Implementation of Staff Training Curriculum Aimed at Improving MDS Coding in a Long-Term Care Setting

Maureen Burns  
*College of Saint Benedict/Saint John's University*, mburns001@csbsju.edu

Emalee Driemeyer  
*College of Saint Benedict/Saint John's University*, edriemeye001@csbsju.edu

Caitlin O'Toole  
*College of Saint Benedict/Saint John's University*, cotoole001@csbsju.edu

Eliana Scheett  
*College of Saint Benedict/Saint John's University*, escheett001@csbsju.edu

Erin Sticha  
*College of Saint Benedict/Saint John's University*, esticha001@csbsju.edu

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Implementation of Staff Training Curriculum Aimed at Improving MDS Coding in a Long-Term Care Setting

CSB/SJU NRSG 395 Quality Improvement Capstone Project
Maureen Burns, Emalee Driemeyer, Caitlin O'Toole, Eliana Scheett, Erin Sticha
FADE Model

01 Focus
   • define process to be improved

02 Analyze
   • collect and analyze data

03 Develop
   • develop action plans for improvement

04 Execute
   • implement the action plans

05 Evaluate
   • measure and monitor the system to ensure success
Elim Milaca long-term care and rehabilitation facility in Milaca, MN
Possible areas of Improvement

- Staff Resiliency in COVID-19
- Resident Resiliency
- Staff Biases
- Improvement in Charting to reduce Error
Focus

Frequency of charting errors in resident mobility resulting in MDS fines.
Our Goal

Maintaining or improving the mobility of residents at the *Elim Milaca* facility through education aimed to improve MDS coding and charting accuracy.
Why do we want to address this issue?

- Residents may not actually be declining, but due to assistance that they were receiving from the staff and the charting that was documented, it makes it look like the residents are requiring more assistance than they really need.
- Not only has a negative impact on the facility and its effectiveness of care for the residents, but also has a negative impact on the residents.
- We are going to look at specifically the assistance with ambulation around the facility as well as transfers.
Minimum Data Set (MDS)

- Maintains continuity of patient care.
- Much of documentation that is done in the long-term care setting involves a system called the Minimum Data Set or MDS.
- This system is used to ensure residents receive the correct level of care required.
- Also used for payment reimbursement and data mining (QI purposes).
Current Issue

Currently receive $0.94/resident/day

Could receive $3.50/resident/day

Overall annual loss of $50,000 in this one area
Analysis

- Literature Review
- Data Collection
- Root Cause
• **Accurate Documentation:**
  • Employers utilizing documentation systems (EHR, MDS, etc.) should implement accessible and ongoing education regarding the importance of accurate charting as well as the best practices for the efficient charting of patient care (Penoyer et al. 2014).

• **Daily Autonomy:**
  • Studies have shown that maintaining as much independence as possible with completing ADLs helps to improve quality of life through the aging process. (Tornero-Quiñones et al. 2020).

• **Physical Activity:**
  • The reviews of trained volunteer-led physical activity programs aging populations showed the importance of physical activity and the positive impacts that it has on this population (Lim et al. 2021).
Data Collection

Chart review looking specifically at the “MDS Assessment D1 – walk in corridor/self-performance” section in the facility’s Matrix charting system.

Data was collected from 23 resident’s quarterly or significant change assessments.

Categorized resident’s current MDI code for ambulation on the unit compared to their previous level.

Assigned each resident a status label as declining, stable, or improved.

Revealed specific causes as to why discrepancies in MDS coding occurred in resident ambulation status.

New staff made many of the noted errors suggesting need for more staff education.
<table>
<thead>
<tr>
<th>Name</th>
<th>Category</th>
<th>Reason</th>
</tr>
</thead>
<tbody>
<tr>
<td>GP</td>
<td>Stable</td>
<td>Charting error - improving</td>
</tr>
<tr>
<td>HS</td>
<td>Decline</td>
<td>Charting error - stable</td>
</tr>
<tr>
<td>AN</td>
<td>Decline</td>
<td>COVID protocols</td>
</tr>
<tr>
<td>AS</td>
<td>Decline</td>
<td>True</td>
</tr>
<tr>
<td>BR</td>
<td>Decline</td>
<td>True</td>
</tr>
<tr>
<td>JW</td>
<td>Decline</td>
<td>Charting error - stable</td>
</tr>
<tr>
<td>MO</td>
<td>Stable</td>
<td></td>
</tr>
<tr>
<td>GK</td>
<td>Decline</td>
<td>True</td>
</tr>
<tr>
<td>DM</td>
<td>Decline</td>
<td>True</td>
</tr>
<tr>
<td>JM</td>
<td>Decline</td>
<td>Charting error - stable</td>
</tr>
<tr>
<td>ET</td>
<td>Decline</td>
<td>True and charting error</td>
</tr>
<tr>
<td>RS</td>
<td>Decline</td>
<td>True</td>
</tr>
<tr>
<td>BM</td>
<td>Decline</td>
<td>True</td>
</tr>
<tr>
<td>MH</td>
<td>Stable</td>
<td></td>
</tr>
<tr>
<td>DS</td>
<td>Improved</td>
<td></td>
</tr>
<tr>
<td>GB</td>
<td>Stable</td>
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<tr>
<td>RH</td>
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<td></td>
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<tr>
<td>MS</td>
<td>Stable</td>
<td></td>
</tr>
<tr>
<td>LM</td>
<td>Improved</td>
<td></td>
</tr>
<tr>
<td>JR</td>
<td>Stable</td>
<td></td>
</tr>
<tr>
<td>TK</td>
<td>Stable</td>
<td></td>
</tr>
<tr>
<td>BG</td>
<td>Stable</td>
<td></td>
</tr>
</tbody>
</table>
Data Distribution

**Improve, Decline, and Stable**
- 50% Stable
- 41% # Improve
- 9% # Decline

**True vs. Error Decline**
- 73% # true declines
- 27% # Error declines

**Charting Error Frequency**
- 77% Correct
- 23% Incorrect
Shifts in Functional Status Between Assessments

![Previous MDS Codes vs. Current MDS Codes Frequency](chart.png)
Root Cause

- Charting errors made by staff
- Assist residents more than necessary to improve time effectiveness in care
- Misunderstanding of MDS code system
Develop Potential Solutions
Selected Solution and Plan for Implementation

- Training Video
- Educational Presentation
- New Flowsheets
- Patient Identification Coding
Commitment

- Centers for Medicare & Medicaid Services (CMS)
  - Measure performance: Quality Measures
  - Scores for these measures.
  - Based on an average.

- Short-Stay Quality Measures: 100 days or less or covered under the Medicare Part A Skilled Nursing Facility (SNF) benefit.

<table>
<thead>
<tr>
<th>Percentage of short-stay residents who improved in their ability to move around on their own</th>
<th>74%</th>
</tr>
</thead>
<tbody>
<tr>
<td>MiIaca Elim Meadows Health Care Center</td>
<td></td>
</tr>
<tr>
<td>National average: 73.1%</td>
<td></td>
</tr>
<tr>
<td>Minnesota average: 75.8%</td>
<td></td>
</tr>
</tbody>
</table>

- Long-Stay Quality Measures: 101 days or more

| Percentage of long-stay residents whose need for help with daily activities has increased | 14.7% |
| MiIaca Elim Meadows Health Care Center                                                    |     |
| National average: 15.7%                                                                   |     |
| Minnesota average: 14%                                                                   |     |
Execution & Implementation
Video Training
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Code Clarification

Independent
- May set up a bed, adjust feet or raise edge of bed, but does not lift or change position of the patient, and does not offer assistance in doing so.

Supervision
- May give lifting assistance and may be needed for oral hygiene, eating, bathing, or other self-care activities.

Limited vs. Extensive Assistance
- Limited: Assisted with activity; staff provide guidance and assistance only.
- Extensive: Assisted with activity; staff provide weight-bearing assistance.

Total Dependence
- Assisted with activity; staff provide weight-bearing assistance.
- Total dependence is usually associated with severe disabilities or life-threatening conditions.
Original Flow Chart for ADL Coding
Our Modified Flow Chart for ADL Coding

Start Here – STOP at the First Code that Applies

Did the activity occur at least once?  
→ YES  NO
  → Did the activity occur at least once or twice?  
  → YES  NO

**Code 0: Independent**  
"NO talk/NO touch"

Did the resident fully perform the ADL activity without any staff help/supervision every time? (7 days/week)  
→ YES  NO

**Code 1: Supervision**  
"YES talk/NO touch"

Did the resident fully perform the activity without any staff help/oversight at least 3 times AND required a higher level of assistance, but less than 3 times?  
→ YES  NO

**Code 4: Total Dependence**  
"ZERO patient participation"

Did the resident require Total Dependence every time? (7 days/week)  
→ YES  NO

**Code 3: Extensive Assistance**  
"ANY pushing, pulling, or lifting"

Did the resident require Extensive Assistance 3 or more times? (3-7 days/week)  
→ YES  NO

**Code 2: Limited Assistance**  
"YES talk/NO push/NO pull/NO lift"

Did the resident require Limited Assistance 3 or more times? (3-7 days/week)  
→ YES  NO

**Code 1: Supervision**  
"YES talk/NO touch"

Did the resident require verbal oversight such as cueing or oversight 3 or more times? (3-7 days/week)  
→ YES  NO

**Code 3: Extensive Assistance**  
"ANY pushing, pulling, or lifting"

Did the resident require a combination of Total Dependence and Extensive Assistance 3 or more times but NOT at the same level 3 times?  
→ YES  NO

**Code 2: Limited Assistance**  
"YES talk/NO push/NO pull/NO lift"

Did the resident require a combination of Total Dependence, Extensive Assistance, and/or Limited Assistance 3 or more times but NOT 3 times at the same level?  
→ YES  NO
New Code Status Resource for all Direct Care Staff

Code Status

<table>
<thead>
<tr>
<th>Code 0: Independent</th>
<th>Code 1: Supervision</th>
</tr>
</thead>
<tbody>
<tr>
<td><em>NO talk/NO touch</em></td>
<td><em>YES talk/NO touch</em></td>
</tr>
</tbody>
</table>

**Explanation**

A resident is **independent** if they **never** need staff supervision OR assistance. Staff do not touch the resident, but may 'set up' an ADL. For example, laying out clothes - staff do not physically or verbally assist the resident and are not present for the actual ADL (i.e. dressing).

A resident requires **supervision** if you do not touch the person during the ADL. You may provide **verbal cues** and act as a **stand-by assist** and are present during the ADL. However, if you do touch the resident at any time, they advance to another level of assistance.

A resident requires **limited assistance** if the hands-on interaction is strictly for **guidance**. It is less common for a resident to function at this level of assistance than the other levels. Limited assistance is equivalent to Contact Guard Assist (CGA). Staff do not lift, push, or pull - ONLY TOUCH.

A resident requires **extensive assistance** if ANY kind of pushing, pulling, or lifting is needed by staff. Staff will touch AND bear weight while the resident participates in the ADL. MOST hands-on assist requires weight bearing. Minimum and maximum assistance are both extensive assistance.

A resident who is **totally dependent** on staff will not participate in the ADL all 7 days/week. They are unable to help with the task, so staff complete the ADL from start-to-finish. e.g. patient is in a coma or unresponsive.

Remember...

- A resident can require different levels of assistance depending on the task. Always chart each ADL individually and accurately.
- If a resident is requiring a higher level of care than usual, notify nursing ASAP. Interventions such as physical therapy may be appropriate and implemented.
- Communicate with nursing whenever charting limited assistance - it is less common a resident is assisted at this level.
- Incorrectly charting a level of assistance can negatively impact the revenue to care for all residents. If a resident's condition declines, notify nursing to document this correctly.

Code Status

<table>
<thead>
<tr>
<th>0 = Independent</th>
<th>1 = Supervision</th>
</tr>
</thead>
<tbody>
<tr>
<td>2 = Limited</td>
<td>3 = Extensive</td>
</tr>
<tr>
<td>4 = Total Dependence</td>
<td>5 = Activity occurred once or twice/week</td>
</tr>
<tr>
<td>6 = Activity did not occur</td>
<td>Staff Assistance</td>
</tr>
</tbody>
</table>

1 = Independent
2 = Minimum assistance
3 = Maximum assistance
Evaluation of Effectiveness & Dissemination

- Staff training materials have been integrated into new-hire orientation at Elim Milaca
- MDS coordinator has seen a reduction in charting errors while completing MDS audits/assessments since implementation of QI
- DoN recognizes that there is a greater understanding among staff of MDS codes related to resident ambulation


