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Hi, this is Dave Johnson from IPRO. I am a Senior Quality Improvement Specialist and have been with IPRO, in the upstate Albany office, since 2002. I am an Administrator by background since 1976 and am certified to teach the MDS 3.0.

My goal in this session is to briefly explain the self-performance coding for the ADLs... more specifically... bed mobility and transfer and its impact on your high risk pressure ulcer quality measure. I subtitled this presentation "The MDS as a 2nd language" and there is a reason for that... I will show you how the MDS, in some cases, defines things in some very different ways than what you might think... and if you are not familiar with both the definitions and the inner workings of the MDS as they relate to the quality measures... you will miscode the MDS and cause your quality measures to be inaccurate.

For those of you who may not know, there are many quality measures that are calculated from the MDS submissions from your buildings. Those quality measures are posted regularly by CMS on the nursing home compare website, available to the public. The same quality measures are also used by the department of public health in preparation of your facility's annual certification survey.

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As an outline of this presentation, I will talk the impact of the MDS coding... including regulatory, the publically reported "image" of your facility... specifically on nursing home compare and I will touch on the MDS coding role in reimbursement.

I will talk about what I will call "common everyday definitions" as they compare to the MDS definitions... the role that plays in the calculation of your high-risk pressure ulcer statistic... I will spent a decent amount of time explaining the difference between the MDS definition of "limited" and "extensive"... and I will offer some simple illustrations.

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Just for consideration as you view this presentation… here are some simple questions…
What is your QAPI process specific to the accurate capture and collection of information to code the MDS self-performance area in section G of the MDS?
Do you have a formalized process to capture, track and monitor activities of daily living?
Do appropriate staff members understand how important the accurate and appropriate capture of ADL self-performance is?
And lastly, does your appropriate staff understand the difference in the MDS definitions of "extensive" and "limited"?

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The primary resources for this presentation are both the RAI Manual for the MDS 3.0, and the specification manual for the quality measures. I will quote sections of these resources and provide occasional screen prints from the manuals to show the actual verbiage. What you will be seeing is exactly what the resources say…

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As far as the impact or the far reaching effects of the MDS coding...

It sets the stage for your regulatory survey. All of your MDS data through submissions is available in the CASPER system. That same data is available and reviewed by surveyors prior to your on-site survey.

The MDS coding feeds directly into the data that is updated and publically reported on the nursing home compare website.

And the MDS coding plays a significant role in the reimbursement received by a facility to care for the individual residents. There are many items on the MDS that translate directly to payment.

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As an example, I am now going to speak about one of the measures directly impacted by the self-performance codes on the MDS... that measure being high risk pressure ulcers.

Using pressure ulcer "risk" for example... there are common accepted contributors for the risk of developing a pressure ulcer... whether they be things like current research, clinical practice and co-morbid conditions. There is also the use of a validated risk tool such as the Braden Scale.

Interestingly enough, NONE of these things are considered when calculating the risk for the development of pressure ulcers when dealing with the MDS.

There are also two very direct questions on the MDS that ask about pressure ulcer risk (M0100 - The Determination of Pressure Ulcer Risk and M0150 – Risk of Pressure Ulcers)... but those 2 questions, regardless of how you answer them, have NOTHING to do with how the quality measure calculates risk.

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In the quality measure specifications, high risk is based solely on ANY of 3 criteria... specifically being comatose, having a diagnosis or risk of malnutrition, or having what the measure calls "impaired bed mobility or transfer" when coding the self-performance section of the ADLs. That is it for the quality measure determination of risk... NO other comorbidities or risk factors commonly associated with the actual risk for the development of pressure ulcers are used or considered.

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This slide is a screen print directly from the specification manual showing the definition, or their interpretation, of "high risk". The items on the MDS are specific and I will speak to that shortly.

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On this slide, I show the actual section of the MDS form where I specifically indicate the self-performance area for both bed mobility and transfer.

The exact self-performance codes that cause the determination of high risk IN EITHER bed mobility or transfer are specific to extensive assistance, total dependence, activity occurred only once or twice... or activity did not occur... again, within the 7-day look-back period.

There is a coding requirement for extensive assistance that it had to occur 3 or more times within the 7-day lookback period. Remember that the coding is for the ENTIRE 7-day look-back period... 24 hours a day for the entire 7 days.... and you are counting "occurrences".... so it is entirely possible to hit the mandated "3 or more" times within the same shift... if not within the first hour!

This may sound like a small issue, but I can tell you that many times, the ADL section of the MDS is mis-coded because people are injecting their "normal" definition of extensive instead of applying the MDS definition. They are NOT the same. The MDS has a very different definition of the word extensive.

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On this slide, I have taken a section directly from the current RAI Manual to show the coding instructions for G0110, Column 1, ADL Self-Performance. If you look down through the definitions, the coding for independent and supervision are pretty self-explanatory. Where the issue comes in is the difference between limited and extensive. Limited assistance speaks to "guided maneuvering of limbs or other non-weight bearing assistance" while extensive assistance details "weight bearing support 3 or more times". The difference between the 2 levels is that "weight bearing support".

And remember a code on the MDS of extensive assistance, total dependence, activity occurred only once or twice, or activity did not occur... specifically for either bed mobility or transfer, will place that resident at high risk.

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Some further clarifications offered in the RAI Manual differentiates between guided maneuvering and weight bearing assistance. The example detailed talks about lifting a spoon or cup to the mouth... to illustrate the weight bearing piece. If the staff member supports SOME of the weight of the resident's hand or performs part of the activity for the resident, that example is weight bearing assistance. In this example, if a resident can lift the cup or utensil, but need staff assistance to guide their hand to their mouth... that is guided maneuvering.

Now, think about applying this same "rule" to either bed mobility or transfer... helping to slide someone up in bed, helping a resident to stand or sit comfortably in a chair by supporting some weight.

There is no "minimum" amount of weight to be supported so don't get caught in the trap of thinking about heavy lifting. Imagine a piece of paper on a table... if I lift the piece of paper in the air, that is weight bearing support. If I slide the paper across the table, that is guided maneuvering.

Back to this slide, the clarifications are very specific to NOT record the resident's potential capability to perform the ADL activity and DO NOT confuse this level of assistance with what the resident SHOULD be receiving according to the care plan. The level of assistance might be very different from what is indicated on the care plan and you are to record "what actually happened".

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From the RAI Manual, the coding instructions for each ADL activity request that you use the algorithm on page G-6 which I will speak to in a moment.

The manual also dictates that you need to "consider each episode of the activity that occurred during the 7-day look-back period". Remember that we are talking 7 days... 24 hours per day. I will give a simple example of counting each episode... say, for example, that you have a resident who needs to use the restroom and they are sitting in a chair in their room. You provide weight bearing assistance to help them stand, and ambulate them to the restroom. That assist in transfer counts as one episode. After visiting the restroom, you

ambulate the resident back to their chair and assist them, again with some weight bearing support, to ease them back into their chair. That assist in transfer back to the chair also counts as an episode. So right there, in the span of 10 or 15 minutes, you already had 2 episodes of weight bearing support in transfer. Remember the "rule of 3", the fact that any weight bearing support is considered extensive, and the fact that again, you are looking at an entire 7-day period... 24 hours a day.

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Continued ADL coding instructions from the manual specifically state that self-performance may vary from day to day, shift to shift... or even within the same shift... reasons could be varied from mood... to medical condition or medications... even to relationship issues with various care givers. The manual details, again, the assessment capturing the total picture of the actual 7 days/24 hours per day.

The third bullet mentions the "rule of 3" where it actually states that it is only necessary to know whether or not the activity occurred 3 or more times within the 7 days. You do not need to know the exact number of times the activity occurred... again, just if it occurred 3 or more times.

They also recommend that all of the self-performance coding is completed for all ADLs BEFORE beginning the ADL support section capturing the actual number of staff involved.

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Previously, I pointed out that the manual mentioned the use of an algorithm provided for the self-performance coding on the MDS.

For purposes of this presentation and to make it readable on the slide, I have taken the algorithm and split it between 2 slides.

The first part clearly starts the algorithm asking very simple questions about number of occurrences to either code a 7 for "occurred only 1 or 2 times" or an 8 for "activity did not occur".... then leading to the "3 or more times rule"..

Then it starts to question the level of self performance along with staff performance.

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On this split slide, the algorithm continues to include weight bearing, non-weight bearing and supervision. There is additional explanation on the right hand side for the rule of 3 when the levels of self performance vary.
This algorithm is in the RAI Manual as a full page document.

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I pulled a couple of actual examples from the RAI manual to quickly review....

In the first example, a resident slid to the foot of the bed 4 times in the 7-day look-back period. Two staff had to physically lift and reposition the resident toward the head of the bed. The resident did assist by pushing with his legs. The self performance coding for this would be extensive assistance because it was weight bearing with the support coming from 2 staff members.

In the second example, the female resident required partial lift and weight bearing support during transfer for 14 times during the 7-day look-back period... with one person physical assist.

I show you these two examples to illustrate that the number of staff involved has nothing to do with the self-performance coding for the resident. Both cases required some level of weight bearing assistance... they met the rule of 3.... and would be coded extensive assistance for the appropriate ADL activity.... the first being bed mobility... the second being transfer.

BOTH of these residents would be deemed at "high risk" for the development of pressure ulcers just because of the self-performance coding.

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As you think about everything I have presented thus far in this presentation and you may be trying to figure out how to apply it to your facility processes... here is a place to start...
Ask the staff "did you touch the resident?" If so, have them explain in an attempt to capture ANY weight bearing support during the interaction.
Does your facility use gait belts? If so, does your staff use the gait belt to assist a resident while standing or sitting? If you really look at your processes, you

will probably find that the staff provides some level of weight bearing support... and remember, there is no "minimum" amount of weight in weight bearing support. Otherwise, the gait belt must be a fashion statement.

The simple act of lifting a resident's feet or legs on or off the bed... if you were to ask a CNA if that was extensive, they would say "no"... but according to the RAI manual... IT IS.

Assisting a resident to stand or sit by supporting their arm or elbow... or assisting a resident to roll on their side while in bed.. whether to reposition or for example... during wound care... ALL of those examples are weight bearing support and if they happen 3 or more times within the 7-day look-back period, the resident would be coded, for that particular ADL, as extensive assistance.

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Now, to just quickly return to the discussion of high risk... specifically for the pressure ulcer quality measure... If your residents are not capture appropriately in the ADL section of the MDS, they will be EXCLUDED from the high risk pressure ulcer calculation... both the numerator AND denominator.

If your denominator is understated, it will not be an HONEST representation of your resident population... and your high risk pressure ulcer quality measure will be OVERSTATED... or inflated.

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Think about the following example...

A facility with 137 long stay MDSs submitted... and 10 of those MDSs indicated the presence of either stage 2, 3 or 4 unhealed pressure ulcers at the time of assessment.

In this example, the denominator included 83 out of the 137 residents that had been deemed as "high risk" because of any of the 3 MDS criteria... comatose, dx

or risk of malnutrition... or impaired self-performance in either bed mobility or transfer... in this case, 61% of the long stay population.

The 10 triggers divided by 83 equates to a 12% high risk pressure ulcer quality measure calculation. Compare that to the current NYS average of 8.4% and the national average of 6.7%.

In this example, there are 54 long stay residents deemed to be at low risk.... basically left on the table. Now based on what I have presented and the definition of what qualifies for extensive assistance... and thereby high risk... those 54 residents may not have had to be touched by the staff. Is that a true reflection of the resident population and how is it effecting reimbursement?

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Now take the same 137 long stay MDS submissions... keeping the same 10 who triggered for the measure as having an unhealed stage 2, 3 or 4 pressure ulcer. BUT with the accurate and honest capture of the self-performance coding for either bed mobility or transfer, 118 of those 137 long stay residents (a full 86%) are determined to be at HIGH RISK by MDS definition, the 10 triggers are then divided by 118... calculating to an 8% high risk pressure ulcer quality measure... a far better quality measure to be posted publically on nursing home compare.

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A very quick review of the scenario... the same 10 residents triggered for the quality measure... BUT with the increased honest capture of self-performance coding for bed mobility and/or transfer... the result becomes a 4 percentage point reduction... a full 33% change!

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What is your facility's current practice to collect and determine the levels of self-performance to be coded on the MDS? Do you have CNA sheets? Is the MDS terminology mirrored on those sheets or is there a "common language" attempt

to help the staff better understand the MDS definitions? Is there a misunderstanding of the definitions or is your form actually fostering a continued misunderstanding and miscoding of the MDS? Do you suffer from repetitive charting?

I have dealt with some facilities who use a comprehensive note to capture the necessary information to back up the MDS coding... If that is your practice, are all shifts interviewed to collect the entire picture? How are the questions posed to the staff? Does the interviewing nurse understand the MDS definitions? And does the interviewer use the MDS terminology or a more common translation of the definitions to make sure they have a clear picture?

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As far as next steps... pull your real time data from the CASPER system. I would recommend that you view our narrated presentation entitled CASPER 101 that is available on our website. It provides clear direction on making the best use of the CASPER system... including real time data. Our website is www.nursinghomes.ipro.org.

Compare the denominators of physical restraints and high risk pressure ulcers. The physical restraint denominator is a reflection of the long stay MDSs that have been submitted currently in the CASPER system. The high risk pressure ulcer denominator reflects those long stay residents who have been deemed BY MDS as being at high risk for the development of a pressure ulcer... and remember that the self-performance codes for bed mobility and transfer are a major contributor to that statistic. The difference between those 2 statistics, those long stay residents NOT qualifying for high risk... and you have to ask yourself... is that a true representation of your resident population?

Review your facility's process to capture and document ADL self performance and support.

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Is accurate information being collected from all shifts to ensure an accurate coding for the 7-day look-back period?

Remember that the self-performance codes should take into account each occurrence... Not just once per shift.

And ensure, through staff education, that there is a competency of the RAI Manual definitions for the self-performance ADLs... particularly the difference between extensive and limited.

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I want to just take a minute to mention the value and role of consistent assignment. A consistent caregiver is more likely to have the accurate knowledge of their residents' self-performance through their normal shift. The day-to-day knowledge will foster the coding accuracy of the MDS to make sure that the assessments are a clear and honest representation of their residents.

For more information on consistent assignment, check out our website at www.nursinghomes.ipro.org.

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I know that I have presented a lot of information regarding the difference between the MDS definitions of extensive and limited.... and the impact of a misunderstanding and inaccurate capture of the information.

I leave you with this slide that contains the contact information for everyone on the IPRO Nursing Home Team.

All of us are well-versed in the quality measures along with the RAI Manual and have an abundant resource library available to you to support your efforts in quality improvement.

If you have any questions about the content of this presentation, please feel free to contact any of us directly.

I thank you for your time and have a great day!