

Back to Basics: OBRA Scheduling

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What's an OBRA

- OMRA: Omnibus Budget Reconciliation Act of 1987 created regulatory framework to ensure good clinical practice
- Developed as a “standardized” approach for clinicians to “assess, plan, and provide individualized care”
- Looks at the residents holistically

Resident Assessment Instrument (RAI)-Overview

- Problem identification process used in long term care
 - Assessment
 - Decision-making
 - Care planning
 - Identification of Outcomes
 - Implementation
 - Evaluation
- Mandated for all residents in “certified” LTC beds
- Process guided by the July 2010 RAI User's Manual and updates
- **** Updates as of May 2011, Aug 2011, Sept 2011, Jan 2012, Nov 2012, May 2013, Oct 2013, Oct 2014, errata document Feb 2015, Oct 2015**

Manual Resource

- Website: <https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/NursingHomeQualityInits/MDS30RAIManual.html>
- *The Manual is the “Final Answer” per the Final Rule*
- Purchase from a Publisher such as:
 - Med Pass, Briggs, HC Pro
- Recommend:
 - Notebook version so it can be easily updated
 - Subscription for automatic updates

RAI Manual

- This is the FINAL answer
- All answers are in the manual but may not always be clear
- Even if CMS representative “verbally” says something does not make it so till it is in the manual. (Final Rule 2014)

Resident Assessment Instrument (RAI)

- General purpose of the RAI (clinical) process is to
 - Provide a standardized method for comprehensive assessment of complex nursing home residents.
 - Establish a plan of care that serves as a basis for communication of care needs
 - Assist facility staff to look at residents holistically...as a whole person with individual problems, needs, strengths, and preferences

Resident Assessment Instrument (RAI)

- Positive outcomes of the RAI process
 - Residents respond to Individualized Care
 - Staff communication has become more effective
 - Resident and family involvement in care has increased
 - Increased clarity of documentation

» Oct. 2015 RAI User's Manual pg. 1-10 to 1-11

Resident Assessment Instrument (RAI)

- Involves the following process (3- steps)
 - Minimum Data Set (MDS)--initial assessment
 - Care Area Assessment (CAAs)--in-depth assessment and problem identification
 - Plan of care--development of problems (risks/actual problems), goals setting and establishing interventions/approaches
- Used to identify resident specific
 - Problems
 - Potential problems (risks)
 - Strengths
 - Preferences

Privacy Act Statement

- Privacy Act
- Last updated Oct 2013
- Given as part of the admission packet
- Signature is not required

– RAI Manual page 1-16 and 1-18

RAI Goals for MDS 3.0

- Introduce advances in assessment measures
- Increase the clinical relevance of items
- Improve the accuracy and validity of the tool
- Increase user satisfaction
- Increase the resident's voice by introducing more resident interview items

Copyright

- MDS 3.0 is copyrighted but can be distributed freely
- Pfizer holds the copyright to the PHQ-9 and has given permission to use the tool in association with MDS 3.0
- Hospital Elder Life Program, LLC holds the copyright for the CAM and have given permission to use the tool in association with MDS 3.0

• Oct 2015 RAI 1-18

Regulation Requirements

- Assessment accurately reflects the resident's status
- RN conducts or coordinates each assessment with appropriate participation of health professionals
 - LPN role: data collection
- Process include direct observation, as well as communication with resident & direct care staff on all shifts
- Nursing homes determine
 - Who participates
 - How the process is completed
 - How the information is documented while remaining in regulation requirements and manual instructions.

• RAI Manual page 1-7-8

RAI--MDS documentation

- The MDS must be supported by documentation in the clinical record during the look back period for the particular question being answered
- Use all sources for completing the MDS:
 - Review of the clinical record
 - Resident interview and observation
 - Communication with direct care staff
 - Communication with resident's physician
 - Communication with resident's family

RAI--MDS documentation

- Get acquainted with the RAI manual...this will guide the coding process
- Listen to the November 2014 webinar: <http://www.nursinghomehelp.org/supgr.html>
- Remember accurate completion of the MDS will ensure:
 - Accurate triggering for CAA completion leading to a comprehensive plan of care
 - Accurate payment for PPS reimbursement
 - Accurate quality indicator/quality measure reports
 - Accurate quality measure reports at Nursing Home Compare
- Make sure all staff are familiar with and the importance of Assessment Reference Date (ARD)
 - Watch time frames for MDS items

Supporting Documentation

- The chart must support the MDS coding decision
- Good clinical practice is an expectation of CMS
- Staff interviews are to be done with all appropriate residents and documented during the look back period (MDS or an actual note if something needs to be noted)
 - Date of completion noted in section Z

Accessibility

- 15 months of MDS's must be kept in a centralized location as deemed by facility policy and procedure
- **Easily and readily accessible to staff**
- After 15 months Items A0500-A1600 must be maintained in the active clinical record *until resident is discharged return not anticipated or return anticipated and didn't*
- Either a hand written **or** a computer generated copy is equally acceptable

Assessment Terminology

- Entry
 - Resident enters facility
 - Two types
 - Admission
 - Reentry
- Must complete Entry tracking record every time the resident comes in your building

Assessment Terminology

- Admission
 - Admitted for the first time to facility
 - Is readmitted after a discharge return not anticipated
 - Is readmitted after discharge return anticipated when return was not within 30 days of discharge

Assessment Terminology

- Reentry
 - Is readmitted to the facility
 - **And** was discharged return anticipated
 - **And** returned within 30 days of discharge

Assessment Terminology

- Discharge
 - Resident is discharged from the facility to a private residence
 - Resident is admitted to a hospital or other care setting
 - Resident has a hospital observation stay greater than 24 hours
 - ***Resident is transferred from a Medicare and/or Medicaid certified bed to a non certified bed***
- Must complete discharge assessment
- ARD must be the day of discharge

Chapter 2

Discharge – return not anticipated

- Important point for homes which have certified beds and non certified beds in their building and a resident leaves the certified to a non certified bed. Code as follows:
 - A0310F Discharge return not anticipated
 - A2000 Date of move to new room
 - A2100 Location: Another nursing home or swing bed
 - There is an example of coding this on page 2-35 in the Manual

Chapter 2 Discharges

- Pg. 2-36: ARD for discharge is not set prospectively. May be coded on the assessment anytime during completion period (i.e. discharge date + 14 days)
- Discussion on the use of “-” when unable to determine response. May combine discharge with other assessments when indicated
- Unplanned should be completed the best you can

Assessment Terminology

- Leave of Absence (LOA)
 - Temporary home visit of at least one night
 - or
 - Therapeutic leave of at least one night
 - Hospital observation < 24 hours & **not** admitted
- No MDS **BUT** If there are condition changes they should be documented in the medical record and if necessary complete a sig change MDS

Assessment Terminology

- Death in facility
 - Dies in facility
 - Dies while on leave of absence
 - Dies in route to the hospital or prior to admission to the hospital
 - Death in facility tracking record

Assessment Terminology

- Assessment Completion
 - Comprehensive: Completion of MDS & CAAs & Care Plan
 - Non-comprehensive: Completion of MDS
- Assessment Submission
 - Comprehensive: Care Plan completion + 14 days
 - Non-comprehensive:
 - MDS completion date + 14 days
 - Entry/discharge (death) date + 14 days

Assessment Requirements

1. Omnibus Budget Reconciliation Act (OBRA) – Federal quality of care/life
 - Required by OBRA 1987 for Medicare certified and/or Medicaid certified nursing homes
Done regardless of age, diagnosis, length of stay, payment source or payer source
 - All residents in a certified bed
 - Clinical Assessments

Comprehensive Assessments Admission

- A0310A= 01
- ARD = No later than 14th day of admission
- MDS & CAAs completion = No later than 14th day
- Care plan completion = CAAs completion + 7 days
- Submission = Care plan completion + 14 days
- Following an admission, first comprehensive
- One admission per resident

Short Term or Respite Residents

- Discharged is less than 14 days an admission assessment is not necessary
- An entry record is required and a discharge assessment if the stay is less than 14 days.
- An entry record and full admission is required if the stay is greater than 14 days.
- if they stay longer than 24 hours without leaving, then it is respite and MDS required. Less than 24 hours then it is Adult Day Care

Non-Comprehensive Assessments Quarterly

- A0310A= 02
- ARD = No later than ARD of previous OBRA assessment + 92 days
- MDS completion = ARD + 14 days
- Submission = MDS completion + 14 days
- More than 4 quarterlies may be completed on a particular resident in a given year

Comprehensive Assessments Annual

- A0310A= 03
- **ARD** = No later than:
 - **ARD** of previous comprehensive + 366 days and
 - **ARD** of previous quarterly + 92 days
- MDS & CAAs completion = ARD + 14 days
- Care plan completion = CAAs completion + 7 days
- Submission = Care plan completion + 14 days
- ****** If quarterly assessments are completed early the annual may also be completed early or an extra qtrly may be done******

Late Clinical Assessments

- ARD late: greater than 14 days from admission or greater than 92/366 from last qtrly/comprehensive
- Completion late: greater than 2 weeks from ARD or if admission/sig change greater than 2 wks from admission or sig change ID'd
- Submission late: Greater than 2 weeks from completion date

Comprehensive Assessments Sig Change Assessment

- A0310A= 04
- ARD = No later than 14th day after determination
- MDS & CAAs completion = No later than 14th day after determination
- Care plan completion = CAAs completion + 7 days
- Submission = Care plan completion + 14 days
- Pg 2-18: Reminder emphasis when competing OBRA assessment & you realize should be a Sig change, complete a sig change

Comprehensive Assessments Sig Change Assessment

- Can not be completed before an admission assessment
- Terminally ill resident
 - If admitted to the facility with Hospice a significant change is not necessary, hospice is included as part of the admission assessment
 - Enrolls in hospice program
 - ARD within 14 days from effective date of hospice election statement
 - **Changes hospice provider (new Oct. 2015)**
 - Revokes hospice care
 - ARD within 14 days:
 - Effective date of hospice election revocation
 - Expiration date of certification of terminal illness
 - Date order states resident is no longer terminally ill

Sig Change and Hospice

- Pg. 2-21
- *Don't over think or over work it*
 - *Admitted with hospice then the admission assessment will show hospice (00100 K)*
 - *Hospice comes on board or stops before admission completed*
 - *Add it or adjust ARD to accommodate when hospice has the papers signed going on or coming off*
 - *This saves you from doing an Admission assessment then a Sig change*
 - *Time frame for ARD must still be within the admission requirements*

Comprehensive Assessments SCSA

- Referral for PASRR Level II
 - Significant Change may also require a new PASRR Level II
 - Required by law
 - An individual known or suspected to have a mental illness, *intellectual disability ("mental retardation" in the regulation)*, or related condition
 - Do not wait until the SCSA is complete
 - <http://health.mo.gov/seniors/nursinghomes/pasrr.php>

Comprehensive Assessments SCSA

- A decline or improvement in a resident's status that:
 - Will not normally resolve itself without intervention or by implementing standard disease-related clinical intervention
 - Impacts more than one area of resident's health status
 - Requires IDT review and/or revision of care plan
- Manual lists examples – **not** all inclusive list. See page 2-22 – 2-25
- Individually based
- Listen to webinar from March 2014 on Significant Change Assessments: <http://www.nursinghomehelp.org/supgr.html>

Comprehensive Assessments Sig Correction to Prior Assessment

- A0310A= 05
- ARD = No later than 14th day after determination
- MDS & CAAs completion = No later than 14th day after determination
- Care plan completion = CAAs completion + 7 days
- Submission = Care plan completion + 14 days

Chapter 2

- Documentation of identification of the following needs to be in the clinical record
 - Significant error (page 2-28)
 - Significant change (page 2-21)

Comprehensive Assessments SCPA

- Significant error is an error in an assessment where:
 - Resident's overall clinical status is not accurately represented; and
 - Resident has not changed but the coding is such that it does not represent the care of the resident. Care Plan does represent the care of the resident.
 - Error has not been corrected via submission of a more recent assessment

Non-Comprehensive Assessments Sig Correction Qtrly Assessment

- A0310A= 06
- ARD = No later than 14th day after determination
- MDS completion = No later than 14th day after determination
- Submission = MDS completion + 14 days

Chapter 2

- **Reminders:**
 - Pg. 2-29: *Qtrly assessment started, went to hospital and returned 2 days later. If no sig change needed, complete the assessment that had been started and completion is done by day 14 after the original ARD*
 - Pg. 2-30: *Dies during the assessment process. Place whatever is done with the MDS in the chart with a note on why it was not completed. Complete Death in Facility record*
 - *ARD always drives the due date for the next ARD*

A0310 F Entry / Discharge Reporting

- 01: Entry record
- MDS completion = Entry date + 7 days
- Submission = Entry date + 14 days
- Every time a resident enters facility
- This is NOT the first assessment since the most recent admission (A0310 E)

Discharge Types

- A0310G
 - Type of Discharge
 - Planned
 - Unplanned

Unplanned Discharge

- This comes in to play if the resident is discharged prior to completion of the interviews
- If the discharge is unplanned then the interviews can not be done and should be marked as such and the observation is completed based on staff interviews and documentation.
- Examples:
 - Acute care transfer to hospital or emergency department to stabilize or determine if admission is necessary
 - Resident unexpectedly leaves the facility against medical advice
 - Resident unexpectedly deciding to go home or to another setting

A0310 F Entry / Discharge Reporting

- 10: Discharge Assessment - Return not anticipated within 30 days
- MDS completion = Discharge date + 14 days
- Submission = MDS completion + 14 days
- 11: Discharge assessment – return anticipated within 30 days
- MDS completion = Discharge date + 14 days
- Submission = MDS completion + 14 da

Discharge Assessments

- Pg 2-36 Discharge Assessment: ARD is NOT set prospectively as with other assessments. ARD is equal to discharge date and may be coded on the assessment any time during the Discharge assessment completion period. Which is Discharge date = 14 calendar days

A0310 F Entry / Discharge Reporting

- 12: Death in facility record
- MDS completion = Discharge (death) date + 7 days
- Submission = Discharge (death) + 14 days
- 99: Not an Entry /Discharge record

Combination Rules

- Time frames coincide for both assessment types
- Most stringent requirements for ARD, item set and CAA must be met
- All required items are complete
- MO has no state specific sections or requirements
 - Such as Discharge Assessments changing from Return anticipated to Not Anticipated or they die after discharge

Brain Teasers

- Resident stayed 13 days do I still have to do an admission assessment?
- No, if you have some of it completed do not delete just save it in the software, but you do not have to complete it Page 2-17

Brain Teasers

- I have a respite person who stayed 16 days do I still need to do an admission since it is respite?
- Yes, even though they are “respite” they stayed through the 14th day thus an admission is required page 2-14

Brain Teasers

- Resident was admitted and discharge within an hour of arrival do I need to do anything?
- Yes you need to do an entry record to acknowledge they were in the building and then a discharge based on what information you have for that hour Page 2-10

Brain Teasers

- I am doing an Annual assessment and realize there has been significant change, the paper work is the same as the annual so I don't need to do anything else.
- Wrong: See page 2-18 You need to acknowledge that a significant change has occurred.

Brain Teasers

- We have a resident that goes in and out of the facility frequently and we expect him to return. We don't need to do an entry and discharge each time
- Wrong: CMS requires an Entry tracking and Discharge assessment each time they enter and leave the building page 2-19

Brain Teasers

- The resident is on hospice and is declining I need to do a significant change with this decline.
- Not necessarily, you need to determine if the terminal condition is causing the deterioration Someone with dementia has had a stroke yes, vs dementia and has become bedfast, no page 2-25

Brain Teasers

- I can not combine an entry record or death in facility record with any other type of assessment
- Correct: See page 2-16. These to records are done for tracking reasons and are not a clinical data collection tool

Brain Teasers

- Comprehensive assessments include the MDS, CAA process as well as care planning
- Correct see page 2-17

Brain Teasers

A significant change is only comparing the most recent prior MDS and the current one.

No, It is the comparison of the current status to the most recent comprehensive assessment and any subsequent quarterly assessment
page 2-21