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MDS Alert

Regulatory Change: PBJ is Here; Is Your Facility Scoring Well?

Hint: Pay special attention to your RN staffing.

So much of the long-term care industry is in flux right now, while the **Centers for Medicare and Medicaid Services** (CMS) makes changes large and small. Throughout 2018, payroll-based journal (PBJ) data collection and its use in ranking your facility, will be ramping up. Some facilities have already been submitting their staffing data for a while now, but now that CMS' dependence on PBJ is complete, you should make sure you have a handle on everything.

"Staffing in nursing homes has a substantial impact on the quality of care and outcomes residents' experience. For more than 10 years, CMS has been posting information on facility staffing measures on Nursing Home Compare, including the number of hours of care on average provided to each resident per day by nursing staff as reported by a facility," says **David Wright,** director of the **Quality, Safety and Oversight Group** (formerly Survey & Certification Group) in an April 2018 memo to surveyors.

"CMS has been using staffing data collected through forms that are completed manually by nursing homes and submitted approximately once a year (Forms CMS-671, Long Term Care Facility Application for Medicare and Medicaid, and CMS-672, Resident Census and Conditions of Residents). Through these forms, nursing homes have been providing data on the total hours their staff worked over the most recent two-week period prior to their standard survey," the memo explains.

Note: As of June 1, 2018, facilities no longer need to complete or submit the staffing section of the CMS-671 form.

The complete transition to the PBJ system should, theoretically, iron out some of those inconsistencies, because the data being used is data already being submitted elsewhere and is auditable and should therefore be more accurate.

"CMS collects, tracks and analyzes Skilled Nursing Facility (SNF) staffing data. The purpose of this metric is to gauge quality of care as this information not only depicts the staffing levels, but, it may be an indicator of staffing turnover, which correlate to the quality of care rendered. The information is posted publicly on the Nursing Home Compare website," says **Kris Mastrangelo,** president and CEO of **Harmony Healthcare International** in Topsfield, Massachusetts. "The AHCA Quality Cabinet Committee inquired to CMS the intent of posting the 'expected' staffing information. CMS responded that the underlying implications are that 'not all Skilled Nursing Facilities require the same level of staffing.'"

Understand How Staffing Data Used to Evaluate Quality

CMS believes that the number of RNs at a skilled nursing facility directly correlates to a better level of care for residents.

CMS used to rely on the data generated through the submission of other forms, including CMS-672 form (Resident Census and Conditions of Residents), to figure out how many residents were in Medicare- or Medicaid-certified beds, and then extrapolate from those numbers the appropriate staffing.

Now that PBJ is used to evaluate staffing, the resident census is compiled from MDS assessments. "The staffing measures are derived from data submitted each quarter through the Payroll-Based Journal System (PBJ), along with daily resident census derived from Minimum Data Set, Version 3.0 (MDS 3.0) assessments, and are case-mix adjusted based on the distribution of MDS 3.0 assessments by Resource Utilization Groups, version IV (RUG-IV group)," says the **Five-Star Technical Users' Guide**. NOTE: CMS revised the Five-Star User's Guide again in May 2018 with "more detail about the resident census calculation."

One facet of the big change involves how nursing hours are measured: with PBJ, staffing is measured via two "quarterly

case-mix adjusted measures," which includes total nursing hours per resident day (RN + LPN + nurse aide hours) and RN hours per resident day.

Though LPNs may perform a lot of the duties that power long-term care, their hours can no longer be included in the RN staffing. Here's whose hours qualify where and the corresponding job code appears in parentheses, according to the Five-Star Technical Users' Guide:

- RN hours: Includes RN director of nursing (job code 5), registered nurses with administrative duties (job code 6), and registered nurses (job code 7)
- LPN hours: Includes licensed practical/licensed vocational nurses with administrative duties (job code 8) and licenses practical/vocational nurses (job code 9)
- Nurse aide hours: Includes certified nurse aides (job code 10), aides in training (job code 11), and medication aides/technicians (job code 12)

However: Not everyone who "works" at your facility should necessarily be included. "The PBJ staffing data include both facility employees (full-time and part-time) and individuals under an organization (agency) contract or an individual contract. The PBJ staffing data do not include 'private duty' nursing staff reimbursed by a resident or his/her family. Also not included are hospice staff and feeding assistants," the Five-Star Technical Users' Guide says.

Important: "Nursing homes whose audit identifies significant inaccuracies between the hours reported and the hours verified, or facilities who fail to submit any data by the required deadline will be presumed to have low levels of staff. This will result in a one-star rating in the staffing domain, which will drop their overall (composite) star rating by one star for a quarter," the CMS memo says.

Know RN Staffing Particularly Important

With PBJ, CMS will have a much better idea of how much of your staff - categorized by their qualifications - are on site each day. The new requirement for RNs is at least 8 consecutive hours a day, 7 days a week. Failure to staff accordingly can mean a big drop in quality rating.

"We believe the presence of an RN onsite every day is extremely important to improving the health and safety of nursing home residents. We are also concerned about the risks that the absence of an RN introduces. Therefore, facilities reporting 7 or more days in a quarter with no RN hours will receive a one-star staffing rating, which will drop their overall (composite) rating by one star. This action will be implemented in July 2018," the memo says.

The memo also notes that most of the days that facilities failed to report an RN presence were weekends. This new requirement for more RN time on schedule, seven days a week, fits nicely with the newish timeline requirements for baseline care plans.

"While the majority of nursing homes are reporting an RN onsite each day, submitted staffing data show that there are some facilities that don't. We recognize that emergency situations can sometimes arise leading to the temporary absence of an RN. We also recognize that there may be instances where an RN was working onsite but was reported as not being there. That said, we are concerned with recurring instances or aberrant patterns of days with no RN onsite," the memo says.

Good news: If you've already had trouble attracting needed staff because your facility's location is rural, your facility may be eligible for a waiver. "Some of the criteria for a waiver include that the facility has demonstrated it is has been unable to recruit the needed staff, that the facility is located in a rural area where the supply of skilled nursing facility services isn't sufficient to meet the needs of Page 5- State Survey Agency Directors residents, and that the facility has only patients whose physicians have indicated that they don't require the services of a registered nurse or a physician for a 48-hour period," the memo says.

Pay Attention to MDS Discharge Assessments

Nurse assessment coordinators should pay special attention to discharge assessments because these assessments have a critical role in the data pulled from the MDS to evaluate how many residents are present on a particular day, and

therefore the facility's staffing needs.

NACs should pay extra attention to resident assessment timelines, and make sure that they and colleagues are hitting assessment completion and submission timelines, says **Jane Belt, MS, RN, RAC-MT, QCP,** curriculum development specialist at the **American Association of Nurse Assessment Coordination (AANAC)**.

Beware: The consequences may be dire, with failure to submit MDS discharges resulting in pretty severe penalties, including a temporary or - more permanent - drop to one-star status.

In item # 3 on page 7 of the Five-Star Technical Users' Guide there is specific guidance on how discharge assessments come into play:

a) "If a resident has a MDS discharge assessment, use the discharge date reported on that assessment and assume that the resident no longer resides in the facility as of the date of discharge on the last assessment. If there is a subsequent admission assessment, then assume that the resident re-entered the nursing home on the entry date indicated on the admission assessment.

b) "For any resident with an interval of 150 days or more with NO assessments, assume the resident no longer resides in the facility as of the 150th day from the last assessment. (This assumption is based on the requirement for facilities to complete MDS assessments on all residents at least quarterly). If no assessment is present, assume the resident was discharged, but the facility did not transmit a discharge assessment.

"For any particular date, residents whose assessments do not meet the criteria in #3 above prior to that date are assumed to reside in the facility. The count of these residents is the census for that particular day."

In the May 2018 revision, CMS added:

"NOTE ON RESIDENT MATCHING: MDS assessments for a given resident are linked using the Resident Internal ID. The Resident Internal ID is a unique number, assigned by the Quality Improvement Evaluation System (QIES) Assessment Submission and Processing (ASAP) system, which identifies a resident. The combination of State and Resident Internal ID uniquely identifies a resident in the national repository."

The process by which the Resident Internal ID is created is described by the MDS 3.0 Provider User's Guide - Appendix B, quoted below, which you can access here: https://qtso.cms.gov/download/guides/MDS/mds_30/Prvdr_Users_AppB.pdf.

"The following MDS items are used to define the Resident Internal ID:

- State ID
- Facility Internal ID (QIES ASAP system number)
- Social Security Number (SSN)
- Last Name
- First Name
- Date of Birth
- Gender

"Therefore, in order to achieve an accurate census, it is imperative that, in addition to having complete assessment data for each resident including discharge assessment data, residents are assigned correct Resident Internal IDs. To facilitate this, providers must ensure that MDS items, in particular the items indicated above, are entered correctly on each assessment. Providers must also carefully monitor the Final Validation Report, generated upon MDS submission, for any errors. Providers should work with their State RAI Coordinator or State Automation Coordinator to correct any errors that arise during assessment submission.

"In addition to using their Final Validation Report to validate the file structure and data content of each successful MDS submission, providers can monitor their MDS data using additional Certification and Survey Provider Enhanced Reports (CASPER) Reports. There are CASPER Reports for Admissions, Discharges, Duplicate Residents, Errors, and daily Rosters, among others."

Resource: Full descriptions of these reports are available in Section 6 of the CASPER Reporting MDS Provider User's Guide available at the following link: https://qtso.cms.gov/download/guides/casper/cspr_sec6_mds_prvdr.pdf. Information about Final Validation Reports and error messages in the reports is available in Sections 4 and 5 of the MDS 3.0 Provider User's Guide, which you can access at the following link: https://qtso.cms.gov/mdstrain.html.