VALUE

of Certification

PLUS!!

AANAC

AMERICAN ASSOCIATION OF
NURSE ASSESSMENT COORDINATION

Sara's *Story*

The *Genius* Behind Staff Success

My great-grandmother suffered from Alzheimer's disease. I say she suffered because she was what was referred to as a "yeller," often calling out for no apparent reason. She lived in a long-term care facility in the early 1990s. One day I went to see her and found the door to her room tightly closed and the TV volume turned way up so no one could hear her cries. Worst of all, no one cared. I decided I would never enter another nursing home as long as I lived. It was not just that I would not work in a nursing home; my plan was to never enter one again.

This proved to be a false declaration. Eventually I changed my mind and became a nursing home administrator with a passion for change. Over my 18 years in long-term care, I have seen an abundance of change. When I began in 1995 as a social worker, I was given a list of problems on a dot-matrix printer page and told that every quarter I should circle one or two problems and interventions for each resident and give it to a nurse who would put the information into the MDS. WELCOME to the MDS! I did MDSs this way for two years before I was educated on what the acronym stood for. This was my introduction to what would eventually become my lifeline to providing excellent person-centered care.

Learning to navigate the MDS is difficult, and RAC-CT training has brought all of us to an entirely new level. Once the facility leaders were trained properly on the specifics of the tool, taking the information became relatively simple. More importantly, using the information to design a person-centered approach to care has become quite straightforward. This approach begins with a nurse assessment coordinator dropping by each floor in the morning to huddle with staff and learn what happened overnight, including any change in status and any occurrences. Staff immediately modify care plans as needed, based on the feedback of the interdisciplinary team. Because it is done daily, this only takes 30 minutes to complete. We stay on top of it through constant communication with all staff members.

It is important to me that all my nurse leaders are RAC-CT certified and that they understand the coding and scheduling process of the MDS as well as the CAAs. Not only because of the reimbursement piece, but also because I believe in the integrity that the certification conveys. Personally, I am comforted knowing that my RAC-CT–certified team understands the process and is coding correctly. The inclusion in their RAC-CT training of several modules focused on care planning has provided an additional benefit for the facility and residents by emphasizing the importance of resident choices, hopes, and continued dignity.

All of our MDS coordinators and DONs are RAC-CT certified. However, as everyone is responsible for completing the MDS correctly, we continue to provide staff education programs at all levels, using our internal experts to lead these meetings. Daily huddles provide improved communication, which has helped us head off emerging complications with residents before they become problems. Improved communication among all stakeholders supports assessments and necessary interventions. Conversely, it is hard to know we need to intervene if no one is communicating or following up with assessments.

The outcome of promoting RAC-CT training at St. Paul Health Center has been, first, improved care and, at a close second, improved care plans. These improved care plans have moved the care that we provide to become more resident focused. I would encourage everyone involved in MDSs and care planning, including facility administrators, to become RAC-CT certified. It not only helps the facility to grow and prosper, it helps individuals grow within their careers.

Most importantly, this is our residents' home. These are our residents' lives. We need to allow them to live as they see fit. And when LTC caregivers thoroughly understand the MDS 3.0, we help to move long-term care (and our teams) in that direction.

Sara Dent, NHA, MBA
Administrator
Saint Paul Health Center
Denver, Colorado

VALUE OF CERTIFICATION TOOLKIT

MDS Update *Quiz*

Being unfamiliar with current regulations puts your entire facility at risk for increased audits, improper reimbursement, and substandard quality. Use this short MDS quiz to test your team's knowledge on the most recent RAI User's Manual *changes. Didn't get a perfect score? That's exactly what AANAC's RAC-CT® Certification is designed for; to fill in those gaps that traditional education programs don't cover. Read on for more evidence that you can't afford to not have your staff certified.*

1. When setting the ARD (Item A2300) for a Discharge Assessment:

a. The ARD for a Discharge Assessment equals the discharge date (Item A2000)

b. The ARD must be opened and set on the day a resident unexpectedly leaves

c. The ARD cannot be set and the Discharge Assessment opened more than two days after discharge

d. The ARD of a Discharge Assessment cannot be the same as another assessment type

2. The RUG grouper will filter for Special Care High and Special Care Low if:

a. A resident receives at least 26% of their total calories through a parenteral or tube feeding

b. A resident receives at least 501 cc/day or more of fluid intake by IV or tube feeding

c. A resident must receive the required intake for the entire 7-day look-back period

d. All must be true

3. According to the Rule of Three, full staff performance can be considered weight-bearing assist.

a.   True   b.   False

4. For RUGs in FY 2014, the grouper will sum the totals in MDS 3.0 Items O0410 (A4), O0400 (B4), and O0400 (C4) to determine the total number of days of therapy.

a.   True   b.   False

5. When considering if an End Of Therapy Resumption (EOT-R) is appropriate the resident must resume therapy under all of the following conditions except:

a. Same Therapy Disciplines (physical, occupational, and speech therapy) involved

b. Same number of treatment days and estimated minutes

c. Same therapist involved in the treatment plan

d. Same number of calendar days

6. If the MDS ARD for a Medicare resident's 14-Day PPS assessment is set on day 21, how many default days will the facility need to bill?

a. Two days

b. Three days

c. Six days

d. Seven days

Steps to Certification

YOU STEER. WE HELP. THEY SUCCEED. **EVERYBODY WINS.**

STEP 1 *Decide Which Certification is Right for Your Team*

AANAC's Resident Assessment Coordinator – Certified (RAC-CT®) is the nationally accepted designation for long-term care professionals. This ten course program remains the standard by which individuals demonstrate their comprehensive competence and professionalism in assessment and person-centered care. AANAC also offers the Certified Nurse Executive (C-NE) Certification for nurse leaders and nurses looking to be leaders in their facilities.

STEP 2 *Determine Eligibility and Skill Level*

Each of AANAC's certification programs has unique and specific requirements that a candidate must meet to attain certification. For RAC-CT Certification, we recommend that the individual have at least six months of experience in long-term care and for C-NE we require the individual be an RN.

STEP 3 *Complete Required Course Work*

AANAC education courses are offered year-round through online training, printed manuals, and live workshops hosted across the nation. Both RAC-CT and C-NE Certifications consist of ten individual courses (seven required and three electives) each of which are paired with a final exam that must be passed with an 80% or higher to successfully pass.

Purchase online courses or manuals

Find a workshop near you

STEP 4 *Receive the Certification*

Once all course exams and requirements are completed, your staff member will receive a letter from the AANAC Education Department including a RAC-CT certificate highlighting the certification completion date and a complimentary lapel pin. Encourage your staff to display their certificates, wear their pins, and use their credentials proudly, showing everyone that comes into your facility that your staff has the competence and professionalism to improve the lives of residents anywhere they are.

STEP 5 *Compliment Their Knowledge*

Proving one's knowledge through AANAC certification is just the beginning of the journey. Keep your team on top by exploring other education opportunities including Medicare University and regular Webinars on the LTC topics that matter most. Promote knowledge sharing with peers on AANAConnect, and never miss out on breaking news with regular visits to the "Need to Know" section on AANAC.org for updates as they occur.

Use MDS to
Improve Quality

This is a problem:

The interdisciplinary team got its wires crossed and completely missed a Quarterly MDS assessment that should have had an ARD no later than six weeks ago. In compliance with MDS rules, the team set the ARD immediately for the current date and completed the late assessment. Team members commented that they hoped they wouldn't get a deficiency for a late assessment when survey time rolled around.

While such a deficiency certainly is a possibility, surveyors also can pick up critical information related to the resident's quality of care and quality of life from an MDS.

In this case, for example, the delay in the assessment caused the surveyors to focus in on the time frame in which the assessment should have been completed. They noted that the look-back would have captured significant new functional decline and a new onset of urinary incontinence that already had continued for three weeks. Thus, a Significant Change in Status Assessment (SCSA) would have been required instead of the Quarterly. Since the SCSA was not completed on time, the Care Area Assessments did not trigger; further, more in-depth assessment was not completed; and the care plan was not updated. The chart revealed that about two weeks after the SCSA would have been completed, the resident got out of bed unassisted to go to the bathroom, dripped urine and slipped on it, fracturing a hip and a shoulder. The deficiencies the facility received were much more significant than a late assessment.

Speaking of falls:

When investigating a fall, which is a significant Quality of Care issue, valuable information about risk can come from the MDS, whether it's the facility or a surveyor looking at the incident. And proactively, problems in any of the following areas may be a red flag for risk for falls:

- ADLs (G0110)
- Balance (G0300)
- Wandering (E1000)
- S/S of delirium (C1300)
- Antianxiety (N0410B) and Antidepressant (N0410C)
- Fall since admission or prior assessment (whichever is most recent) (J1800)

When a surveyor investigates a fall, these items are a good place to start to determine whether the MDS contained red flags that the facility missed.

Here's another example of how the MDS can identify or support survey deficiencies:

You are the staff member assigned to complete MDS item B0200, Hearing. You've followed all of the instructions in the RAI User's Manual for collecting relevant information. As a result, you enter the code 2 on the MDS indicating moderate difficulty. You are confident that you've arrived at the correct coding decision, and you feel sure that any auditor, such as a surveyor or a consultant, would agree that this is an accurate assessment.

But, while the accuracy of the coding decision is supported by the chart, this code displayed on the MDS potentially has additional meaning for the surveyor or other auditor—it is a spotlight on a problem that can have significant quality of care (QOC) and quality of life (QOL) implications for the resident. Hearing deficits can result in depression, boredom, and social isolation; the mismatch between communication with the resident and the resident's responses may be misinterpreted as cognitive impairment; the resident's preferences might not be adequately identified and honored.

Nursing home providers who look at the MDS through the lens of Quality of Care and Life, as illustrated by the examples above, can go a long way toward preventing problems before they occur.

Rena R. Shephard,
MHA, RN, RAC-MT, C-NE
President, RRS Healthcare Consulting Services

MDS Documentation:
Is Your Facility at Risk?

Documentation typically involves a process for recording information as a means of providing evidence. Employees must understand the importance of documentation requirements, as well as what can occur when documentation is missing or inaccurate. Nurse leaders whose team members do not know how and what to document are at risk for negative outcomes including reduced RUG scores, lost reimbursement, and even suspicion of fraudulent practices.

There are a number of reasons for inaccurate RUG scores for short or long-stay residents. The following examples can result in both under- or over-payment to the facility:

- Using outdated MDS manuals
- Poor understanding of MDS definitions
- Lack of understanding of coding rules
- Coding that does not portray the individual's actual performance
- Inadequate documentation to support coding of the individual's true performance
- Contradictions in information recorded in the medical record and ultimately on the MDS

Educate nurses so they understand how to document and code late loss ADLs. Accurately recording self-performance and staff support in the categories of bed mobility, transfer, toilet use, and eating will result in RUG scores that reflect the individual's actual performance. Following MDS guidelines and documenting evidence of depression and treatment assists a facility to achieve accurate RUG scores under Special Care High, Special Care Low, and Clinically Complex when the Depressed/Not Depressed split is understood. If staff do not receive adequate education in these areas, underpayment or overpayment may result.

Inaccurate coding impacts more than a facility's reimbursement. Charges of fraudulent practices may result. In one recent example, CNAs who were inadequately trained in how to code self and staff performance made a significant documentation error. A resident had required supervision with no physical help from staff (1/0) for ambulation and transfer. CNAs properly coded this on the ADL flow sheet. The resident experienced a fall that resulted in an injury necessitating extensive assistance of two CNAs (3/3). The inadequately trained CNAs continued copy-cat charting by recording a code of 1/0 even after the fall. The injury was a reportable incident to the Department of Health, and when records were viewed by the investigating surveyor, the charting inaccuracy was discovered. The surveyor determined that the notification to the DOH was not timely, and the inaccurate charting came under suspicion of an attempted cover-up. The Attorney General's Office was called in, and the CNAs were charged with falsifying a medical record. This incident resulted in eight CNAs from one facility being terminated, and they are awaiting a final decision from authorities.

There are two key activities that a nurse leader can take to avoid negative outcomes related to coding and documentation. First, every employee must understand how and why to document accurately. Provide detailed education that includes a return demonstration by the employee to demonstrate competency in coding and documenting. Place a special emphasis on late loss ADLs and coding compliance. Include this training in new employee orientation, repeat it annually and with any MDS coding updates. Second, perform audits of existing MDSs for a random 10% of residents in the facility. If concerns are identified, expand the audit sample, looking for trends. Determine that individuals completing sections of the MDS have current manuals, and that they refer to them. Incidences have occurred in which MDS 2.0 definitions were remembered, and MDS 3.0 changes were not followed. As audits reveal weakness or inaccuracies, provide targeted education to address the issues. Schedule audits periodically and report outcomes to the Quality Assessment and Assurance Committee. The entire team can work together to achieve documentation, coding, and reimbursement success.

Betty Frandsen,
RN, NHA, MHA, C-NE
Curriculum Development Specialist, AANAC