MDS Alert

In The Spotlight: Kick The MDS Into High Gear For Short-Stay

Follow the beat of this SNF to pick up the pace of assessment and care.

There's nothing so "minimum" about the Minimum Data Set when you're caring for short-stay patients.

The mammoth instrument isn't quite as streamlined as it might be to meet the needs of high-acuity post-op rehab patients with comorbidities or medically complex patients. For example, many of the patients admitted to **Superior Woods Health Care Center in** Ypsilanti, MI, require only a short period of higher acuity SNF services after elective orthopedic surgeries or a bout of pneumonia complicated by other conditions.

"They view the SNF stay as a blip in their lives, and want to go on with their care, improve and return to the community," explains **Sheryle Thomas, RNC,** the MDS coordinator for the Mariner Healthcare-owned skilled nursing facility.

On the other hand, some postacute patients admitted to the facility are very sick with end-stage disease.

The MDS assessment, which was designed for long-term care patients, doesn't really provide the picture a SNF is looking for in short-stay cases. And trying to make the assessment fit can be a major challenge, albeit one that Superior Woods has tackled with great success.

So follow the facility's lead to tailor the MDS and other assessments to meet postacute patients' needs in real time - and target resources to produce optimal outcomes and patient satisfaction.

Perform standardized admission assessments along with the MDS to target resources on the identified problem areas.

Example: You admit a patient for rehab after elective knee replacement surgery who doesn't seem completely cognitively intact, postulates facility administrator **Maureen McGee**. And based on your initial assessment, you also determine the patient appears depressed.

In such a case, the interdisciplinary team would further assess the patient using the Folstein Mini-Mental and Geriatric Depression Scale and other more in-depth assessment tools to help better plan her care, explains McGee.

Move to the tune of your own bell curve in transitioning patients with nursing needs to rehab.

Many of Superior Woods' patients don't want to follow the "optimal flow of care" transitioning from a nursing RUG to higher levels of rehab, says Thomas. "For example, a postacute resident requiring rehab might initially go into SE3 where you set an early assessment reference date to capture the IVs in the hospital, and then into increasing levels of therapy - and finally, to skilled restorative," she explains.

"Some patients want to do that - others don't - and you have to accommodate, to some extent, the individual's input into his own plan of care," as long as it's medically safe to do so, Thomas adds.

Assess and address pain within the context of patients' treatment goals and desired comfort levels. In the MDS world, a facility gets dinged on the pain quality measures (QMs) if a patient has daily mild pain with one instance of moderate pain - or a single episode of horrible or excruciating pain during the lookback (J2a = 2 and J2b = 2 or J2b = 3).

Yet patients with subacute or post-op rehab needs have different ideas about their pain management needs. "Some want

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to tolerate a certain level of daily pain ... to participate more aggressively in therapy than others," says Thomas.

"And some people have negative feelings about taking opioid drugs even after being educated about the medications, and they are entitled to their beliefs," Thomas adds.

Pain levels also change as patients develop new conditions or can't tolerate a drug and start on a new one - or when the facility attempts to wean a person from pain medication after surgery. "Or the person may report more pain because they're being more active, which is actually a positive step in their recovery," Thomas says.

Example: A patient stands up and grimaces due to a moment of pain, which goes away as soon as she gets moving. "That moment of pain may not be an important issue to that particular person," yet it would reflect on the MDS and potentially the quality measure, Thomas observes.

All that being said, Superior Woods' pain quality measures look good because the interdisciplinary staff anticipates and addresses patients' pain from admission on.

Also, the postacute pain quality measure doesn't reflect short-stay residents who are discharged before the 14-day MDS is due, which helps nursing facilities that care for a lot of rehab or post-op patients who have pain upon admission.

Bottom line: If you admit patients with very painful conditions that require time to get under control, analyze your pain QMs within the context of your case-mix population.

Also be prepared to explain your scores and pain management program to surveyors and consumers.

4. Tackle the challenge of coding and analyzing dehydration. Superior Woods' interdisciplinary staff has found a correlation between coding dehydration and a resident passing away from end-stage disease. Nevertheless, the dehydration pops up as a sentinel event on the QIs. "In such cases, the interdisciplinary team should determine whether the staff should have prevented the person's dehydration," McGee says. "For example, was the person on hospice or dying and refusing to drink toward the end of life?"

Advance directives can really help the facility feel comfortable knowing and honoring the patient's wishes in such situations. Superior Woods obtains advance directives at admission and updates them annually or when the person undergoes a significant change, reports Thomas.

Tip: Code patients as end-stage in Section J when they have a physician-certified life expectancy of six months or less, which will help explain the resident's condition to surveyors (even though it won't keep the resident from triggering the QI).

Before coding, however, keep in mind that the physician actually has to document that prognostic statement in the medical record. Generic statements, such as "doing poorly" or "patient on a downhill course," won't suffice for MDS purposes, says Thomas.

If the physician refuses to document a life expectancy of six months or less - and that clearly appears to be the patient's prognosis - ask him to explain his rationale so you can counter it, if appropriate. For example, is the physician concerned that communicating the prognosis in writing might have a negative emotional impact on the resident/family - or pose reimbursement consequences if he continues to order treatments?

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