



Oklahoma State
Department of Health

NEWS YOU CAN USE

Oklahoma State Department of Health
Quality Improvement & Evaluation Service (405) 271-5278
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MDS

Special points of interest:

- Exercise
- Director's Corner: the Governor's Healthy Aging Summit
- MDS Q and A
- Automation Tips, Reminders & Updates

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Exercise: the healthiest thing a person can do -Wanda Roberts, RN

It is conventional wisdom that exercise is good for you. Despite this knowledge individuals continue to live out a sedentary existence. In fact, the World Health Organization (WHO) listed physical inactivity as the world's fourth leading cause of global mortality. In the United States only about 40% of Americans get enough exercise. Among the states, Oklahoma ranks as the 44th least active state in the na-

tion.¹ The risks of being sedentary have been documented in hundreds of studies. Frequently, when older people lose the capability of doing things on their own, it doesn't come about just because they've aged. It usually occurs when they are not active. Lack of physical activity also can lead to more doctor visits, hospitalizations, and medication use. Living a long and healthy life is best achieved by exercising regularly. In fact,

studies continue to show that exercising and being physically active improve the health and well-being of all people including those who are frail and aging.

One 10 year study done by the British Medical Journal showed that men past middle age who changed their physical activity levels from low to high achieved the same physical benefit at the close of the study as those who had (continued on page 2)

Director's Corner: Diane Henry, RN

On December 15, 2014, Governor Mary Fallin kicked off an Oklahoma initiative to improve the health of older adults over the next four years. Over 300 individuals representing health care organizations and associations, tribal organizations, nursing homes, and private citizens registered for the governor's "Healthy Aging Summit: Living Longer Better".

The purpose of the summit was to reach agreement on statewide goals for significant improvements in health outcomes for older adults.

The keynote speaker was Dr. Roger Landry, President of Masterpiece Living and author of "Live Long,

Die Short: A Guide to Authentic Health and Successful Aging." Dr. Landry shared many "Pearls of Wisdom". One that stood out included, to live a healthier lifestyle, people should:

- Move around
- Have a strong social network
- Make sure everyone in the community has a role or purpose
- Work for the higher purpose of survival

Dr. Landry encouraged all Oklahomans to get up and move throughout the day. Moving more would not only lead to a decrease in falls, it would also improve balance, chronic diseases, GI tract motility and even mood.

"This is a critical time to hold a summit for healthy aging in Oklahoma. While we have many challenges in Oklahoma, we are well positioned to build on and strengthen innovative partnerships to drive dramatic improvements in the health of our older adults," said Dr. Terry Cline, Commissioner and Secretary of Health and Human Services.

(Adapted from the Oklahoma State Department of Health's Summary Report on the Governor's Healthy Aging Summit).

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Exercise (continued from page 1)

started the study with a high activity level. The conclusion of this study was that someone who becomes physically active has the same impact on their longevity as one who stops smoking.

Actually, there are a number of remarkable benefits resulting from exercise. Increasingly literature strongly proposes that exercise may diminish cognitive impairment and reduce dementia risks. One study among individuals with dementia or cognitive impairment revealed that after 6-12 months of exercise their cognitive scores were improved compared with sedentary controls. The study concluded that ongoing, moderate-intensity physical exercise should be considered as a remedy for decreasing cognitive risks and reducing cognitive decline in all ages.²

Exercise has also shown (counterintuitively to some) to improve on symptoms associated with osteoarthritis. Strength training exercises performed by men and women for eight weeks resulted in decreased pain and greater mobility than in those who did not strength train. Staying active is also the most important thing that can be done to maintain a healthy back. Experts believe that regular exercise benefits by strengthening back and abdominal muscles and therefore averting pain.

Regular, moderate physical activity can also elevate your mood. It is useful in managing stress, and being active on a regular basis may help reduce feelings of depression.

Studies also suggest that exercise can help improve or maintain the ability to shift quickly between tasks, plan an activity, and ignore irrelevant information.³

When older adults cannot do the recommended amounts of physical activity due to health conditions, they should be as physically active as their abilities and conditions allow.⁴

Studies also show that regular exercise also lowers your risk of heart attack, coronary artery disease, type 2 diabetes, high blood pressure, stroke, breast and colon cancer, and obesity. It helps reduce insomnia, improves strength, balance and coordination which in turn decreases the risk of falling, fracturing a bone, or receiving a head injury.

Aerobic or moderate physical activity for the elderly is defined by the WHO as including: "leisure time physical activity (for example: walking, dancing, gardening, hiking, swimming), transportation (e.g. walking or cycling), occupational (if the individual is still engaged in work), household chores, play, games, sports or planned exercise, in the context of daily, family, and community activities."⁴

In order to improve overall health and reduce the risk of

non-communicable diseases, depression, and cognitive decline the WHO recommends the following for aged adults:

- To do at least 150 minutes of moderate-intensity aerobic physical activity in any time combination throughout the week. For example: 10 min increments 3 times a day.
- Aerobic activity should be performed in bouts of at least 10 minutes duration
- For additional health benefits, older adults should increase their moderate-intensity aerobic physical activity to 300 minutes per week
- Older adults, with poor mobility, should perform physical activity to enhance balance and prevent falls on 3 or more days per week
- Muscle-strengthening activities, involving major muscle groups, should be done on 2 or more days a week
- When older adults cannot do the recommended amounts of physical activity due to health conditions, they should be as physically active as their abilities and conditions allow.⁴

1.OSDH State of the States Health 2014 <http://www.ok.gov/health/pub/boh/state/>
 2.John Hopkins Medical Letter Health After 50, 2009 Sept; 21(7):4-5: Exercise: the universal antidote for aging.
 3.Exercise: Benefits of Exercise. (2015, January 1). Retrieved from <http://nihseniorhealth.gov/exerciseforolderadults/healthbenefits/01.html>
 4.Physical Activity and Older Adults. (2015, January 1). Retrieved from http://www.who.int/dietphysicalactivity/factsheet_olderadults/en/



George Burns (who lived to be 100) used to say, "If I knew I was going to live this long, I would have taken better care of myself!"

MDS Coding Tips: ADLs Section G

“Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being...”
(Code of Federal Regulation, 42 CFR 483.25)

When coding ADLs in section G consider all episodes of the activity that occurred during the 7-day look-back period to gain the most accurate coding of the resident’s self-performance. There may be a wide variation in the resident’s performance depending on the time of day, medical condition, level of fatigue, staff assisting, etc.

The responsibility of the person completing the assessment is to give the most accurate overall picture of the resi-

dent’s performance during the look-back period. To promote the residents’ highest level of functioning the staff must identify what the resident is able to do for him/herself. Staff should make a record of when assistance is received and clarify the type and level of assistance provided by each discipline.

If a resident uses special adaptive devices such as a walker, device to assist with socks, a dressing stick, long-handled grabber, or adaptive eating utensils, code ADL Self-

Performance and ADL Support Provided based on the level of assistance the resident requires when using such items.

ADL ASPECTS

Components of an ADL activity. These are listed next to the activity in the item set. For example, the components of G0110G (Dressing) include: how the resident puts on, fastens and takes off all items of clothing, including donning/removing a prosthesis or TED hose.

MDS Questions and Answers

Following are Q&As that were discussed during our December MDS 3.0 Clinical Training. Responses are from the RAI Manual currently in effect:

Q1. When coding management of an ostomy under toileting in Section G does this include staff “managing” the ostomy or just the resident?

A1. First identify what the resident is able to do for him/herself, noting type and level of assistance provided by staff, if needed. If the resident required oversight, encouragement or cueing three or more times in the 7-day look-back period, then code as Supervision in column 1 and for column 2, determine if setup help only or one person assist.

Q2. How do we code if staff are required to push the resident in the wheelchair?

A2. Since ADL’s are coded based on the Rule of 3, the following scenario will be

used in order to provide an accurate response: Mr. B is an 80 year old male who was admitted to the nursing home with a wound on his right foot due to Mr. B stepping on a sharp object and then falling, causing a second wound on his left hand. The MDS Coordinator is now preparing to complete Mr. B’s Quarterly assessment. She notices the doctor ordered no weight bearing on Mr. B’s right leg until wound healed on his foot. Due to the wound on his left hand, Mr. B was unable to self-propel his wheelchair (W/C). Therefore, staff members had to push Mr. B in his W/C multiple times and adjust the foot pedals for Mr. B to raise his legs and place his feet on the pedals. The last 2 days of the look-back period, the MDS Coordinator notices documentation in the medical record that the wounds on Mr. B’s right foot and left hand had healed and the doctor discontinued wound care. Physical Therapy was ordered to evaluate and

treat for strengthening and ambulation training with a walker. Therefore, for the 7-day look-back period, staff members pushed Mr. B in his W/C 25 times, but not every time.

In response to this specific scenario, the coding would be extensive assistance. The resident is in the W/C, which now contains the resident’s weight, so the staff are providing weight bearing assistance.

Q3. The nursing home sent a resident to the ER for complications following a hip fracture. The resident died while in the ER due to an embolism. Should the nursing home complete a Death in Facility or a Discharge assessment?

A3. Since the resident was admitted to the hospital and treated in the ER, a Discharge assessment would be completed. Refer to your documentation and the resident’s status at the time of discharge to determine if the Discharge is coded Return anticipated or Return not anticipated.



MDS Automation Tips

Bob Bischoff—Program Manager, MDS/OASIS Automation

Do you have a 3rd party vendor submitting for you?

In the event you do have a 3rd party vendor, what safeguards are in place for ensuring that the validation reports are reviewed for warnings and rejected error record messages. What communication level exists between you and the vendor? I would like to share a scenario with you that occurred since our last newsletter. First, I received a call from the State surveyor regarding the lack of data appearing on the QM report. I advised the surveyor of numerous records that rejected and some large gaps of time between submissions. I later received a call from the MDS coordinator at the facility and advised her of the same information. She was quite surprised and asked who her vendor was. I was unable to answer, as this is an agreement between her facility and the vendor. Later she called again, as she needed passwords to access various CASPER reports. We eventually accomplished the task and about 5 days later she could verify the reports. Unfortunately for this facility, it was too late as they were already out of compliance. I share this with you because my goal is to do my best to assist you in maintaining compliance with the submission requirements. More and more surveys are going to be the Quality Indicator Survey (QIS) and much of this survey is MDS driven. I recommend you review validation reports and utilize the Quality Measure (QM) reports for any possible red flags in order to remain compliant. Please contact our office for any assistance needed.



HOSPICE Discharge

The topic of Hospice discharge and the requirement of completing a Significant Change in Assessment (SCSA) came up during our December MDS 3.0 Clinical Workshop as one of the Q&A's. Due to the discussion, we felt all nursing homes could benefit from the clarification below:

The RAI Manual is quite clear on the requirements which are listed on pages 2-21 and 2-22, of the manual currently in effect. A SCSA is required to be performed when a resident is receiving hospice services and then decides to discontinue those services (known as revoking of hospice care). The assessment reference date (ARD) must be within 14 days from one of the following: 1) the effective date of the hospice election revocation (which can be the same or later than the date of the hospice election revocation statement, but not earlier than); 2) the expiration date of the certification of terminal illness; or 3) the date of the physician's or medical director's order stating the resident is no longer terminally ill. So the key in determining if the SCSA is required due to discharge from HOSPICE is based on one of the three as stated above. Clarification related to this should be directed to the HOSPICE to determine if the HOSPICE is discharging for any of the above reasons. It is recommended that you request documentation from the hospice company regarding how they view the change in level of care (e.g. discharge to hospital). Contact us, your Oklahoma QIES Help Desk for any questions.

Contact Us!

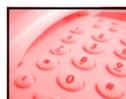
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Automation Tip: Assessments are being transmitted late. Please review the OBRA submission timelines on pages 2-15 and 2-16 in order to remain compliant with the regulation. All other submission timelines are located on page 5-3 of the RAI manual under the category of transmitting data.

To summarize, submit within 14 days of completion.

MARK YOUR CALENDAR!

Upcoming MDS Training (Tentative)

Automation

April 9, 2015

Shawnee

3 Day Clinical Training

June 10-12, 2015

OKC

Automation

October 14, 2015

Shawnee

3 Day Clinical Training

December 9, 2015

Shawnee



Website:

<http://mds.health.ok.gov>