MDS in Adult Family Care Homes: MDS-ALS

CASE MIX TEAM
Revised August 2015

MDS-ALS Training: Agenda

- History of MDS-ALS
- Purpose
- Definitions
- Schedule of Assessments
- Case Mix Index, RUG groups
- MDS-ALS Assessment Tool
- Corrections
- Quality Indicators

Training Requirement

MaineCare Benefits Manual, Chapter II, Section 2.07-1.A.4.a:

Only staff trained in completion of the MDS-ALS by the Department may conduct or coordinate assessments.
**History of MDS-ALS**

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**MDS-ALS Training: Purpose**

Who, What, Where, Why and, When…

of Case Mix

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So... Who completes the MDS-ALS?

...The MDS Coordinator with help from:

- The resident
- Facility staff
- Family
- Clinical records
Assessors Responsibilities

- Conduct interviews
- Read the manual
- Attend training
- Accuracy and timeliness
- Maintain confidentiality
- Edit and submit all MDS/ALS
- Review submission reports

MDS-ALS Training: Purpose

And... What is Case Mix?

Case Mix is a system of reimbursement that pays facilities according to the amount of time spent providing care to residents.

Residents are grouped according to the amount of time needed to provide their care

And... Where is the assessment done?

MDS-ALS assessment is completed in the facility

- All residents
- Regardless of payer source

The MDS-ALS cannot be completed if the resident is not in the facility. For example, if in the hospital or on a therapeutic leave.
MDS-ALS Training: Purpose

And... Why do we need to do MDS-ALS Assessments?

1. To provide information to guide staff in developing a realistic individualized Service Plan.
2. To place a resident into a payment group within the Case Mix System.
3. To provide information that determines the Quality Indicators.
4. To show an accurate picture of the resident’s condition, the type and amount of care needed.

MDS-ALS Training: Purpose

And... When are assessments done?

<table>
<thead>
<tr>
<th>Type of Assessment</th>
<th>When Completed</th>
<th>Example</th>
</tr>
</thead>
<tbody>
<tr>
<td>Admission Assessment</td>
<td>Initial Admission</td>
<td>By the end of the 30th day after admission, as represented by the 3200 data. Admission is for 61.</td>
</tr>
<tr>
<td>365th day of initial comprehensive LTCPA</td>
<td>365th day of assessment date entered in 3200 as represented by the 3200 data. Admission is for 61.</td>
<td></td>
</tr>
<tr>
<td>Annual Assessment</td>
<td>When 365 days of an MDS-BSA assessment</td>
<td>365th day of assessment date entered in 3200 as represented by the 3200 data. Admission is for 61.</td>
</tr>
<tr>
<td>Significant Change Assessment</td>
<td>Only significant change has occurred</td>
<td>Assistant must be completed by the end of the last resident day following change in the resident’s condition. Significant change (3200)</td>
</tr>
<tr>
<td>Other</td>
<td>When required by Case Mix Nurse</td>
<td>365th day of Case Mix Nurse as represented by 3200 data.</td>
</tr>
<tr>
<td>Transfers to/from Facility</td>
<td>When resident is discharged, transferred or deceased</td>
<td>365th day of Case Mix Nurse as represented by 3200 data.</td>
</tr>
<tr>
<td>MDS-ALS Form (Section A1, Through A4) of the MDS-ALS Form</td>
<td>Complete any form of the MDS-ALS at any time to assess the resident in the admission system.</td>
<td>Complete any form at the time of admission to a facility.</td>
</tr>
</tbody>
</table>

MDS-ALS Training: Timeliness and Accuracy

Timeliness

MaineCare Benefits Manual, Chapter II, Section 2.07-I.A.8:

“The Department will sanction providers who fail to accurately complete assessments in a timely manner.”
Accuracy

Documentation is required to support the time periods and information coded on the MDS-ALS. (MBM, chapter II, Section 2.07-1.A.4.c)

Penalty for Falsification: The Department may sanction a provider whenever the provider willfully and/or knowingly certifies (or causes another individual to certify) a material and false statement in an assessment. This may be in addition to any other penalties provided by statute.

Case Mix

Case Mix Quality Assurance Review

About every 6 months, a Case Mix nurse reviews a sample of MDS-ALS assessments and resident records to check the accuracy of the MDS-ALS assessments.

Insufficient, inaccurate or lack of documentation to support information coded on the MDS-ALS may lead to an error.
MDS-ALS Training

Poor Documentation could mean:

Lower payment than the facility could be receiving, OR

Overpayment which could lead to repayment to the State (Sanctions). This is due to either overstating the care a resident received or insufficient documentation to support the care that was coded.

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

Sanctions:

- 2% Error rate 34% or greater and less than 37%
- 5% Error rate 37% or greater and less than 41%
- 7% Error rate 41% or greater and less than 45%
- 10% Error rate 45% or greater
- 10% If requested reassessments not completed within 7 days
There are a total of 8 case mix classification or RUG (Resource Utilization Groups) groups, including one default group used when a resident cannot be classified into one of the other classification groups.

### RUG Groups

<table>
<thead>
<tr>
<th>RUG Code</th>
<th>ALS Score</th>
<th>ADL Score</th>
<th>IADL Score</th>
<th>Weight</th>
<th>Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>AV2</td>
<td>ALS 7-9</td>
<td>ADL 7-28</td>
<td>IADL 0-2</td>
<td>1.657</td>
<td>$7.85</td>
</tr>
<tr>
<td>AV1</td>
<td>ALS 7-9</td>
<td>ADL 0-2</td>
<td>IADL 2-10</td>
<td>1.210</td>
<td>$5.44</td>
</tr>
<tr>
<td>AV2</td>
<td>ALS 5-6</td>
<td>ADL 7-28</td>
<td>IADL 0-2</td>
<td>1.300</td>
<td>$6.19</td>
</tr>
<tr>
<td>AH1</td>
<td>ALS 5-6</td>
<td>ADL 0-2</td>
<td>IADL 2-10</td>
<td>1.027</td>
<td>$4.09</td>
</tr>
<tr>
<td>AV2</td>
<td>ALS 2-4</td>
<td>IADL 0-2</td>
<td>IADL 2-10</td>
<td>0.924</td>
<td>$3.67</td>
</tr>
<tr>
<td>AH1</td>
<td>ALS 2-4</td>
<td>IADL 0-2</td>
<td>IADL 2-10</td>
<td>0.904</td>
<td>$3.61</td>
</tr>
<tr>
<td>AL1</td>
<td>ALS 2-4</td>
<td>IADL 0-2</td>
<td>IADL 2-10</td>
<td>0.551</td>
<td>$2.70</td>
</tr>
<tr>
<td>BC1</td>
<td>Unclassified</td>
<td></td>
<td></td>
<td>0.551</td>
<td>$2.70</td>
</tr>
</tbody>
</table>

### Documentation Guidelines

<table>
<thead>
<tr>
<th>ALS</th>
<th>Field</th>
<th>Commentary</th>
</tr>
</thead>
<tbody>
<tr>
<td>85</td>
<td>Cognitive Skills for Basic Communication</td>
<td>Documentation must be found in the record of the resident’s activities. Assess the resident’s ability to communicate.</td>
</tr>
<tr>
<td>868</td>
<td>Independent Observation</td>
<td>Evidence regarding the resident’s ability to be independent.</td>
</tr>
<tr>
<td>875</td>
<td>Fear of Pain, Death</td>
<td>Evidence regarding the resident’s fear of pain, death, or other adverse events.</td>
</tr>
<tr>
<td>876</td>
<td>Injury, fall, or other</td>
<td>Evidence regarding the resident’s injuries, falls, or other adverse events.</td>
</tr>
<tr>
<td>877</td>
<td>Use of Incontinence Supplies</td>
<td>Evidence regarding the resident’s use of incontinence supplies.</td>
</tr>
<tr>
<td>878</td>
<td>Use of OTC Medications</td>
<td>Evidence regarding the resident’s use of over-the-counter medications.</td>
</tr>
<tr>
<td>879</td>
<td>Use of Prescribed Medications</td>
<td>Evidence regarding the resident’s use of prescribed medications.</td>
</tr>
<tr>
<td>880</td>
<td>Use of Lice Control Medications</td>
<td>Evidence regarding the resident’s use of lice control medications.</td>
</tr>
<tr>
<td>881</td>
<td>Use of Personal Items</td>
<td>Evidence regarding the resident’s use of personal items.</td>
</tr>
<tr>
<td>882</td>
<td>Use of Assistive Devices</td>
<td>Evidence regarding the resident’s use of assistive devices.</td>
</tr>
<tr>
<td>883</td>
<td>Use of Physical Therapy</td>
<td>Evidence regarding the resident’s use of physical therapy.</td>
</tr>
</tbody>
</table>

MDS-ALS Training: Purpose

Case Mix Resident Classification Groups and Weights

8/20/15
### DOCUMENTATION for ADL Scores

<table>
<thead>
<tr>
<th>ALS</th>
<th>FIELD</th>
<th>COMMENTARY</th>
</tr>
</thead>
<tbody>
<tr>
<td>G1m</td>
<td>Bed mobility</td>
<td>All assessment must be documented for all skills within the last 7 days.</td>
</tr>
<tr>
<td>G1h</td>
<td>Transfer</td>
<td>Self-performance scores only.</td>
</tr>
<tr>
<td>G1w</td>
<td>locomotion</td>
<td></td>
</tr>
<tr>
<td>G1a</td>
<td>Eating</td>
<td></td>
</tr>
<tr>
<td>G1s</td>
<td>Eating</td>
<td></td>
</tr>
<tr>
<td>G1n</td>
<td>Personal hygiene</td>
<td></td>
</tr>
</tbody>
</table>

### DOCUMENTATION for IADL & Bathing Scores

<table>
<thead>
<tr>
<th>ALS</th>
<th>FIELD</th>
<th>COMMENTARY</th>
</tr>
</thead>
<tbody>
<tr>
<td>G2</td>
<td>Bathing/MF</td>
<td>Evidence about how the resident takes a full body bath. Code for most dependent resident over the last 7 days.</td>
</tr>
<tr>
<td>G3a</td>
<td>Arrange Shopping</td>
<td>Evidence within the record of the level of independence that the resident expresses in the performance and the type of assistance provided over 30 days.</td>
</tr>
<tr>
<td>G3b</td>
<td>Shopping</td>
<td></td>
</tr>
<tr>
<td>G3c</td>
<td>Managing Finances</td>
<td></td>
</tr>
<tr>
<td>G3d</td>
<td>Paying Bills</td>
<td></td>
</tr>
<tr>
<td>G3e</td>
<td>Aranging Medicines</td>
<td></td>
</tr>
<tr>
<td>G3f</td>
<td>Preparing Snacks</td>
<td></td>
</tr>
<tr>
<td>G3g</td>
<td>Light Housework</td>
<td></td>
</tr>
<tr>
<td>G3h</td>
<td>Laundry</td>
<td></td>
</tr>
</tbody>
</table>

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**Submitting the MDS-ALS**

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

Catherine Gunn-Thiele  
Muskie School of Public Service  
PO Box 9300  
Portland, Me. 04104-9300  
Office Phone: 780-5576
### Section AA: Identification Information

**Face Sheet: Background Information**
Completed at the time of the resident's initial admission to the facility.

**Section AB: Demographic Information**
**Section AC: Customary Routine**
**Section AD: Face Sheet Signatures and dates**

### Section A: Identification and Background Information

<table>
<thead>
<tr>
<th>Field</th>
<th>Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>Resident Name</td>
<td>First, Middle, Last, Last 4 Digit SSN</td>
</tr>
<tr>
<td>Security Number</td>
<td>Social Security Number</td>
</tr>
<tr>
<td>Resident No.</td>
<td>Assignment No.</td>
</tr>
<tr>
<td>Admission Date</td>
<td>Start of Observation Period</td>
</tr>
<tr>
<td>Admission Reason</td>
<td>Admission Assessment: Annual assessment, Significant change in status assessment</td>
</tr>
</tbody>
</table>

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8/20/15
**MDS-ALS Training: Purpose**

When to complete a Significant Change MDS-ALS assessment:

- Resident has experienced a “major change”
- Not self-limited
- Impacts more than one area of the resident’s clinical status
- Requires review and/or changes to the service plan
- Improvement or decline
- Completed by the end of the 14th day following the documented determination

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**MDS-ALS Training: Assessment Tool**

Section B: Cognitive Patterns

1. Memory
   - Memory (read and write or not)
     a. Short-term memory OK—remembering to read after 6 minutes
     b. Long-term memory OK—names appear in reading list
     c. Memory OK
     d. Memory poor
     e. Memory unknown

2. Orientation
   - Chronology of the resident’s route or day
     a. The name in the facility home
     b. Location in the facility
     c. Self-orientation

3. Cognitive Skills: Reasoning
   - Make decisions regarding care of self/tilt
     a. Inability to make decisions to attend care
     b. Inability to make decisions in new situation
     c. Inability to make decisions to attend care
     d. Inability to make decisions in new situation

4. Health Status
   - MDS-ALS Training: Cognitive Patterns

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**MDS-ALS Training: Assessment Tool**

Section C: Communication/Hearing Patterns

1. Hearing
   - (With hearing aid or not)
     a. Hears normal
     b. Hears normal
     c. Hears normal
     d. Hears normal
     e. Hears normal

2. Comprehension
   - (Check at last 7 days)
     a. Hears normal
     b. Hears normal
     c. Hears normal
     d. Hears normal
     e. Hears normal

3. Speech
   - (Check at last 7 days)
     a. Speech normal
     b. Speech normal
     c. Speech normal
     d. Speech normal
     e. Speech normal

4. Understanding
   - (Check at last 7 days)
     a. Understands
     b. Understands
     c. Understands
     d. Understands
     e. Understands

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Section E: Mood and Behavior Patterns

1. SPECIFIC DYSFUNCTIONS: Label all dysfunctions present in the patient.
   - Unsteady gait
   - Difficulty with transfers
   - Incontinence
   - Sleep disturbances

2. OBSERVABLE BEHAVIORAL CHANGES:
   - Mood swings
   - Irregular eating
   - Changes in socialization

3. SUBJECTIVE REPORTS:
   - Patient's report
   - Caregiver's report
   - Observer's report

4. INTERVENTIONS:
   - Medications
   - Physical therapy
   - Occupational therapy
   - Speech therapy

5. OUTCOMES:
   - Improvement
   - No change
   - Decline
MDS-ALS Training: Assessment Tool

SECTION F. PSYCHOLOGICAL WELL-BEING

ADL SELF-PERFORMANCE
Measures what the resident actually did (not what he or she might be capable of doing) within each ADL category over the last 7 days.
G2. Bathing Self-Performance

How resident takes full-body bath/shower, sponge bath, and transfers in/out of tub/shower (EXCLUDE shaving of back and hair). **Check for most dependent in self-performance during last 7 days.**

- 0. Independent—No help provided
- 1. Supervision—Oversight help only
- 2. Physical help limited to transfer only
- 3. Physical help in part of bathing activity
- 4. Total dependence
- 6. Activity itself did not occur during entire 7 days.

G5. IADL Self-Performance

- a. Resident arranged for shopping for clothing, snacks, or other incidentals.
- b. Resident shopped for clothing, snacks, or other incidentals.
- c. Resident arranged for/arranged for/transportation to get to appointments, outings, necessary engagements.
- d. Resident managed finances including banking, handling checkbook, or paying bills.
- e. Resident managed cash, personal needs allowance.
- f. Resident prepared meals, light meals.
- g. Resident used phone.
- h. Resident did light housework such as making own bed, dusting, or taking care of belongings.
- i. Resident sorted, folded, or washed own laundry.

Note: this section has a 14-day look back period.
H4. Use of Incontinence Supplies

0. Always Continent
1. Resident incontinent and able to manage supplies independently.
2. Resident incontinent and receives assistance with managing supplies.
3. Resident incontinent and does not use incontinence supplies. For example, resident refuses to use the supplies or hides their soiled garments.

A. Mr. Q was taken to the toilet after every meal, before bed, and once during the night. He was never found wet.
B. Mr. R had an indwelling catheter in place during the entire 14-day assessment period. He was never found wet.
C. Although she is generally continent of urine, every once in a while (about once in two weeks) Mrs. T doesn’t make it to the bathroom in time after receiving her daily diuretic pill.
D. Late in the day when she is tired, Mrs. A sometimes (but not all days) has more episodes of urinary incontinence.

Section I: Diagnosis

All diseases and conditions must have physician documented diagnosis in the clinical record.

Do not include conditions that have been resolved or no longer affect the resident’s functioning or service plan.
Section J covers Health Conditions and Possible Medication Side Effects…

A lot of territory!

- J1. Problem conditions
- J2. Extrapyramidal signs and symptoms
- J3 and 4. Pain Symptoms and location
- J5 and 6. Pain interference and management
- J7. Accidents
- J8. Fall risk
Section L: Oral / Dental Status

- a. Has dentures or removable bridge
- b. Some natural teeth intact does not have or does not use dentures or partial plate
- c. Broken, loose or new false or real teeth
- d. Interdental gum, gingival or buccal tissue bleeding, suction or oral abscesses
- e. Daily cleaning of teeth/dentures or daily mouth care by resident or aide
- f. Residence has difficulty brushing teeth or dentures
- g. NONE OF ABOVE

Section M: Skin Condition

- 1. Bed sores
- a. Has bed sores/pressure points that are too deep
- b. Has bed sores/pressure points that are superficial

Section N: Activity Pursuit Patterns
Section P: Special Treatments and Procedures (cont.)

- P4. Rehab / Restorative care
- P5. Skill Training
- P6. Adherence With Treatments/Therapies Programs
- P7. General Hospital Stays
- P8. Emergency Room (ER) Visit(s)
- P9. Physician Visits

Note: Code the number of days the physician changed the resident’s orders, not including order renewals without change. (Enter “0” if none.)
Section P: Special Treatments and Procedures

P11. Abnormal Lab Values
P12. Psychiatric Hospital Stay(s)
P13. Outpatient Surgery

Section Q: Service Planning

Note: this item refers to Resident self-identified goals

Section R: Discharge Potential
Section S: Assessment Information and Signatures

Section T: Preventive Health

Note: 12 month look back period for preventive health measures.

Section U: Medications list
Scoring of the MDS-ALS

3 step process:

1. Calculate ALS (Assisted Living Score)
2. Calculate ADL score
3. Calculate IADL / Bathing (IADL/B) score
ADL Score

IADL / Bathing Score

Final RUG Score
It's QUESTION TIME!!

Don't FORGET!

Reminders:
ASK questions!
ASK more questions!
Attend training as needed

Contact Information
- MDS Help Desk: 624-4019
  MDS3.0.DHHS@maine.gov
- Lois Bourque RN: 592-5909
  Lois.Bourque@maine.gov
- Heidi Coombe RN: 441-6754
  Heidi.L.Coombe@maine.gov
- Darlene Scott-Rardon RN: 215-4797
  Darlene.Scott@maine.gov
- Maxima Corriente RN: 215-3589
  Maxima.Corriveau@maine.gov
- Sue Pinette RN: 287-3933
  Suzanne.Pinette@maine.gov