Assessment History
In 1994 a workgroup made up of providers, Muskie School and DHHS representatives was established to provide recommendations for:

- RCA form design and content
- Development of the classification system
- Case Mix payment system
- Quality Indicator development
1995 Time Study
Twenty five Level 2 Facilities, with a total of 626 residents, participated in this time study. This included residents:

- In small facilities
- With head injuries
- With Alzheimer’s Disease
- With Mental illness
1999 Time Study
Thirty-two Facilities, with a total of 735 residents, participated in this time study. Facilities were selected according to:

- Overall population
- Presence of complex residents
- Presence of residents with mental health issues
- Presence of residents with Alzheimer’s or other Dementia
- Presence of elderly population
Residents were more dependent in ADL’s
There was an increase in residents with Alzheimer’s and other Dementias.
There was an increase in wandering and intimidating behaviors.
There was an increase in the amount of time needed to care for these residents
The Case Mix Grouper needed to be revised.
3 Purposes of The MDS-RCA

1. To identify the majority of the residents strengths, needs and preferences that provides information to guide staff in developing an individualized Service Plan.

2. To place a resident into a payment group within the Case Mix System of Reimbursement.

3. To provide information that will determine the Facility’s Quality Indicators.
Service Plans

- The purpose of the Service Plan is to provide individualized care to the resident by addressing the problems and needs identified by the MDS-RCA.

- The Service Plan needs to state an approach and a realistic goal for each identified problem or need.
What Is Case Mix?

- Case Mix is a system of reimbursement that pays according to the amount of time spent with residents.
- Residents are grouped according to the amount of time used in their care.
Case Mix Goals

- Improve equity of payment to providers
- Provide incentives to facilities for accepting higher acuity residents
- Strengthen the quality of care and quality of life for residents
- Improve access to residential care services for high acuity residents
How Does Case Mix Affect a Facility?

- Facilities can increase their reimbursement by admitting those residents whose care requires more of the staff’s time. These residents are higher acuity.

- Higher acuity residents include those with Alzheimer’s or other dementia, dependence in Activities of Daily Living, and mental health problems.
# Clinical Indicators Identifying the RCA-RUG Classification

<table>
<thead>
<tr>
<th>Group</th>
<th>ADL Splits</th>
<th>MDS-RCA Item</th>
</tr>
</thead>
<tbody>
<tr>
<td>Impaired Cognition</td>
<td>0-11; 12-14; 15-28</td>
<td>Sevemly Impaired Decision Making [B3=3]</td>
</tr>
<tr>
<td>Clinically Complex</td>
<td>0-1; 2-6; 7-11; 12-28</td>
<td>Any of the following conditions:</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Ulcers due to any cause ([M2a,b,c, or d &gt;0])</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Quadruplegia [I1z=checked]</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Burns [M1b=checked]</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• MS [I1w=checked]</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Radiation/ Chemotherapy [P1aa=checked]</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Hemiplegia/hemiparesis [I1v=checked]</td>
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<tr>
<td></td>
<td></td>
<td>• 4 or more physician order changes [P10&gt;=4]</td>
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<tr>
<td></td>
<td></td>
<td>• Aphasia [I1r=checked]</td>
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<tr>
<td></td>
<td></td>
<td>• Explicit Terminal Prognosis [I1ww=checked]</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Monitoring for Acute Conditions [P3a=1or P3a=2 or P3a=3 or P3b=1 or P3b=2 or P3b=3]</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Oxygen [P1ab=checked]</td>
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<td></td>
<td></td>
<td>• RT 5 or more days a week [P1bda &gt;= 5]</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• CP [I1s]</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Diabetics receiving daily injections [I1a=1 and O4ag=7]</td>
</tr>
<tr>
<td>Behavioral Health</td>
<td>0-4; 5-15; 16-28</td>
<td>Two or more indicators of depression, anxiety or sad mood [count of the number of items E1a-E1r exhibited at all (&gt;0)] OR Three or more interventions or programs for mood, behavior, or cognitive loss [three or more items in P2a-P2j checked] OR Delusions (J1e) or Hallucinations (J1f)</td>
</tr>
<tr>
<td>Physical</td>
<td>0-3; 4-7; 8-10; 11-28</td>
<td>MDS-RCA Assessment RUG items contain invalid or missing data.</td>
</tr>
<tr>
<td>Not Classifiable</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
What Are Quality Indicators?

Quality Indicators Are:

- Identifying flags
- Identify exemplary care
- Identify potential care problems
- Identify residents for review
- Information
- Based solely from responses on the MDS-RCA
Quality Indicators

History:

A workgroup of providers and state representatives held a number of meetings. This group was involved in the development of the MDS-RCA and the quality indicators. The form is consistent with the MDS which is used in nursing homes. The MDS-RCA has additional items to address the needs of the population served in RCFs. The same is true of the quality indicators. They are more reflective of the social model. The quality indicators were developed to provide the foundation for quality assurance and improvement activities.
Quality Indicators

The Reports (Language to Learn):

**Numerator**- Describes all residents in that group with a specific trait.

**Denominator**- All residents considered for that group.

**Prevalence**- The status of a resident at a point in time (as of the current assessment.)

**Incidence**- The change in status of a resident over a period of time (from the previous assessment to the current assessment.)

**Risk Adjustment**- Separation of resident populations into two groups: Those at high risk and those at low risk (All other residents)

**Percentage**- The number of residents that actually have a QI (numerator) divided by the number that could have a QI (denominator)

The list of the individual Quality Indicators with definitions is called the “Matrix”
Quality Indicators

The QI Report is specific to your facility and compares your ranking to statewide averages.

Review the reports. Compare your facility’s percentage to the state average. Why are we so much higher/lower? Evaluate. Conclusion?

When reviewing the QI Reports, remember that some of the assessments that the data was drawn from may be up to 6 months or older.
Completing the MDS-RCA

- Collect information to complete the MDS-RCA from a variety of sources.
- Collect information from the medical record, but observe and interview the resident for yourself.
- Collect information by interviewing caregivers and family members as well.
Accuracy of the MDS-RCA

- Always complete the MDS-RCA as accurately as possible.
- If supporting documentation is inaccurate, do not complete an inaccurate MDS-RCA using that documentation.
- Pay attention to the timeframe in each section of the MDS-RCA. Timeframes are always the last 7 days unless specified otherwise.
Confidentiality

- The person completing the MDS-RCA is responsible to maintain the confidentiality of all information collected.
- Reassure the resident that any information he or she supplies about themselves is confidential.
- Conduct interviews in a private area in a confidential manner.
The Assessment Reference date is the last day of the observation period. This date is used to count backward in time for the required number of days asked for in each section of the MDS-RCA. Admission day is counted as day 1. Calendar days and not business days are to be used. There should be no more than 7 days between the A5 date (assessment reference date) and the S2b date (completion date).
MDS-RCA Definitions

Quality Indicators- Indicators of quality, or flags. The MDS-RCA is the source document for these indicators.

R.U.G.- Resource Utilization Groups

Payment Items- These are certain services, conditions, diagnosis and treatments that are on the MDS-RCA. They place a resident into one of the 4 major R.U.G. groups.

Instrumental Activities of Daily Living (IADLS)- Real world situations based on the social model.

Cognition (Cognitive Ability)- The ability to recall what is learned or known and the ability to make ADL and IADL decisions.
Assessment Date (A5)- The **LAST DAY** of the observation period. This date, not the end date, is used to count backwards in time for the required number of days as per the instruction at the top of each MDS-RCA section/item.

**REMINDEERS:**

* Admission day is counted as day 1

* Calendar days not business days are to be used when counting for the MDS-RCA date.

* If the number of days to count backward in time is not specified at the top of a section or item, use 7 days.
Types and Timing of Assessment

- **Admission Assessment** - Completed by the 30th day post admission as represented by the S2b date.

- **Semi Annual Assessment** - Completed within 6 months of the Admission or Annual Assessment. S2b date to S2b date should be no more than 6 months.

- **Annual Assessment** – Completed within 12 months of the Admission Assessment or last Annual Assessment.
Types and Timing of Assessment

- **Significant Change Assessment** — To be completed by the 14th day after a significant change in the resident’s condition has been determined. Completion date represented at S2b.

- **Other** — Completed upon request by the Case Mix Nurse. Must be completed within 7 days of the Case Mix Nurse visit as represented at S2b.
Types and Timing of Assessment

- **Discharge Tracking Form** — To be completed within 7 days of the permanent discharge of a resident. These are not completed for temporary discharges to the hospital or LOA’s.

- **Basic Assessment Tracking Form** — To be completed within 7 days each time an MDS-RCA or Discharge Tracking Form is completed.
Significant Change Assessment

A significant change assessment is done when there is either a decline or improvement that has major impact and will be permanent.

Therefore: A significant change assessment would not be warranted if the resident had, for example, a urinary tract infection or flu.

Also, one would not be warranted if a resident deteriorated during an illness and it was expected the resident would return to their previous state of health at the completion of the illness.
An assessment needs to be completed when there is a **MAJOR** change in **more than one area** of the resident’s functional status that is permanent and requires the Service Plan to be revised.

The assessment is to be completed by the end of the 14\textsuperscript{th} day from the day the significant change occurred.

Whenever a significant change is done, the “clock” restarts, and the S2b date is used to determine when the next semi-annual and annual assessments are due.

**Significant Change Assessment**
Submission of MDS-RCA

Submit completed assessments through the Maine MDS Submission Management System (SMS):

The SMS site can be found on the Muskie School of Public Service MDS Technical Information Website:

http://muskie.usm.maine.edu/mds/

Or contact
Catherine Gunn Thiele
Residential Care Data Specialist
Muskie School of Public Service
P.O. Box 9300
Portland, Maine 04104-9300
(207) 780-5576
Physical Functioning

This section is vital in evaluating a resident’s self-performance and the amount of staff support required before an appropriate service plan can be developed.

G1a-h:

• Evaluate for each 24-hour period for the last 7 days.
• Refer to the “resident’s self performance and staff support” guidelines

Reasons why a resident may not be independent include Arthritis, Asthma, COPD, Diabetes, and side effects from medications.
Definitions

**Self-Performance:** What a resident actually performs/accomplishes of her/his ADLs, not what she/he is capable of performing/accomplishing.

**Non-Weight Bearing (physical) Assistance:** The care-giver guides the resident’s body or extremities.

**Weight Bearing (physical) Assistance:** The care-giver (not the resident) bears the weight of the resident’s body or extremities.

**Bedfast/Chair fast:** In bed or a recliner type chair, in own room, at least 22 of each 24 hour period.

**Street Clothes:** Not dressed in pajamas, Johnny, or other night wear.

**“8” Code:** This code can only be used in section “G” and only if the activity was not performed during the entire last 7 day period. You would not usually code this for eating or toileting.
Coding

Self-Performance-

0-Independent: No staff assistance or supervision or provided no more than 1-2 times.

1-Supervision: Encouragement or cueing provided by the staff 3 or more times or encouragement or cueing plus non weight-bearing assistance provided 1 or 2 times.

2-Limited Assistance: The resident is highly involved in the activity and received physical help in guided maneuvering of limbs or other non weight-bearing assistance 3 or more times OR limited assistance (3 or more times) PLUS weight bearing assistance 1 or 2 times.

3-Extensive Assistance: The resident performed part of the activity and received assistance of the following types 3 or more times:

a) Weight-bearing support

b) Full staff assistance during part but not all of last 7 days
4- Total Dependence: Full staff assistance of the entire activity each time it occurred over the entire 7 day period. There was no participation by the resident.

**Staff Support**

0- No support

1- Setup help only. I.E. - cutting the resident’s meat, buttering bread, etc.

2- One person physical assistance

3- Two or more staff provide physical assistance
Therapies (P1ba,bc, and bd)

A therapy started before admission may be counted if continued post admission and may be provided in or outside of the facility.

Specialized Rehabilitation such as Physical, Occupational, Speech or Respiratory therapy MUST be ordered by a physician and provided by a qualified therapist.
Enteral Feeding

Tube Feeding

100% = Code 4 for self-performance and 2 for one staff assist.

If in addition to the enteral feeding, some solids/liquids are consumed by mouth, code 3 for self-performance and 2 for one staff assist.
Special Treatments and Procedures

**Intervention Programs**

**P2b-Special Behavior Management Program:** This would be a part of the facility’s Service Plan for behaviors identified in E4a through j.

**E4a-** Frequently signs and symptoms of mood distress are treatable and behavior problems may be a sign of depression.*

**P3- Need for On-Going Monitoring:** The need for on-going monitoring of an acute condition or a new treatment/medication must be determined by the physician or registered nurse.**
Correction Policy

On July 1st, 2004, the MDS-RCA Correction Request Form was implemented as part of a new MDS-RCA correction policy. This policy enables facilities to correct erroneous MDS-RCA data previously submitted and accepted into the database.

The use of this form is at the facilities discretion and is intended to remedy concerns about the accuracy of the data in the State database.
Correction Policy

**Modification:** A modification should be requested when a valid MDS-RCA record is in the State MDS-RCA database, but the information in the record contains errors. Inaccuracies can occur for a variety of reasons, such as transcription errors, data entry errors, software product errors, item coding errors or other errors.

**Inactivation:** A MDS-RCA record must be inactivated when an incorrect reason for assessment has been submitted in item A6, Reason for Assessment. The record must then be resubmitted with the correct reason for assessment. An Inactivation should also be used when an invalid record has been accepted into the State MDS-RCA database.

*A record is considered to be invalid if:*

1) The event did not occur.
2) The record submitted identifies the wrong resident.
3) The record submitted identifies the wrong reasons for assessment.
4) Inadvertent submission of a non-required record.
Correction Policy

If the error is clinical and fits the definition of “significant change”, a significant change assessment must be completed.

The “Correction Request Form” is the last page of the 12/03 MDS-RCA form.
# RCA Assessment Schedule

<table>
<thead>
<tr>
<th>Type of Assessment</th>
<th>When Performed</th>
<th>MDS_RCA Completion</th>
</tr>
</thead>
<tbody>
<tr>
<td>Admission Assessment (Comprehensive)</td>
<td>At Initial Admission</td>
<td>By end of 30th day post adm</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Represented by S2b date</td>
</tr>
<tr>
<td>Semi Annual Assessment</td>
<td>Within 6 months of last Comprehensive MDS-RCA</td>
<td>Within 7 days of ARD(A5)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Represented by S2b date</td>
</tr>
<tr>
<td>Annual Assessment. (Comprehensive)</td>
<td>Within 12 months of last Comprehensive MDS-RCA</td>
<td>Within 7 days of ARD(A5)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Represented by S2b date</td>
</tr>
<tr>
<td>Significant Change Assess. (Comprehensive)</td>
<td>Only if Sig. change has occurred. See manual</td>
<td>By 14th day after change</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Has occurred</td>
</tr>
<tr>
<td>Discharge Tracking Form</td>
<td>When a res is discharged Transferred or deceased</td>
<td>Within 7 days of the event</td>
</tr>
<tr>
<td>Other Requested Assess.</td>
<td>When requested by Case Mix nurse</td>
<td>Within 7 days of request</td>
</tr>
</tbody>
</table>
### RCA Documentation Requirements for MDS/RCA Scoring

Key for Possible Record Locations:
- **PPN**: Physician's Progress Notes
- **PO**: Physician's Orders
- **PD**: Physician’s Diagnosis
- **CN**: Consultation Notes
- **HHR**: Home Health Record
- **PN**: Provider Notes
- **FS**: Flow Sheets
- **SP**: Service Plan
- **SSN**: Social Service Notes
- **MS**: Monthly Summary (specific time)
- **ADL**: ADL Flow Sheet
- **MAR**: Medication Administration Record
- **AT**: Assessment Tool (other than RCA)

<table>
<thead>
<tr>
<th>MDS/RCA Impaired Condition</th>
<th>field</th>
<th>commentary</th>
<th>Possible record location</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>B3</strong></td>
<td>Cognitive Skills for Daily Decision Making</td>
<td>Examples of the resident’s ability to actively make decisions re task of daily life</td>
<td>PN, MS, AT, FS, ADL</td>
</tr>
<tr>
<td>Problem Behaviors/ Conditions</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>E1a-E1r</strong></td>
<td>Indicators of Depression</td>
<td>Indicators must be present in the residents record within the time frame</td>
<td>PN, MS, FS, ADL</td>
</tr>
<tr>
<td><strong>J1e</strong></td>
<td>Delusions</td>
<td>Describe examples of fixed, false belief, Not shared by others</td>
<td>PN, MS, CN</td>
</tr>
</tbody>
</table>
## Documentation Guidelines cont

<table>
<thead>
<tr>
<th>J1f</th>
<th>Hallucinations</th>
<th>Describe examples of auditory, visual, gustatory, olfactory false perceptions occurring without real stimuli</th>
<th>PN, MS, CN</th>
</tr>
</thead>
<tbody>
<tr>
<td>P2a-P2j</td>
<td>Intervention Prog. Mood, Behavior, Cognitive Loss</td>
<td>Evidence in the Service Plan and carrying out in the record for each program</td>
<td>PN, MS, SP, FS, ADL</td>
</tr>
<tr>
<td>Clinically Complex</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>I1A &amp; O4Ag</td>
<td>Diabetic Receiving Daily Insulin Inject.</td>
<td>Physician Diag. Daily Insulin Injections</td>
<td>PD, PO, PN, MAR, CN</td>
</tr>
<tr>
<td>I1r</td>
<td>Aphasia</td>
<td>A Doctor's diagnosis Must be in the record</td>
<td>CN, PN, PD</td>
</tr>
<tr>
<td>I1S</td>
<td>Cerebral Palsy</td>
<td>A Doctor's diagnosis Must be in the record</td>
<td>CN, PN, PD</td>
</tr>
</tbody>
</table>
## Documentation Guidelines cont

<table>
<thead>
<tr>
<th>Code</th>
<th>Condition</th>
<th>Notes</th>
<th>Codes</th>
</tr>
</thead>
<tbody>
<tr>
<td>I1V</td>
<td>Hemiplegia/Hemiparesis</td>
<td>A Doctor’s diagnosis in the record. ADL’s must support diag.</td>
<td>CN,PN,PD,ADL</td>
</tr>
<tr>
<td>I1W</td>
<td>Multiple Sclerosis</td>
<td>A Doctor’s diagnosis in the record.</td>
<td>CN,PD,PN</td>
</tr>
<tr>
<td>I1WW</td>
<td>Explicit Terminal Prognosis</td>
<td>A Doctor must document the res. is terminally ill with no more than 6 months to live. Doc Of diag. &amp; deteriorating clinical course</td>
<td>PO,PD,PN,CN,MS</td>
</tr>
<tr>
<td>I1z</td>
<td>Quadriplegia</td>
<td>A Doctor’s diagnosis in the record. ADL’s should support diag.</td>
<td>PD,PN,CN,ADL</td>
</tr>
<tr>
<td>M1b</td>
<td>Burns- 2\textsuperscript{nd} degree 3\textsuperscript{rd} degree</td>
<td>A Doctor or RN must document in the Record.</td>
<td>PN,CN,MS,AT</td>
</tr>
</tbody>
</table>
### Documentation Guidelines cont

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</thead>
<tbody>
<tr>
<td><strong>M2</strong></td>
<td>Ulcers</td>
<td>Must be Staged by an RN, as they appear during the observation period.</td>
<td>CN, PN, MS, AT</td>
</tr>
<tr>
<td><strong>P1aa</strong></td>
<td>Chemotherapy/Radiation</td>
<td>Any type of Cancer drug given by any route. Include implants. Must CA diag.</td>
<td>PO, PD, CN, PN, MAR MS</td>
</tr>
<tr>
<td><strong>P1ab</strong></td>
<td>Oxygen</td>
<td>Must have a Dr. order and evidence in the record that the O2 was actually adm.</td>
<td>PO, PN, MAR, FS MS</td>
</tr>
<tr>
<td><strong>P1bda</strong></td>
<td>Respiratory Therapy 5 or &gt; days a week</td>
<td>Evidence of Treatment Plan (Service Plan) &amp; Carrying out with number of minutes spent with the resident</td>
<td>PO, MAR, SP, MS PN</td>
</tr>
<tr>
<td><strong>P3a&amp;b</strong></td>
<td>Need for On-Going Monitoring New Medication/Tx.</td>
<td>Evidence of acute condition or new med/tx Must be determined by a Dr or RN</td>
<td>PO, CN, PN,</td>
</tr>
</tbody>
</table>
### Documentation Guidelines cont

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>Notes</th>
<th>Status</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>P10</strong></td>
<td>4 or &gt; order changes</td>
<td>Includes written, telephone, fax or consultation orders that are new or altered</td>
<td>PO</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Does NOT include standing orders, admission orders, return adm. or renewals without change.</td>
<td></td>
</tr>
<tr>
<td><strong>Physical Function</strong></td>
<td></td>
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<td></td>
</tr>
<tr>
<td><strong>G1aA-G1gA</strong></td>
<td>Self Performance Bed Mobility- Personal Hygiene</td>
<td>Must be doc all 3 shifts SELF PERFORMANCE ONLY</td>
<td>ADL,PN,FS</td>
</tr>
</tbody>
</table>