ADLs... Are you coding the information accurately?

The IPRO Nursing Home Team
February 17, 2016
Primary sources of information for this presentation…

- CMS’s RAI Version 3.0 Manual


- www.nursinghomes.ipro.org

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Why talk about ADLs?

QIO 11th Scope of Work

- Composite Score
  - Includes MDS information taken directly from 11 clinical “long-stay” quality measures
    - The proper capture and MDS coding of certain “late loss” ADLs directly impacts 2 of those 11 clinical “long-stay” quality measures.
    - The proper capture and coding of ADLs provides accurate information for your current population.
  - Reimbursement impact...
Brief Description of the Composite Score...

• The data used to calculate your facility’s Composite Score comes directly from MDS records that are submitted from your facility.

• The Composite Score is comprised of 13 NQF-endorsed long-stay quality measures....
  • With 2 of those quality measures directly impacted by the proper capture and coding of the ADLs.

• More specific information on the Composite Score is available on our website...
  www.nursinghomes.ipro.org
Which QMs are Impacted by ADLs?

- High Risk Pressure Ulcers (Long Stay)
- Increased ADL Help (Long Stay)
Section G – Functional Status...

4 “Late Loss” ADLs...
- Bed Mobility
- Transfer
- Eating
- Toilet Use

Only Self-Performance Coding is considered...
Not Staff Support
Quality Measure focus...

% of High-Risk Residents with Pressure Ulcers (Long Stay)
Common Definitions vs. MDS Definitions…

Pressure Ulcer “Risk”…

• “Common” accepted standard-
  • Current Research
  • Use of a validated tool (i.e. Braden Scale)
  • Co-Morbid Conditions

• Direct MDS Questions-
  • M0100 Determination of Pressure Ulcer Risk
  • M0150 Risk of Pressure Ulcers
Common Definitions vs. MDS Definitions…

MDS 3.0 “Calculation of Risk”…

Comatose  (B0100 Comatose = 1)

OR

Active Diagnosis of Malnutrition or At Risk for Malnutrition  (I5600 is checked.)

OR

Impairment in Bed Mobility or Transfer
“High Risk” determination …

In the quality measure specifications, “High-Risk” for the development of pressure ulcers is based solely on any of three criteria...

**Denominator**

All long-stay residents with a selected target assessment who meet the definition of high risk, except those with exclusions. Residents are defined as high-risk if they meet **one or more** of the following three criteria on the target assessment:

1. Impaired bed mobility or transfer indicated, by *either or both* of the following:
   1.1. Bed mobility, self-performance (G0110A1) = [3, 4, 7, 8].
   1.2. Transfer, self-performance (G0110B1) = [3, 4, 7, 8].
2. Comatose (B0100 = [1])
3. Malnutrition or at risk of malnutrition (I5600 = [1]) (checked).
“High Risk” determination …

In the quality measure specifications, “High-Risk” for the development of pressure ulcers is based solely on any of three criteria...

Comatose (B0100 = [1]), Malnutrition or at risk of Malnutrition (I5600 is checked), Impaired bed mobility or transfer as indicated by either or both of the following...

Bed Mobility, Self-Performance (G0110A1) = [3,4,7 or 8]
Transfer, Self-Performance (G0110B1) = [3,4,7 or 8]
Why is this important for the HR PU QM?

The correct capture and coding of the self-performance ADL codes for bed mobility and/or transfer will increase the denominator.

Change either side of any Quality Measure equation…

YOU CHANGE THE MATH!
“Extensive” vs “Limited”…

Coding Instructions for G0110, Column 1, ADL-Self Performance

- **Code 0, independent:** if resident completed activity with no help or oversight every time during the 7-day look-back period.
- **Code 1, supervision:** if oversight, encouragement, or cueing was provided three or more times during the last 7 days.
- **Code 2, limited assistance:** if resident was highly involved in activity and received physical help in guided maneuvering of limb(s) or other non-weight-bearing assistance on three or more times during the last 7 days.
- **Code 3, extensive assistance:** if resident performed part of the activity over the last 7 days, help of the following type(s) was provided three or more times:
  - Weight-bearing support provided three or more times.
  - Full staff performance of activity during part but not all of the last 7 days.
- **Code 4, total dependence:** if there was full staff performance of an activity with no participation by resident for any aspect of the ADL activity. The resident must be unwilling or unable to perform any part of the activity over the entire 7-day look-back period.
- **Code 7, activity occurred only once or twice:** if the activity occurred but not three times or more.
- **Code 8, activity did not occur:** if the activity did not occur or family and/or non-facility staff provided care 100% of the time for that activity over the entire 7-day period.
Further Clarifications…

- Differentiating between guided maneuvering and weight-bearing assistance: determine who is supporting the weight of the resident’s extremity or body. For example, if the staff member supports some of the weight of the resident’s hand while helping the resident to eat (e.g., lifting a spoon or a cup to mouth), or performs part of the activity for the resident, this is “weight-bearing” assistance for this activity. If the resident can lift the utensil or cup, but staff assistance is needed to guide the resident’s hand to his or her mouth, this is guided maneuvering.

- Do NOT record the staff’s assessment of the resident’s potential capability to perform the ADL activity. The assessment of potential capability is covered in ADL Functional Rehabilitation Potential Item (G0900).

- Do NOT record the type and level of assistance that the resident “should” be receiving according to the written plan of care. The level of assistance actually provided might be very different from what is indicated in the plan. Record what actually happened.
Coding Instructions

For each ADL activity:

- To assist in coding ADL self performance items, please use the algorithm on page G-6.
- Consider each episode of the activity that occurred during the 7-day look-back period.
- In order to be able to promote the highest level of functioning among residents, clinical staff must first identify what the resident actually does for himself or herself, noting when assistance is received and clarifying the types of assistance provided (verbal cueing, physical support, etc.).
- Code based on the resident’s level of assistance when using special adaptive devices such as a walker, device to assist with donning socks, dressing stick, long-handle reacher, or adaptive eating utensils.
- For the purposes of completing Section G, "facility staff" pertains to direct employees and facility-contracted employees (e.g. rehabilitation staff, nursing agency staff). Thus, does not include individuals hired, compensated or not, by individuals outside of the...
ADL Coding Instructions…

- A resident’s ADL self-performance may vary from day to day, shift to shift, or within shifts. There are many possible reasons for these variations, including mood, medical condition, relationship issues (e.g., willing to perform for a nursing assistant that he or she likes), and medications. The responsibility of the person completing the assessment, therefore, is to capture the total picture of the resident’s ADL self-performance over the 7-day period, 24 hours a day (i.e., not only how the evaluating clinician sees the resident, but how the resident performs on other shifts as well).

- The ADL self-performance coding options are intended to reflect real world situations where slight variations in self-performance are common. Refer to the algorithm on page G-6 for assistance in determining the most appropriate self-performance code.

- Although it is not necessary to know the actual number of times the activity occurred, it is necessary to know whether or not the activity occurred three or more times within the last 7 days.

- Because this section involves a two-part evaluation (ADL Self-Performance and ADL Support), each using its own scale, it is recommended that the Self-Performance evaluation be completed for all ADL activities before beginning the ADL Support evaluation.
Algorithm for Self-Performance Coding...

G0110: Activities of Daily Living (ADL) Assistance (cont.)

ADL Self Performance Algorithm

START HERE

Did the activity occur at least 1 time?

Yes

Did activity occur 3 or more times?

Yes

Did resident fully perform the ADL activity without ANY help or oversight from staff every time?

No

Code 8 Activity Occurred only 1 or 2 times

No

Code 7 The ADL Activity (or any part of the ADL) was not performed by the resident or staff at all

Code 0 Independent

Yes

Did resident require full staff performance every time?

No

Code 4 Total Dependence

Yes

Did resident require full staff performance at least 3 times but not every time?

No

Code 3 Extensive Assistance

Yes

INSTRUCTIONS
Follow the arrows on the flowchart to determine correct coding, starting at the 'Did Activity Occur?' box.

Instructions for Rule of 3
- When an activity occurs three times at any one given level, code that level.
- When an activity occurs three times at multiple levels, code the most dependent. Exceptions are total dependence (4) – activity must require full assist every time; and activity did not occur (6) – activity must not have occurred at all or barely.
Algorithm for Self-Performance Coding (continued)...

- When an activity occurs three times at any one given level, code that level.
- When an activity occurs three times at multiple levels, code the most dependent. Exceptions: total dependence (4) – activity must require full assist every time; and activity did not occur (6) – activity must not have occurred at all or family and/or non-facility staff provided care 100% of the time for the activity over the entire 7-day period. Example: three times extensive assistance (3) and three times limited assistance (2) – code extensive assistance (3).
- When an activity occurs at more than one level but not three times at any one level, apply the following:
  - Episodes of full staff performance are considered to be weight-bearing assistance (when every episode is full staff performance - this is total dependence).
  - When there are 3 or more episodes of a combination of full staff performance and weight-bearing assistance - code extensive assistance (3).
  - When there are 3 or more episodes of a combination of full staff performance/weight bearing assistance, and non-weight bearing assistance, code limited assistance (2).
  - If none of the above are met, code supervision.
Consider this example...

This number represents the total number of your “long stay” population found to be “at risk” for the development of pressure ulcers by MDS criteria.

This number represents the total number of your “long stay” population.
Consider this example…

The difference between those two numbers represents the number of your long stay population that (in effect) don’t need to be touched by your staff when it comes to either bed mobility or transfer…

In this example, that number equates to

38 residents.

You know your residents…

Is your statistic an appropriate representation of your resident population?
Consider this example...

Right now, the HR PU QM for this example is 13.2%.

By simply increasing the honest capture of the self performance in either bed mobility or transfer for the 38 (supposedly) “low risk” residents...

A sample statistic could be 12 triggers out of 120... or 10%... Still leaving 9 long stay residents for consideration or appropriate / validated exclusion.
Based on your own statistics…

Is there room for improvement in the process for the appropriate, honest and accurate capture of the self-performance levels?

Does there appear to be a clear understanding of the MDS definitions of “extensive” versus “limited”?

Is your High Risk Pressure Ulcer Quality Measure being unfairly inflated because of a “disconnect” in your facility processes related to the capture and coding of the ADLs?
Quality Measure focus...

% of Residents Whose Need for Help with ADLs Has Increased (Long Stay)
Numerator…

Long-stay residents with selected target and prior assessment assessments that indicate the need for help with late-loss Activities of Daily Living (ADLs) has increased when the selected assessments are compared. The four late-loss ADL items are self-performance bed mobility (G0110A1), self-performance transfer (G0110B1), self-performance eating (G0110H1), and self-performance toileting (G0110I1).
What is considered “an increase”? 

An increase is defined as an increase in two or more coding points in one late-loss ADL item 

or

a one point increase in coding points in two or more late-loss ADL items.

Note that for each of the four “late loss” ADL items, if the value is equal to [7, 8] on either the target or prior assessment, then it is considered equal to [4] to allow for appropriate comparison.
# Section G – Functional Status

<table>
<thead>
<tr>
<th>Section G</th>
<th>Functional Status</th>
</tr>
</thead>
<tbody>
<tr>
<td>G0110. Activities of Daily Living (ADL) Assistance</td>
<td>Refer to the ADL flow chart in the RAI manual to facilitate accurate coding</td>
</tr>
</tbody>
</table>

**Instructions for Rule of 3**
- When an activity occurs three times at any one given level, code that level.
- When an activity occurs three times at multiple levels, code the most dependent, exceptions are total dependence (4), activity must require full assist every time, and activity did not occur (8), activity must not have occurred at all. Example, three times extensive assistance (3) and three times limited assistance (2), code extensive assistance (3).
- When an activity occurs at various levels, but not three times at any given level, apply the following:
  - When there is a combination of full staff performance, and extensive assistance, code extensive assistance.
  - When there is a combination of full staff performance, weight bearing assistance and/or non-weight bearing assistance code limited assistance (2).
- If none of the above are met, code supervision.

<table>
<thead>
<tr>
<th>1. ADL Self-Performance</th>
<th>2. ADL Support Provided</th>
</tr>
</thead>
<tbody>
<tr>
<td>Code for resident's performance over all shifts - not including setup. If the ADL activity occurred 3 or more times at various levels of assistance, code the most dependent - except for total dependence, which requires full staff performance every time</td>
<td>Code for most support provided over all shifts; code regardless of resident's self-performance classification</td>
</tr>
</tbody>
</table>

**Coding:**
- **Activity Occurred 3 or More Times**
  0. Independent - no help or staff oversight at any time
  1. Supervision - oversight, encouragement or cueing
  2. Limited assistance - resident highly involved in activity; staff provide guided maneuvering of limbs or other non-weight-bearing assistance
  3. Extensive assistance - resident involved in activity, staff provide weight-bearing support
  4. Total dependence - full staff performance every time during entire 7-day period

**Activity Occurred 2 or Fewer Times**
- 7. Activity occurred only once or twice - activity did occur but only once or twice
- 8. Activity did not occur - activity did not occur or family and/or non-facility staff provided care 100% of the time for that activity over the entire 7-day period

**Self-Performance**

**Support**

Enter Codes in Boxes

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**Quality Improvement Organizations**

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**IPRO Serving New York State**
ADL Self-Performance coding…

Measures what the resident actually did (not what he or she might be capable of doing) within each ADL category over the last 7 days according to a performance-based scale.
Bed Mobility…

How resident moves to and from lying position, turns side or side, and positions body while in bed or alternate sleep furniture.
How resident moves between surfaces including to or from: bed, chair, wheelchair, standing position (excludes to/from bath/toilet).
Eating…

How resident eats and drinks, regardless of skill. Do not include eating/drinking during medication pass. Includes intake of nourishment by other means (e.g., tube feeding, total parenteral nutrition, IV fluids administered for nutrition or hydration).
Eating (continued) ...

Residents with tube feeding, TPN, or IV fluids...

— Code extensive assistance (1 or 2 persons): if the resident with tube feeding, TPN, or IV fluids did not participate in management of this nutrition but did participate in receiving oral nutrition. This is the correct code because the staff completed a portion of the ADL activity for the resident (managing the tube feeding, TPN, or IV fluids).

— Code totally dependent in eating: only if resident was assisted in eating all food items and liquids at all meals and snacks (including tube feeding delivered totally by staff) and did not participate in any aspect of eating (e.g., did not pick up finger foods, did not give self tube feeding or assist with swallow or eating procedure).
Toilet Use...

How resident uses the toilet room, commode, bedpan, or urinal; transfers on/off toilet; cleanses self after elimination; changes pad; manages ostomy or catheter; and adjusts clothes. Do not include emptying of bedpan, urinal, bedside commode, catheter bag or ostomy bag.
A high “Increased ADL Help QM” statistic may be a clear sign of “yo-yo” coding. (inconsistent application of the MDS definitions & guidance)
How can you tell if you may have a problem?

Pull your CASPER / QIES data

- MDS 3.0 Facility Level Quality Measure Report
- MDS 3.0 Resident Level Quality Measure Report
  - Suggested “Date Range”
    - The CASPER / QIES data is re-calculated every Monday.
    - Use the most recent Monday date for BOTH the “From” and “Thru” date.*

- Look at the residents who are currently “triggering” for the “Increased ADL Help QM”.
  - Is it a true representation of the resident?

* The suggested “date range” will provide you with your most “real time” data from the latest MDS for every resident currently on your roster.
Something to consider…

A high quality measure statistic for “increased ADL help” could be an indication of…

- Misunderstanding of the MDS-specific definitions
  - “Extensive” vs. “Limited”

- A system that makes information capture difficult
  - Each “episode” vs. “once per shift”

- Technology/Software Limitations
  - Programming with MDS language vs. “common sense”
  - Ability to capture and summarize individual “occurrences”

- Lack of Consistent Assignment
  - Missing the value of a deeper resident/caregiver relationship
If you decide to focus on ADL capture…

Understand and anticipate that your “Increased ADL Help” quality measure may increase (validation process)

- Once coding is consistently applied, the “Increased ADL Help” QM will level off.
- Any changes in self-performance levels should be actual instead of “anecdotal”.

“The MDS as a Second Language” needs to become a competency requirement within your facility. Constant teaching, reminders and reinforcement combined with a valid complementary system of information capture will foster MDS coding accuracy and, ultimately, honest quality measures.
Next Steps to Consider…

Does your facility have a method of capturing the self-performance coding that is in alignment with the MDS guidance?

Do you have a consistent, and timely, process to review your MDS data for validity prior to submission?

- **Always Determine Legitimacy**
  - During care-planning, with the MDS available, review the self-performance coding for both bed mobility and transfer.
    - Validate any code less than “3” / extensive assistance (0, 1, or 2)
In Summary…

The proper and accurate capture and coding of the ADL self-performance information has wide-reaching implications…

- The accurate and honest coding of your MDSs
- The valid posting of your HR PU and Increased ADL QMs
- The accurate calculation of your facility’s Composite Score
- Let’s not forget reimbursement…
For more information

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