CMS’s RAI Version 3.0 Manual
October 2016

RAI  Resident Assessment Instrument
SOM  Utilization Guidelines from the State Operations Manual
CAAs  Care Area Assessments
MDS  Minimum Data Set
Purpose

Assessment Tool – Utilized to identify resident care problems that are addressed in an individualized person-centered care plan

Reimbursement – Medicare FFS RUGs; Some Medicare Advantage use RUGs; CMI for Medicaid
Purpose

• MDS based quality measures were developed to assist with state survey and certification
• Nursing Home providers with quality improvement
• Nursing Home consumers in understanding the quality of care provided by the NF

Quality of Care Monitoring
Federal Regulations

Require:

• The assessment accurately reflects the resident’s status

• A registered nurse conducts or coordinates each assessment with appropriate participation of health professionals

• The assessment process includes direct observation, as well as communication with the resident and direct care staff on all shifts
Federal Regulations

Required multiple sources of information:

- Resident
- Direct care staff on all shifts
- Resident’s medical record
- Physician
- Family / guardian / significant other (as appropriate or acceptable)

The information should cover the same observation period as specified by the MDS items and should be validated for accuracy by the team completing the assessment
Nursing Process

- Assessment
- Decision Making
- Care Planning
- Implementation
- Evaluation

Interdisciplinary Focus
42 CFR (Code of Federal Regulations)

- §483.20 Resident Assessment
- §483.21 Comprehensive Person Centered Care Planning

REQUIREMENTS OF PARTICIPATION
MDS - Chapter 2

• Requirements and Responsibilities of Nursing Homes related to the RAI

• Assessment Types and Definitions

• Completion Timeframes
MDS - Chapter 3

• Item by item guide
• Each section starts with the *Intent*
  – reason(s) for including this set of assessment items in the MDS
• *Item Display* – to facilitate accurate resident assessment using the MDS, each assessment section is accompanied by screenshots
MDS - Chapter 3

• *Item Rationale* – The purpose of assessing this aspect of a resident’s clinical or functional status

• *Health-Related Quality of Life* – How the condition, impairment, improvement, or decline being assessed can affect a resident’s quality of life. In addition, to the importance of staff understanding the relationship of the clinical or functional issue related the residents’ quality of life
MDS - Chapter 3

- **Planning for Care** – How assessment of the condition, impairment, improvement, or decline being assessed can contribute to appropriate care planning

- **Steps for Assessment** – Sources of information and methods for determining the correct response for coding each MDS item
MDS - Chapter 3

• **Coding Instructions** - The proper method of recording each response, with explanations of individual response categories

• **Coding Tips and Coding Tips for Special Populations** - Clarifications, issues of note and conditions to be considered when coding individual MDS items

• **Examples** - Case examples of appropriate coding for most, if not all, MDS sections/items
CAA - Basics

Intent:

• The MDS does not constitute a comprehensive assessment. Rather, it is a preliminary assessment to identify potential resident problems, strengths, and preferences.

• Care areas are triggered by MDS item responses that indicate the need for additional assessment based on problem identification, known as “triggered care areas,” which form a critical link between the MDS and decisions about care planning.
CAA - Basics

• 20 Care Area Assessments – The CAAs cover the majority of care areas known to be problematic for the NF resident

• The MDS identifies actual or potential problem areas and the CAA process provides further assessment

• CAA documentation
  o May appear anywhere in the resident’s medical record
  o Location and date of CAA documentation (Section V of the MDS 3.0)
CAA - Basics

• A specific tool for completion is not mandated
• Specific guidance on how to understand or interpret the triggered areas is not provided
• Instructed to identify and use tools that are current and grounded in current clinical standards of practice
• Use of sound clinical problem solving and decision making skills is imperative
CAA - Basics

CAA process

• Identification of Triggered CAAs
  - Care Area Trigger logic - Complex!
• Analysis of Triggered CAAs
• Decision Making
• CAA Documentation
Delirium CAT Logic Table

Triggering Conditions (any of the following):

1. Worsening mental status is indicated by the BIMS summary score having a non-missing value of 00 to 15 on both the current non-admission comprehensive assessment (A0310A = 03, 04 or 05) and the prior assessment, and the summary score on the current non-admission assessment being less than the prior assessment as indicated by:

   \[(A0310A = 03, 04, OR 05) AND \]

   \[((C0500 >= 0) AND (C0500 <= 15)) AND \]

   \[((V0100D >= 0) AND (V0100D <= 15)) AND \]

   \[(C0500 < V0100D)\]

2. Acute mental status change is indicated on the current comprehensive assessment as follows:

   \[C1600 = 1\]
• Triggering Conditions (any of the following):
  1. Cataracts, glaucoma, or macular degeneration on the current assessment as indicated by:
     \[ \text{I6500} = 1 \]
  2. Vision item has a value of 1 through 4 indicating vision problems on the current assessment as indicated by:
     \[ \text{B1000} \geq 1 \text{ AND } \text{B1000} \leq 4 \]
Triggering Conditions (any of the following):
1. ADL assistance for toileting was needed as indicated by:
   \[(G0110I1 \geq 2 \text{ AND } G0110I1 \leq 4)\]
2. Resident requires a indwelling catheter as indicated by:
   \[H0100A = 1\]
3. Resident requires an external catheter as indicated by:
   \[H0100B = 1\]
4. Resident requires intermittent catheterization as indicated by:
   \[H0100D = 1\]
5. Urinary incontinence has a value of 1 through 3 as indicated by:
   \[H0300 \geq 1 \text{ AND } H0300 \leq 3\]
6. Resident has moisture associated skin damage as indicated by:
   \[M1040H = 1\]
CAA - Basics

Documentation for each triggered CAA should describe:

• 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 that affect the staff’s decision to proceed to care planning
CAA - Basics

Documentation for each triggered CAA should describe:

• Factors that must be considered in developing individualized care plan interventions
• Need for referrals or further evaluation
• What research, resource(s) or assessment tool(s) were used in performing the CAA. *(Only needed if not addressed by facility policy.)*
• Completion of Section V (CAA Summary) of the MDS
CAA - Basics

• Documentation must also occur when the decision is made **NOT** to proceed to a care plan

• All members of the IDT should be trained in assessment and be capable of determining what is necessary and appropriate for a particular resident

• Education is Important – Education is often the missing link to the provision of Quality of Care
CAA - Basics

- The CAAs should help lead the way to individualized care plans that can result in more time-effective and efficient approaches and improved resident outcomes & satisfaction

- Understand the F-tags connected to each CAA
  - Activities, F248
  - Dental Care, F412
  - Falls, F323
  - Pressure Ulcers, F314

Many More!
Quality Measures

• Developed from MDS-based indicators
  o Represent the quality of care provided in nursing homes
• Multiple areas of the resident’s functioning and health status are addressed
• More than just 5 Star Quality Measures
  o Only 13 out 24 MDS Based used for 5 Star
Quality Measures

A closer look at the QM’s used for Five Star Rating

MDS Based
• 9 Long Stay
  o Cumulative days in the facility greater than or equal to 101 days – end of target period
• 4 Short Stay
  o Cumulative days in the facility less than or equal to 100 – end of target period
Quality Measures

• **TARGET PERIOD** - The span of time that defines the QM reporting period (e.g. calendar quarter)

• **TARGET DATE** – The event date for an MDS record; Entry Record it is equal to the entry date at A1600; Discharge Record or Death in Facility it is equal to the discharge date at A2000; for all other records it is equal to the ARD at A2300

• **STAY** – The period of time between a resident’s entry into a facility and either a discharge or the end of that target period, whichever comes first

• **EPISODE** – A period of time spanning one or more stays. An episode begins with an admission and ends with a discharge or the end of a target period, whichever comes first

*NOTE: Difference between stay and episode is that a stay ends with any type of discharge and an episode only ends if the discharge was a death in facility, discharge return not anticipated and discharge return anticipated, but the resident does not return in 30 days of discharge.*
Quality Measures

- **Cumulative days in the facility (CDIF)** – The total number of days within an episode during which the resident was in the facility. Sum of the number of days within each stay included in an episode. Only days within the facility count.

- **Target Assessment Selection Period** – Most recent 3 months, latest assessment that is contained within the resident’s selected episode and is a qualifying assessment type and the target date is no more than 120 days before the end of the episode.

- **Look-Back Scan** – All assessments are scanned within the current episodes that have target dates no more than 275 days prior to the target assessment. The target assessment and all qualifying earlier assessments in the scan. Earlier assessment included if it is contained within the resident’s episode, has a qualifying assessment, its target date is on or before the target date for the target assessment and its target date is no more than 275 days prior to the target date of the target assessment.
Quality Measures

MDS items (long stay)

• Section G – help for ADLs increased, move independently worsened, high-risk pressure ulcers
• Section M – high-risk pressure ulcers
• Section B – high-risk pressure ulcers
Quality Measures

MDS items (long stay)

• Section I – high-risk pressure ulcers, UTI, antipsychotic meds.
• Section H – indwelling catheter
• Section P – physically restrained
• Section J – moderate to severe pain, falls with major injury
• Section N – antipsychotic meds
Quality Measures

MDS items (short stay)

- Section G – physical function improves
- Section M – new or worsened pressure ulcers
- Section J – moderate to severe pain
- Section N – newly received antipsychotic
- Section I – newly received antipsychotic
Quality Measures

• Be familiar with the QM lingo
• Have a basic understanding of the calculation
• Serves as an important tool for quality improvement
• Staff working with the QMS need to develop an understanding of the focus of each measure, the MDS items that enter into each and the relationship of those items to each other
• Focus needs to be on the accuracy of the MDS data and quality of resident care
Quality Measures

- Quality Measures should be an integral part of the Quality Assessment and Assurance Committee
- Problems should be addressed through a program of process improvement
- Excellent care may not be reflective through the QMS if the underlying MDS data is not accurate
- MDS coding errors are common
- MDS coding instructions are complex
Quality Measures

• Inaccurate coding leads to inaccurate care plans and inappropriate resident care that may lead to poor outcomes

• Errors distort the data, resulting in inaccurate score

• Problems that contribute to inaccurate MDS coding are poor chart documentation, ineffective communication between IDT members, not obtaining information across all shifts for the entire 7 days
(a) Baseline Care Plans

- The facility must develop and implement a baseline care plan that includes instructions needed to provide effective and person-centered care of the resident
- Meet professional standards of quality care
- Developed within 48 hours of admission
- Include minimum healthcare information necessary to properly care for resident
(a) Baseline Care Plans

• Should include, but not limited to:
  o Initial goals based on admission orders
  o Physician orders
  o Dietary orders
  o Therapy services
  o Social services
  o PASARR recommendations, if applicable
(a) Baseline Care Plans

- The facility must provide the resident and their representative with a summary of the baseline care plan that includes but is not limited to:
  - Initial goals of the resident
  - A summary of the resident’s medications and dietary instructions
  - Any services and treatments to be administered by the facility and personnel acting on behalf of the facility
  - Any updated information based on the details of the comprehensive care, as necessary
(a) Baseline Care Plans

- The facility may develop a comprehensive care plan in place of the baseline care plan if the comprehensive care plan is:
  - Developed within 48 hours of the resident’s admission
  - Meets the requirements listed in paragraph (b) of §483.21 with the exception of (b)(2)(i)
SOM - §483.21

(b) Comprehensive Care Plans

- Must develop and implement a comprehensive person centered care
- Consistent with resident’s rights set forth at §483.10(c)(2) & (c)(3) Planning and implementing care
  - Participate in the development and implementation of his/her care plan including but not limited to:
    - Right to participate in planning process, including the right to identify individuals or roles to be included in the care planning process, the right to request meetings and the right to request revisions
(b) Comprehensive Care Plans

- Participate in the development and implementation of his/her care plan including but not limited to:
  - Right to participate in establishing the expected goals and outcomes of care, the type, amount, frequency and duration of care
  - Right to be informed, in advance, of changes to the plan of care
  - Right to receive the services and/or items included in the plan of care
  - Right to see the care plan, right to sign after significant changes to the plan of care
(b) Comprehensive Care Plans

- Facility shall inform the resident of the right to participate in his or her treatment and shall support the resident in this right, planning process must:
  - Facilitate the inclusion of the resident and/or resident representative
  - Include an assessment of the resident’s strengths and needs
  - Incorporate the resident’s personal and cultural preferences in developing goals of care
(b) Comprehensive Care Plans

• Measureable objectives and timeframes to meet the resident’s medical, nursing, and mental and psychosocial needs

• Must describe the following:
  
  o Services are to attain or maintain the resident’s highest practicable physical, mental, and psychosocial well being as required under §483.24, §483.25, §483.40

  o Any services that would otherwise be required under §483.24, §483.25, §483.40, but are not provided due to the resident’s exercise of rights under §483.10, including the right to refuse treatment, §483.10(c)(6)
Quality of Life
Quality of Care
Behavioral Health Services
(b) Comprehensive Care Plans

• Must describe the following:
  o Any specialized services or specialized rehab services the facility will provide as a result of PASARR recommendations
  o In consult with the resident and the resident’s representative:
    • Resident’s goals for admission and desired outcomes
    • Resident’s preference and potential future discharge
      o Must document desire to return to the community was assessed, referrals to local agencies, etc..
    • Discharge plan in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in §483.21(c) discharge planning
(b) Comprehensive Care Plans

• Developed within 7 days after completion of the comprehensive assessment
• IDT involvement with preparation
• Reviewed and revised by IDT after each assessment
• Services provided must:
  - Meet professional standards of quality
  - Be provided by qualified persons
  - Be culturally-competent and trauma-informed
    • More information will be available at a later date - Phase 3
(c) Discharge Planning

• **Process:**
  
  o Must develop and implement an effective discharge planning process that focuses:
    
    • On the resident’s discharge goals
    • The preparation of residents to be active partners and effectively transition to post-discharge care
    • The reduction of factors leading to preventable readmissions

• Must be consistent with discharge rights set forth under §483.15(b)
(c) Discharge Planning

- Ensure the discharge needs are identified and result in development of a discharge plan
- Include regular re-evaluation of residents to identify changes, which may result in modification of the discharge plan, plan needs to be updated as needed to reflect changes
- IDT involvement – ongoing process of developing the discharge plan
- Consider caregiver/support person availability and the resident’s or caregiver’s/support person(s) capacity and capability to perform required care, this is part of the identification of discharge needs
(c) Discharge Planning

- Resident and resident representative involvement in developing the discharge plan, must be informed of final plan

- Address resident’s goals of care and treatment preferences

- Resident interests in receiving information regarding returning to the community must be documented that the resident was asked
(c) Discharge Planning

• Return to the community
  o If resident is interested in returning to the community, documentation must be present of any referrals to local contact agencies, etc.
  o Comprehensive care plan and discharge must be updated to reflect responses from referrals
  o If return to community is not feasible, must document who made the decision and why
(c) Discharge Planning

• **Summary:**
  
  o Must include, but not limited to:

  • Summary of the resident’s stay: dx, course of illness/treatment or therapy, pertinent labs, radiology, consults results
  
  • Include items from §483.20(b)(1)
  
  • Reconciliation of all pre-discharge medications with resident’s post-discharge medications (both prescribed and over the counter)
  
  • Post-discharge plan of care – developed with resident, must include where the resident plans on residing, any arrangements that have been made for follow up care and post discharge medical and non-medical services
Medicare

• The Medicare Prospective Payment System utilizes the Resident Assessment Instrument – MDS to determine the type of services the resident is receiving

• Based on the completed MDS data a resident is placed in one of 66 Resource Utilization Groups (RUG IV)
Medicare

8 RUG Categories
Rehab + Ext Services - 9 Classifications
Rehabilitation - 14 Classifications
Extensive Services - 3 Classifications
Special Care High and Low - 16 Classifications
Clinically Complex - 10 Classifications

Behavior Problems - 4 Classifications
Reduce Physical Function - 10 Classifications
Medicare

• SNF QRP and SNF VBP
  o Claims based information
  o MDS based

• Proposed changes from RUG to RCS
  o Information will continue to be gathered from the MDS
  o Future changes to the MDS
Thank you for your time and participation today!

Any questions on today’s presentation, please contact:

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