Documenting The Care You Provide: ADL Accuracy

Presented by:

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Documenting the Care You Provide: ADL Accuracy

HARMONY UNIVERSITY
The Provider Unit of
Harmony Healthcare International, Inc.
(HHI)

Presented by:

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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

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Documenting the Care You Provide: ADL Accuracy

- **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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Communication & Coaching: A Nurse's Guide to Creating a Harmonious Atmosphere
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Speaker:
Christine Twombly, SW Regional Consultant

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Program Objectives

- The learner will be able to define the late-loss ADLs
- The learner will be able to define the levels of assistance (self-performance)
- The learner will be able to identify the impact of ADL coding and the calculation of the ADL score
- The learner will be able to discuss the impact ADL scoring has on payment
- The learner will be able to discuss an ADL coding case study

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CNA Role in Documentation

- Because the CNA is the direct caregiver and the person who spends the most time providing care, they are likely the first to see changes in function
- Accuracy in documentation is critical to highlight changes and generate the appropriate referrals
- Decline in function is not a normal part of aging but rather is the product of diseases and conditions
- Decline in function must be identified in order for it to be evaluated, a plan of care developed and treatment provided

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CNA Role in Documentation

- When the patient functions below their capability for a prolonged period of time, functional losses may become permanent
- Documentation may help to qualify the beneficiary for long-term care, if needed
- For example, a patient inaccurately coded as independent may not qualify for additional care in the facility. The patient may therefore be denied long term care coverage and discharged into a potentially unsafe situation.

Document What Occurred

- Code for actual patient performance and actual support provided
- Code for the highest level over the course of the entire shift
- Do not code for a level of care provided on previous shifts/days
- Never code based upon what the patient is "expected" or "capable" of doing
- Patient self-performance and support received will vary day-to-day and shift-to-shift due to a variety of reasons

Late Loss ADLs

- Bed Mobility
- Transfers
- Eating
- Toileting

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Late Loss ADLs

- **Late loss ADLs** are those considered the "last" to deteriorate
- Assistance received to perform these late loss ADLs **reflect the degree and amount of resources** (staff time, number of staff and staff effort) provided by facility staff to provide appropriate care
- Assistance with ADLs may be related to a variety of physical as well as psychosocial and cognitive conditions

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Section G: Principles of Accurate Assessment

- 7-day look-back period (since admission or readmission only)
- Assess
- Observe
- Consult with all interdisciplinary team across all shifts to capture accurate assist levels
- Ask probing questions, beginning with the general and proceeding to the more specific

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Section G: Principles of Accurate Assessment

- Do **NOT** include assistance provided by **family** or other **visitors** when capturing assist level
- Do **NOT** code ambulance transfer assistance or assistance from hospice
- Code assist provided by **facility staff** only
- Facility staff **does** refer to direct employees and facility-contracted employees
- Facility staff **does not** refer to individuals hired outside the facility's management and administration

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Activities of Daily Living (ADLs) Key Points Regarding MDS Coding

- The intent is to capture **what the resident actually does**, not what they could, would or should do
- Assistance needed **varies** from day to day, from shift to shift and even during a particular shift
- **The reason that the assistance was required is irrelevant**; it simply matters that it was needed

Self Performance = 0 (Independent)

- No help or staff oversight at any time (and ADL occurred at least three times)

Self Performance = 1 (Supervision)

- Oversight, encouragement, or cueing was provided three or more times

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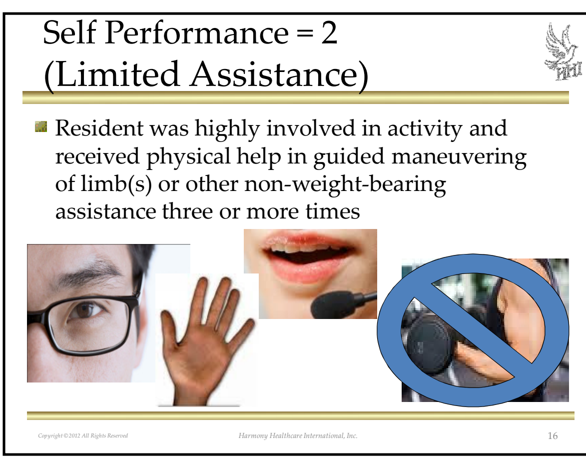

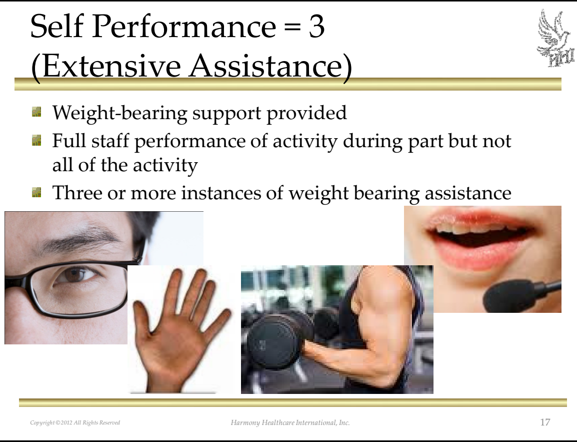

Self Performance = 4 (Total Dependence)

- Full staff performance of an activity with **no participation by resident** for any aspect of the ADL activity occurred three or more times
- The resident must be **unwilling or unable** to perform any part of the activity

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ADL Occurred Two or Fewer Times

- **(7) Activity occurred only once or twice** – activity did occur but only once or twice in the entire 7-day period
- **(8) Activity did not occur –** if the activity did not occur or family and/or non-facility staff provided care 100% of the time for that activity over the entire 7-day period

Instructions for the Rule of 3

- When an activity occurs three times at any one given level, code that level
- When an activity occurs three times at multiple levels, code the most dependent, exceptions are independent (0), total dependence (4) and activity did not occur (8)
  - Example: Three times extensive (3) and three times limited (2), code extensive assistance (3)

Instructions for the Rule of 3

- When an activity occurs at various levels, but not three times at any given level, apply the following:
  - When there is a combination of full staff performance (4), and extensive assistance (3), code extensive assistance (3)
  - When there is a combination of full staff performance (4), weight bearing assistance (3) and/or non-weight bearing assistance (2) code limited assistance (2)

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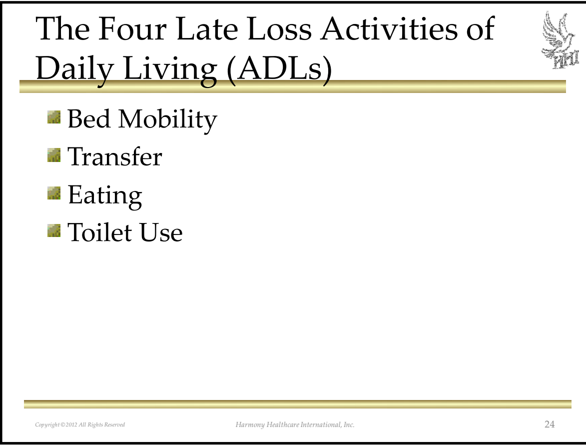
Instructions for the Rule of 3

- If none of the preceding rules are met, code supervision (1)
- Use the **ADL Algorithm Chart** (*RAI User's Manual* page G-6) to guide ADL coding decisions

ADL Support Provided

- **ADL Support Provided:** Code for **most support provided** over all shifts; code regardless of resident's self-performance classification
  - **Coding:**
    0. No setup or physical help from staff
    1. Setup help only
    2. One person physical assist
    3. Two+ persons physical assist
    8. ADL activity itself did not occur during entire period



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The Late Loss ADLs Defined

- ***Bed mobility*** - how resident moves to and from lying position, turns side to side, and positions body while in bed or alternate sleep furniture
- ***Transfer*** - how resident moves between surfaces including to or from: bed, chair, wheelchair, standing position (excludes to/from bath/toilet)

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The Late Loss ADLs Defined

- ***Eating*** - how resident eats and drinks, regardless of skill. Do not include eating/drinking during medication pass. Includes intake of nourishment by other means (e.g., tube feeding, total parenteral nutrition, IV fluids administered for nutrition or hydration).
- ***Toilet use*** - how resident uses the toilet room, commode, bedpan, or urinal; transfers on/off toilet; cleanses self after elimination; changes pad; manages ostomy or catheter; and adjusts clothes. Do not include emptying of bedpan, urinal, bedside commode, catheter bag or ostomy bag.

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Bed Mobility

- How the resident moves to and from a lying position (including lifting legs), turns side-to-side, and positions body while in bed

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Bed Mobility

- Includes anything that happens while the patient is on the mattress or if the patient sleeps in a recliner chair or cardiac chair
- **Ask:** *How did the activity occur (patient move while in bed) regardless of skill or capability?*

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Bed Mobility

- **Ask:** *How much help did the patient receive to position while in bed?*
- Keep in mind that if clinically the patient is unable to participate or needs Extensive Assist, two assist is warranted for patient and staff safety

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Bed Mobility Includes

- Positioning head on pillow, positioning legs or arms on pillow and positioning and repositioning side to side
- Lifting hand to place on side rail to assist patient to turn
- Swinging the legs onto the bed following independent transfer

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Bed Mobility Includes

- Boosting towards the head of the bed, even if independently turning side to side
- Lifting hand to place on side rail to assist patient to turn
- Moving from supine (flat) to sitting
- Moving from sitting to supine (flat)

Bed Mobility Includes

- Putting out your hand for patient to use to pull up
- Lifting limbs back into the bed for the restless patient trying to get up unassisted
- Assisting patient by lifting hand to reach trapeze to then independently boost self up in bed

Transfers

- Transfers are defined as how the patient moves from one surface to the other:
  - Chair to bed
  - Bed to chair
  - Chair to standing
  - Sit to stand

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Transfers

- Transfers are defined as how the patient moves from one surface to the other:
  - Stand to sit
  - Ambulance to bed
  - Ambulance to standing
  - Wheelchair transfers

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Transfers

- **Example:** The patient is ambulatory with only distant supervision. The patient received a gentle boost to move from a chair without arms in the dining room to stand. The patient can transfer independently when in her room in the appropriate chair with arms.
- **Coding:** The patient is an **Extensive Assist** as the highest level of support over the shift is extensive while in the dining room. Do not code due to capacity. Capture assist actually provided.

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Transfers

- **Low Beds:** How does the patient get up from the low bed. Keep in mind the patient may be a high fall risk during the night and may transfer independently after up and moving.
  - **Coding: Extensive Assist** x 2
  - Rationale: 2 staff members assist the patient from the low to floor bed to stand on this shift

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Transfers

- **Bed Alarms:** Bed alarms are generally utilized for patients that should not transfer independently. The staff responds to the alarm to ensure that the patient safely transfers.
- Any "touch assist" = Limited
- Any weight-bearing support = Extensive Assist

Transfers

- **Example:** *On the day of admission, the patient arrives via stretcher and facility staff assists with the transfer of the patient from stretcher to the bed. The staff boosts the patient to the top of the bed, utilizing the lift sheet and assisting in lifting the legs.*
- **Coding:** Both transfer and bed mobility for this shift is **Extensive Assist** of 2
- Rationale: Patient received weight-bearing assistance and the most support provided was 2 or more assist. This patient may be able to position independently side to side, but for this shift is Extensive Assist x 2

Eating

- Eating refers to how the patient takes in nourishment, foods and fluids. This also includes tube feedings and IV hydration.
- Eating is often under-coded as often it is considered in relationship to meals only

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Eating

- Eating/fluid intake also occurs between meals and often at night
- Once physical contact is made, assist has been provided
- Coding is based on actual performance and not skill level

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Eating

- **Example:** *Patient is independent with breakfast lunch and dinner when in the dining room. During last rounds on 3-11 and on the night shift, patient needs assist to hold a cup and bring it to her mouth in order to take in fluids. Weight bearing support or dependence for fluid intake occurs during this time only.*
- **Coding:** Patient would therefore not be coded as Independent for this shift despite coding of Independent on days due to the ability to eat at the dining room table during waking hours. Patient is an **Extensive Assist** for eating if participated in any fashion.
- No participation on behalf of the patient = Dependent

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Eating

- **Example:** *Patient is too tired to finish meal. Patient allows staff to spoon feed the dessert and provide the last of the fluids on the tray. Patient is usually independent with cues.*
- **Coding: Extensive Assist**. Patient is an Extensive Assist as she was dependent in a portion of the activity

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Eating

- **Example:** *This cognitively impaired patient is distracted during meal time. Staff loads the fork and places it in the patients hand (touch=limited), staff lifts the fork in the patient's hand to her mouth to start the task of feeding. Staff does this twice during the beginning of the meal and the patient is then able to finish the meal with verbal cues.*
- Coding: **Extensive Assistance**. Patient is not independent *as* touch assist provided. Patient required Extended Assist as staff lifted the patient's hand with fork. There is no percent of feeding or weight bearing support factored into extensive assist.

Eating

- Set up of the tray is not considered an assist
- General supervision in a dining room due to facility policy does **not** mean the patient is a "supervised"

Eating

- Patient must require supervision to code on the flow sheets
- Always consider intake of food and fluids during the entire shift (not just meals)

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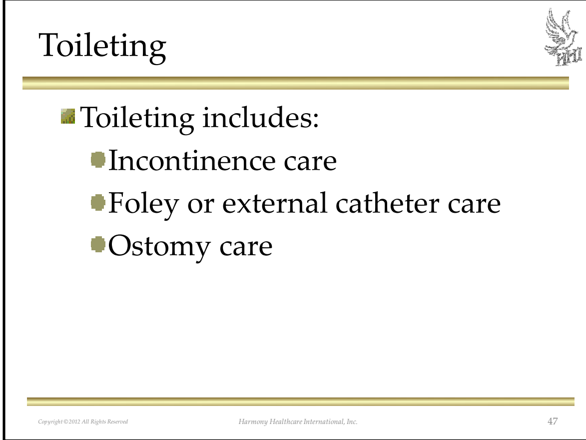
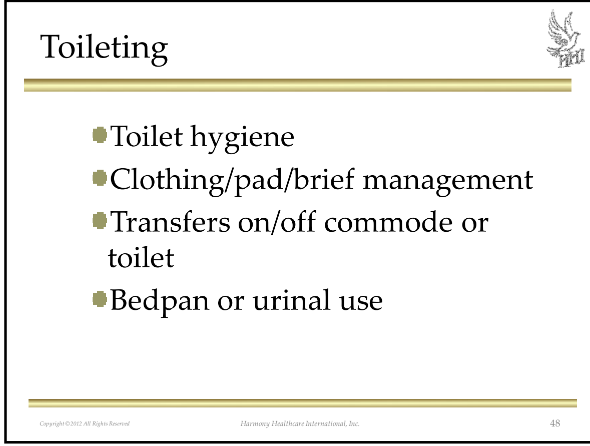
Toileting

- Toileting refers to the ***management of elimination***
- Toileting does not indicate that the patient actually used the toilet or commode





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Toileting

- **Example:** *The patient is a Hoyer lift for transfers and does not use the toilet or commode. She is incontinent frequently. Incontinence care is provided on rounds and as needed. Patient receives two assist to turn in order to change bed linens, clean, don incontinence product and reposition in bed.*
- **Coding:** Patient would be coded as **Extensive Assist** or Dependent (depending on patient participation) of 2 people

Toileting

- **Example:** *Patient has an indwelling catheter and is ambulatory. Patient ambulates to the bathroom and is independent with toilet use for bowels. Staff manages the indwelling catheter and leg bag.*
- **Coding:** Patient is an **Extensive Assist** of one staff for toileting as he is dependent for a portion of the toileting task to include catheter care and management

Additional ADLs

- These activities do not impact reimbursement or Quality Measure reports
- Accuracy is nonetheless important for the highest overall quality of care and quality of life
- Facilities strive to maintain the patient at the highest level of function
- These activities must be broken down into sub-tasks as well

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Additional ADLs

- ***Walk in room*** - how resident walks between locations in his/her room
- ***Walk in corridor*** - how resident walks in corridor on unit
- ***Locomotion on unit*** - how resident moves between locations in his/her room and adjacent corridor on same floor. If in wheelchair, self-sufficiency once in chair.

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Additional ADLs

- ***Locomotion off unit*** - how resident moves to and returns from off-unit locations (e.g., areas set aside for dining, activities or treatments). If facility has only one floor, how resident moves to and from distant areas on the floor. If in wheelchair, self-sufficiency once in chair.
- ***Dressing*** - how resident puts on, fastens and takes off all items of clothing, including donning/removing a prosthesis or TED hose. Dressing includes putting on and changing pajamas and housedresses.

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Additional ADLs

- ***Personal hygiene*** - how resident maintains personal hygiene, including combing hair, brushing teeth, shaving, applying makeup, washing/drying face and hands (excludes baths and showers)

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What is a Subtask?

- A **component (or part)** of the activity
- For example, the subtasks of **Toilet Use** include:
  - Transferring on/off toilet
  - Cleansing self after elimination
  - Changing pads/briefs
  - Managing ostomy or catheter
  - Adjusting clothes

Examples of Subtasks

- Spend a few minutes **talking to your neighbors**
- As a group, determine what are the **subtasks of the following ADLs:**
  - **Bed Mobility**
  - **Personal Hygiene**
  - **Dressing**

What is Set Up help?

- Providing the resident with **materials or devices necessary to perform the ADL independent**.
- This can include giving or holding out an item that the resident takes from the caregiver

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Your Turn: Examples of Set Up

- Bed Mobility
- Transfer
- Locomotion
- Dressing
- Eating
- Toilet Use
- Personal Hygiene

ADL Practice – Bed Mobility

- Mrs. S. is unable to physically turn, sit up, or lie down in bed. Two staff members must physically turn her every two hours without any physical participation at any time from her at any time. She does verbally direct the staff as to how she wants to be positioned.

ADL Practice - Transfer

- Staff must supervise Mrs. Q as she transfers from her bed to wheelchair daily. Staff bring the chair next to the bed and then remind her to hold on to the chair and position her body slowly.

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ADL Practice - Eating

- Mr. F. begins eating each meal daily by himself. Today, he stated he was tired and unable to complete the meal. One staff member physically supported his hand to bring the food to his mouth and provided verbal cues to swallow the food. The resident was then able to complete the meal.

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ADL Practice – Toilet Use

- Mrs. M. has had recent bouts of dizziness. The resident required one staff member to assist and provide weight-bearing support to her as she transferred to the bedside commode.

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How Is ADL Status Reported and Recorded in Your Facility?

- Let's discuss **the system** in your facility to report/record **ADL status**
- Does it **work well**?
- Are you capturing **the true picture** of the resident?
- Why or why not?
- How can it be **improved**?

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Calculating the Late Loss ADL Score

- The four late loss ADLs are used to calculate the Late Loss ADL score
- This score influences the final RUG-III or RUG-IV classification
- It is important that staff who are participating in the RAI Process know how to calculate a Late Loss ADL score

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RUG-IV ADL SCORE
Step One

To calculate the ADL score use the following chart for bed mobility (G0110A), transfer (G0110B), and toilet use (G0110I).

Self-Performance Column 1	Support Column 2	ADL Score
-,0,1,7 or 8	Any number	0
2	Any number	1
3	-,0-2	2
4	-,0-2	3
3 or 4	3	4

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RUG-IV ADL SCORE
Step Two

To calculate the ADL score for eating (G0110H), use the following chart.

Self-Performance Column 1	Support Column 2	ADL Score
-,0,1,2, 7 or 8	-,0, 1,8	0
2, 7	2	2
3	2	3
4	2	4

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RUG-IV ADL SCORE Step Three

- Add the four Late Loss ADL scores for the total Late Loss ADL score
- The score can range from 0-16
- 0 = very independent patient
- 16 = totally dependent patient

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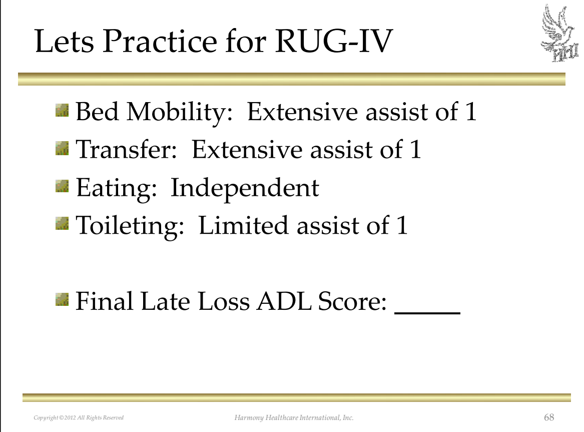

Lets Practice for RUG-IV

- Bed Mobility: Extensive assist of 2
- Transfer: Extensive assist of 1
- Eating: Independent
- Toileting: Limited assist of 1

- Final Late Loss ADL Score: _____

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Lets Practice for RUG-IV

- Bed Mobility: Total assist of 2
- Transfer: Extensive assist of 2
- Eating: Extensive assist of 1
- Toileting: Total assist of 2

- Final Late Loss ADL Score: _____

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Financial Impact of MDS Accuracy

- MDS 3.0 assessment accuracy fosters **patient-centered and individualized clinical care plans**
- Assessment accuracy leads to **accurate reimbursement** for the care provided to the patient
- The following examples are intended to highlight the clinical implications of **accurate** MDS 3.0 assessments

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ADL Scoring Part A Impact

Bed Mobility:	3,3 = 4
Transfer:	3,2 = 2
Toileting:	3,3 = 4
Eating:	1,2 = 2
Total	12

RVC = $488.21 per day

$488.21 x 30 days = $14,646.30

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ADL Scoring Part A Impact

- Bed Mobility: 3,2 = 2
- Transfer: 3,2 = 2
- Toileting: 3,3 = 4
- Eating: 1,2 = 2

Total 10

RVB = $422.77 per day

$422.77 x 30 days = $12,683.10

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ADL Scoring Part A Impact

- 30 days RVC = $14,646.30

vs.

- 30 days RVB = $12,683.10

Dollar impact (1 patient) = $1,963.20

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ADL Scoring Part A Impact

Dollar impact (1 patient) = $1,963.20

x30 patients = $58,896.00

x12 months = $706,752.00

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ADL Scoring Part A Impact

- Patient receiving **720 minutes** of therapy with **one discipline for at least five days** per week and **a second discipline for at least three days** per week = **Rehab Ultra** RUG
- ADL Score = **6**
- RUB = **$569.08 per day**

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ADL Scoring Part A Impact

- Patient receiving **720 minutes** of therapy with **one discipline for at least five days** per week and **a second discipline for at least three days** per week = **Rehab Ultra High** RUG
- ADL Score = **5**
- RUA = **$475.84 per day**

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ADL Scoring Part A Impact

Dollar Impact (per day) = $93.24

Dollar impact (per 30 days) = $2,797.20

x30 patients = $83,916.00

x12 months = $1,006,992.00

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ADL Scoring Part A Impact

- Patient receiving **325 minutes** of therapy with **one discipline for at least five days** per week = **Rehab High** RUG
- ADL Score = **11**
- RHC = **$425.41 per day**

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ADL Scoring Part A Impact

- Patient receiving **325 minutes** of therapy with **one discipline for at least five days** per week = **Rehab High** RUG
- ADL Score = **5**
- RHA = **$337.08 per day**

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ADL Scoring Part A Impact

Dollar Impact (per day) = $88.33

Dollar impact (per 30 days) = $2,649.90

x30 patients = $79,497.00

x12 months = $953,964.00

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ADL Scoring Part A Impact

- Patient has a tracheostomy and does own trach care daily.
- ADL Score = **2**
- RUG Score = **ES2**
- ES2 = **$536.47 per day**

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ADL Scoring Part A Impact

- Patient has a tracheostomy and does own trach care daily
- ADL Score = **1**
- RUG Score = **CA1**
- CA1 = **$227.30 per day**

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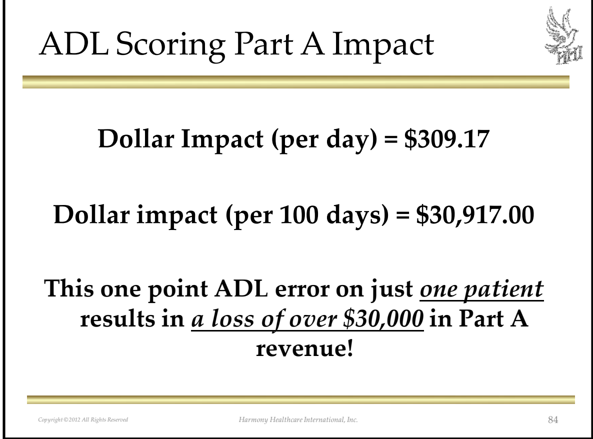

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ADL Scoring Part A Impact

- Patient receiving **45 minutes** of therapy with **three days per week** (any combination of three disciplines) **= Rehab Low** RUG
- ADL Score = **11**
- RLB = **$363.35 per day**

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ADL Scoring Part A Impact

- Patient receiving **45 minutes** of therapy with **three days per week** (any combination of three disciplines) **= Rehab Low** RUG
- ADL Score = **10**
- **RLA** but…..
- ***Index Maximizes* to PC2 = $279.65**

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ADL Scoring Part A Impact

Dollar Impact (per day) = $83.70

Dollar impact (per 14 days) = $1,171.80

x10 patients = $11,718.00

x12 months = $140,616.00

The patient is now in the **"lower 14"** and **highly prone to audit** by the FI/MAC!

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Key Points for the Nursing Assistant

- When in doubt ask the MDSC or Medicare/Medicaid nurse to assist in breaking down the activity for more accurate coding
- Each situation is unique and all portions of the activity weighed carefully to make the proper coding decision
- Clearly identify the value of your hard work, as a vital member of the interdisciplinary team you have the most accurate information as the direct caregiver

Key Points for the Nursing Assistant

- Your input helps identify issues that result in the best care delivery
- Do not feel compelled to code the rehab patient higher than actual function in order to show progress
- The patient needs to be performing at a consistent level upon therapy discharge and accuracy may identify additional areas of focus to achieve this desired level

Final Thoughts…

- Documentation to support coding is a must
- Focus on four late loss ADLs
- Accuracy begins at the bedside with the CNA all three shifts (don't forget nights!)
- Ensure reporting and/or documentation all other disciplines regarding ADLs
- Educate frontline nursing staff as well as IDT
- Ensure an audit protocol (MDS and documentation)

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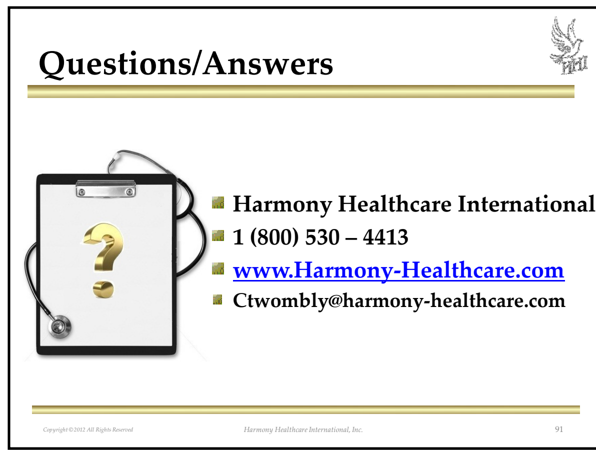

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or

CASE MIX ANALYSIS

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