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Medicare/Medicaid: Resident Assessment In Long Term Care Facilities- HCFA's New Rule.

The Health Care Financing Administration (HCFA) on December 23, 1997 issued a final rule that establishes a resident assessment instrument for long term care facilities participating in the Medicare and Medicaid programs for use when conducting periodic assessments of residents' functional capacity.

The resident assessment instrument (RAI) consists of a minimum data set (MDS) of elements, common definitions, and coding categories needed to perform a comprehensive assessment of a long term care facility resident.

According to HCFA, the use of a resident assessment instrument is intended to produce a comprehensive, accurate, standardized, reproducible assessment of each long term care facility resident's functional capacity.

Each state can require use of the standard Federal resident assessment instrument or an alternative instrument designated by the state and approved by HCFA.

We have reproduced here all of the new changes to Section 483.20, which is aimed directly at long term care facilities.

We have also included some of the changes to Section 483.315, which is aimed at state agencies. It specifies some of the core Federal requirements for states in defining assessment criteria for long term care facilities in the state.

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By way of background, HCFA published its proposed rule for a resident assessment instrument for long term care in December, 1992. HCFA's December, 1997 announcement of its final rule includes an extraordinarily complex discussion of the official public comments that were submitted following publication of its December, 1992 proposed rule, and of the rationales behind specific elements of the final rule, which due to length we are unable to reproduce.

The effective date is March 23, 1998 (except for the facility computerization requirements which take effect June 22, 1998.)
FEDERAL REGISTER, December 23, 1997

REQUIREMENTS FOR STATES AND LONG TERM CARE FACILITIES

Sec. 483.20 Resident assessment in long term care facilities.
(Note that paragraphs (b) and (c) are newly revised and new paragraphs (d) through (j) are being added to read as follows:)

(b) Comprehensive assessments.

(1) Resident assessment instrument. A facility must make a comprehensive assessment of a resident's needs, using the resident assessment instrument (RAI) specified by the State. The assessment must include at least the following:

(i) Identification and demographic information.
(ii) Customary routine.
(iii) Cognitive patterns.
(iv) Communication.
(v) Vision.
(vi) Mood and behavior patterns.
(vii) Psychosocial well-being.
(viii) Physical functioning and structural problems.
(ix) Continence.
(x) Disease diagnoses and health conditions.
(xi) Dental and nutritional status.
(xii) Skin condition.
(xiii) Activity pursuit.
(xiv) Medications.
(xv) Special treatments and procedures.
(xvi) Discharge potential.
(xvii) Documentation of summary information regarding the additional assessment performed through the resident assessment protocols.
(xviii) Documentation of participation in assessment.

The assessment process must include direct observation and communication with the resident, as well as communication with licensed and nonlicensed direct care staff members on all shifts.

(2) When required. A facility must conduct a comprehensive assessment of a resident as follows:

(i) Within 14 calendar days after admission, excluding readmissions in which there is no significant change in the resident's physical or mental condition. (For purposes of this section, "readmission" means a return to the facility following a temporary absence for hospitalization or for therapeutic leave.)

(ii) Within 14 calendar days after the facility determines, or should have determined, that there has been a significant change in the resident's physical or mental condition. (For purposes of this section, a "significant change" means a major decline or improvement in the resident's status that will not normally resolve itself without further intervention by staff or by implementing standard disease-related clinical interventions, that has an impact on more than one area of the resident's health status, and requires interdisciplinary review or revision of the care plan, or both.)

(iii) Not less often than once every 12 months.

(c) Quarterly review assessment. A facility must assess a resident using the quarterly review instrument specified by the State and approved by HCFA not less frequently than once every 3 months.

(d) Use. A facility must maintain all resident assessments completed within the previous 15 months in the resident's active record and use the results of the assessments to develop, review, and revise the resident's comprehensive plan of care.

(e) Coordination. A facility must coordinate assessments with the preadmission screening and resident review program under Medicaid in part 483, subpart C to the maximum extent practicable to avoid duplicative testing and effort.

(f) Automated data processing requirement. (1) Encoding data. Within 7 days after a facility completes a resident's assess-

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ment, a facility must encode the following information for each resident in the facility:

(i) Admission assessment.

(ii) Annual assessment updates.

(iii) Significant change in status assessments.

(iv) Quarterly review assessments.

(v) A subset of items upon a resident's transfer, reentry, discharge, and death.

(vi) Background (face-sheet) information, if there is no admission assessment.

(2) Transmitting data. Within 7 days after a facility completes a resident's assessment, a facility must be capable of transmitting to the State information for each resident contained in the MDS in a format that conforms to standard record layouts and data dictionaries, and that passes standardized edits defined by HCFA and the State.

(3) Monthly transmittal requirements. A facility must electronically transmit, at least monthly, encoded, accurate, complete MDS data to the State for all assessments conducted during the previous month, including the following:

(i) Admission assessment.

(ii) Annual assessment.

(iii) Significant change in status assessment.

(iv) Significant correction of prior full assessment.

(v) Significant correction of prior quarterly assessment.

(vi) Quarterly review.

(vii) A subset of items upon a resident's transfer, reentry, discharge, and death.

(viii) Background (face-sheet) information, for an initial transmission of MDS data on a resident that does not have an admission assessment.

(4) Data format. The facility must transmit data in the format specified by HCFA or, for a State which has an alternate RAI approved by HCFA, in the format specified by the State and approved by HCFA.

(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public.

(ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so.

(g) Accuracy of assessments. The assessment must accurately reflect the resident's status.

(h) Coordination. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals.

(i) Certification. (1) A registered nurse must sign and certify that the assessment is completed.

(2) Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment.

(j) Penalty for falsification. (1) Under Medicare and Medicaid, an individual who willfully and knowingly--

(i) Certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or

(ii) Causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than $5,000 for each assessment.

(2) Clinical disagreement does not constitute a material and false statement.

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Subpart F--Requirements That Must be Met by States and State Agencies, Resident Assessment

Sec. 483.315 Specification of resident assessment instrument.

(b) ...The RAI that the State specifies must be one of the following:

(1) The instrument designated by HCFA.

(2) An alternate instrument specified by the State and approved by HCFA, ...

(3) After specifying an instrument, the State must provide periodic educational programs for facility staff to assist with implementation of the RAI.

(e) Minimum data set (MDS). The MDS includes assessment in the following areas:

(1) Identification and demographic information, which includes information to identify the resident and facility, the resident's residential history, education, the reason for the assessment, guardianship status and information regarding advance directives, and information regarding mental health history.

(2) Customary routine, which includes the resident's lifestyle prior to admission to the facility.

(3) Cognitive patterns, which include memory, decision making, consciousness, behavioral measures of delirium, and stability of condition.

(4) Communication, which includes scales for measuring hearing and communication skills, information on how the resident expresses himself or herself, and stability of communicative ability.

(5) Vision pattern, which includes a scale for measuring vision and vision problems.

(6) Mood and behavior patterns, which include scales for measuring behavioral indicators and symptoms, and stability of condition.

(7) Psychosocial well-being, which includes the resident's interpersonal relationships and adjustment factors.

(8) Physical functioning and structural problems, which contains scales for measuring activities of daily living, mobility, potential for improvement, and stability of functioning.

(9) Continence, which includes assessment scales for bowel and bladder incontinence, continence patterns, interventions, and stability of continence status.

(10) Disease diagnoses and health conditions, which includes active medical diagnoses, physical problems, pain assessment, and stability of condition.

(11) Dental and nutritional status, which includes information on height and weight, nutritional problems and accommodations, oral care and problems, and measure of nutritional intake.

(12) Skin condition, which includes current and historical assessment of skin problems, treatments, and information regarding foot care.

(13) Activity pursuit, which gathers in-

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formation on the resident's activity preferences and the amount of time spent participating in activities.

(14) Medications, which contains information on the types and numbers of medications the resident receives.

(15) Special treatments and procedures, which includes measurements of therapies, assessment of rehabilitation/restorative care, special programs and interventions, and information on hospital visits and physician involvement.

(16) Discharge potential, which assesses the possibility of discharging the resident and discharge status.

(17) Documentation of summary information regarding the additional assessment performed through the resident assessment protocols.

(18) Documentation of participation in assessment.

(f) Resident assessment protocols (RAPs). At a minimum, the RAPs address the following domains:

(1) Delirium.
(2) Cognitive loss.
(3) Visual function.
(4) Communication.
(5) ADL functional/rehabilitation potential.
(6) Urinary incontinence and indwelling catheter.
(7) Psychosocial well-being.
(8) Mood state.
(9) Behavioral symptoms.
(10) Activities.
(11) Falls.
(12) Nutritional status.
(13) Feeding tubes.
(14) Dehydration/fluid maintenance.
(15) Dental care.
(16) Pressure ulcers.
(17) Psychotropic drug use.
(18) Physical restraints.

FEDERAL REGISTER, December 23, 1997
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