Operationalizing MDS Changes Effective October 2023 – SDOH, TOH Information, and Functional Status

Jennifer LaBay RN, RAC-MT, RAC-MTA, QCP, CRC

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Learner Objectives

After participating in this presentation, learners will be able to:

- Recognize the social determinants of health (SDOH), transfer of health (TOH) information, and new functional status items that will be added to the MDS effective Oct. 1, 2023
- Provide operational considerations and best practices to prepare the interdisciplinary team for the upcoming changes

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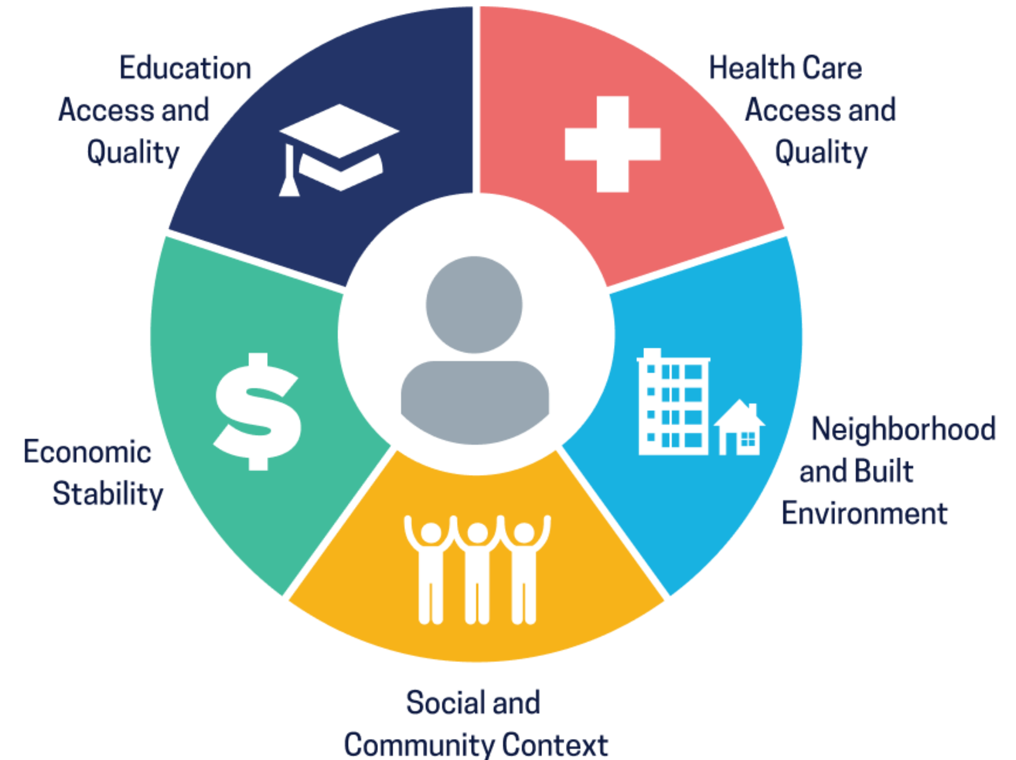
What are SDOH?

- The conditions in the environments where people are born, live, learn, work, play, worship, and age that affect a wide range of health, functioning, and quality-of-life outcomes and risks
  - Healthy People 2030, U.S. Department of Health and Human Services, Office of Disease Prevention and Health Promotion. Retrieved 2.6.23, from https://health.gov/healthypeople/objectives-and-data/social-determinants-health



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Social Determinants of Health (SDOH) MDS 1.18.11 Effective Oct. 1, 2023

- Ethnicity
  - A1005
- Race
  - A1010
- Language
  - A1110
- Transportation
  - A1250
- Health Literacy
  - B1300
- Social Isolation
  - D0700

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Operational Considerations

- New MDS data elements that had not been collected previously, operations managers will likely need to consider how data will be collected, documented tracked, and eventually coded
  - Who will interview the resident and document the data?
  - Where will the data be documented?
  - Who will collect the data and when?
  - What tracking will be needed of the data?
  - Who will be responsible for coding data on the MDS?
  - Who will be responsible for using this data in care planning?
- Interdisciplinary training
  - To ensure an accurate understanding of *RAI User's Manual* Instruction
- Consider policy impact
  - New
  - Revised

A1005 Ethnicity

A1005. Ethnicity

Are you of Hispanic, Latino/a, or Spanish origin?

↓ **Check all that apply**

- ☐ **A.** No, not of Hispanic, Latino/a, or Spanish origin
- ☐ **B.** Yes, Mexican, Mexican American, Chicano/a
- ☐ **C.** Yes, Puerto Rican
- ☐ **D.** Yes, Cuban
- ☐ **E.** Yes, another Hispanic, Latino/a, or Spanish origin
- ☐ **X.** Resident unable to respond
- ☐ **Y.** Resident declines to respond

If "Y" is selected, no other response choices can be checked

- Information gathering must start with the resident
- If the resident is unable to answer, others (family, significant other, or legal guardian) may be asked
- If others are not available, the medical record may be used to determine
- If the **resident declines** to respond, **other resources cannot be used** to answer the question

A1010 Race

A1010. Race

What is your race?

↓ **Check all that apply**

- ☐ **A.** White
- ☐ **B.** Black or African American
- ☐ **C.** American Indian or Alaska Native
- ☐ **D.** Asian Indian
- ☐ **E.** Chinese
- ☐ **H.** Korean
- ☐ **I.** Vietname
- ☐ **J.** Other Asi
- ☐ **K.** Native Ha
- ☐ **L.** Guamani
- ☐ **M.** Samoan
- ☐ **N.** Other Pa
- ☐ **X.** Resident unable to respond
- ☐ **Y.** Resident declines to respond
- ☐ **Z.** None of the above

If "Y" is selected, no other response choices can be checked

- Information gathering must start with the resident
- If the resident is unable to answer, others (family, significant other, or legal guardian) may be asked
- If others are not available, the medical record may be used to determine
- If the **resident declines to respond, other resources cannot be used** to answer the question

A1110 Language

A1110. Language	
	A. What is your preferred language? [ ][ ][ ][ ][ ][ ][ ][ ][ ][ ][ ][ ][ ][ ][ ]
Enter Code [ ]	B. Do you need or want an interpreter to communicate with a doctor or health care staff? 0. No 1. Yes 9. Unable to determine

- Enter the preferred language the resident primarily speaks or understands after interviewing the resident and family, significant other and/or guardian/legally authorized representative and/or reviewing the medical record
- If the resident, family member, significant other, guardian/legally authorized representative and/or medical record documentation cannot or does not identify preferred language, enter a dash (-) in the first box

Operational Considerations Language

- Facility-wide assessment should identify interpreter needs of the facility
- Consider unmet needs of the resident if an interpreter is not used when needed
- Consider barriers to cultural considerations if interpreter is not used when needed
- May impact:
  - Accurate assessment
  - Care planning
  - Need for an interpreter
  - Current process for assessing language needs

Operational Considerations
Ethnicity and Race

- Facility-wide assessment should be used to identify resident population having unique cultural preferences
- Race and ethnicity should be used to identify possible cultural preferences of residents in the facility
  - This information can be used to further investigate and develop a culturally competent care plan
- Identify need to staff training or education based on unique culturally differences of residents in the facility
- May impact:
  - Care planning
  - Current process for gathering data
  - Staff training and education

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Care Planning to Address Cultural Preference

- It is important for facilities to be aware of the impact of culture and cultural preferences on the provision of care and have an understanding of the cultural norms and practices of the individuals they care for
- For example, in some cultures, it may be considered taboo to direct care at end of life; or in other cultures care must be provided by caregivers of the same sex as the resident
- Staff must understand the cultural preferences of the individual and how it impacts the delivery of care

-State Operations Manual, Appendix PP

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Care Planning to Address Cultural Preference

- There are many aspects of cultural preferences which may impact the delivery of care, such as:
  - Food preparation and choices
  - Clothing preferences such as covering hair or exposed skin
  - Physical contact or provision of care by a person of the opposite sex
  - Cultural etiquette, such as avoiding eye contact or not raising the voice

-State Operations Manual, Appendix PP

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Care Planning to Address Cultural Preference

- Consider:
  - Offering **activities that are culturally relevant** to resident populations within the facility
  - Group activities with both sexes may not be permitted or appropriate in some cultures, or the type of programming may be in conflict with his/her cultural preferences
  - Providing reading materials, movies, newspapers **in the resident’s preferred language** may help orient a resident to date, times and events
  - Allowing the performance of religious rites at end of life to the extent possible
  - Certain medications, procedures or treatments may be prohibited

-State Operations Manual, Appendix PP

Care Planning to Address Cultural Preference

- Consider:
  - Does the care plan describe interventions that reflect the resident's cultural preferences, values and practices?
  - The facility failed to identify a resident's cultural dietary restrictions related to eating pork. After eating her dinner, upon realization that she had eaten pork, the resident began crying inconsolably and screaming that this was explicitly forbidden in her culture and faith of Islam. The resident remained tearful and inconsolable for several days, and would not eat the food provided by the facility, which resulted in weight loss and serious psychosocial harm

-State Operations Manual, Appendix PP

A1250 Transportation

Completed at the **start** of the Medicare stay (5-Day PPS)

Completed at the **end** of the Medicare stay with a **planned** discharge

Look-back is the past 6 months to a year

A1250. Transportation (from NACHC©)
Has lack of transportation kept you from medical appointments, meetings,
Complete only if A0310B = 01 or A0310G = 1 and A0310H = 1

↓	Check all that apply
☐	A. Yes, it has kept me from medical appointments or from get
☐	B. Yes, it has kept me from non-medical meetings, appointme
☐	C. No
☐	X. Resident unable to respond
☐	Y. Resident declines to respond

- Information gathering must start with the resident
- If the resident is unable to answer, others (family, significant other, or legal guardian) may be asked
- If others are not available, the medical record may be used to determine
- If the **resident declines to respond, other resources cannot be used** to answer the question

If "Y" is selected, no other response choices can be checked

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A1250 Transportation

Rationale:

- Access to transportation for ongoing healthcare and medication access needs is essential to effective care management
- Understanding resident transportation needs can help organizations assess barriers to care and facilitate connections with available community resources

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Operational Considerations Transportation

- Consider developing a new questionnaire or adding a section to current IDT tools to collect the new data
  - Who will ask this question?
  - How and where will it be documented?
  - Who is responsible to use this information in care planning and discharge planning?
- Consider how the local contact agency may be able to assist with transportation barriers with planning for discharge
- May Impact:
  - Discharge planning
  - Care plan
  - Current policy/process

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B1300 Health Literacy

Item Rationale/Health-related Quality of Life on page B-14

B1300. Health Literacy

Complete only if A0310B = 01 **or** A0310G = 1 and A0310H = 1

Enter Code

How often do you need to have someone help you when you read instructions, pamphlets, or other written material from your doctor or pharmacy?

0. **Never**
1. **Rarely**
2. **Sometimes**
3. **Often**
4. **Always**
7. **Resident declines to respond**
8. **Resident unable to respond**

This is a resident self-report item, no other resource should be used to identify the response even if the resident is unable to respond.

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DEFINITION:

Health literacy is the degree to which individuals have the capacity to obtain, process, and understand basic health information and services needed to make appropriate health decisions.

Heath Literacy

Rationale:

- Similar to language barriers, low health literacy interferes with communication between provider and resident
- Health literacy can also affect residents' ability to understand and follow treatment plans, including medication management
- Poor health literacy is linked to lower levels of knowledge of health, worse outcomes, the receipt of fewer preventive services, and higher medical costs and rates of emergency department use
- Assessing for health literacy will facilitate better care coordination and discharge planning

Operational Considerations
Health Literacy

- Data collected on social risk factors in order to determine which factors have the biggest impact on health outcomes
- Consider how health literacy data will be used in the transfer of health information to the resident
- Consider how health literacy data will direct the methods used for teaching self-care, medication management, and other discharge planning services
- Consider how health literacy data will be used to coordinator care and discharge planning
- May impact:
    - Current process/policy
    - Care plan
    - Discharge plan

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Operational Considerations
Health Literacy

- Train staff on how to communicate health material
  - Teach-back methods
  - Skill/level appropriate material
  - Communication methods needs to be resident-centered
- Policies and practices that address health literacy
  - Training for nurses on communication practices
  - How to measure health literacy

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D0700 Social Isolation

D0700. Social Isolation

Enter Code	How often do you feel lonely or isolated from those around you?
	0. **Never**
	1. **Rarely**
	2. **Sometimes**
	3. **Often**
	4. **Always**
	7. **Resident declines to respond**
	8. **Resident unable to respond**

DEFINITION

SOCIAL ISOLATION Refers to an actual or perceived lack of contact with other people, such as living alone or residing in a remote area.

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Social Isolation

Intent:

- **Social isolation** refers to an actual or perceived lack of contact with other people and tends to increase with age
  - Is a risk factor for physical and mental illness
  - Is a predictor of mortality
  - Is important to assess in order to identify engagement strategies

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Operational Considerations
Social Isolation

- Consider how this data will impact care planning and discharge planning
- Consider facility-wide interventions that may be implemented when social isolation or risk of social isolation is identified
- Consider how outside services/groups may reduce the risk of social isolation
  - Pet therapy services, church groups, clubs
- May impact:
  - Current process/policy
  - Care plan

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Care Planning Considerations for Self-Reported Social Isolation

- Adapted from the National Institute on Aging
  - Find an activity the resident enjoys
  - Help the resident connect with other residents with similar interests
  - Assist the resident to schedule a time to stay in touch with family or friends
  - Identify if an exercise group or restorative nursing program is appropriate to meet the resident's physical activity needs

Discharge Planning Considerations for Self-Reported Social Isolation

- Adapted from the National Institute on Aging
  - Does the resident have family, friend, or neighbor who can regularly check-in or call the resident
  - Identify community-based support options
  - If technology-based communication will be used, provide training to the resident on how use as part of discharge education

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A2121 Provision of Current Reconciled Medication List to Subsequent Provider at Discharge

Transfer Of Health Information SNF QRP

A2121. Provision of Current Reconciled Medication List to Subsequent Provider at Discharge

Complete only if A0310H = 1 and A2105 = 02-12

Enter Code

At the time of discharge to another provider, did your facility provide the resident's current reconciled medication list to the subsequent provider?

0. **No** - Current reconciled medication list not provided to the subsequent provider → Skip to A2200, Previous Assessment Reference Date for Significant Correction
1. **Yes** - Current reconciled medication list provided to the subsequent provider

DEFINITION :

Providing the current reconciled medication list at the time of transfer or discharge can be accomplished by any means, including active means (e.g., by mail, electronically, or verbally) and more passive means (e.g., a common electronic health record [EHR], giving providers access to a portal). Page A-45

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A1805 Entered From and A2105 Discharge Status

A2105. Discharge Status

Complete only if A0310F = 10, 11, or 12

Enter Code

01. **Home/Community** (e.g., private home/apt., board/care, assisted living, group home, transitional living, other residential care arrangements) → Skip to A2123, Provision of Current Reconciled Medication List to Resident at Discharge
02. **Nursing Home** (long-term care facility)
03. **Skilled Nursing Facility** (SNF, swing beds)
04. **Short-Term General Hospital** (acute hospital, IPPS)
05. **Long-Term Care Hospital** (LTCH)
06. **Inpatient Rehabilitation Facility** (IRF, free standing facility or unit)
07. **Inpatient Psychiatric Facility** (psychiatric hospital or unit)
08. **Intermediate Care Facility** (ID/DD facility)
09. **Hospice** (home/non-institutional)
10. **Hospice** (institutional facility)
11. **Critical Access Hospital** (CAH)
12. **Home under care of organized home health service organization**
13. **Deceased**
99. **Not listed** → Skip to A2123, Provision of Current Reconciled Medication List to Resident at Discharge

Operational Considerations Entered from and Discharge Status

- Review current applications for admission and make changes as needed
- Assess current referral forms and determine if the additional data can be obtained, or if changes will be needed
- Add data collection items to current tools to include the additional section questions
- Alert team members as to where the data will be kept and how to access
- Cross-check to ensure the status on the Medicare claim matches the status on MDS – add to triple check

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A2123 Provision of Current Reconciled Medication List to Resident at Discharge

A2123. Provision of Current Reconciled Medication List to Resident at Discharge

Complete only if A0310H = 1 and A2105 = 01, 99

Enter Code

At the time of discharge, did your facility provide the resident's current reconciled medication list to the resident, family and/or caregiver?

0. **No** - Current reconciled medication list not provided to the resident, family and/or caregiver → Skip to A2200, Previous Assessment Reference Date for Significant Correction
1. **Yes** - Current reconciled medication list provided to the resident, family and/or caregiver

A2121 and A2123 were both added to meet requirements for SNF Quality Reporting Program Transfer of Health Information Measures

Items A2121 and A2123 are asking about a process that has or has not been completed in the facility.

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Route of Current Reconciled Medication List Transmissions A2122, Subsequent Provider and A2124, Resident

A2122. Route of Current Reconciled Medication List Transmission to Subsequent Provider

Indicate the route(s) of transmission of the current reconciled medication list to the subsequent provider.

Complete only if A2121 = 1

A2124. Route of Current Reconciled Medication List Transmission to Resident

Indicate the route(s) of transmission of the current reconciled medication list to the resident/family/caregiver.

Complete only if A2123 = 1

↓ **Check all that apply**

		Route of Transmission
☐	**A.**	**Electronic Health Record** (e.g., electronic access to patient portal)
☐	**B.**	**Health Information Exchange**
☐	**C.**	**Verbal** (e.g., in-person, telephone, video conferencing)
☐	**D.**	**Paper-based** (e.g., fax, copies, printouts)
☐	**E.**	**Other methods** (e.g., texting, email, CDs)

Check all that apply

Operational Considerations
Transfer of Health Information

- Consider health literacy when determining the best route to provide the resident with the health information
  - How will staff determine best route based on this data?
- If the reconciled medication list was not provided, it's a best practice to document why it was not provided
- Consider how direct care staff completing this task will document the process and route to support MDS coding
  - Update current discharge worksheets, new user defined assessments, template to include in nurse’s notes
- Likely just the beginning of the data expected to be shared
- May impact:
  - Policies
  - Current process/forms
  - Care plan
  - Discharge planning

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GG0115 Functional Limitation in Range of Motion

GG0115. Functional Limitation in Range of Motion

Code for limitation that interfered with daily functions or placed resident at risk of injury in the last 7 days

Coding:

0. **No impairment**
1. **Impairment on one side**
2. **Impairment on both sides**

Enter Codes in Boxes

☐	A. **Upper extremity** (shoulder, elbow, wrist, hand)
☐	B. **Lower extremity** (hip, knee, ankle, foot)

DEFINITION

FUNCTIONAL LIMITATION IN RANGE OF MOTION

Limited ability to move a joint that interferes with daily functioning (particularly with activities of daily living) or places the resident at risk of injury.

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GG0115 Functional Limitation in Range of Motion

- Coding for functional ROM limitations is a three-step process:
  - Test the resident's upper and lower extremity ROM
  - If the resident is noted to have limitation of upper- and/or lower-extremity ROM, review GG0130 and GG0170 and/or directly observe the resident to determine whether the limitation interferes with function or places the resident at risk for injury
  - Code GG0115A and GG0115B as appropriate

Do not look at limited ROM in isolation. Must determine if limitation interferes with function or places the resident at risk for injury.

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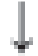
GG0120 Mobility Devices

GG0120. Mobility Devices

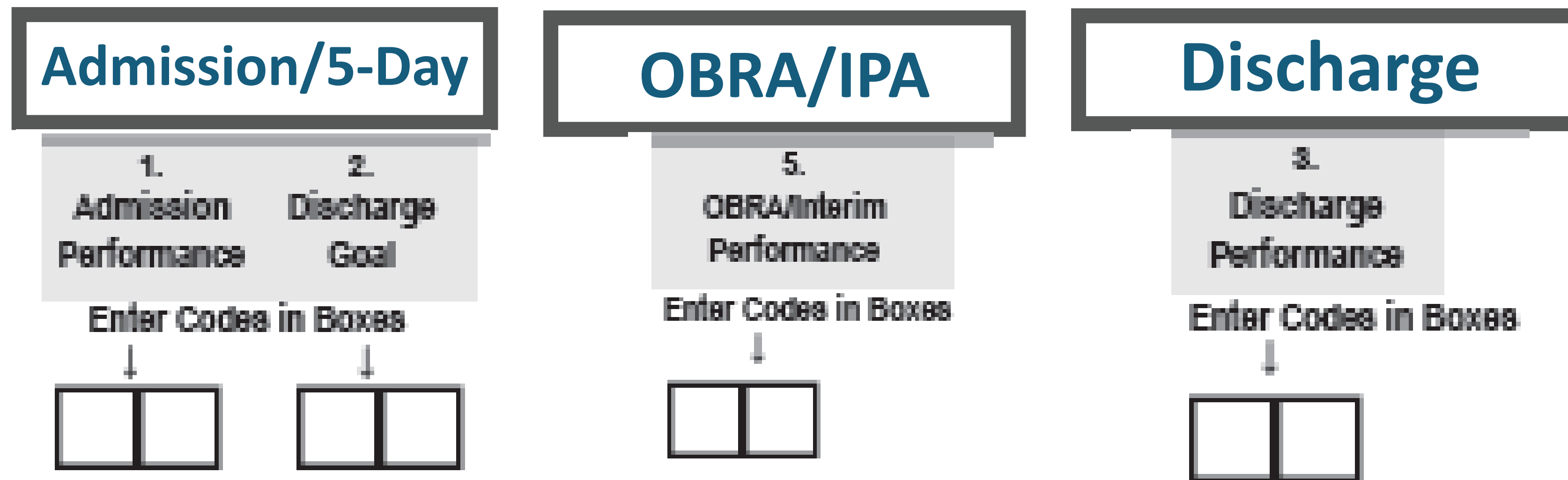
Check all that were normally used in the last 7 days



- ☐ A. Cane/crutch
- ☐ B. Walker
- ☐ C. Wheelchair (manual or electric)
- ☐ D. Limb prosthesis
- ☐ Z. None of the above were used

GG0130 Self-Care and GG0170 Mobility

- Usual performance is collected at the start of the stay, with each OBRA assessment, and at the end of the stay
- Discharge goal(s) are established only on the 5-Day PPS Assessment



GG0130 and GG0170 Column 1. Admission Performance Assessment Period

Type of Assessment	Look-Back Period
Standalone Medicare 5-Day PPS assessment	First three days of the stay starting with A2400B
Standalone OBRA Admission assessment	First three days of the stay starting with A1600
Combined Medicare 5-Day PPS assessment and any OBRA assessment (Admission, Quarterly, Annual, Significant Change in Status, Significant Correction)	First three days of the stay starting with A2400B

Column 3. Discharge Performance Assessment Period

Type of Assessment	Look-Back Period
OBRA Discharge	Discharge date (A2000) plus two previous calendar days
Part A PPS Discharge	End date of most recent Medicare Part A stay (A2400C) and two previous calendar days
Combined OBRA and Part A PPS discharge	End date of most recent Medicare Part A stay (A2400C) and two previous calendar days

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Column 5. OBRA/Interim Performance Assessment Period

Type of Assessment	Look-Back Period
Interim Payment Assessment	Assessment Reference Date (ARD) and two previous calendar days
Standalone OBRA assessment other than Admission (Quarterly, Annual, Significant Change in Status, Significant Correction)	ARD and two previous calendar days

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GG0130I Personal Hygiene: New Item

1. Admission Performance	2. Discharge Goal	
Enter Codes in Boxes ↓	↓	
☐☐		I. **Personal hygiene:** The ability to maintain personal hygiene, including combing hair, shaving, applying makeup, washing/drying face and hands (excludes baths, showers, and oral hygiene).

Recycled from section G

Coding Tips

- Complete GG0130I for all OBRA or Discharge assessments (A0310F = 10 or 11). [not completed on stand-alone PPS]
- Personal hygiene involves the ability to maintain personal hygiene, including combing hair, shaving, applying makeup, and washing and drying face and hands (**excludes** baths, showers, and **oral hygiene**)

GG0170FF Tub/shower transfer: New Item

1. Admission Performance	2. Discharge Goal	
Enter Codes in Boxes		
		FF. Tub/shower transfer: The ability to get in and out of a tub/shower.

Complete GG0130FF when A0310A = 01 – 06 or A0310F = 10 or 11. [not completed on stand-alone PPS]

Coding Tips

- Tub/shower transfers involve the ability to get into and out of the tub or shower. **Do not include washing, rinsing, drying, or any other bathing activities in this item**
- If the resident does not get into or out of a tub and/or shower during the observation period, use one of the "activity not attempted" codes (07, 09, 10, or 88)

Operational Considerations Functional Status

Update ADL flowsheets

- EMR software will likely have a solution built-in
  - CNA documentation cannot just flow into Section GG
  - Qualified clinician must assess information from all sources to determine usual performance
- Determine how you want the data collected by those involved in resident care
  - CNA, nursing, rehab
  - Interviews with resident, family, and direct care staff
- May impact:
  - Policies
    - Section G language will need to be removed
  - Process
    - Consider the education needed
  - Care plan

Operational Considerations Functional Status Medical Record Documentation

- "Documentation in the medical record is used to support assessment coding of Section GG. Data entered should be consistent with the clinical assessment documentation in the resident's medical record." (RAI, Chapter 3, p. GG-21)
- Each facility can decide how to meet this requirement
  - Flow sheets are not a Federal requirement
- MDS scheduling considerations with new section GG assessment periods

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Operational Considerations Functional Status

- Section GG data is likely going to be the basis of many reporting items and comparisons in future
- Ensure accurate and timely data
- Car transfer items may be used to determine the transportation mode
  - Personal car vs. Wheelchair van vs. ambulance

Questions

Email:

jlabay@aapacn.org

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Resources

- National Center for Chronic Disease Prevention and Health Promotion
  - https://www.cdc.gov/chronicdisease/healthequity/nccdphps-approach-to-health-equity.html
- Healthy People 2030, U.S. Department of Health and Human Services, Office of Disease Prevention and Health Promotion. Retrieved 2.6.23, from https://health.gov/healthypeople/objectives-and-data/social-determinants-health
- Encyclopedia of Public Health
  - https://link.springer.com/referenceworkentry/10.1007/978-1-4020-5614-7_629#:~:text=Cultural%20determinants%20include%20ethnicity%2C%20race,beliefs%2C%20socioeconomic%20class%20and%20education.

Resources

- Home Health Virtual Training – Part 1 Social Determinants of Health
  - https://www.cms.gov/medicare/quality-initiatives-patient-assessment-instruments/homehealthqualityinits/home-health-quality-reporting-training
- State Operations Manual (SOM) Appendix PP
  - https://www.cms.gov/medicare/provider-enrollment-and-certification/guidanceforlawsandregulations/downloads/appendix-pp-state-operations-manual.pdf
- National Institute on Aging
  - https://www.nia.nih.gov/health/loneliness-and-social-isolation-tips-staying-connected?utm_source=partner-social-share&utm_medium=affiliate&utm_campaign=socisolation-toolkit-2021&utm_term=riskfactors

Resources
State Operations Manual, Appendix PP

- The following resources are intended for informational purposes only:
  - The National Center for Cultural Competence
    - https://nccc.georgetown.edu
  - The National Standards for Culturally and Linguistically appropriate Services in Health and Health Care (developed by the Office of Minority Health in HHS)
    - https://www.thinkculturalhealth.hhs.gov/clas/blueprint
  - Office of Minority Health "Think Cultural Health" website
    - https://www.thinkculturalhealth.hhs.gov
  - Georgetown University publication: Cultural Competence in Health Care: Is it important for people with chronic conditions
    - https://hpi.georgetown.edu/agingsociety/pubhtml/cultural/cultural.html

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