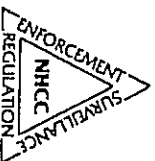


**Modifying RUGs:
Responding to Consumer Concerns
in New York State**

by Cynthia Rudder, Ph.D.

Director

*Nursing Home Community Coalition
of New York State*



Funding for this project provided by:

**The Retirement Research Foundation
United Hospital Fund
The New York State Legislature**

August 1991

ACKNOWLEDGEMENTS

I would like to take this opportunity to thank the specific members of the Task Force for all the work they accomplished: Phyllis Antis, Claudette Marseille, Ann Wyatt, Alice Hall Beck, Sue Lai, Lois Schram and Tom Spicuzza.

Thanks also goes to The Retirement Research Foundation, The United Hospital Fund and the New York State Legislature for providing us with the funds to conduct this project.

TABLE OF CONTENTS

	<u>PAGE</u>
EXECUTIVE SUMMARY.....	1
INTRODUCTION.....	4
CONSUMER CONCERNS.....	5
PROJECT OBJECTIVE AND GOALS.....	8
METHODOLOGY.....	9
RESEARCH FINDINGS.....	10
RECOMMENDATIONS.....	14
BIBLIOGRAPHY.....	26
APPENDICES	
A. Tables and Figures	
B. Patient Review Instrument - PRI	
C. Minimum Data Set Plus - MDS+	

EXECUTIVE SUMMARY

The New York State nursing home Medicaid reimbursement system, RUGs - Resource Utilization Groups, needs to be modified in order to reflect consumer concerns.

Consumer Concerns

RUGs does not encourage good care.

* Facilities get higher reimbursement if residents are sicker or more dependent; their rate goes down if residents improve.

* RUGs allows facilities to make profits or cut losses by not spending in resident care services; facilities can admit sicker and more dependent residents, thereby receive high reimbursement, without spending the money needed for their care.

RUGs leads to access problems for lighter care residents

* Because RUGs pays less for residents who have lighter care needs, facilities are less likely to admit them. Often these individuals have no place else to go; they remain in hospitals or they remain inappropriately at home.

The assessment tool to measure resident needs is not valid for all residents

* With a reimbursement system that pays facilities a rate that is based upon measured resident needs, the accuracy of the assessment tool is crucial. Many consumers and care providers do not believe that the instrument used in this system is valid for residents with cognitive impairment.

The time and motion study used to estimate cost of needed care is not valid

* The reimbursement rates paid to facilities are based upon a study that measured actual time spent with residents in a sample of facilities in New York State in 1983. Consumers believe that this study measured what was and not what should be and did not select facilities known for good care and "state-of-the-art" practices.

There is no linkage between surveillance and reimbursement

* Facilities receive their full reimbursement rates whether or not they give good care. Under RUGs, profits can be made or losses can be offset by using direct care revenues at the same time the facility is giving poor care as evidenced by surveyor findings or negative resident outcomes. There are few penalties within the reimbursement system for poor care.

Recommendations for Change

- * Encouraging Good Care: Investment of Public Monies into High Quality, Innovative Programs

Pay facilities more for admitting disenfranchised people and giving high quality services.

- Add three new categories or supplements to the RUGS system for: residents with cognitive impairment; residents with special psychosocial needs; and residents with special maintenance needs.
- Require facilities to give specific services in order to receive increased reimbursement.
- Evaluate services given for continued reimbursement.

- * Encouraging Good Care: Linking Reimbursement to Surveillance and Negative Resident Outcomes

- Remove the profit incentive from direct resident care services.
- Require money be spent in direct care services if survey findings or negative outcomes indicate care problems.
- Require state surveyors to develop ways to evaluate services given to the three new categories of residents listed above.

- * Encouraging Good Care: Introduction of a Quality Incentive Involving Acknowledgement and Appreciation

- The state should officially acknowledge facilities that give quality care and facilities that improve their care over time.

- * Encouraging Good Care: Giving Incentives for Encouraging Resident Independence

- RUGS must incorporate certain incentives for encouraging independence and less restrictive treatments. Generally, the system should pay more for treatments and services that help residents progress or maintain their ability to eat, walk, toilet themselves, dress, bathe, etc.

- * Conduct a new time and motion study.

- Include facilities with low incidences of negative resident care findings.
- Include facilities with innovative and state-of-the-art programs for dementia, rehabilitation, ambulation, independence and a good quality of life.

- Include facilities with high staffing levels.
- Use a clinical group of consumers, nurses, social workers, nurse aides and other nursing home staff to determine if the time information gathered makes "clinical" sense. Make changes if necessary.

*** Develop a better State Auditing System**

- New York State must have a better idea about how public monies are being used in facilities. Before assuming that nursing home providers need more money, the state must make sure that the money it is already putting into the system is being used appropriately and efficiently.

INTRODUCTION

On January 1, 1986, a new nursing home Medicaid reimbursement system began in New York State. Called RUGS-II - Resource Utilization Groups - it is a casemix system that estimates nursing home direct resident care costs such as nursing, activities, social services, therapy and pharmacy. RUGS attempts to do the following: assess the amount of care needed by each nursing home resident; estimate the cost of care needed; and pay nursing homes a reimbursement rate based upon the expected costs of such care. A facility rate is based upon the mix of "cases" or different groups that residents fall into based upon their needs. The system includes a profit incentive for direct resident care services. If a facility spends less than it receives for resident care, it can make a profit; if it spends more than it receives, it suffers a loss.

Prior to the introduction of the RUGS system in New York State, long term care facilities were paid a set daily amount for each day of care given to Medicaid residents. This rate was derived from past costs with increases to allow for inflation. There were only two classes of rates: one for a skilled nursing facility (the higher level of care) and one for a health related facility (the lower level of care). Care for Medicaid residents at each skilled nursing facility and each health related facility was reimbursed at the same rate no matter what the differences in medical and staff needs.

RUGS was an attempt to relate the reimbursement rate that a facility receives to the nursing home resident's present clinical and resource needs. This is accomplished by the following procedure. First, using a diagnostic tool developed in 1985 (called the PRI, the Patient Review Instrument - see Appendix B), each resident is assessed upon admission and every six months thereafter, and assigned or reassigned to one of sixteen different categories. Second, an estimated price of caring for residents within each group, or category, is given. This price is based upon a "time and motion" study conducted in 1983 which measured staff and medical treatment time spent with residents in each category. This study was conducted in a sample of facilities which had no documented problems. Third, a facility rate is derived from the resident mix of different categories.

CONSUMER CONCERNS

Since the inception of RUGs consumers have raised many concerns about the system.

1. There are Poor Incentives for Care in the System

RUGs pays more for "sicker residents" and RUGs pays more the more dependent a resident is.

Under the RUGs system, "sicker residents" are generally defined as those who are more physically functionally impaired or dependent in activities of daily living such as eating, toileting and transferring. This has led to a number of perceived problems:

(1) consumers believe that facilities are encouraged to take only the highest reimbursed resident and to hold beds vacant until they can admit this resident. There is some indication that this is true. In 1990, the New York State Health Department conducted a one day census of the number of vacant beds in nursing homes in the New York City area. On that day, over 700 beds were vacant in the nursing homes. What is interesting about this figure is that it was almost the same number as that of patients crowding the city's emergency rooms awaiting for the beds held by people waiting for nursing home beds.

(2) consumers believe that a critical access problem has developed for the lighter care or more independent nursing home resident with cognitive impairments (the lowest reimbursed resident under the RUGs system) and for residents with behavioral problems, AIDS and addiction problems.

This problem has had serious complications for hospitals and for patients. Many of these patients are sitting in hospitals, inappropriately filling needed beds, waiting for a nursing home bed. Information derived from many sources indicate that the patients that stay the longest in hospitals across the state awaiting nursing home care are these residents.¹

(3) consumers believe that once facilities admit residents, they have little incentive to get residents better or to help them maintain themselves at their present level; if they do, their reimbursement rate will drop.

¹Information and studies conducted by: The United Hospital Fund; New York State Health Department; Health Systems Agencies across the state. See Bibliography. Although it is true that prior to the RUGs system the heavier care patient was backlogged in hospitals, an argument can be made that it is the lighter care patient who is most inappropriately waiting in hospitals. The care they need such as socializing and activities is unavailable.

RUGs allows facilities to make profits in direct care.

Consumers believe that the profit motive in the direct resident care services encourages facilities to maximize their direct care revenue by admitting heavy care residents and then using that increased revenue, not to care for the needs of the residents, but to increase their profit or offset their losses in other areas such as administration or housekeeping, etc.

NHCC conducted a study² evaluating the impact of RUGs on resident care. The study demonstrated that for the first two years of RUGs implementation, nursing homes admitted sicker and more dependent residents in order to receive the highest reimbursement. However, they took in substantially more revenue in direct resident care services than they expended on such care. At the same time, the report demonstrates that there were high raises for administrative costs in comparison to nursing costs. The report also discusses the evidence that there is not enough hands-on staff in New York State nursing homes³ Combined with the incentive discussed above to keep residents dependent, consumers believe that this incentive is dangerous; it could lead to less staff with a concurrent use of restrictive treatment such as restraints, catheters and feeding tubes.

In order to counteract the potential negative effects of RUGs, the State Health Department developed a new inspection system. A recent report by NHCC, evaluating this new system, indicates that surveyors are not finding the problems they should in certain areas relating to the potential negative effects of RUGs.⁴

2. The Patient/Resident Assessment Tool is not Valid for all Patients/Residents

The validity of the diagnostic tool used to assess the medical and staff needs of each resident in the system is critical to the validity and success of the casemix system. Many experts, care providers and consumers believe that the PRI does not accurately measure the resource needs of the beginning level Alzheimer and dementia residents or those residents with behavior problems. In addition, the nursing home population has changed significantly since the PRI was developed and many experts believe that the new population characteristics are not being measured by the PRI.

²For more information see "Case Mix Reimbursement and the Nursing Home Resident in New York State: Suggestions for Change," written by Cynthia Rudder, Ph.D., NHCC, 1989.

³It is important to remember that there is a shortage of health care workers in New York State. Although there clearly is a shortage of nurse, it is unclear if there is a shortage of nurse aides throughout the state.

⁴See "Evaluation of NYQAS: A Consumer Perspective," by Cynthia Rudder, Ph.D., NHCC, 1990.

3. The "Time and Motion" Study is not Valid

In order to estimate the different medical and care needs of different residents, a study of actual time spent in a sample of facilities in New York State was conducted. Information from this study was used to differentiate between the different categories in terms of staff time needed.

Consumers are concerned that the sample, although including only nursing homes without documented problems, did not specifically include nursing homes known to give high quality care. It did not specifically include facilities with innovative or state-of-the-art programs in dementia, rehabilitation or quality of life. It did not specifically include facilities with high staff ratios where you would be more likely to see different types of care being given in addition to physical care. In addition, consumers are concerned that the State measured only what was and not what should be.

4. There is no Linkage Between Surveillance and Reimbursement

Consumers are concerned that under RUGs, profits can be made or direct care revenue used to offset losses at the same time the facility is giving poor care as evidenced by surveyor findings or negative care outcomes. There is no linkage between good care and reimbursement.

PROJECT OBJECTIVE

To suggest ways of restructuring RUGs to respond to consumer concerns.

PROJECT GOALS

1. To suggest modifications to RUGs to change some of the incentives that are leading to care and access problems.
2. To evaluate the PRI and suggest modifications.
3. To evaluate the time and motion study and to suggest modifications.
4. To suggest ways to modify the RUGs system to help to alleviate the alternative level of care problems (patients who are awaiting nursing home beds are on "alternative level of care" status) in our state's hospitals and the access problems of patients from both the hospital and the community.
5. To suggest ways of adding incentives that encourage independence and high quality of life and discourages restrictive treatments such as restraints, feeding tubes and catheters.
6. To suggest ways to link surveillance and reimbursement.
7. To suggest ways to link positive resident outcomes to reimbursement.

METHODOLOGY

1. A Task Force was established to meet the project's goals. The Task Force was made up of representatives from the following groups:

The Alzheimer's Association, New York City Chapter;

The National Association of Social Workers, New York City Chapter;

The New York City Department of Aging; and

The New York State Nurses Association.

In addition, a representative of the Health and Hospitals Corporation (care provider for 3000 nursing home residents) participated as an ex-officio provider member of the Task Force.

2. NHCC's Director interviewed by telephone consumers and regulators in states and Canada which were using a casemix methodology for nursing home Medicaid reimbursement to evaluate different reimbursement elements for suggestions for changes in RUGs. In addition, she analyzed the reimbursement regulations from each of these states and Canada.
3. The project's consultant, Charles Phillips, Ph.D., M.P.H., one of the principal investigators on the project to evaluate and design the Minimum Data Set for nursing homes and a member of the Advisory Committee to the Health Care Financing Administration's (HCFA) Multistate Medicare Demonstration project, analyzed the 1983 RUG data base in New York State used in the development of the RUGs model to address a number of the issues raised in this report.⁵

⁵ Phillips, Charles, PhD, MPH, "Resource Use, ADL Functional Level, and Cognitive Impairment," "The RUGs System and Cognitively Impaired Residents," and "The Cost for Restrained Residents," Background memos prepared for NHCC, July 18, 1991, May 13, 1991 and April 29, 1991,

RESEARCH FINDINGS

Cognitive Impairment

The beginning level dementia resident seems to be having the most trouble being admitted to nursing homes in New York State under the RUGs system. Many providers do not believe that the resource needs of these residents are being properly assessed and paid for. They believe that these residents need more staff time than is presently being measured with the present PRI. Therefore, they believe they are not receiving the reimbursement needed to care for these residents.

There is support that the cognitively impaired do take differing amounts of resource time than those who are not cognitively impaired.

1. Research conducted by Charles Phillips indicates a number of findings relevant to the present project. He found that:

- (1) there is a positive relationship between resource provision and cognitive impairment: residents who are cognitively impaired take more staff time to care for (see Table 1 in Appendix A);
- (2) there is a positive relationship between cognitive impairment and ADL functioning: residents who are more and more cognitively impaired are also residents who are more and more functionally impaired (see Table 2 in Appendix A);
- (3) the relationship between ADL functioning and resource use varies across residents with different levels of cognitive function: residents who are moderately cognitively impaired and have few ADL needs have higher resource needs than similar residents with less cognitive impairment (see Figure 1 in Appendix A); and
- (4) the ability of RUGs to accurately explain resource use is better for those residents with little or no impairment and worse for those who were highly impaired: RUGs is at its most inaccurate in estimating the cost of caring for those residents with the highest level of cognitive impairment. (see Table 4 in Appendix A).

Dr. Phillips also found that adding an indicator of cognitive impairment to RUGs increased the power of RUGs to explain resource needs only marginally. However, he makes the argument that increases in explanatory power should not be the sole criterion for choosing the groups to include in a case mix system. "Recognizing groups with special needs or at special risk of poor care or poor access are also reasonable bases for increasing the number

of groups used in a case mix reimbursement system."⁶
"The addition of such groups may not greatly enhance the statistical power of one's case mix model, but it may significantly enhance the usefulness of the model in allowing state policy-makers to pursue their goals of equal access and improved quality of care for a very vulnerable population of impaired elderly."⁷

2. Brant Fries, Ph.D. and David R. Mehr, M.D., M.S. of the University of Michigan, recently presented findings conducted under a Health Care Financing Administration (HCFA) project to develop and demonstrate a nursing home case mix system on the national level. The Multistate Nursing Home Case Mix and Quality Project involves the design of a resident level resource use classification system for Medicare and Medicaid.⁸ Their findings related to cognitive dysfunction and resource use in nursing homes. They looked at delirium, depression and cognitive impairment. Similar to Dr. Phillips findings, they found that there was in fact a difference in staff time that was not accounted for in levels of ADL dependence. However, this difference was only significant for the least impaired residents in ADL functioning. Given these findings, they have recommended that a new group be added to RUGs called "Cognitive Impairment/Behavior Problem". This group would include relatively high physically functioning residents who are either impaired in short term memory, decision-making or orientation or who have daily behavioral problems. In addition, they recommended that facility programs or services be required for reimbursement for residents falling into this category.

Psychosocial Needs

The research conducted by Fries and Mehr under HCFA's demonstration project discussed above, also found that residents with depression used statistically more resources than those without depression. For each level of activities of daily living functioning, depressed residents required slightly more nursing staff time, but the differences were most significant for the mildly to heavily impaired depressed residents. The authors suggest the addition of sub categories of depression to residents with acute, episodic problems with physician care at least weekly, i.e., the clinically complex category. Here too, they recommended that these categories should require documentation of focused care plans and differentiated care to qualify for any increased payment.

⁶Phillips, Charles, PhD, MPH, "Resource Use, ADL Functional Level, and Cognitive Impairment," Background paper prepared for NHCC, July 18, 1991, p. 1.

⁷Ibid., p. 8.

⁸Office of Research and Demonstration, HCFA. Under contract 500-89-0046, The Technical Design for the Multistate Nursing Home Case Mix and Quality Demonstration Project. A preliminary paper, February, 1991. NHCC's Director is a member of the project's Advisory Committee.

Special Maintenance Needs

1. Research conducted for HCFA's demonstration project⁹ also suggested the need to add an additional category for residents in the cognitive impaired, behavior problem, or reduced physical functioning groups (the lowest reimbursed groups). This category would be for residents in need of nursing rehabilitation such as amputation care, active and passive range of motion, splint and brace assistance, training in dressing, grooming, eating, swallowing, locomotion, mobility, or transfer and a toileting program.
 2. The research conducted by Charles Phillips added some interesting information in this area. He analyzed the cost of using physical restraints versus not using physical restraints. His research indicates the following:¹⁰
 - (1) restrained residents received 50 percent more nurse aide time than did residents who were free from restraints (see Table 5);
 - (2) the total difference in care time between residents who were restrained and those who were not restrained was about 33 percent (see Table 5);
 - (3) controlling for the effects of functional status, cognitive status, and behaviors, restrained residents used slightly less licensed staff time but received about seven minutes more aide time per day than the non-restrained residents (see Table 6 in Appendix A); and
 - (4) looking at licensed staff time and aide time together (after weighting by relative wage scales), residents who are restrained receive significantly more time than do similar residents who are not restrained (see Table 6).
- Thus, in contradiction to the beliefs of many providers who state that if they don't use restraints, they will have to hire more staff, he found that the restrained residents were more costly to care for. Those residents who were restrained received much higher amounts of nurse aide time, even when he controlled for differences in functional status. According to these results, it would be less costly not to use restraints at all.

⁹A preliminary paper, May 16, 1991.

¹⁰Phillips, Charles, PhD., MPH, "The Cost of Care for Restrained Residents," Background memo for NHCC, April 29, 1991.

Dr. Phillips notes that his data base did not include differences in resource time for removal of restraints from residents who had been restrained over a long period of time. It is clear that the restoration of any reversible loss of function caused by the restraint use may be costly.

RECOMMENDATIONS

The task force was most concerned about the need to solve the crucial problems of both access and appropriate care for nursing home residents. A delicate balance had to be accomplished. In order to better the access to nursing homes for certain disenfranchised groups, acknowledgement had to be made of the extra revenue needed to care for them. But, it is not enough to just offer increased revenue; it is also necessary to make sure that protections are in place to assure that those residents whose admittance is financially encouraged receive the care they need.

With this in mind, the task force made recommendations to add revenue for facilities both admitting certain identified groups and giving them the specific programs they required.

It was also clear that it was necessary to not only tie reimbursement to services given but also to link reimbursement to positive outcomes. Thus, it was suggested that facilities receive more funding if they admit certain residents, provide the appropriate programs and give quality care as determined by positive outcomes.

Specific Recommendations

I. Encouraging Good Care: Investment of Public Monies into High Quality, Innovative Programs to help both to alleviate the access problems in the state as well as to provide the resources for good care.

Three new categories of residents, needing added resources, should either be added to the RUGS classification system or should be considered for supplementary reimbursement.

In addition, for facilities to receive any extra reimbursement, they must give high quality services to meet the needs of these residents.

A. RESIDENTS WITH COGNITIVE IMPAIRMENT.

Group Characteristics

This group would include only residents with diagnoses of mild or moderate dementia. These residents will be identified by the following characteristics as measured on the MDS+11: they are less alert, easily distracted; they

¹¹The MDS+, Minimum Data Set Plus, is the assessment tool that is required for all nursing homes in New York State to help in developing care plans. It is not, at this time, being used for assessment of needs related to resource use and reimbursement (See Appendix C).

have a changing awareness of environment; they have periods of motor restlessness or lethargy; they are moderately impaired in cognitive skills for daily decision making; they resist care; they need supervision; they need limited assistance or extensive assistance with bathing, dressing, toileting and eating; and they need activities of daily living activities to be broken into a series of sub - tasks.

Programmatic Requirements

The facility must develop protocols that include the following components:

1. Creation of an interdisciplinary care team to develop individualized care plans.

The care team must consist of a registered nurse, doctor, social worker, aide, physical therapist, occupational therapist, family member, and, as needed, dietitian and recreation and activity directors.

2. Development and implementation of individualized care plans that will include:

- a. an identification of the resident's functional problems and goals
 - b. one or more interventions carried out daily
 1. environmental structure - the setting must enhance safety and security
 2. cognitive programs involving and meeting communication needs
 3. programs that meet the needs of residents with behavioral and/or psychosocial problems.
 4. programs that assist residents in their activities of daily living.
 - a. cueing
 - b. task segmentation
 - c. encouraging
 - d. toileting schedule
 5. nighttime alternatives to the use of physical and/or chemical restraints for residents who cannot sleep
 - c. evaluation of interventions and reassessment of resident needs if appropriate.
3. Development of good staff/resident interaction and care

- a. resident to staff (aide) ratio of at least one to four.
 - b. consistency of staff assignment
 - c. supportive program for staff
 - d. education for staff
 - e. meaningful staff appreciation program
4. Development of a family care plan that will include:
- a. an identification of the family's needs and goals.
 - b. one or more services provided at least every other week
 - 1. procedures for families to meet with appropriate disciplines for discussions
 - 2. support groups
 - 3. education
 - 4. services to help family to relate to resident

B. RESIDENTS WITH SPECIALIZED PSYCHOSOCIAL NEEDS.

Group Characteristics

This category would include four types of residents: those with specified medical diagnoses; those with a secondary diagnosis of mental illness and/or socially inappropriate or disruptive behaviors; those with recent traumatic events or changed status; and those residents with family and informal support problems. Each of these groups must also demonstrate behaviors indicating difficulty coping.

The four types of residents are:

- 1. Specific medical diagnoses: terminal illness, HIV positive and addiction (addiction needs no accompanying behaviors). All except addiction is on the MDS+. Addiction must be added to the list of diagnoses.
- 2. Secondary diagnosis of mental illness such as depression and/or socially inappropriate or disruptive behaviors (needs to be added to the MDS+).
- 3. Recent traumatic events: loss of family member in the last 6 months; amputation or major surgery within the last 6 months (needs to be added to the MDS+); and a recent diagnosis of a permanent progressive disease.

4. Family and informal support problems.

This group includes those people who, as evidenced on the MDS+, do not have personal contact with family or friends or who openly express conflict or anger with family or friends.

Accompanying Behaviors indicating problems in coping are:

Mood and behavior patterns: tearfulness, emotional groaning, sighing, breathlessness, motor agitation such as pacing handwringing or picking; pervasive concern with health; recurrent thoughts of death; suicidal thoughts or actions; failure to eat or take medications; withdrawal from self-care or activities; reduced communications; resisting care; socially inappropriate/ disruptive behavior

Programmatic Requirements

1. Development of an interdisciplinary care team to develop individualized care plans.

The care team must consist of a social worker, any other qualified mental health professional, nurses' aide, registered nurse, family member and resident.

2. Development and implementation of individualized care plans that will include:

a. an assessment that must demonstrate the elimination of any other causes for the distress.

b. one or more interventions at least once a week

1. individual case work
2. group work
3. community involvement

c. evaluation of interventions and reassessment if appropriate.

3. Development of good staff/resident interaction and care.

- a. elicit information from floor staff about the resident and family
- b. help floor staff to help resident and family
- c. educate staff

4. Development of family care plans that will include:

- a. identification of needs and goals
- b. one or more services provided at least once every two weeks
 1. procedures for families to meet with appropriate disciplines for discussions.
 2. support groups
 3. education
 4. services to help family relate to the resident

C. RESIDENTS WITH SPECIAL MAINTENANCE NEEDS

Group Characteristics. This group will include:

1. recent discharges (within 30 days) from a formal rehabilitation program (this would have to be added to the MDS+).
2. residents at risk for fall, contractures and deterioration: residents who have fallen in the last 30 days; residents who have a condition and or disease that makes resident's ADL (Activities of Daily Living) precarious of deteriorating (add to MDS+); residents who need one person physical assist for bed mobility, transfer and locomotion; residents who have deteriorated in any ADL from one self-performance category to another or from one support category to the other (as measured on the MDS+).
3. residents who have recently been released from long term usage (6 months or longer) of physical restraints (need to add to MDS+).
4. residents who move from a behavioral problem category because of participation in a behavior program (not because of the introduction of a psychotropic drug).
5. residents who are incontinent or have a catheter or who do not use the toilet/commode/urinal but who do not have a neurogenic bladder (need to add to the MDS+) and who have the cognitive ability (short term memory) to learn toilet and bladder training.
6. residents who suffer a sudden (within the last 30 days) deterioration in eating ability.

Programmatic Requirements

This intensive six week program involves the training of nurses' aides under the supervision of a licensed nurse. The aides will integrate all the normal care routines (dressing, bathing, toileting, eating, grooming, etc.) during all of the resident's waking hours, with the specific needed nursing rehabilitation. These activities

must be coordinated with the activities of other staff, such as dietary, etc.

1. Creation of an interdisciplinary care team to develop individualized care plans.

The team must consist of a registered nurse, rehabilitation therapists, recreation specialists, aide, family and resident.

2. Development and implementation of individualized care plans which must include:

a. an identification of the resident's functional problems and goals.

b. description of the intensive six week program with the specific routines aides will conduct with the resident

c. evaluation of intervention must be conducted on an on-going basis, at least monthly.

If the resident does not demonstrate progress or maintenance of abilities, the care plan must be rewritten and the resident must be reassessed.

If, after the six week program, the resident demonstrates unexpected regression, the resident is readmitted to the program.¹²

3. Development of good staff/resident interaction and care.

a. consistency of staff

b. resident to staff ration of at least one aide to every six residents.

4. Development and implementation of a family care plan that must include:

a. identification of family needs and goals

b. provision of services

1. procedures for families to meet with appropriate disciplines for discussions.

¹²Since the facility will be given a higher reimbursement rate for residents in this category for six months even though the program is only six weeks long, the ability to readmit residents who need a repeat of the program during this six months should be encouraged.

2. support groups
3. education
4. services to help family relate to resident

II. Encouraging Good Care: Linking Reimbursement to Surveillance and Positive Outcomes

A. Removal of the profit incentive in direct resident care.

In order to counter the potential negative incentive to keep residents sicker and to encourage the hiring of necessary staff rather than use restrictive treatments, the profit incentive must be removed from the direct resident care costs. If facilities do not spend all the revenue given for direct care, the remaining amount must be given back to the state. This does not remove the profit incentive in other non-direct areas such as administration, housekeeping, grounds, etc.

B. Requiring money be spent in direct care services if survey findings or data from PRI indicate care problems.

If "a" above is not adopted, than it will be necessary to develop a linkage between survey findings and retention of the right to make a profit.

A facility must be required to spend all of the direct care revenue it receives on direct care services for the following year or be required to return the left over amount to the state if the facility receives:

- (1) any deficiency in the following areas: resident rights, admission, transfer and discharge rights; resident behavior and facility practice; quality of life; resident assessment; quality of care; nursing services; dietary services; physician services; and specialized rehabilitation services; or

- (2) a "low quality" score, derived from all casemix adjusted resident outcome information gathered by the PRI: use of restraints, incidence of accidents, presence of decubiti, psychotropic drug use, incidence of continence, ambulation, use of catheters, eating abilities, behavior, etc.

C. Development of new survey protocols

In order to link the reimbursement facilities will receive (to provide the programs for the three new

classes of residents) to the surveillance system effectively, the State Health Department must develop protocols for its surveyors to survey the three programs outlined above. If, over a period of time, two or three surveys, a facility is found deficient, based upon the developed protocols, the facility must lose the right to offer the program, thereby losing the reimbursement.

III. Encouraging Good Care: Introduction of a Quality Incentive Involving Acknowledgement and Appreciation

The State Health Department should officially acknowledge facilities that give quality care and facilities that improve their care over time. Such facilities must have an agreed upon percent of Medicaid admissions and must have complied with standards of care as evidenced by survey findings.

Facilities should be asked to apply for recognition. Decisions can be made using information from two sources: a quality factor derived from PRI outcome data, related or adjusted to the population served; and, from inspections by a group consisting of consumers, ombudspople, advocates and consumer representatives of provision of a high quality of life for individualized and creative care.

A. Positive outcomes from PRI data

1. use of restraints
 - a. low incidence¹³ of restraint use.
 - b. improvement¹⁴ over time in restraint use without an increase in the use of psychotropic drugs.
2. use of psychotropic drugs
 - a. low incidence of use.
 - b. improvement over time without an increase in the use of physical restraints.
3. decubitus
 - no development while in the nursing home
4. continence
 - a. high incidence of continence.

¹³An objective number defining low incidence must be decided upon. This number is related to good care and not to how other facilities in the state are doing.

¹⁴Here too, the number used is related to good care.

- b. high incidence of incontinent residents being taken to the bathroom.
- c. improvement over time.
- d. low incidence of deterioration

5. ambulation

- a. high number of residents maintaining passive or active ambulatory status
- b. improvement over time.

6. catheters

- a. low incidence
- b. low incidence of continued catheter use
- c. low incidence of recurrent urinary tract infections

7. eating

- a. low incidence of tube feeding
- b. low incidence of deterioration in eating ability
- c. improvement over time

8. contractures

- a. low incidence of new contractures
- b. improvement over time

9. behavior

- a. low incidence of new behavior problems
- b. improvement over time

10. accidents

- a. low incidence without increase in physical restraints
- b. improvement over time

B. Providing an atmosphere for individualized and creative care

- 1. evidences of resident and family satisfaction

2. evidences of ability to adapt the facility to the individual's habits and preferences
3. evidences of resident and family participation in decision making.
4. evidences of development of new and innovative programs fostering positive objectives.
5. evidences of positive staff/resident interactions.

IV. Encouraging Good Care: Giving Incentives for Encouraging Resident Independence.

RUGs must incorporate certain incentives for encouraging independence and the use of less restrictive treatment. Generally, the system should pay more for treatments and services that help residents progress or maintain their ability to eat, walk, toilet themselves, dress, bathe, etc.

We suggest the following changes for the PRI or for any scoring for the MDS+ to accomplish this:

- A. Add an additional level to the scores of each ADL function to pay more for maintenance programs to train residents to be remain or become independent. This level should be given the highest score, thus giving facilities added reimbursement for encouraging independence.¹⁵
- B. Change levels in ADL scoring on the PRI
 1. eating: leave levels 1, 2, and 3 the same; add a new 4 and 5 and 6 to encourage partial hand feeding, resident participation and total hand feeding if necessary.
 - a. 4: "partially hand fed; resident may manually participate but not enough for adequate intake". This gives some weight to resident participation and encourages more independence.
 - b. 5: "totally hand fed, tube or parentally fed for primary intake of food". This gives equal weight to hand feeding and tube feeding instead of more weight to tube feeding.
 - c. 6: maintenance program to train residents to feed themselves (described above).

¹⁵If the new category "RESIDENTS WITH SPECIAL MAINTENANCE NEEDS" is added to the system as recommended above, this level should not be used.

2. mobility: add to the ADL scores (at present mobility is not used to weight scores at all); leave levels 1, 2 and 5 the same; 3 becomes 4; add a new 3, and 6 to encourage supervised ambulation
 - a. 3: "wheels with no supervision assistance, except for difficult maneuvers". This gives some weight to differing levels of independence.
 - b. 4: "walks with constant one-to-one supervision and/or constant physical assistance".
 - c. 6: maintenance program for ambulation
3. toileting: leave 1, 2 and 4 the same; 3 becomes 5; 5 becomes 6; add a new 3 and 7 to encourage continence and/or toileting schedules and programs.
 - a. 3: "continent of bladder and bowel; unable to find the bathroom, needs direction to the toilet". This gives some weight to differing levels of independence.
 - b. 7: bowel and bladder training or scheduling
- C. In scoring, no two levels should be collapsed. Each level must have its own weight.

V. Data Collection

A new "time and motion" study must be conducted.

Charles Phillips, in his memo on the RUGs system and the cognitively impaired¹⁶ states that it is important to note that the RUGs system is not exactly a model of resource utilization. What was measured in the time and motion study were the resources provided to nursing home residents due to decisions made by facility staff.

The new sample must include facilities with the lowest incidence of negative outcomes: facilities with innovative and state-of-the-art programs for dementia, rehabilitation, ambulation, independence and a good quality of life for their residents. It must include facilities with high staffing levels. With such facilities in the sample, we will be able to better discriminate among care categories because all types of care are more likely to be given. Those facilities with lower staff levels may spend most, if not all, of their staff time on meeting only the physical needs of their residents. In addition, a clinical group consisting of consumers, nurses, social workers, nurses aides and other nursing home staff should be used to determine if the resource time information gathered from the time and

¹⁶Phillips, Charles, PhD, MPH, "The RUGs System and Cognitively Impaired Residents," Background memo prepared for NHCC, May 13, 1991.

motion study make "clinical" sense. If they do not, the relative times should be changed.

VI. The task force, after analyzing both the PRI and the MDS+, agreed that the definitions for measuring independence and dependence in the ability to perform activities of daily living on the MDS+ was superior to the PRI. Thus, the group recommends using the MDS+ instead of the PRI in the future. However, the issues raised above dealing with the encouraging of independence must be incorporated and that the many items added to the PRI for quality assurance must be added to the MDS+ so that we can continue gathering data on potential negative outcomes.

V. Need for Better State Auditing to help make decisions on the appropriateness of spending.

Over \$4.5 billion is spent on nursing home care in New York State each year. That is about \$45,000 for each nursing home resident. While consumers are concerned about the care being given, providers are complaining that they are not being given enough money to care for the residents they have and that they need higher Medicaid reimbursement.

Before giving more money to the nursing home providers, New York State must better evaluate how the public monies going into nursing home care are being used. How well managed are nursing homes? How much of Medicaid reimbursement is going into administration costs? What do these costs consist of? Are they appropriate given the demand being made on public monies? How do these administrative costs compare to costs for pharmacy? nurses' aides? therapies? How should they compare? Are staff levels adequate? We no longer can give public monies without clear accountability and monitoring of the effectiveness and appropriateness of the use of these monies.

BIBLIOGRAPHY

1. Health Systems Agency of Western New York, Inc. "Alternate Level of Care: Issues, Trends and Implications," June, 1990.
2. New York State Department of Health: Office of Health Systems Management. "Report on the Hospital Alternate Care Population- New York City Experience and Statewide Applicability: Recommendations and Workplans to Facilitate Residential Health Care and Home Care Placements," September, 1990.
3. Office of Research and Demonstration: Health Care Financing Administration (HCFA) under contract 500-89-0046, "The Technical Design for the Multistate Nursing Home Case Mix and Quality Demonstration Project." Preliminary draft papers, February and May, 1991.
4. Phillips, Charles, PhD., "The Cost of Care for Restrained Residents," Background memo prepared for NHCC, April 29, 1991.
5. Phillips, Charles, PhD., "Resource Use, ADL Functional Level, and Cognitive Impairment," Background memo prepared for NHCC, July 14, 1991.
6. Phillips, Charles, PhD., "The RUGs System and Cognitively Impaired Residents," Background memo prepared for NHCC, May 13, 1991.
7. Rudder, Cynthia, PhD. "Case Mix Reimbursement and the Nursing Home Resident in New York State: suggestions for Change." The Nursing Home Community Coalition of New York State (NHCC), June, 1989.
8. Rudder, Cynthia, PhD. "Evaluation of the New York State Quality Assurance System (NYQAS): A Consumer Perspective." The Nursing Home Community Coalition of New York State (NHCC), December, 1990.
9. United Hospital Fund. "Transitional Care: The Problem of Alternate Level of Care in New York City," November, 1989.
10. Unpublished report. "Comparison of RUGs Groups of Clients in Community Seeking Nursing Home Care and Patients on Alternate Level of Care in Syracuse Hospitals," August 22, 1989.

APPENDIX A
TABLES AND FIGURES

TABLE 1: Resource Provision and Cognitive Function

	Care Time Provided (in minutes)				
	All Residents	Indep.	Mod. Indep.	Mod. Impair.	Impaired
RN	11	9	10	12	15
LPN	17	15	16	16	20
AIDE	72	51	65	85	100
TOTAL	100	75	91	112	136
N =	3,427	1,061	930	658	586

As a resident becomes more cognitively impaired, the staff time needed to care for her/him increases.

Source: Phillips, Charles, PhD, MPH, "The RUG-II System and Cognitively Impaired Residents," Background memo prepared for NHCC, May 13, 1991.

TABLE 2: The Relationship Between Cognitive Impairment and ADL Function

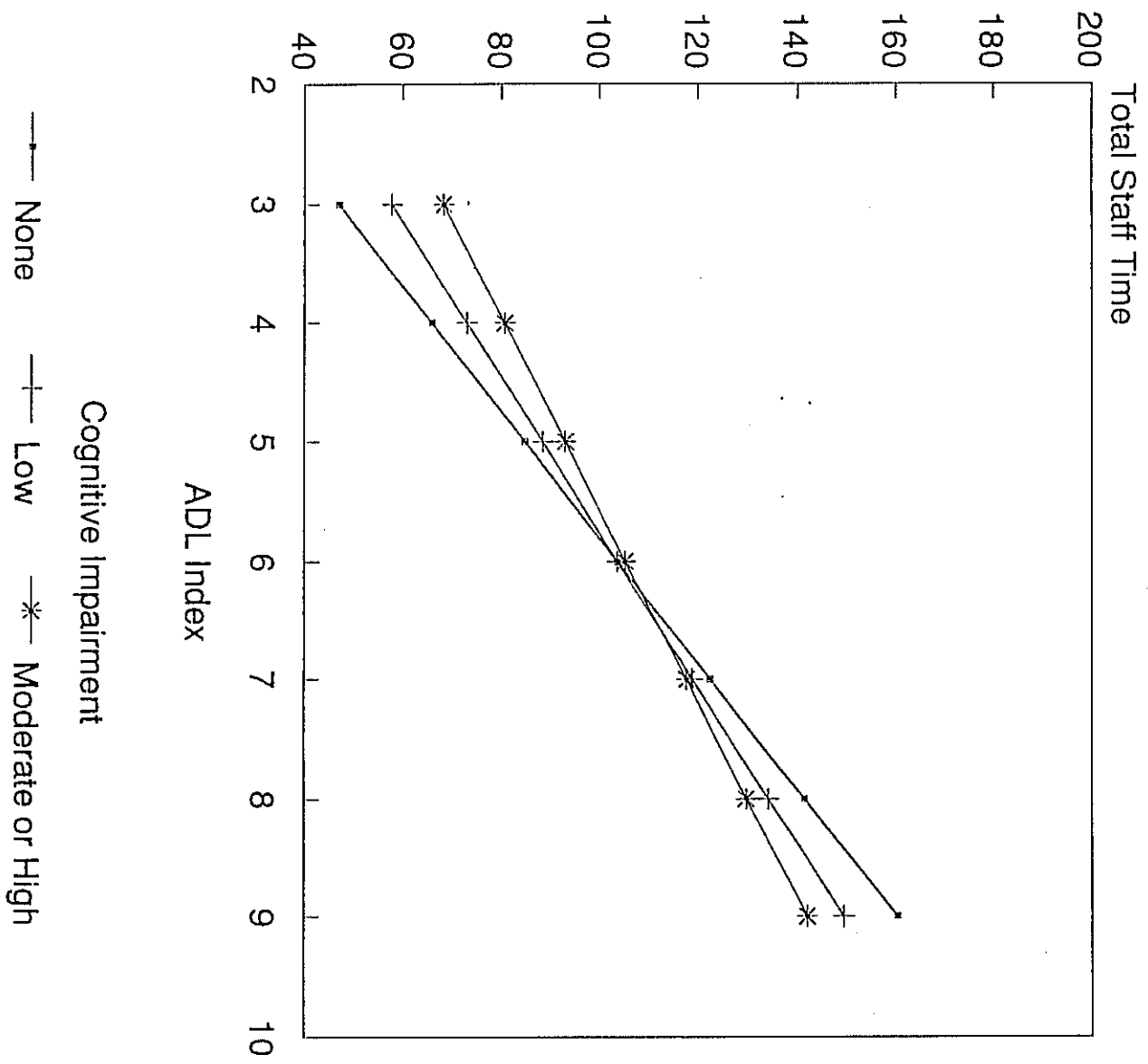
ADL Index Value	Cognitive Impairment				Row Total
	None	Low	Moderate	High	
3	<u>63.0%</u>	<u>41.7%</u>	15.7%	1.2%	1,166
4	6.6	6.3	5.8	1.4	175
5	<u>14.0</u>	<u>18.7</u>	14.9	5.6	453
6	9.3	<u>17.4</u>	<u>21.1</u>	10.6	462
7	3.0	10.2	<u>21.3</u>	<u>18.3</u>	374
8	3.4	4.4	14.3	<u>43.9</u>	428
9 or 10	1.0	1.2	7.0	<u>19.0</u>	176
Column Total	. 100.3%*	99.9%	100.1%	100%	3,234

*Percentages may not equal 100 due to rounding.

Residents who are more cognitively impaired are likely to have the greatest need for staff assistance in ADL functioning.

Source: Phillips, Charles, PhD, MPH, "Resource Use, ADL Functioning, and Cognitive Impairment," Background memo prepared for NHCC, July 18, 1991.

Figure 1: Time, ADL Needs, & Cognition
 (Source: Phillips, May 18, 1991)



Among residents with fewer ADL needs,
 residents with moderate/high cognitive
 impairment require more staff time

TABLE 3: Percent of Variation in Staff Time Explained by the RUG-II System -- For Residents with Differing Levels of Cognitive Functioning*

	Type of Resources		
	Total Time	Aide Time	Licensed Time
Cognitive Function			
Independent			
R-Square	.48	.45	.24
Modified Independence			
R-Square	.43	.42	.19
Moderately Impaired			
R-Square	.34	.28	.28
Impaired			
R-Square	.27	.15	.23

*These models were estimated with the RUGS-II categories represented as dummy variables.

The RUG-II system's ability to accurately predict a resident's resource use depends, in part, on the resident's cognitive function. The system is most accurate in predicting the resource use of residents with little or no cognitive impairment and least accurate for those residents with the greatest cognitive impairment.

Source: Phillips, Charles, PhD, MPH, "The RUG-II System and Cognitively Impaired Residents," Background memo prepared for NHCC, May 13, 1991.

TABLE 4: Staff Time and Restraint Use

Average Care Time	Presence or Absence of Restraints*	
	<u>Present</u>	<u>Absent</u>
licensed time (min.)	32	27
aide time (min.)	95	66
weighted time	101	76

*Presence of restraints means regular use for day or night.

Residents who are restrained receive more staff time than do residents who are not restrained.

Source: Phillips, Charles, PhD, MPH, "The Cost of Care for Restrained Residents," Background memo prepared for NHCC, April, 29, 1991.

TABLE 5: Care Provision and Restraint Use: Comparing Similar Residents

Variables In the Model	Care Provision*		
	<u>Nurse</u>	<u>Aide</u>	<u>Wtd.</u>
Intercept	25.58**	80.06**	83.07**
15 binary variables representing RUG-II classes	---	(not reported)	---
Restraint Use	-0.19	7.38**	4.86**
R-Square	.25	.46	.45

*Entries in the table are unstandardized regression coefficients. For presentational clarity, coefficients not reported for each specific RUGS-II category.

**p<.01

Controlling for other characteristics that might affect resource use, residents who are restrained receive significantly more staff time than do residents who are not restrained.

Source: Phillips, Charles, PhD, MPH, "The Cost of Care for Restrained Residents, Background memo prepared for NHCC, April, 29, 1991.

APPENDIX B
PATIENT REVIEW INSTRUMENT - PRI*

*Sections relevant to this report

III. ACTIVITIES OF DAILY LIVING (ADLS)

Answer questions 19-22 according to how each task was completed 60% of the time during the past four weeks or since admission, whichever is shorter (regardless of cause). Read the Changed Condition Rule and definitions in the instructions.

19 EATING: PROCESS OF GETTING FOOD BY ANY MEANS FROM THE RECEPTACLE INTO THE BODY (FOR EXAMPLE, PLATE, CUP, TUBE).

- 1 = Feeds self without supervision or physical assistance. May use adaptive equipment.
- 2 = Requires *intermittent* supervision (that is, verbal encouragement/guidance) and/or minimal physical assistance with minor parts of eating, such as cutting food, buttering bread or opening milk carton.
- 3 = Requires continual help (encouragement/teaching/physical assistance) with eating or meal will not be completed.
- 4 = Totally fed by hand; patient does not manually participate.
- 5 = Tube or parenteral feeding for primary intake of food. (Not just for supplemental nourishment.)

19 (117)

20 MOBILITY: HOW THE PATIENT MOVES ABOUT.

- 1 = Walks with no supervision or human assistance. May require mechanical device (for example, a walker), but not a wheelchair.
- 2 = Walks with intermittent supervision (that is, verbal cueing and observation). May require human assistance for difficult parts of walking (for example, stairs, ramps).
- 3 = Walks with *constant* one-to-one supervision and/or constant physical assistance.
- 4 = *Wheels* with no supervision or assistance, except for difficult maneuvers (for example, elevators, ramps). May actually be able to walk, but generally does not move.
- 5 = *Is wheeled*, chairfast or bedfast. Relies on someone else to move about, if at all.

20 (118)

21 TRANSFER: PROCESS OF MOVING BETWEEN POSITIONS, TO/FROM BED, CHAIR, STANDING. (EXCLUDE TRANSFERS TO/FROM BATH AND TOILET).

- 1 = Requires no supervision or physical assistance to complete necessary transfers. May use equipment, such as railings, trapeze.
- 2 = Requires *intermittent* supervision (that is, verbal cueing, guidance) and/or physical assistance for difficult maneuvers only.
- 3 = Requires one person to provide constant guidance, steadiness and/or physical assistance. Patient may participate in transfer.
- 4 = Requires two people to provide constant supervision and/or physical lift. May need lifting equipment.
- 5 = Cannot and is not gotten out of bed.

21 (119)

22 TOILETING: PROCESS OF GETTING TO AND FROM A TOILET (OR USE OF OTHER TOILETING EQUIPMENT, SUCH AS BEDPAN), TRANSFERRING ON AND OFF TOILET, CLEANSING SELF AFTER ELIMINATION AND ADJUSTING CLOTHES.

- 1 = Requires no supervision or physical assistance. May require special equipment, such as a raised toilet or grab bars.
- 2 = Requires *intermittent* supervision for safety or encouragement; or *minor* physical assistance (for example, clothes adjustment or washing hands).
- 3 = Continent of bowel and bladder. Requires constant supervision and/or physical assistance with major/all parts of the task, including appliances (i.e., colostomy, ileostomy, urinary catheter).
- 4 = Incontinent of bowel and/or bladder and is not taken to a bathroom.
- 5 = Incontinent of bowel and/or bladder, but is taken to a bathroom every two to four hours during the day and as needed at night.

22 (120)

IV. BEHAVIORS

23 VERBAL DISRUPTION: BY YELLING, BAITING, THREATENING, ETC.

- 1 = None during the past four weeks. (May have verbal outbursts which are not disruptive.)
- 2 = Verbal disruption one to three times during the past four weeks.
- 3 = Short-lived disruption at least once per week during the past four weeks or *predictable* disruption regardless of frequency (for example, during specific care routines, such as bathing).
- 4 = Unpredictable, recurring verbal disruption at least once per week for no foretold reason.
- 5 = Patient is at level #4 above, but does not fulfill the active treatment and psychiatric assessment qualifiers (in the instructions).

23 (121)

24 PHYSICAL AGGRESSION: ASSAULTIVE OR COMBATIVE TO SELF OR OTHERS WITH INTENT FOR INJURY. (FOR EXAMPLE HITS SELF, THROWS OBJECTS, PUNCHES, DANGEROUS MANEUVERS WITH WHEELCHAIR).

- 1 = None during the past four weeks.
- 2 = Unpredictable aggression during the past four weeks (whether mild or extreme), but not at least once per week.
- 3 = Predictable aggression during specific care routines or as a reaction to normal stimuli (for example, bumped into), regardless of frequency. May strike or fight.
- 4 = Unpredictable, recurring aggression at least once per week during the past four weeks for no apparent or foretold reason (that is, not just during specific care routines or as a reaction to normal stimuli).
- 5 = Patient is at level #4 above, but does not fulfill the active treatment and psychiatric assessment qualifiers (in the instructions).

24 (122)

PATIENT NAME (please print) _____

LAST

F I

M I

25 DISRUPTIVE, INFANTILE OR SOCIALLY INAPPROPRIATE BEHAVIOR: CHILDISH, REPETITIVE OR ANTISOCIAL **PHYSICAL** BEHAVIOR WHICH CREATES **DISRUPTION WITH OTHERS** (FOR EXAMPLE, CONSTANTLY UNDRESSING SELF, STEALING, SMEARING FECES, SEXUALLY DISPLAYING ONESELF TO OTHERS), EXCLUDE VERBAL ACTIONS. READ THE INSTRUCTIONS FOR OTHER EXCLUSIONS.

25 (123)

- 1 = No infantile or socially inappropriate behavior, whether or not disruptive, during the past four weeks.
- 2 = Displays this behavior, but is not disruptive to others (for example, rocking in place).
- 3 = Disruptive behavior during the past four weeks, but not at least once per week.
- 4 = Disruptive behavior at least once per week during the past four weeks.
- 5 = Patient is at level #4 above, but does not fulfill the active treatment and psychiatric assessment qualifiers (in instructions).

26 HALLUCINATIONS: EXPERIENCED AT LEAST ONCE PER WEEK DURING THE PAST FOUR WEEKS. VISUAL, AUDITORY OR TACTILE PERCEPTIONS THAT HAVE NO BASIS IN EXTERNAL REALITY.

26 (124)

- 1 = Yes
- 2 = No
- 3 = Yes, but does not fulfill the active treatment and psychiatric assessment qualifiers (in the instructions).

V. SPECIALIZED SERVICES

27 PHYSICAL AND OCCUPATIONAL THERAPIES: READ INSTRUCTIONS AND QUALIFIERS. EXCLUDE REHABILITATIVE NURSES AND OTHER SPECIALIZED THERAPISTS (FOR EXAMPLE, SPEECH THERAPIST). ENTER THE LEVEL, DAYS AND TIME (HOURS AND MINUTES) PER WEEK.

P.T. Level (125)	<input type="checkbox"/>			
P.T. Days (126)	<input type="checkbox"/>			
P.T. Time (127-130)	<input type="checkbox"/>			
	HOURS		MIN/WEEK	

- A. Physical Therapy (P.T.).....
- B. Occupational Therapy (O.T.).....

- 1 = Does not receive.
- 2 = Maintenance Program - Requires and is currently receiving physical and/or occupational therapy to help stabilize or slow functional deterioration.
- 3 = Restorative Therapy - Requires and is currently receiving physical and/or occupational therapy for four or more consecutive weeks.
- 4 = Receives therapy, but does not fulfill the qualifiers stated in the instructions. (For example, restorative therapy given or to be given for only two weeks.)

DAYS AND TIME PER WEEK: ENTER THE CURRENT NUMBER OF DAYS AND TIME (HOURS AND MINUTES) PER WEEK THAT EACH THERAPY IS PROVIDED. ENTER ZERO IF AT #1 LEVEL ABOVE. READ INSTRUCTIONS AS TO QUALIFIERS IN COUNTING DAYS AND TIME.

28 NUMBER OF PHYSICIAN VISITS: ENTER ONLY THE NUMBER OF VISITS DURING THE PAST FOUR WEEKS THAT ADHERE TO THE PATIENT NEED AND DOCUMENTATION QUALIFIERS IN THE INSTRUCTIONS. EXCLUDE VISITS BY PSYCHIATRISTS.

28 (137-139)

29 MEDICATIONS

- A. Monthly average number of medications ordered.
- B. Monthly average number of psychoactive medications ordered.

29A (139-140)	<input type="checkbox"/>	<input type="checkbox"/>
29B (141-142)	<input type="checkbox"/>	<input type="checkbox"/>

DIAGNOSIS

30 PRIMARY PROBLEM: THE MEDICAL CONDITION REQUIRING THE LARGEST AMOUNT OF NURSING TIME. THIS MAY NOT BE THE ADMISSION DIAGNOSIS BY THE PHYSICIAN.

30 (143-147)

If code cannot be located, print medical name here: _____

31 QUALIFIED ASSESSOR: I HAVE PERSONALLY OBSERVED/INTERVIEWED THIS PATIENT AND COMPLETED THIS PRI:

- Yes
- No

I CERTIFY THAT THE INFORMATION CONTAINED HEREIN IS A TRUE ABSTRACT OF THE PATIENT'S CONDITION AND MEDICAL RECORD.

Signature of Qualified Assessor	Assessor Identification Number
_____	31 <input type="checkbox"/> (144-152)

APPENDIX C
MINIMUM DATA SET PLUS - MDS+1

The form used by New York State is in a different format and adds a few more questions relating specifically to New York State.

Resident _____ Date: _____ Facility: _____ Prov. No. _____

Minimum Data Set Plus for Nursing Home Resident Assessment and Care Screening (MDS+)

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

Assessment Start Date - -

Original (0) or Corrections (#)

Signature of RN _____

Assessment Coordinator _____

SECTION A. IDENTIFICATION AND BACKGROUND INFORMATION

1. RESIDENT NAME	First: _____ (M) _____ Last: _____
2. SOCIAL SECURITY NO.	<input type="text"/>
3. MEDICAID NO. (if applicable)	<input type="text"/>
4. MEDICAL RECORD NO.	<input type="text"/>
5. REASON FOR ASSESSMENT	1. Initial admission assess. 5. Significant change in status 2. Hosp./Medicare reassess. 6. Quarterly 3. Readmission, not Medicare 7. Other (e.g., UR) 4. Annual assessment
6. CURRENT PAYMENT SOURCE(S) FOR NH STAY	(Billing Office to code payment sources) 0. Not used 2. Ancillary 1. Per diem 3. Bath Medicaid Medicare VA Sell pay/Private Insur. CHAMPUS Other
7. RESPONSIBILITY/LEGAL GUARDIAN	(Check all that apply.) Legal guardian <input type="checkbox"/> Family member responsible <input type="checkbox"/> Other legal oversight <input type="checkbox"/> Resident responsible <input type="checkbox"/> Durable power attorney <input type="checkbox"/> NONE OF ABOVE <input type="checkbox"/> health care proxy
8. ADVANCED DIRECTIVES	(For those items with supporting documentation in the medical record, check all that apply.) Living will <input type="checkbox"/> Feeding restrictions <input type="checkbox"/> Do not resuscitate <input type="checkbox"/> Medication restrictions <input type="checkbox"/> Do not hospitalize <input type="checkbox"/> Other treatment restrictions <input type="checkbox"/> Organ donation <input type="checkbox"/> NONE OF ABOVE <input type="checkbox"/> Autopsy request <input type="checkbox"/>
9. DISCHARGE PLANNED WITHIN 3 MOS.	(Does not include discharge due to death) 0. No 1. Yes 2. Unknown/Uncertain
10. MARITAL STATUS	1. Never married 3. Widowed 5. Divorced 2. Married 4. Separated

SECTION B. COGNITIVE PATTERNS

1. COMATOSE	(Persistent vegetative state/no discernible consciousness) 0. No 1. Yes (Skip to SECTION G.)
2. MEMORY	(Recall of what was learned or known; code correct response) a. Short-term memory OK — seems/appears to recall after 5 minutes 0. Memory OK 1. Memory problems b. Long-term memory OK — seems/appears to recall long past 0. Memory OK 1. Memory problems

= Code the appropriate response. = Check all the responses that apply.

3. MEMORY/RECALL ABILITY	(Check all that resident normally able to recall during last 7 days) Current season <input type="text"/> Location of own room <input type="text"/> Staff names/aces <input type="text"/> That he/she is in a nursing home NONE OF ABOVE are recalled
4. COGNITIVE SKILLS FOR DAILY DECISION-MAKING	Made decisions regarding tasks of daily life (Code responses) 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/f rarely made decisions
5. INDICATORS OF DELIRIUM - PERIODIC DISORDERED THINKING/AWARENESS	(Check if condition over last 7 days appears different from usual functioning.) Less alert, easily distracted Changing awareness of environment Episodes of incoherent speech Periods of motor restlessness or lethargy Cognitive ability varies over course of day NONE OF ABOVE
6. CHANGE IN COGNITIVE STATUS	Change in resident's cognitive status, skills, or abilities — in last 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 situation 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 <input type="checkbox"/> Hearing aid, present and not used <input type="checkbox"/> Other receptive comm. technique used (e.g., lip read) <input type="checkbox"/> NONE OF ABOVE <input type="checkbox"/>
3. MODES OF EXPRESSION	(Check all used by resident to make needs known.) Speech <input type="checkbox"/> American Sign Language or Braille <input type="checkbox"/> Writing messages to express or clarify needs <input type="checkbox"/> Other <input type="checkbox"/> Signs/gestures/sounds <input type="checkbox"/> NONE OF ABOVE <input type="checkbox"/>
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	Speech unclear 0. No 1. Yes
6. ABILITY TO UNDERSTAND OTHERS	(Understanding verbal information content — however able) 0. Understands 1. Usually understands — may miss some pertinent 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 over last 90 days 0. No Change 1. Improved 2. Deteriorated

Resident _____

Date: _____

Facility: _____

Prov. No. _____

SECTION D. VISION PATTERNS		1	2	3
1. VISION	(Able 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. Highly impaired — limited vision, not able to see news-paper headlines, appears to follow objects with eyes 3. Severely impaired — no vision or appears to see only light, color, or shapes			
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) Experiences any of following: sees halos or rings around lights, sees flashes of light; sees "curtains" over eyes NONE OF ABOVE			
3. VISUAL APPLIANCES	Glasses; contact lenses; lens implant; magnifying glass 0. No 1. Yes			

SECTION E. MOOD AND BEHAVIOR PATTERNS		1	2	3	4	5	6	7	8	9	10
1. SAD OR ANXIOUS MOOD	(Check all that apply during last 30 days.) VERBAL EXPRESSIONS OF DISTRESS by resident (sadness, sense that nothing matters, hopelessness, worthlessness, unrealistic fears, vocal expressions of anxiety or grief) DEMONSTRATED (OBSERVABLE) SIGNS OF MENTAL DISTRESS - Tearfulness, emotional groning, sighing, breathlessness - Motor agitation such as pacing, handwringing or picking - Pervasive concern with health - Recurrent thoughts of death — e.g., believes he/she about to die, have a heart attack - Suicidal thoughts/actions - Failure to eat or take medications - Withdrawal from self-care, or leisure activities - Reduced communications - Early morning awakening with unpleasant mood NONE OF ABOVE										
2. MOOD PERSISTENCE	Sad or anxious mood intrudes on daily life over last 7 days — not easily altered, doesn't "cheer up" 0. No 1. Yes										
3. PROBLEM BEHAVIOR	(Code for behavior in last 7 days) 0. Behavior not exhibited in last 7 days 1. Behavior of this type occurred less than daily 2. Behavior of this type occurred daily or more frequently a. WANDERING (moved with no rational purpose; seemingly oblivious to needs or safety) b. VERBALLY ABUSIVE (others were threatened, screamed at, cursed at) c. PHYSICALLY ABUSIVE (others were hit, shoved, scratched, sexually abused) d. SOCIALLY INAPPROPRIATE/DISRUPTIVE BEHAVIOR (made disrupting sounds, noisy, screams, self-abusive acts, sexual behavior or disclosing in public, smeared/ threw food/secret, hearing, rummaged through others' belongings)										
4. RESIDENT RESISTS CARE	(Check all types of resistance that occurred in the last 7 days.) Resisted taking medications/injection Resisted ADL assistance Resisted eating NONE OF ABOVE										

5. BEHAVIOR MANAGEMENT PROGRAM	Behavior problem has been addressed by clinically developed behavior management program. (Note: do not include programs that involve only physical restraints or psychotropic medications in this category.) 0. No behavior problem 1. Yes, addressed 2. No, not addressed		
6. CHANGE IN MOOD	Change in mood in last 90 days 0. No change 1. Improved 2. Deteriorated		
7. CHANGE IN PROBLEM BEHAVIOR	Change in problem behavioral signs in last 90 days 0. No change 1. Improved 2. Deteriorated		

SECTION F. PSYCHOSOCIAL WELL-BEING		1	2	3	4	5
1. SENSE OF INITIATIVE/ INVOLVEMENT	At ease interacting with others At ease doing planned or structured activities At ease doing self-initiated activities Establishes own goals Pursues involvement in life of facility (e.g., makes friends/friends; involved in group activities; responds positively to new activities; assists at religious services) Accepts invitations into most group activities Adjusts easily to changes in routine NONE OF ABOVE					
2. UNSETTLED RELATIONSHIPS	Cover/lopesn conflict with and/or repeated criticism of staff Unhappy with roommate Unhappy with residents other than roommate Openly expresses conflict/tanger with family or friends Absence of personal contact with family/friends Recent loss of close family member/friend Avoids interactions with others NONE OF ABOVE					
3. PAST ROLES	Strong identification with past roles and life status Expresses sadness/anger/empty feeling over lost roles/status NONE OF ABOVE					

SECTION G. ACTIVITY PREFERENCE PATTERNS		1	2	3	4	5	6	7	8	9	10
1. TIME AWAKE	(Check appropriate time periods over last 7 days.) Resident awake most or all of the time (i.e., naps no more than one hour per time period) in the: Morning <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Afternoon <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Evening <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> NONE OF ABOVE										
2. AVERAGE TIME INVOLVED IN ACTIVITIES	0. Most (more than $\frac{2}{3}$ of time) 1. Some (between $\frac{1}{3}$ and $\frac{2}{3}$ of time) 2. Little (less than $\frac{1}{3}$ of time) 3. None										
3. PREFERRED ACTIVITY SETTINGS	(Check all settings in which activities are preferred.) Own room <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Day/activities room <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Inside Night/ unit <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Outside facility <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> NONE OF ABOVE										
4. GENERAL ACTIVITIES PREFERENCES (Adapted to resident's current abilities)	(Check all PREFERENCES whenever or not activity is currently available to resident.) Cards/other games <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Crafts/art <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Exercise/sports <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Music <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Read/write <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Spiritual/religious activities <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Trio/s/shopping <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Walking/wheeling outdoors <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Watch TV <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Gardening/plants <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Talking/conversing <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Helping others <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> NONE OF ABOVE										

= Code the appropriate response.

= Check all the responses that apply.

Resident _____ Date: _____ Facility: _____

Prov. No. _____

SECTION G. CONTINUED

3. PREFERENCES MORE OR DIFFERENT ACTIVITIES/CHOICES:	1. Yes 0. No
4. ISOLATION ORDERS	Resident is under medical orders for isolation which prohibits participation in group activities 1. Yes 0. No

SECTION H. PHYSICAL FUNCTIONING AND STRUCTURAL PROBLEMS

1. 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+ times during last 7 days — OR — Supervision 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+ 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.	1	2
------------------------------------------------------------------------------------------------------------------------	---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------	---	---

2. 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-person physical assist	1	2
3. BED MOBILITY	How resident moves to and from lying position, turns side to side, and positions body while in bed		
4. TRANSFER	How resident moves between surfaces — (from: bed, chair, wheelchair, standing position (EXCLUDE toilet/room partition))		
5. LOCOMOTION	How resident moves between locations in his/her room and adjacent corridor on same floor. If in wheelchair, self-sufficiently once in chair		
6. DRESSING	How resident puts on, fastens, and takes off all items of street clothing, including donning/removing prostheses		
7. EATING	How resident eats and drinks (regardless of skill)		
8. TOILET USE	How resident uses the toilet room (or commode, bedpan, urinal); transfers on/off toilet, cleanses, changes pad, manages ostomy or catheter, adjusts clothes		
9. 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)		
1. BATHING	a. 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. Bathing Self-Performance codes appear below.) 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	1	2
	b. Tub/windood bath Shower	3	4
		Bed bath Bath lift	
		NONE OF ABOVE	

= Code line appropriate response. = Check all the responses that apply.

4. BODY CONTROL PROBLEMS	Balance — partial or total loss of ability to stand Bedfast all or most of the time Hemiplegia/hemiparesis Quadriplegia Arm — partial or total loss of voluntary movement	Hand — lack of dexterity (e.g., problem using toothbrush or adjusting hearing aid) Leg — partial or total loss of voluntary movement Trunk — partial or total loss of ability to position, balance, or turn body Amputation NONE OF ABOVE	1	2	3	4	5	6	7	8	9	10	11	12
5. CONTRACTURES	Contractures — None Contractures — Face/neck Contractures — Shoulder/elbow Contractures — Brace/prosthesis Contractures — Wheelchair self Other person wheeled	Contractures — Hand/wrist Contractures — Hip/knee Contractures — Foot/ankle Contractures —												
6. MOBILITY APPLIANCES/DEVICES	Cane/walker Brace/prosthesis Wheeled self Other person wheeled	Lifted (manually/mechanically) Transfer aid (slide brd) Trapeze NONE OF ABOVE												

7. TASK SEGMENTATION	Resident requires that some or all of ADL activities be broken into a series of sub-tasks so that resident can perform them. 0. No 1. Yes		
8. CHANGE IN ADL SELF-PERFORMANCE	Change in ADL Self-Performance in last 90 days 0. No change 1. Improved 2. Deteriorated		
9. ADL FUNCTIONAL REHAS. POTENTIAL	Resident believes he/she capable of increased independence in at least some ADLs Direct care staff believe resident capable of increased independence in at least some ADLs Resident able to perform task/activity but is very slow Major difference in ADL self-performance or ADL support in mornings and evenings (at least a one category change in self-performance or support in any ADL) Self-performance restricted due to absence of assistive devices (e.g., brace or wheelchair) Tires noticeably during most days Active avoidance of activity for which resident is physically/cognitively capable (e.g., fear of falling) NONE OF ABOVE		

SECTION I. CONTINENT CONTROL TASKS

1. CONTINENCE SELF-CONTROL CATEGORIES (Code for resident performance over all shifts.)	0. CONTINENT — Complete control 1. USUALLY CONTINENT — BLADDER, incontinent episodes once a week or less; BOWEL, less than weekly 2. OCCASIONALLY INCONTINENT — BLADDER, 2 - 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		
2. BOWEL CONTINENCE	Control of bowel movement, with appliance or bowel continence programs, if employed		
3. BLADDER CONTINENCE	Control of urinary bladder function (if double, volume insufficient to soak through underpants), with appliances (e.g., Foley) or continence programs, if employed		
4. INCONTINENCE RELATED TESTING	(Skip if resident's bladder and bowel continence codes equal 0 or 1 and no catheter is used.) Resident has been tested for a urinary tract infection Resident has been checked for presence of fecal impaction There is adequate bowel elimination NONE OF ABOVE		

Resident _____ Date: _____ Facility: _____

Prov. No. _____

SECTION 1. CONTINUED

3. APPLIANCES AND PROGRAMS	Any scheduled toileting plan	3. Did not use toilet room: _____ a. commode/urnal _____ b. Pads/briefs used _____ c. Enemas/irrigation _____ d. Ostomy (bowel) _____ e. NONE OF ABOVE _____	9
4. CHANGE IN URINARY CONTINENCE	Change in urinary continence/appliances or programs in last 90 days	0. No change 1. Improved 2. Deteriorated	11

SECTION 1. SKIN CONDITION AND FOOT CARE

1. STASIS ULCER	Open lesion caused by poor venous circulation to lower extremities	0. No 1. Yes	12
2. PRESSURE ULCERS	Record the number of sites for presence of each stage of pressure ulcers. If none are present at the stage stated, record "0" (zero) in the space provided. Code all that apply to resident during last 7 days.)	No. at Stage	13
	a. Stage 1. A persistent area of skin redness (without a break in the skin) that does not disappear when pressure is relieved.		14
	b. Stage 2. A partial thickness loss of skin layers that presents clinically as an abrasion, blister, or shallow crater.		15
	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.		16
	d. Stage 4. A full thickness of skin and subcutaneous tissue is lost, exposing muscle and/or bone.		17
3. HISTORY OF RESOLVED/ CURED PRESSURE ULCERS	Resident has had a pressure ulcer that was resolved/ cured in last 90 days.	0. No 1. Yes	18

4. OTHER SKIN LESIONS OR PROBLEMS PRESENT	Skin desensitized to pain, pressure, discomfort Abrasions, bruises Burns (second or third degree) Surgical wounds Cuts (other than surgery) Open lesions other than stasis/pressure ulcers, or cuts Rashes NONE OF ABOVE	19 20 21 22 23 24 25 26
5. ACTIVE SKIN CARE PROGRAM	Preventive/Protective Skin Care Turning/repositioning program Pressure relieving pads, bed/chair pads (e.g., egg crate pads) Surgical wound or pressure ulcer care Other skin care/treatment Special nutrition/hydration program Special application/treatments/medications Ostomy care (e.g., trach) (routine/stable) NONE OF ABOVE	27 28 29 30 31 32 33 34 35

6. SPECIAL STOCKINGS	During the last 7 days has the resident used TED or similar stockings?	0. No 1. Yes	36
7. FOOT CARE	(Check all that apply to resident during LAST 30 DAYS.) Preventive/Protective Foot Care (e.g., special shoes, inserts, pads, toe separators, nail/callus trimming, etc.) Active Foot Care Treatments: Foot soaks Dressing with and without topical medications, etc. NONE OF ABOVE	37 38 39 40 41 42	

= Code the appropriate response. = Check all the responses that apply.

SECTION 1. DISEASE DIAGNOSES/HEALTH CONDITIONS

Check only those diseases diagnosed in the last 90 days that have a relationship to current ADL status, cognitive status, behavior status, medical treatments, or risk of death. (Do not list quiescent diagnoses.)

1. DISEASES	(If none apply, CHECK the NONE OF ABOVE box)	43
HEART/CIRCULATION	a. Atherosclerotic heart disease (ASHD) b. Cardiac dysrhythmia c. Congestive heart failure d. Hypertension e. Hypotension f. Peripheral vascular disease g. Other cardiovascular disease	44 45 46 47 48 49 50
NEUROLOGICAL	h. Alzheimer's disease i. Dementia other than Alzheimer's j. Aphasia k. Cerebrovascular accident (stroke) l. Multiple Sclerosis m. Parkinson's disease n. PULMONARY o. Emphysema/Asthma/COPD p. Pneumonia	51 52 53 54 55 56 57 58 59 60 61 62
PSYCHIATRIC/MOOD	q. Anxiety disorder r. Depression s. Manic depressive (bipolar disease) t. SENSORY u. Cataracts v. Glaucoma w. OTHER x. Allergies y. Anemia z. Arthritis aa. Cancer ab. Diabetes mellitus ac. Explicit terminal prognosis ad. Hypothyroidism ae. Osteoporosis af. Seizure disorder ag. Sepsicemia ah. Urinary tract infection in last 30 days ai. NONE OF ABOVE	63 64 65 66 67 68 69 70 71 72 73 74 75 76 77 78 79 80 81 82 83 84 85 86 87 88 89 90 91 92 93 94 95 96 97 98 99 100

2. OTHER CURRENT DIAGNOSES AND ICD-9 CODES	a. _____ b. _____ c. _____ d. _____ e. _____ f. _____	101 102 103 104 105 106
--------------------------------------------	----------------------------------------------------------------------	----------------------------------------

3. PROBLEMS/ CONDITIONS AND SIGNS/ SYMPTOMS	(Check all that are present in last 7 days, UNLESS OTHER TIME FRAME INDICATED)	107
Constipation	a. Recurrent lung aspirations in last 90 days	108
Diarrhea	b. Shortness of breath (Dyspnea)	109
Dizziness/vertigo	c. Vomiting	110
Fecal impaction	d. Respiratory infection	111
Fever	e. Chest Pain	112
Hallucinations/delusions	f. NONE OF ABOVE	113
Internal bleeding		114
Joint Pain		115
Pain — Resident complains or shows evidence of pain daily or almost daily		116

4. EDEMA	(Check all that apply in the last 7 days.)	117
Edema — none	a. Edema — localized not pitting	118
Edema — generalized	b. Edema — pitting	119
	c. Edema — other	120

5. ACCIDENTS	a. Fall — past 30 days b. Fall — past 31-180 days c. Hip fracture in last 180 days d. Other fractures in last 180 days e. NONE OF ABOVE	121 122 123 124 125
6. STABILITY OF CONDITIONS	a. Conditions/diseases make resident's cognitive, ADL, or behavior status unstable-fluctuating, precarious, or deteriorating. b. Resident experiencing an acute episode of a flare-up of a recurrent/chronic problem. c. NONE OF ABOVE	126 127 128

SECTION L ORAL/NUTRITIONAL STATUS			
1. ORAL PROBLEMS	Chewing problem Swallowing problem Mouth pain NONE OF ABOVE	1 2 3 4	
2. HEIGHT AND WEIGHT	a. Record height in inches b. Record weight in pounds	HT (in.) WT (lb.)	1 1
3.1. NUTRITIONAL PROBLEMS	Complains about the taste of many foods Insufficient fluid: dehydrated Did NOT consume all/ almost all liquids provided during last 3 days	1. Regular complaint of hunger 2. Leaves 25%+ food uneaten at most meals 3. NONE OF ABOVE	1 1 1
3.2.			
4.1. NUTRITIONAL APPROACHES	Parenteral/IV Feeding tube Mechanically altered diet Syringe (oral feeding)	1. Therapeutic diet 2. Dietary supplement between meals 3. Plate guard, stabilized built-up utensil, etc. 4. NONE OF ABOVE	1 1 1 1

SECTION M ORAL/GENERAL STATUS			
1. ORAL STATUS AND DISEASE PREVENTION	Debris (soft, easily movable substances) present in mouth prior to going to bed at night Has dentures and/or removable bridge Somewhat natural teeth lost — does not have or does not use dentures (or partial plates) Broken, loose, or carious teeth Inflamed gums (gingivitis); swollen or bleeding gums; oral abscesses, ulcers, or rashes Daily cleaning of teeth/dentures NONE OF ABOVE	1 2 3 4 5 6 7 8 9	

SECTION N SPECIAL TREATMENTS, DEVICES, PROCEDURES & SUPPLIES			
1. SPECIAL TREATMENTS AND PROCEDURES	a. SPECIAL CARE — (Check treatments received during the last 14 days.) Chemotherapy Radiation Dialysis Suctioning Trach care IV meds.	1. Transfusions 2. O2 3. Intake/Output 4. Ventilator/Respirator 5. Other 6. NONE OF ABOVE	1 1 1 1 1 1
	b. THERAPIES — Enter the number of days and total minutes each of these therapies was administered (for at least 10 minutes) in the last 7 days: (Enter 0 if none) Box A = # of days administered for 10 minutes or more Box B = total # of minutes provided in last 7 days: A B		
	a. Speech — language pathology, audiology services b. Occupational therapy c. Physical therapy d. Psychological therapy (any licensed prof.) e. Respiratory therapy f. Recreation therapy		

2. REHABILITATION/RESTORATIVE CARE	Record the NUMBER OF DAYS each of the following rehabilitation/restorative technique/practice was provided for more than or equal to 15 minutes per day to the resident in the last 7 days. (Enter 0 if none.) a. Range of Motion (passive) b. Range of Motion (active) c. Splint/Brace Assistance d. Reality Orientation e. Remobilization f. Training and Skill Practice in: 1. Locomotion/Mobility g. Dressing/Grooming h. Eating/Swallowing i. Transfer j. Amputation care	
3. DEVICES AND RESTRAINTS	Use the following code for last 7 days: 0. Not used 1. Used less than daily 2. Used daily a. Bed rails b. Trunk restraint c. Limb restraint d. Chair prevents rising	
4. SUPPLIES	Record the number of units of the supply listed that have been used or consumed by the resident in the past 7 days. (Enter 0 if none.) a. Sterile Dressings b. Unique/Special Decubitus Care Supplies c. Peritoneal Dialysis Supplies	
5. PHYSICIAN VISITS/ORDERS	IN THE PRIOR 30-DAY PERIOD since the resident was admitted, how many times has the physician (authorized assistant/practitioner) changed the resident's orders? (Do not include order renewals without change.)	
6. NO LAB TEST	Check if no laboratory tests performed in the last 90 days. (Skip to Section O.)	1
7. LABORATORY TEST	How many lab samples (blood/urine/etc.) have been collected IN THE PAST 30 DAYS?	
8. ABNORMAL LAB RESULTS	a. How many laboratory tests were returned with abnormal values during the past 90 days? b. How many abnormal values resulted in treatment or care planning in the past 30 days?	
SECTION O MEDICATION USE		
1. NUMBER OF MEDICATIONS	Record the number of different medications used in the last 7 days: (Enter 0 if none used. Skip to Item 5.)	
2. NEW MEDICATIONS	Resident has received new medication during the last 90 days. 0. No 1. Yes	1
3. INJECTIONS	Record the number of days injections of any type received during the last 7 days.	
4. DAYS RECEIVED FOLLOWING MEDICATION	Record the NUMBER OF DAYS during the last 7 days: enter 0 if not used; enter 1 if long-acting meds. used less than weekly. a. Antipsychotics b. Antianxiety/hypnotics c. Antidepressants	

Code line appropriate response. Check all the responses that apply.

Resident _____

Date: _____

Facility: _____

Prov. No. _____

SECTION O. CONTINUED

5. PREVIOUS MEDICATION RESULTS	<p>Skip this question if resident currently receiving antipsychotics, antidepressants, or anti-anxiety/hypnotics — otherwise code correct response for last 90 days.</p> <p>Resident has previously received psychoactive medications for a mood or behavior problem, and these medications were effective (without undue adverse consequences).</p> <p>0. No, drugs not used 1. Drugs were effective 2. Drugs were not effective 3. Drug effectiveness unknown</p>
--------------------------------	------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------

SECTION P. PARTICIPATION IN ASSESSMENT

1. PARTICIPATION IN ASSESSMENT	Resident:	0. No	1. Yes	2. No family
	Family:	0. No	1. Yes	2. None
	Significant Other:	0. No	1. Yes	2. None

P.2. SIGNATURES OF THOSE COMPLETING THE ASSESSMENT:

a. Signature of RN Assessment Coordinator	b. End Date
c. Signature _____ Title _____ Sections _____ Date _____	
d. _____	
e. _____	
f. _____	
g. _____	
h. _____	

P.3. CASE MIX GROUP
Medicare

State

= Code the appropriate response. = Check all the responses that apply.

