



Coding Instructions G0110(1)

0 Independent

No help or staff oversight **every time** and the activity occurred at least three times

1 Supervision

Oversight, encouragement, or cueing (no hands-on assistance) was provided **three or more times**

2 Limited Assistance

Resident highly involved in activity, staff provided physical help in guided maneuvering of limbs or other non-weight-bearing assistance **three or more times**

Visit us at AANAC.org | Copyright © 2017

56



Coding Section G0110(1)

3 Extensive Assistance

Resident performed part of the activity and the help of the following type(s) was provided **three or more times**:

- Provided weight-bearing support **three or more times OR**
- Provided full staff performance of activity **three or more times** during part (but not all) of 7-day look-back period

Visit us at AANAC.org | Copyright © 2017

57



Coding Section G0110(1)

- Guided Maneuvering vs. Weight Bearing
 - Determine **who is supporting the weight**
 - Putting hat on resident’s head → non-weight-bearing
 - Lifting arm into sleeve → weight-bearing
 - Supporting some of weight of resident’s hand and, with resident, lifting a spoon or cup to mouth → weight-bearing
 - Resident lifts utensil or cup, but staff must guide it to mouth → guided maneuvering

Visit us at AANAC.org | Copyright © 2017

58



Coding G0110(1)

4 Total Dependence

- **Full staff performance** of an activity with no participation by resident for any aspect of the ADL activity and the activity occurred **three or more times**
- Complete non-participation or unwillingness by the resident to perform any part of the activity over the entire 7-day look-back period
- Code 4 used only if the resident was unwilling or unable to perform any part of the activity
- If resident performed any part of the activity, it **would not** be coded 4

Visit us at AANAC.org | Copyright © 2017

59



Coding G0110(1)

7 Activity Occurred Only Once or Twice

The ADL activity occurred only one or two times in the look-back period

8 Activity did not occur

The activity did not occur or family and/or non-facility staff provided care 100% of the time for that activity over the entire 7-day look back period

Visit us at AANAC.org | Copyright © 2017

60



Coding G0110(1) Example¹

- Coding scale 1 to 3 – Rule of Three
 - When an activity occurs at least three times and occurs at multiple levels but not three times at any one level:

Episodes of full staff performance are considered to be weight-bearing assistance (when every episode is full staff performance, this is Total Dependence)

Example: Full staff performance × 1
 Weight-bearing assistance × 2
 Non-weight-bearing assistance × 2
 Code: Extensive Assistance

Visit us at AANAC.org | Copyright © 2017

G1



Coding G0110(1) Example²

- Coding scale 1 to 3 – Rule of Three (continued)
 - When an activity occurs at least three times and occurs at multiple levels but not three times at any one level:

When there is a combination of full staff performance and weight-bearing assistance for total of 3 or more, code 3, Extensive Assistance

Example: Full staff performance × 2
 Weight-bearing assistance × 2
 Code: Extensive Assistance

four episodes weight-bearing

Visit us at AANAC.org | Copyright © 2017

G2



Coding G0110(1) Example³

- Coding scale 1 to 3 – Rule of Three (continued)
 - When an activity occurs at least three times and occurs at multiple levels but not three times at any one level:

When there is a combination of full staff performance/ weight-bearing assistance and non-weight-bearing assistance three or more times, code 2, Limited Assistance

Example: Full staff performance × 1
 Weight-bearing assistance × 1
 Non-weight-bearing assistance × 1
 Code: Limited Assistance

Visit us at AANAC.org | Copyright © 2017

G3



G0400: Functional Limitation in ROM

- **Functional Limitation in ROM**
 - Record **functional** limitation that **interferes with daily functioning** (particularly with ADLs), or **places the resident at risk for injury**
 - This is a functional assessment
 - The presence of a limitation in ROM is not by itself reason to code it in G0400
 - Amputation: Do not make assumptions – same rules apply as for anyone else

Visit us at AANAC.org | Copyright © 2017

67



G0400: Functional Limitation in ROM

Use assessment method required by *RAI User's Manual*:

- **Focus is resident's ability to move the limb**
- Consider only **active and active-assisted ROM**
- Assessor may guide limb to assist with active ROM
- May observe resident's activities, such as brushing hair or donning pants, to assess for this item

Visit us at AANAC.org | Copyright © 2017

68



G0400: Functional Limitation in ROM

- **Two-step assessment process**
 - **Step 1: Determine if there is a limitation** in active or active-assisted ROM
 - If no, code 0
 - If yes, go to step 2
 - **Step 2: Does the limitation in ROM interfere with function or place the resident at risk for injury?**
 - If no, code 0
 - If yes, code either 1 or 2

Visit us at AANAC.org | Copyright © 2017

69



Discharge Goals Based on Expectations at Admission

Expected to Improve

- The IDT determines the resident is expected to make gains in function by discharge

Not Expected to Improve

- The IDT determines the resident is not expected to progress to a higher level of functioning during the Medicare Part A stay

Expected to Decline

- The IDT determines decline in function is anticipated and unavoidable

Visit us at AANAC.org | Copyright © 2017

85



SECTION H

BLADDER AND BOWEL

Intent

The intent of the items in this section is to gather information on the use of bowel and bladder appliances, the use of and response to urinary toileting programs, urinary and bowel continence, bowel training programs, and bowel patterns. Each resident who is incontinent or at risk of developing incontinence should be identified, assessed, and provided with individualized treatment and services to achieve or maintain as normal elimination function as possible

Visit us at AANAC.org | Copyright © 2017

86



Section H: Bladder and Bowel

- Incontinence should be investigated to determine underlying causes and resident-specific plan for fostering continence should be developed, implemented, monitored, evaluated, and revised as necessary
- Coding focuses on objective presence of incontinence, catheter use, and programs and appliances

Visit us at AANAC.org | Copyright © 2017

87



H0200: Urinary Toileting Program

Look-back to this item is **since** the most recent of the following:

- Admission/Entry or Reentry
- or
- Since incontinence was first noted in the facility

Visit us at AANAC.org | Copyright © 2017

88



H0200: Urinary Toileting Program

Captures **three aspects** of toileting program or trial:

– Toileting trial (H0200A)

- At least three days of observing toileting patterns with prompting to toilet and recording results in a bladder record or voiding diary
- **Code 0, No**, is correct code for any resident who did not participate in a toileting trial for any reason, including that the resident was continent or had a catheter or urinary ostomy
- If voiding diary shows no pattern due to total incontinence, H0200A = 0, No, because a toileting program is not appropriate for the resident

Visit us at AANAC.org | Copyright © 2017

89



H0200: Urinary Toileting Program

Response (H0200B)

– Whether toileting **program or trial is currently in place (H0200C)**

- **Code 0, No:** Toileting interventions in progress, but were used *less than four* of the seven days. Also if no toileting interventions are being used
- **Code 1, Yes:** Program implemented at least **four days**

Visit us at AANAC.org | Copyright © 2017

90



H0200: Urinary Toileting Program

- To be captured as **toileting program** or trial, must include specific approach that is **organized, planned, documented, monitored, evaluated, consistent with facility's policies and current standards of practice**
- **Possible interventions**
 - Prompted voiding
 - Individualized scheduled toileting program
 - Bladder retraining program

Visit us at AANAC.org | Copyright © 2017

91



H0300: Urinary Continence

- **Continence:** Any void that occurs voluntarily or as the result of prompted toileting, assisted toileting, or scheduled toileting
- If a device is used for part of the look-back period or intermittently, consider any voids while device is not in use or between device use
- **Coding options are based on number of incontinent episodes in 7-day look-back period**
- Indwelling or condom catheter, urinary ostomy, or no urine output for the entire seven days → Code 9, not rated

Visit us at AANAC.org | Copyright © 2017

92



H0400: Bowel Continence

- Code based on frequency of episodes of bowel incontinence due to any cause

Code 0 – No bowel incontinence

Code 1 – One incontinent episode regardless of amount or time of day

Code 2 – Incontinent more than once but had at least one continent episode

Code 3 – No continent BMs

Code 9 – Had ostomy or no BM entire seven days

Visit us at AANAC.org | Copyright © 2017

93



H0500: Bowel Toileting Program

- Medical record indicates:
 - Implementation of **individualized, resident-specific bowel toileting program** based on assessment of resident's unique bowel pattern
 - Evidence program was communicated to staff and resident
 - Notations of resident's response and subsequent evaluations

Visit us at AANAC.org | Copyright © 2017

94



H0600: Bowel Patterns

- **Constipation:**
 - Two or fewer bowel movements (BMs) or
 - For most BMs, stool is hard and difficult to pass, no matter what the frequency of bowel movements
- **Fecal Impaction**
 - Large mass of dry, hard stool, can develop in rectum *due to chronic constipation*. May be so hard that resident is unable to move it from the rectum. Watery stool from higher in the bowel or irritation from the impaction may move around the mass and leak out

Visit us at AANAC.org | Copyright © 2017

95



SECTION I ACTIVE DIAGNOSES

Visit us at AANAC.org | Copyright © 2017

96



I0100 – I8000: Active Diagnoses

- **Examples** of indicators of active diagnoses:
 - Recent onset or acute exacerbation indicated by a positive study test, or procedure
 - Hospitalization for acute symptoms and/or recent change in therapy
 - Symptoms and abnormal signs specifically attributable to an ongoing decompensated disease
 - Ongoing therapy with meds or other interventions to manage a condition that requires monitoring for therapeutic efficacy to monitor potential adverse effects

Visit us at AANAC.org | Copyright © 2017

100



I0100 – I8000: Active Diagnoses

Z Codes

- When a resident receives aftercare following a hospitalization, a Z code will be assigned
- When Z codes are used, **another diagnosis for the related primary medical condition** should be checked in items I0100-I7900 or entered in I8000

Visit us at AANAC.org | Copyright © 2017

101



I2300: Urinary Tract Infection

- Active for **I2300** - (30-day look-back rather than 7 days) – **Both of the following must be present in last 30 days:**
 - Physician (or physician designee) documented diagnosis of UTI in last 30 days
 - Determined that the resident had a UTI using **evidence-based criteria** in the last 30 days
 - Such as McGeer, NHSN, or Loeb

Make sure physician involved in discussion about desired criteria

Visit us at AANAC.org | Copyright © 2017

102



J0100: Pain Management (5-day look back)

- **J0100A** – received *scheduled* pain medication
 - Pain med order defines dose and specific time interval for administration
 - **Code 1, Yes**, if even one (1) dose of scheduled pain med was received
 - If scheduled pain med *ordered but refused by resident* = no scheduled pain med, **code 0, No**

Pain Medication Regimen
 Pharmacological agent(s) prescribed to relieve or prevent the recurrence of pain. Include all medications used for pain management by any route and any frequency during the look-back period. Include oral, rectal, transcutaneous, subcutaneous, intramuscular, intravenous injections or intraspinal delivery. This item does not include meds that primarily target treatment of the underlying condition, such as chemotherapy or steroids, although such treatments may lead to pain reduction

Visit us at AANAC.org | Copyright © 2017

106



J0100: Pain Management

- **J0100B** – received PRN pain medication **OR** was offered and declined
 - Pain med order specifies dose and indicates med may be given on as-needed basis at specified time interval
 - **If PRN pain med was received or was offered and declined, code 1, Yes**



- Pain Management Regimen definition applies to both J0100A/B
- For J0100A/B, do NOT consider medications that primarily treat the underlying condition

Visit us at AANAC.org | Copyright © 2017

107



J0100: Pain Management

J0100C – non-medication pain management interventions received

- Documentation must demonstrate that non-pharmacological interventions were:
 - Scheduled as part of care plan
 - Received by the resident
 - Assessed for effectiveness

Visit us at AANAC.org | Copyright © 2017

108



J0300–J0600: Pain Assessment Interview
5-Day Look-Back Period

- **Conduct** interview near end of look-back, preferably day of or day before ARD
- Ask the questions in the order on the MDS
- If resident is *unable to answer J0300*, Pain Presence, stop interview and go to Staff Assessment for Pain
- If the resident answers J0300 then proceed to J0400
- If resident does not answer a question or gives nonsensical response to J0400 through J0600, code 9 and go to next question

Visit us at AANAC.org | Copyright © 2017

109



J0600: Pain Intensity

- Use *either* **Numeric Rating Scale (J0600A)** or **Verbal Descriptor Scale (J0600B)**
- Skip the scale not used
- Review response options with resident
 - Offer visual aid displaying options for the scale you’re using
 - Resident may provide a verbal response or can write responses, point to the desired response, use sign language or cue cards

Visit us at AANAC.org | Copyright © 2017

110



J1700: Fall History on Admission/Entry or Reentry

What is a fall?

- Unintentional change in position coming to rest on the ground, floor, or next lower surface (e.g., onto a bed, chair, or bedside mat)
- May be witnessed, reported by the resident or an observer, or identified when a resident is found on the floor or ground
- Falls include any fall, regardless of where it occurred (home, while out in community, or NH)
- Intercepted fall: The resident would have fallen if he/she had not caught him/herself or had not been intercepted by another person (this **IS** a fall)

Visit us at AANAC.org | Copyright © 2017

111



J1700: Fall History on Admission

- Falls are **not** a result of an overwhelming external force (e.g., a resident is pushed by another resident or knocked down by a cart or object)

J1800: Any Fall Since Admission/Entry or Reentry or Prior Assessment

- Look-back is since the most recent **OBRA** or **scheduled PPS** assessment, whichever is more recent
- Documents any falls that occurred at any location since admission or most recent assessment, whichever is more recent
- If J1800 = 0, No: Skip to K0100

Visit us at AANAC.org | Copyright © 2017

112



J1900: Number of Falls

- Look-back is since admission/entry or reentry or prior assessment (OBRA or scheduled PPS), whichever is more recent
- Code them according to number that fall into each category according to severity of fall-related injury
- Document any injury that occurred as a direct result of the fall, or was recognized within a short period of time after the fall (i.e., hours to a few days) and attributed to the fall (review any follow-up medical info (e.g., ER, MRI, CT scan results) even if after the ARD. If extent of injury is identified after ARD/submitted to QIES ASAP, modify the MDS

Visit us at AANAC.org | Copyright © 2017

113



New Item 10/1/18: J2000 Prior Surgery

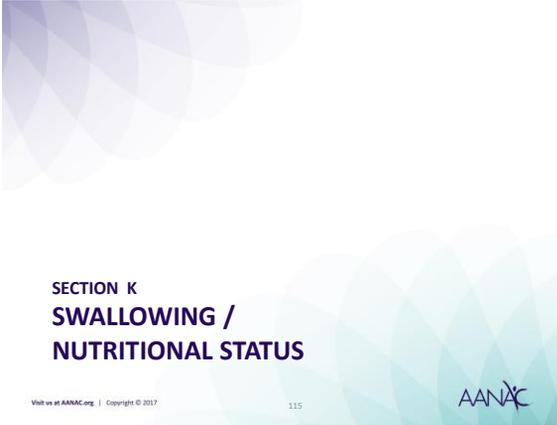
J2000. Prior Surgery ←	
Enter Code	Did the resident have major surgery during the 100 days prior to admission?
<input type="checkbox"/>	0. No Another risk adjustor for the 4 new SNF
	1. Yes QRP functional outcomes measures
	8. Unknown

- Asks about history of major surgery during the 100 days prior to admission
- Criteria for major surgery – must meet **all 3**:
 - Resident was an inpatient in an acute care hospital for at least one day in the 100 days prior to admission to the skilled nursing facility (SNF),
 - Resident had general anesthesia during the procedure, **and**
 - Surgery carried some degree of risk to the resident's life or the potential for severe disability

Visit us at AANAC.org | Copyright © 2017

114

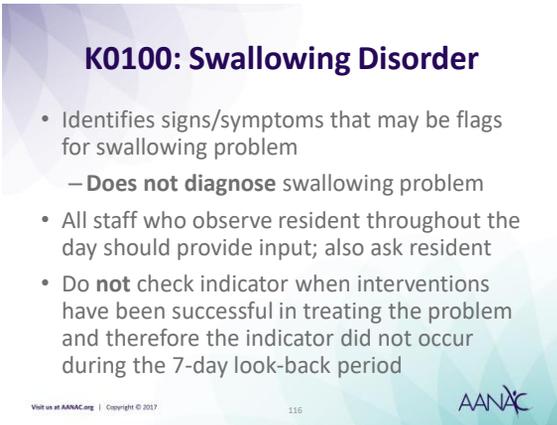




**SECTION K
 SWALLOWING /
 NUTRITIONAL STATUS**

Visit us at AANAC.org | Copyright © 2017 115

AANAC

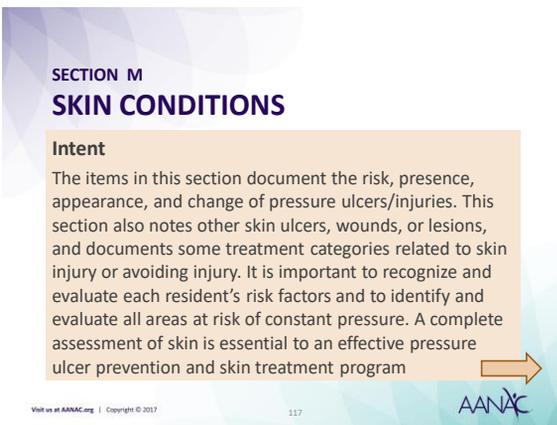


K0100: Swallowing Disorder

- Identifies signs/symptoms that may be flags for swallowing problem
 - **Does not diagnose** swallowing problem
- All staff who observe resident throughout the day should provide input; also ask resident
- Do **not** check indicator when interventions have been successful in treating the problem and therefore the indicator did not occur during the 7-day look-back period

Visit us at AANAC.org | Copyright © 2017 116

AANAC



**SECTION M
 SKIN CONDITIONS**

Intent

The items in this section document the risk, presence, appearance, and change of pressure ulcers/injuries. This section also notes other skin ulcers, wounds, or lesions, and documents some treatment categories related to skin injury or avoiding injury. It is important to recognize and evaluate each resident's risk factors and to identify and evaluate all areas at risk of constant pressure. A complete assessment of skin is essential to an effective pressure ulcer prevention and skin treatment program

Visit us at AANAC.org | Copyright © 2017 117

AANAC

Section M: Skin Conditions

- **IMPERATIVE:** Before proper treatment and wound management can be determined, the underlying cause or etiology must be determined
- Only selected types of skin conditions are captured; cuts, lacerations, and rashes are not
- Skin problems are coded if they were present during the 7-day observation period even if they were present and coded on a previous MDS assessment

Visit us at AANAC.org | Copyright © 2017

118



M0100: Determination of Pressure Ulcer/Injury Risk

Asks to describe how the risk for pressure ulcers/injuries was determined

M0100. Determination of Pressure Ulcer Risk	
↓ Check all that apply	
<input type="checkbox"/>	A. Resident has a stage 1 or greater, a scar over bony prominence, or a non-removable dressing/device
<input type="checkbox"/>	B. Formal assessment instrument/tool (e.g., Braden, Norton, or other)
<input type="checkbox"/>	C. Clinical assessment
<input type="checkbox"/>	Z. None of the above

Visit us at AANAC.org | Copyright © 2017

119



M0210:

Unhealed Pressure Ulcers/Injuries

- Must determine **etiology** of each wound to code properly
- Oral Mucosal ulcers caused by pressure should **not** be coded in Section M. (p. M-5) (capture in L0200C)
- Mucosal pressure ulcers are not staged using the skin pressure ulcer staging system because anatomical tissue comparisons cannot be made. Therefore, mucosal ulcers (for example, those related to nasogastric tubes, nasal oxygen tubing, endotracheal tubes, urinary catheters, etc.) should not be coded here

Visit us at AANAC.org | Copyright © 2017

120



M0210:

Unhealed Pressure Ulcers/Injuries

- If a pressure ulcer is surgically closed with a flap or graft, it should be coded as a surgical wound, not a pressure ulcer, even if graft or flap fails
- Resident with DM has heel ulcer from pressure that is present during the 7-day look-back period, capture it as a Pressure Ulcer/Injury
- Resident with DM has ulcer on bottom of foot that is closer to the metatarsals and present during the 7-day look-back period – do not capture it as PrU. This is coded as diabetic ulcer (M1040). It is not likely that pressure is the primary cause of the resident's ulcer when the ulcer is in this location

Visit us at AANAC.org | Copyright © 2017

121



M0210:

Unhealed Pressure Ulcers/Injuries

- If a resident had a pressure ulcer/injury that healed during the look-back period of the current assessment, but there was no documented pressure ulcer on the prior assessment – do *not* capture on current assessment
- Scabs and eschar are different both physically and chemically. Scab represents healing, while eschar is dead tissue
- If two pressure ulcers/injuries occur on the same bony prominence and are separated, at least superficially, by skin, then count them as two separate areas and stage separately

Visit us at AANAC.org | Copyright © 2017

122



**M0300: Current Number of
 Unhealed Pressure Ulcers/Injuries**

- Asks about the number of pressure ulcers/injuries at each stage during look-back period
 - See staging definitions on MDS form
 - Ulcer staging is based on the deepest anatomical soft tissue damage that is visible or palpable
 - Pressure ulcers do not heal in reverse sequence; clinical standards do not support reverse or backstaging

Visit us at AANAC.org | Copyright © 2017

123



M0300: Current Number of Unhealed Pressure Ulcers/Injuries

- Captures number of stage 1, 2, 3, and 4 PrUs and unstageable pressure ulcers/injuries that were present **at that stage on admission/reentry**
 - **Present on admission/reentry** means:
 - The pressure ulcer/injury was present at the time of admission/entry or reentry to this nursing home **AND**
 - The stage has not worsened at any time since admission **AND**
 - The pressure ulcer/injury was **NOT** acquired while the resident was in the care of this nursing home during any stay

Visit us at AANAC.org | Copyright © 2017

124



M0300: Current Number of Unhealed Pressure Ulcers/Injuries

- When a pressure ulcer/injury that was present on admission, *increases in numerical stage*, it becomes **in-house acquired** and is no longer coded as “present on admission”
- If a pressure ulcer/injury was present on admission and becomes unstageable due to slough/eschar, the area is coded at M0300F and is not coded as “present on admission”
- If a pressure ulcer/Injury was unstageable on admission or reentry and becomes stageable, **it should be considered as “present on admission” at the stage at which it first becomes numerically staged**. If it subsequently increases in numerical stage, that higher stage **should not be coded as “present on admission”**

Visit us at AANAC.org | Copyright © 2017

125



M0300: Current Number of Unhealed Pressure Ulcers/Injuries

- If a pressure ulcer/injury was originally acquired in facility and the resident is hospitalized. The resident returns with an ulcer/injury at the same stage, **do not code** as present on admission
- If resident with a pressure ulcer/injury **present on admission or reentry** is hospitalized and returns with the ulcer at same numerical stage, the area is still coded as **present on admission** because it originally was acquired outside the facility and has not changed in stage
- If resident with pressure ulcer/injury is hospitalized and the ulcer increases in numerical stage while in the hospital, it should be coded as **present on admission** at the that higher stage upon reentry

Visit us at AANAC.org | Copyright © 2017

126

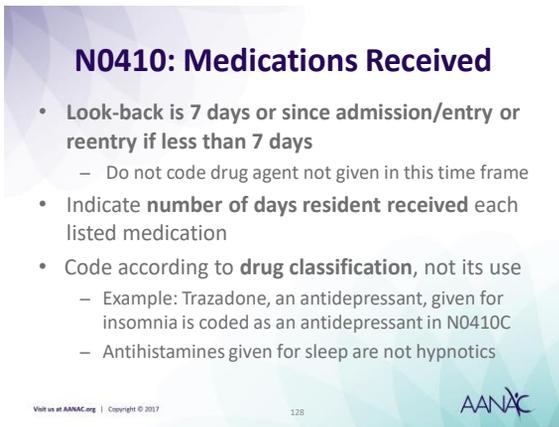




SECTION N
MEDICATIONS

Visit us at AANAC.org | Copyright © 2017 127



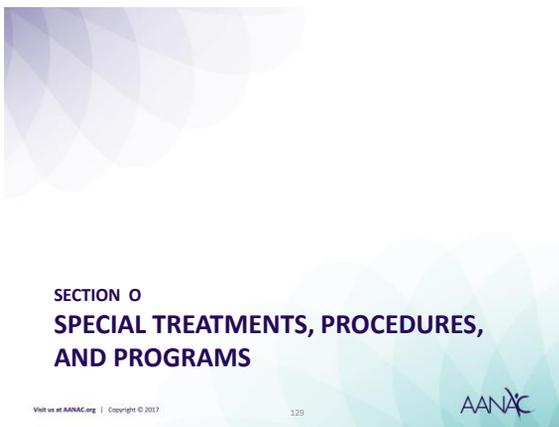


N0410: Medications Received

- Look-back is **7 days or since admission/entry or reentry if less than 7 days**
 - Do not code drug agent not given in this time frame
- Indicate **number of days resident received** each listed medication
- Code according to **drug classification**, not its use
 - Example: Trazadone, an antidepressant, given for insomnia is coded as an antidepressant in N0410C
 - Antihistamines given for sleep are not hypnotics

Visit us at AANAC.org | Copyright © 2017 128





SECTION O
**SPECIAL TREATMENTS, PROCEDURES,
AND PROGRAMS**

Visit us at AANAC.org | Copyright © 2017 129



O0100: Special Treatments, Procedures, and Programs

Look-back is 14 days

Code listed services if received by resident in look-back and when they meet the definitions even if provided only once

The decision to code a service is **completely separate** from any related determinations about Medicare Part A coverage

Visit us at AANAC.org | Copyright © 2017

130



O0100: Special Treatments, Procedures, and Programs

- Do **not** code services in O0100 provided solely in conjunction with a surgical or diagnostic procedure, including routine pre- and post-operative procedures
- Do **not** code IVs, IV meds or transfusions administered during chemotherapy or dialysis under the respective items in K0510A, O0100H, O0100I
- **Do code even if resident performed it him or herself**

Visit us at AANAC.org | Copyright © 2017

131



O0100: Special Treatments, Procedures, and Programs

- **O0100H: IV medications**
 - **Include:** Any drug or biological via intravenous push or drip through central or peripheral port, epidural, intrathecal, and baclofen pumps
 - **Do not include:** Saline or heparin flush, IV fluids without meds, IV meds administered during dialysis or chemo, subcutaneous pumps
 - Dextrose 50% and Lactated Ringers given by IV are **not** medications and are **not coded** here

Visit us at AANAC.org | Copyright © 2017

132



O0100: Special Treatments, Procedures, and Programs

- **O0100M: Isolation or quarantine (4 criteria)**
 1. Active infection, highly contagious, acquired by physical contact, airborne, or droplet transmission
 2. Precautions must be over and above standard precautions: transmission-based (contact, droplet, and/or airborne)
 3. In a room alone because of active infection and cannot have a roommate (single room isolation required)
 4. Resident must remain in his/her room because of the high level of contagion

Visit us at AANAC.org | Copyright © 2017

133



O0500: Restorative Nursing

- Nursing care that promotes ability to adapt and **adjust to living as independently and safely as possible**
 - May be initiated:
 - On admission if not skilled rehab candidate
 - When restorative needs arise during a stay
 - In conjunction with skilled rehab
 - Does not require physician's order

Visit us at AANAC.org | Copyright © 2017

134



O0500: Restorative Nursing

- Captures only very **specific, organized programs** that meet the precise definitions in the RAI Manual
 - The care must fall within 1 of the 10 practice categories identified in the *RAI User's Manual*
 - The care must have been **delivered during the 7-day observation period** of the assessment
 - The specific modality must have been **delivered for a period of at least 15 minutes** during that day
 - Enter "0" if any modality was delivered for less than 15 minutes
 - The 15 minutes do not have to occur all at the same time

Visit us at AANAC.org | Copyright © 2017

135



OBRA SCHEDULING

Visit us at AANAC.org | Copyright © 2017

AANAC

The RAI Process

- Per OBRA '87, residents must be clinically assessed using the MDS:
 - Within 14 days of admission
 - Quarterly
 - Annually
 - When a significant change in status occurs
 - When an uncorrected significant error is identified in a previously completed MDS

Visit us at AANAC.org | Copyright © 2017

140

AANAC

OBRA Types of Assessments

- OBRA reason for Assessment: A0310A:
 - 01: Admission assessment
 - 02: Quarterly review assessment
 - 03: Annual assessment
 - 04: Significant Change in Status Assessment (SCSA)
 - 05: Significant Correction to Prior Comprehensive Assessment (SCPA)
 - 06: Significant Correction to Prior Quarterly Assessment (SCQA)

Visit us at AANAC.org | Copyright © 2017

141

AANAC

MDS Assessment Item Sets₁

- **Eleven** item sets for nursing homes. Certain items are active based on the assessment reason:
 1. Comprehensive Item Set (NC)
 2. Quarterly Item Set (NQ)
 3. PPS Item Set (NP)
 4. OMRA - Start of Therapy (NS) (standalone)
 5. OMRA - Start of Therapy and Discharge (NSD)
 6. OMRA Item Set (NO)
 - Items active on standalone End of Therapy OMRA and a Change of Therapy OMRA
 - Resumption of Therapy (EOT-R) items at O0450A and O0450B included on this item Set

Visit us at AANAC.org | Copyright © 2017

142



MDS Assessment Item Sets₂

7. EOT OMRA and Discharge Item Set (NOD) - PPS EOT OMRA combined with a Discharge assessment (either return anticipated or not anticipated)
8. Discharge Item Set (ND) – standalone OBRA D/C (either return anticipated or not anticipated) used when resident physically discharged from the facility
9. Part A PPS Discharge (NPE) – standalone Part A Discharge (used for SNF QRP); completed when MCR Part A stay ends, but remains in the facility
10. Tracking Item Set (NT) – active on Entry Tracking Record or Death in Facility Tracking Record
11. Inactivation Request Item Set (XX)
 - Set of Items active on request to inactive a record in MDS QIES ASAP system

Visit us at AANAC.org | Copyright © 2017

143



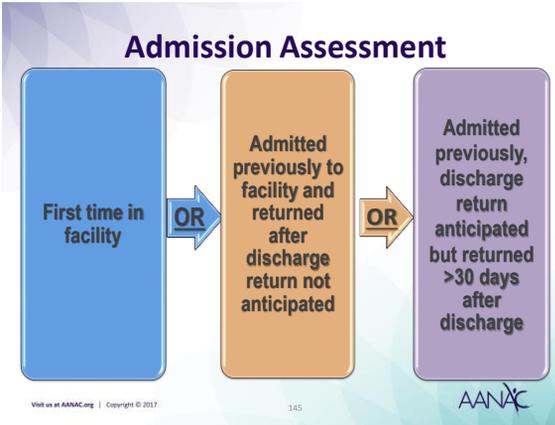
Timing of Future OBRA-Required Assessments



Visit us at AANAC.org | Copyright © 2017

144





Admission Assessment Timeline

- Day of admission counts as day one
- All sections must be completed by the end of day 14
- Must be signed off by RNAC at V0200B2 no later than day 14
- If discharged before end of day 14, Admission assessment not required

Visit us at AANAC.org | Copyright © 2017

Admission Assessment Timeline

- **Z0400** – Dates team members completed their sections, no later than Day 14 and no later than the date of MDS completion at Z0500B
- **Z0500B** – MDS completion, must be on or after the latest date in Z0400 and no later than Day 14
- **V0200B2** – CAA completion, must be on or after MDS completion (Z0500B) and no later than Day 14
- **V0200C2** – Care plan completion, must be on or after CAA completion (V0200B2) but no later than seven days after CAA completion

Visit us at AANAC.org | Copyright © 2017

Summary of Requirements

A0310. Type of Assessment

Enter Code

0	4
---	---

A. Federal OBRA Reason for Assessment

01. Admission assessment (required by day 14)

02. Quarterly review assessment

03. Annual assessment

04. Significant change in status assessment

**Significant Change in
 Status Assessment
 (SCSA)**

A0310A = 04

Visit us at AANAC.org | Copyright © 2017 151

SCSA

- Required when resident status meets criteria
- Admission Assessment must be in QIES ASAP system before SCSA will be accepted
- Determine based on comparing current status to most recent Comprehensive Assessment and any subsequent Quarterly Assessments

Visit us at AANAC.org | Copyright © 2017 152

SCSA

- Significant change in status = major 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
 - The decline is not considered "self-limiting"
 - Does not return to baseline within 14 days
 - Has an impact on **more than one area** of the resident's health status; and
 - Requires interdisciplinary review or revision of the care plan, or both

Visit us at AANAC.org | Copyright © 2017 153

SCSA

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

Visit us at AANAC.org | Copyright © 2017 154

Significant Change in Status Assessment (SCSA)

Examples
 (This is not an exhaustive list)

Visit us at AANAC.org | Copyright © 2017 155

SCSA

- **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[®]), e.g., increase in the number of areas where behavioral symptoms are coded as being present and/or the frequency of a symptom increases for items in Section E (Behavior);
 - Changes in frequency or severity of behavioral symptoms of dementia that indicate progression of the disease process since the last assessment;

Visit us at AANAC.org | Copyright © 2017 156

SCSA

- **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)

Visit us at AANAC.org | Copyright © 2017

157



SCSA

- **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
 - Begin 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

Visit us at AANAC.org | Copyright © 2017

158



SCSA

- **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

Visit us at AANAC.org | Copyright © 2017

159



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 an SCSA, an SCSA is required

Visit us at AANAC.org | Copyright © 2017

160



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
 - ARD must be within 14 days from the effective date of hospice

Visit us at AANAC.org | Copyright © 2017

161



SCSA and Hospice Election

- If resident is admitted on hospice benefit, the facility should complete the Admission Assessment and capture hospice
 - 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)

Visit us at AANAC.org | Copyright © 2017

162



SCSA and Hospice Discontinues

- An SCSA is required to be performed when a resident receiving hospice services *discontinues* those services (revocation 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

Visit us at AANAC.org | Copyright © 2017

163



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

Visit us at AANAC.org | Copyright © 2017

164



SCSA or Not?

- SCSA not required under the following circumstances:
 - Short-term acute illness from which the IDT expects full recovery
 - Well-established, predictable cyclical patterns of clinical signs and symptoms associated with previously diagnosed conditions (bipolar disease, etc.)
 - Resident continues to make steady progress under current course of care
 - Resident has stabilized and discharge is expected in the immediate future

Visit us at AANAC.org | Copyright © 2017

165



PPS

Visit us at AANAC.org | Copyright © 2017



SNF PPS Assessments

- Must be completed to establish rate
- Assessments required to recalculate the RUG to reflect changing acuity
 - **Scheduled:** At set intervals
 - **Unscheduled:** For specific clinical situations
- RUG-IV category computed by an assessment is billed to Medicare for a specific time period as long as Part A coverage criteria are met

Visit us at AANAC.org | Copyright © 2017

167



Case Mix Index

RUG	Rural	Urban
RUB	59	59
RMX	58	58
RHL	57	57
ES2	56	56
RML	55	55
RVC	53	54
RLX	52	53
RUA	54	51
HE2	50	50
HD2	46	49
RHC	47	48
RVB	49	47

- Weight or numeric score assigned to each RUG that **reflects relative resources** predicted to provide care to a resident
- **Higher Case Mix Weight** means:
 - **Greater the resource requirements** for the resident
 - **Higher reimbursement rate**

Visit us at AANAC.org | Copyright © 2017

168



Scheduled Assessments on Return From a Leave of Absence

- **Leave of Absence (LOA)**, which does **not** require completion of either a Discharge assessment or an Entry tracking record, occurs when a resident has a:
 - Temporary home visit of at least one night, or
 - Therapeutic leave of at least one night, or
 - Hospital observation stay less than 24 hours and the hospital does not admit the patient
- Scheduled PPS assessment schedule picks up where it left off prior to the leave of absence

Visit us at AANAC.org | Copyright © 2017

172



Midnight Rule

- SNF cannot bill Part A for the days preceding the midnights the resident was not in the facility
- Only calendar days billable to Part A are counted when establishing the assessment schedule for a resident
 - On return from LOA, assessment schedule must be **adjusted to exclude those non-billable days** when scheduling future assessments

Visit us at AANAC.org | Copyright © 2017

173



Part A PPS Discharge Assessment (NPE)

- The Part A PPS Discharge assessment was implemented in FY 2017 to provide the information needed to calculate Quality Measures associated with the SNF Quality Reporting Program (SNF QRP) under the Improving Medicare Post-Acute Care Transformation (IMPACT) Act of 2014
- The Part A PPS Discharge item set, known as the NPE item set, is required when Part A ends and the resident remains in the nursing facility with a different payer

Visit us at AANAC.org | Copyright © 2017

174



Part A PPS Discharge Assessment (NPE)

- The item to activate the *Item Set* comes from **A0310H. Is this a SNF PPS Part A Discharge (End of Stay) Assessment (NPE)? Yes or No**
- Because the assessment is used to calculate QMs for the SNF-QRP, it contains specific demographic and administrative items, and items from:
 - Section GG: Functional Abilities and Goals
 - Section J: Items about fall history
 - Section M: Skin Conditions (pressure ulcers)
 - Section X: Enables correction of NPE

Visit us at AANAC.org | Copyright © 2017

175



Part A PPS Discharge Assessment (NPE)

- Required item set when a resident's SNF's Medicare Part A stay ends, and resident remains in the facility
 - The ARD for a standalone Part A PPS Discharge assessment must be the date entered at A2400C (End date of the most recent Medicare stay)
- When a Part A resident is physically discharged from the facility, the Part A Discharge assessment may be combined with an OBRA Discharge if the A2400C date was the day of or one day prior to the physical discharge
 - When NPE and OBRA Discharged combined (using the OBRA Discharge item set), the ARD must be the A2000 Discharge Date

Visit us at AANAC.org | Copyright © 2017

176



Part A PPS Discharge Assessment (NPE)

Some additional situational coding guidance

- If the Part A stay ends earlier than one day before discharge, the PPS and OBRA Discharge assessments must be completed separately
- If the resident dies on the *End date of most recent Medicare stay (A2400C)*:
 - A Death in Facility record is required
 - No OBRA or Part A PPS Discharge Assessment is required

Visit us at AANAC.org | Copyright © 2017

177



Part A PPS Discharge Assessment (NPE)

Additional situational coding guidance

- Part A PPS Discharge assessment may be combined with **most** scheduled PPS and OBRA-required assessments
- When combining the Part A PPS Discharge assessment with PPS scheduled assessments:
 - ARD (A2300) must equal the A2400C (end of most recent Medicare stay) date **AND**
 - ARD must fall within the allowed ARD window of the PPS scheduled or unscheduled assessment being completed
- The Part A PPS Discharge assessment **cannot** be combined with unscheduled PPS assessments

Visit us at AANAC.org | Copyright © 2017

178



Part A PPS Discharge Assessment

COMPLETION TIME FRAMES

- ARD may be coded on the assessment anytime during the assessment completion period (i.e., *End date of most recent Medicare stay* [A2400C] + 14 calendar days)
- Must be completed (item Z0500B) within 14 days after the *End date of most recent Medicare stay* (A2400C + 14 calendar days)
- Must be submitted within 14 days after the MDS completion date (Z0500B + 14 calendar days) (p. 2-46)

Visit us at AANAC.org | Copyright © 2017

179



Keys to Remember

- Section GG only applies to residents admitted to a Medicare Part A skilled stay
- Section GG must be completed at the time of admission and at the time of discharge. If you are combining an Admission with a 5-day, you will complete both Section G and Section GG
- Assessment designed to assess resident's current (**USUAL**) level of function at the time of admission – BEFORE initiating any therapeutic interventions
- Section GG performance codes are **NOT** like Section G

Visit us at AANAC.org | Copyright © 2017

180



Unscheduled Assessments

- Used when it is **necessary to recalculate the RUG-IV level *between* scheduled assessments:**

1. Start of Therapy Other Medicare-Required Assessment
(SOT OMRA, A0310B = 07 and A0310C = 1)
2. End of Therapy OMRA
(EOT OMRA, A0310B = 07 and A0310C = 2)
3. Start and End of Therapy OMRA
(A0310B = 07 and A0310C = 3)
4. Change of Therapy OMRA
(A0310B = 07 and A0310C = 4)

Visit us at AANAC.org | Copyright © 2017

181



Unscheduled Assessments

- These OBRA clinical assessments may need to be completed on an SNF PPS resident and may impact RUG-IV level:

1. Significant Change in Status Assessment
2. Significant Correction to a Prior Comprehensive Assessment

Visit us at AANAC.org | Copyright © 2017

182



Other Medicare-Required Assessments (OMRA)

- SNF PPS assessment completed for **three** reasons:
 1. When **therapy stops and Part A will continue**
 2. When **therapy starts between scheduled assessments**
 3. When **intensity of therapy** now given **changes** after therapy RUG established
- **Purpose:** To **recalculate RUG** between scheduled assessments to ensure that:
 - Non-rehabilitation RUG is available to bill non-therapy days
 - Rehabilitation RUG level is available to bill any therapy days

Visit us at AANAC.org | Copyright © 2017

183



Start of Therapy OMRA (SOT OMRA)

- **Optional** assessment to calculate a Rehab RUG for resident in non-Rehab RUG when:
 - Rehab services are initiated between scheduled assessments, or
 - Rehab services started within a regular assessment window in situations in which not enough therapy was delivered for a Rehabilitation RUG to be calculated

Visit us at AANAC.org | Copyright © 2017

184



Start of Therapy OMRA (SOT OMRA)

- **ARD is set for Day 5, 6, or 7; first day of therapy counts as Day 1**
 - First day of therapy = date of first therapy evaluation, whether treatment provided or not
- Sets payment rate starting on the **earliest start of therapy date** (date of earliest therapy evaluation)

Visit us at AANAC.org | Copyright © 2017

185



End of Therapy OMRA (EOT OMRA)

- Purpose: To establish a non-therapy payment rate when:
 - A resident is being discharged from therapy but will continue on Medicare Part A for a non-therapy reason for at least three (3) days
 - A resident who is receiving therapy has a break in the furnishing of therapy for at least three (3) consecutive days regardless of reason

Visit us at AANAC.org | Copyright © 2017

186



End of Therapy OMRA (EOT OMRA)

- ARD must be set on calendar Day 1, 2, or 3 after the last day therapy services were provided
 - All facilities are considered seven-day-a-week providers
 - Weekends and holidays when a department is closed are not excluded from the count
 - The last day of therapy is Day 0
- Sets payment starting the day after the **latest therapy end date** regardless of the day selected for ARD

Visit us at AANAC.org | Copyright © 2017

187



EOT OMRA Situations

THU	FRI	SAT	SUN
Last Therapy Session	Non-Therapy Day	Non-Therapy Day	Non-Therapy Day

Required to bill ANY Part A days after planned or unplanned break in therapy for at least three days

THU	FRI	SAT	SUN
Therapy Treatment	Non-Therapy Day	Non-Therapy Day	Discharge

No EOT due in this case. Resident did not miss three days of therapy

Visit us at AANAC.org | Copyright © 2017

188



EOT-R Resumption of Therapy

- May be used:
 - When a skilled resident resumes therapy within 4-5 days of the last therapy treatment
 - Resumes at the same RUG-IV classification level that had been in effect prior to the EOT OMRA
 - Resumes with the same therapy plan of care that had been in effect prior to the EOT OMRA

00450. Resumption of Therapy - Complete only if A0310C = 2 or 3 and A0310F = 99

Enter Code:

A. Has a previous rehabilitation therapy regimen (speech, occupational, and/or physical therapy) ended, as reported on this End of Therapy OMRA, and has this regimen now resumed at exactly the same level for each discipline?

0. No → Skip to 00500, Restorative Nursing Programs

1. Yes

B. Date on which therapy regimen resumed:

Month: Day: Year:

Visit us at AANAC.org | Copyright © 2017

189



COT OMRA

- If COT OMRA was required:
 - Payment begins on Day 1 of that COT observation period and continues for the remainder of the current payment period, unless the payment is modified by a subsequent COT OMRA or other PPS assessment

Visit us at AANAC.org | Copyright © 2017

193



COT OMRA

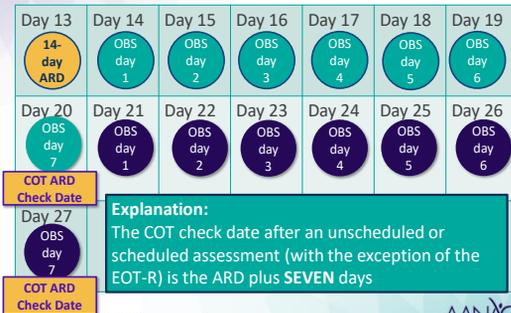
- COT observation period:
 - Rolling 7-day window *beginning*
 - On the day following ARD of most recent assessment, or
 - On the day therapy resumes with EOT-R OMRA
 - *Ending every seven calendar days thereafter* or
 - On the ARD of next scheduled assessment

Visit us at AANAC.org | Copyright © 2017

194



COT Assessment Example: Rolling Observation and Check Date



Visit us at AANAC.org | Copyright © 2017

195



CAAs

- CAAs are **required** only with comprehensive assessments
 - Admission assessment (MDS item A0310A = 01)
 - Annual assessment (MDS item A0310A = 03)
 - Significant Change in Status Assessment (MDS item A0310A = 04)
 - Significant Correction to prior Comprehensive Assessment (MDS item A0310A = 05)

Visit us at AANAC.org | Copyright © 2017

202



CAAs

- CAAs are **not** required with:
 - Quarterly assessments (A0310A = 02)
 - Significant Correction to Prior Quarterly Assessment (A0310A = 06)
 - SNF PPS reimbursement assessments (A0310B)

Visit us at AANAC.org | Copyright © 2017

203



The Care Plan

The care plan:

- The working action plan developed from the findings that resulting from the CAAs
 - Development of a person-centered, individualized, care plan designed to address the resident's specific problems, risk factors, needs, goals, preferences, and choices

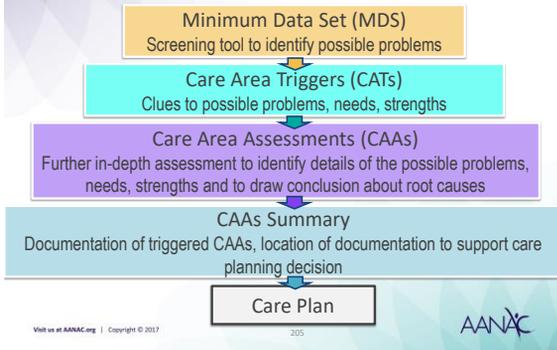


Visit us at AANAC.org | Copyright © 2017

204



Anatomy of the RAI



The Triggers

- A **Care Area Trigger (CAT)** – MDS response indicating that clinical factors exist that may or may not represent a condition that should be care planned
- When a resident’s status on a particular MDS item matches one of the CATs → the care area is **triggered for further assessment**
- Triggers flag conditions that warrant further investigation
- Chapter 4. Section 4.10 reviews the 20 Care Areas CAT Logic Tables

Visit us at AANAC.org | Copyright © 2017



Triggering a CAA

- May be triggered by **more than 1 answer option**.
- For example, for item B1000, Vision:

B1000. Vision

Ability to see in adequate light (with glasses or other visual appliances)

Enter Code

0. Adequate - sees fine detail, such as regular print in newspapers/books
1. Impaired - sees large print, but not regular print in newspapers/books
2. Moderately impaired - limited vision; not able to see newspaper headlines but can identify objects
3. Highly impaired - object identification in question, but eyes appear to follow objects
4. Severely impaired - no vision or sees only light, colors or shapes; eyes do not appear to follow objects

- Entering any code other than 0, which indicates adequate vision, triggers CAA 3, Visual Function; but also Vision CAA triggered by checking I6500 (cataracts, glaucoma, or macular degeneration)

Visit us at AANAC.org | Copyright © 2017



Triggering a CAA

- For some, a **combination of two or three items** triggers the care area for assessment
- Example: For balance deficit to trigger CAA 5, ADL Functional/Rehabilitation Potential
 - Cognition must not be severely impaired (C1000 = 0, 1, or 2 or BIMS score \geq 5) **AND**
 - One of the balance items (G0300 A-E) must be coded unsteady

Visit us at AANAC.org | Copyright © 2017

208



Triggering a CAA

- Some are a **comparison of the current assessment to the most recent prior PPS or OBRA assessment**
 - A trigger for CAA 8, Mood State, compares mood interview total severity score (D0300) on the current comprehensive assessment to the corresponding score on most recent prior
 - If score is greater on the current assessment, the CAA triggers

Visit us at AANAC.org | Copyright © 2017

209



Key Point

The trigger is a small piece and only the beginning of the investigation process



the investigation process

Visit us at AANAC.org | Copyright © 2017

210



Conducting the Assessment

- **Step 3: Conduct thorough assessment** of the entire Care Area using all available sources
 - Include factors that could cause or contribute to the symptom
 - Include factors for which the symptom places the resident at risk
 - Some factors will be on the MDS, *some will not*

Visit us at AANAC.org | Copyright © 2017

214



What to Use to Conduct the Assessment

- **Tools requirement:**
 - Specific tools for conducting the assessment are not mandated by regulations
 - They must be *current, evidence-based or expert-endorsed research and clinical practice guidelines/resources*
 - *The facility should be able to identify the resources they use upon request*

Visit us at AANAC.org | Copyright © 2017

215



What to Use to Conduct the Assessment

- **Tools Option 1:**
 - *Review of Indicators* for each care area provided in **Appendix C**
 - Each provides a checklist of indicators that guides the assessment for the particular care area
 - Also provides space and guidelines for documentation

Visit us at AANAC.org | Copyright © 2017

216



What to Use to Conduct the Assessment

- **Tools Option 2:** Appendix C also offers a list of resources that may be used for this purpose:
 - May be accessed online or through professional associations or other organizations
 - Not an exhaustive list — providers are free to use others that meet regulatory requirement
- Develop a systematic approach for selection of tools:
 - Decide on criteria the tools must meet
 - Outline the process to be used to obtain candidate protocols, practice guidelines, etc.
 - Design the process for review of the tools

Visit us at AANAC.org | Copyright © 2017

217



Conducting the Assessment

- **Step 4: Synthesize the information** collected and draw conclusions based on that information
 - What is **causing** or **contributing** to the problem for this resident?
 - What is this resident at **risk** for related to the problem?
 - What other **health professionals** should be involved?

Visit us at AANAC.org | Copyright © 2017

218



CAA Documentation

- The **nature of the issue** or condition — what is the problem for this resident?
- **Causes and contributing factors**
- **Complications** affecting or caused by the care area for this resident
- **Risk factors** that arise because of the presence of the condition
- **Factors that must be considered** in developing individualized care plan interventions
- Need for **referrals** to other health professionals

Visit us at AANAC.org | Copyright © 2017

219



Key Point

Regardless of tool or format, documentation should walk the surveyor through the evidence of the root causes, contributing factors, risk factors, referrals to other health professionals

Visit us at AANAC.org | Copyright © 2017

220



Key Point

The care plan is the outcome of the process and therefore is not a required component of CAA documentation

Visit us at AANAC.org | Copyright © 2017

221



Care Planning

Visit us at AANAC.org | Copyright © 2017

222



Whose Goals Are They, Anyway?

- *I remember once in my career thinking to myself, "I should probably go ask the resident what she thinks of this care plan goal that I set for her," but then deciding I didn't have time. Stop and think for a minute — Whose goals are they? Whose care plan is it? Whose life is it? Remember: What happens to a resident, always has been and always will be about **their** life*

• Carmen Bowman
Former Colorado Department of Health Surveyor

Visit us at AANAC.org | Copyright © 2017

223



Introduction

The care planning requirements reflect the facility's responsibilities to develop and implement a comprehensive person-centered care plan for each resident and to be informed in a language he or she can understand and also be informed, in advance, of changes to the plan. The care plan includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment

Visit us at AANAC.org | Copyright © 2017

224



Person-Centered

- Person-centered care means to focus on the resident as the locus of control and support the resident in making their own choices; having control over their daily lives
- **Theme: Residents and representatives are informed, involved, and in control**
- Resident involvement and making choices is interspersed throughout Revised Requirements of Participation

Visit us at AANAC.org | Copyright © 2017

225



Fostering Quality

- **Care planning fosters quality resident care by:**
 - Facilitating communication among Interdisciplinary Team (IDT) members
 - Providing staff with consistent information about the resident's problems, strengths, and needs
 - Instructing staff on how to assist the resident to meet their needs and choices
 - Allowing updates and revisions according to the resident's changing needs and preferences
 - Including the resident's voice and choice

Visit us at AANAC.org | Copyright © 2017

226



Care Plan Development

The care plan must aim to address the following:

- Assist resident to achieve goals
- Individualize interventions that honor preferences
- Preserve and build on strengths
- Prevent avoidable decline
- Manage risk factors
- Evaluate treatment objectives and care outcomes – what does the resident think
- Respect the resident's right to refuse treatment
- Offer alternative treatments
- Use an IDT approach
- Involve resident, family, or resident representative
- Direct care staff must be involved in process
- Assessing and planning meet the resident's goals, preferences, needs and expected outcomes
- Use current standards of practice
- CMS's RAI 3.0 Manual, Chapter 4

Visit us at AANAC.org | Copyright © 2017

227



The Bridge to Care Planning

Definition of critical thinking

The intellectual process of reasoning, of logically analyzing all available data

Purpose of critical thinking:

To explore a situation, phenomenon, question, or problem to arrive at a hypothesis or conclusions about it that integrates all available information and can, therefore, be convincingly justified

Kurfiss, 1988

Visit us at AANAC.org | Copyright © 2017

228



Care Plan Development

- The process of the RAI assessments is the foundation of care planning in long-term care
- The full RAI Process is designed to result in a plan of care that guides all levels of the resident's caregivers and is agreement with the resident or their representative
- Services provided or arranged by the facility must:
 - Meet professional standards of quality
 - Be provided by qualified persons in accordance with each resident's written plan of care
 - Be culturally-competent and trauma-informed (Phase 3 of the SOM – effective 11/28/2019)

Visit us at AANAC.org | Copyright © 2017

229



Care Plan Development

- While the RAI process is an excellent assessment, it's focus is on functional status only – not every issue will be identified
- Facility must address all issues, concerns, strengths, and goals of the resident even if not triggered by the RAI process
- For a care plan to be effective, the entire resident must be assessed, with identification of the interrelationship of all aspects of the individual's physical, mental, and psychosocial status on the resident's condition

Visit us at AANAC.org | Copyright © 2017

230



Care Plan Development

- In developing the holistic care plan, **utilize all available assessment data**. In addition to the RAI assessments, other assessments might include:
 - Admission nursing assessment
 - Hydration, Intake and Output, fall risk, risk for skin breakdown and other nursing assessments
 - Hospital History and Physical
 - All ancillary department assessments
 - Lab and x-ray reports
 - Documented discussions with resident & representative

Visit us at AANAC.org | Copyright © 2017

231



Care Plan Development

- The RAI Version 3.0 guides the nursing home team to view residents as individuals who consider both quality of care and quality of life as significant and necessary
- RAI components and the revised regulations require a resident-centered emphasis
- The interdisciplinary approach influences the resident's experience of care by consulting with the resident and impacting work practices of the team
- A holistic focus helps the IDT generate individualized, person-centered/directed plans of care that guide day-to-day care for residents

Visit us at AANAC.org | Copyright © 2017

232



Care Plan Development

- Six general care planning areas CMS considers useful for nursing homes. Ultimately - the resident's status, choices, preferences, and goals should determine what is addressed in a care plan
 1. Functional status – problems on MDS and CATs link to issues and/or conditions on the care plan
 2. Rehabilitation/restorative nursing – resident's potential for improvement or maintenance from any rehab (PT, OT, SLP, psychological, respiratory); awareness of referral needs
 3. Health maintenance – monitoring disease conditions being treated; terminal care; special treatments such as dialysis or ventilator support

Visit us at AANAC.org | Copyright © 2017

233



Care Plan Development (cont.)

4. Discharge planning – on admission, annually and as needed; what needs to happen, what does the resident want for a safe discharge
5. Medications – non-pharmacological approaches, intent, indication, monitoring, action needed when progress not as expected, adverse consequences, gradual dose reductions, drug regimen reviews
6. Daily care needs – specific to the resident; person-centered based on resident's choices, preferences

Visit us at AANAC.org | Copyright © 2017

234



**Looking More Closely at the Revised ROP:
 Comprehensive Person-Centered Care Plans**

Comprehensive care plan must describe:

- Measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment
- Services to help resident achieve highest level of function
- Services that would be required but are not provided due to resident's right to refuse

Visit us at AANAC.org | Copyright © 2017

235



Person-Centered Care Planning

Comprehensive care plan must describe:

- Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations
- In consultation with the resident and the resident's representative(s)—
 - Resident's goals for admission and desired outcomes
 - Resident's preference and potential for future discharge

Visit us at AANAC.org | Copyright © 2017

236



Person-Centered Care Planning

Comprehensive care plan must include:

- Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose
- Discharge plans in the comprehensive care plan, as appropriate

Visit us at AANAC.org | Copyright © 2017

237



Rights and Choice

While federal regulations affirm the resident's right to participate in care planning and to refuse treatment, the regulations do not create the right for a resident, legal surrogate or representative to demand that the facility use specific medical intervention or treatment that the facility deems inappropriate. The regulations hold the facility accountable for the resident's care and safety. Verbal consent or signed consent forms do not eliminate a facility's responsibility to protect a resident

Visit us at AANAC.org | Copyright © 2017

238



Care Plan Components

- Although federal regulations do not dictate a specific care plan format, regulations do mandate the components to be included in a care plan:
 - Problem list/problem statements specific to individual
 - Measurable objectives
 - Measurable timetables
 - Interventions to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being
 - Interventions that would be required but are not provided due to resident's refusal of treatment
 - Date of the entry, signature of the IDT member, discipline responsible for implementation



Visit us at AANAC.org | Copyright © 2017

239



Care Plan Components

The problem statement:

Regardless of the wording or format, the problem statement must contain enough information to ensure that interventions selected are related to the true problem

Example:

For a resident who fell, the problem statements below would result in different interventions:

- Fall climbing out of bed unassisted
- Slipped on urine walking to bathroom

Visit us at AANAC.org | Copyright © 2017

240



Care Plan Components: The Goal

- **Goal – Reasonable expected outcome** of care based on the content of the specified problem, strengths, needs or preferences which provides precise objectives that the resident desires to meet:
 - **Action-oriented**
 - **Goal for the resident**, not for staff
 - **Measurable**
 - **Time-limited**
 - **Individualized** for each resident



Visit us at AANAC.org | Copyright © 2017

241



Care Plan Components: Interventions

- **Interventions are:**
 - **Instructions** to the IDT
 - Developed by **correlating assessment data with goals of care and resident's desires**
 - **Specific to the individual's problems, needs, strengths, and preferences and choices**
 - **Interdisciplinary**, with assigned accountability
 - **Consistent** with the established plan of care
 - Based on **professional standards** of quality

Visit us at AANAC.org | Copyright © 2017

242



Care Plan Components: Interventions

- Interventions are **instructions** to the IDT which should include **concise, focused action statements of direction regarding the resident's care:**
 - Action verb, such as *ambulate*
 - Amount, distance, quantity, such as *30 feet*
 - Method to be utilized, such as *with front-wheeled walker*
 - Frequency, when appropriate, such as *TID*
 - Additional clarifying information or direction, such as, *with gait belt and limited assist*

Visit us at AANAC.org | Copyright © 2017

243



QUESTIONS

Visit us at AANAC.org | Copyright © 2017

244



We provide the **building blocks** to help you succeed in your role.

AANAC offers **educational tools** and **resources** to help you in your long-term care journey.



Visit AANAC.org/LTC-Tools-and-Resources for an additional **FREE** tool related to this session's topic.

Visit us at AANAC.org | Copyright © 2017



References

- AANAC: www.AANAC.org
- CMS MDS 3.0 Information Site: www.cms.gov/NursingHomeQualityInits/25_NHQIMDS30.asp
- CMS Website – PPS: www.cms.hhs.gov/SNFPPS/01_overview.asp
- QIES Technical Support – MDS 3.0 Information:
 - <https://www.qtso.com/mds30.html>

Visit us at AANAC.org | Copyright © 2017

245



References

- **IMPACT Act Web Page:**
<http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Post-Acute-Care-Quality-Initiatives/IMPACT-Act-of-2014-and-Cross-Setting-Measures.html>
- **GlobalRPh Drug Reference,** <http://globalrph.com/drug-A.htm>
- **USP Pharmacological Classification of Drugs,**
<http://www.usp.org/usp-healthcare-professionals/usp-medicare-model-guidelines/medicare-model-guidelines-v50-v40#Guidelines6>. *Directions:* Scroll to the bottom of this webpage and click on the pdf download for “USP Medicare Model Guidelines
- **Medline Plus,**
<https://www.nlm.nih.gov/medlineplus/druginformation.html>

Visit us at AANAC.org | Copyright © 2017

247