NEWS & VIEWS

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Drug Regimen Review and Accurate MDS Coding

By:
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In October 1990, the Office of Inspector General (OIG) issued a management advisory report titled Reducing Medication Problems of the Elderly. The stated purpose of this report was to "identify actions which the Department of Health and Human Services could take to improve compliance among the elderly with their medication regimens."

The medication utilization problems noted in the 1990 OIG report as affecting the health and quality of life for a significant number of elder adults are still a growing concern. Nearly 30 years have passed, and the Centers for Medicare & Medicaid Services (CMS) continues to work to reduce these issues for the elderly and to address the increasing billions of dollars spent annually through the Medicare and Medicaid programs for physician visits and other medical associated services.

One effort of CMS occurred with a revision of the regulation for medication oversight that became effective November 28, 2017. F756 Drug Regimen Review outlines a process that must be used by a consultant pharmacist to conduct a drug regimen review of each resident's medication orders and medical record at least monthly, including a review of the resident's medical chart content. For new admissions, this is to be completed at the time of admission or as close to the date of a SNF PPS admission as possible. After conducting the review, the consultant pharmacist must list any irregularities along with his or her recommendations in a written report to the attending physician, the medical director and the director of nursing. These reports must be acted upon. This includes any drug that meets the criteria for an unnecessary drug.

In its continuing effort to make regulations person-centered, the CMS announced in 2016 its intention to introduce more key features to the MDS (Minimum Data Set) 3.0 program. These involved new requirements effective October 1, 2018, for coding in MDS Section N Medications.

These changes address expectations for the prompt performance and follow-up on Drug Regimen Review findings for newly admitted and readmitted Medicare Part A residents.

Skilled nursing facilities (SNFs) must now collect three new MDS items. Two items are collected at admission-drug regimen review (N2001) and the medication follow-up (N2003)-and the third item upon discharge-medication intervention (N2005).

What is a Drug Regimen Review and who performs it?

Nursing homes are required to secure the services of a consultant pharmacist who is trained in the oversight of pharmaceuticals delivered to long-term care facility residents. Having a consultant pharmacist who is skilled in the area of geriatric medications can also be very helpful.

The consultant pharmacist is the person who performs a comprehensive drug regimen review for individual residents in a SNF. A CMS Contractor (RTI International) provided this explanation of the Drug Regimen Review SNF Quality Reporting Program Quality Measure purpose): to access whether SNFs are adequately measuring the "percentage of patient/resident stays in which a drug regimen review was conducted at the time of admission and that a timely follow-up with a physician occurred each time potential clinically significant medication issues were identified throughout that stay." Additionally, three key definitions for this QM were identified:

1. Medication reconciliation -- This is the process used to identify the "most accurate and current list of medications, particularly during care transitions." The assessment includes the "name, dosage, frequency and the route."
2. Drug regimen review- an analysis of all "medications or drugs the resident is taking to identify potential clinically significant medication issues."
3. Potential clinically significant medication issues -- issues that the pharmacist consultant/clinician would determine needed interventions, such as alerting the physician and/or others and the timely completion of recommended actions (by midnight of the next calendar day) to avoid any adverse outcomes.

This review must at a minimum include the resident's complete medical record, including the drug list, current laboratory reports, consultation reports and the nursing and medical progress notes. The purpose of the Drug Regimen Review is to identify medications the resident is receiving that may not be needed or that might be more appropriate at a lower dosage. Through this process of drug regimen review, previously unrecognized interactions like drug to drug or drug to disease may be identified. It is also possible that better tolerated medications might be identified as well as medications that have more convenient dosing schedules.

Consider this case study where conducting Drug Regimen Reviews for the residents might have prevented a fine due to deficiencies related to pain and medication management:

After a health survey of the facility in May, a Washington nursing home was fined $117,000 for deficiencies related to the pain and medication management of five residents and poor medication management regarding residents with infections.

One of the residents told the surveyors that he "experienced pain almost constantly," but the staff had reduced his opioid pain medication dosage. When the resident requested that his pain medication dose be increased, staff told him that taking the opioid medication with another medication he was receiving was dangerous. The surveyors reported that there was no indication that staff tried to work with the resident and his physician to develop a pain treatment plan or attempt to discuss or find alternate treatment solutions.

In several other instances, the facility "was not able to obtain timely refills for pain medications" and this resulted in residents' missing dosages and experiencing pain. For one resident, the facility failed to provide medication promptly to treat an infection, "causing unnecessary pain, anxiety and harm."

The Department of Social and Health Services along with a fine of $3,000 recommended that the Centers for Medicare & Medicaid Services (CMS) consider imposing a civil money penalty and terminate the nursing home's certification if compliance was not achieved by November.

The nursing home agreed to make changes designed to improve residents' pain treatments including reviewing pain management plans with residents. The nursing home agreed to ensure that residents with infections were reviewed to ensure that medications being administered were appropriate for their diagnoses.

A June follow-up visit indicated that the nursing home had corrected the earlier deficiencies.

Why is Accuracy in MDS Coding Important?

Nursing homes are placed under a microscope from many perspectives. Federal and State governing bodies are seeking to protect the elderly and provide person-centered care and also prevent fraud, waste and abuse that costs billions of taxpayer dollars each year. Potential residents and their families want to choose the right facility for the quality of care needed.

MDS 3.0 has become more than a comprehensive assessment tool for residents in an SNF. It is a "data-packed tool that drives care, reimbursement and quality outcomes." Every piece of data within every MDS section needs to accurately reflect each resident based on the Resident Assessment Instrument (RAI). The RAI must be used correctly and effectively to ensure the right care is provided for residents who leave a hospital and are transferred into a long-term care facility. The RAI assists SNF staff in identifying and providing the necessary elements a resident requires for quality of life and quality of care.

The RAI for Nursing Homes is made up of three elements-the Minimum Data Set (MDS) Version 3.0, the Care Area Assessment (CAA) process and the RAI Utilization Guidelines. All three parts of the RAI work together to provide "information about a resident's functional status, strengths, weaknesses and preferences." They also provide guidance about the need for further assessment when problems are identified. [CMS's RAI Version 3.0 Manual]

- **Minimum Data Set (MDS)**- "A core set of screening, clinical, and functional status elements, including common definitions and coding categories" that "form the foundation of a comprehensive assessment for all residents in Medicare or Medicaid certified nursing homes. These items in the MDS provide standardized communication about a resident's problems and conditions that is used within a nursing home, between nursing homes and between nursing homes and outside agencies."
- **Care Area Assessment (CAA) Process**- "This process is designed to assist the assessor to systematically interpret the information recorded on the MDS. The CAA process helps a clinician focus on key issues identified during the assessment process."
    - **Care Area Triggers (CATS)** - identify residents who have or are at risk for developing specific functional problems and require further assessment.
    - **Care Area Assessment** - further investigation of triggered areas to determine if interventions are required in care planning.
    - **CAA Summary (Section V of the MDS 3.0)** - provides a location for documentation of care areas that have been triggered from the MDS and the decisions made about whether to proceed to care planning.
    - **Utilization Guidelines** - These guidelines provide instructions for when and how to use the RAI including how to complete the RAI. It also provides the structured frameworks for integrating MDS and other clinical information.

Making the leap from the data gathered in the MDS and the evaluation of that data through the CAA Process to the need for accuracy is not a huge jump. Quality measures (QMs) are driven by MDS 3.0 data and the MDS involves some "tricky" coding rules which make for susceptible errors.

The new requirements in MDS Section N-Drug Regimen Review form a good backdrop supporting the need for accuracy in MDS coding. For example, N2001 Drug Regimen Review is to be completed only if Section A0310B has the **code 01** entered - Indicating a "5-day scheduled assessment." Then, the new sections N2001 and N2003 are also to be completed due to the individual being a newly admitted or readmitted Medicare Part A resident. As such, a Drug Regimen Review is required and should be completed as close to the time of admission as reasonably possible.

Accuracy in MDS 3.0 coding is also needed to prevent the submission of claims for reimbursement that may result in either under payment, over payment or having a claim for reimbursement rejected. Compliance with F756 Drug Regimen Review is a component of ensuring that residents only receive medications that are appropriate for them and in correct doses, and that facilities submit accurate MDS data and related reimbursement claims for medications that their residents truly need. A combined look at F756 and Section N of the MDS is part of a facility's effort to eliminate fraud, waste and abuse and provide quality care.

Worker Fatigue and How One Hospital Mitigates the Risks

By:
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Fatigue hits all of us like an invisible cannonball. Perhaps you work for a moving company and lift heavy boxes, massive furniture, and pianos. Maybe you're a brewer and use heavy equipment to concoct beer throughout the long hours of the night to serve your thirsty customers. You could be a McDonald's worker, working the night shift serving delicious and rather addictive fries. Fatigue comes to all kinds of workers.

If you're a healthcare professional, you may know a little something about fatigue. You may work as a CNA in a nursing home, working the night shift repeatedly. You are exhausted from your daily tasks. The quality of care you provide may suffer, or even worse, you may commit an error. Maybe you provided a resident with the wrong medication. Things get serious.

The topic of fatigue has been a growing area of concern in the healthcare industry. Such a concern has been noted by Northwestern Memorial Hospital (NHM), which has created a strong initiative aimed at reducing risk associated with employee fatigue. The initiative has been successful in crafting policies that include "sleeping during scheduled breaks, as well as the need to support team members taking uninterrupted breaks during their shifts."

With consultation provided by the Nursing Best People and Professional Excellence (NBP&PE), NHM was able to critically review its own policies and establish several goals, including the goals of having employee-friendly break policies and establishing occasional resting periods.

With guidance from the NBP&PE, NHM's new policy reads as follows:

Sleeping, preparing to sleep or being in a sleep-like position in patient care and/or public hospital space at any time is prohibited. However, an employee with authorization from a person in charge may rest or sleep while on break in a designated non-patient care, nonpublic hospital space during non-working periods.

The next task assigned to the NBP&PE was to create a system of education and awareness to ensure compliance with the newly established break policies. In areas of the facility with inconsistent break times, NBP&PE coaches would provide training and guidelines. Documented systems were established to track breaks of staff members.

Employee feedback was considered a vital aspect of assessing current fatigue levels of staff members. For example, incident report forms incorporated questions asking the employee how many shifts were worked before the incident took place, as well as how many shifts in total were worked for the entire week. This allowed administrators and managers to track trends and, as a result, target specific areas of the facility in need of training and education regarding effective break policies.

Perhaps the most intriguing outcome of NHM's reforms was the establishment of "quiet rooms." NHM previously had a multi-purpose break room but remodeled the room for napping. The rules of the room include: no talking, no food, and music-listening restricted to ear phones.

Lastly, the hospital established the "transportation kitty." Oftentimes, healthcare workers face the dangers of fatigued driving after a long day's work. To combat this problem directly, the facility made transportation passes and cab vouchers, otherwise known as a transportation kitty, available to employees. A log oversees the use of the transportation kitty to ensure the service is being used practically. In a way, this program epitomizes NHM's progress in ensuring employees are safe from the dangers and risks associated with fatigue. Other care facilities can follow suit and establish their own employee-friendly break policies as well.

Progress toward this goal begins with a self-assessment. Is workplace morale low? Are employees submitting complaints of long hours and too many night shifts? Are basic mistakes being made that jeopardize the health and safety of the employees? A critical evaluation may reveal fatigue to be a primary cause.

Source:

http://www.nurseleader.com/article/S1541-4612(13)00322-4/pdf

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