REHAB perspectives

FALL 2010

Adjusting to change

MDS 3.0 has arrived. Are YOU prepared?

A Guide to MDS 3.0 and RUG-IV for therapy service providers

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President's Message

The implementation of industry-changing government regulations is never an easy undertaking, and that's certainly true for the new Minimum Data Set (MDS) 3.0 and the Resource Utilization Group – Version Four (RUG-IV) case-mix classification system, which took effect October 1.

Substantial changes — which include required and scripted patient interviews, updated medical definitions, and new assessments — eliminate some processes that many healthcare providers have grown familiar with across the years. But, these changes also create new opportunities for therapists and skilled nursing facilities (SNFs) that have prepared for them.

Aegis Therapies has spent the past 12 months preparing — always keeping in mind the needs of our patients. Getting ready involved hours of training for thousands of employees at more than 1,000 locations across the nation. We created training modules with quizzes and conducted workshops with management staff. We tracked therapy minutes to learn from the data. And we transitioned to a new software system. Our goal was to ensure that October 1 was just like any other day for our staff and patients.

Aegis worked in tandem with Golden LivingCenters, our largest partner, to coordinate changes between therapists and MDS coordinators in our LivingCenters. Like all SNFs, LivingCenters face operational and fiscal challenges resulting from MDS 3.0 and RUG-IV.

In this issue of *Rehab Perspectives*, we review major changes now in place with MDS 3.0 and RUG-IV and describe steps taken to prepare for these modifications. We also share our perspective on practices that can help maintain fiscal and operational health under the new MDS 3.0 and RUG-IV. As our industry adjusts to changes under the new systems, we hope this information proves useful to you.

Martha Schram
President
Aegis Therapies

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MDS 3.0 Has Arrived. Are You Prepared?

Although the changes affecting SNFs are sweeping, a smooth transition is possible

The Minimum Data Set (MDS) 3.0 and Resource Utilization Group – Version Four (RUG-IV) finally took effect on October 1, putting in place sweeping revisions that affect the way long-term care facilities around the country assess patients and conduct rehabilitative therapy.

"This is not just an update where things are tweaked and changed," explained Michele Self, Vice President of Clinical Reimbursement for Golden Living. "This is a totally new process."

The Centers for Medicare and Medicaid Services (CMS) designed MDS 3.0 to improve upon the reliability, accuracy, and usefulness of MDS 2.0, which was introduced in 1987. The final version of the new MDS was released October 1, 2009, and skilled nursing facilities (SNFs) across the nation have worked to prepare their staffs, in particular those responsible for assessments and therapy services in each facility.

Many proactive providers started training for revisions in MDS 3.0 and RUG-IV months before they took effect, in an effort to make the transition a smooth one.

RUG-IV expands the number of classifications from 53 to 66 and includes new categories, such as one for patients with Parkinson's disease.

At Golden Living, MDS coordinators like Registered Nurse Assessment Coordinator (RNAC) Valerie Wagner, RN, started training for the new MDS and RUG-IV back in April. Wagner, whose formal title is Senior Director of Resident Assessment for Golden LivingCenter – Wabasso, a 44-bed SNF in Minnesota, learned about new assessments and other changes in stages, and then practiced how those changes would affect day-to-day operations. The take-charge approach and a positive outlook from staff helped make the transition a smooth one, said Wagner. "I didn't

Until providers get more familiar with MDS changes, including the addition of scripted interviews and new assessments, it may be difficult to know exactly how long assessments will take. This should change over time.

feel it was overwhelming. We approached it as, 'This is more or less what it is going to be so we're going to make it work.'"

Scripted interviews

One positive change to the resident assessment process for SNFs under the new MDS is the addition of scripted interviews. Previously, staff completed assessments largely by examining patients and reading charts. MDS 3.0 requires formal patient interviews, which coincides with an ongoing industry-wide culture change that seeks to place residents' needs and wants ahead of operations and lessen the institutional feel of SNFs.

Along with scripted interviews, MDS 3.0 also incorporates industry-accepted standardized tests to assess residents. For example, a test of cognition now involves asking patients questions as part of the Brief Interview for Mental Status, which incorporates standardized questions within. MDS 3.0 also updated and expanded a section related to Wound Care, adapting industry guidelines from the National Pressure Ulcer Advisory Panel for staging wounds such as pressure ulcers.

Training on the scripted interviewing process began about seven months before its implementation, Self noted. Staff members responsible for sections of assessments were educated on changes to those sections and on the scripted interviewing process. Training also focused on ways to incorporate patient and resident interviews into the daily care process.

Time is a big concern for nurses responsible for completing patient and resident interviews, along with all of the other assessments and changes that come with MDS 3.0 and RUG-IV. Research cited by CMS suggests the assessment process should take less time under the new MDS, but some MDS coordinators say that remains to be seen. As Self explains, MDS coordinators have a learning curve with the new system, and until that is surpassed, it will be difficult to judge how long assessments will take. Moreover, SNFs now must complete a discharge assessment for each patient, which may pose challenges particularly for SNFs with many short-term rehab patients.

Shanda Aase, RN, Director of Resident Assessments for Golden LivingCenter – St. Louis Park Plaza in Minnesota, believes that for residents and patients who remain focused during interviews, the assessment process under the new MDS should most likely take less time.

RUG category changes

Coinciding with the launch of MDS 3.0 is the implementation of RUG-IV, which expands the number of classifications from 53 to 66 and includes new categories, such as one for patients with Parkinson's disease.

The elimination of the "look-back" period in the MDS 3.0 assessment process will make it more difficult for patients with complex medical needs to be placed into the highest-paying extensive services RUG, because SNFs no longer can refer to the services a patient received in the hospital for RUG classification purposes.

Choosing an appropriate assessment reference date (ARD) has become more important under MDS 3.0 and RUG-IV in light of the elimination of the look-back period in the new MDS, Self added. The ARD should reflect services provided to ensure that reimbursement adequately covers the costs of care. For example, if a patient needs oxygen on the fourth day after admission for a breathing problem, the ARD should reflect the use of that service so it can be recorded in the appropriate RUG classification.

ADL scoring

Another change that will affect a patient's RUG classification is how CMS tallies points for the Activities of Daily Living (ADL) section of MDS 3.0. Exactly how this will impact SNFs is not clear because each patient presents differently. But, the potential exists for some residents to end up in lower reimbursement categories simply because of changes CMS has made to point assignments.

"There will be some patients who stay the same and some who have a decline in their RUG," said Self. "This is something we are watching to make sure we're really coding these accurately."

Bill Goulding, National Director of Outcomes and Reimbursement for Aegis Therapies, which is part of the Golden Living family of companies, noted that during training, staff reviewed ADL definitions and reviewed scoring of patients to assess whether staff was doing this accurately under the guidelines for the new MDS. According to Goulding, MDS coordinators and certified nurse aides should know definitions for bed mobility, transfers, toileting, and eating and also should fully comprehend guidelines for coding in order to accurately reflect patients' abilities.

New or changed assessments

Not all patients admitted to a SNF are able to begin therapy immediately, and MDS 3.0 eliminates the ability of SNFs to project a patient's need for therapy minutes over the first 14 days. Instead, a new, optional Start of Therapy Other Medicare Required Assessment (OMRA) allows therapists to begin treatment when patients are healthy enough to do so and for facilities to capture a higher-

paying RUG as soon as patients can begin therapy.

MDS 3.0 also requires that an End of Therapy OMRA is completed within one to three days of the end of treatment, instead of within eight to 10 days. Additionally, Medicare is no longer paying for therapy beyond the last day these services are provided for a patient.

There also is a new, optional short-stay assessment to capture therapy RUGs for SNF patients who are discharged unexpectedly on or before their eighth day and who have received less than five days of rehab therapy.

Meanwhile, Section Q of the MDS 3.0 now requires that SNFs ask residents and patients if they would like to be informed of resources that may help them return to their community. SNFs are responsible for putting residents in touch with agencies or other resources that provide this assistance. Self noted that Golden LivingCenters have compiled lists of state agencies and other local resources that are capable of assisting residents. Also, Golden Living staff has been developing relationships with these agencies in an effort to facilitate patient and resident requests.

Assessing ADLs under MDS 3.0

CMS has changed the coding and the index scoring methodology for Activities of Daily Living (ADLs) in the new MDS, potentially affecting which RUG a patient is placed into.

According to Michele Self, Vice President of Clinical Reimbursement for Golden Living, it will be important for clinicians to thoroughly understand definitions and consider all aspects of each of the four ADL tasks when conducting patient assessments.

The tasks include:

Bed Mobility: With this activity, set-up involves handing the trapeze, putting the side-rail up, and handing pillows to the resident. Residents are then evaluated on their ability to reposition in bed, move from a lying to sitting position (or vice versa), and turn side-to-side.

Eating: Set-up involves cutting foods, opening packets, handling drinking glasses, and placing items within reach or providing one food at a time. Patients are then evaluated based on how they eat their meals, take snacks, and drink fluids.

Toileting: This activity is set up by handing the resident the bedpan or urinal, placing articles within reach to change an ostomy, manage a catheter, or change briefs/pads. Patients are then evaluated on their ability to transfer on/off a commode or bedpan, clean themselves after elimination (including changing a pad, brief, ostomy, or managing a catheter). Also evaluated is the patient's ability to handle their clothing.

Transfers: Set up includes giving the resident a transfer board and locking brakes on a wheelchair for safety. Patients are assessed on their ability to rise to a standing position from the bed or chair, pivot or take a couple of steps from bed to chair, or their ability to lower themselves to a sitting position on the bed or chair.

For more information, access CMS' MDS 3.0 RAI Manual at http://www.cms.gov/NursingHomeQualityInits/45_NHQIMDS30TrainingMaterials.asp.

Communication is key moving forward

Communication between MDS coordinators, therapists, and other staff that fill out assessments is essential under MDS 3.0. In keeping with the ongoing culture change movement, MDS coordinators and care teams must balance deadlines for assessments with staff availability and patient preferences for scheduling.

To prepare for these changes, Aase asked for input from staff about how they would prefer to handle the scheduling process, given the importance of ARDs. Questions she asked included: "How will the assessment fit best into your schedule?" and "Would you prefer to handle all your patient interviews in one day or do you want to spread them out?"

She adds that "Fostering good working relationships with others in your facility definitely is going to make things easier."

At Golden LivingCenters, MDS coordinators and rehab therapy coordinators hold daily management meetings to plan patient therapy and assessments. Meanwhile, a newly adopted software system known as PointClickCare (PCC) automates the MDS 3.0 and RUG-IV classification process in LivingCenters. PCC works in tandem with another software system newly adopted by Aegis Therapies to enable better coordination between MDS coordinators and therapists.

Training LivingCenter staff on MDS and RUG changes involved a months-long process that introduced changes piecemeal and grew more intense in September and October, with reviews of more complex changes, Self said. Staff participated in webinars, reviewed training modules, and took part in workshops. Golden Living representatives also participated in CMS conference calls and attended helpful training sessions conducted by the agency. All in all, MDS coordinators received several hours per month of training beginning in April, and more hours were added in subsequent months.

Given significant therapy-related changes to the MDS (see related article) some training of LivingCenter staff was coordinated with Aegis staff. Additionally, a process was created to address any staff questions about the new systems, Goulding said.

What remains to be seen

As LivingCenters adjust to the new systems, Golden Living is monitoring the need for more MDS coordinators based on the time it will take to complete the new assessments, Self explained.

Another issue still working itself out is states' transition to MDS 3.0 and RUG-IV. MDS coordinators in many states are still working with MDS 2.0 and RUG-III, Self noted. Keeping in contact with state officials and staying abreast of state changes as they occur will be important as states move to adopt the new systems.

The learning process will likely be ongoing for MDS coordinators, according to Wagner, who estimates it may "take a good six months to a year to get somewhat comfortable, familiar, and more proficient" with the new systems.

She recommends that companies find the "best athletes" to be MDS coordinators. "You want to put your best person in that position. You need someone who is well organized, self motivated, and out to do what is best for the resident." ■

A Guide to MDS 3.0 and RUG-IV for Therapy Providers

Rehab program coordinators and therapists are adjusting to a new definition and allocation for concurrent therapy, as well as the elimination of Section T

Although Section T has been eliminated under MDS 3.0 and RUG-IV, therapists and MDS coordinators have new assessments at their disposal, including the Start of Therapy Other Medicare Required Assessment and the short-stay assessment.

Although skilled nursing facilities (SNFs) bear the brunt of the sweeping changes in the way Medicare services are weighed and reimbursed under MDS 3.0 and RUG-IV, rehabilitation therapy providers also have had to adjust to revisions, the most significant being the new definition and allocation for concurrent therapy and the elimination of Section T, which enabled therapy minute projections.

According to the Centers for Medicare and Medicaid Services (CMS), concurrent therapy for Medicare Part A should be limited to two patients at a time who are not performing the same or similar tasks. Both patients must be in the treating therapist's or assistant's line of sight. Meanwhile, group therapy for Medicare Part A is newly defined as the treatment of two to four residents who are performing similar activities and are supervised by a therapist or assistant who is not supervising other individuals.

Jaclyn Warshauer, PT, Senior Clinical Claims Review Specialist for Aegis Therapies, says it is important for therapists and rehabilitation program coordinators (RPCs) to understand the new therapy minute definitions from CMS and their practical implications, because the amount of therapy provided to a patient impacts their RUG classification. What many therapists currently think of as concurrent therapy may actually be group therapy under

the new CMS definitions. And under MDS 3.0, CMS is allocating only half of the minutes reported for concurrent therapy toward a patient's RUG requirement.

Aegis formed a task force in October 2009 to begin preparing for changes resulting from the MDS 3.0 and RUG-IV. At that time, therapists also began recording individual, group, and concurrent therapy minutes — both to help RPCs understand patterns in the mode in which therapy services were provided and to enable therapists to practice recording minutes according to these new requirements.

Although the MDS 3.0 is now in effect, tracking daily therapy minutes still is useful for therapy providers, as it can help identify patterns and reasons for practices, said Bill Goulding, National Director of Outcomes and Reimbursement for Aegis Therapies.

In addition to tracking therapy minutes, RPCs would benefit from enhanced communication and collaboration under the new MDS and RUG systems. Aegis rehabilitation program coordinators and MDS coordinators meet daily to plan patients' therapy schedules and determine appropriate assessment reference dates (ARDs). "Collaboration always was encouraged but is even more important under MDS 3.0," said Mark Besch, Vice President of Clinical Operations for Aegis.

Investing in technology also may be worthwhile for therapy providers. At Aegis locations, for example, a new software system is helping therapists track minutes and modes of therapy provided and also to plan future therapy sessions. The system also is providing data that is helpful in decision-making for RPCs and MDS coordinators.

Out with the old, in with the new

Another prominent change to the MDS 3.0 is the elimination of "Section T," which was used to estimate how much therapy a resident would receive during the first 14 days of their SNF stay. In its place, CMS implemented the optional Start of Therapy Other Medicare Required Assessment (SOT OMRA). This SOT OMRA will, for example, enable SNFs to capture a therapy RUG for SNF patients who may need a time to stabilize before beginning therapy services. The SOT OMRA should not impact the approach for care of most SNF patients who need therapy, said Goulding. "But now we have the option not to start right away, especially if a nursing RUG makes more sense clinically for the patient," he explained.

Goulding adds that since projections for therapy minutes are no longer possible, evaluating patients as early as possible in their stay for therapy needs is even more important. This may mean changing staff schedules to cover more hours — perhaps even on weekends — that would not have been covered under the old MDS. Therapy providers will have to balance the availability of staff with patients' scheduling, and one option to better fit patient needs may be to stagger staff schedules.

Another new assessment that therapists and MDS coordinators have at their disposal is the short-stay assessment. Patients must receive five days of therapy before a therapy RUG can be captured, but this benchmark may not be reached if patients are unexpectedly discharged before their eighth day in the SNF. The short-stay assessment is designed to help SNFs and therapy providers capture some rehab therapy reimbursement for these patients, if they meet certain criteria.

Tracking daily therapy minutes may be useful as therapy providers adjust to CMS' new definition and allocation for concurrent therapy, among other changes.

Goulding conservatively estimates that about 10 percent of SNF patients are short-stays, and says that the addition of the new assessment "is an opportunity, as long as providers are aware of it."

Other therapy-specific changes

MDS 3.0 also changed the traditional OMRA. It is now referred to as the End of Therapy OMRA (EOT OMRA), and gives MDS coordinators one to three days following the end of a patient's therapy to complete this assessment, compared with eight to 10 days under MDS 2.0. With this change to the OMRA also comes a change in reimbursement. The rehab RUG reimbursement now stops on the last day that therapy services are provided.

CMS also has changed its reimbursement policy for care provided by rehab aides and therapy students. Aides now can only count minutes for setting up patient specific therapy treatment. Restrictions have been placed on student minutes, such as only counting them if a therapist is present and in the line of sight and not supervising others.

Ultimately, providers seeking a compass for success under MDS 3.0 and RUG-IV should embrace collaboration and communication, said Warshauer, adding that early planning helped make October 1 "just another day" for Aegis and Golden LivingCenters. ■

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