MDS Alert

MDS Management: How To Sew Up Top-Notch Fiscal, Survey Outcomes

4 steps will ensure you avoid common snags in the team process.

Teamwork is the name of the game if you want to win fair payment and keep surveyors and DAVE 2 at bay.

In fact, any facility where the MDS nurse still ends up doing most of the assessments without getting feedback from the other disciplines is like a dinosaur going out on a limb. For one, the facility has one person determining its payment and quality indicators/measures, cautions **Peter Arbuthnot**, regulatory analyst for **American HealthTech Inc**. in Jackson, MS. And the RAI manual requires the RAI process to be interdisciplinary, he adds. To ensure your team members pull together to keep the MDS on target, consider these key strategies:

1. Train each member of the team to understand the RAI rules and their respective role in the MDS assessment process. That includes "coding [requirements] and the timelines for completing the MDS and RAPs," says **Ron Orth, RN, NHA**, principal of **Clinical Reimbursement Solutions** in Milwaukee. "Each team member should also know her responsibility for documenting their assessments to support what's coded on the MDS--and the clinical and financial implications for not having the correct documentation," he adds.

2. Develop a consistent format to ensure the team members share their assessment information with each other for coding the MDS, suggests **Marilyn Mines, RN, BC**, director of clinical services for **FR&R Healthcare Consulting** in Deerfield, IL. If you silo assessments, some MDS items won't be coded accurately. That's especially true for Section E (mood and behaviors), cautions Orth.

Another example: Coding a resident's hearing in Section C could be inaccurate if a person with a louder or more "guttural" voice makes the assessment, says Mines. The resident might be able to hear that person easily but can't understand a softer-spoken person, she notes.

One option: At some facilities, the team members meet to complete the MDS in a room with a computer so they can input the coding, notes consultant **Maureen Wern**. That way the team can share assessments to ensure they come up with the correct coding. "The social worker in charge of Section E might say, 'This is what I have for Mary,' and then someone in activities might pipe up and say, 'Mary was tearful in activities last week,'" relays Wern, CEO of **Wern & Associates** in Warren, OH.

Reluctant to add yet another meeting to the schedule? Make time at the end of care planning meetings when everyone is together to review the MDS information, suggests Mines.

Great idea: Implement a "universal progress note" in the chart where "anyone from any discipline, licensed or not, can chart information they want to share about the resident," suggests Mines. In her experience as a DON, Mines found that approach can provide a "treasure trove" of information.

Using the right interdisciplinary documentation tools can also help share information.

3. Use a team approach in selecting the best assessment reference date to get the RUG with the highest case mix index. For example, "some places will say they have morning meetings, but they spend that time talking about the patient and never about setting the ARD that's best for the facility's reimbursement," says **Cindy Hart, CPA, LPN**, a consultant with **LW Consulting Inc**. in Jenkintown, PA. "The dialogue should include give and take" among the discipline members where they see how various ARDs play out "payment wise," Hart says.

Example: Nursing might want to set the 14-day assessment ARD on day 11 to capture the IV from the hospital lookback, but therapy says, "If you give us three more days, we can get the resident into rehab ultra," which will pay more, notes Wern.

4: Keep the full-court press going for quarterly assessments. Facilities tend to do a good job on the OBRA-required admission assessment, notes Arbuthnot. But some of them lose steam by the quarterly. If that happens, the MDS nurse may just pull up the previous assessment and go around asking people if anything has changed--and they say, "I don't think so," observes Arbuthnot. "But that's not what the **Centers for Medicare & Medicaid Services** has in mind," he warns.

Best practice approach: Each team member at **Baldomero Lopez State Veterans' Nursing Home** does his or her own part of the MDS for the quarterly. And they compare notes on a resident's "evolving status" in between assessments, reports **Maureen Woods, RN,** MDS coordinator for the facility in Land O' Lakes, FL. For example, "dietary will say I've noticed a slight weight loss--do you see anything going on with the person?" says Woods. And the team pulls the computerized information forward from the previous quarterly assessment to compare it to the resident's current status, says Woods. But they do so to allow the team to "spot a decline that people may miss otherwise."