

MDS SURVEYS


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- **February 2013:** Skilled Nursing Facilities often Fail to Meet Care Planning and Discharge Planning Requirements
- Findings
 - 37% of stays SNFs did not develop care plans that met requirements or did not provide services in accordance with care plans
 - 31% of stays SNFs did not meet discharge planning requirements
- Medicare paid approximately \$5.1 billion for stays in which SNFs did not meet these quality of care requirements





PAYMENTS AND QUALITY OF CARE OTHER RECENT STUDIES

- 2006-2008 SNFs increasingly billed for higher paying categories, even though beneficiary characteristics remained largely unchanged
- 5 facilities did not provide adequate staffing and services to beneficiaries, resulting in beneficiaries' developing pressure ulcers, malnutrition, dehydration, and side effects from not receiving medications (Department of Justice [DOJ] and Cathedral Rock 2010)
- SNFs billed one quarter of claims in error in 2009, resulting in \$1.5 billion in inappropriate Medicare payments



OIG RECOMMENDATIONS

- Strengthen the regulations on care planning and discharge planning
- Provide guidance to SNFs to improve care planning and discharge planning
- Increase surveyor efforts to identify SNFs that do not meet care planning and discharge planning requirements and to hold these SNFs accountable
- Link payments to meeting quality of care requirements
- Follow up on the SNFs that failed to meet care planning and discharge planning requirements

OIG RECOMMENDATIONS TO CMS

- Strengthen the regulations on care planning and discharge planning to reflect current standards of practice
 - Documentation of services provided including why services were not provided or why it was not care planned (as noted in the Care Area Assessment [CAA])
 - Discharge planning be interdisciplinary team, including a physician
- CMS response: concurred and is conducting a comprehensive review of participation requirements; Reaching out to stakeholders for public input



OIG RECOMMENDATIONS TO CMS

- Provide guidance to SNFs to improve care planning and discharge planning
 - Reiterate and expand on the care planning discharge planning requirements
 - Care Planning: addressing problem areas identified in the assessment, must be customized and include measurable objectives and time frames; should be based interdisciplinary team member communication and not viewed as a "documentation exercise"
 - Discharge Planning: discharge summary needs to provide an adequate clinical picture of the beneficiary and individualized care instructions, care coordination and safe transition
- CMS concurred: Quality Improvement Organizations (QIO) are enrolling facilities to improve the overall quality of care with one item focusing on care planning



OIG RECOMMENDATIONS TO CMS

- Increase surveyor efforts to identify SNFs that do not meet care planning and discharge planning requirements and to hold these SNFs accountable
 - CMS should increase surveyor efforts to make SNFs more accountable
 - Provide surveyors with detail guidance to improve the detection of noncompliance, particularly discharge planning (revise interpretive guidelines and train surveyors and cite facilities for non compliance)
- CMS concurred: will consider ways to increase oversight of care planning and discharge planning; will review current citations for improvement in its enforcement efforts



OIG RECOMMENDATIONS TO CMS


- Link payments to meeting Quality of Care Requirements
 - CMS should link SNF payments more closely to meeting the Quality of Care Requirements
 - Example: CMS could incorporate quality measures for care planning and discharge planning in its SNF Value-Based Purchasing program
- CMS concurred and will consider incorporating care planning and discharge planning in future nursing home demonstrations



OIG RECOMMENDATIONS TO CMS



- Follow up on the SNFs that failed to meet care planning and discharge planning requirements
 - OIG will provide CMS with list of SNFs that failed care planning and discharge planning requirements or provided poor quality of care
 - It may indicate a wider problem in the facility
- CMS concurred: will analyze the survey data and determine appropriate methods to strengthen enforcement of CMS requirements



S&C:15-06-NH

- October 31, 2014: Nationwide Expansion of Minimum Data Set (MDS)-Focused Survey
 - Pilot done summer 2014 in 5 states with 5 homes in each state (total of 25 homes)
 - **24 out of 25 homes were cited for MDS-related issues**



SURVEY FINDING EXAMPLES

- Inaccurate staging and documentation of pressure ulcers
- Lack of knowledge regarding the classification of antipsychotic drugs
- Poor coding regarding the use of restraints



RESIDENT ASSESSMENT: 483.20

- MDS Related Tags
 - F272 Comprehensive Assessments
 - F273 Comprehensive Assessment 14 Days after Admission
 - F274 Comprehensive Assessment after Significant Change
 - F275 Comprehensive Assessment at Least Every 12 Months
 - F276 Quarterly Assessment at Least Every 3 Months



RESIDENT ASSESSMENT: 483.20

- MDS Related Tags
 - F278 Assessment Accuracy/Coordinated/Certified
 - F279 Develop Comprehensive Care Plans
 - F280 Right to Participate Planning Care-Revise CP
 - F286 Maintain 15 months of Resident Assessments
 - F287 Encoding/Transmitting Resident Assessment



NURSING HOME STAFFING

- Will assess the accuracy of information on staffing
- Only collected on the annual survey
- No information of how staffing levels may fluctuate
- Will assess the staffing levels during the MDS-focused surveys



STATE AGENCIES

- MDS/Staffing-Focused Review surveys will vary from state to state and will be directed by CMS
- States will be expected to allocate 2 surveyors for each survey
- Surveys will require an estimated 2 days on average
- Surveyors will complete and submit post survey information to CMS (questionnaire about the process and findings)



FOCUSED SURVEYS

- To begin in early FY 2015
- CMS with state input will determine how many surveys to be done and when
 - MO will be doing 12 MDS-focused surveys
 - Uncertain of other state numbers to be done
- CMS will collaborate with states to identify the specific facilities to be surveyed
- CMS is developing both the survey protocol and tool for the states to use
 - Record review, resident observations, and staff and/or resident interviews to validate coding and staffing levels
 - Will ask a series of questions regarding staffing and MDS-related practices

A slide titled "TRAINING" with a red arrow pointing right. The background is light green with a white arrow on the left. A 3D illustration shows a red figure pointing at a whiteboard, with several blue figures sitting at desks in front of it. The text is as follows:


TRAINING

- Mandatory half day web-based training for State Agency (SA) staff conducting reviews
- One manager or trainer within the SA will also need to attend the training prior to initiating the surveys
- CMS will provide the support necessary to conduct the surveys

A slide titled "ENFORCEMENT IMPLICATIONS" with a red arrow pointing right. The background is light green with a white arrow on the left. A 3D illustration shows a red figure pointing at a whiteboard, with several blue figures sitting at desks in front of it. The text is as follows:

ENFORCEMENT IMPLICATIONS

- Inaccuracies and insufficient staffing noted during the survey will result in relevant citations
 - Including those related to quality of care and or life, or nursing services
- The concerns may be cited or referred to the Survey Agency as a complaint for further review



WELCOME MEMO FROM THE SUMMER DEMONSTRATION

- MDS survey is not intended to impact a facility standard survey cycle
- If deficient practices are found:
 - Statement of deficiencies will be issued
 - Plan of correction will be required
- An exit conference will be conducted at the conclusion of the survey



MDS SURVEY

- Surveyors will need access to:
 - MDS assessments and associated information to support the coding
 - Designate a contact person familiar with the process (e.g. the MDS coordinator) to assist with the finding of medical record supporting documentation

MDS SURVEY

- Information required immediately upon entrance:
 - Facility census number
 - Alphabetical resident census, with room numbers, noting if anyone is not in the facility at this time
 - Copy of the facility floor plan



MDS SURVEY

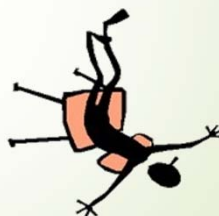
- Provide within one hour of entrance:
 - 10 most recent **OBRA** required MDS assessments completed and submitted, plus medical records to support that MDS; must be OBRA required and/or OBRA combined with a PPS reason
 - Policies and procedures related to the RAI, including the MDS and the Quality Measures
 - Staffing schedule for ALL staff involved in scheduling, coding, and transmitting MDS and their role in the process
 - Name and contact info for the QA&A coordinator

MDS SURVEY

- Current residents and room numbers with any of the following conditions and or devices in use in the last 90 days
 - Pressure ulcers
 - Indwelling catheters
 - Restraints other than side rails
 - Urinary tract infections
 - Antipsychotic medications

MDS SURVEY

- A list of all residents who fell in the past 12 months
 - Date of fall
 - Resulting injury



PANIC

NOW WHAT?

Let's look at the specific areas that could be targeted!




PRESSURE ULCERS

- Does the wound report match the MDSs for that resident?
- Does the MDS reflect the terminology used in the RAI manual?
 - Deep tissue injury
 - Pressure ulcers that have worsened
 - Debrided pressure ulcers vs surgical closing
 - Proper documentation on why it is not a pressure ulcer of a bony prominence



CATHETERS

- Including all types of catheters that drain urine from the body (urethral, suprapubic, nephrostomy, etc.)
- Medical diagnosis supporting the need
- Noted on the care plan
- Proper care being provided



RESTRAINTS

- It's not the device, but *the effect* of the device for that resident
- Do you have a comprehensive assessment on how you came up with the answer on the MDS?
http://primaris.org/sites/default/files/resources/Restraints%20and%20Falls/Device%20Decision%20Guide%20Final_508.pdf
- Has the resident and or family been educated on the risk and benefits of such a device?

URINARY TRACT INFECTIONS

- This is a 30-day look back for the MDS
- The chart **must** include the following 4 things to mark it on the MDS
 - Physician, NP, etc. has provided the diagnosis of UTI
 - Signs and symptoms attributed to UTI (fever, signs of painful urination, pain, confusion or change in mental status, change in character of urine)
 - "Significant lab findings" determined by the prescriber
 - Current treatment

ANTIPSYCHOTICS


- Medications are to be coded according to the medication's therapeutic category and/or pharmacological classification
- Include if given only in the last 7 days
- What non-pharmacological interventions have been tried and are care planned
- In Section N of the MDS, you are looking at the class of medication, **not** the reason for giving





FALLS

- Review the definition of a fall:
 - Unintentional change in position coming to rest on the ground, floor, or next lower surface
 - May be witnessed, reported by resident or identified by finding resident on the floor or ground
 - May occur in any setting
 - Not a result of overwhelming external force
 - Intercepted fall where resident catches himself or herself or is intercepted by another person is still considered a fall



J1800/J1900 ASSESSMENT GUIDELINES

- Code falls reported by the resident, family, or significant other even if not documented in the medical record
- Code the level of injury for each fall that occurred during the look-back period
- If the resident has multiple injuries in a single fall, code for the highest level of injury

FALLS

- Understand the MDS difference of Injury and Major Injury:
 - Injury (except major): includes skin tears, abrasions, lacerations, superficial bruises, hematomas and sprains, or any fall related injury that causes the resident to complain of pain
 - Major injury: includes bone fractures, joint dislocations, closed head injuries with altered consciousness, subdural hematoma

QUESTIONS TO ASK YOURSELF

- RAI Coordinator: house-trained, learned from another person, or by the seat of their pants
 - Formal training:
 - <http://mlnmonursing.org/MDS> - 2-day training in Columbia (\$299 a person)
 - <http://www.aanac.org> - Classroom or self study (\$600-\$800 a person)
 - Free ongoing training
 - Monthly webinars and support group meetings offered through QIPMO
<http://www.nursinghomehelp.org/supgr.html>



MORE QUESTIONS

- Staffing numbers: there is no mandated number of staff for MO to complete the MDS; each facility can determine its own needs
 - Ball park is 60 residents per coordinator BUT this does not reflect how many are Medicare residents and the number of "other duties as assigned"
 - Interdisciplinary approach is encouraged; CMS leaves it up to the facility (RAI Manual pg.1-7)
- Does your MDS coordinator have the tools to do the job
 - Computer with decent internet connection - www.qtso.com
 - Current manual - www.medpass.com, www.briggs.com

MISSOURI RESOURCES

QIPMO Educators and
Leadership Coaches!

Contact Jessica Mueller
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