Bed Mobility: Tips for Teaching CNAs

Caralyn Davis, staff writer

The MDS 3.0 doesn’t offer any magic bullets that guarantee accurate coding of bed mobility (MDS item G0110A) or the other late-loss activities of daily living (ADLs) that impact everything from resident care to facility reimbursement. (To learn how the total ADL score is calculated under the RUG-IV system, see page 6 – 19 of the MDS 3.0 RAI User’s Manual.) However, implementing five key steps can help MDS nurses put certified nursing assistants (CNAs) on the path to accurate coding of bed mobility, says Deb Myhre, RN, C-NHSE, RAC-MT, a consultant with Ankeny, Iowa-based Continuum Health Care Services.

continued on page 3

The Ethics of Advance Directives

F. R. Abrams, MD

Basically, everyone who is mentally competent and of age has the right to accept or refuse any medical care, including life-saving care. Before advance directives were established, patients who were ill and unable to communicate had their critical decisions left to family and health professionals, who might not know how they wished to be treated—or not treated.

A solution was needed to honor the rights of patients should they become incapacitated and unable to express their wishes. An idea was implemented to allow people, foreseeing a disabling health condition, to write a thoughtful document in advance of a crisis that asserts their treatment preferences.

When friends, families, and healthcare personnel act in good faith to carry out a once-competent patient’s lawful wishes, having the guidance of this legal document protects patient and family from arbitrary outside interference.

* This became a constitutional right by the 1990 Supreme Court decision Cruzan v. Director, Missouri Department of Health. Any health care facility that receives federal funds must inform patients upon admission about advance directives.

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There is no freedom like seeing myself as I am and not losing heart.

—ELIZABETH J. CANHAM
to the SNF PPS Notice of Proposed Rule Making

The Centers for Medicare and Medicaid Services (CMS) issued a notice of proposed rule-making in April, 2011, with a focus on SNF PPS payments. CMS requested feedback from the long-term care community on how the proposed rule changes would affect long-term care provision. AANAC requested that members provide their thoughts and feedback on the proposed changes and responded to CMS on June 27, 2011.

Overall, AANAC members voiced concerns over some of the changes aimed at decreasing costs by 11.3%. CMS reported that the organization always focuses on maintaining budget neutrality, and recent changes, specifically seen in RUG-IV, had pushed the budget 11.3% higher than anticipated. The first rule change that AANAC has requested CMS reconsider involves the requirement that there be exactly 4 participants in group therapy. This requirement does not take into account the possibility that one group therapy member may have to miss a session for illness or other reasons, which under the new rule would require either the provision of services free of charge or rescheduling the entire group. It is our recommendation that CMS continue with the existing policy of limiting the group therapy size to a maximum of four residents per therapist.

Additionally, CMS has proposed a new Change of Therapy (COT) OMRA. The proposed rule suggests that the payment system under the COT will no longer be a prospective payment system. It also seems appropriate that CMS consider that an isolated break of a day or two occasionally, from skilled services is acceptable and providers should not be financially penalized for such a break that causes a temporary change in the RUG-IV classification.

AANAC also suggests that regarding the EOT OMRA, CMS should consider the possibility that a resident may miss three consecutive days of therapy and still have received all of his or her planned services and required therapy minutes and days for that given week. Therefore, in such a case, an EOT OMRA seems inappropriate and inconsistent with CMS’ guidance regarding therapy requirements for the RUG-IV-based PPS.

Please see our website for the full text of the AANAC response to the CMS notice of proposed rule-making.
Bed Mobility, continued from page 1

1. Teach the complete definition.

On page G-1 of Chapter 3 of the MDS 3.0 RAI User’s Manual, bed mobility is defined as “how resident moves to and from lying position, turns side to side, and positions body while in bed or alternate sleep furniture.” But when Myhre does ADL teaching and asks CNAs to define bed mobility, the standard answer is incomplete. “They often say ‘moving side to side,’ and that’s it,” she notes. “CNAs usually don’t mention any of the other components of the definition, and that is a detriment to accurate coding.”

CNAs also blend together the definitions of bed mobility and transfer (MDS item G0110B), points out Jane Belt, RN, MS, RAC-MT, manager of the Clinical Group at Plante & Moran PLLC in Columbus, Ohio. “Often, CNAs code the assistance they provide all in one ADL rather than breaking it down into the two different tasks that have occurred. When you are transferring someone, usually there is some sort of positioning or bed mobility attached to that transfer, and that separate coding needs to be captured as well,” she explains. “Transfer is surface to surface (e.g., the surface of the chair, the surface of the bed). So once the resident’s bottom is on the mattress of the bed, everything else that happens is bed mobility. For example, getting the resident’s legs into and out of bed and getting the resident’s legs in position in bed are all part of bed mobility, not transfer.”

2. Focus on limited assistance and extensive assistance.

While CNAs need to learn how to code both ADL Self-Performance (column 1) and ADL Support Provided (column 2), the key sticking point for bed mobility, as well as the other late-loss ADLs, typically is understanding the difference between limited assistance (“2”) vs. extensive assistance (“3”) in the ADL Self-Performance column, says Myhre. A resident received limited assistance “if the resident was highly involved in the activity and received physical help in the form of guided maneuvering of limb(s) or other non-weight-bearing assistance three or more times during the last seven days,” explains Myhre. A resident received extensive assistance “if help of the following type(s) was provided three or more times: weight-bearing support provided three or more times, or full staff performance of the activity during part but not all of the last seven days,” she relates.

Getting the resident’s legs into and out of bed and getting the resident’s legs in position in bed are all part of bed mobility, not transfer.

3. Make sure documentation systems can capture more than one episode per shift.

“Many facilities still have simple documentation forms that allow CNAs to enter one code for bed mobility on the day, evening, and night shifts seven days a week,” says Myhre. “For example, the CNA might enter a 3 for extensive assistance on the night shift of Day One, but nothing in the documentation tells the MDS nurse how many times extensive assistance was provided during that shift. Facilities have to have good documentation systems that can capture each episode, especially for short stays or emergent discharges that have a shortened look-back period for getting three or more episodes.”

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Advance directives are just what they sound like. In advance, speculating upon a variety of possible medical circumstances of illness or accident, a person writes directions, anticipating some future time when he or she might be unable to voice preferences about how he or she wants to be treated (or not treated) under the specified health conditions. When friends, families, and healthcare personnel act in good faith to carry out a once-competent patient’s lawful wishes, having the guidance of this legal document protects patient and family from arbitrary outside interference. It saves guesswork in critical situations because the person most involved—the patient—has considered the decisions and situations in advance, and may also have specified an agent who will be sure they are implemented.

Without foreknowledge of a patient’s desires, someone uninformed must make decisions for that person. Advance directives are the patient’s statements, but they are subject to interpretation by caregivers because the wording may be ambiguous. No one who writes one can anticipate precisely his or her future circumstances. Some patients fail to discuss their wishes with anyone else, not even their family or, indeed, the doctor who is expected to implement the details of care. Some health situations call for help in day-to-day decision making. Questions often occur in long-term care facilities regarding feeding, restraints, or sedation for progressively demented patients. Even generally healthy patients could become delirious from drugs or fever, or temporarily unconscious from a blow to the head or a metabolic condition. They would need some short-term help for decisions about treatment.

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There are medical facts that everyone needs to know in order to make future health decisions. Caregivers need to know the conditions, such as the need for a feeding tube or decreased cognition, for which a specific advance directive is most useful in order to guide a patient through the process of composing a directive at a time when the patient is able to make decisions. Often, explaining directives and obtaining signatures for them is assigned to a nurse who, especially in long-term care facilities, has the most continuous contact with a patient and is the one asked the most questions by the patient.

Many patients enter long-term care facilities in a clearly competent mental state, but unfortunately, this state may change over time. Learning the patient’s preferences for treatment in the event of future cognitive disability is a matter that ought to be dealt with as soon as reasonably possible after admission. The nurse must be familiar with a variety of conditions in order to best advise the patient he or she wishes to assist.

When should this discussion about future health decisions take place and with whom?

- Anytime patients decide to really take charge of future care, to raise questions with their doctor, nurse, and family about end-of-life treatment, and to face the possibility that, sometime, health decisions might have to be made for them. But many patients are waiting for someone to ask them these questions. A nurse may have to be the one who breaks the ice, asking a patient a question such as, “Have you thought about how you want to be treated if you become seriously ill—and may be unable to express your wishes?”

- Certainly advance directives are essential if patients have or suspect they have:
  - an incurable disease with a fatal prognosis
  - a disease from which prolonged survival is rare
  - a disease that severely diminishes the quality of life

- They are of great importance whenever patients are:
  - undergoing anesthesia
  - undergoing treatment that poses significant risk to life

**Advanced Directives, continued from page 4**

Often, explaining directives and obtaining signatures for them is assigned to a nurse who, especially in long-term care facilities, has the most continuous contact with a patient and is the one asked the most questions by the patient.
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Dear Betty,

Do you have suggestions on how to deal with negative staff in the nursing department?

RN Supervisor

Dear RN,

Negativity is like a virus that spreads causing problems with productivity and morale, and may ultimately prevent a department from achieving success, so you are wise to seek ways to remove it before it increases. Although everyone has moments of negativity about his or her work, when it becomes a habit, it becomes a problem. Many people believe that negativity is just part of the individual’s personality. As nurse leaders, however, we have a responsibility to act when the health of our department is in jeopardy. We cannot change others’ personalities, but we can work on changing their negative behaviors. For the good of all, we must help negative people recognize their harmful behaviors and replace them with positive actions. Before you can help the person deal with their negativity, you must manage your own reaction. Frustration and even anger can rise within us when our staff undermines departmental harmony with negativity. Identifying the presence of negative behaviors will be the easy part. Turning negative habits into positive ones will take longer. When negativity occurs as you talk with an employee, take a moment to check how you are projecting your message. According to experts, in face-to-face interactions with others, 50% or more of our message is interpreted by how we look and 25 – 38% by how we say it, such as tone, volume, and pitch. Less than 25% of a receiver’s understanding comes from the actual words we say.

Keep the following points in mind to manage your emotions before helping others deal with theirs:

- Don’t take the other person’s behavior personally. They likely behave this way in an attempt to get perceived needs satisfied.
- If the difficult person reminds you of someone else who “gets to you,” separate them in your mind. They are individuals who should be dealt with separately.
- Draw on your own communication and listening skills to get the negative person to work with you.
- Avoid becoming negative in response to their behavior. Strong personality types often transfer negativity to others, so determine not to pick up their bad attitude.

When meeting with the employee, describe the negative habit specifically. Valid examples make it easier for the person to understand how he/she comes across to others. For a nurse you might say, “When team members report something to you, you have a habit of responding in a way that others view as sarcastic.” State a specific example of when this occurred, and encourage discussion. Describe the impact this has on others, including potential outcomes that could affect resident care. Tell the nurse, “Staff members may stop coming to you when true problems arise, and resident care may be compromised.” Then teach a new, more positive behavior you would like them to adopt. Be consistent in shaping their new behavior. It takes at least 21 consecutive days to break an old habit and to add a positive one in its place.

Your goals are to help the person realize that negativity is not appropriate and to adopt positive behaviors. Reassure them of their value to the team and the residents. If the negativity continues, remain professional. Don’t respond with “negativist” behavior. Prevention is the best way to manage negativity, but when negativity has already invaded your community, reverse those trends through training and by helping staff replace bad habits with positive actions.

—Betty

Betty Frandsen, RN, NHA, MHA, C-NE, has worked in long term care for over 30 years, including 14 years as a Director of Nursing, and as an Administrator in both Pennsylvania and New York. She served as Vice President of Education and Regulatory Affairs for AANAC, and is a past president of NADONA/LTC.

If you have a nursing management or leadership question that Betty could help with, send your problem to iserio@aanac.org.
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INTENSIVE 1
Focus on . . . Care & Choice
Rena R. Shephard, MHA, RN, RAC-MT, C-NE
Karyn Leible, RN, MD, CMD
Diana Sturdevant, MS, GCNS-BC

EMPHASIZING:
Physical Assessment
MDS 3.0
Care Area Assessments
Care Planning
Culture Change

INTENSIVE 2
Focus on . . . Quality
Kenneth Daily, LNHA
Jennifer Pettis, RN, WCG, RAC-MT, C-NE

EMPHASIZING:
QI/QM
Value-Based Purchasing
Audits
Survey
Consumer Reporting
QAPI

INTENSIVE 3
Focus on . . . Reimbursement
Ron Orth, RN, NHA, CPC, RAC-MT
Christine Openshaw, MA CCC, RAC-CT
Lisa Hohlbein, RN, BS, RAC-MT

EMPHASIZING:
MDS 3.0
RUG-IV/PPS
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Medicare Reimbursement
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AANAC Comments on the Notice of Proposed Rule Making

CMS Survey—Cert Letter S&C.11-31-NH: MDS Modifications and Nursing Home Compare (7/11)

CASPER Reporting User’s Guide for MDS Providers—UPDATED (7/11)

Reimbursement Tip

An ER visit does not interrupt the 100 Part A days if the resident was never an ‘inpatient’ of a hospital.

Ronald A. Orth, President
Clinical Reimbursement Solutions
Milwaukee, WI

Treatment of Members Policy

AANAC has posted the Treatment of Members Policy on the website. If you need to access it, please click here.

FAQ referral

Do you have a question you need answered NOW? Members of AANAC can go directly to the experts! Go to the FAQ section of the website. The answer may be right in front of you!

Unscramble the following words to answer the corresponding statement above each scrambled word. Transfer the shaded letters to the shaded area below to answer the following question regarding the CMS proposed final rule changes discussed in the May 17 Leader.

The current assessment schedule allows the first 30 days of payment to be based on days 5 – 11 of what period?

What did Ultra High Rehab do to budget neutrality?

CMS is concerned providers are using too many of these in MDS preparation.

Task 4 – What does it include?

Betty Frandsen teaches us to prepare for what?
What documentation is required to be able to use the 042 ICD-9 code to qualify for the 128% AIDS add-on? Also, is this code blocked if transmission is attempted?

CMS does not have specific documentation requirements. However, in order to use the 042 code, the resident needs to have documented (like all diagnosis) an active symptomatic HIV infection. If you look up the code, the physician could document any of the following:

- AIDS
- AIDS Related Complex
- Symptomatic HIV Infection

Keep in mind that if a person is HIV+ only, then ICD-9 042 is not the correct code.

There is no block to transmitting this code on the UB-04 claim form. While some states have a block on submitting the 042 diagnosis code on the MDS, the same rule does not apply to submitting the 042 diagnosis on the UB-04.

Ronald A. Orth, RN, NHA, CPC, RAC-MA
(raorth@clinicalreimbursement.com)

A Part A resident was admitted 6/14/11 and then discharged return not anticipated on 6/28/11 to an assisted living facility (ALF). It was decided she was not ready for AL and was readmitted to our SNF on 6/29/11 under the same Part A benefit period. On the Entry tracking record, should A2400A (Has the resident had a Medicare-covered stay since the most recent entry?) be coded no? Or should it be yes because Medicare will continue under previous benefit period?

Since she was discharged with return not anticipated, it is a new admission. Code the Entry tracking record as “admission.” A new Admission assessment will be required. The first assessment done will be the 5-day rather than the Readmission/Return assessment, since the resident was discharged with return not anticipated. A2400A will be “yes,” since Part A started again on readmission, and A2400B will be 6/29, the start date of the most recent Medicare stay. You are picking up the count of Medicare days where you left off but are re-starting the PPS schedule at day 1.

Carol Maher, RN-BC, RAC-CT (cmaher0121@earthlink.net)

For J0100, Pain Management, can you count Celebrex for arthritis pain and Neurontin if ordered and used for pain?

If the Neurontin is used to directly target neuropathic pain, then, yes, this would be included.

NSAIDs such as Celebrex actually target the arthritis inflammation—decreasing the inflammation decreases the pain. According to the RAI User’s Manual, “This item does not include medications that primarily target treatment of the underlying condition, such as chemotherapy or steroids, although such treatments may lead to pain reduction” (ch. 3, p. J-1). However, I think many folks are not distinguishing between the use of NSAIDs for inflammation versus targeting pain directly and are capturing them as pain relievers even for conditions such as arthritis. When in doubt, contact your state RAI coordinator.

Rena R. Shephard, MHA, RN, RAC-MT, C-NE (RRS2000@aol.com)

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MDSCRAMBLER Answer Key

ADMISSION
4. Get out on the floor to discuss ADL ability.

Sometimes due to time constraints or even habit, MDS nurses rarely leave the MDS office and rely strictly on documentation to code the MDS. “Talking to staff and to the residents is extremely important,” says Myhre. “Schedule your discussion around a time for actual observation of ADLs. This strategy has several benefits. It gives the MDS nurse an opportunity to teach CNAs correct coding. It also ensures that documentation is capturing what is the resident’s actual ability and not what the CNA thinks the resident should be doing. It also gives CNAs the opportunity to ask questions and shows them that the MDS nurse is interested in how they take care of their residents. Taking the time upfront to do these teaching moments on a routine basis should save time in the long run because MDS nurses can be more confident in the accuracy of the CNA documentation.”

Talking to staff and observing them in action is the best way to identify coding inaccuracies, notes Myhre. For example, when Myhre teaches, she often finds that CNAs who lift a resident’s legs from a sitting position into bed code that as limited assistance because they “didn’t do anything else for the resident.” Teaching staff at the bedside can help MDS nurses address such misunderstandings, she points out.

5. Educate constantly.

Some MDS nurses limit staff education to an annual inservice on ADL coding. However, once-a-year ADL education isn’t going to ensure accurate coding, says Myhre. “You need to teach on a routine basis (e.g., monthly or quarterly), or you will end up with CNAs misunderstanding the definitions or copy-cat charting.”

It’s also important for MDS nurses to go beyond a verbal teaching method. “Don’t tell them—show them,” stresses Myhre. “CNAs have a wide variety of educational abilities, so if you just say the words without explaining or showing the concepts, I don’t see that they understand it as well as if you use an actual resident or if you do role-play.”

Myhre offers these additional tips on educating CNAs:

- Develop scenarios to show examples of bed mobility coding and use an empty room to provide a “teaching moment.”

- Create an “ADL of the month” segment for monthly inservices. “Take 15 minutes and use scenarios with quizzes and prizes,” she suggests. “Have the staff think of scenarios, and see the examples of coding for bed mobility on pages G-8 and G-9 of Chapter 3 of the MDS 3.0 RAI User’s Manual.”

- Develop an “MDS ADL team.” This will allow the CNAs to be directly involved in resident care options, she notes. “The team can meet as the facility deems necessary to discuss residents’ ADL ability and coding; residents’ functional rehabilitation potential; and what the direct-care workers can do to help the residents reach their maximum potential.”

Editor’s note: To find out when Myhre is teaching, see the AANAC 2011 Workshop Schedule, page 12.
# AANAC 2011 Workshop Schedule

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