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Nursing Home Resident Assessment

Quality of Care

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EXECUTIVE SUMMARY

PURPOSE

To assess the current state of practice of implementing nursing home resident assessments.

BACKGROUND

The Office of Inspector General undertook a series of nursing home inspections examining the quality of care in nursing homes. This report is a part of that series. A companion report "Nursing Home Resident Assessment: Resource Utilization Groups" reviews the integration of the skilled nursing facility prospective payment system with the resident assessment.

The Nursing Home Reform Act mandates that nursing homes use a clinical assessment tool known as the Resident Assessment Instrument to identify residents' strengths, weaknesses, preferences, and needs in key areas of functioning. This assessment is an integral part of the residents' medical record. It is designed to help nursing homes thoroughly evaluate residents and provides each resident with a standardized, comprehensive, and reproducible assessment. Upon completion of the assessment, the information guides the team to prepare individualized care plans for each resident. The minimum data set (MDS) is a component of the resident assessment which contains a standardized set of essential clinical and functional status measures. Triggers from the minimum data set identify conditions for additional assessment and review, and cause the nursing home to further evaluate a resident using Resident Assessment Protocols (RAPs) which lead to the care plan.

This inspection is based on information gathered from three different sources: a medical review of nursing home medical records for a sample of 640 nursing home residents, a self-administered survey of 64 nursing home MDS coordinators, and a telephone survey of 64 nursing home administrators.

FINDINGS

Generally, nursing homes follow a systematic process when implementing Resident Assessments

All MDS coordinators report that an interdisciplinary team evaluates each resident and participates in the completion of the MDS form. Almost all facilities, 81 percent, have a full time registered nurse in the MDS coordinator position. Almost all nursing homes have

some kind of ongoing training for staff that participate in the MDS. A review of signed MDSs indicates that 85 percent of nursing homes had at least four professionals assess each resident.

However, we found differences between the MDS and the rest of the medical record, some of which may affect care planning

Differences

A medical record review of the MDS shows an average of 17 percent of the 406 fields for each resident are different from the medical record. We determined a difference to exist when our reviewers' assessment did not match that of the nursing home. An explanation of possible reasons for this are discussed in the body of the report.

One of the highest rates of difference is 31 percent in section G, Physical Functioning and Structural Problems. The goal of this section is to assess the resident and develop a plan of care that maintains or improves the resident's level of involvement in their activities of daily living. This is to assure the resident is functioning at his or her highest potential. Many MDS coordinators (40 percent) report section G is the most difficult to complete, and 20 percent of the MDS coordinators report that they would make changes to section G. This is one of the most subjective sections of the MDS.

Resident Assessment Protocols

Resident Assessment Protocols, or RAPs, flow from the MDS and guide the residents' plans of care. In practice, there are key elements or questions in the MDS that when answered in a specific way "trigger" one of 18 RAPs. Seventy-six percent of the RAP decisions were the same for both our reviewers and the nursing home. However, in 14 percent of the records, the RAP was not triggered by the nursing home when our reviewers indicated one was triggered, and subsequently no care plan was developed for the resident. In 11 percent of the records, the nursing home triggered RAPs when our reviewer did not. Again, possible reasons are discussed in the body of the report.

Care planning

When reviewing whether there were care plans generated from the RAPs for our sample residents, we found that 26 percent of triggered RAPs do not have care plans. One possible explanation for lack of care planning is that the medical issue may have been addressed, resolved, or included in another RAP.

Plans of care are generally being followed

We also reviewed the progress notes for 30 days after the care planning date to determine whether the care plan was implemented. Thirty-day progress notes from the medical record indicate follow up by the staff on almost all care plans. Almost all MDS coordinators agree that care plans evolve from the MDS evaluations and their direct care staff use the care plans to provide treatment to the residents. The director of nursing, MDS coordinator, or the direct care nurse is usually responsible for assuring that the care plan is implemented. All MDS coordinators report reviewing the plan of care on some schedule. Almost three-quarters of the coordinators report that the care plan is reviewed quarterly; more than 80 percent say it is reviewed as needed.

RECOMMENDATIONS

Clearly, nursing homes are attempting to systematically complete the MDS and implement the plans of care. However, they are having difficulty administering an inherently complex process. There are apparently differences in nursing home staffs' understanding of the MDS and the resident assessment process.

Based on our findings and the concerns of the nursing home MDS coordinators and administrators, we recommend that HCFA:

- more clearly define MDS elements, especially section G, and

- work with the nursing home industry to provide enhanced and coordinated training to nursing homes to be sure that similar and accurate information about the MDS is being disseminated.

AGENCY COMMENTS

We received comments from the Health Care Financing Administration. They concur with both of our recommendations and describe a number of important steps they are taking to improve understanding and implementation of the resident assessment, particularly the MDS. We appreciate HCFA's thoughtful consideration of our report.

The HCFA also provided technical comments which we have incorporated in the report. The full text of the comments is provided in Appendix C. This also contains HCFA's comments on our companion report about the relationship between the resident assessment and the reimbursement system. We discuss these comments in the other report.

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INTRODUCTION

PURPOSE

To assess the current state of practice of implementing nursing home resident assessments.

BACKGROUND

The Senate Special Committee on Aging held hearings in the summer of 1998 following reports by the Health Care Financing Administration (HCFA) and the General Accounting Office (GAO) of serious concerns about nursing home residents' care and well-being. Subsequently, the Office of Inspector General (OIG) undertook a series of nursing home inspections examining the quality of care in nursing homes. They include trends in reported abuse among residents, the role of the ombudsman in protecting residents, the capacity of the State survey and certification program, the trends in the Online Survey Certification and Reporting System (OSCAR) data, the access of nursing home survey results and access to nursing homes. This report is a part of that series. A companion report "Nursing Home Resident Assessment: Resource Utilization Groups," reviews the integration of the skilled nursing facility prospective payment system with the resident assessment.

Generally a nursing home is a residential facility which offers daily living assistance to people who are either physically or mentally unable to live independently. Residents are provided rooms, meals, assistance with daily living, and, in most cases, some medical treatment for those residents who require it.

Medicare Part A can help pay for skilled nursing facility (SNF) care for up to 100 days in a benefit period when a beneficiary meets certain conditions. These conditions include a requirement of daily skilled nursing or rehabilitation services, a prior three consecutive day stay in a hospital, admission to the SNF within a short period of time after leaving the hospital, treatment for the same condition that was treated in the hospital, and a medical professional certifying the need for daily skilled nursing or rehabilitation care. In 1990 Medicare paid $1.7 billion to nursing homes. In 1998 this amount had increased to $10.4 billion[1]. Medicare pays only a small portion of the nation's nursing home bills. Most bills are paid by personal funds, purchased long-term care insurance, and Medicaid.

[1]U.S. Department of Health and Human Services, Health Financing Administration, Office of the Actuary, National Health Statistics Group: http://www.hcfa.gov/stats/nhe-oact/tables.

Medicaid coverage varies among States. Medicaid eligible beneficiaries who require custodial care such as help with eating, bathing, taking medicine and toileting, as well as those who require skilled care may have a nursing home stay paid by Medicaid. Medicaid payments to nursing homes in 1996 totaled $40.6 billion. Despite the increase in Medicare and Medicaid payments, concern remains about the quality of care in nursing homes.

In 1986 the Institute of Medicine conducted a study on nursing home regulation and reported prevalent problems regarding the quality of care for nursing home residents and the need for stronger Federal regulations. In 1987 the GAO reported that over one third of nursing homes were operating under the Federal minimum standards. This report, along with widespread concern regarding nursing home conditions, led Congress to pass the Omnibus Budget Reconciliation Act (OBRA 1987). As a part of OBRA 1987, Congress passed the comprehensive Nursing Home Reform Act (P.L. 100-203), expanding requirements that nursing homes have to comply with prior to Medicare or Medicaid certification.

The Resident Assessment

The Nursing Home Reform Act mandates that nursing homes use a clinical assessment tool known as the Resident Assessment Instrument (RAI) to identify residents' strengths, weaknesses, preferences, and needs in key areas of functioning. The RAI is designed to help nursing homes thoroughly evaluate residents and provides each resident with a standardized, comprehensive, and reproducible assessment. "With consistent application of item definitions, the RAI ensures standardized communication both within the facility and between facilities. Basically, when everyone is speaking the same language, the opportunity for misunderstanding or error is diminished considerably."[2]

The RAI was developed by a research consortium under contract with the the health Care Financing Administration (HCFA) and consists of three key components: the Minimum Data Set (MDS), Triggers and Resident Assessment Protocols (RAPs), and Utilization Guidelines. Most States required nursing homes to begin implementing the RAI in 1991. It was intended that the RAI be a dynamic tool, and HCFA began developing version 2.0 of the RAI in early 1993 which is now in use. The HCFA is committed to continuous reviews and updates.

The RAI is intended to be completed by an interdisciplinary team of nursing home staff who gather facts about the residents' strengths and needs. The interdisciplinary team should ideally include dieticians, speech, physical and occupational therapists, social workers, pharmacists, and nurses. The attending physician is also an important participant

[2]U.S. Department of Health and Human Services, Health Care Financing Administration, *Long Term Care Resident Assessment Instrument User's Manual Version 2.0* October, 1995.

in the RAI process providing valuable input on sections of the MDS and RAPs. Federal regulations require each individual who completes a portion of the RAI to sign, date, and certify its accuracy. Regulations also require a registered nurse sign and certify that the assessment is complete. Upon completion of the assessment, the information guides the team to prepare individualized care plans for each resident.

The Minimum Data Set

The MDS 2.0, a component of the RAI, contains a standardized set of essential clinical and functional status measures. It must be collected on every resident in the nursing home at regular intervals during their nursing home stay regardless of the method of payment. Nursing homes are required to "conduct initially and periodically a comprehensive, accurate, standardized, reproducible assessment of each resident's functional capacity." [3] All residents must be completely assessed in the first 14 days after admission, promptly after a significant change in their physical or mental condition, and at least once every 12 months. Additionally, all MDS assessments must be reviewed at least every 3 months to assure continued accuracy. The prospective payment system was phased into nursing homes in July of 1998, and all nursing homes were expected to comply with the new system in January of 1999. Skilled nursing facilities are required to classify residents into one of 44 Resource Utilization Groups (RUGs-III) based on assessment data from the MDS for reimbursement. Since the implementation of the prospective payment system there is a more frequent MDS schedule for those residents reimbursed by Medicare Part A.

Triggers and Resident Assessment Protocols

Specific responses to MDS items alert the nursing home to potential problems for the resident. These "triggers" are associated with specific questions on the MDS. If one or a combination of MDS elements are triggered, the resident is identified as someone who has or may develop specific functional or clinical problems. Triggers identify conditions for additional assessment and review, and cause the nursing home to further evaluate a resident using Resident Assessment Protocols (RAPs). Triggers indicate that specific clinical factors are present that may or may not represent a condition that should be addressed in the plan of care. The MDS responses that define triggers are specified in each RAP.

The Nursing Home Reform Act requires RAPs at the 14 day comprehensive assessment, significant changes, and annually. The RAPs assist in the development of plans of care. There are 18 RAPs in Version 2.0 of the Resident Assessment Instrument. They include items such as cognitive loss/dementia, ADL function/rehabilitation, psychosocial well-

[3]U.S. Department of Health and Human Services, Health Care Financing Administration, *Long Term Care Resident Assessment Instrument User's Manual Version 2.0* October, 1995

being, nutritional status, dehydration/fluid maintenance, and pressure ulcers.

Plans of Care

The theory behind the RAI is that a strong link between MDS, RAPs and care planning is essential to provide each resident with a solid approach to prevent avoidable decline and build upon current strengths. Meaningful care planning takes into account the unique traits of each resident which translates into providing good quality of care and quality of life. The OBRA '87 requires that each nursing home resident have a comprehensive plan of care. This plan is based on information gathered by the MDS and any further review and assessment. The plans of care must include measurable objectives and timetables to meet the resident's medical, nursing, and mental needs identified in the comprehensive assessment. The services provided under the plan of care are to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being. The plans of care are to be periodically reviewed and revised when necessary after each assessment.

MDS Coordination

When Medicare reimbursement became linked to resident assessments, MDS coordinator roles became more vital to nursing homes. MDS coordinators are generally registered nurses who oversee the assessments and paperwork in order to guarantee proper completion. The MDS coordinators work with an interdisciplinary staff to produce the written and electronic documents necessary for Medicare reimbursement. The MDS coordinator also assures that each resident's MDS is coded accurately so that the nursing home is financially able to provide all necessary services.

In addition MDS coordinators affect the quality of care of the residents. Completing a thorough and accurate comprehensive assessment enables the nursing home to provide appropriate plans of care for each resident. The MDS coordinators can provide a global picture of each resident and can spot weaknesses in their plans of care.

Prior Studies

The Research Triangle Institute completed a study in 1995 entitled "Evaluation of the Nursing Home Resident Assessment Instrument" that examined the effect of the resident assessment instrument on quality of care in nursing homes. One finding suggested that administrators and directors of nursing positively accepted the RAI and believed it helped individualize the plans of care. Another key finding suggested the overall quality of care and care planning improved in nursing homes when the RAI was implemented. In addition, the study indicated that the RAI significantly reduced hospitalization rates and improved resident outcomes in certain areas.

However, recent reports by the Office of Inspector General[4] and another researcher[5] found that the failure to provide comprehensive assessments was among the 10 most frequently cited deficiencies in nursing homes. A 1996 study for HCFA reported that between 25 and 30 percent of nursing homes were deficient in their development of comprehensive assessments and/or comprehensive care plans.

METHODOLOGY

This inspection is based on information gathered from three different sources: a medical review of nursing home medical records for a sample of 640 nursing home residents, a self-administered survey of 64 nursing home MDS coordinators, and a telephone survey of 64 nursing home administrators. We conducted our field work between June and August 1999.

Sample Selection

We selected Medicare, Medicaid, and private pay nursing home residents using a three-stage stratified, cluster sample. First, we selected a stratified sample of eight States to include the four States with the most certified nursing home beds (California, New York, Texas, and Illinois), two States randomly selected from the four currently using a prospective payment system for Medicaid reimbursement in a HCFA demonstration project (Mississippi and Maine), and two States randomly selected from the remaining 40 States (Connecticut and Virginia).

Skilled nursing facilities refers to nursing homes that participate in Medicare. Nursing facilities refers to nursing homes certified to participate in Medicaid. For the purposes of this study, we will refer to Medicare, Medicaid, and private pay facilities as nursing homes because we included all payor types for the sample selection.

Next, we randomly chose eight nursing homes in each of the eight sample States, excluding nursing homes with a bed count of less than 60 to ensure a sufficient number of residents who fit the selection criteria. Finally, we randomly selected 10 residents in each nursing home for a total of 640 residents. This selection was made from all nursing home residents who were in the 64 sample nursing homes in December 1998, regardless of payment source. These residents were admitted to the nursing home between July 1998 and December 1998. We selected the 14 day admission assessment completed for the resident from July to December 1998 and reviewed all the medical records prior to this

[4] Department of Health and Human Services, Office of Inspector General, Office of Evaluations and Inspections, *Nursing Home Survey and Certification: Deficiency Trends OEI-02-98-00330,* March 1999.

[5] Charlene Harrington, Ph.D. *The Regulation and Enforcement of Federal Nursing Home Standards, 1991-1996* University of California, Department of Social and Behavioral Sciences, March 1998.

assessment. Data for all samples were weighted and projected to the universe.

Medical Review and Analysis

Comparison with the medical record. We obtained the services of a medical review contractor who employed nurses with experience in completing the MDS in nursing homes and in consulting and training on the MDS process to conduct the review. These nurses visited each nursing home and completed a 14 day assessment based on the resident's medical record for the same 14 day time period. In doing so, our reviewers did not refer to the original MDS during their review nor did they contact the residents or the staff to complete their assessments. They were instructed to complete each field of the assessment only if there was sufficient and reliable information in the medical record to warrant a determination. Subsequently, we made a comparison of the results for each field. In this way, we were able to determine if the nursing homes' resident assessment was consistent with the rest of the medical record.

Nine residents did not fit our selection criteria, thus leaving a sample of 631 residents. All but three completed copies of the MDS were forwarded to us by the nursing home. The nurses were unable to complete some fields in the MDS due to lack of information in the medical record[6]. Most of these fields required information that was inappropriate for a 14 day assessment. All other fields had sufficient information for our reviewers to complete the MDS.

The methodology is useful to identify differences between what our reviewers would have entered in the MDS based on a review of the other medical records, versus what the facility nurses observed in the actual physical assessment of the patient. Our method does not permit a specific determination of why the differences occurred -- e.g., an error in the MDS review by the observing nurse, an error or omission in the medical record, or simply an honest difference of opinion given a similar set of facts. However, overall such differences might highlight the need to take steps to ensure greater consistency.

Triggering of RAPS. Additionally, the reviewers generated appropriate RAPs based on the MDS that they prepared. Resident Assessment Protocols generated by the nursing home were not available for 75 of our sample residents leaving 556 of 631 residents. We compared the RAPs generated by our reviewers to those of the nursing home.

Plans of care. Finally, our reviewers evaluated the medical records for the 30 day period after the MDS was completed to determine if plans of care were appropriately developed, and if the 30 day progress notes reflected implementation of the plans of care. They reviewed all records where a RAP was generated and there was a plan of care to determine if the care plan was implemented.

[6] These fields include B6, C7, E3, E5, G3a, G9, H4, I3, K3, N5a, R1a, R1b, and R1c.

Surveys

We sent a self-administered questionnaire to each MDS coordinator in the 64 nursing homes in our sample and asked questions regarding the implementation of the resident assessment and plans of care. We had a 100 percent response rate from the MDS coordinators. We obtained information regarding the characteristics, training, and coordination of the staff who complete the assessments and plans of care. In addition, we looked at the structures and processes the staff use to perform the resident assessment and their satisfaction with the process.

Interviews

We conducted structured telephone interviews in July 1999 with nursing home administrators in each of the 64 sample nursing homes. We had a 100 percent response rate from the nursing home administrators. We asked them questions regarding the implementation of the resident assessment and plans of care. During these interviews, we also obtained information from them regarding the characteristics, training, and coordination of the staff who complete the assessments and plans of care. We also looked at the structures and processes the staff used to fulfill the resident assessment instrument requirements and their satisfaction with the process.

Limitations

The results of this analysis are limited by the information available in the medical record. In some cases, the nursing home completes the MDS based on observation of or discussion with the resident about which there may not be any other information in the medical record.

For Section P: Special Treatment and Procedures, which includes minutes of occupational and physical therapy given in the last 7 days, the reviewer compared the therapy logs to the MDS. In some cases, the logs were kept in units of 15 minutes. The reviewers converted the units to minutes.

This inspection was conducted in accordance with the **Quality Standards for Inspections** issued by the President's Council on Integrity and Efficiency.

FINDINGS

Generally, nursing homes follow a systematic process when implementing Resident Assessments

Interdisciplinary team

All MDS coordinators report that an interdisciplinary team evaluates each resident and participates in the completion of the MDS form. About 75 percent of MDS coordinators indicate that the interdisciplinary team is composed primarily of physical therapists, speech therapists, occupational therapists, activity directors, dietitians, social workers and floor nurses for all 5, 14, 30, 60 and 90-day assessments. All MDS coordinators say that the interdisciplinary team gets together to discuss the patient's current condition as well as to discuss and monitor the plans of care. Ninety-three percent of MDS coordinators report that the same staff are also responsible for completing the patients' plan of care.

A review of signed MDSs indicates that 85 percent of nursing homes had at least four professionals assess each resident. Less than 3 percent of MDSs are completed only by a registered nurse. Physicians rarely sign the MDS; there is no requirement that they do so.

MDS coordinator

Almost all facilities have a person in the position of MDS coordinator. Eighty-one percent of MDS coordinators are registered nurses, and the remainder are either LPNs or LVNs (15 percent) or social workers (4 percent). Although a MDS coordinator is not required to be a registered nurse, a registered nurse is required to sign and verify all sections of the MDS. About 20 percent of administrators also state the MDS coordinator does not sign the completed MDS in his or her nursing home.

Almost all MDS coordinators have at least 2 years experience in a geriatric setting, and over 50 percent have more than 10 years experience. The role of the MDS coordinator in nursing homes is a fairly new position. About 60 percent of MDS coordinators have worked 1 year or less in a MDS coordinator role at their current nursing home. Over 65 percent have no prior experience as a MDS coordinator in another nursing home.

Almost all MDS coordinators are full time employees and only work in one nursing home, although MDS coordinators fill multiple roles in that nursing home. Over half indicate that they have responsibilities other than that of MDS coordinator. About 20 percent of those who have other responsibilities serve as the director or assistant director of nursing while about 70 percent serve in other RN managerial roles.

Regarding the MDS process, 73 percent of MDS coordinators say they sometimes have difficulty adhering to the MDS time schedules. More than half of these say it is due to the rapid admission and discharge rates of residents. One-quarter say this is due to insufficient staff.

Training

Both MDS coordinators and nursing home administrators report ongoing training for all staff that participate in the MDS. About 70 percent of nursing home administrators state that the ongoing training is required by the nursing home. Nursing home administrators say that their staff is trained by private consultants, corporations, fiscal intermediaries, State associations, and the Health Care Financing Administration.

MDS Coordinators say that ongoing training is most commonly a combination of formal workshops outside the nursing home, formal training within the nursing home, informal on-the-job training, or referencing the MDS manual. Seventy-three percent say that their on-going MDS training includes formal workshops, either at the facility or another location.

About 80 percent of MDS coordinators find the MDS manual to be clear and easily understandable, however, only 42 percent of nursing home administrators believe their staff feel the same way. Some administrators report that their staff find the manuals to be vague and confusing and open to interpretation. MDS coordinators who do not find the manuals clear and easily understandable suggest that the MDS manual could be clearer, more specific, more descriptive, and with more examples and situations. Specifically, the activities of daily living (ADL) in section "G" are reportedly most difficult.

According to both administrators and MDS coordinators, updates that affect the MDS come from several sources, primarily HCFA memos and bulletins and State memos and bulletins. About half (56 percent) of nursing home administrators and 40 percent of MDS coordinators mention other professional organizations as a source for updates, and approximately 40 percent of both groups mention the Internet as the source for updates; particularly the HCFA and the American Health Care Association site.

However, we found differences between the MDS and the rest of the medical record, some of which may affect care planning

Differences

An average of 17 percent of the 406 fields for each resident are different from the medical record. We determined a difference to exist when our reviewers' assessment did not match that of the nursing home. See Table 1 on the following page for a complete listing

of difference rates for all MDS sections. At least 3 percent of the fields for all residents have differences. Difference rates for residents range from 3 percent to 30 percent. Only 1 percent of residents have MDS difference rates of 5 percent or less, and 11 percent of residents have difference rates of 10 percent or less.

Table 1
Rates of Differences for All Sections of the MDS

Section	**Rates**	**# of Fields**
B. Cognitive Patterns	20%	15
C. Communication/Hearing Patterns	10%	15
D. Visual Patterns	24%	5
E. Mood and Behavior Problems	12%	27
F. Psychosocial Well-Being	22%	19
G. Physical Functioning & Structural Problems	31%	52
H. Continence in Last 14 Days	15%	17
I. Disease Diagnosis	5%	57
J. Health Conditions	16%	37
K. Oral/Nutritional Status	10%	21
L. Oral/Dental Status	22%	7
M. Skin Condition	15%	32
N. Activity Pursuit Patterns	26%	24
O. Medications	24%	8
P. Special Treatments & Procedures	15%	56
Q. Discharge Potential & Overall Status	37%	4
T. Therapy Supplement for Medicare PPS	29%	10
TOTAL	**17%**	**406**

Source: OIG medical review

As noted in the background section, the methodology used in this report is useful to identify differences between what our reviewers would have entered in the MDS based on a review of the other medical records, versus what the facility nurses observed in the actual physical assessment of the patient. Our method does not permit a specific

determination of why the differences occurred -- e.g., an error in the MDS review by the observing nurse, an error or omission in the medical record, or simply an honest difference of opinion given a similar set of facts. However, overall the differences revealed in our review highlight the need to take steps to ensure greater consistency.

One of the consequences of our analysis is the fact that some categories are affected more than others. Among sections with the highest difference rate are Section G: Physical Functioning and Structural Problems (31 percent) and Section Q: Discharge Potential and Overall Status (37 percent). The goal of Section G is to assess the resident and develop a plan of care that maintains or improves the resident's level of involvement in their activities of daily living (ADLs). The ADLs assure the resident is functioning at his or her highest potential. A resident's ADL performance may vary from day to day or shift to shift; therefore, a proper assessment takes into account multiple perspectives over the course of 7 days. Fields within Section G with the highest difference rate are Self-performance Assessment of Locomotion off Unit (47 percent) and Self-performance Assessment of Locomotion on Unit (47 percent). Section Q, Discharge Potential and Overall Status, which also has a high difference rate, includes questions that are answered with information gathered from the caregivers, the resident and his family. The information is quite subjective and may change due to a number of factors such as whether the resident likes the nursing home.

Thirty-nine percent of nursing home MDS coordinators report Section G the most difficult to complete. When asked which section they would change, 20 percent report they would change Section G. Some explained that the "staff views capabilities differently [and the capabilities] remain subjective" and they "would like more well-defined levels." Some MDS coordinators also note that some sections on the MDS are "repetitive" and that the assessment needs to be condensed.

Three sections have low difference rates of 10 percent or less. They include Section I: Disease Diagnosis (5 percent), Section C: Communication/Hearing Patterns (10 percent), and Section K: Oral/Nutritional Status (10 percent). The criteria for evaluating a disease or infection in Section I is much less subjective than other fields.

Resident Assessment Protocols

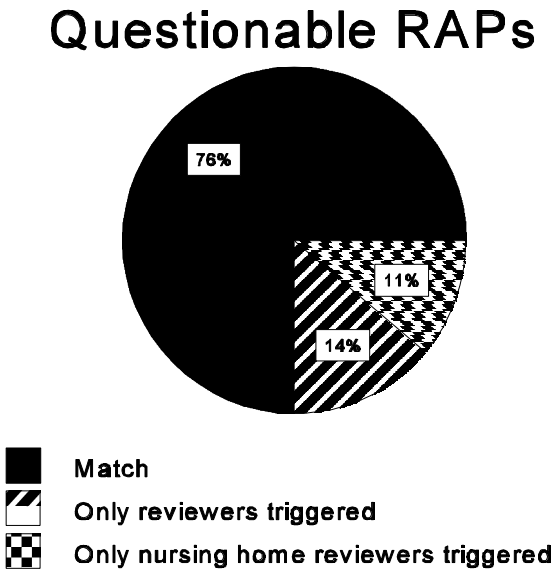
Resident Assessment Protocols, or RAPs, flow from the MDS and guide the resident's plan of care. In practice, there are key elements or questions in the MDS that when answered in a specific way "trigger" one of the 18 RAPs. For example, if in the "cognitive pattern" section of the MDS a resident's decision making ability was coded as moderately or severely impaired that would trigger the "cognitive loss" RAP and that weakness would have to be addressed in the residents plan of care.

Another consequence of our analysis is a concern that the differences that we found appear to be significant enough to affect the care planning process. In order to determine

if that was the case, we looked at the RAPs. As can be seen in Chart 1, 76 percent of the RAP decisions are the same for both our reviewers and the nursing home. However, in 14 percent of the records, the RAP was not triggered by the nursing home, and subsequently no care plan was developed for the resident. One possible explanation for the lack of care planning is that the medical issue may have been addressed, resolved, or included in another RAP. However, our analysis did not include whether or not this actually occurred.

In 11 percent of the records, the nursing home triggered RAPs when our reviewer did not. Differences on the MDS may have resulted in different RAPs being triggered. In addition, if information regarding a resident's condition is absent from the medical record, our reviewer would not have noted the condition on the MDS which could have resulted in a missed RAP trigger.

Chart 1



Source: OIG medical review

Table 2 on the following page lists the 18 RAPs and the decisions of both the medical record reviewer and the nursing home. The RAPs with the greatest differences are "Psychosocial Well-Being" (38 percent), "Activities" (37 percent), and "Mood State" (37 percent). The RAPs with the least differences are "Feeding Tubes" (2 percent) and "ADL Functional Rehabilitation Potential" (10 percent). We tested the RAPs by payor source, and we found no clear evidence that payment source makes a difference.

Almost all MDS coordinators (86 percent) report that the RAPs are helpful when developing the plan of care. Additionally, some coordinators would like to see additional RAPs generated about pain management, the management of infections, and respiratory conditions.

Table 2

Nurse Reviewer and Nursing Home Responses to RAPs

Resident Assessment Protocol (RAP)	Total Difference (%)	Reviewer Trigger Only (%)	NH Trigger Only (%)
Psychosocial Well-Being	38	17	21
Activities	37	14	24
Mood State	37	18	18
Visual Function	36	22	14
Dehydration	34	18	16
Dental Care	33	19	14
Psychotropic Drug Use	30	25	5
Nutritional Status	29	11	18
Falls	27	15	12
Communication	21	11	10
Behavioral Symptoms	19	15	5
Pressure Ulcers	19	12	8
Physical Restraints	18	16	1
Urinary Incontinence	18	11	7
Cognitive Loss	18	7	11
Delirium	16	7	9
ADL Rehab Potential	10	7	3
Feeding Tubes	2	2	0

* Percentages do not add to 100 percent due to rounding. Source: OIG medical review

Care planning

When reviewing whether appropriate care plans were generated from the RAPs for our sample residents, we found that 26 percent of triggered RAPs do not have care plans. However, the medical issue may have been addressed, resolved, or included in another RAP. "Psychotropic Drug Use", "Dental Care", and "Visual Function" are the RAPs most commonly missing care plans. Residents who require dentures or eye glasses will always trigger the "Dental Care" or "Visual Function" RAPs, however, care planning is usually unnecessary if the resident already has these devices. "Feeding Tubes" is the RAP which most consistently results in care planning.

It is noteworthy that nursing homes occasionally completed care plans for RAPs not triggered. "Falls" is an example where 8 percent of the medical records indicated care plans when the RAP was not triggered.

Plans of care are generally being followed

We then reviewed the progress notes for 30 days after the care planning date to determine whether the care plan was implemented. Thirty-day progress notes from the medical record indicate follow up by the staff on virtually all care plans.

Almost all MDS coordinators agree that care plans evolve from the MDS evaluations and their direct care staff use the care plans to provide treatment to the residents. The director of nursing, MDS coordinator, or the direct care nurse is usually responsible for assuring that the care plan is implemented. All MDS coordinators report reviewing the plan of care on some schedule. Almost three-quarters of the coordinators report that the care plan is reviewed quarterly; more than 80 percent say it is reviewed as needed.

RECOMMENDATIONS

Clearly, the nursing homes are attempting to systematically complete the MDS and implement the plans of care. However, they are having difficulty administering an inherently complex process. There are apparently differences in nursing home staffs' understanding of the MDS and the resident assessment process.

Based on our findings and the concerns of the nursing home MDS coordinators and administrators, we recommend that HCFA:

- more clearly define MDS elements, especially section G, and
- work with the nursing home industry to provide enhanced and coordinated training to nursing homes to be sure that similar and accurate information about the MDS is being disseminated.

AGENCY COMMENTS

We received comments from the Health Care Financing Administration. They concur with both of our recommendations and describe a number of important steps they are taking to improve understanding and implementation of the resident assessment, particularly the MDS. We appreciate HCFA's thoughtful consideration of our report.

The HCFA also provided technical comments which we have incorporated in the report. The full text of the comments is provided in Appendix C. This also contains HCFA's comments on our companion report about the relationship between the resident assessment and the reimbursement system. We discuss these comments in the other report.

APPENDIX A

Confidence Intervals for Key Findings

We calculated confidence intervals for the key findings. The point estimate and 95 percent confidence interval are given for each of the following findings. The point estimates and confidence intervals for the findings vary based on the standard error for each individual finding.

KEY FINDINGS	POINT ESTIMATE	CONFIDENCE INTERVAL
Percent of nursing homes had 4 or more professions assess each resident	85%	+/- 7%
Percent of MDS coordinators who are registered nurses	81%	+/- 9%
Percent of nursing home administrators who find the MDS manuals clear and easily understandable	42%	+/- 19%
Percent of MDS coordinators who find the MDS manuals clear and easily understandable	80%	+/- 9%
Percent of MDS coordinators who find Section G difficult	39%	+/- 25%
Percent of MDS coordinators who would change Section G	20%	+/-16%
Percent of MDS fields with differences	17%	+/- 2%
Percent of RAPs that match	76%	+/- 2%
Percent of RAPs triggered by our reviewers but not the nursing homes	14%	+/- 6%
Percent of RAPs triggered by nursing homes but not our reviewers	11%	+/- 5%
Percent of triggered RAPs without care plans	26%	+/- 6%

APPENDIX B

Minimum Data Set

In this appendix we have included a complete copy of the Minimum Data Set.

Resident _____ Numeric Identifier _____

MINIMUM DATA SET (MDS) — *VERSION 2.0*
FOR NURSING HOME RESIDENT ASSESSMENT AND CARE SCREENING
FULL ASSESSMENT FORM

(Status in last 7 days, unless other time frame indicated)

SECTION A. IDENTIFICATION AND BACKGROUND INFORMATION

1. RESIDENT NAME — a. (First) b. (Middle Initial) c. (Last) d. (Jr/Sr)

2. ROOM NUMBER

3. ASSESSMENT REFERENCE DATE
a. *Last day of MDS observation period* — Month / Day / Year
b. Original (0) or corrected copy of form (enter number of correction)

4a. DATE OF REENTRY — Date of reentry from most recent temporary discharge to a hospital in last 90 days (or since last assessment or admission if less than 90 days) — Month / Day / Year

5. MARITAL STATUS — 1. Never married 2. Married 3. Widowed 4. Separated 5. Divorced

6. MEDICAL RECORD NO.

7. CURRENT PAYMENT SOURCES FOR N.H. STAY (*Billing Office to indicate; check all that apply in last 30 days*)

Medicaid per diem	a.	VA per diem	f.
Medicare per diem	b.	Self or family pays for full per diem	g.
Medicare ancillary part A	c.	Medicaid resident liability or Medicare co-payment	h.
Medicare ancillary part B	d.	Private insurance per diem (including co-payment)	i.
CHAMPUS per diem	e.	Other per diem	j.

8. REASONS FOR ASSESSMENT [*Note—If this is a discharge or reentry assessment, only a limited subset of MDS items need be completed.*]
a. Primary reason for assessment
1. Admission assessment (required by day 14)
2. Annual assessment
3. Significant change in status assessment
4. Significant correction of prior full assessment
5. Quarterly review assessment
6. Discharged—return not anticipated
7. Discharged—return anticipated
8. Discharged prior to completing initial assessment
9. Reentry
10. Significant correction of prior quarterly assessment
0. *NONE OF ABOVE*

b. *Codes for assessments required for Medicare PPS or the State*
1. Medicare 5 day assessment
2. Medicare 30 day assessment
3. Medicare 60 day assessment
4. Medicare 90 day assessment
5. Medicare readmission/return assessment
6. Other state required assessment
7. Medicare 14 day assessment
8. Other Medicare required assessment

9. RESPONSIBILITY/ LEGAL GUARDIAN (*Check all that apply*)

Legal guardian	a.	Durable power attorney/financial	d.
Other legal oversight	b.	Family member responsible	e.
Durable power of attorney/health care	c.	Patient responsible for self	f.
		NONE OF ABOVE	g.

10. ADVANCED DIRECTIVES (*For those items with supporting documentation in the medical record, check all that apply*)

Living will	a.	Feeding restrictions	f.
Do not resuscitate	b.	Medication restrictions	g.
Do not hospitalize	c.	Other treatment restrictions	h.
Organ donation	d.		
Autopsy request	e.	*NONE OF ABOVE*	i.

SECTION B. COGNITIVE PATTERNS

1. COMATOSE (*Persistent vegetative state/no discernible consciousness*) 0. No 1. Yes **(If yes, skip to Section G)**

2. MEMORY (*Recall of what was learned or known*)
a. Short-term memory OK—seems/appears to recall after 5 minutes 0. Memory OK 1. Memory problem
b. Long-term memory OK—seems/appears to recall long past 0. Memory OK 1. Memory problem

3. MEMORY/ RECALL ABILITY (*Check all that resident was normally able to recall during last 7 days*)

Current season	a.	That he/she is in a nursing home	d.
Location of own room	b.		
Staff names/faces	c.	*NONE OF ABOVE* are recalled	e.

4. COGNITIVE SKILLS FOR DAILY DECISION-MAKING (*Made decisions regarding tasks of daily life*)
0. *INDEPENDENT*—decisions consistent/reasonable
1. *MODIFIED INDEPENDENCE*—some difficulty in new situations only
2. *MODERATELY IMPAIRED*—decisions poor; cues/supervision required
3. *SEVERELY IMPAIRED*—never/rarely made decisions

5. INDICATORS OF DELIRIUM—PERIODIC DISORDERED THINKING/ AWARENESS (*Code for behavior in the last 7 days.*) [*Note: Accurate assessment requires conversations with staff and family who have direct knowledge of resident's behavior over this time.*]
0. Behavior not present
1. Behavior present, not of recent onset
2. Behavior present, over last 7 days appears different from resident's usual functioning (e.g., new onset or worsening)

a. EASILY DISTRACTED—(e.g., difficulty paying attention; gets sidetracked)
b. PERIODS OF ALTERED PERCEPTION OR AWARENESS OF SURROUNDINGS—(e.g., moves lips or talks to someone not present; believes he/she is somewhere else; confuses night and day)
c. EPISODES OF DISORGANIZED SPEECH—(e.g., speech is incoherent, nonsensical, irrelevant, or rambling from subject to subject; loses train of thought)
d. PERIODS OF RESTLESSNESS—(e.g., fidgeting or picking at skin, clothing, napkins, etc; frequent position changes; repetitive physical movements or calling out)
e. PERIODS OF LETHARGY—(e.g., sluggishness; staring into space; difficult to arouse; little body movement)
f. MENTAL FUNCTION VARIES OVER THE COURSE OF THE DAY—(e.g., sometimes better, sometimes worse; behaviors sometimes present, sometimes not)

6. CHANGE IN COGNITIVE STATUS Resident's cognitive status, skills, or abilities have changed as compared to status of **90 days ago** (or since last assessment if less than 90 days) 0. No change 1. Improved 2. Deteriorated

SECTION C. COMMUNICATION/HEARING PATTERNS

1. HEARING (*With hearing appliance, if used*)
0. *HEARS ADEQUATELY*—normal talk, TV, phone
1. *MINIMAL DIFFICULTY* when not in quiet setting
2. *HEARS IN SPECIAL SITUATIONS ONLY*—speaker has to adjust tonal quality and speak distinctly
3. *HIGHLY IMPAIRED* absence of useful hearing

2. COMMUNICATION DEVICES/ TECHNIQUES (*Check all that apply during last 7 days*)

Hearing aid, present and used		a.
Hearing aid, present and not used regularly		b.
Other receptive comm. techniques used (e.g., lip reading)		c.
NONE OF ABOVE		d.

3. MODES OF EXPRESSION (*Check all used by resident to make needs known*)

Speech	a.	Signs/gestures/sounds	d.
Writing messages to express or clarify needs	b.	Communication board	e.
American sign language or Braille	c.	Other	f.
		NONE OF ABOVE	g.

4. MAKING SELF UNDERSTOOD (*Expressing information content—however able*)
0. *UNDERSTOOD*
1. *USUALLY UNDERSTOOD*—difficulty finding words or finishing thoughts
2. *SOMETIMES UNDERSTOOD*—ability is limited to making concrete requests
3. *RARELY/NEVER UNDERSTOOD*

5. SPEECH CLARITY (*Code for speech in the last 7 days*)
0. *CLEAR SPEECH*—distinct, intelligible words
1. *UNCLEAR SPEECH*—slurred, mumbled words
2. *NO SPEECH*—absence of spoken words

6. ABILITY TO UNDERSTAND OTHERS (*Understanding verbal information content—however able*)
0. *UNDERSTANDS*
1. *USUALLY UNDERSTANDS*—may miss some part/intent of message
2. *SOMETIMES UNDERSTANDS*—responds adequately to simple, direct communication
3. *RARELY/NEVER UNDERSTANDS*

7. CHANGE IN COMMUNICATION/ HEARING Resident's ability to express, understand, or hear information has changed as compared to status of **90 days ago** (or since last assessment if less than 90 days) 0. No change 1. Improved 2. Deteriorated

☐ = When box blank, must enter number or letter [a.] = When letter in box, check if condition applies

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SECTION D. VISION PATTERNS

1.	VISION	(*Ability to see in adequate light and with glasses if used*) 0. *ADEQUATE*—sees fine detail, including regular print in newspapers/books 1. *IMPAIRED*—sees large print, but not regular print in newspapers/books 2. *MODERATELY IMPAIRED*—limited vision; not able to see newspaper headlines, but can identify objects 3. *HIGHLY IMPAIRED*—object identification in question, but eyes appear to follow objects 4. *SEVERELY IMPAIRED*—no vision or sees only light, colors, or shapes; eyes do not appear to follow objects	
2.	VISUAL LIMITATIONS/ DIFFICULTIES	Side vision problems—decreased peripheral vision (e.g., leaves food on one side of tray, difficulty traveling, bumps into people and objects, misjudges placement of chair when seating self)	a.
		Experiences any of following: sees halos or rings around lights; sees flashes of light; sees "curtains" over eyes	b.
		NONE OF ABOVE	c.
3.	VISUAL APPLIANCES	Glasses; contact lenses; magnifying glass 0. No 1. Yes	

SECTION E. MOOD AND BEHAVIOR PATTERNS

1.	INDICATORS OF DEPRESSION, ANXIETY, SAD MOOD	(*Code for indicators observed in last 30 days, irrespective of the assumed cause*) 0. Indicator not exhibited in last 30 days 1. Indicator of this type exhibited up to five days a week 2. Indicator of this type exhibited daily or almost daily (6, 7 days a week)	
		VERBAL EXPRESSIONS OF DISTRESS	
		a. Resident made negative statements—e.g., "*Nothing matters; Would rather be dead; What's the use; Regrets having lived so long; Let me die*"	
		b. Repetitive questions—e.g., "*Where do I go; What do I do?*"	
		c. Repetitive verbalizations—e.g., calling out for help. ("*God help me*")	
		d. Persistent anger with self or others—e.g., easily annoyed, anger at placement in nursing home; anger at care received	
		e. Self deprecation—e.g., "*I am nothing; I am of no use to anyone*"	
		f. Expressions of what appear to be unrealistic fears—e.g., fear of being abandoned, left alone, being with others	
		g. Recurrent statements that something terrible is about to happen—e.g., believes he or she is about to die, have a heart attack	
		h. Repetitive health complaints—e.g., persistently seeks medical attention, obsessive concern with body functions	
		i. Repetitive anxious complaints/concerns (non-health related) e.g., persistently seeks attention/reassurance regarding schedules, meals, laundry, clothing, relationship issues	
		SLEEP-CYCLE ISSUES	
		j. Unpleasant mood in morning	
		k. Insomnia/change in usual sleep pattern	
		SAD, APATHETIC, ANXIOUS APPEARANCE	
		l. Sad, pained, worried facial expressions—e.g., furrowed brows	
		m. Crying, tearfulness	
		n. Repetitive physical movements—e.g., pacing, hand wringing, restlessness, fidgeting, picking	
		LOSS OF INTEREST	
		o. Withdrawal from activities of interest—e.g., no interest in long standing activities or being with family/friends	
		p. Reduced social interaction	
2.	MOOD PERSISTENCE	One or more indicators of depressed, sad or anxious mood **were not easily altered by attempts to "cheer up", console, or reassure the resident over last 7 days** 0. No mood indicators 1. Indicators present, easily altered 2. Indicators present, not easily altered	
3.	CHANGE IN MOOD	Resident's mood status has changed as compared to status of **90 days ago** (or since last assessment if less than 90 days) 0. No change 1. Improved 2. Deteriorated	
4.	BEHAVIORAL SYMPTOMS	**(A)** *Behavioral symptom frequency in last 7 days* 0. Behavior not exhibited in last 7 days 1. Behavior of this type occurred 1 to 3 days in last 7 days 2. Behavior of this type occurred 4 to 6 days, but less than daily 3. Behavior of this type occurred daily **(B)** *Behavioral symptom alterability in last 7 days* 0. Behavior not present OR behavior was easily altered 1. Behavior was not easily altered	(A) (B)
		a. WANDERING (moved with no rational purpose, seemingly oblivious to needs or safety)	
		b. VERBALLY ABUSIVE BEHAVIORAL SYMPTOMS (others were threatened, screamed at, cursed at)	
		c. PHYSICALLY ABUSIVE BEHAVIORAL SYMPTOMS (others were hit, shoved, scratched, sexually abused)	
		d. SOCIALLY INAPPROPRIATE/DISRUPTIVE BEHAVIORAL SYMPTOMS (made disruptive sounds, noisiness, screaming, self-abusive acts, sexual behavior or disrobing in public, smeared/threw food/feces, hoarding, rummaged through others' belongings)	
		e. RESISTS CARE (resisted taking medications/ injections, ADL assistance, or eating)	

5.	CHANGE IN BEHAVIORAL SYMPTOMS	Resident's behavior status has changed as compared to **status of 90 days ago** (or since last assessment if less than 90 days) 0. No change 1. Improved 2. Deteriorated	

SECTION F. PSYCHOSOCIAL WELL-BEING

1.	SENSE OF INITIATIVE/ INVOLVEMENT	At ease interacting with others	a.
		At ease doing planned or structured activities	b.
		At ease doing self-initiated activities	c.
		Establishes own goals	d.
		Pursues involvement in life of facility (e.g., makes/keeps friends; involved in group activities; responds positively to new activities; assists at religious services)	e.
		Accepts invitations into most group activities	f.
		NONE OF ABOVE	g.
2.	UNSETTLED RELATIONSHIPS	Covert/open conflict with or repeated criticism of staff	a.
		Unhappy with roommate	b.
		Unhappy with residents other than roommate	c.
		Openly expresses conflict/anger with family/friends	d.
		Absence of personal contact with family/friends	e.
		Recent loss of close family member/friend	f.
		Does not adjust easily to change in routines	g.
		NONE OF ABOVE	h.
3.	PAST ROLES	Strong identification with past roles and life status	a.
		Expresses sadness/anger/empty feeling over lost roles/status	b.
		Resident perceives that daily routine (customary routine, activities) is very different from prior pattern in the community	c.
		NONE OF ABOVE	d.

SECTION G. PHYSICAL FUNCTIONING AND STRUCTURAL PROBLEMS

1. (A) ADL SELF-PERFORMANCE—(*Code for resident's PERFORMANCE OVER ALL SHIFTS during last 7 days—Not including setup*)
   0. *INDEPENDENT*—No help or oversight —OR— Help/oversight provided only 1 or 2 times during last 7 days
   1. SUPERVISION—Oversight, encouragement or cueing provided 3 or more times during last7 days —OR— Supervision (3 or more times) plus physical assistance provided only 1 or 2 times during last 7 days
   2. *LIMITED ASSISTANCE*—Resident highly involved in activity; received physical help in guided maneuvering of limbs or other nonweight bearing assistance 3 or more times —OR—More help provided only 1 or 2 times during last 7 days
   3. *EXTENSIVE ASSISTANCE*—While resident performed part of activity, over last 7-day period, help of following type(s) provided 3 or more times:
      — Weight-bearing support
      — Full staff performance during part (but not all) of last 7 days
   4. *TOTAL DEPENDENCE*—Full staff performance of activity during entire 7 days
   8. *ACTIVITY DID NOT OCCUR* during entire 7 days

(B) ADL SUPPORT PROVIDED—(*Code for MOST SUPPORT PROVIDED OVER ALL SHIFTS during last 7 days; code regardless of resident's self-performance classification*)

0. No setup or physical help from staff
1. Setup help only
2. One person physical assist
3. Two+ persons physical assist
8. ADL activity itself did not occur during entire 7 days

			(A) SELF-PERF	(B) SUPPORT
a.	BED MOBILITY	How resident moves to and from lying position, turns side to side, and positions body while in bed		
b.	TRANSFER	How resident moves between surfaces—to/from: bed, chair, wheelchair, standing position (EXCLUDE to/from bath/toilet)		
c.	WALK IN ROOM	How resident walks between locations in his/her room		
d.	WALK IN CORRIDOR	How resident walks in corridor on unit		
e.	LOCOMOTION ON UNIT	How resident moves between locations in his/her room and adjacent corridor on same floor. If in wheelchair, self-sufficiency once in chair		
f.	LOCOMOTION OFF UNIT	How resident moves to and returns from off unit locations (e.g., areas set aside for dining, activities, or treatments). If **facility has only one floor**, how resident moves to and from distant areas on the floor. If in wheelchair, self-sufficiency once in chair		
g.	DRESSING	How resident puts on, fastens, and takes off all items of **street clothing**, including donning/removing prosthesis		
h.	EATING	How resident eats and drinks (regardless of skill). Includes intake of nourishment by other means (e.g., tube feeding, total parenteral nutrition)		
i.	TOILET USE	How resident uses the toilet room (or commode, bedpan, urinal); transfer on/off toilet, cleanses, changes pad, manages ostomy or catheter, adjusts clothes		
j.	PERSONAL HYGIENE	How resident maintains personal hygiene, including combing hair, brushing teeth, shaving, applying makeup, washing/drying face, hands, and perineum (EXCLUDE baths and showers)		

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2.	BATHING	How resident takes full-body bath/shower, sponge bath, and transfers in/out of tub/shower (EXCLUDE washing of back and hair.) *Code for most dependent in self-performance and support.* (A) BATHING SELF-PERFORMANCE codes appear below	(A)	(B)
		0. Independent—No help provided		
		1. Supervision—Oversight help only		
		2. Physical help limited to transfer only		
		3. Physical help in part of bathing activity		
		4. Total dependence		
		8. Activity itself did not occur during entire 7 days *(Bathing support codes are as defined in item 1, code B above)*		
3.	TEST FOR BALANCE (see training manual)	*(Code for ability during test in the last 7 days)* 0. Maintained position as required in test 1. Unsteady, but able to rebalance self without physical support 2. Partial physical support during test; or stands (sits) but does not follow directions for test 3. Not able to attempt test without physical help		
		a. Balance while standing		
		b. Balance while sitting—position, trunk control		
4.	FUNCTIONAL LIMITATION IN RANGE OF MOTION (see training manual)	*(Code for limitations during last 7 days that interfered with daily functions or placed resident at risk of injury)* (A) *RANGE OF MOTION* 0. No limitation 1. Limitation on one side 2. Limitation on both sides (B) *VOLUNTARY MOVEMENT* 0. No loss 1. Partial loss 2. Full loss	(A)	(B)
		a. Neck		
		b. Arm—Including shoulder or elbow		
		c. Hand—Including wrist or fingers		
		d. Leg—Including hip or knee		
		e. Foot—Including ankle or toes		
		f. Other limitation or loss		
5.	MODES OF LOCOMOTION	*(Check all that apply during last 7 days)* Cane/walker/crutch (a.); Wheeled self (b.); Other person wheeled (c.); Wheelchair primary mode of locomotion (d.); *NONE OF ABOVE* (e.)		
6.	MODES OF TRANSFER	*(Check all that apply during last 7 days)* Bedfast all or most of time (a.); Bed rails used for bed mobility or transfer (b.); Lifted manually (c.); Lifted mechanically (d.); Transfer aid (e.g., slide board, trapeze, cane, walker, brace) (e.); *NONE OF ABOVE* (f.)		
7.	TASK SEGMENTATION	Some or all of ADL activities were broken into subtasks during **last 7 days** so that resident could perform them 0. No 1. Yes		
8.	ADL FUNCTIONAL REHABILITATION POTENTIAL	Resident believes he/she is capable of increased independence in at least some ADLs (a.); Direct care staff believe resident is capable of increased independence in at least some ADLs (b.); Resident able to perform tasks/activity but is very slow (c.); Difference in ADL Self-Performance or ADL Support, comparing mornings to evenings (d.); *NONE OF ABOVE* (e.)		
9.	CHANGE IN ADL FUNCTION	Resident's ADL self-performance status has changed as compared to status of **90 days ago** (or since last assessment if less than 90 days) 0. No change 1. Improved 2. Deteriorated		

SECTION H. CONTINENCE IN LAST 14 DAYS

1.	CONTINENCE SELF-CONTROL CATEGORIES *(Code for resident's PERFORMANCE OVER ALL SHIFTS)* 0. *CONTINENT*—Complete control *[includes use of indwelling urinary catheter or ostomy device that does not leak urine or stool]* 1. *USUALLY CONTINENT*—BLADDER, incontinent episodes once a week or less; BOWEL, less than weekly 2. *OCCASIONALLY INCONTINENT*—BLADDER, 2 or more times a week but not daily; BOWEL, once a week 3. *FREQUENTLY INCONTINENT*—BLADDER, tended to be incontinent daily, but some control present (e.g., on day shift); BOWEL, 2-3 times a week 4. *INCONTINENT*—Had inadequate control BLADDER, multiple daily episodes; BOWEL, all (or almost all) of the time		
a.	BOWEL CONTINENCE	Control of bowel movement, with appliance or bowel continence programs, if employed		
b.	BLADDER CONTINENCE	Control of urinary bladder function (if dribbles, volume insufficient to soak through underpants), with appliances (e.g., foley) or continence programs, if employed		
2.	BOWEL ELIMINATION PATTERN	Bowel elimination pattern regular—at least one movement every three days (a.); Constipation (b.); Diarrhea (c.); Fecal impaction (d.); *NONE OF ABOVE* (e.)		

3.	APPLIANCES AND PROGRAMS	Any scheduled toileting plan	a.	Did not use toilet room/ commode/urinal f.
		Bladder retraining program	b.	Pads/briefs used g.
		External (condom) catheter	c.	Enemas/irrigation h.
		Indwelling catheter	d.	Ostomy present i.
		Intermittent catheter	e.	*NONE OF ABOVE* j.
4.	CHANGE IN URINARY CONTINENCE	Resident's urinary continence has changed as compared to status of **90 days ago** (or since last assessment if less than 90 days) 0. No change 1. Improved 2. Deteriorated		

SECTION I. DISEASE DIAGNOSES

Check only those diseases that have a relationship to current ADL status, cognitive status, mood and behavior status, medical treatments, nursing monitoring, or risk of death. (Do not list inactive diagnoses)

1.	DISEASES	*(If none apply, CHECK the NONE OF ABOVE box)*		
		ENDOCRINE/METABOLIC/ NUTRITIONAL		Hemiplegia/Hemiparesis v.
		Diabetes mellitus	a.	Multiple sclerosis w.
		Hyperthyroidism	b.	Paraplegia x.
		Hypothyroidism	c.	Parkinson's disease y.
		HEART/CIRCULATION		Quadriplegia z.
		Arteriosclerotic heart disease (ASHD)	d.	Seizure disorder aa.
		Cardiac dysrhythmias	e.	Transient ischemic attack (TIA) bb.
		Congestive heart failure	f.	Traumatic brain injury cc.
		Deep vein thrombosis	g.	**PSYCHIATRIC/MOOD**
		Hypertension	h.	Anxiety disorder dd.
		Hypotension	i.	Depression ee.
		Peripheral vascular disease	j.	Manic depression (bipolar disease) ff.
		Other cardiovascular disease	k.	Schizophrenia gg.
		MUSCULOSKELETAL		**PULMONARY**
		Arthritis	l.	Asthma hh.
		Hip fracture	m.	Emphysema/COPD ii.
		Missing limb (e.g., amputation)	n.	**SENSORY**
		Osteoporosis	o.	Cataracts jj.
		Pathological bone fracture	p.	Diabetic retinopathy kk.
		NEUROLOGICAL		Glaucoma ll.
		Alzheimer's disease	q.	Macular degeneration mm.
		Aphasia	r.	**OTHER**
		Cerebral palsy	s.	Allergies nn.
		Cerebrovascular accident (stroke)	t.	Anemia oo.
		Dementia other than Alzheimer's disease	u.	Cancer pp.
				Renal failure qq.
				NONE OF ABOVE rr.
2.	INFECTIONS	*(If none apply, CHECK the NONE OF ABOVE box)*		
		Antibiotic resistant infection (e.g., Methicillin resistant staph)	a.	Septicemia g.
		Clostridium difficile (c. diff.)	b.	Sexually transmitted diseases h.
		Conjunctivitis	c.	Tuberculosis i.
		HIV infection	d.	Urinary tract infection **in last 30 days** j.
		Pneumonia	e.	Viral hepatitis k.
		Respiratory infection	f.	Wound infection l.
				NONE OF ABOVE m.
3.	OTHER CURRENT OR MORE DETAILED DIAGNOSES AND ICD-9 CODES	a. _____ .		
		b. _____ .		
		c. _____ .		
		d. _____ .		
		e. _____ .		

SECTION J. HEALTH CONDITIONS

1.	PROBLEM CONDITIONS	*(Check all problems present in last 7 days unless other time frame is indicated)*		
		INDICATORS OF FLUID STATUS		Dizziness/Vertigo f.
		Weight gain or loss of 3 or more pounds within a 7 day period	a.	Edema g.
		Inability to lie flat due to shortness of breath	b.	Fever h.
		Dehydrated: output exceeds input	c.	Hallucinations i.
		Insufficient fluid; did **NOT** consume all/almost all liquids provided during **last 3 days**	d.	Internal bleeding j.
		OTHER		Recurrent lung aspirations in **last 90 days** k.
		Delusions	e.	Shortness of breath l.
				Syncope (fainting) m.
				Unsteady gait n.
				Vomiting o.
				NONE OF ABOVE p.

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2.	PAIN SYMPTOMS	*(Code the highest level of pain present in the last 7 days)*		
		a. **FREQUENCY** with which resident complains or shows evidence of pain 0. No pain (*skip to J4*) 1. Pain less than daily 2. Pain daily	b. **INTENSITY** of pain 1. Mild pain 2. Moderate pain 3. Times when pain is horrible or excruciating	
3.	PAIN SITE	*(If pain present, check all sites that apply in last 7 days)*		
		Back pain	a.	
		Bone pain	b.	
		Chest pain while doing usual activities	c.	
		Headache	d.	
		Hip pain	e.	
		Incisional pain	f.	
		Joint pain (other than hip)	g.	
		Soft tissue pain (e.g., lesion, muscle)	h.	
		Stomach pain	i.	
		Other	j.	
4.	ACCIDENTS	*(Check all that apply)*		
		Fell in **past 30 days**	a.	
		Fell in **past 31-180 days**	b.	
		Hip fracture in **last 180 days**	c.	
		Other fracture in **last 180 days**	d.	
		NONE OF ABOVE	e.	
5.	STABILITY OF CONDITIONS	Conditions/diseases make resident's cognitive, ADL, mood or behavior patterns unstable—(fluctuating, precarious, or deteriorating)		a.
		Resident experiencing an acute episode or a flare-up of a recurrent or chronic problem		b.
		End-stage disease, 6 or fewer months to live		c.
		NONE OF ABOVE		d.

SECTION K. ORAL/NUTRITIONAL STATUS

1.	ORAL PROBLEMS	Chewing problem		a.
		Swallowing problem		b.
		Mouth pain		c.
		NONE OF ABOVE		d.
2.	HEIGHT AND WEIGHT	*Record (a.) height in inches and (b.) weight in pounds. Base weight on most recent measure in last 30 days; measure weight consistently in accord with standard facility practice—e.g., in a.m. after voiding, before meal, with shoes off, and in nightclothes* a. HT (in.) b. WT (lb.)		
3.	WEIGHT CHANGE	a. **Weight loss**—5 % or more in **last 30 days**; or 10 % or more in **last 180 days** 0. No 1. Yes		
		b. **Weight gain**—5 % or more in **last 30 days**; or 10 % or more in **last 180 days** 0. No 1. Yes		
4.	NUTRITIONAL PROBLEMS	Complains about the taste of many foods	a.	
		Regular or repetitive complaints of hunger	b.	
		Leaves 25% or more of food uneaten at most meals		c.
		NONE OF ABOVE		d.
5.	NUTRITIONAL APPROACHES	*(Check all that apply in last 7 days)*		
		Parenteral/IV	a.	
		Feeding tube	b.	
		Mechanically altered diet	c.	
		Syringe (oral feeding)	d.	
		Therapeutic diet	e.	
		Dietary supplement between meals		f.
		Plate guard, stabilized built-up utensil, etc.		g.
		On a planned weight change program		h.
		NONE OF ABOVE		i.
6.	PARENTERAL OR ENTERAL INTAKE	*(Skip to Section L if neither 5a nor 5b is checked)*		
		a. Code the proportion of **total calories** the resident received through parenteral or tube feedings in the **last 7 days** 0. None 3. 51% to 75% 1. 1% to 25% 4. 76% to 100% 2. 26% to 50%		
		b. Code the average **fluid intake** per day by IV or tube in **last 7 days** 0. None 3. 1001 to 1500 cc/day 1. 1 to 500 cc/day 4. 1501 to 2000 cc/day 2. 501 to 1000 cc/day 5. 2001 or more cc/day		

SECTION L. ORAL/DENTAL STATUS

1.	ORAL STATUS AND DISEASE PREVENTION	Debris (soft, easily movable substances) present in mouth prior to going to bed at night		a.
		Has dentures or removable bridge		b.
		Some/all natural teeth lost—does not have or does not use dentures (or partial plates)		c.
		Broken, loose, or carious teeth		d.
		Inflamed gums (gingiva); swollen or bleeding gums; oral abscesses; ulcers or rashes		e.
		Daily cleaning of teeth/dentures or daily mouth care—by resident or staff		f.
		NONE OF ABOVE		g.

SECTION M. SKIN CONDITION

				Number at Stage
1.	ULCERS (Due to any cause)	*(Record the number of ulcers at each ulcer stage—regardless of cause. If none present at a stage, record "0" (zero). Code all that apply during last 7 days. Code 9 = 3 or more.) [Requires full body exam.]*		
		a. Stage 1. A persistent area of skin redness (without a break in the skin) that does not disappear when pressure is relieved.		
		b. Stage 2. A partial thickness loss of skin layers that presents clinically as an abrasion, blister, or shallow crater.		
		c. Stage 3. A full thickness of skin is lost, exposing the subcutaneous tissues - presents as a deep crater with or without undermining adjacent tissue.		
		d. Stage 4. A full thickness of skin and subcutaneous tissue is lost, exposing muscle or bone.		
2.	TYPE OF ULCER	*(For each type of ulcer, code for the highest stage in the last 7 days using scale in item M1—i.e., 0=none; stages 1, 2, 3, 4)*		
		a. Pressure ulcer—any lesion caused by pressure resulting in damage of underlying tissue		
		b. Stasis ulcer—open lesion caused by poor circulation in the lower extremities		
3.	HISTORY OF RESOLVED ULCERS	Resident had an ulcer that was resolved or cured in **LAST 90 DAYS** 0. No 1. Yes		
4.	OTHER SKIN PROBLEMS OR LESIONS PRESENT	*(Check all that apply during last 7 days)*		
		Abrasions, bruises		a.
		Burns (second or third degree)		b.
		Open lesions other than ulcers, rashes, cuts (e.g., cancer lesions)		c.
		Rashes—e.g., intertrigo, eczema, drug rash, heat rash, herpes zoster		d.
		Skin desensitized to pain or pressure		e.
		Skin tears or cuts (other than surgery)		f.
		Surgical wounds		g.
		NONE OF ABOVE		h.
5.	SKIN TREATMENTS	*(Check all that apply during last 7 days)*		
		Pressure relieving device(s) for chair		a.
		Pressure relieving device(s) for bed		b.
		Turning/repositioning program		c.
		Nutrition or hydration intervention to manage skin problems		d.
		Ulcer care		e.
		Surgical wound care		f.
		Application of dressings (with or without topical medications) other than to feet		g.
		Application of ointments/medications (other than to feet)		h.
		Other preventative or protective skin care (other than to feet)		i.
		NONE OF ABOVE		j.
6.	FOOT PROBLEMS AND CARE	*(Check all that apply during last 7 days)*		
		Resident has one or more foot problems—e.g., corns, calluses, bunions, hammer toes, overlapping toes, pain, structural problems		a.
		Infection of the foot—e.g., cellulitis, purulent drainage		b.
		Open lesions on the foot		c.
		Nails/calluses trimmed during **last 90 days**		d.
		Received preventative or protective foot care (e.g., used special shoes, inserts, pads, toe separators)		e.
		Application of dressings (with or without topical medications)		f.
		NONE OF ABOVE		g.

SECTION N. ACTIVITY PURSUIT PATTERNS

1.	TIME AWAKE	*(Check appropriate time periods over last 7 days)* Resident awake all or most of time (i.e., naps no more than one hour per time period) in the:		
		Morning	a.	
		Evening		c.
		Afternoon	b.	
		NONE OF ABOVE		d.
(If resident is comatose, skip to Section O)				
2.	AVERAGE TIME INVOLVED IN ACTIVITIES	**(When awake and not receiving treatments or ADL care)** 0. Most—more than 2/3 of time 2. Little—less than 1/3 of time 1. Some—from 1/3 to 2/3 of time 3. None		
3.	PREFERRED ACTIVITY SETTINGS	*(Check all settings in which activities are preferred)*		
		Own room	a.	
		Day/activity room	b.	
		Inside NH/off unit	c.	
		Outside facility		d.
		NONE OF ABOVE		e.
4.	GENERAL ACTIVITY PREFERENCES (adapted to resident's current abilities)	*(Check all PREFERENCES whether or not activity is currently available to resident)*		
		Cards/other games	a.	
		Crafts/arts	b.	
		Exercise/sports	c.	
		Music	d.	
		Reading/writing	e.	
		Spiritual/religious activities	f.	
		Trips/shopping		g.
		Walking/wheeling outdoors		h.
		Watching TV		i.
		Gardening or plants		j.
		Talking or conversing		k.
		Helping others		l.
		NONE OF ABOVE		m.

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5.	PREFERS CHANGE IN DAILY ROUTINE	*Code for resident preferences in daily routines* 0. No change 1. Slight change 2. Major change	
		a. Type of activities in which resident is currently involved	
		b. Extent of resident involvement in activities	

SECTION O. MEDICATIONS

1.	NUMBER OF MEDICATIONS	(*Record the number of different medications used in the last 7 days; enter "0" if none used*)	
2.	NEW MEDICATIONS	(*Resident currently receiving medications that were initiated during the last 90 days*) 0. No 1. Yes	
3.	INJECTIONS	(*Record the number of DAYS injections of any type received during the last 7 days; enter "0" if none used*)	
4.	DAYS RECEIVED THE FOLLOWING MEDICATION	(*Record the number of DAYS during last 7 days; enter "0" if not used. Note—enter "1" for long-acting meds used less than weekly*) a. Antipsychotic b. Antianxiety c. Antidepressant d. Hypnotic e. Diuretic	

SECTION P. SPECIAL TREATMENTS AND PROCEDURES

1.	SPECIAL TREATMENTS, PROCEDURES, AND PROGRAMS	a. SPECIAL CARE—*Check treatments or programs received during the last 14 days*	
		TREATMENTS Chemotherapy Dialysis IV medication Intake/output Monitoring acute medical condition Ostomy care Oxygen therapy Radiation Suctioning Tracheostomy care Transfusions	Ventilator or respirator (t.) **PROGRAMS** a. Alcohol/drug treatment program (m.) b. Alzheimer's/dementia special care unit (n.) c. Hospice care (o.) d. Pediatric unit (p.) e. Respite care (q.) f. Training in skills required to return to the community (e.g., taking medications, house work, shopping, transportation, ADLs) (r.) g. *NONE OF ABOVE* (s.)
		b. **THERAPIES** - *Record the number of days and total minutes each of the following therapies was administered (for at least 15 minutes a day) in the last 7 calendar days (Enter 0 if none or less than 15 min. daily)* **[Note—count only post admission therapies]** **(A) = # of days** administered for **15 minutes or more** **(B) = total # of minutes** provided in **last 7 days**	DAYS (A) / MIN (B)
		a. Speech - language pathology and audiology services	
		b. Occupational therapy	
		c. Physical therapy	
		d. Respiratory therapy	
		e. Psychological therapy (by any licensed mental health professional)	
2.	INTERVENTION PROGRAMS FOR MOOD, BEHAVIOR, COGNITIVE LOSS	(**Check all interventions or strategies used in last 7 days**—no matter where received)	
		Special behavior symptom evaluation program	a.
		Evaluation by a licensed mental health specialist in **last 90 days**	b.
		Group therapy	c.
		Resident-specific deliberate changes in the environment to address mood/behavior patterns—e.g., providing bureau in which to rummage	d.
		Reorientation—e.g., cueing	e.
		NONE OF ABOVE	f.
3.	NURSING REHABILITATION/ RESTORATIVE CARE	*Record the NUMBER OF DAYS each of the following rehabilitation or restorative techniques or practices was provided to the resident for more than or equal to 15 minutes per day in the last 7 days (Enter 0 if none or less than 15 min. daily.)*	
		a. Range of motion (passive) b. Range of motion (active) c. Splint or brace assistance **TRAINING AND SKILL PRACTICE IN:** d. Bed mobility e. Transfer f. Walking g. Dressing or grooming h. Eating or swallowing i. Amputation/prosthesis care j. Communication k. Other	

4.	DEVICES AND RESTRAINTS	(*Use the following codes for last 7 days.*) 0. Not used 1. Used less than daily 2. Used daily	
		Bed rails a. — Full bed rails on all open sides of bed b. — Other types of side rails used (e.g., half rail, one side) c. Trunk restraint d. Limb restraint e. Chair prevents rising	
5.	HOSPITAL STAY(S)	Record number of times resident was admitted to hospital with an overnight stay **in last 90 days** (or since last assessment if less than 90 days). (*Enter 0 if no hospital admissions*)	
6.	EMERGENCY ROOM (ER) VISIT(S)	Record number of times resident visited ER without an overnight stay **in last 90 days** (or since last assessment if less than 90 days). (*Enter 0 if no ER visits*)	
7.	PHYSICIAN VISITS	In the **LAST 14 DAYS** (or since admission if less than 14 days in facility) how many days has the physician (or authorized assistant or practitioner) examined the resident? (*Enter 0 if none*)	
8.	PHYSICIAN ORDERS	In the **LAST 14 DAYS** (or since admission if less than 14 days in facility) how many days has the physician (or authorized assistant or practitioner) changed the resident's orders? *Do not include order renewals without change.* (*Enter 0 if none*)	
9.	ABNORMAL LAB VALUES	Has the resident had any abnormal lab values during the **last 90 days** (or since admission)? 0. No 1. Yes	

SECTION Q. DISCHARGE POTENTIAL AND OVERALL STATUS

1.	DISCHARGE POTENTIAL	a. Resident expresses/indicates preference to return to the community 0. No 1. Yes	
		b. Resident has a support person who is positive towards discharge 0. No 1. Yes	
		c. Stay projected to be of a short duration— discharge projected **within 90 days** (do not include expected discharge due to death) 0. No 2. Within 31-90 days 1. Within 30 days 3. Discharge status uncertain	
2.	OVERALL CHANGE IN CARE NEEDS	Resident's overall self sufficiency has changed significantly as compared to status of **90 days ago** (or since last assessment if less than 90 days) 0. No change 1. Improved—receives fewer supports, needs less restrictive level of care 2. Deteriorated—receives more support	

SECTION R. ASSESSMENT INFORMATION

1.	PARTICIPATION IN ASSESSMENT	a. Resident: 0. No 1. Yes b. Family: 0. No 1. Yes 2. No family c. Significant other: 0. No 1. Yes 2. None	
2.	SIGNATURES OF PERSONS COMPLETING THE ASSESSMENT:		
		a. Signature of RN Assessment Coordinator (sign on above line)	
		b. Date RN Assessment Coordinator signed as complete — Month — Day — Year	
		c. Other Signatures — Title — Sections — Date	
		d. — Date	
		e. — Date	
		f. — Date	
		g. — Date	
		h. — Date	

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SECTION T. THERAPY SUPPLEMENT FOR MEDICARE PPS

1. SPECIAL TREATMENTS AND PROCEDURES

a. **RECREATION THERAPY**—*Enter number of days and total minutes of recreation therapy administered (**for at least 15 minutes a day**) in the **last 7 days** (Enter 0 if none)*

	DAYS (A)	MIN (B)
(A) = **# of days** administered for 15 minutes or more		
(B) = **total # of minutes** provided in last 7 days		

Skip unless this is a Medicare 5 day or Medicare readmission/return assessment.

b. **ORDERED THERAPIES**—*Has physician ordered any of following therapies to begin in FIRST 14 days of stay—physical therapy, occupational therapy, or speech pathology service?*
0. No 1. Yes

If not ordered, skip to item 2

c. Through day 15, provide an estimate of the number of days when at least 1 therapy service can be expected to have been delivered.

d. Through day 15, provide an estimate of the number of therapy minutes (across the therapies) that can be expected to be delivered?

2. WALKING WHEN MOST SELF SUFFICIENT

Complete item 2 if **ADL self-performance score for TRANSFER** (***G.1.b.A*) *is 0,1,2, or 3 AND at least one of the following are present:***

- Resident received physical therapy involving gait training (P.1.b.c)
- Physical therapy was ordered for the resident involving gait training (T.1.b)
- Resident received nursing rehabilitation for walking (P.3.f)
- Physical therapy involving walking has been discontinued within the past 180 days

Skip to item 3 if resident did not walk in last 7 days

(***FOR FOLLOWING FIVE ITEMS, BASE CODING ON THE EPISODE WHEN THE RESIDENT WALKED THE FARTHEST WITHOUT SITTING DOWN. INCLUDE WALKING DURING REHABILITATION SESSIONS.***)

a. **Furthest distance walked** without sitting down during this episode.

0. 150+ feet
1. 51-149 feet
2. 26-50 feet
3. 10-25 feet
4. Less than 10 feet

b. **Time walked** without sitting down during this episode.

0. 1-2 minutes
1. 3-4 minutes
2. 5-10 minutes
3. 11-15 minutes
4. 16-30 minutes
5. 31+ minutes

c. **Self-Performance in walking** during this episode.

0. *INDEPENDENT*—No help or oversight
1. *SUPERVISION*—Oversight, encouragement or cueing provided
2. *LIMITED ASSISTANCE*—Resident highly involved in walking; received physical help in guided maneuvering of limbs or other nonweight bearing assistance
3. *EXTENSIVE ASSISTANCE*—Resident received weight bearing assistance while walking

d. **Walking support provided** associated with this episode (code regardless of resident's self-performance classification).

0. No setup or physical help from staff
1. Setup help only
2. One person physical assist
3. Two+ persons physical assist

e. **Parallel bars** used by resident in association with this episode.

0. No 1. Yes

3. CASE MIX GROUP

Medicare _____ State _____

APPENDIX C

Agency Comments

In this appendix, we present in full the comments from the Health Care Financing Administration.

DEPARTMENT OF HEALTH & HUMAN SERVICES

Health Care Financing Administration

The Administrator
Washington, D.C. 20201

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OFFICE OF INSPECTOR GENERAL

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Exec Sec

DATE: NOV - 3

TO: June Gibbs Brown
Inspector General

FROM: Michael M. Hash
Acting Administrator

SUBJECT: Office of Inspector General (OIG) Draft Reports: "Nursing Home Resident Assessment, Quality of Care," (OEI-02-99-00040) and "Nursing Home Resident Assessment, Resource Utilization Groups (RUGs)," (OEI-02-99-00041)

Thank you for the opportunity to review and comment on the above-referenced draft reports. Nursing home residents deserve and expect access to safe, quality care. In 1998, the Health Care Financing Administration (HCFA) began an aggressive initiative to promote quality care and to strengthen the enforcement process for the 1.6 million beneficiaries who reside in nursing homes. HCFA now requires States to crack down on nursing homes that repeatedly violate health and safety standards and has strengthened the inspection process to increase its focus on preventing bedsores, malnutrition, and resident abuse. In addition, HCFA has created Nursing Home Compare, a searchable database available at www.medicare.gov, to give consumers access to comparative information about nursing homes, including annual inspection results and the health status of residents. HCFA is taking these actions to make sure that residents get the quality care and safe environment that they deserve.

We have carefully reviewed your two reports on minimum data set (MDS) accuracy, and we agree that both highlight the need for HCFA to integrate the findings into our ongoing training and accuracy improvement efforts. HCFA has always been attentive to matters concerning the accuracy of MDS information, given its uses for the development of care plans, for quality monitoring, payment, consumer and provider feedback, policy development and research. We have dedicated significant resources and have sponsored a variety of projects aimed at monitoring and ensuring the accuracy of MDS information.

We are concerned, however, about the conclusions that might be drawn based on the OIG's comparisons of RUG-III classification of cases between their reviewers and the skilled nursing facility (SNF) staff. We believe that too limited data were analyzed (very

few facilities were paid under the prospective payment system (PPS) at the time of the study) and there were limitations associated with the methodology (recognized in both reports). As noted in our manuals and repeated in our training programs, the MDS is an integral part of the medical record; it is not an abstraction form. The OIG's methodology relies in part on an erroneous interpretation of certain language from HCFA's medical review Program Memoranda (cited on page 10 of the RUG report). While this language was intended to make clear that the MDS is an integral part of the medical record, there is no expectation that all information found in the MDS will be duplicated elsewhere in the medical record, as the OIG's report suggests. Rather the MDS, in conjunction with other clinical documentation, provides a full view of the beneficiary's clinical course in a given time period. Vital information must be obtained from a variety of sources. Therefore, an item-by-item validation of the MDS using other entries in the medical record cannot be assumed. The OIG's interpretation of the language in these Program Memoranda points to the need for HCFA to clarify the subject instructions.

HCFA believes that these are important areas for examination and looks forward to working closely with the OIG in designing a methodology for the next phase of its study of the RUG-III system and MDS accuracy. We appreciate the effort that went into these reports. Our detailed comments on the OIG's recommendations follow.

OIG Recommendation
We recommend that HCFA more clearly define MDS elements, especially Section G.

HCFA Response
We concur. Since the MDS was first implemented, we have made efforts on an as needed, ongoing basis to clarify item definitions and coding instructions. We recognize the need to make Section G, in particular, easier to understand and code. In addition, we are evaluating a new coding methodology for capturing activities of daily living (ADL) information, for possible implementation with version 3.0 of the MDS.

OIG Recommendation
We recommend that HCFA work with the nursing home industry to provide enhanced and coordinated training to nursing homes to be sure that similar and accurate information about the MDS and RUG is being disseminated.

HCFA Response
We concur. HCFA has an ongoing responsibility for the development and dissemination of educational programs and materials that will promote a uniform understanding of MDS requirements and improve the accuracy of MDS information. Some of our projects aimed at monitoring and ensuring the accuracy of MDS information have been carried

out since initial implementation of MDS requirements in 1991. Most recently for example, we provided training and clarification on items in the Activities sections of the MDS (Sections F and N) via a national Satellite Broadcast for Nursing Home Activities surveyors and providers on September 29. We also have additional short- and long-range plans for training that include the following:

- HCFA is planning further national SNF PPS training for early 2001 to update the fiscal intermediaries and providers on changes in the payment system and clarify existing policy and processes. The use of the MDS and RUG information by providers and medical reviewers will be a significant topic addressed during this training.

- By spring 2001, we plan to develop and release MDS policy and item coding clarifications for areas of the MDS that are considered most confusing and most in need of clarifications, such as Section G. The MDS items addressed will be prioritized based on feedback from a variety of MDS accuracy studies, including those completed by the OIG and Abt Associates, and feedback solicited from the industry via formal requests for comments and focus group meetings. These clarifications will be posted on HCFA's MDS web site. Wide dissemination of these clarifications will provide updated MDS coding information to State agencies and others who train providers. We are also pursuing the possibility of disseminating this information directly to facilities via State MDS information "bulletin boards" that are part of a facility computer interface with States in the MDS submission process.

- We will review clarifications of policy and coding instructions and provide accompanying training materials at HCFA's annual, national resident assessment instrument (RAI) conference in May of 2001. This conference is attended by State and regional office RAI and MDS Automation Coordinators, and representatives of national provider organizations.

- We plan to revise the Long Term Care Resident Assessment Instrument User's Manual for the MDS version 2.0, to incorporate Questions & Answers and clarification information published since the last publication of the User's Manual (October 1995). In addition, the revised manual will include new chapters relative to new policies implemented since 1995, including MDS Automation and Electronic Transmission, SNF PPS and MDS Correction Policy. We will develop and disseminate a draft, revised manual for comments and anticipate that a final manual will be published following a comment period, by the end of calendar year 2001.

- We plan to develop a standard MDS training program, for use by State agencies, fiscal intermediaries, providers and others in MDS training programs to achieve uniformity and consistency in terms of MDS training across the country. We will begin by developing training programs for those areas of the MDS identified as high priorities for clarification, as mentioned above. We hope to be able to expand this training program to cover the entire RAI instrument and process.

In addition, HCFA maintains ongoing communication with State, regional, technical staff and contractors by hosting standing, monthly phone conferences with combined State and regional MDS and RAI Coordinators, and separately with regional office MDS and RAI Coordinators. We also host standing, bimonthly phone conferences with State MDS technical staff, and separately with HCFA's MDS system contractors. Further, communication with providers through their trade organizations is an ongoing activity.

OIG Recommendation

We recommend that HCFA require that nursing homes establish an audit trail to validate the 109 MDS elements that drive the RUG code from other parts of the medical record paying particular attention to therapy minutes and the ADL.

HCFA Response

While we do not concur with this specific approach to validation, future HCFA plans for validating and ensuring the accuracy of the MDS data do include proposed funding of a Program Safeguard Contractor (PSC) to undertake the auditing and verification of MDS reports. Given the importance of MDS data accuracy to the assignment of Medicare SNF patients to appropriate RUG categories, we will begin approaching this verification function from both a data validation and a program integrity perspective. In addition, such an arrangement provides HCFA with a valuable external mechanism to evaluate individual State performance regarding the accuracy of data being reported. Accuracy protocols will be provided to the PSC for implementation in 2001.

Attachment