FREE WEBINAR

Connecting the MDS Data Dots

Using SNF patient data for personalized care planning

TUES, JULY 23 | 2 PM CT

SKILLED NURSING

YOUR SPEAKER

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Objectives

Learner will:

1. Understand how recent regulatory changes fit into person-centered care delivery.

2. Apply their knowledge of the data elements to establish strategies for effective care planning and successful discharges; resulting in high quality, effective care.

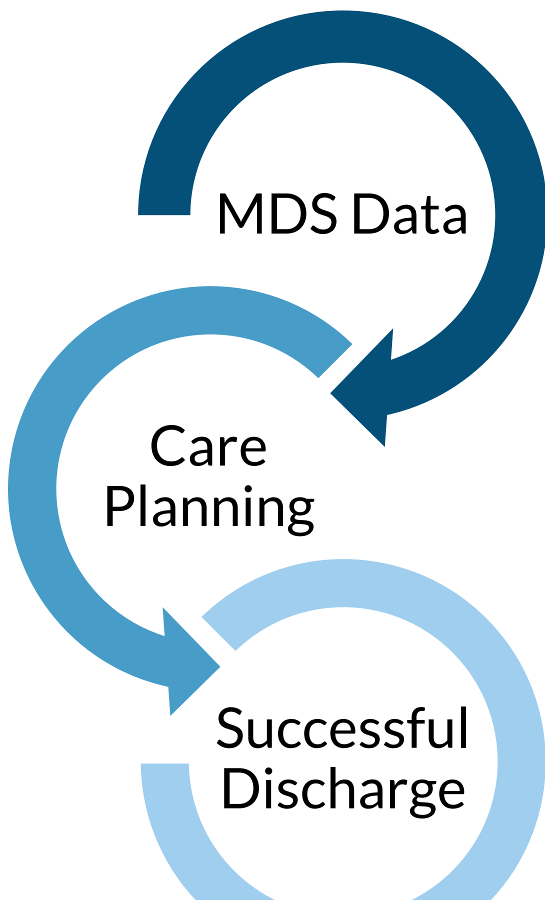
3. Analyze effective and ineffective approaches to integrating these changes into care delivery and monitor outcomes; regroup as necessary.

POLL #1

How well did your organization implement the 10/1/2023 MDS changes?

a) Like CHAMPIONS
b) Like runner-ups
c) We were in the game
d) What MDS changes?

Critical Connections



MDS DATA

Purpose of the MDS

Accuracy is CRITICAL, as is supporting documentation!

Resident ______________ Identifier ______________ Date ______________

Section Z - Assessment Administration

Z0400. Signature of Persons Completing the Assessment or Entry/Death Reporting

I certify that the accompanying information accurately reflects resident assessment information for this resident and that I collected or coordinated collection of this information on the dates specified. To the best of my knowledge, this information was collected in accordance with applicable Medicare and Medicaid requirements. I understand that this information is used as a basis for ensuring that residents receive appropriate and quality care, and as a basis for payment from federal funds. I further understand that payment of such federal funds and continued participation in the government-funded health care programs is conditioned on the accuracy and truthfulness of this information, and that I may be personally subject to or may subject my organization to substantial criminal, civil, and/or administrative penalties for submitting false information. I also certify that I am authorized to submit this information by this facility on its behalf.

Signature	Title	Sections	Date Section Completed
A.			

The MDS must be COMPLETE, ACCURATE, & SUPPORTED in the MEDICAL RECORD.

MDS (v1.18.11) Changes 10/1/2023

- No more Section G, ALL EYES on GG!
- Social Determinants of Health
  - Ethnicity, race, language/interpreter, transportation, health literacy and social isolation
- Section N; indications of use for medications, schizophrenia dx
- Current Reconciled Medication List
  - Provided?
  - How?
- Section K: Nutritional Approaches
  - Admission
  - Discharge
- Section O: Special Treatments
  - More detail
  - Admission
  - Discharge

Additions to the Medicare Part A PPS Discharge Assessment

The changes on 10/1/2023 increased this assessment by 10 pages.

- Social Determinants of Health; ethnicity, race, transportation, health literacy (Sections A/B)
- Expanded “Entered From” List
- Reconciled Medication List (Section A)
- BIMS/Delerium (Section C)
- PHQ2-9 (Section D)
- Pain Assessment Interview (Section J)
- Swallowing/Nutritional Status (Section K)
- High-Risk Drug Classes/Indications (Section N)
- Special Treatments (Section O)

The IMPORTANCE of the Medicare Part A PPS Discharge Assessment

Coding ACCURACY on this assessment can affect SNF:

- Quality Reporting Program (QRP)
- Value Based Purchasing Program (VBP)
- Five Star Quality Rating System
- Survey

Proposed MDS (v1.19.1) Changes for 10/1/2024

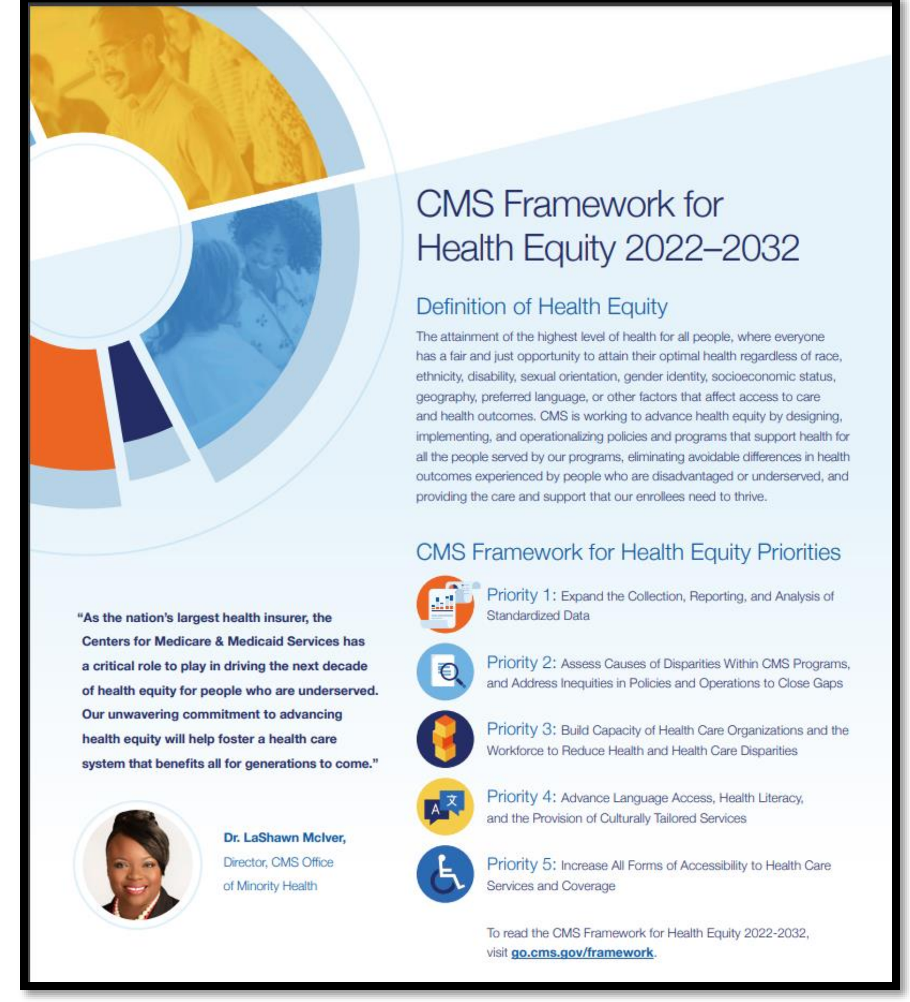
Section R: Health Related Social Needs

- Living Situation
- Food Insecurities
- Utilities
- Transportation (Modified slightly from current version)

Why are we now collecting this data?

- Increased focus on resident self-reporting, stronger voice via interviews to impact their care.
- Disparities in health outcomes require better data related to the social determinants of health, in order to better understand and address these disparities.

CMS Framework for Health Equity 2022–2032



CMS Framework for Health Equity 2022–2032

Definition of Health Equity

The attainment of the highest level of health for all people, where everyone has a fair and just opportunity to attain their optimal health regardless of race, ethnicity, disability, sexual orientation, gender identity, socioeconomic status, geography, preferred language, or other factors that affect access to care and health outcomes. CMS is working to advance health equity by designing, implementing, and operationalizing policies and programs that support health for all the people served by our programs, eliminating avoidable differences in health outcomes experienced by people who are disadvantaged or underserved, and providing the care and support that our enrollees need to thrive.

CMS Framework for Health Equity Priorities

- Priority 1: Expand the Collection, Reporting, and Analysis of Standardized Data
- Priority 2: Assess Causes of Disparities Within CMS Programs, and Address Inequities in Policies and Operations to Close Gaps
- Priority 3: Build Capacity of Health Care Organizations and the Workforce to Reduce Health and Health Care Disparities
- Priority 4: Advance Language Access, Health Literacy, and the Provision of Culturally Tailored Services
- Priority 5: Increase All Forms of Accessibility to Health Care Services and Coverage

To read the CMS Framework for Health Equity 2022-2032, visit go.cms.gov/framework.

"As the nation's largest health insurer, the Centers for Medicare & Medicaid Services has a critical role to play in driving the next decade of health equity for people who are underserved. Our unwavering commitment to advancing health equity will help foster a health care system that benefits all for generations to come."

Dr. LaShawn McIver,
Director, CMS Office of Minority Health

MDS DATA

- Training on HOW to collect the data per the RAI Manual.
- What is the data collection process? Who is responsible for what?
- Where is the data housed? Access?
- What data collection tools are being used?
- What is the impact of the data? Care, reimbursement, QRP, VBP, Five Star?
- We must educate on WHY the data is being collected.
- Eventually, assess effectiveness of the process.

POLL #2

Who completes Section GG?

a) Nursing
b) Therapy
c) It is an interdisciplinary collaboration that includes a note in the medical record explaining how the score was derived
d) I don’t know.

Care Plan

Purpose of the Care Plan

1. Assisting the resident in achieving their goals.
2. Individualized interventions that honor the resident's preferences.
3. Addressing ways to try to preserve and build upon resident strengths.
4. Preventing avoidable declines in functioning or functional levels or otherwise clarifying why another goal takes precedence (e.g., palliative approaches in end of life situation).
5. Managing risk factors to the extent possible or indicating the limits of such interventions.
6. Applying current standards of practice in the care planning process.
7. Evaluating treatment of measurable objectives, timetables and outcomes of care

Purpose of the Care Plan (con't)

8. Respecting the resident's right to decline treatment.
9. Offering alternative treatments, as applicable.
10. Using an interdisciplinary approach to care plan development to improve the resident's abilities.
11. Involving resident, resident's family and other resident representatives as appropriate.
12. Assessing and planning for care to meet the resident's goals, preferences, and medical, nursing, mental and psychosocial needs.
13. Involving direct care staff with the care planning process relating to the resident's preferences, needs, and expected outcomes.

RAI Process

- 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**.

Components of Care Planning

- Section Q: Participation in Assessment and Goal Setting
  - Interviewing the resident or designated individuals places the resident or their family at the center of the decision making. (RAI Page Q-1)
- Active participation by residents in the assessment process and development of their care plan, often experience improved quality of life and better quality of care based on their needs, goals and priorities.
- Care plans should be individualized, resident involvement supports this and addresses dignity and self-determination survey and certification requirements.
- The resident’s goals should be the basis for care planning.

What if we need to change course or pivot?

- Identify the change that occurred.
- Communicate to the care team.
- Communicate with the patient/family.
- Modify care plan.

Successful Discharge

Transitions of Care/Discharge Planning

Discharge Planning MUST start on day one!

- Admitted from/Discharged to
- Reconciled Medication List
- Health Literacy
- Social Isolation
- Transportation
- Participation in Goal Setting
- Social Determinants of Health (SDOH)

National Transitions of Care Coalition (NTOCC)

Care Transitions Seven Essential Intervention Categories

- Medication Management Services & Coordination
- Transition Planning
- Patient and Identified Family Caregiver Engagement & Education
- Information Transfer
- Follow-Up Care
- Healthcare Provider Engagement & Shared Accountability Across the Healthcare Continuum
- Physical Health, Mental Health, Social Determinants of Health Triune

Resource: Your discharge planning checklist

Action Items

Your health

Throughout the discharge process, write down the names and phone numbers of people to call if you have questions or concerns.

- ☐ Ask about complications to watch for and what to do about them.
- ☐ Use the "My drug list" on page 5 to write down the full list of prescription drugs, over-the-counter drugs, vitamins, and herbal supplements that you take. Be sure to include items that you took at home, and note any changes or additions while you were in the facility.
- ☐ Review the "My drug list" with the staff and ask which items and dosage (or strength) you should continue to take after you leave. Share this updated drug list with your healthcare providers.

Action Items

Recovery & support

- ☐ Ask where you'll get care after you're discharged. Do you have options (like home health care)? Tell the staff what you prefer.
- ☐ Ask if you'll need medical equipment (like a walker), if it's covered by Medicare, and who will arrange for its delivery.
- ☐ Ask if you're ready to do the activities below. Circle the ones you need help with, and discuss your concerns with the staff:
  - Bathing, dressing, using the bathroom, climbing stairs
  - Cooking, food shopping, house cleaning, paying bills
  - Driving to doctors' appointments, picking up prescriptions
- ☐ Ask the staff to show you and your caregiver, if you have one, any other tasks that require special skills (like changing a bandage or giving a shot). Then, show them you can do these tasks.
- ☐ Talk to a social worker if you're concerned about how you and your family are coping with your illness. Write down information about support groups and other resources.
- ☐ Talk to a social worker or your health plan if you have questions about what your insurance will cover and how much you'll have to pay. Ask about possible ways to get help with your costs.
- ☐ Ask for written discharge instructions (that you can read and understand) and a summary of your current health status. Bring this information and your completed "My drug list" to your follow-up appointments.

Action Items

For a caregiver

- ☐ Write down any questions you have about the items on this checklist or the discharge instructions and discuss them with the staff.
- ☐ Can you give the patient the help they need?
  - What tasks do you need help with?
  - Do you need any education or training?
  - Talk to the staff about getting the help you need before discharge.
  - Write down the name and phone number of a person you can call if you have questions.
- ☐ Get prescriptions and any special diet instructions early, so you won't have to make extra trips after discharge.

Active Discharge Planning

An active discharge plan means a plan that is being currently implemented. In other words, the resident's care plan has current **goals** to **make specific arrangements** for discharge, staff are taking **active steps** to accomplish discharge, and there is **a target discharge date** for the near future.

Discharge Planning

- Should include an assessment of the discharge living environment to determine if it is a safe location/environment
- Should include an assessment of transportation access to medical appointments, pharmacy and grocery store
- Should include an assessment of social support and risk of social isolation
- Discharge documents should be individualized for health literacy and language preferences
- Using social determinants of health when developing a resident's discharge plan can assist in identifying and addressing potential risks that could adversely affect the resident's ability to safely discharge back to the community
- Patient/family/caregiver education; return demonstration

What does a “successful” discharge look like?

Claims Based Measures:

- Rehospitalizations
- Outpatient Emergency Department Visit
- Discharge to Community
- Medicare Spending per Beneficiary

Discharge Function Score

Discharge Function Score

"The Discharge Function Score measure determines how successful each SNF is at achieving an expected level of functional ability for its residents at discharge." (Discharge Function Score for Skilled Nursing Facilities (SNFs) Technical Report)

- This will be used across settings.
- Includes residents who received physical or occupational therapy at the time of admission.
- Based on 3 self-care items and 8 mobility items from Section GG.
- ANA (Activity Not Attempted) will be scored based on a statistical imputation model that considers the scores on all the other items in the Item Set and determines the probability of the missing score.
- A risk adjusted "Expected DC Score" will be calculated, to create this Quality Measure; % of patients that achieve the expected Discharge Function Score. Risk adjustment controls for admission function score, age, and clinical conditions.

- Replaces Discharge Mobility and Discharge Self-Care

Discharge Function Score

ITEM	DESCRIPTION
GG0130A	Self-care: Eating
GG0130B	Self-care: Oral Hygiene
GG0130C	Self-care: Toileting Hygiene
GG0170A	Mobility: Roll Left and Right
GG0170C	Mobility: Lying to Sitting on Side of Bed
GG0170D	Mobility: Sit to Stand
GG0170E	Mobility: Chair/Bed-to-Chair Transfer
GG0170F	Mobility: Toilet Transfer
GG0170I	Mobility: Walk 10 Feet
GG0170J	Mobility: Walk 50 Feet with 2 Turns
GG0170R	Mobility: Wheel 50 Feet with 2 Turns

Discharge Function Score Implications

Programs Impacted

- SNF Quality Reporting Program (FY2025)
- SNF Value Based Purchasing Program (FY 2027)
- Five Star Quality Rating System (Oct. 2024)
- Care Compare (Oct. 2024)

Physical function is predictive of successful discharge to the community and re-hospitalization rates.

How do we use these changes for better care delivery?

- COMMUNICATION, COMMUNICATION, COMMUNICATION
- Everyone on the care team needs to have AND understand the IMPACT of the data.
- HOW do we make that happen?
  - Morning meeting/stand-up.
  - Designated documentation areas in the EHR.
    - SBAR: Situation, Background, Assessment, Recommendation
  - Designated documentation areas on the units.

Integration Challenges

- TIME!
- Access to the information.
- Understanding of the importance of the information.
- System/process to make it happen.
- Back-up plan.

You must constantly evaluate and modify.

This is a GREAT QAPI topic!

Key Takeaways

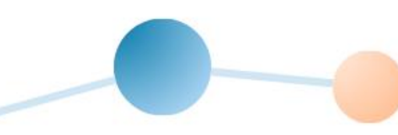
- There is a lot of data on the MDS and it must be collected per the RAI Manual instructions and guidance.
- Following those instructions should ensure accuracy.
- The MDS serves many purposes; it must be COMPLETE, ACCURATE, and SUPPORTED in the Medical Record.
- The data needs to be shared with the care team and used in conjunction with the patient to establish an individualized care plan.
- Discharge planning should begin day one, common challenges for successful transitions of care must be addressed in an effort to have a successful discharge.
- Use QAPI to evaluate effectiveness; modify as needed.
- They are reviewing your data; referral sources, public, downstream partners, CMS, payors…what do you want them to see?

Resources

- N Rahman, A., MSW, & A Applebaum, R., PhD. (2009). The Nursing Home Minimum Data Set Assessment Instrument: Manifest Functions and Unintended Consequences - Past, Present, and Future. The Gerontologist, Vol. 49(No. 6), 727–735.
- CMS's RAI Version 3.0 Manual https://www.cms.gov/files/document/finalmds-30-rai-manual-v11811october2023.pdf
- Centers for Medicare & Medicaid Services. (2023). *State operations manual, Appendix PP – Guidance to surveyors for long term care facilities*. https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/som107ap_pp_guidelines_ltcf.pdf
- Discharge Planning Checklist https://www.medicare.gov/publications/11376-your-discharge-planning-checklist.pdf
- National Transitions of Care Coalition https://www.ntocc.org/knowledge-and-resource-center
- Discharge Function Score https://www.cms.gov/files/document/snf-discharge-function-score-technical-report-february-2023.pdf-0

Resources

- Discharge Function Score Imputation Appendix File https://www.cms.gov/medicare/quality/snf-quality-reporting-program/measures-and-technical-information
- CMS Framework for Health Equity https://www.cms.gov/files/document/cms-framework-health-equity-ad.pdf
- Pope, Barbara B. RN, CCNS, CCRN, MSN; Rodzen, Lisa RN, BSN; Spross, Gene RN, BSN. Raising the SBAR: How better communication improves patient outcomes. Nursing 38(3):p 41-43, March 2008. | DOI: 10.1097/01.NURSE.0000312625.74434.e8



CONSULTING SERVICES

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Post Acute Care:

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- Compliance
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- Rehab agency/group practice

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Questions

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Thanks for joining us!

Recording and slides will be available here:
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