Providing Patient Centered Care in Skilled Nursing Facilities
ISHA Saturday, April 16 - 12:30 - 2:30 pm
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Abstract
- Providing speech therapy services in skilled nursing facilities can be a daunting and rewarding experience.
- This session will describe roles of key interdisciplinary team members, including AR and audiology collaboration (hearing loss in geriatrics), discuss medical complexities affecting clinical decision making, describe methods for identifying resident change and provide regulatory guidance for “skilled care” by a speech-language pathologist/audiologist.

OBRA 1987

The Omnibus Budget Reconciliation Act of 1987 (OBRA ’87) dramatically changed the way Skilled Nursing Facilities (SNFs) approached resident care, radically modifying nursing home regulations and the survey process.

The federal government established a requirement for comprehensive assessment as the foundation for planning and delivering care to nursing home residents.

Mandated that facilities “provide necessary care and services to help each resident attain or maintain their highest practicable physical, mental, and psychosocial well-being” and “ensure that the resident obtains optimal improvement or does not deteriorate within the limits of a resident’s right to refuse treatment, and within the limits of recognized pathology and the normal aging process.”

(CFR 42, Part 483.25

Determining Need for Skill

- Evidenced Based Practice
- Complexity and Sophistication
- Medical Diagnoses
- Individualized Frequency and Duration

Evidenced Based Practice

The services shall be considered under accepted standards of medical practice to be a specific and effective treatment for the patient’s condition. Acceptable practices for therapy services are found in:
- Medicare manuals (such as this manual and Publications 100-03 and 100-04),
- Contractors Local Coverage Determinations (LCDs and NCDs are available on the Medicare Coverage Database: http://www.cms.hhs.gov/mcd and
- Guidelines and literature of the professions of physical therapy, occupational therapy and speech-language pathology.

To be considered reasonable and necessary, the following conditions must be met: (CMS Publication 150-02, Medicare Benefit Policy Manual, Chapter 15, Section 250.2(b))
The services shall be of such a level of complexity and sophistication or the condition of the patient shall be such that the services required can be safely and effectively performed only by a qualified therapist. Services that do not require the performance or supervision of a therapist are not skilled and are not considered reasonable or necessary therapy services, even if they are performed or supervised by a qualified professional. If the contractor determines the services furnished were of a type that could have been safely and effectively performed only by or under the supervision of such a qualified professional, it shall presume that such services were properly supervised when required. However, this presumption is rebuttable, and, if in the course of processing claims it finds that services are not being furnished under proper supervision, it shall deny the claim and bring this matter to the attention of the Division of Survey and Certification of the Regional Office. To be considered reasonable and necessary, the following conditions must be met: (CMS Publication 100-02, Medicare Benefit Policy Manual, Chapter 15, Section 220.2(B))

Complexity and Sophistication

- The services shall be of such a level of complexity and sophistication as the condition of the patient shall be such that the services required can be safely and effectively performed only by a qualified therapist.
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Medical Diagnoses

- While a beneficiary’s particular medical condition is a valid factor in deciding if skilled therapy services are needed, a beneficiary’s diagnosis or prognosis should never be the sole factor in deciding that a service is or is not skilled. The key issue is whether the skills of a qualified therapist are needed to treat the illness or injury, or whether the services can be carried out by non-skilled personnel. See item C for descriptions of skilled (rehabilitative) services.

Medical History

Onset or Exacerbation Date

- Onset/Exacerbation Date: the date of the functional change which as a result of dx indicated the need for skilled care
- Chronic Conditions: May not be the date of dx for condition, however related to exacerbation of dx process
- New Conditions: CVAs/TBI will be date of new insult

In conjunction current symptoms

- Provide correlation of why new onset has resulted in symptoms requiring your unique skilled services.

To be considered reasonable and necessary, the following conditions must be met: (CMS Publication 100-02, Medicare Benefit Policy Manual, Chapter 15, Section 220.2(B))

Frequency and Duration

- There must be an expectation that the patient’s condition will improve significantly in a reasonable (and generally predictable) period of time, or the services must be necessary for the establishment of a safe and effective maintenance program required in connection with a specific disease state. In the case of a progressive degenerative disease, service may be intermittently necessary to determine the need for assistive equipment and/or establish a program to maximize function (see item D for descriptions of maintenance services); and
- The amount, frequency, and duration of the services must be reasonable under accepted standards of practice. The contractor shall consult local professionals or the state or national therapy associations in the development of any utilization guidelines.

Key Facility IDT

- Administrators, Owners. May be “in-house” or contract therapy.
- Therapy Providers- PT, OT, ST, PTA and COTA, note that Medicare does not recognize SLPAs as providers.
- Nursing- Director of Nursing, RN, LPN, CNAs.
- Dietary- Registered Dietician, Dietary Manager, Dietary Assistants
- Social Worker
- Residents, Family Members

Speech Pathology- Reasons for Referral

- Coughing, throat clearing, watery eyes and/or runny nose at meals
- Decreased PO intake
- Increased time to complete meals/SOB at meals
- Refusal to eat/painful swallowing
- Decreased ability to respond to ?s, ability to communicate needs, decreased vocal loudness, and for ability to follow commands
- Increased forgetfulness
- Poor attention to task, problem solving and/or safety awareness
Physical Therapy - Reasons for Referral

- Shuffle Gait
- Unsteady Gait
- Frequent Falls
- Weakness
- Pain
- Open Wound
- Swelling
- Contractures

- Unable to get in/out of bed
- Needs help to walk or transfer
- Limited ROM
- Unable to maneuver w/c
- Leg splint causing redness
- Restraint needs

Occupational Therapy - Reasons for Referral

- Weakness
- Contractors
- Difficulty Dressing
- Vision Problems
- Restraint Needs
- Difficulty grooming
- Limited Range of motion
- Unable to follow directions

- Poor problem solving skills
- Unable to get on or off the toilet
- Unable to use hand in task
- Hand/wrist splint causing redness
- Memory problems

Individual Therapy

- Individual Therapy
  - Therapy provided on an individual basis
  - “One on one”

Individual Therapy Example

- Mr. Weary is receiving SLP services for dysphagia. He received one on one treatment time of 30 minutes.

  - MDS Record:
    - Individual Therapy = 30 minutes
    - All 30 minutes are counted toward MDS

Concurrent Therapy

- Concurrent Therapy
  - Treatment of 2 residents at the same time, when the residents are not performing the same or similar activities, regardless of payor source, both of whom must be in line-of-sight of the treating therapist for Part A.
  - When a Part A resident receives therapy that meets this definition, it is defined as concurrent therapy for the Part A resident, regardless of the payor source of the second resident.

Concurrent Therapy Example

- Tammy Therapist is treating two Part A patients. She assists Mr. A with Therapeutic Exercises in order to improve Lower Extremity strength due to knee buckling during gait. She also performs interventions with Ms. B for balance activities. She goes back and forth between the two patients. Total treatment time is 20 minutes.

  - MDS Record:
    - Concurrent for each patient is 20 minutes.
    - 10 minutes is counted toward RUG.
Group Therapy

- Part A: as the treatment of 4 residents, regardless of payor source, who are performing the same or similar activities.
- Part B: treatment of two patients or more, regardless of payor source, at the same time.

Group Therapy Example

Ollie, OT, is performing a Group activity with 4 patients for cooking. While in the activity, the patients work on fine motor skills for chopping and measuring, balance activities by reaching in cabinets and cognition by ability to follow directions. The treatment for all 4 patients lasts one hour.

- MDS Record:
  - Group Therapy: 60 minutes for all four patients
  - 15 minutes are counted toward RUG score

Co-Treatment

- Part A:
  - When two clinicians, each from a different discipline, treat one resident at the same time with different treatments, both disciplines may code the treatment session in full.
- Part B:
  - Therapists, or therapy assistants, working together as a “team” to treat one or more patients.
  - Cannot bill separately for the same or different service provided at the same time to the same patient.

Co Treatment Example: ST/OT

Speech and Occupational Therapy may provide co-treatment to an individual during meal time in order to yield greater meal time functional outcomes for an individual with dysphagia in addition to self feeding deficits.

Co Treatment Example PT/ST

Physical and Speech Therapy may provide co-treatment for an individual who presents with gait disturbance in addition to cognitive impairments affecting their abilities to negotiate obstacles in facility in order to yield greater functional outcomes for ability to ambulate throughout environment.

Medical Complexities
Reason for Referral

- Patient referred to ST due to decline of cognitive-communicative deficits and patient is now unable to perform executive function abilities secondary to lack of spontaneous recovery following hospitalization.
- Current Medical Hx: Current medical hx includes but not limited to: UTI, HTN, GERD, COPD, and dementia, AMS
- Past Medical History: PMH includes but not limited to: UTI, HTN, dementia, GERD, COPD, T12 compression fx, acute back pain, TIA, R wrist fx

Delirium- DSM IV

Disturbance of Consciousness (i.e. reduced clarity of awareness of the environment) with reduced ability to focus, sustain, or shift attention
- Not due to a pre-existing, established, or evolving dementia
- Disturbance develops over a short time (usually hours to days), and tends to fluctuate during the day
- Evidence supports disturbance as caused by the direct physiological consequences of a general medical condition

Dementia and Depression

Assessment Tool- Geriatric Depression Scale
https://www.healthcare.uiowa.edu/igec/tools/depression/GDS.pdf

Prior to Testing Rule Out Depression/Delirium
One widely used screening tool is the Geriatric Depression Scale Short Form
A score of 5 suggests depression, while a score of 10 or more is highly suggestive of depression.

Rule out delirium
Acute disturbance of brain function, associated with physical illness
Results in disturbance of memory, language skills and orientation
Can develop in hours & days; dementia takes months and years

Confusion Assessment Method (CAM)

The Confusion Assessment Method (CAM) includes two parts. Part one is an assessment instrument that screens for overall cognitive impairment. Part two includes only those four features that were found to have the greatest ability to distinguish delirium or reversible confusion from other types of cognitive impairment.

Description
Approximately 15 - 60% of elderly patients experience a delirium prior to or during a hospitalization but the diagnosis is missed in up to 70% of cases. Delirium is associated with poor outcomes such as prolonged hospitalization, functional decline, and increased use of chemical and physical restraints. Delirium increases the risk of nursing home admission. Individuals at high risk for delirium should be assessed daily using a standardized tool to facilitate prompt identification and management. Risk factors for delirium include older age, prior cognitive impairment, presence of infection, severe illness or multiple co-morbidities, dehydration, psychotropic medication use, alcoholism, vision impairment and fractures.

Derived from:

When to screen for potential skilled need?

- UTI, repeat Urinary Analysis (UA) and completed course of Antibiotic Therapy (ABT)
- Surgical Intervention, Discharge from hospital >10 days after surgery/hip fracture.
- Polypharmacy, complete thorough chart review, speak with nursing regarding adjustment to new medications.
What about Chronic/Progressive Conditions?

- COPD/CHF
- Progressive Neurological Diagnoses
- Late Effects CVA

Individuals with Chronic Conditions

- Rehabilitative therapy may be needed, and improvement in a patient’s condition may occur, even when a chronic, progressive, degenerative, or terminal condition exists.
- For example, a terminally ill patient may begin to exhibit self-care, mobility, and/or safety dependence requiring skilled therapy services. The fact that full movement from baseline to plof or partial recovery is not possible does not necessarily mean that skilled therapy is not needed to improve the patient’s condition or to maximize his/her functional abilities.
- The deciding factors are always whether the services are considered reasonable, effective treatments for the patient’s condition and require the skills of a therapist, or whether they can be safely and effectively carried out by non-skilled personnel.

Identification of Functional Changes

Resident Assessment Index

Minimum Data Set (MDS)
- Screening tool to identify possible problems

Care Area Triggers (CATs)
- Clues to possible problems, needs, strengths

Care Area Assessments (CAAs)
- Further, in-depth assessment to identify details of the possible problems, needs, strengths & to draw conclusions about root causes

CAA Summary
- Documentation of triggered CAAs, location of documentation to support care planning

Resident Assessment Index (RAI) Overview

STEP ONE:
The Minimum Data Set (MDS), a screening tool that provides information about the resident’s functional status.

STEP TWO:
Care Area Assessments (CAAs), a set of 20 different assessments that are further, in-depth evaluation of specific functional areas. A CAA must be completed for each care area that is identified as a possible problem, or triggered, as a result of the MDS assessment. After completing the CAA, a clinical decision is made based on the results as to whether the possible problem is in fact a real problem. When a problem is identified, the next step is to determine the root causes and contributing factors for the resident related to the problem, and the need for referrals to other disciplines.

STEP THREE:
Care Plan, the working action plan that is developed based on the findings that result from the CAAs. The development of an individualized, interdisciplinary care plan designed to address the resident’s specific problems, strengths, preferences, risk factors, and complications is the primary purpose of the RAI process.

**WE Want to be HERE**

MDS Sections

| SECTION A. Identification Information |
| SECTION B. Hearing, Speech and Vision |
| SECTION C. Cognitive Patterns |
| SECTION D. Mood |
| SECTION E. Behavior |
| SECTION F. Preferences for customary routine and activities |
| SECTION G. Functional Status |
| SECTION H. Bladder and Bowel |
| SECTION I. Active Diagnoses |
| SECTION J. Health Conditions |
| SECTION K. swallow/Nutritional Status |
| SECTION L. Oral/Dental Status |
| SECTION M. Skin Conditions |
| SECTION N. Medication |
| SECTION O. Special Treatment, Procedures, and Programs |
| SECTION P. Reentries |
| SECTION Q. Participation in Assessment and Goal Setting |
| SECTION R. Care Area Assessment (CAA) Summary |

Detailed breakdown in handout titled MDS 3.0 Coding Tool
Care Area Assessments (CAAs)

CAAs are included in comprehension assessments including: Admission assessment; Annual assessment; Significant Change in Status Assessment; Significant Correction to Prior Comprehensive Assessment. Not required in the Quarterly assessments and the Significant Correction to Prior Quarterly Assessment.

1. Delirium 11. Falls
3. Visual Function 13. Feeding Tube(s)
5. ADLs-Functional Status 15. Dental Care
6. UI & Indwelling Catheter 16. Pressure Ulcer(s)
7. Psychosocial Well-Being 17. Psychotropic Medication Use
8. Mood State 18. Physical Restraints
10. Activities 20. Return to Community Referral

MDS Section B: Hearing Speech Vision

B0100 Comatose
B0200 Hearing
B0300 Hearing Aide
B0600 Speech Clarity
B0700 Makes Self Understood
B0800 Ability to Understand Others
B1000 Vision

B0200 Hearing Scoring

Ability to hear (with hearing aid or hearing appliances if normally used).

0. Adequate - no difficulty in normal conversation, social interaction, listening to TV.
1. Minimal difficulty - difficulty in some environments (e.g., when person speaks softly or setting is noisy).
2. Moderate difficulty - speaker has to increase volume and speak distinctly.
3. Highly impaired - absence of useful hearing

B0300 Hearing Aide Scoring

Hearing aid or other hearing appliance used in completing B0200, Hearing.

0. No
1. Yes

Effect of Hearing Loss

Problems with hearing can contribute to sensory deprivation, social isolation, and mood and behavior disorders.

Unaddressed communication problems related to hearing impairment can be mistaken for confusion or cognitive impairment.

Collaboration with Audiology

Evaluation and treatment for disorders of the auditory system may be covered and medically necessary when it has been determined by a speech-language pathologist in collaboration with an audiologist that the hearing impaired beneficiary's current amplification options (hearing aid, other amplification device or cochlear implant) will not sufficiently meet the patient's functional communication needs. Audiologists and speech-language pathologists both evaluate beneficiaries for disorders of the auditory system using different skills and techniques, but only speech-language pathologists may provide treatment.
Aural Rehabilitation- Medical Necessity

Medically Necessary inclusions:

Auditory processing evaluation and treatment such as those related to neurological impairments or the absence of natural auditory stimulation that results in impaired ability to process sound.

Note: Certain auditory processing disorders require diagnostic audiological tests in addition to speech-language pathology evaluation and treatment.

Speech Therapy- Aural Rehab

Examples of rehabilitation include but are not limited to treatment that focuses on comprehension, and production of language in oral, signed or written modalities; speech and voice production, auditory training, speech reading, multimodal (e.g., visual, auditory-visual, and tactile) training, communication strategies, education and counseling. In determining the necessity for treatment, the beneficiary's performance in both clinical and natural environment should be considered. (MBPM, 2014)

May be indicated for individuals coded at 3 “Highly Impaired”- absence of useful hearing on MDS Section B0200 Hearing

Aural Rehabilitation: Evaluation

Evaluation Inclusions:

Evaluation of comprehension and production of language in oral, signed or written modalities, speech and voice production, listening skills, speech reading, communications strategies, and the impact of the hearing loss on the patient/client and family.

Evaluation 92626 Evaluation of Auditory Rehabilitation Status (first hour); 92627 each additional 30 minutes

Treatment 92507- CMS Instructs use for auditory rehabilitation

B0600 Speech Clarity Scoring

B0600. Speech Clarity.
Select best description of speech pattern.
0. Clear speech - distinct intelligible words.
1. Unclear speech - slurred or mumbled words.
2. No speech - absence of spoken words.

B0700 Language Expression

Ability to express ideas and wants, consider both verbal and non-verbal expression.

0. Understood.
1. Usually understood - difficulty communicating some words or finishing thoughts but is able if prompted or given time.
2. Sometimes understood - ability is limited to making concrete requests.
3. Rarely/never understood

Language Expression Defined

Makes Self Understood Able to express or communicate requests, needs, opinions, and to conduct social conversation in his or her primary language, whether in speech, writing, sign language, gestures, or a combination of these.

Deficits in the ability to make one’s self understood (expressive communication deficits) can include reduced voice volume and difficulty in producing sounds, or difficulty in finding the right word, making sentences, writing, and/or gesturing.
B0800 Language Comprehension

B0800. Ability To Understand Others.

Understanding verbal content, however able (with hearing aid or device if used).

0. Understands - clear comprehension.
1. Usually understands - misses some part/intent of message but comprehends most conversation.
2. Sometimes understands - responds adequately to simple, direct communication only.
3. Rarely/never understands

Language Comprehension Defined

Comprehension of direct person-to-person communication whether spoken, written, or in sign language or Braille.

Includes the resident’s ability to process and understand language. Deficits in one’s ability to understand (receptive communication deficits) can involve declines in hearing, comprehension (spoken or written) or recognition of facial expressions.

Speech Therapy- Motor Speech

Affects:

- Intelligibility- clarity
- Resonance- nasal quality
- Prosody- intonation patterns
- Intensity- loudness
- Coordination between Respiration/Phonation

Often seen associated with decreased vocal/voice functions

- Affecting vocal quality (hoarse, harsh, breathy)
- Also secondary to vocal abusive behaviors; forms of vocal dysfunction; presence of polyps, nodules, etc.

Corresponds with B0600: Speech Clarity

Speech Therapy- Expressive Language

- Reduced ability to complete automatic speech tasks
- Reduced ability to name objects and pictures
- Decreased ability to make needs known across various levels including structured and unstructured interactions with individuals and groups

Corresponds with Section B0700: Makes Self Understood

0- Understood; 1 Usually Understood; 2- Sometimes Understood; 3. Rarely /never understood

Speech Therapy- Receptive Language

Also referred to as Auditory Comprehension

- Reduced ability to discriminate body parts, objects, and pictures
- Reduced ability to follow one-step; two-step and multi-step commands
- Reduced ability to respond to yes/no and open ended questions
- Reduced ability to comprehend conversational interactions

Corresponds with Section B0800: Ability to Understand Others

0- Understands; 1 Usually Understands, 2 Sometimes Understands; 3 Rarely/never understood

Section C: Cognitive Patterns

Intent

The items in this section are intended to determine the resident’s attention, orientation and ability to register and recall new information.

These items are crucial factors in many care-planning decisions.
BIMS Administration

Setting the Optimal Communication Environment

- Reduce background noise
- Ensure resident has adequate sensory awareness including wearing glasses and hearing aids

English as a Second Language Learners

- Review Language item (A1100), to determine if the resident needs or wants an interpreter. If the resident needs or wants an interpreter, complete the interview with an interpreter.

Written Administration

- When staff identify that the resident's primary method of communication is in written format, the BIMS can be administered in writing. The administration of the BIMS in writing should be limited to this circumstance.

CMS Video

http://www.youtube.com/watch?v=Uq4BOnbiYmI
10:39 to 14:04

- Introduce task and ensure understanding
- Utilize slow and simple speech to increase resident’s comprehension
- Sensory Aspects:
  - Hearing: Auditory Trainer
  - Vision: Glasses
  - Temperature

C0100

C0100: Should Brief Interview for Mental Status Be Conducted?

Rationale: Health-related Quality of Life

- Information identifies if the interview will be attempted.
- Most residents are able to attempt the Brief Interview for Mental Status (BIMS).
- A structured cognitive test is more accurate and reliable than observation alone for observing cognitive performance.

Without an attempted structured cognitive interview, a resident might be mislabeled based on his or her appearance or assumed diagnosis.
- Structured interviews will efficiently provide insight into the resident’s current condition that will enhance good care.

Regulation Review: Interviewable Residents

Survey-and-certification memo 12-45-NH, issued by the Centers for Medicare and Medicaid Services (CMS) on Sept. 28 2012, contained the advance interim guidance that updates the traditional survey process that is defined in Tasks 1-5C in Appendix P, “Survey Protocol for Long-term Care Facilities,” of the State Operations Manual (SOM).

Included guidance for surveyors to determine if residents are being appropriately considered “Interviewable”

Interviewable Residents

Interviewable Resident: This is a resident who has sufficient memory and comprehension to be able to answer coherently the majority of questions contained in the Resident Interview. These residents can make day-to-day decisions in a fairly consistent and organized manner.

- To assist in determining if a resident is “interviewable,” consider the results of the resident’s MDS - Brief Interview for Mental Status (BIMS). The BIMS is a brief screening tool that aids in detecting cognitive impairment, but does not assess all possible aspects of cognitive impairment. For resident interview purposes, the results of the BIMS are as follows.
  - If a resident’s BIMS score is:
    - 8-15, the resident may be identified as “Interviewable”; and
    - 0-7 or 99, the resident may be identified as a “Family Interview Candidate.”

State Operations Manual (SOM)

Interviewable Status

- If a resident has language barriers, the surveyor should ask staff if there is someone who serves as an interpreter to talk directly with the resident in order to screen the resident for the interview status. If the resident is interviewable and gives permission, the interpreter could subsequently assist with the interview. If an interpreter is not available, record the resident as “Not Interviewable.” The lack of an interpreter may highlight potential concerns with the facility’s ability to communicate with the resident. If there are concerns with communication, the team could initiate the resident for investigation in either Phase 1 or Phase 2.
- Other barriers could make it challenging to confirm the interview status, such as hearing loss or aphasia. Do not ask the facility staff to identify or confirm a resident’s interview status, but if necessary, find a staff person to assist you in talking with the resident.
Interview Barriers

Do not ask the facility staff to identify or confirm a resident’s interview status, but if necessary, find a staff in person to assist you in talking with the resident.

BIG PICTURE:
Can our staff adequately communicate with residents

Auditory
Verbal Understanding
Verbal Communication

Written Understanding
Written Communication

Where can staff locate BEST Practices for each resident?

C0200: Repetition of 3 words

C0200. Repetition of Three Words.

Ask resident: “I am going to say three words for you to remember. Please repeat the words after I have said all three. The words are: sock, blue, and bed. Now tell me the three words.”

Number of words repeated after first attempt.

0. None.
1. One.
2. Two.
3. Three.

After the resident’s first attempt, repeat the words using cues (‘sock, something to wear; blue, a color; bed, a piece of furniture’). You may repeat the words up to two more times.

C0300: Temporal Orientation

C0300. Temporal Orientation (orientation to year, month, and day).

Ask resident: “Please tell me what year it is right now.”

A. Able to report correct year.
   0. Missed by > 5 years or no answer.
   1. Missed by 2-5 years.
   2. Missed by 1 year.
   3. Correct.

B. Able to report correct month.
   0. Missed by > 1 month or no answer.
   1. Missed by 6 days to 1 month.
   2. Accurate within 5 days.
   3. Incorrect or no answer.

C. Able to report correct day of the week.
   0. Incorrect or no answer.
   1. Correct.

C0400: Recall

C0400. Recall.

Ask resident: “Let’s go back to an earlier question. What were those three words that I asked you to repeat?”

If unable to remember a word, give cue (something to wear; a color; a piece of furniture) for that word.

A. Able to recall “sock”.
   0. No - could not recall.
   1. Yes, after cueing (“something to wear”).
   2. Yes, no cue required.

B. Able to recall “blue”.
   0. No - could not recall.
   1. Yes, after cueing (“a color”).
   2. Yes, no cue required.

C. Able to recall “bed”.
   0. No - could not recall.
   1. Yes, after cueing (“a piece of furniture”).
   2. Yes, no cue required.

Potential Cause of BIMS Difficulty

**Communication between IDT members administering various portions of MDS is crucial**

- Hearing Impairment
  - Review Section B0200 Hearing
- Cognitive Impairment
  - Memory
  - Processing
- Language Barrier
  - Review Language item A 1100
- Language Impairment
  - Expressive- B0700: Makes Self Understood
  - Receptive- B0800: Ability to Understand Others

BIMS Impairment CAA Triggers

Triggers flag conditions that warrant further investigation

1. Delirium
2. Cognitive Loss
5. ADL/Functional Status

A Care Area Trigger is an MDS response indicating that clinical factors exist that may or may not represent a condition that should be care planned. When a resident’s status on a particular MDS item matches one of the CAT’s the care area is triggered for further assessment.
Case Studies/Collaboration
Nursing & Therapy

Ms. Adams is noted with decreased performance on BIMS Section C: 0200 Repetition of 3 words. In addition, she is noted with impairment in B:0200 coded as 2. Moderate difficulty speaker has to increase volume and speak distinctly.

Q: What skilled service may benefit Ms. Adams?
A: Potential ST for Aural Rehabilitation

Mr. Jones is noted with decreased performance on BIMS Section C: 0300 Temporal Orientation for day, week, and year. In addition, he is noted in Section G 0100 to require Supervision—oversight, encouragement, and cueing for Dressing and Bed Mobility.

Q: What skilled service(s) may benefit Mr. Jones?
A: ST and OT as Temporal Orientation assesses environmental orientation. Need for cues with ADL tasks in environment may indicate functional decline related to abilities to effectively complete task in environment with least amount of supervision.

ADL Self-Performance Change Warranting OT Screening

<table>
<thead>
<tr>
<th>MOS Area</th>
<th>OT Referral Secondary to the following</th>
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<tbody>
<tr>
<td>A. Bed Mobility</td>
<td>Decreased strength, ROM and/or coordination of UE affecting ability to</td>
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<td></td>
<td>complete task; Cognitive impairment affecting ability to follow commands.</td>
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<tr>
<td>B. Transfer</td>
<td>Decreased strength, ROM and/or coordination of UE affecting ability to</td>
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<td></td>
<td>complete task; Cognitive impairment affecting ability to follow commands.</td>
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<tr>
<td>G. Dressing</td>
<td>Increased cueing or oversight needed due to cognitive and language</td>
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<td>impairment.</td>
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<tr>
<td>B. Eating</td>
<td>Increased cueing or oversight needed due to cognitive</td>
</tr>
<tr>
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<td>(sequencing the steps, safety awareness and/or problem solving) or</td>
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<td>language impairment (ability to comprehend the spoken language of</td>
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<td>caregivers or express needs).</td>
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<tr>
<td>F. Toilet Use</td>
<td>Increased cueing or oversight needed to follow commands.</td>
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<tr>
<td>J. Personal Hygiene</td>
<td>Decreased strength, ROM and/or coordination affecting ability to complete</td>
</tr>
<tr>
<td></td>
<td>task; Reduced visual field or neglect; Cognitive impairment affecting ability</td>
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<td>to follow commands.</td>
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ADL Self-Performance Change Warranting PT Screening

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<tr>
<th>MOS Area</th>
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<tr>
<td></td>
<td>complete task; Cognitive impairment affecting ability to follow commands.</td>
</tr>
<tr>
<td>B. Transfer</td>
<td>Decreased strength, ROM and/or coordination of UE affecting ability to</td>
</tr>
<tr>
<td></td>
<td>complete task; Cognitive impairment affecting ability to follow commands.</td>
</tr>
<tr>
<td>G. Dressing</td>
<td>Decreased strength, ROM and/or coordination of UE affecting ability to</td>
</tr>
<tr>
<td></td>
<td>complete task; Reduced visual field or neglect; Cognitive impairment</td>
</tr>
<tr>
<td></td>
<td>affecting ability to follow commands.</td>
</tr>
<tr>
<td>B. Eating</td>
<td>Decreased visual field, reduced fine motor skills, contractions, cognitive</td>
</tr>
<tr>
<td></td>
<td>impairments.</td>
</tr>
<tr>
<td>F. Toilet Use</td>
<td>Increased cueing or oversight needed to follow commands.</td>
</tr>
<tr>
<td>J. Personal Hygiene</td>
<td>Decreased strength, ROM and/or coordination affecting ability to complete</td>
</tr>
<tr>
<td></td>
<td>task; Reduced visual field or neglect; Cognitive impairment affecting ability</td>
</tr>
<tr>
<td></td>
<td>to follow commands.</td>
</tr>
</tbody>
</table>

Section: K Swallow Phase

<table>
<thead>
<tr>
<th>K0100A</th>
<th>Swallow Phase</th>
<th>Oral Prep (weak lips) or Oral Prep (weak tongue)</th>
</tr>
</thead>
<tbody>
<tr>
<td>K0100B</td>
<td>Swallow Phase</td>
<td>Oral Prep (weak lip seal) or Oral Prep (decreased tongue ROM)</td>
</tr>
<tr>
<td>K0100C</td>
<td>Swallow Phase</td>
<td>Oral Phase (base of tongue) or Pharyngeal Phase</td>
</tr>
<tr>
<td>K0100D</td>
<td>Swallow Phase</td>
<td>Pharyngeal Phase or Esophageal Phase (pain)</td>
</tr>
</tbody>
</table>

Questions?
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