

# MDS/ASSISTED LIVING SERVICES ASSESSMENT

CASE MIX

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# Case Mix

What is Case Mix?

A reimbursement system used by MaineCare, to pay providers according to the amount of time spent with the resident.



# Case Mix

## Case Mix Goals

To Improve:

1. Quality of care for the Resident
2. Quality of life for the Resident
3. Equity of payment to providers



# Case Mix



## How Does Case Mix work?

1. The AFC Home must complete and submit an MDS/ALS on each resident admitted.
2. Case Mix uses the information on the completed MDS/ALS to group the Resident into one of the 8 ALS Groups.
3. MaineCare pays the AFC the corresponding amount per day for that resident's ALS Group.

# Case Mix

## Purposes of MDS/ALS

1. To provide information that identifies the Residents strengths, needs and preferences, in order to develop a Service Plan.
2. To develop Quality Indicators
3. To group the Resident into the appropriate ALS Group for payment.

# Case Mix

## Completing the MDS/ALS

Every individual, regardless of payment source, must be assessed, using the MDS/ALS



# Case Mix

## Assessor Responsibilities

MDS/ALS assessors will need to conduct interviews with clients, families and staff that care for residents.



# Case Mix

## **Assessor Responsibilities**

- Read the training manual
- Attend a training session
- Complete assessments in an accurate and timely manner
- Maintain client confidentiality

# Case Mix

## Assessor Responsibilities

- Edit all completed MDS/ALS
- Submit completed MDS/ALS to Muskie School
- Review all submission reports to assure that all MDS/ALS were received and accepted at Muskie School

# Case Mix

## Submitting the MDS/ALS

Completed MDS/ALS assessments are submitted within 30 days of completion to:

Catherine Gunn-Thiele  
Muskie School of Public Service  
509 Forest Ave., 2<sup>nd</sup> Floor  
PO Box 9300  
Portland, Me. 04104-9300  
Office Phone: 780-5576



# Case Mix

## Assessment Types/Timing

## Admission



Providers must complete the MDS/ALS within 30 days of admission.

The admission assessment includes all items on the Face Sheet and the Assessment.

# Case Mix

## Assessment Types/Timing

### Face Sheet

The face sheet is completed one time only, on the admission assessment.

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## **Assessment Types /Timing**

### **Semi-Annual/Annual**

Completed within 180 days from the date of the last assessment, based on the completion date found in Section S, Item 2b.

This assessment includes all assessment items

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## **Assessment Types/Timing**

### **Significant Change**

This assessment is completed within 14 days after the determination is made of a significant change in a resident's status.  
(Improvement or Decline)

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## Significant Change

- A significant change is defined as a major change in the resident's status that –
- a. Is not self limiting
  - b. Impacts on more than one area of the resident's health status
  - c. Requires review and revision of the Service Plan

# Case Mix

## **Assessment Types/Timing**

### **Significant Change**

Significant change assessments include all assessment items and reset the clock for the assessment completion schedule.

The next assessment will be due within 180 days of the S2b date on the Significant Change Assessment.

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## **Assessment Types/Timing**

## **Discharge Tracking Forms**

A Discharge Tracking Form is completed within 7 days of a resident's permanent discharge, transfer, or death.

The Discharge Tracking Form consists of section D1 through section D3.

# Case Mix

Review by CM Nurse

A CM nurse will call the facility to inform them of the planned visit



# Case Mix

## Review by Case Mix Nurse

CM nurse will review the Resident's record to validate the documentation that supports the coding on the MDS/ALS. The Resident and staff may also be interviewed

CM nurse will keep the facility informed regarding any issues that might develop during the review



# Case Mix

## **Review by Case Mix Nurse**

At the end of the visit the CM nurse will conduct an exit interview

Findings will also be given in writing at that time

If the error rate exceeds the threshold allowed, 34%, the facility will be sanctioned

# Case Mix

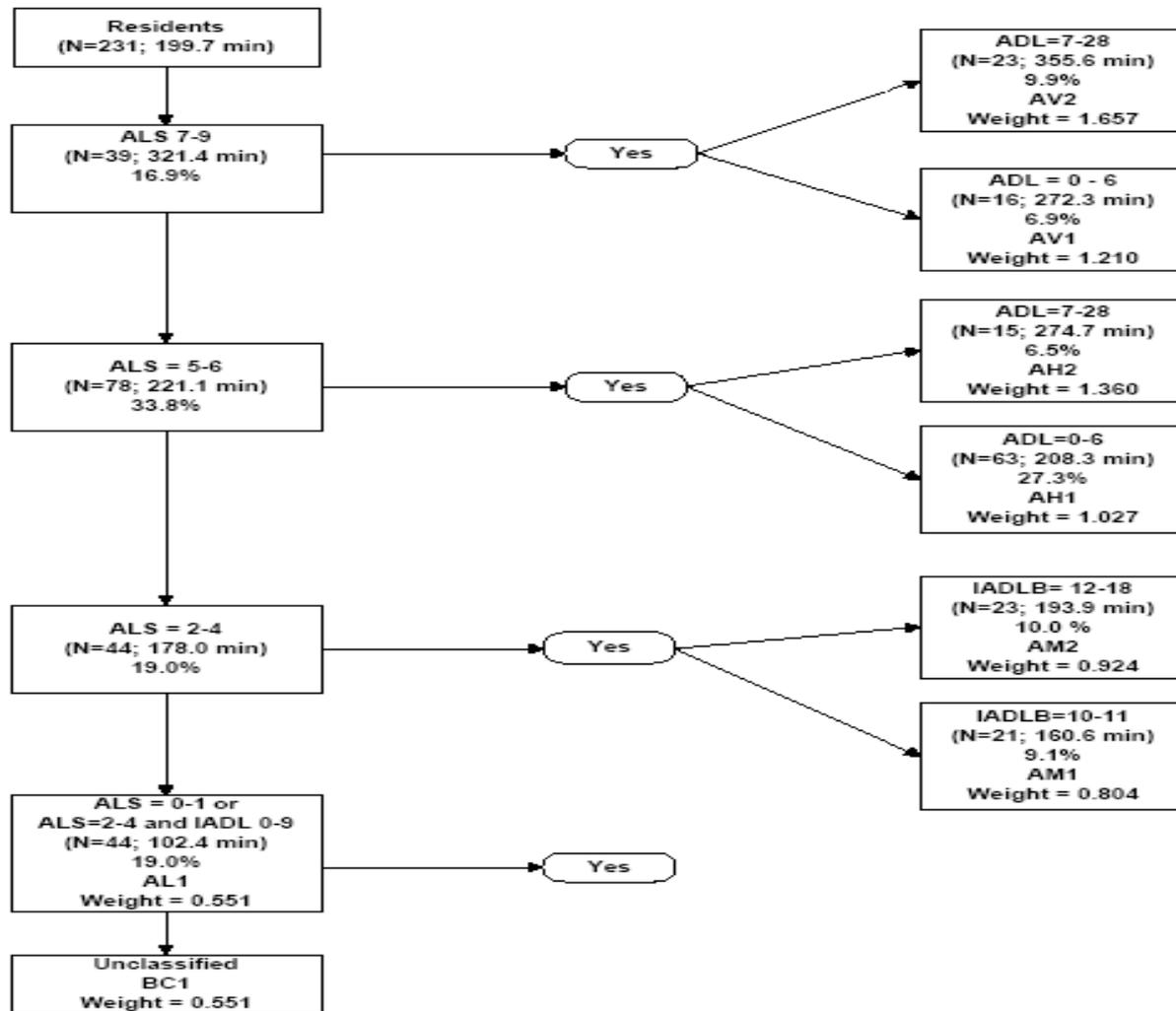
What are the Payment Groups?

What are the Payment Items?

What documentation is required?



**Assisted Living Resource Classification Groups  
Tree Diagram  
Predicting: Total Resident Specific Time  
Variance Reduction 28.40%**



[1] Resident Specific Time (RST) from all staff participating in the study over the three day period. 26 (11.3%) residents were not classifiable due to missing information.

# MaineCare Adult Family Care Home Resource Utilization Classification System

Resource Utilization Group (RUG) Classification System Items  
Description Code\*

**(SEE HANDOUT)**

# ALS DOCUMENTATION REQUIREMENTS FOR MDSALS SCORING

## Key for Possible Record Location

PN-Provider Notes / MS-Monthly Summary (Specific to Time Frame) / CN-Consult Note / PO-Physician Order/

FS-Flow Sheet/ ADL-Act of Daily Living/MAR-Med AdmRecord/AT-Assess.Tool(other than ALS)

ALS	FIELD	COMMENTARY	POSSIBLE RECORD LOCATION
B3	Cognitive Skills for Daily Decision Making	Documentation must be found in the record of the resident's ability to actively make decisions regarding tasks of daily living in the last 7 days.	PN,MS, CN,FS,AT
E1a-r	Indicators of Depression	Evidence & observations of these indicators must be present in the resident's record within the last 30 days..	PN,MS,ADL,AT,FS
G5ac G5ag	Assist. with phoning Assist. with arranging transport.	Evidence within the record of the resident involvement in the activity. Document the level of independence that best represents the client's functioning & the type of assistance provided over 30 days.	PN,MS,ADL
H4	Use of incontinent supplies	Evidence within the record of resident's management of incontinence supplies within the last 14 days. (pads, briefs, ostomy, catheter)	PN,MS,ADL,FS
O5f	Administration of OTC medications	Evidence within the record that the resident <u>DID NOT</u> administer OTC meds within the last 7 days.	PN,MS,AT,MAR
O6	Medication Preparation & Administration	Evidence in the record that the resident prepared/administered <u>NONE</u> , <u>SOME</u> or <u>ALL</u> of their medications within the last 7 days.	PN,MS,MAR,FS
P10	Physicians Order Changes	Include the number of DAYS that the Physician or authorized assistant changed the residents written, telephoned, or faxed orders within the last 14 days. <u>DOES NOT INCLUDE:</u> admission orders, return admission orders or orders without change.	PO

**Key for Possible Record Location**

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**DOCUMENTATION for ADL Scores**

<b>ALS</b>	<b>FIELD</b>	<b>COMMENTARY</b>	<b>POSSIBLE RECORD LOCATION</b>
G1aa G1ba G1ca G1da G1ea G1fa G1ga	Bed mobility Transfer Locomotion Dressing Eating Toilet use Personal hygiene	All areas must be documented for all shifts within the last 7 days. Self Performance score only.	PN,MS,ADL

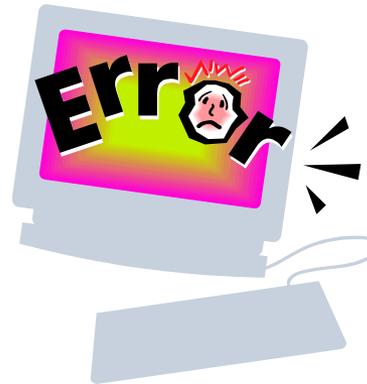
**DOCUMENTATION for IADL & Bathing Scores**

<b>ALS</b>	<b>FIELD</b>	<b>COMMENTARY</b>	<b>POSSIBLE RECORD LOCATION</b>
G2	Bathing(SP)	Evidence about how the resident takes a full body bath. Code for <u>most dependent</u> within the last 7 days.	PN,MS,ADL,FS
G5aa G5ab G5ad G5ae G5af G5ah G5ai	Arrange Shopping Shopping Manage Finances Manage cash/allow Prepares Snacks Light Housework Laundry	IADLs done with help or done by others. Evidence within the record of the level of independence that best represents the clients functioning and the type of assistance provided over 30 days.	PN,MS,ADL,FS

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## Payment Errors

Inaccurate documentation, too little documentation, or no documentation to support the information coded on the MDS/ALS may cause a payment error.



# Case Mix

## Inaccurate Documentation

**Never do an inaccurate assessment to match inaccurate documentation.**

If, after interviewing staff and interviewing/observing the resident, you feel that the documentation is inaccurate, write a note in the record to explain and code the MDS/ALS accurately



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Questions????????

