MDS Interview:
What Does "Sock, Bed, Blue" Mean to You?

Presented by:

HARMONY UNIVERSITY

The Provider Unit of

Harmony Healthcare International, Inc.

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MDS Interview: What Does "Sock, Bed, Blue" Mean to You?

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Harmony Healthcare International, Inc.(HHI)

Presented by:

Christine Twombly, RNC, RAC-MT
Regional Consultant / Trainer

Speaker Bio

- Clinical Consultant and Trainer with Harmony Healthcare International (HHI)
- Over 26 years of experience in Long-Term Care
- Certified Gerontological Nurse
- Certified AANAC Master Teacher and Certified Resident Assessment Coordinator (RAC-CT)
- Licensed Health Care Risk Manager (LHRM)
- Hands-on experience with MDS assessments and related care planning
- Extensive experience with SNFs to conduct Medicare documentation and billing compliance assessments and providing assistance with third-party medical review and the appeals process

MDS Interview: What Does "Sock, Bed, Blue" Mean to You?

- **Disclosures**: The planners and presenters of this educational activity have no relationship with commercial entities or conflicts of interest to disclose
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MDS Interview: What Does "Sock, Bed, Blue" Mean to You?
Disclosure

Speaker:
Christine Twombly, RNC, RAC-MT

- The speaker has no relevant financial relationships to disclose
- The speaker has no relevant nonfinancial relationships to disclose

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MDS Interview: What Does "Sock, Bed, Blue" Mean to You?
Criteria for Successful Completion

- Complete Sign-in and Sign-Out on Attendance Form
- Attendance for entire session
- Completion and submission of speaker evaluation form.

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Today's Objectives

- The learner will be able to identify MDS sections which are coded based on scripted resident interview
- The learner will be able to describe three specific techniques that can be used to achieve accurate interview results
- The learner will be able to demonstrate an understanding of key RUG reimbursement and Quality Measure impacts of the resident interviews
- The learner will be able to summarize strategies for utilization of resident interview data to drive quality of care and improve quality of life in the SNF

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CMS Has Expressed Concern…

- Overuse or inappropriate use of dashes on assessments
- Skipped interviews
- Per CMS, "**Every assessment must be completed as fully as possible with all available information at the time of the assessment**"

The Importance of Accurate Interviews

The Importance of Accurate Interviews

- CMS stressed the importance of the interviews and the need to make every attempt to complete them
- State survey agencies have verified that, in some cases, interviews are not completed when the resident could participate
- Failure to complete the interviews places the facility at risk for citation during survey

The Importance of Accurate Interviews

- Resident interviews are an important aspect of the entire care planning process
- All residents capable of any communication should be asked to provide information regarding what they consider to be the most important facets of their lives

The Importance of Accurate Interviews

- Several MDS 3.0 sections require direct interview of the resident as the primary source of information
- Self-report is the **single most reliable indicator** of these topics
- Resident interview should become part of a supportive care environment that assists residents to fulfill their choices over aspects of their lives

The Importance of Accurate Interviews

Bottom Line:

It's all about the Resident.

Steps to Prepare for a Successful Interview:

- Interview Approaches:
  - **Introduce yourself** to the resident
  - Be sure the resident **can hear what you are saying**
  - Ask whether the resident would like an **interpreter** (language or signing)
  - Find a **quiet, private area** where you are not likely to be interrupted or overheard

Steps to Prepare for a Successful Interview:

- Interview Approaches (Cont.)
  - **Sit where the resident can see you clearly and you can see his or her expressions**
    - Ask the resident where you should sit so that he or she can see best
  - **Establish rapport and respect**
  - **Explain the purpose of the questions to the resident**

Steps to Prepare for a Successful Interview:

- Interview Approaches (Cont.)
  - **Say and show the item responses**
  - **Ask the questions** as they appear in the questionnaire

Steps to Prepare for a Successful Interview:

- Interview Approaches (Cont.)
  - Break the question apart if necessary

    Unfolding refers to the use of a general question about the symptom followed by a sequence of more specific questions if the symptom is reported as present

Steps to Prepare for a Successful Interview:

- Interview Approaches
  - Break the question apart (Cont.)

    Disentangling refers to separating items with several parts into manageable pieces

Steps to Prepare for a Successful Interview:

- Interview Approaches (Cont.)
  - **Clarify using echoing**
    - Echoing means simply restating part of the resident's response
  - **Repeat** the response options as needed
  - **Move on to another question** if the resident is unable to answer

Steps to Prepare for a Successful Interview:

- Interview Approaches (Cont.)
  - **Break up the interview** if the resident becomes tired or needs to leave for rehabilitation, etc.
  - **Do not try to talk a resident out of an answer**

Steps to Prepare for a Successful Interview:

- Record the resident's response
  - Do not record what you believe he or she should have said
- If the resident becomes sorrowful or agitated sympathetically respond to his or her feelings
  - Allow emotional expression
  - You may need to finish the interview later

Steps to Prepare for a Successful Interview:

- Remember that resident preferences may be influenced by many factors
- A residents physical and/or psychological state or environment may play a role in current preferences
- Resident preferences can be a challenge to discern

To Proceed or Not Proceed…

- A simple, performance-based assessment of cognitive function can quickly define a resident's cognitive status
- The majority of residents, even those with moderate to severe cognitive impairment, are able to answer simple questions within the interview structure

Before You Begin…

- A1100 A & B: Language
- B0200: Hearing
- B0700: Makes Self Understood

A1100: Language

- This item is completed only on Comprehensive Assessments:
  - Admission
  - Annual
  - Significant Change in Status (SCSA)
  - Sig Correction to Prior Comprehensive (SCPA)

A1100: Language

- **Coding Instructions:**
  - **Code 0, no:**
  - **Code 1, yes**: If the resident (or family or medical record if resident unable to communicate) indicates that he or she needs or wants an interpreter to communicate with a doctor or health care staff
  - Specify preferred language. Proceed to 1100B and enter the resident's preferred language

A1100: Language

- **RAI Coding Tips:**
  - American Sign Language (ASL) should be reported as the preferred language if the resident communicates with this language

B0200: Hearing

- Assessed **using his or her normal hearing appliance(s)**
- Observe the resident communicating
- Ask the resident about hearing function in different situations
- Consult the resident's family, direct care staff, activities personnel, and speech or hearing specialists
- Be **aware of how you are cueing** the resident (e.g., speaking louder, making sure they are looking at you etc.)

B0200: Hearing

- **Code 0, adequate**
- **Code 1, minimal difficulty**: The resident hears speech at conversational levels but has **difficulty hearing when not in quiet listening conditions or when not in one-on-one situations**. The resident's hearing is adequate after environmental adjustments are made.

B0200: Hearing

- **Code 2, moderate difficulty**: Although hearing-deficient, the **resident compensates** when the speaker adjusts tonal quality and speaks distinctly; or the resident can hear only when the speaker's face is clearly visible
- **Code 3, highly impaired**: **Absence of useful hearing**. There is no comprehension of conversational speech, even when the speaker makes maximum adjustments

B0700: Makes Self Understood

- Assess using the resident's **preferred language**. Ability to express or communicate requests, needs, opinions, conduct social conversation in primary language
- Observe his or her interactions with others in different settings and circumstances

Definition Makes Self Understood

- Able to express or communicate **requests, needs, opinions** and to conduct social conversation in his or her **primary language**, whether in speech, writing, sign language, gestures or a combination of these

Definition Makes Self Understood

- Deficits in the ability to make one's self understood (expressive communication deficits) can include **reduced voice volume** and difficulty in producing sounds, or difficulty in **finding the right word**, making sentences, writing, and/or gesturing

Makes Self Understood

- **Code 0, understood**
- **Code 1, usually understood:** If the resident has **difficulty communicating some words or finishing thoughts** but is able if prompted or given time. He or she may have **delayed responses** or may require some prompting to make self understood.

Makes Self Understood

- **Code 2, sometimes understood:** If the resident has limited ability but is able to **express concrete requests regarding at least basic needs** (e.g., food, drink, sleep, toilet)
- **Code 3, rarely or never understood:** If, **at best**, the resident's **understanding is limited** to staff interpretation of highly individual, resident-specific sounds or body language (e.g., indicated presence of pain or need to toilet)

MDS 3.0

SECTION C:
COGNITIVE PATTERNS

Section C: Cognitive Patterns

- Intent:
  - The items in this section are intended to determine the resident's attention, orientation and ability to register and recall new information. These items are crucial factors in many care-planning decisions

Section C: Cognitive Patterns

- **CMS clarified** that while conducting the Brief Interview for Mental Status (BIMS):
  - Interviewers need to use the words and related category cues as indicated
  - If the interview is being conducted with an **interpreter** present, the interpreter should use the **equivalent** words and similar, relevant prompts for category cues

C0100: Should Brief Interview for Mental Status Be Conducted?

- Determine of the resident is **rarely/never understood** verbally or in writing
- If rarely/never understood, skip the BIMS and proceed to C0700 –C0100 (Staff Assessment of Mental Status)

Steps for Assessment: BIMS

- Appendix E provides details regarding how to administer the BIMS in writing
  - Directly provide the written questions for each item in C0200 through C0400 **at one sitting** and **in the order provided**
  - For each BIMS question, show the resident a sheet of paper or card with the instruction for that question from the form clearly written in a large enough font to be easily seen

Relevancy of the BIMS

- The BIMS has a direct relationship to Quality of Life:
  - Direct or performance-based testing of cognitive function decreases the chance of incorrect labeling of cognitive ability and improves detection of delirium
  - The BIMS is an opportunity to observe residents for signs and symptoms of delirium (C1300)

Relevancy of the BIMS

- The BIMS has a direct relationship to Quality of Life (Cont.)
  - Cognitively intact residents may appear to be cognitively impaired because of extreme frailty, hearing impairment or lack of interaction
  - Some residents may appear to be more cognitively intact than they actually are

Relevancy of the BIMS

- The BIMS has a direct relationship to Quality of Life (Cont.)
  - When cognitive impairment is incorrectly diagnosed or missed, appropriate communication, worthwhile activities and therapies may not be offered

Relevancy of the BIMS

- The BIMS has a direct relationship to Quality of Life (Cont.)
  - A resident's performance on cognitive tests can be compared over time
  - If performance worsens, then an assessment for delirium and or depression should be considered

Relevancy of the BIMS

- The BIMS has a direct relationship to resident-centered care plans:
  - Assessment of a resident's mental state provides a direct understanding of resident function that may:
    - Enhance future communication and assistance, and
    - Direct nursing interventions to facilitate greater independence such as posting or providing reminders for self-care activities

Relevancy of the BIMS

- The BIMS has a direct relationship to resident-centered care plans (Cont.)
  - A resident's performance on cognitive tests can be compared over time
  - An abrupt change in cognitive status may indicate delirium and may be the only indication of a potentially life threatening illness
  - A decline in mental status may also be associated with a mood disorder

Relevancy of the BIMS

- The BIMS has a direct relationship to resident-centered care plans (Cont.)
  - Awareness of possible impairment may be important for maintaining a safe environment and providing safe discharge planning
  - Care plans can be more individualized based upon reliable knowledge of resident function

Relevancy of the BIMS

- The BIMS has a direct relationship to resident-centered care plans (Cont.)
  - Abrupt **changes in cognitive status** (as indicative of a delirium) often signal an underlying potentially life threatening illness and **a change in cognition** may be the only indication of an underlying problem

C0200: Repetition of Three Words

- Say to the resident: **"I am going to say three words for you to remember. Please repeat the words after I have said all three. The words are: sock, blue, and bed."**
- Immediately after presenting the three words, say to the resident: **"Now please tell me the three words"**

C0200: Repetition of Three Words

- **Code 0, none:** If the resident did not repeat any of the 3 words on the **first attempt**
- **Code 1, one:** If the resident repeated only 1 of the 3 words on the **first attempt**
- **Code 2, two:** If the resident repeated only 2 of the 3 words on the **first attempt**
- **Code 3, three:** If the resident repeated all 3 words on the **first attempt**

C0200: Repetition of Three Words

- After the residents first attempt to repeat the words, regardless of coding, the following must be said: **"The words are sock, something to wear; blue, a color: and bed, a piece of furniture"** (category cues)
- Category cues serve as a hint that helps prompt residents' recall ability
- Putting words in context stimulates learning and fosters memory of the words that residents will be asked to recall in item C0400, even among residents able to repeat the words immediately

C0200: Repetition of Three Words

- If the resident recalled **two or fewer words**, say to the resident: **"Let me say the three words again. They are sock, something to wear; blue, a color; and bed, a piece of furniture. Now tell me the three words."**
- If the resident **still does not recall** all three words correctly, you may **repeat the words and category cues one more time**

C0200: Repetition of Three Words

- If words are repeated back in a sentence or **out of order** they are still counted as correct
- Only show written words if the patients uses written words to communicate

C0200: Repetition of Three Words

- If the resident **does not repeat** all three words after **three attempts**, re-assess ability to **hear**
  - If the resident can hear, move on the next question. If he or she is unable to hear, attempt to maximize hearing (e.g., alter environment, use hearing amplifier, etc.) before proceeding

C0300: Temporal Orientation

- Present each question **separately**
- Allow **30 seconds to respond**
- **Do not** provide cues. If the resident asks for cues say, "**I need to know if you can answer the questions without help from me.**"

C0300: Incorrect vs. Nonsensical

- **Stop the interview** after completing "Day of the Week" if:
  - There has been **no verbal or written response** to any of the questions up to this point, **OR**
  - There has been no verbal or written response to **some questions** up to this point and for all others, the resident has given a **nonsensical response**

C0300: Incorrect vs. Nonsensical

A nonsensical response is defined as any response that is **unrelated, incomprehensible, or incoherent**; it is not informative with respect to the item being rated

C0300: Incorrect vs. Nonsensical

- RAI Coding Tips:
  - An incorrect answer must be differentiated from a nonsensical answer to correctly determine if the interview should be stopped

C0400: Recall

- **"Let's go back to an earlier question. What were those three words that I asked you to repeat?"**
- **Allow up to 5 seconds for response**
  - For any word that is **not correctly recalled** after 5 seconds, provide a category cue
  - **"Something to wear", "a color"** and or **and "a piece of furniture"**

C0400: Recall

- **Code 0, no—could not recall:** If the resident **cannot recall** the word even after being given the **category cue** or if the resident responds with a **nonsensical answer** or chooses not to answer the item
- **Code 1, yes, after cueing:** If the resident requires the **category cue** to remember the word
- **Code 2, yes, no cue required:** If the resident **correctly** remembers the word spontaneously **without cueing**

C0500: Summary Score

- Scores from a carefully conducted BIMS assessment where residents can hear all questions and the resident is not delirious suggest the following distributions:
  - 13-15: **Cognitively intact**
  - 8-12: **Moderately impaired**
  - 0-7: **Severe impairment**

Incomplete Interview

- To have an incomplete interview, a resident had to choose not to answer or had to give completely unrelated, nonsensical responses to **four or more** BIMS items
- In that case, code "99" as the summary score
- The interviewer will proceed to the Staff Assessment of Mental Status

C0700: Short-Term Memory

- Determine the resident's short term memory status by asking him or her:
  - To describe an event **5 minutes** after it occurred if you can validate the resident's response,
  - To follow through on a direction given 5 minutes earlier
  - Observe the resident's cognitive functioning in varied daily activities,
  - Observe across all shifts and departments, and
  - Review the medical record for clues to the resident's short term memory during the look-back period

C0700: Short-Term Memory

- **Code 0, memory OK**: If the resident recalled information **after 5 minutes**
- **Code 1, memory problem**: If the most representative level of function shows the **absence** of recall **after 5 minutes**

C0800: Long-Term Memory

- Determine resident's long-term memory status by engaging in conversation and/or reviewing memorabilia with the resident or observing response to family who visit
- Ask questions for which you can validate the answers from review of the medical record, general knowledge, the resident's family, etc.

C0800: Long-Term Memory

- **Code 0, memory OK**: If the resident **accurately recalled** long past information
- **Code 1, memory problem**: If the resident **did not recall** long past information or **did not recall it correctly**

C0900: Memory/Recall Ability

- Check C0900A, **current season**: **Correctly** refers to weather for the **time of year, legal holiday, religious celebrations**, etc.
- Check C0900B, **location of own room**: If resident can find the way to the room
- Check C0900C, **staff names and faces**: Is able to **distinguish staff members from family members**, visitors and other residents
- Check C0900D, **that he or she is in a nursing home**: Determine that he or she is currently living in a nursing home
- Check C0900Z, **none of the above was recalled**

Pulling it All Together…

- Resident-centered care planning:
  - When a resident who cannot be interviewed presents with an intact memory/recall after five minutes ("short-term memory OK"), there is a greater likelihood of normal cognition
  - An observed "memory problem" should be taken into consideration in planning for care

Pulling it All Together…

- Resident-centered care planning (Cont.)
  - Identified memory problems typically indicate the need for:
    - Assessment and treatment of an underlying related medical problem (particularly if this is a new observation) or adverse medication effect, or …

Pulling it All Together…

- Resident-centered care planning (Cont.)
  - Possible evaluation for other problems with thinking;
  - Additional nursing support;
  - Intermittent or frequent prompting during daily activities ; and
  - Additional support during recreational activities

Pulling it All Together…

- Resident-centered care planning (Cont.)
  - An observed "memory/recall problem" with these items may indicate the need for:
    - Exclusion of an underlying related medical problem (particularly if this is a new observation) or adverse medication effect;
    - Possible evaluation for other problems with thinking;

Pulling it All Together…

- Resident-centered care planning (Cont.)
  - Additional signs, directions, pictures or verbal reminders to support the resident's independence;
  - An evaluation for acute delirium if this represents a change over the past few days to weeks;

Pulling it All Together…

- Resident-centered care planning (Cont.)
  - An evaluation for chronic delirium if this represents a change over the past several weeks to months; or
  - Additional nursing support;
  - The need for emotional support, reminders and reassurance to reduce anxiety and agitation

MDS 3.0

Section D:
MOOD

Section D-Mood

- Intent:
  - The items in this section address mood distress, a serious condition that is underdiagnosed and undertreated in the nursing home and is associated with significant morbidity. It is particularly important to identify signs and symptoms of mood distress among nursing home residents because these signs and symptoms can be treatable.

Section D-Mood

- Assessment/coding in this section does not assign a diagnosis of depression or other mood disorder
- Assessors are simply responsible to record the presence or absence of specific clinical mood indicators
- Facility staff should incorporate these indicators when developing individualized care plans

Section D0100: Should Resident Mood Interview be Conducted?

- Review **Makes Self Understood** item (B0700) to determine if the resident is understood at least sometimes (B0700 = 0, 1, or 2)
- Review **Language** item (A1100) to determine if the resident needs or wants an interpreter to communicate with doctors or health care staff (A1100 = 1)
  - If the resident needs or wants an interpreter, complete the interview with an interpreter

Section D0100: Should Resident Mood Interview be Conducted?

- If it is not possible for a needed interpreter to be present the day before or day of the ARD, code D0100 = 0 to indicate that an interview was not attempted and complete items D0500-D0650
- **Coding Instructions:**
  - **Code 0, no**
  - **Code 1, yes**

Relevancy of the PHQ-9

- The PHQ-9 has a direct relationship to Quality of Life:
  - Most residents who are capable of communicating **can answer questions about how they feel**
  - Obtaining information about mood directly from the resident, sometimes called "**hearing the resident's voice**," is more reliable and accurate than observation alone for identifying a mood disorder

Relevancy of the PHQ-9

- The PHQ-9 has a direct relationship to Quality of Life (Continuation)
  - Depression can be associated with:
    - Psychological and physical distress (e.g., poor adjustment to the nursing home, loss of independence, chronic illness, increased sensitivity to pain)
    - Decreased participation in therapy and activities (e.g., caused by isolation)

Relevancy of the PHQ-9

- The PHQ-9 has a direct relationship to Quality of Life (Continuation)
  - Decreased functional status (e.g., resistance to daily care, decreased desire to participate in activities of daily living [ADLs])
  - Poorer outcomes (e.g., decreased appetite, decreased cognitive status)

Relevancy of the PHQ-9

- The PHQ-9 has a direct relationship to resident-centered care plans:
  - **Symptom-specific information** from direct resident interviews will allow for the incorporation of the resident's voice in the individualized care plan
  - If a resident cannot communicate, then Staff Mood Interview (D0500 A-J) should be conducted

Relevancy of the PHQ-9

- The PHQ-9 has a direct relationship to resident-centered care plans (Continuation)
  - Findings suggesting mood distress should lead to:
    - Identifying causes and contributing factors for symptoms,
    - Identifying interventions (treatment, personal support, or environmental modifications) that could address symptoms, and
    - Ensuring resident safety

Relevancy of the PHQ-9

- The PHQ-9 has a direct relationship to resident-centered care plans (Cont.)
  - The score can be communicated among health care providers and used to track symptoms and how they are changing over time
  - The score is useful for knowing when to request additional assessment by providers or mental health specialists for underlying depression

D0200: Mood Interview (PHQ-9©)

D0200: Mood Interview (PHQ-9©)

- Look-back period = 14 days
- Looks back to prior to admission
- Conduct the interview the day before or day of the ARD
- **Suggested language:** "Over the last 2 weeks, have you been bothered by any of the following problems?"

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D0200: Mood Interview (PHQ-9©)

- Then, for each question in Resident Mood Interview (D0200), **read the item as it is written**
- Do not provide definitions because the meaning **must be** based on the resident's interpretation. For example, the resident defines for himself what "tired" means; the item should be scored based on the resident's interpretation.
- Each question **must be asked in sequence** to assess presence (column 1) and frequency (column 2) before proceeding to the next question
- **Enter code 9** for any response that is unrelated, incomprehensible, or incoherent or if the resident's response is not informative with respect to the item being rated

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D0200: Mood Interview (PHQ-9©)

- **Coding Instructions for Column 1. Symptom Presence:**
  - **Code 0, no:** If resident indicates symptoms listed are not present enter 0. Enter 0 in Column 2 as well
  - **Code 1, yes:** If resident indicates symptoms listed are present enter 1. Enter 0, 1, 2, or 3 in Column 2, Symptom Frequency
  - **Code 9, no response:** If the resident was unable or chose not to complete the assessment, responded nonsensically and/or the facility was unable to complete the assessment. Leave Column 2, Symptom Frequency, blank

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D0200: Mood Interview (PHQ-9©)

- Coding Instructions for Column 2. Symptom Frequency:
  - **Code 0, never or 1 day:** If the resident indicates that he or she has never or has only experienced the symptom on 1 day
  - **Code 1, 2-6 days (several days):** If the resident indicates that he or she has experienced the symptom for 2-6 days
  - **Code 2, 7-11 days (half or more of the days):** If the resident indicates that he or she has experienced the symptom for 7-11 days
  - **Code 3, 12-14 days (nearly every day):** If the resident indicates that he or she has experienced the symptom for 12-14 days

D0200: Mood Interview (PHQ-9©)

- Record the resident's responses as they are stated, **regardless of whether the resident or the assessor attributes the symptom to something other than mood**
- Further evaluation of the clinical relevance of reported symptoms should be explored by the responsible clinician

D0200: Mood Interview (PHQ-9©)

- **Coding Tips and Special Populations:**
  - If the resident uses his own words to describe a symptom, this should be briefly explored. If it is determined that the resident is reporting the intended symptom but using his own words, ask them to tell you how often they were bothered by that symptom.
  - Select only one frequency response per item
  - If the resident has difficulty selecting between two frequency responses, code for the higher frequency

D0200: Mood Interview (PHQ-9©)

- **Coding Tips and Special Populations (Continuation)**
  - Some items (e.g., item F) contain more than one phrase. If a resident gives different frequencies for the different parts of a single item, select the **highest frequency** as the score for that item.
  - Residents may respond to questions:
    - Verbally,
    - By pointing to their answers on the cue card, OR
    - By writing out their answers

D0200: Mood Interview (PHQ-9©)

- **Interviewing Tips and Techniques:**
  - Repeat a question if you think that it has been misunderstood or misinterpreted
  - If the resident goes of the topic the assessor should gently guide the conversation back to the topic
  - If the resident has difficulty selecting a frequency response, start by offering a single frequency response and follow with a sequence of more specific questions. This is known as **unfolding.**

D0200: Mood Interview (PHQ-9©)

- **Interviewing Tips and Techniques (Continuation)**
  - Noncommittal responses such as "not really" should be explored. Probe by asking neutral or nondirective questions such as:
    - "What do you mean?"
    - "Tell me what you have in mind"
    - "Tell me more about that"
    - "Please be more specific"
    - "Give me an example"
  - Sometimes respondents give a long answer to interview items. Summarize their longer answer and then ask them which response option best applies.
  - This is known as **echoing**

D0200: Mood Interview (PHQ-9©)

- **Interviewing Tips and Techniques (Continuation)**
  - If the resident has difficulty with longer items, separate the item into shorter parts, and provide a chance to respond after each part
  - This is known as **disentangling**, this method is helpful with resident who have moderate cognitive impairment but can respond to simple, direct questions

D0300: Total Severity Score

- **Definition:**
  - The score does not diagnose a mood disorder or depression but provides a standard score which can be communicated to the resident's physician, other clinicians and mental health specialists for appropriate follow up
  - The **Total Severity Score** is a summary of the frequency scores on the PHQ-9© that indicates the extent of potential depression symptoms and can be useful for knowing when to request additional assessments and track symptoms and how they change over time

D0300: Total Severity Score

- **Steps for Assessment:**
  - After completing D0200 A-1:
    - Add the numeric scores across all frequency items in **Resident Mood Interview** (D0200) Column 2
    - Do not add up the score while you are interviewing the resident. Instead, focus your full attention on the interview.
    - The **maximum resident score is 27** (9 × 3)

D0300: Total Severity Score

- PHQ-9© **Total Severity Score** can be used to track changes in severity over time. **Total Severity Score** can be interpreted as follows:
  - 1-4: Minimal depression
  - 5-9: Mild depression
  - 10-14: Moderate depression
  - 15-19: Moderately severe depression
  - 20-27: Severe depression

Incomplete Interview

- **Coding Instructions**:
  - The interview is successfully completed if the resident answered the frequency responses of at least 7 of the 9 items on the PHQ-9©
  - If symptom frequency is blank for 3 or more items, the interview is deemed **NOT** complete. **Total Severity Score** should be coded as "99" and the **Staff Assessment of Mood** should be conducted.
  - Enter the total score as a two-digit number. The **Total Severity Score** will be between **00** and **27**
  - **"99"** is coded if symptom frequency is blank for 3 or more items)

D0350: Follow-up to D02001

- Complete item D0350 **only** if item D02001 **Thoughts That You Would Be Better Off Dead, or of Hurting Yourself in Some Way** = 1 indicating the possibility of resident self-harm
  - **Code 1, no:** If responsible staff or provider was not informed that there is a potential for resident self-harm
  - **Code 2, yes:** If responsible staff or provider was informed that there is a potential for resident self-harm

D0500: Staff Assessment of Resident Mood (PHQ-9-OV)

- Staff should complete the PHQ-9-OV **Staff Assessment of Mood** to ensure that signs or symptoms of mood, behaviors distress are identified and treated in patients who are unable or unwilling to complete the PHQ-9© **Resident Mood Interview**
- If the resident is **not able to complete the PHQ-9©, because of communication/refusal or inability to participate** then a scripted interview with staff who knows the resident well should be completed to provide critical information to understand the mood and for care plans

 Harmony Healthcare International, Inc. 100

D0500: Staff Assessment of Resident Mood (PHQ-9-OV)

- Interview **staff from all shifts** who know the resident best. Conduct interview in a location that protects resident privacy.
- Encourage staff to report symptom frequency, **even if the staff believes the symptom to be unrelated to depression**
- If frequency cannot be coded because the resident has been **in the facility for less than 14 days**, talk to family or significant other and review transfer records to form the selection of a frequency code

 Harmony Healthcare International, Inc. 101

D0500: Staff Assessment of Resident Mood (PHQ-9-OV)

- **Coding Instructions for Column 1: Symptom Presence:**
  - **Code 0, no:** If symptoms listed are not present. Enter 0 in Column 2, **Symptom Frequency**
  - **Code 1, yes:** If symptoms listed are present. Enter 0, 1, 2, or 3 in Column 2, **Symptom Frequency**

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D0500: Staff Assessment of Resident Mood (PHQ-9-OV)

- **Coding Instructions for Column 2. Symptom Frequency:**
  - **Code 0, never or 1 day: I**f staff indicate that the resident has never or has experienced the symptom on only 1 day
  - **Code 1, 2-6 days (several days): I**f staff indicate that the resident has experienced the symptom for 2-6 days
  - **Code 2, 7-11 days (half or more of the days): I**f staff indicate that the resident has experienced the symptom for 7-11 days
  - **Code 3, 12-14 days (nearly every day): I**f staff indicate that the resident has experienced the symptom for 12-14 days

D0600: Total Severity Score

- **Steps for Assessment:**
  - *After completing items D0500 A-J:*
    - Add the numeric scores across all frequency items for **Staff Assessment of Mood, Symptom Frequency** (D0500) Column 2
    - Maximum score is 30 (3 × 10)

Section D and RUG-IV

- Section D is used to calculate the end-split calculation of "1" or "2" for some RUG-IV categories
- A PHQ-9 or PHQ-9-OV **Total Severity Score of 10 or greater** will yield a "2" end-split
- This end-split affects some nursing-only categories

Section D and RUG-IV

- The RUG-IV categories affected by the **depression end-split** are:
  - Special Care High
  - Special Care Low
  - Clinically Complex
- Be mindful of the **Index Maximization** property of the RUG-IV system

Pulling it All Together…

- Resident-centered care planning:
  - Symptom-specific information from direct resident interviews will allow for the incorporation of the resident's voice in the individualized care plan
  - The PHQ-9© Total Severity Score also provides a way for health care providers and clinicians to easily identify and track symptoms and how they are changing over time

Pulling it All Together…

- Resident-centered care planning (Continuation)
  - Recognition and treatment of depression in the nursing home can be lifesaving, reducing the risk of mortality within the nursing home and also for those discharged to the community
  - It is well-known that untreated depression can cause significant distress and increased mortality in the geriatric population beyond the effects of other risk factors

Section F:
PREFERENCES FOR CUSTOMARY ROUTINE AND ACTIVITIES

Section F: Preferences for Customary Routine and Activities

- Intent:
  - The intent of items in this section is to obtain information regarding the resident's preferences for his or her daily routine and activities
  - The facility should use this as a guide to create an individualized care plan
  - Not intended to be all-inclusive

Section F: Preferences for Customary Routine and Activities

- **Current** preferences "while you are in this facility"
- There is no look-back provided for the resident
- There questions can be completed anytime within the 7-day look-back period

F0300: Should Interview for Daily and Activity Preferences be Conducted

- Resident interview should be conducted if the resident can respond:
  - Verbally,
  - By pointing to answers on a **Cue Card, or**
  - By **writing out their answers**

Relevancy of the Preference Interview

- The Preferences for Customary Routine and Activities interview has a direct relationship to Quality of Life:
  - Most residents capable of communicating can answer questions about what they like
  - Obtaining information about preferences directly from the resident, sometimes called "hearing the resident's voice," is the most reliable and accurate way of identifying preferences

Relevancy of the Preference Interview

- The Preferences for Customary Routine and Activities interview has a direct relationship to Quality of Life (Continuation)
  - If a resident cannot communicate, then **family or significant other who knows the resident well** may be able to provide useful information about preferences

Relevancy of the Preference Interview

- The Preferences for Customary Routine and Activities interview has a direct relationship to Quality of Life (Continuation)
  - Individuals who live in nursing homes continue to have **distinct lifestyle preferences**
  - A lack of attention to lifestyle preferences can contribute to depressed mood and increased behavior symptoms

Relevancy of the Preference Interview

- The Preferences for Customary Routine and Activities interview has a direct relationship to Quality of Life (Cont.)
  - Resident responses that something is **important but that they can't do it or have no choice** can provide clues for understanding pain, perceived functional limitations and/or perceived environmental barriers

Relevancy of the Preference Interview

- The Preferences for Customary Routine and Activities interview has a direct relationship to resident-centered care plans:
  - Quality of life can be greatly enhanced when the caregiver respects the resident's choice regarding anything that is important to the resident
  - Interviews allow the resident's voice to be reflected in the care plan

Relevancy of the Preference Interview

- The Preferences for Customary Routine and Activities interview has a direct relationship to resident-centered care plans (Continuation)
  - Information about preferences that comes **directly from the resident provides specific information** for individualized daily care and activity planning
  - **Care planning should be individualized** and based on the resident's preferences

Relevancy of the Preference Interview

- The Preferences for Customary Routine and Activities interview has a direct relationship to resident-centered care plans (Continuation)
  - Care planning and care practices that are **based on resident preferences** can lead to
    - Improved mood,
    - Enhanced dignity, and
    - Increased involvement in daily routines and activities

Relevancy of the Preference Interview

- The Preferences for Customary Routine and Activities interview has a direct relationship to resident-centered care plans (Continuation)
  - Incorporating resident preferences into care planning is a **dynamic, collaborative process**
  - Residents **may adjust their preferences** in response to events and changes in status
  - The interview is intended as **a first step in an ongoing dialogue** between care providers and the residents

Relevancy of the Preference Interview

- The Preferences for Customary Routine and Activities interview has a direct relationship to resident-centered care plans (Continuation)
  - Care plans should be **individualized to each resident's preferences**
  - Care plans should be **updated as the residents preferences change**, paying special attention to preferences that **the resident states are important**

F0400/F0500: Interview for Daily and Activity Preferences

- Suggested language:
  - "I am going to ask you how important various activities and routines are to you while you are in this home. I will ask you to answer using the choices you see on this card."
  - **[Read the answers while pointing to cue card]:** "'Very Important,' 'Somewhat important,' 'Not very important,' 'Not important at all,' or 'Important, but can't do or no choice.'"

F0400/F0500: Interview for Daily and Activity Preferences

- Explain each of the interview response choices and show the resident a **clearly written list or cue card** of the following response options:
  1. Very important
  2. Somewhat important
  3. Not very important
  4. Not important at all

F0400/F0500: Interview for Daily and Activity Preferences

5. Important, but can't do or no choice (This response indicates that the topic is important to the resident but that they are physically unable to participate or have no choice about participating because of the nursing home's schedules or resources)
9. No response or non-responsive

F0400/F0500: Interview for Daily and Activity Preferences

- If the resident cannot report preferences, then interview family or significant others
- The assessor would only code "9" if the resident, family and significant other
  - Refused to answer
  - Does not know the answer
  - Does not give an answer for several seconds, does not appear to be formulating answer
  - Provides an incoherent or nonsensical answer

F0400/F0500: Interview for Daily and Activity Preferences

- Stop the interview and skip to Item F0700 if
  - The resident has given 3 nonsensical responses to 3 questions, OR
  - The resident has not responded to 3 of the questions

F0700: Should the Staff Assessment of Daily and Activity Preferences be Conducted?

- Yes, if the resident, family or significant other was **unable to answer 3 or more items** in both sections
- If the total number of unanswered questions in F0400 through F0500 is **equal to 3** or more, the interview is considered incomplete

F0800: Staff Assessment of Daily and Activity Preferences

- Steps for Assessment:
  - Observations of behaviors are to be made by:
    - All shifts
    - All departments
    - Others who have close contact with the resident

Pulling it All Together…

Pulling it All Together…

- Resident-centered care planning:
  - Activities are a way for individuals to **establish meaning** in their lives, and the need for **enjoyable activities and pastimes** does not change on admission to a nursing home
  - A lack of opportunity to engage in **meaningful and enjoyable activities** can result in boredom, depression, and behavior disturbances

Pulling it All Together…

- Resident-centered care planning (Continuation)
  - Individuals vary in the activities they prefer, reflecting **unique personalities**, past interests, perceived environmental constraints, religious and cultural background, and **changing physical and mental abilities**
  - Reflecting these preferences in the care plan will **individualize patient care**

F0800: Staff Assessment of Daily and Activity Preferences

- Resident-centered care planning (Continuation)
  - These questions will be useful for designing **individualized care plans** that facilitate residents' participation in activities they find meaningful
  - Preferences may **change over time** and extend beyond those included in this interview

Pulling it All Together…

- Resident-centered care planning (Continuation)
  - The assessment of activity preferences is intended as a **first step** in an **ongoing informal dialogue** between the care provider and resident
  - These preferences may **change** during the resident's stay!

Pulling it All Together…

- Resident-centered care planning (Continuation)
  - The care plan should be **updated** with **new preferences** or new activities as the resident finds new activities they enjoy
  - Responses may provide **insight** into perceived functional, emotional, and sensory support needs
  - These discoveries should be shared with the Interdisciplinary Team

Section J:
HEALTH CONDITIONS

Section J-Presence of Pain

Section J-Presence of Pain

- Intent:
  - To identify:
    - Presence of pain
    - Pain frequency
    - Effect of pain on function
    - Pain intensity
    - Effectiveness of pain management and control

J0200: Should Pain Assessment Interview Be Conducted?

- Attempt to complete the interview if the resident is at least sometimes understood (B0700 = 0, 1, or 2) and
- Ensure **interpreter is present** or not required

J0200: Should Pain Assessment Interview Be Conducted?

- **Code 0, no**: If the resident is **rarely/never** understood or an interpreter is required but not available. Skip to section J0800, Indicators of Pain or Possible Pain
- **Code 1, yes**: If the resident is at least **sometimes understood** and an interpreter is present or not required
  - Continue to J0300, Pain Presence

Relevancy of the Pain Interview

- The Pain Interview has a direct relationship to Quality of Life:
  - Pain can cause **suffering** and **is associated with inactivity, social withdrawal, depression, and functional decline**
  - Pain can **interfere with participation in rehabilitation**
  - Effective pain management interventions can help to avoid these adverse outcomes

Relevancy of the Pain Interview

- The Pain Interview has a direct relationship to Quality of Life (Continuation)
  - The effects of unrelieved pain **impact the individual in terms of functional decline, complications of immobility, skin breakdown and infections**
  - Pain significantly **adversely affects a person's quality of life** and is tightly linked to depression, diminished self-confidence and self-esteem, as well as an increase in behavior problems, particularly for cognitively-impaired residents

Relevancy of the Pain Interview

- The Pain Interview has a direct relationship to Quality of Life (Continuation)
  - Some older adults limit their activities in order to avoid having pain. Their report of lower pain frequency **may reflect their avoidance of activity more than it reflects adequate pain management**

Relevancy of the Pain Interview

- The Pain Interview has a direct relationship to resident-centered care plans:
  - Goals for pain management for most residents should be to **achieve a consistent level of comfort while maintaining as much function as possible**
  - The interview process provides **a means for patient participation** in the formation of pain management goals
  - The resident is given **a voice** in the interview process

Relevancy of the Pain Interview

- The Pain Interview has a direct relationship to resident-centered care plans (Continuation)
  - Identification of pain management interventions facilitates **review of the effectiveness of pain management and revision of the plan** if goals are not met
  - This provides the opportunity for staff from **all shifts and all members of the Interdisciplinary Team, including the physician,** to address pain goals and pain management

Relevancy of the Pain Interview

- The Pain Interview has a direct relationship to resident-centered care plans (Continuation)
  - Residents may have **more than one source of pain** and will need **a comprehensive, individualized management regimen**
  - Most residents with moderate to severe pain will require regularly dosed pain medication, and some will require additional PRN (as-needed) pain medications for breakthrough pain
  - Some residents with intermittent or mild pain may have orders for PRN dosing only

Relevancy of the Pain Interview

- The Pain Interview has a direct relationship to resident-centered care plans (Continuation)
  - Directly **asking the resident about pain** rather than relying on the resident to volunteer the information or relying on clinical observation significantly improves the detection of pain
  - **Resident self-report is the most reliable means for assessing pain**

Relevancy of the Pain Interview

- The Pain Interview has a direct relationship to resident-centered care plans (Continuation)
  - Pain assessment provides **a basis for evaluation of treatment need, and response to treatment**
  - Assessing whether pain interferes with sleep or activities **provides additional understanding of the functional impact** of pain and potential care planning implications
  - Assessment of pain provides insight into the need to **adjust the timing of pain interventions to better cover sleep or preferred activities**

Relevancy of the Pain Interview

- The Pain Interview has a direct relationship to resident-centered care plans (Continuation)
  - Pain assessment prompts discussion about **factors that aggravate and alleviate pain**
  - Similar pain stimuli can have **varying impact on different individuals**
  - Consistent use of a **standardized pain intensity scale improves the validity and reliability of pain assessment.** Using the same scale in different settings may improve continuity of care.

Relevancy of the Pain Interview

- The Pain Interview has a direct relationship to resident-centered care plans (Continuation)
  - Pain intensity scales allow providers to evaluate whether pain is responding to the pain medication regimen and/or non-pharmacological intervention(s)
  - Care decisions can be based on this evaluation of the pain regimens effectiveness
  - Rates of self-reported pain are higher than observed rates. **The regular and objective use of self-report pain scales enhances residents' willingness to report.**

Section J: Health Conditions

- J0100: Pain Management
  - J0100B. Received PRN pain medications **OR was offered and declined**?

J0300: Pain Presence

- Ask: "Have you had pain or hurting at any time in the last 5 days?"
- Coding Instructions:
  - 0, no
  - 1, yes
  - 9, unable to answer
  - Code No (0) if the resident reports no pain during the interview

J0400: Pain Frequency

- Ask: "How much of the time have you experienced pain or hurting over the last 5 days?"
- Coding Instructions:
  - 1 Almost constantly
  - 2 Frequently
  - 3 Occasionally
  - 4 Rarely
  - 9 Unable to answer

J0500: Pain Effect on Function

- Ask the resident each of the two questions exactly as they are written:
  - J0500A: "Over the Past 5 Days, Has Pain Made It Hard for You to Sleep at Night?"
    - 0, no
    - 1, yes
    - 9, unable to answer

J0500: Pain Effect on Function

- Ask the resident each of the two questions exactly as they are written:
  - J0500B: "Over the Past 5 Days, Have You Limited Your Day-to-day Activities because of Pain?"
    - 0, no
    - 1, yes
    - 9, unable to answer

J0600A & B: Pain Intensity

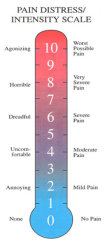
- Administer only one of the pain intensity questions:
  - J0600A. Numeric Rating Scale (00-10 scale)
  - J0600B. Verbal Indicator Scale
- For each resident, try to use the **same scale used on prior assessments**
- If the resident is unable to answer using one scale, the other scale should be attempted

J0600A: Numeric Rating Scale

- "Please rate your worst pain over the last 5 days with zero being no pain, and ten as the worst pain you can imagine"
  - Enter the two digit number (00-10) indicated by the resident where zero is no pain, and 10 is the worst pain imaginable
  - Enter 99 if unable to answer
  - If the Numeric Rating Scale is not used, leave the response box blank

J0600B: Verbal Indicator Scale

- "Please rate the intensity of your worst pain over the last 5 days."
  - Coding Instructions:
    - 1 Mild
    - 2 Moderate
    - 3 Severe
    - 4 Very severe, horrible
    - 9 Unable to answer



J0700: Staff Assessment for Pain

- J0700: Should the Staff Assessment for Pain be Conducted?
  - Complete this item only if the Pain Assessment Interview **(J0200-J0600) was not completed**

0, no If the resident completed the Pain Assessment Interview (0J0400)

1, yes if the resident is unable to complete Pain Assessment Interview (0J0400)

J0800: Staff Assessment for Pain

- **Check all that apply** in the past 5 days based on staff observation of pain indicators.
  - J0800A: Non-verbal sounds
  - J0800B: Vocal complaints of pain
  - J0800C: Facial expressions
  - J0800D: Protective body movements or postures
  - J0800Z: None of these signs observed or documented

J0850: Staff Assessment for Pain

- Frequency of Indicator of Pain or Possible Pain
- 5-Day look-back
- Code for pain frequency:
  - **Code 1,** complained or showed evidence of pain 1 to 2 days
  - **Code 2**, complained or showed evidence of pain on 3 to 4 of the last 5 days
  - **Code 3,** complained or showed evidence of pain on a daily basis

Pulling it All Together…

- Resident-centered care planning:
  - Residents who cannot verbally communicate about their pain are at **particularly high risk** for under-detection and under-treatment of pain
  - Severe cognitive impairment may affect the ability of residents to **verbally communicate**, thus limiting the availability of **self-reported information** about pain. In this population, fewer complaints may not mean less pain

Pulling it All Together…

- Resident-centered care planning (Continuation)
  - Individuals who are unable to verbally communicate may be more likely to use **alternative methods of expression** to communicate their pain
  - Even in this population some verbal complaints of pain **may be made** and should be **taken seriously**

Pulling it All Together…

- Resident-centered care planning (Continuation)
  - Consistent approach to observation improves the **accuracy of pain assessment** for residents who are unable to verbally communicate their pain
  - Particular attention should be paid to using the indicators of pain during activities when pain is **most likely to be demonstrated** (e.g., bathing, transferring, dressing, walking and potentially during eating)
  - Staff must carefully **monitor, track, and document** any possible signs and symptoms of pain

Pulling it All Together…

- Resident-centered care planning (Continuation)
  - Identification of these **pain indicators** can:
    - Provide a basis for more comprehensive pain assessment,
    - Provide a basis for determining appropriate treatment, and
    - Provide a basis for ongoing monitoring of pain presence and treatment response
  - If pain indicators are present, assessment should **identify aggravating/alleviating factors** related to pain

If Unable to Complete the Interviews…

- CMS has identified some scenarios in which the resident interviews may not be able to be completed
- Guidance has been issued for these scenarios

Completing Resident Interviews on Stand-alone OMRAs

- Providers are encouraged to complete resident interviews in as timely a manner and as complete as possible
- Interviews for OMRAs **may occur one to two days after the ARD**
- CMS expects **most OMRAs will not catch providers by surprise**

If Unable to Complete the Interviews…

- Due to unexpected discharge (or other reason):
  - The **gateway questions, C0100, D0100 and/or J0200 should be coded No (0)** and
  - The **staff assessment should be completed**
- Effective 4/1/2012, there are different item sets if discharge is planned or unplanned

Discharge Item Sets

Discharge Assessment (prior to April 1st)
- Maximum 111 questions

New Discharge Assessments:
- Unplanned Discharge Assessment
  - Maximum 77 questions
- Planned Discharge Assessment
  - Maximum 89 questions

Unplanned Discharge

- Acute-care transfer of the resident to a hospital or an emergency department (ED) in order to either stabilize a condition or determine if an acute-care admission is required based on ED evaluation OR
- Resident unexpectedly leaving the facility against medical advice OR
- Resident unexpectedly deciding to go home or to another setting

Unscheduled Assessment Interviews

- Effective April 1, 2012, when coding **a standalone unscheduled PPS assessment (COT, EOT, SOT)**, the interview items may be coded using the responses from the resident on a previous scheduled assessment provided that those responses were **obtained no more than 14 days prior to the ARD of the unscheduled assessment on which those responses will be used**

Interviews for a Standalone OMRA

- For example, assume a facility completes a 14 day assessment and completes the resident interview items on the assessment on the same day as the ARD
- The facility then finds that an EOT OMRA is completed with an ARD set for just a few days after the 14 day

Interviews for a Standalone OMRA

- The facility reviews the interview items and finds that **the responses are still an accurate representation** of the resident's current state
- In this case, the facility may choose simply to carry the interview responses forward from the 14 day assessment to the standalone EOT OMRA

Interviews for a Standalone OMRA

- In the Z0400 field on the EOT OMRA, the facility would have **the individual who conducted the original** interview sign-off this section and input **the date of the original interview**

Final Thoughts

- Even if the resident was unable to complete the interview important insights may be gained from responses that were obtained, observing behaviors, and observing the residents affect during the interview
- Inappropriate use of dashes will affect a facilities QMs because the discharge assessment is used as the target assessment for several measures
- Accurately conducted interviews impact reimbursement (Sections C and D), QM risk adjustments (Section C) and the QMs themselves (Sections D and J)

Final Thoughts

- Resident interviews are about enabling the resident to participate in the creation of their care plan and honoring their personal preferences
- Confused residents should not be automatically "screened out" of the interview process
- CMS has stressed that surveyors will be paying attention to interview completion during survey

Questions/Answers

- **Harmony Healthcare International**
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- **Ctwombly@harmony-healthcare.com**
- **www.Harmony-Healthcare.com**

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or

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RUGS@harmony-healthcare.com

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