MDS and Care Planning for the Interdisciplinary Team

Agenda

- Introduction to the Resident Assessment Instrument
- Assessment timing and scheduling
- Overview of the Care Area Assessment process
- Overview of care planning requirements

Introduction to the Resident Assessment Instrument

Chapter 1

Resident Assessment Instrument

- The purpose of this manual is to offer clear guidance about how to use the Resident Assessment Instrument (RAI) correctly and effectively to help provide appropriate care.
- Providing care to residents with post-hospital and long-term care needs is complex and challenging work. **Clinical competence, observational, interviewing and critical thinking skills, and assessment expertise from all disciplines are required to develop individualized care plans.**
- The RAI helps nursing home staff in gathering definitive information on a resident's strengths and needs, which must be addressed in an **individualized** care plan.

Resident Assessment Instrument

- It also assists staff with evaluating goal achievement and revising care plans accordingly by enabling the nursing home to track changes in the resident's status.
- As the process of problem identification is integrated with sound clinical interventions, the care plan becomes **each resident's unique path** toward achieving or maintaining his or her highest practical level of well-being

Resident Assessment Instrument

- The RAI helps nursing home staff look at residents holistically—as individuals for whom quality of life and quality of care are mutually significant and necessary. Interdisciplinary use of the RAI promotes this emphasis on quality of care and quality of life.
- Nursing homes have found that involving disciplines such as dietary, social work, physical therapy, occupational therapy, speech language pathology, pharmacy, and activities in the RAI process has fostered a more holistic approach to resident care and strengthened team communication.

Content of the RAI

- Minimum Data Set (MDS)
  - A core set of screening, clinical, and functional status elements, including common definitions and coding categories, which forms the foundation of a comprehensive assessment for all residents.
- Care Area Assessment (CAA) Process
  - This process is designed to assist the assessor to systematically interpret the information recorded on the MDS. Once a care area has been triggered, nursing home providers use current, evidence-based clinical resources to conduct an assessment of the potential problem and determine whether or not to care plan for it.
- Care Plan

Uses of MDS Data

- Resident assessment and care planning
- Medicare and Medicaid payment systems
  - Many states use RUGs for their Medicaid rate calculations
  - Medicare Part A uses PDPM to calculate rates
- Monitoring quality of care
- Consumer access to nursing home performance data

What is an Accurate Assessment?

- The RAI process has multiple regulatory requirements.
- Federal regulations at 42 CFR 483.20 (b)(1)(xviii), (g), and (h) require that
  - **(1) the assessment accurately reflects the resident's status**
  - (2) a registered nurse conducts or coordinates each assessment with the appropriate participation of health professionals
  - **(3) the assessment process includes direct observation, as well as communication with the resident and direct care staff on all shifts.**

What is an Accurate Assessment?

- In addition, an accurate assessment **requires collecting information from multiple sources**
- Those sources must include the **resident and direct care staff on all shifts, and should also include the resident's medical record, physician, and family, guardian, or significant other as appropriate or acceptable.**
- It is important to note here **that information obtained should cover the same observation period as specified by the MDS items on the assessment, and should be validated for accuracy** (what the resident's actual status was during that observation period) by the IDT completing the assessment.

What is an Accurate Assessment?

- Nursing homes are left to determine
  - (1) who should participate in the assessment process
  - (2) how the assessment process is completed
  - (3) how the assessment information is documented while remaining in compliance with the requirements of the Federal regulations and the instructions contained within this manual.

Summarizing the Steps for Assessment

- Talk to the resident
- Talk to the family/significant others
- Talk to the staff
- Review the record
- Observe yourself

- Pay attention to the specific look back period and item specific coding instructions

MDS Accuracy

- Updated MDS Manual
  - Most recent update: September, 2019 (was your manual up to date prior to that?)
  - http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/NursingHomeQualityInits/MDS30RAIManual.html
- Errata Documents

MDS Accuracy

- RAI Manual Contents:
  - Chapter 1: RAI Process Overview
  - Chapter 2: Assessment Timing and Scheduling
  - Chapter 3: Item by Item Coding Instructions
  - Chapter 4: Care Area Assessments and Care Planning
  - Chapter 5: Corrections Process
  - Chapter 6: Medicare Reimbursement and Billing

MDS Accuracy

- RAI Manual Appendices
  - Appendix A: Glossary and Common Acronyms
  - Appendix B: State Agency and CMS Regional Office RAI/MDS Contacts
  - Appendix C: Care Area Assessment (CAA) Resources
  - Appendix D: Interviewing to Increase Resident Voice in MDS Assessments
  - Appendix E: PHQ-9 Scoring Rules and Instruction for BIMS (When Administered In Writing)
  - Appendix F: MDS Item Matrix
  - Appendix G: References
  - Appendix H: MDS 3.0 Item Sets

Assessment Timing and Scheduling

Chapter 2

Introduction to the Requirements for the RAI

- The statutory authority for the RAI is found in Section 1819(f)(6)(A-B) for Medicare, and 1919 (f)(6)(A-B) for Medicaid, of the Social Security Act (SSA), as amended by the Omnibus Budget Reconciliation Act of 1987 (OBRA 1987).
- These sections require the Secretary of the Department of Health and Human Services (the Secretary) to specify a Minimum Data Set (MDS) of core elements for use in conducting assessments of nursing home residents
- The OBRA regulations require nursing homes that are Medicare certified, Medicaid certified or both, to conduct initial and periodic assessments for all their residents

Requirements for the RAI, continued

- MDS assessments are also required for Medicare payment (Skilled Nursing Facility (SNF) PPS) purposes under Medicare Part A, or for the SNF Quality Reporting Program (QRP) required under the Improving Medicare Post-Acute Care Transformation Act of 2014 (IMPACT Act)

Requirements for the RAI, continued

- An RAI (MDS, CAA process, and Utilization Guidelines) must be completed for any resident residing in the facility, including:
  - All residents of Medicare (Title 18) skilled nursing facilities (SNFs) or Medicaid (Title 19) nursing facilities (NFs). This includes certified SNFs or NFs in hospitals, regardless of payment source.
  - Hospice residents: When a SNF or NF is the hospice resident's residence for purposes of the hospice benefit, the facility must comply with the Medicare or Medicaid participation requirements, meaning the resident must be assessed using the RAI, have a care plan and be provided with the services required under the plan of care. This can be achieved through cooperation of both the hospice and long-term care facility staff (including participation in completing the RAI and care planning) with the consent of the resident.

Requirements for the RAI, continued

- An RAI (MDS, CAA process, and Utilization Guidelines) must be completed for any resident residing in the facility, including:
  - Short-term or respite residents: An RAI must be completed for any individual residing in the facility more than 14 days in a certified bed
    - If the respite resident is in the facility for ***fewer*** than 14 days, an OBRA Admission assessment is not required; however, an OBRA Discharge assessment is required:
      - Given the nature of a short-term or respite resident, staff members may not have access to all information required to complete some MDS items prior to the resident's discharge. In that case, the "not assessed/no information" coding convention should be used ("-")
      - Regardless of the resident's length of stay, the facility must still have a process in place to identify the resident's needs and must initiate a plan of care to meet those needs upon admission.
      - If the resident is eligible for Medicare Part A benefits, a Medicare assessment will still be required to support payment under the SNF PPS.

Requirements for the RAI, continued

- Chapter 2 also includes instructions for completing assessments with unusual circumstances, including
  - Newly certified facilities
  - Change in ownership
  - Resident transfers

OBRA – Required Tracking Records and Assessments

- Tracking records
  - Entry
  - Death in facility
- Assessments
  - Admission (comprehensive)
  - Quarterly
  - Annual (comprehensive)
  - SCSA (comprehensive)
  - Discharge (return anticipated or return not anticipated)

Overview of the Resident Assessment Instrument (RAI) and Care Area Assessments (CAAs)

Chapter 4

The RAI Process

- The RAI-related processes help staff identify key information about residents as a basis for identifying resident-specific issues and objectives.
- In accordance with 42 CFR 483.21(b) the facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment.
- The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being and any services that would otherwise be required but are not provided due to the resident's exercise of rights including the right to refuse treatment.

MDS is a Starting Point

- The information in the MDS constitutes the core of the required CMS-specified Resident Assessment Instrument (RAI).
- Based on assessing the resident, the MDS identifies actual or potential areas of concern.
- The remainder of the RAI process supports the efforts of nursing home staff, health professionals, and practitioners to further assess these triggered areas of concern in order to identify, to the extent possible, whether the findings represent a problem or risk requiring further intervention, as well as the causes and risk factors related to the triggered care area under assessment.
- These conclusions then provide the basis for developing an individualized care plan for each resident.

The CAA Process Framework

- The CAA process provides a framework for guiding the review of triggered areas, and clarification of a resident's functional status and related causes of impairments.
- It also provides a basis for additional assessment of potential issues, including related risk factors.
- The assessment of the causes and contributing factors gives the interdisciplinary team (IDT) additional information to help them develop a comprehensive plan of care

The CAA Process Framework

- When implemented properly, the CAA process should help staff:
  - Consider each resident as a whole, with unique characteristics and strengths that affect his or her capacity to function;
  - Identify areas of concern that may warrant interventions;
  - Develop, to the extent possible, interventions to help improve, stabilize, or prevent decline in physical, functional, and psychosocial well-being, in the context of the resident's condition, choices, and preferences for interventions; and
  - Address the need and desire for other important considerations, such as advanced care planning and palliative care; e.g., symptom relief and pain management

Care Area Assessments

What are Care Area Assessments?

- To help nursing facilities apply assessment data collected on the MDS, Care Area Assessments (CAAs) are triggered responses to items coded on the MDS specific to a resident's possible problems, needs or strengths.
- The CAAs reflect conditions, symptoms, and other areas of concern that are common in nursing home residents and are commonly identified or suggested by MDS findings.
- Interpreting and addressing the care areas identified by the CATs is the basis of the Care Area Assessment process, and can help provide additional information for the development of an individualized care plan.

The Care Areas

1. Delirium
2. Cognitive Loss/Dementia
3. Visual Function
4. Communication
5. ADL Functional/Rehab Potential
6. Urinary Incontinence/Catheter
7. Psychosocial Wellbeing
8. Mood State
9. Behavioral 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

The Care Area Assessment Process

- The CAA process refers to identifying and clarifying areas of concern that are triggered based on how specific MDS items are coded on the MDS.
- The process focuses on evaluating these triggered care areas using the CAAs, but does not provide exact detail on how to select pertinent interventions for care planning.
- Interventions must be individualized and based on applying effective problem solving and decision making approaches to all of the information available for each resident.

The Care Area Assessment Process

- Care Area Triggers (CATs) identify conditions that may require further evaluation because they may have an impact on specific issues and/or conditions, or the risk of issues and/or conditions for the resident.
- Each triggered item must be assessed further through the use of the CAA process to facilitate care plan decision making, but it may or may not represent a condition that should or will be addressed in the care plan.
- The significance and causes of any given trigger may vary for different residents or in different situations for the same resident.
- Different CATs may have common causes, or various items associated with several CATs may be connected.

The Care Area Assessment Process

- CATs provide a “flag” for the IDT members, indicating that the triggered care area needs to be assessed more completely prior to making care planning decisions.
- Further assessment of a triggered care area may identify causes, risk factors, and complications associated with the care area condition.
- The plan of care then addresses these factors with the goal of promoting the resident’s highest practicable level of functioning:
  - (1) improvement where possible or
  - (2) maintenance and prevention of avoidable declines.
- A risk factor increases the chances of having a negative outcome or complication. For example, impaired bed mobility may increase the risk of getting a pressure ulcer/injury. In this example, impaired bed mobility is the risk factor, unrelieved pressure is the effect of the compromised bed mobility, and the potential pressure ulcer is the complication.

The Care Area Assessment Process

- A care area issue/condition (e.g., falls) may result from
  - a single underlying cause (e.g., administration of a new medication that causes dizziness) or
  - from a combination of multiple factors (e.g., new medication, resident forgot walker, bed too high or too low, etc.).
- There can also be a single cause of multiple triggers and impairments. For example, hypothyroidism is an example of a common, potentially reversible medical condition that can have diverse physical, functional, and psychosocial complications. (see next slide)

The Care Area Assessment Process

- Thus, if a resident has hypothyroidism, it is possible that the MDS might trigger any or several of the following CAAs depending on whether or not the hypothyroidism is controlled, there is an acute exacerbation, etc.:
  - Delirium Cognitive Loss/Dementia, Visual Function, Communication, ADL Functional/Rehabilitation, Urinary Incontinence, Psychosocial Well-Being, Mood State, Behavior Symptoms, Activities, Falls, Nutritional Status, Dehydration, Psychotropic Medication Use, and Pain.
- Even if the MDS does not trigger a particular care area, the facility can use the CAA process and resources at any time to further assess the resident.

The Care Area Assessment Process

- Recognizing the connection among these symptoms and treating the underlying cause(s) to the extent possible, can help address complications and improve the resident's outcome.
- Conversely, failing to recognize the links and instead trying to address the triggers or MDS findings in isolation may have little if any benefit for the resident with hypothyroidism or other complex or mixed causes of impaired behavior, cognition, and mood.
- The RAI is not intended to provide diagnostic advice, nor is it intended to specify which triggered areas may be related to one another or and how those problems relate to underlying causes. It is up to the IDT, including the resident's physician, to determine these connections and underlying causes as they assess the triggered care areas and any other areas pertinent to the individual resident.

Activities Care Area Assessment

- Residents who were assessed in any of the interview items as not very important, not important at all, or important but can’t do or no choice, will trigger the activity care area
- Other MDS item responses are also relevant to this care area
- In order to properly complete the care area, you will also need to talk to the resident and family and make some of your own observations

Activities Care Area Assessment

- Activity preferences prior to admission
- Current activity pursuits
- Health issues that result in reduced activity participation
- Environmental or staffing issues that hinder participation
- Unique skills or knowledge the resident has that they could pass on to others
- Issues that result in reduced activity participation
- Are you going to proceed with an activities care plan?

The Care Area Assessment Process

- The CAA process may help the IDT:
  - Review the resident's situation with a health care practitioner (e.g., attending physician, medical director, or nurse practitioner), to try to identify links among causes and between causes and consequences, and to identify pertinent tests, consultations, and interventions;
  - Determine whether a resident could potentially benefit from rehabilitative interventions;
  - Begin to develop an individualized care plan with measurable objectives and timetables to meet a resident's medical, functional, mental and psychosocial needs as identified through the comprehensive assessment.

Assigning Responsibility for Completing the MDS and CAAs

- Per the OBRA statute, the resident's assessment must be conducted or coordinated by a registered nurse (RN) with the appropriate participation of health professionals.
- It is common practice for facilities to assign specific MDS items or portion(s) of items (and subsequently CAAs associated with those items) to those of various disciplines
- The proper assessment and management of CAAs that are triggered for a given resident may involve aspects of diagnosis and treatment selection that exceed the scope of training or practice of any one discipline involved in the care
- It is the facility's responsibility to obtain the input that is needed for clinical decision making (e.g., identifying causes and selecting interventions) that is consistent with relevant clinical standards of practice.

CAA Documentation

- CAA documentation helps to explain the basis for the care plan by showing how the IDT determined that the underlying causes, contributing factors, and risk factors were related to the care area condition for a specific resident;
- Based on the review of the comprehensive assessment, the IDT and the resident and/or the resident's representative determine the areas that require care plan intervention(s) and develop, revise, or continue the individualized care plan.

CAA Documentation

Required documentation:

- Relevant documentation for each triggered CAA describes:
- Causes and contributing factors;
- The nature of the issue or condition (may include presence or lack of objective data and subjective complaints). In other words, what exactly is the issue/problem for this resident and why is it a problem;
- Complications affecting or caused by the care area for this resident;
- Risk factors related to the presence of the condition that affects the staff's decision to proceed to care planning;

CAA Documentation

Required documentation (continued)

- Factors that must be considered in developing individualized care plan interventions, including the decision to care plan or not to care plan various findings for the individual resident;
- The need for additional evaluation by the attending physician and other health professionals, as appropriate;
- The resource(s), or assessment tool(s) used for decision-making, and conclusions that arose from performing the CAA;
- Completion of Section V (CAA Summary; see Chapter 3 for coding instructions) of the MDS.

CAA Documentation

- Written documentation of the CAA findings and decision making process may appear anywhere in a resident's record; for example, in discipline-specific flow sheets, progress notes, the care plan summary notes, a CAA summary narrative, etc.
- If it is not clear that a facility's documentation provides this information, surveyors may ask facility staff to provide such evidence.
- facilities are responsible for assessing and addressing all care issues that are relevant to individual residents, regardless of whether or not they are covered by the RAI (42 CFR 483.20(b)), including monitoring each resident's condition and responding with appropriate interventions.

CAA Documentation

- By themselves, neither the MDS nor the CAA process provide sufficient information to determine if the findings from the MDS are problematic or merely incidental, or if there are multiple causes of a single trigger or multiple triggers related to one or several causes.
- Although a detailed history is often essential to correctly identify and address causes of symptoms, the RAI was not designed to capture a history (chronology) of a resident's symptoms and impairments. Thus, it can potentially be misleading or problematic to care plan individual MDS findings or CAAs without any additional thought or investigation.

CAA Documentation

- The RAI does not constitute the entire assessment that may be needed to address issues and manage the care of individual residents.
- The MDS may not trigger every relevant issue
- Not all triggers are clinically significant
- The MDS is not a diagnostic tool or treatment selection guide
- The MDS does not identify causation or history of problems

Care Planning

Chapter 4

The Comprehensive Care Plan

- As required at 42 CFR 483.21(b), the comprehensive care plan is an interdisciplinary communication tool.
- It must include measurable objectives and time frames and must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being.
- The care plan must be reviewed and revised periodically, and the services provided or arranged must be consistent with each resident's written plan of care.

The Comprehensive Care Plan

- Good assessment is the starting point for good clinical problem solving and decision making and ultimately for the creation of a sound care plan.
- The CAAs provide a link between the MDS and care planning.
- The care plan should be revised on an ongoing basis to reflect changes in the resident and the care that the resident is receiving (see 42 CFR 483.21(b), Comprehensive Care Plans).
- The regulation does not specify a care plan structure or format.

Care Planning Tips and Clarifications

- Care Plan goals should be measurable. The IDT may agree on intermediate goal(s) that will lead to outcome objectives. Intermediate goal(s) and objectives must be pertinent to the resident's goals, preferences, condition, and situation (i.e., not just automatically applied without regard for their individual relevance), measurable, and have a time frame for completion or evaluation.
- Care plan goal statements should include the **subject** (first or third person), the **verb**, the **modifiers**, the **time frame**, and the **goal(s)**.
- The resident's care plan must be reviewed after each assessment, as required by §483.20, except discharge assessments, and revised based on changing goals, preferences and needs of the resident and in response to current interventions.

Care Planning Tips and Clarifications

- A separate care plan is not necessarily required for each area that triggers a CAA. Since a single trigger can have multiple causes and contributing factors and multiple items can have a common cause or related risk factors, it is acceptable and may sometimes be more appropriate to address multiple issues within a single care plan segment or to cross reference related interventions from several care plan segments.
  - For example, if impaired ADL function, mood state, falls and altered nutritional status are all determined to be caused by an infection and medication-related adverse consequences, it may be appropriate to have a single care plan that addresses these issues in relation to the common causes.

Care Planning Tips and Clarifications

- Residents' preferences and goals may change throughout their stay, so facilities should have ongoing discussions with the resident and resident representative, if applicable, so that changes can be reflected in the comprehensive care plan.
- Review of the CAAs after completing the MDS may raise questions about the need to modify or continue services. Conditions that originally triggered the CAA may no longer be present because they resolved, or consideration of alternative causes may be necessary because the initial approach to an issue, risk, or condition did not work or was not fully implemented

Care Planning Tips and Clarifications

- On the Annual assessment, if a resident triggers the same CAA(s) that triggered on the last comprehensive assessment, the CAA should be reviewed again.
- Even if the CAA is triggered for the same reason (no difference in MDS responses), there may be a new or changed related event identified during CAA review that might call for a revision to the resident's plan of care.
- The IDT with the input of the resident, family or resident's representative determines when a problem or potential problem needs to be addressed in the care plan.