

# Improving your Case Mix: Document for accuracy and funding will follow



**Ontario Long Term Care Facilities (Nursing Homes and Homes for the Aged) have been using the Alberta Levels of Care Classification System on an annual basis since 1992. It is unfortunate that after 10 years of using this system, how to document properly for classification remains a mystery.**

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There is no secret to preparing for classification. However, rumors are often an obstacle to learning the facts behind documenting for clinical accuracy to ensure appropriate funding -- or what is commonly referred to as "documenting for dollars." Let's clarify!

Three main documentation processes that classifiers look at:

- Care Plan
- Quarterly Summary note
- Incidental notes

## 1. CARE PLANS

Ensure all members of the Health care team, on all shifts, are included in the updates. Asking the direct care staff the appropriate questions to describe exactly what they do for that resident in the course of a day not only helps you

capture the care level requirements for the resident during each plan of care review, it also heightens their awareness of what is actually being done. In addition, they will be more apt to let you know of any changes that occur.

Since many of the definitions of the eight-case mix indicators refer to certain times of the day, it is important to specify if there are variances in the resident's need for assistance throughout a 24-hour period. For example, the definition for Transferring states you get the "highest level of assistance required during a 24-hour period." So if the resident only requires a two-person transfer into bed each evening, you get a four for transferring (requires two or more people to provide physical support with or without mechanical lift). Ensure the proper care levels are reflected in each resident's care plan. Classifiers look to the care plan first for information.

## 2. QUARTERLY SUMMARY

To avoid contradictions, all sources of documentation should be updated at the same time for consistency. Some facilities will split up the care plan review and quarterly summary note by shift to save time. But the resident's assessment care plan and most importantly, the quarterly summary note, should be updated by the same person for best practice.

The Summary note should be clearly labeled and in a consistent format (see example on page 4). Quarterly summaries are for ADL & CCL confirmation and BDL incidental note summarization. This note does not have to be lengthy or a duplication of the care plan. Stating the care plan has just been reviewed and ADL & CCL are current, is enough to confirm the plan of care. BDL's must be recorded by reading back over the last three months of notes and summarizing behaviours. Again, you don't re-write the care plan. Simply note the behaviours from the care plan that have been exhibited and whether the interventions recommended from the care plan were effective or updated.

## 3. INCIDENTAL CHARTING

Incidental charting should be a year-round process! Getting your staff accustomed to a specific format for writing behavioural charting can be as simple as implementing SOAP or DAR charting. It is very important to have properly written notes as the charted incidental notes are the proof the classifiers need to determine whether there is over 30-minutes or over two hours of nursing intervention per day. The optimal method for recording this is via a note that has all three of the following components, whether in a format (see example page 4) or in narrative:

1. Behaviour exhibited by the resident must be stated clearly or else it will be impossible to know what the resident is doing and the note is rendered meaningless.
2. Nursing interventions being undertaken must be noted or else it will be impossible to know what is being done and again, the note will be rendered meaningless.
3. Timing and frequency must be noted or it will be impossible to account for all interventions.

Training staff to think about this format at all times will prevent the panic around incidental charting at the end of each summer. If you have found yourself in this

last minute predicament, research which residents will really influence your funding and do focus charting on those residents (see case mix coach for BDLs on page 3).

### CMI & Computers facts vs. fiction

Be wary of anyone who tells you they can “guarantee” an increase in your case mix index (CMI). Classification is based on documentation collected from the resident’s charts, which is then compiled into a case mix based on the average in the province. This means, if one facility increases another will decrease, as each facility is allotted a percentage of the “pie” according to their case mix. Promises to increase your CMI are irresponsible and prey on those that lack a clear understanding of how CMI is derived.

#### Knowledge is the key!

It is people, not computers that will ensure your documentation reflects the funding you deserve.

Any such “guarantee” can only imply that computers will help you cheat your way to higher funding – also known as “gaming.” The two things that will increase your CMI, (without gaming, that is) are:

1. Accurately capturing the care you are providing
2. Actually having a resident population with a higher level of acuity.

The first is something you can control and improve. To assure a facility that their CMI is going to go up means that they are positive your residents’ care levels have increased. For if you are documenting properly, a heavier resident population is the only honest way your funding will go up.

Computer systems are not miracle workers; they are a tool that promotes consistency and education. With the proper knowledge, your documentation will more accurately reflect what your Facility should rightfully receive for the care you need to provide your residents.

Many consultants will get away with these claims to guarantee increases simply because of the lack of education out there. They are taking advantage of high staff turn over rates, new graduates and acute care nurses just not having been oriented to the long-term care classification-based documentation system.

Remember, there are only two legitimate ways to improve your CMI. Unless these people are planning on changing your resident population, they must discuss ways of improving documentation practices. But the latter depends on people not computers. For an industry that relies on documentation for a good portion of its funding, resources should be allocated into proactively educating the staff during an orientation process and ongoing thereafter.

I am certainly not saying that computer systems can’t help. They can be a useful tool to monitor changes in resident status and care level. Furthermore, when implementing a new computer system, the training that goes along with it will often initiate additional classification staff education. This provides the opportunity to review and standardize policy and procedures, refresh documentation skills and refine many care and business processes.

A system that is easy to use and has all the proper tools allows training to focus on how to use the system effectively. Monitoring case mix through a computer system is easier and saves time!

### Case Mix Coach

The rest of this article contains documentation tips. I must emphasize, however, that it is essential when focusing

on documentation for classification that you don’t lose sight of compliance and maintain Ministry of Health (MOH) and College of Nurses (CNO) documentation standards and principles.

### Activities of Daily Living:

**Eating**— ensure you are noting the level of assistance required for most of the meal times during the daytime (2 out of 3 meals a day). For example, even if a resident is independent for breakfast (lively in the morning) yet by the afternoon exhausted and therefore a “total feed” for both lunch and dinner - then it is coded a 4 (needs complete feeding by another person).

Be sure to note the variance in the care plan. Don’t forget that care plans are for the staff not just for classifiers. A resident is a 1 (needs assistance with opening cartons cutting meat etc. but does not require further assistance) if they require only setup to get started. But if they require you to come back to them throughout the meal to encourage or assist, then they are a 2 (intermittent encouragement with or without assist). They are a 3 (constant encouragement with or without assist) if you must stay with the resident 1:1 for the entire meal but if you are feeding that resident then they are a 4 (complete feeding).

If the resident is sitting at a 4-person table that has constant or total residents present (1:4 ratio) the other three are at least a 3. “Constant” means constantly present, not constantly returning to the table. Classification terminology is all about process of elimination: by describing exactly what you do for each resident in their resident-specific care plan, the classifiers will then be able to code accurately. Don’t be afraid to use certain words when describing your care. But don’t just use the classification terminology without expanding on what, for example, intermittent means for that resident.

**Toileting**— unlike eating, coding for toileting includes the whole process of getting to and from a toilet or commode (or use of other toileting equipment), transferring on and off toilet, cleansing self after elimination and adjusting clothes. However it is the level of functioning during the daytime only. So be sure to note variances in a 24-hour period in your care plan.

Even if you just direct a resident to the washroom, remind them to go or ensure they have their equipment than they are at least a 1. If you have to physically go to the washroom at any time to ensure they got there or for safety checks, but you can leave the washroom, then they are a 2 (intermittent supervision). If you cannot leave the resident unattended, due to fall risk or behaviours, then they are at least a 3 (constant supervision &/or physical assist). If you require a 2nd person to assist because of safety (yours or theirs due to heavy care or a behavior) this person is a 4. Have policies in place and available for mechanical lifts. State 2 persons must be present to operate - therefore automatic 4 for toileting/transferring if you document use of mechanical lift in Care Plan. A 4 and 8 (Not Applicable, resident does not use toilet for either bowel or bladder elimination -- i.e. has a catheter and ostomy or uses incontinence products) are the same funding wise. Don't be afraid to note if you do not toilet but be sure to note in the CCL that the resident is on a containment program for consistency.

**Transferring**— is the process of moving between positions (i.e. to/from bed, chair, standing) excluding transfers in/out of bath and on/off toilet. Unlike Toileting, Transferring is coded for the highest level of assistance required during a 24-hour period.

If you are watching/ supervising /ensuring that they have their mobility aid then they are a 1. If you are giving verbal cues/ guiding/ physical assist for difficult maneuvers they are a 2 (intermittent). If you have to be present during the full transfer at least once a day then they are

a 3 (constant). The highest you can get is a 4 (two person) or 8 (resident is comatose or bedridden). If you are to be asking for a 2nd person to assist or require a 2nd person to assist because of safety (yours or theirs due to weight or a behavior) this person is a 4. If you are using a mechanical lift and your facility has a policy that lifts can only be used with 2-person assist then this resident is a 4. If a 4, you'll want to state whether they can weight bear or require mechanical lift to avoid verification. Be sure to word all of the above accurately if variances occur throughout the day in the care plan to avoid verification.

**Dressing**— is the process of getting street clothes on, and indicates the level of assistance required to dress for the first time of the day. Ensure you are describing the first dress of the day in the care plan if there are variances throughout the day. If the resident undresses or layers this isn't counted for dressing, it would be captured under behavioural. It must be street clothing, therefore gowns and housecoats don't count.

If you just discuss and pull out clothing choices for your residents, even the night before, than they are at least a 1 (help assemble). If you are assisting in any way with a zipper or button, the resident is a 2 (intermittent). If you must stay in the room during the entire process of AM street clothing dressing, even if you are just watching for safety while they dress themselves, they are a 3-constant. The highest you can get is 4 (total dress). If you require 2 persons to dress (1 for the task, 1 for behaviour intervention) note the extra time spent as an ineffective coping. As you can see, it is very important to describe what is being provided keeping in mind the definitions of Classification coding. Be sure each resident's care plan is specific to him or her, and abides by compliance as well. Whatever is noted in the care plan is coded as long as there are no inconsistencies, especially in the Quarterly summary.

### **Behaviours of Daily Living:**

Potential for Injury— is the presence of behaviour that places self or others at risk for psycho-social or physical injury and which requires intervention.

Zero would only be for no mention at all on the chart of safety, unsteady gait, seizures etc. If you have mentioned a safety issue and have an intervention in the Care Plan, you automatically get 1 if it's backed up in the Quarterly Summary. For example, High risk for falls r/t unsteady gait – 2 side rails up check q1h, ensure footwear is appropriate ...automatic 1 without a single incidental note.

To be conservative the goal is to get 1. To get a 2 you have to do incidental charting about nursing interventions being provided, which is more than an eyeball check (i.e. wanderer or safety checklists) every hour of the day. Unfortunately, in the end there is no difference in funding between a 1 and a 2. The only way to get a 3 is by having to do incidental charting about nursing interventions being provided, more than an eyeball checklist, every 15-minutes of the day, every day. Have policies in place and available for side rails. If your Facility side rails policy states, if 2 side rails are used then q1hourly checks are mandatory, you get an automatic 1 if "both side rails up" is documented in the Care Plan.

**Ineffective Coping**— is the presence of behaviour that reflects inability to deal appropriately with routine living situations or with individuals and which requires intervention. Zero constitutes no mention of any behavior requiring intervention at all. If you have in the Care Plan and Quarterly summary a behavior plus intervention you have a 1 with no incidental charting required.

Your goal is to get at least a 1. If you spend more than 30-minutes on interventions with a resident and document it consistently then it's a 2. If the behaviors are "predictable", for example, every time you dress or shave

them they resist, then you can avoid incidental charting. If the extra time beyond the ADL procedure adds up to over 30-minutes in 24-hours you can get a 2 by stating clearly and descriptively in the Care Plan and the Quarterly Summary how EVERY time EVERY day this amount of EXTRA time is required for intervention during these tasks. However if every time someone walks into a resident's room they scream it is not predictable. One cannot predict when someone is going to walk into their room. A 3 is the highest coding but you must document either incidentally or "predictably," as above, for over 2-hours a day. It is the ONLY way to receive a "G".

### Continuing Care Level:

Urinary/Bowel Continence, any inappropriate voiding/ bowel elimination causing hygienic or health risk. A zero is if they are always completely continent without assistance or reminders.

Continence is about bladder/bowel control not the physical assist (that's toileting)

If the resident has catheter / ostomy they are a 1. If a resident is "occasionally" incontinent (i.e. once a week) meaning they are continent but have the occasional mistake then they are also a 1. Continence is also not about whether the resident is dry or not—a resident is a 2 (incontinent) if the staff provide a program to maintain continence. A 2 and 3 are the same funding-wise, so when dealing with incontinence, be sure to state in the care plan what type of program the resident is on whether it is a regular toileting program, a containment program (uses briefs) or retraining program. Also note brief size. If a resident is incontinent and wearing "pads" instead of briefs it must be specified in the Care Plan that the staff change, provide pericare and the pads. If a resident wears nothing due to refusal, then be sure to clearly note it in the care plan.

In Summary, we've learned about the eight indicators that affect care requirements, the skills to ensure documentation reflects the resident's physical and behavioural needs and how to prepare and evaluate your documentation for classification. With this information and along with the MOH levels of care, Matrix and category weight calculations you can do a mock classification of your facility to determine your Case Mix Measure.

By monitoring your case mix manually through a mock, or via a computerized system, you can ensure your documentation is accurately describing the care you are providing.

By ensuring your documentation is consistent and valid with the proper definitions, you will get the funding you deserve.

## Quarterly Summary Template

This \_\_\_ year old M / F admitted on \_\_\_ / \_\_\_ / \_\_\_ with Dx of \_\_\_\_\_ has  *been stable* /  *had the following changes* this last quarter;

Biological / Physical: \_\_\_\_\_  
(describe and physical changes; admission to hospital, etc.)

ADL's and CCL's have been reviewed on \_\_\_ / \_\_\_ / \_\_\_ and are current as per care profile.  
(This blanket statement allows for referral to the care plan to avoid the duplication of having to write out ADL's and CCL's. This avoids inconsistencies since you've just reviewed the care plan and are confirming it is up to date)

Behavioral / Psychosocial / Safety: \_\_\_\_\_  
(Behavioral episodes should be summarized here with reference to the interventions on the care plan and whether they are effective)

## 4 Steps of Behavioural Incidental Charting

1. Describe resident's **behaviour**
2. Describe nursing staff's **intervention(s)** used
3. Note **time** and **frequency** of Nursing time spent with resident
4. Evaluate **effectiveness** of your interventions