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Implementation of Staff Training Curriculum Aimed at Improving MDS Coding in a Long-Term Care Setting

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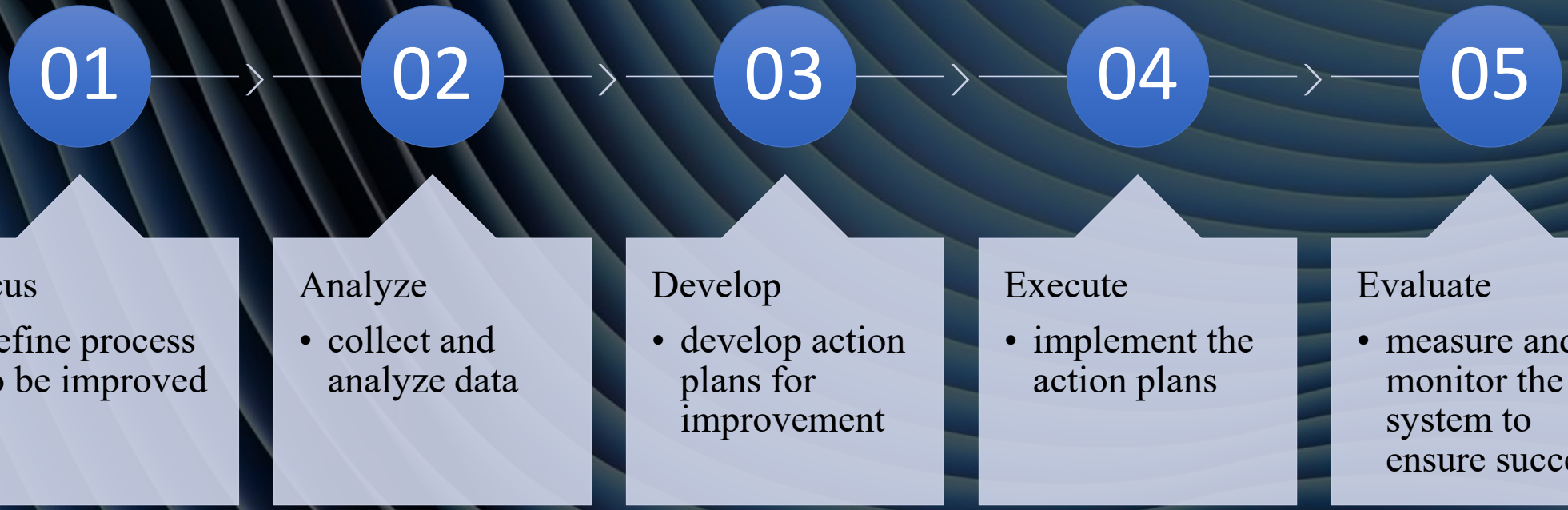
CSB/SJU NRSG 395 Quality Improvement Capstone Project

Maureen Burns, Emalee Driemeyer, Caitlin O'Toole, Eliana Scheett, Erin Sticha

FADE Model


01
Focus
• define process to be improved
02
Analyze
• collect and analyze data
03
Develop
• develop action plans for improvement
04
Execute
• implement the action plans
05
Evaluate
• measure and monitor the system to ensure success

Location

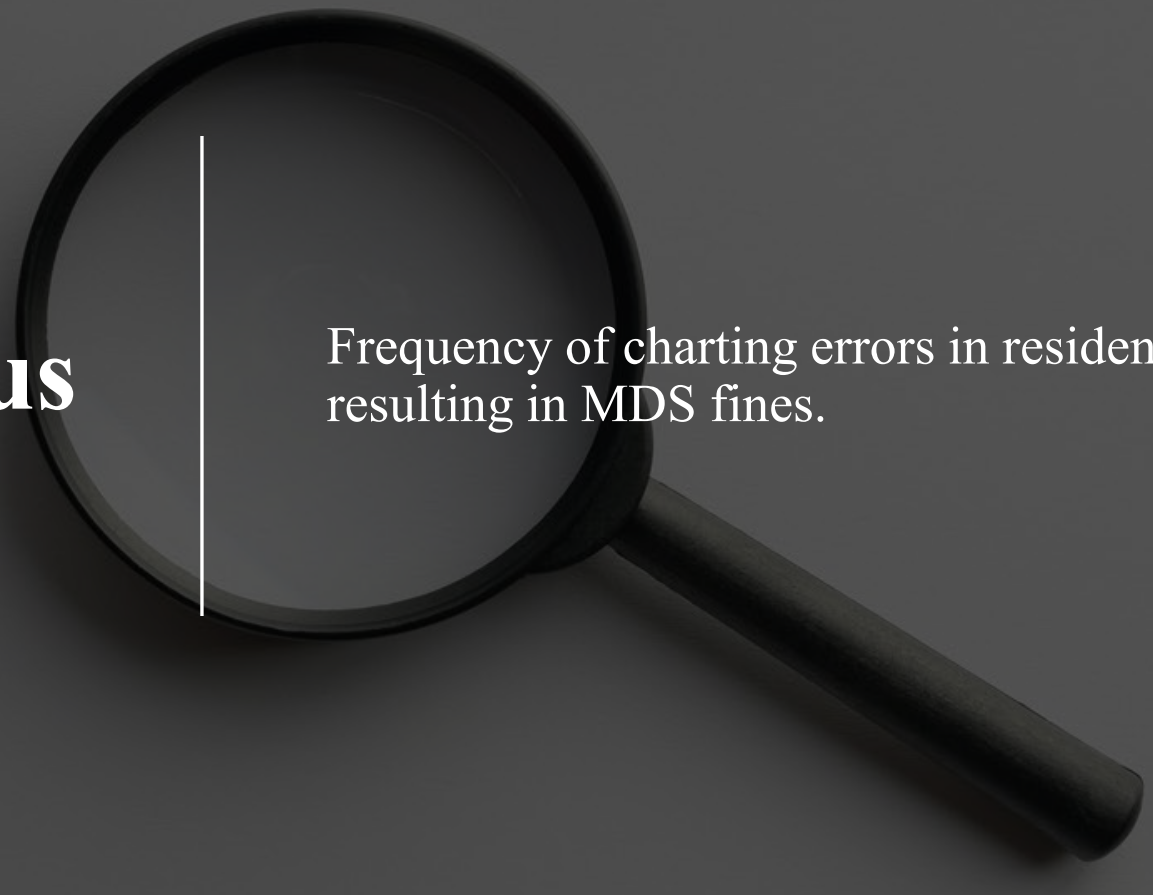
Elim Milaca long-term care and rehabilitation facility in Milaca, MN

Possible areas of Improvement

- Staff Resiliency in COVID-19
- Resident Resiliency
- Staff Biases
- Improvement in Charting to reduce Error

Focus

Frequency of charting errors in resident mobility resulting in MDS fines.



Our Goal

Maintaining or improving the mobility of residents at the *Elim Milaca* facility through education aimed to improve MDS coding and charting accuracy.

Why do we want to address this issue?

- Residents may not actually be declining, but due to assistance that they were receiving from the staff and the charting that was documented, it makes it look like the residents are requiring more assistance than they really need.
- Not only has a negative impact on the facility and its effectiveness of care for the residents, but also has a negative impact on the residents.
- We are going to look at specifically the assistance with ambulation around the facility as well as transfers

Minimum Data Set (MDS)

- Maintains continuity of patient care.
- Much of documentation that is done in the long-term care setting involves a system called the Minimum Data Set or MDS.
- This system is used to ensure residents receive the correct level of care required.
- Also used for payment reimbursement and data mining (QI purposes).

Current Issue

Currently receive
$0.94/resident/day

Could receive
$3.50/resident/day

Overall annual loss of
$50,000 in this one area

Analysis

- Literature Review
- Data Collection
- Root Cause

- Accurate Documentation:
  - Employers utilizing documentation systems (EHR, MDS, etc.) should implement accessible and ongoing education regarding the importance of accurate charting as well as the best practices for the efficient charting of patient care (Penoyer et al. 2014).
- Daily Autonomy:
  - Studies have shown that maintaining as much independence as possible with completing ADLs helps to improve quality of life through the aging process. (Tornero-Quiñones et al. 2020).
- Physical Activity:
  - The reviews of trained volunteer-led physical activity programs aging populations showed the importance of physical activity and the positive impacts that it has on this population (Lim et al. 2021).

Literature Review

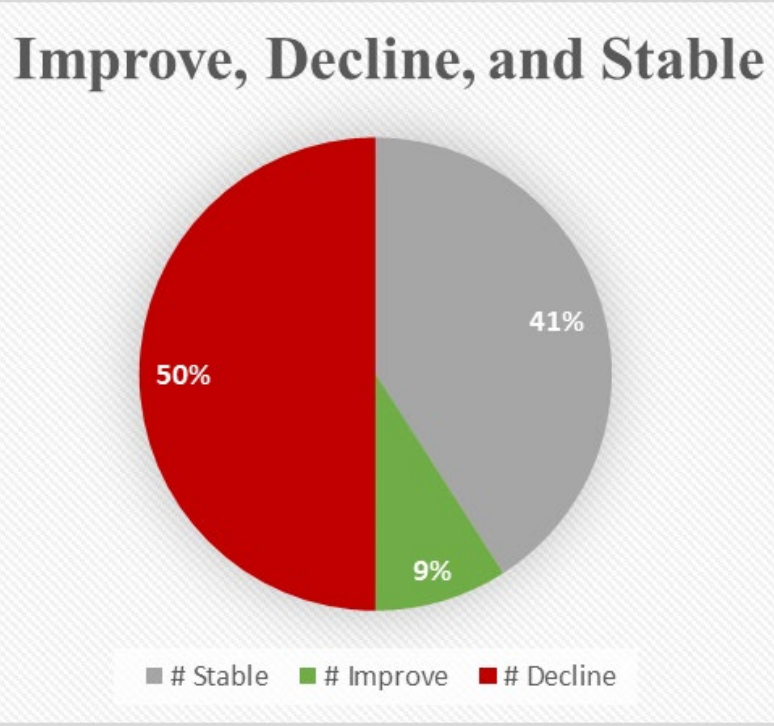
Data Collection

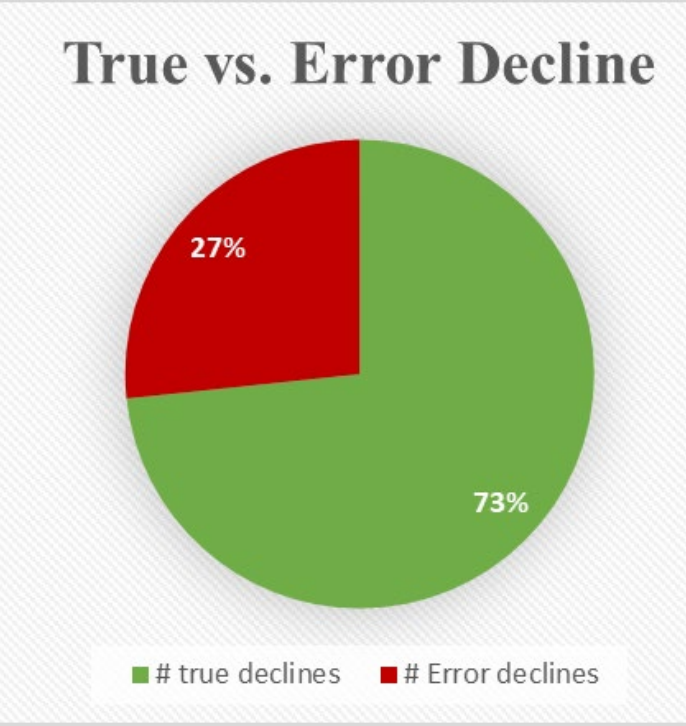
- Chart review looking specifically at the “MDS Assessment D1 – walk in corridor/self-performance” section in the facility’s Matrix charting system
- Data was collected from 23 resident’s quarterly or significant change assessments.
- Categorized resident’s current MDI code for ambulation on the unit compared to their previous level
- Assigned each resident a status label as declining, stable, or improved
- Revealed specific causes as to why discrepancies in MDS coding occurred in resident ambulation status
- New staff made many of the noted errors suggesting need for more staff education

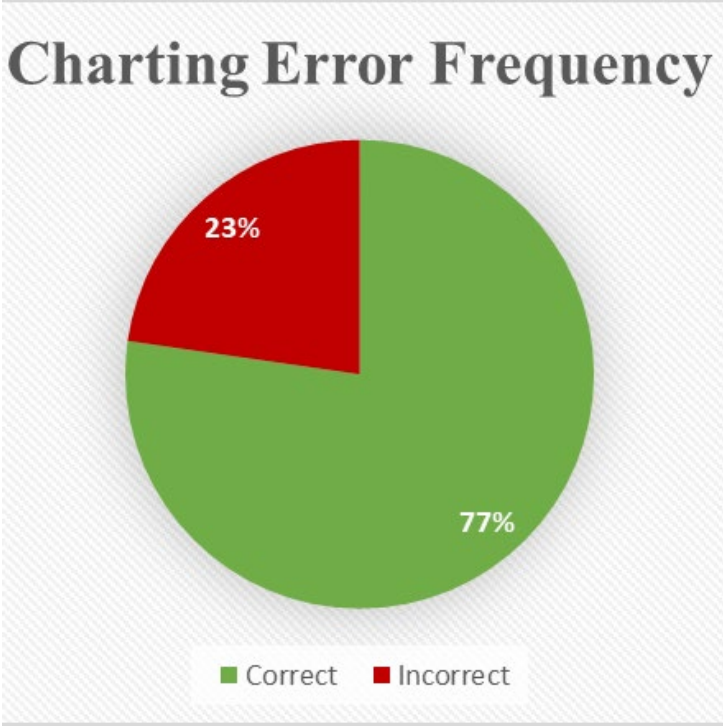
Forming Categories

GP	1	1	Stable (charting error -improving)
HS	2	2	Decline (charting error -stable)
AN	7	2	Decline (COVID protocols)
AS	8	0	Decline (true)
BR	8	7	Decline (true)
JW	1	0	Decline (charting error -stable)
MO	8	8	Stable
GK	7	3	Decline (true)
DM	8	7	Decline (true)
JM	3	3	Decline (charting error -stable)
ET	8	0	Decline (true and charting error)
RS	8	3	Decline (true)
BM	7	3	Decline (true)
MH	8	8	Stable
DS	1	1	Improved
GB	3	3	Stable
RH	8	8	Stable
MS	8	8	Stable
LM	7	8	Improved
JR	8	8	Stable
TK	8	8	Stable
BG	8	8	Stable

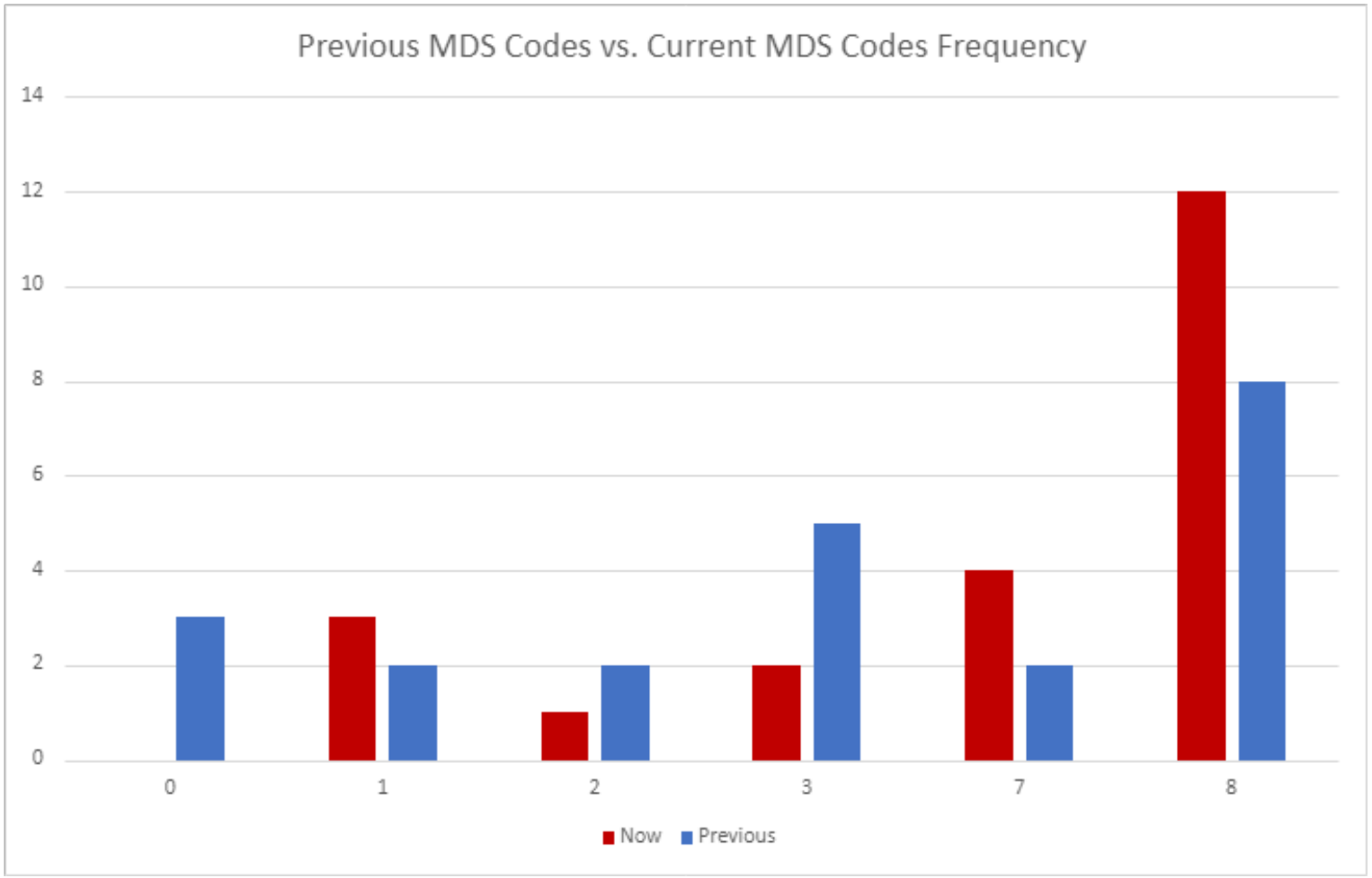
Data Distribution







Shifts in Functional Status Between Assessments



Root Cause

- Charting errors made by staff
- Assist residents more than necessary to improve time effectiveness in care
- Misunderstanding of MDS code system

Develop

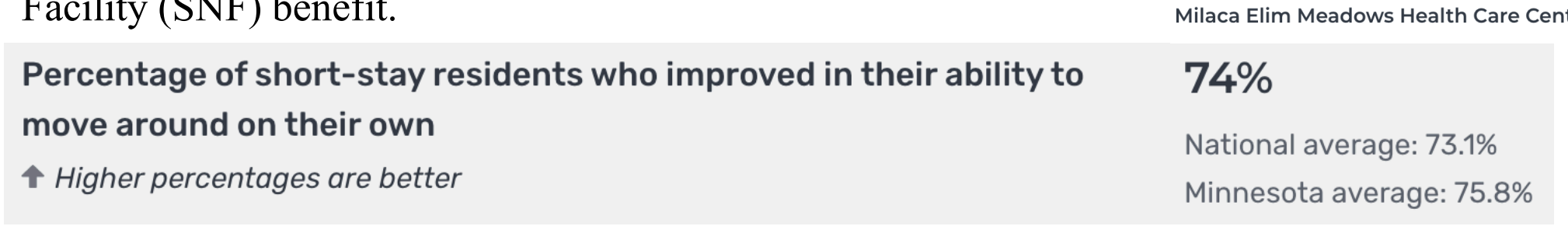
Potential Solutions

Selected Solution and Plan for Implementation

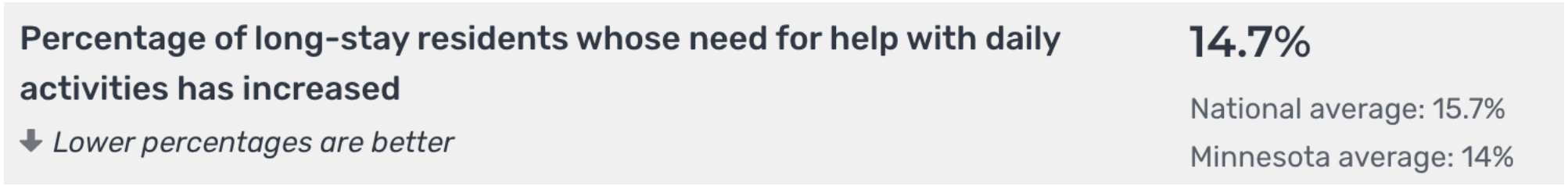
- Training Video
- Educational Presentation
- New Flowsheets
- Patient Identification Coding

Commitment

- Centers for Medicare & Medicaid Services (CMS)
  - Measure performance: Quality Measures
  - Scores for these measures.
  - Based on an average.
- Short-Stay Quality Measures: 100 days or less or coved under the Medicare Part A Skilled Nursing Facility (SNF) benefit.



- Long-Stay Quality Measures: 101 days or more

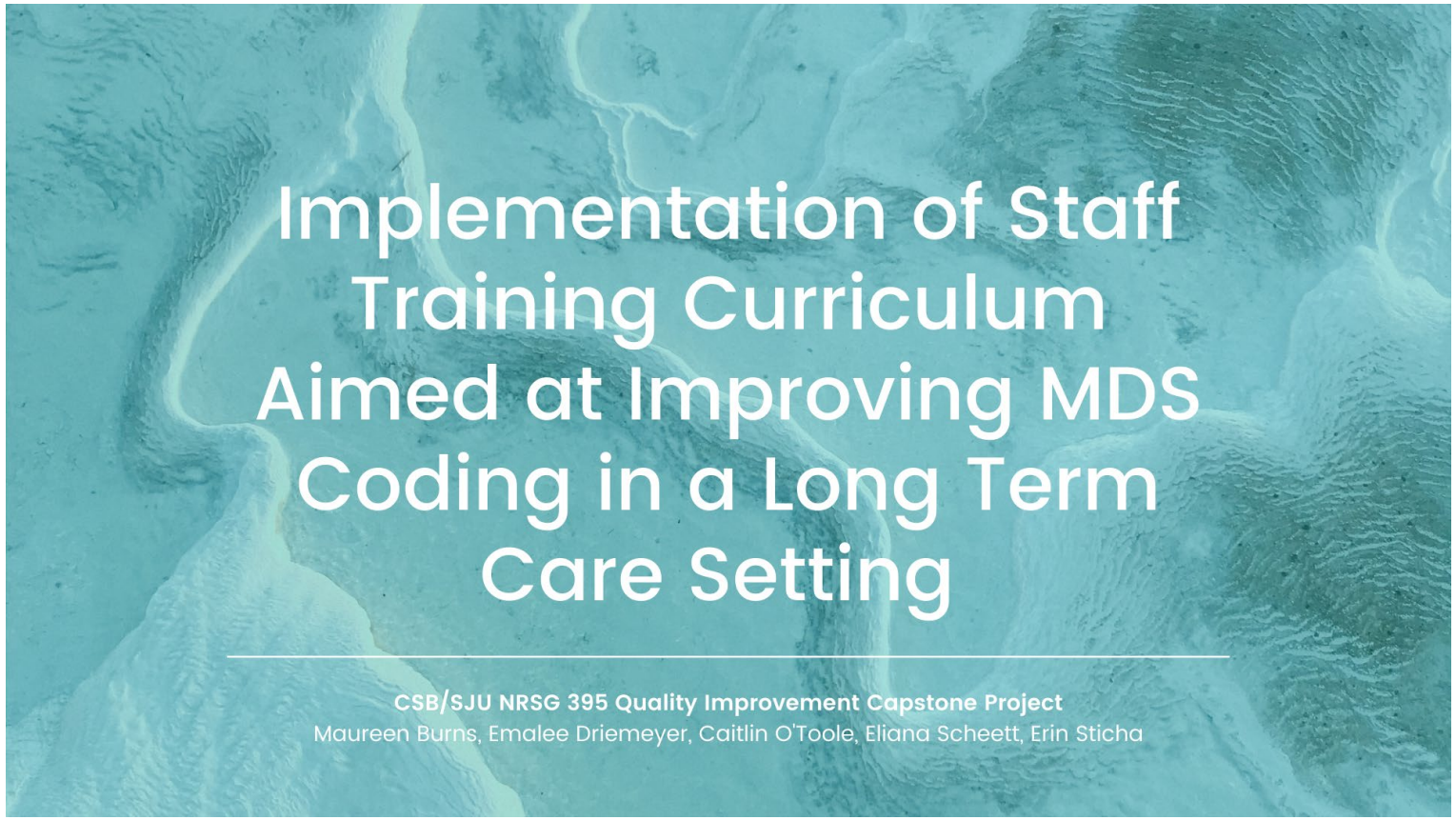


Medicare.gov

Execution & Implementation

Video Training

Educational Presentation



Code Clarification

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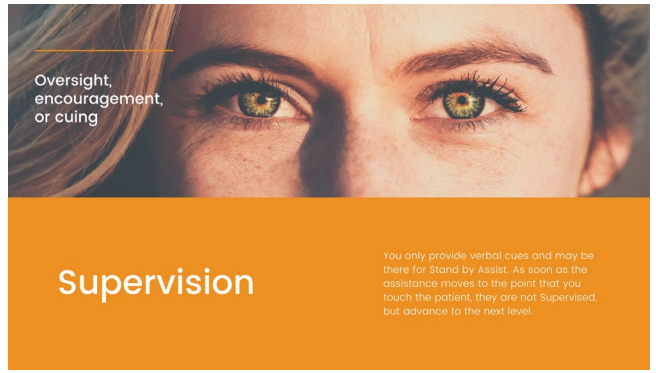
Mobility Independence and Maintaining Functional Status

NO Talk NO Touch

Independent

You may set up a walker next to their bed, or lay out clothes, but you do not assist them in any way physically or verbally. (Remember that people can be independent in some areas and require assistance in others).



Supervision

You only provide verbal cues and may be there for Stand by Assist. As soon as the assistance moves to the point that you touch the patient, they are not Supervised, but advance to the next level.

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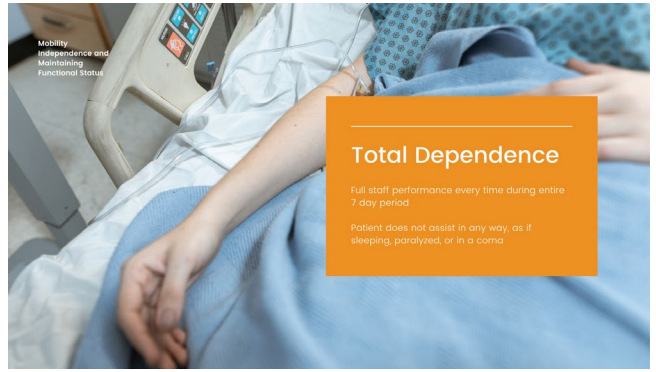
Limited vs. Extensive Assistance

Limited: Resident highly involved in activity; staff provide guided maneuvering of limbs or other **non-weight-bearing assistance**

Extensive: Resident involved in activity, staff provide **weight-bearing support**

Mobility Independence and Maintaining Functional Status

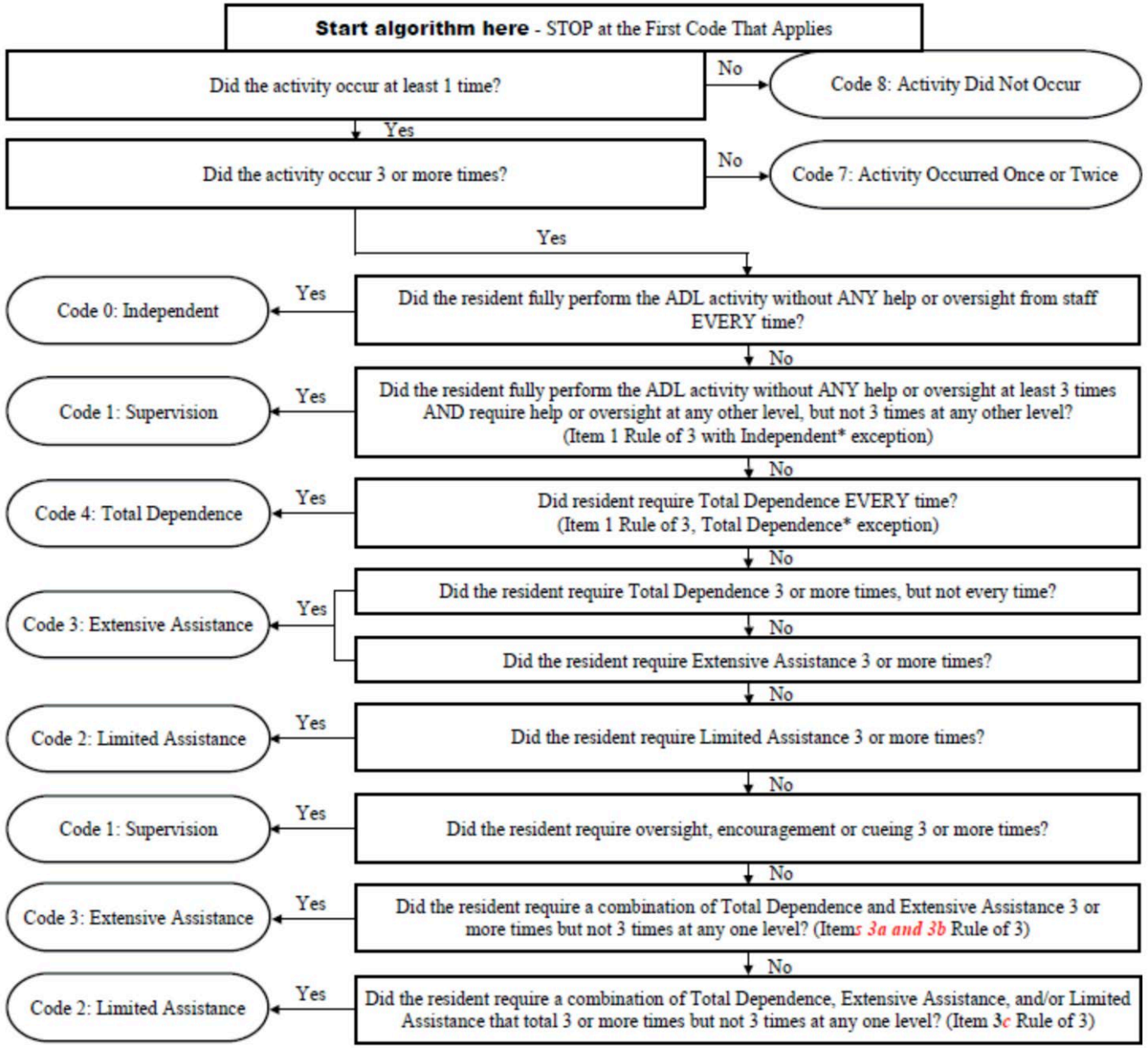


Total Dependence

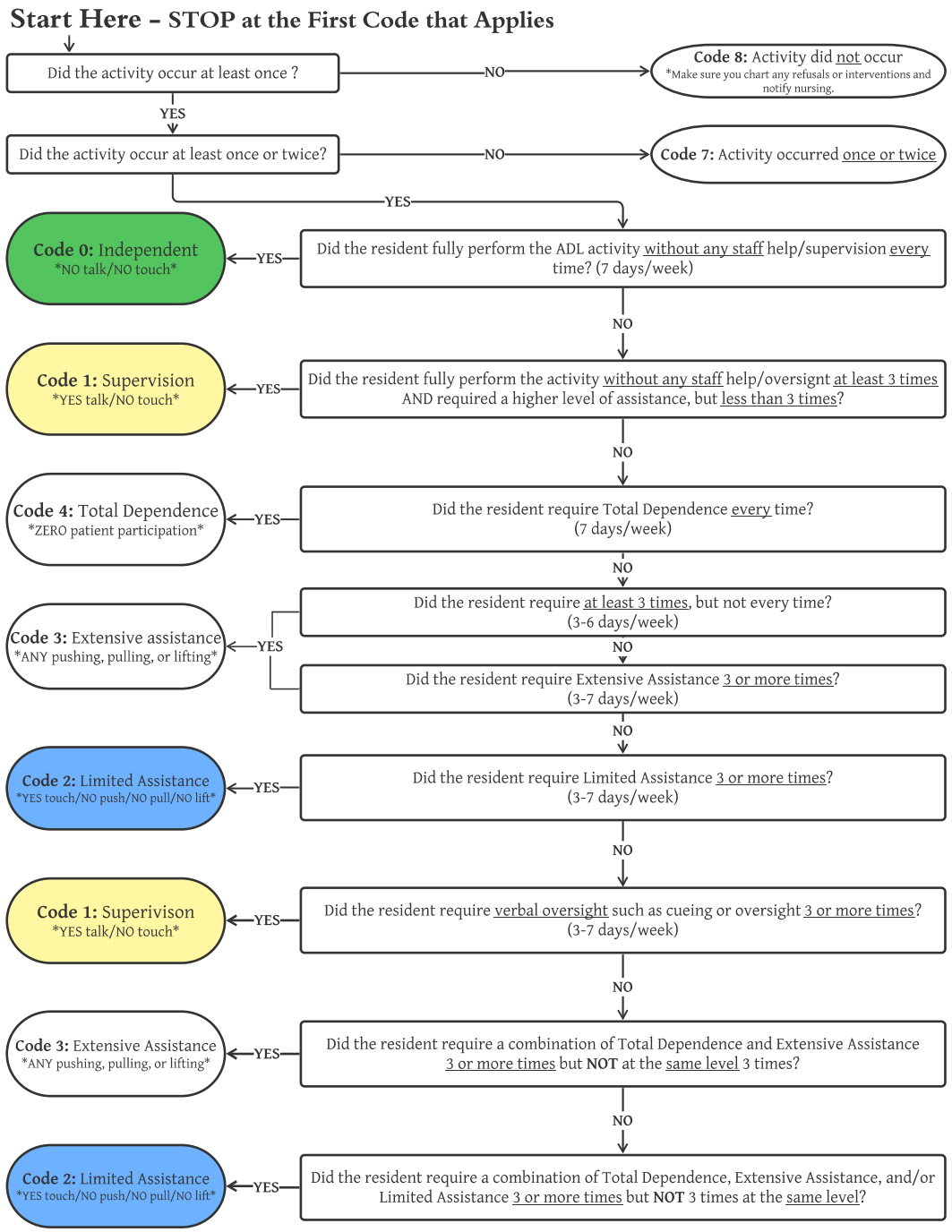
Full staff performance every time during entire 7 day period

Patient does not assist in any way, as if sleeping, paralyzed, or in a coma

Original Flow Chart for ADL Coding



Our Modified Flow Chart for ADL Coding



New Code Status Resource for all Direct Care Staff

Code Status	Explanation *Always consult nursing if you have any questions to avoid charting errors*
Code 0: Independent *NO talk/NO touch*	A resident is ***independent*** if they ***never*** need staff supervision OR assistance. Staff **do not** touch the resident, but may '**set up**' an ADL. For example, laying out clothes - staff **do not** physically or verbally assist the resident and are not present for the actual ADL (i.e. dressing).
Code 1: Supervision *YES talk/NO touch*	A resident requires ***supervision*** if you **do not** touch the person during the ADL. You may provide **verbal cues** and act as a **stand-by assist** and are present during the ADL. However, if you do touch the resident at any time, they advance to another level of assistance.
Code 2: Limited Assistance *YES touch/NO push/NO pull/NO lift*	A resident requires ***limited assistance*** if the hands-on interaction is strictly for **guidance**. It is less common for a resident to function at this level of assistance than the other levels. Limited assistance is equivalent to **Contact Guard Assist (CGA)**. Staff **do not** lift, push, or pull - **ONLY TOUCH**.
Code 3: Extensive assistance *ANY pushing, pulling, or lifting*	A resident requires ***extensive assistance*** if ANY kind of pushing, pulling, or lifting is needed by staff. Staff will **touch AND bear weight** while the resident participates in the ADL. MOST hands-on assist requires weight bearing. **Minimum** and **maximum assistance** are both extensive assistance.
Code 4: Total Dependence *ZERO patient participation*	A resident who is ***totally dependent*** on staff will **not participate** in the ADL all 7 days/week. They are unable to help with the task, so staff complete the ADL from start-to-finish. e.g. patient is in a coma or unresponsive.

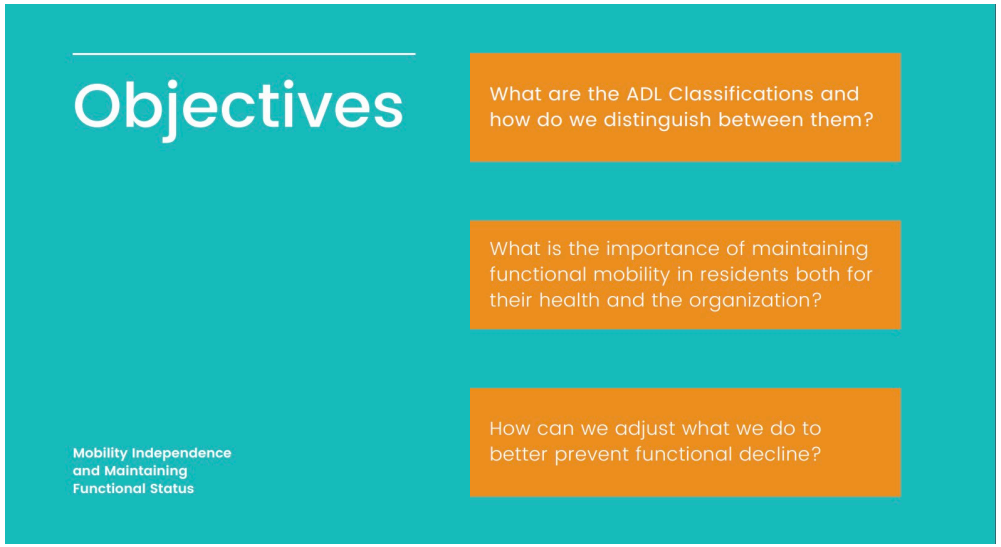
Remember...

- A resident can require different levels of assistance depending on the task. Always chart each ADL individually and accurately.
- If a resident is requiring a higher level of care than usual, notify nursing ASAP. Interventions such as physical therapy may be appropriate and implemented.
- Communicate with nursing whenever charting limited assistance - it is less common a resident is assisted at this level.
- Incorrectly charting a level of assistance can negatively impact the revenue to care for all residents. If a resident's condition declines, notify nursing to document this correctly.

Code Status
0 = Independent
1 = Supervision
2 = Limited assistance
3 = Extensive assistance
4 = Total dependence
7 = Activity occurred once or twice/week
8 = Activity did not occur

Staff Assistance
0 = Independent
1 = Set, supervision
2 = Minimum assistance
3 = Maximum assistance

Evaluation of Effectiveness & Dissemination



- Staff training materials have been integrated into new-hire orientation at Elim Milaca
- MDS coordinator has seen a reduction in charting errors while completing MDS audits/assessments since implementation of QI
- DoN recognizes that there is a greater understanding among staff of MDS codes related to resident ambulation

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