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Utilizing the MDS as a resident's rights and risk-reduction strategy in long-term care

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The frailty syndrome is an emerging concept for providers who care for individuals with significant comorbidities, advanced age, or a decline in functional or cognitive status; the more typical resident receives services in a long-term care facility. In general, frailty is a concept that residents or their families do not understand well. The sequelae of frailty are often underrecognized and minimally addressed by the interdisciplinary team, including the attending physician and physician extenders.

The Minimum Data Set (MDS) can be an effective tool in identifying residents with physical and cognitive decline related to frailty, sarcopenia, and failure to thrive.^[1] Residents and family members often have minimal understanding of the effects of these conditions on weight loss, falls, the development of pressure injuries, and related issues that have become the major foci of regulators and malpractice litigation.

An effective ethics and compliance program seeks to integrate clinical outcomes with regulatory compliance. Importantly, setting expectations for a resident's care goals, and what can or cannot be addressed by nursing care, assists in compliance with the mandated nursing home informed consent provisions. The chief ethics and compliance officer should work collaboratively with leaders in clinical operations to improve the understanding of clinical decline by families of residents most impacted by these diagnoses and syndromes. This collaboration should include identification of communication strategies for meaningful, documented care plan conferences, during which the resident and responsible party are apprised of the implications of frailty.

Case study

Shirley was an 88-year-old woman with diabetes, hypertension, hyperlipidemia, hypothyroidism, osteoarthritis, osteoporosis, and dementia who fell at home and fractured her left hip. Due to her advanced age, the orthopedic fixation of her fracture was deferred, and she was discharged to the community with home health services. Her daughter sought a second opinion from a tertiary care hospital's orthopedic department, which agreed to perform an internal fixation of the left trochanteric fracture. Postoperative, Shirley was transferred to the intensive care unit, transfused, and given medication (pressor agents) to support her blood pressure. During her hospitalization, she developed several minor pressure injuries, which were present upon her discharge to a skilled nursing facility. While in the nursing home, Shirley lost 10% of her weight due to an average oral intake of 25%–50%. The speech therapist noted Shirley had little energy for chewing, even demonstrating difficulty

sucking up fluids with a straw; this condition had progressed when she lived in the community. Her attending physician repeatedly observed in progress notes that Shirley's prognosis was "guarded;" however, there was no documentation of any discussions about the likelihood of decline with the resident or her family. Shirley died six weeks after her admission to the skilled nursing facility. Her family filed suit six months after the death, alleging neglect stemming from the facility's failure to prevent weight loss and the deterioration of her wounds, which became larger and necrotic.

Frailty

Frailty is a condition characterized as increased vulnerability to the adverse outcomes of geriatric syndromes such as falls, disability, delirium, pneumonia, urinary tract infections, COVID-19, and the failure to return to baseline following a stressful physical or psychological event.^[2] Residents may also experience weight loss greater than 8–11 pounds or more than 5% in one year (see FRAIL–NH Scale). An observed decrease in activity and generalized weakness evidenced by low grip strength are commonly seen in older adults with frailty syndrome. In turn, frailty leads to delirium, weight loss, falls, recurrent hospitalizations, malnutrition, fractures, polypharmacy, and increased healthcare costs. These issues contribute to the risk of institutionalization. Still, despite the myriad medical, nursing, and psychosocial issues, residents and families have little understanding of these conditions or the limitations of medicine in ameliorating frailty-related impairments. (See FRAIL–NH Scoring on page X)

Many risk factors identified in the case study, including advanced age, cognitive impairment, and medical comorbidities, are common in nursing home residents. Additionally, polypharmacy, the lack of regular activity, poverty, undernutrition, and isolation contribute to the frailty cycle in which malnutrition and weight loss lead to sarcopenia, i.e., the loss of muscle strength and mass further contributing to the individual experiencing falls, fractures, and head injuries causing disability and death. Sarcopenia causes decreased strength leading to falls, disability, and reduced activity before the cycle begins again.

The MDS as a source of frailty identification

The MDS is typically thought of as a billing tool, but it also provides an opportunity to identify risk factors for frailty. Orthostatic hypotension, falls, and frailty have been examined by Brett Shaw, who identified that the MDS was a source of information that could predict falls in the nursing home population.^[3] The researchers found residents who had fallen during the previous year were likelier to continue to fall. Residents who were considered frail had a greater prevalence of orthostatic hypotension, defined as a drop of 20 mm/hg in the systolic blood pressure from sitting to standing. Unless a practitioner writes an order for a resident's blood pressure to be taken in more than one position, orthostatic hypotension will likely not be identified.

In addition, Shaw found that the Frailty Index — *see index on page X* — helped predict three-year mortality in individuals. Notably, the Frailty Index can be used as a resident education and risk management tool by triggering a discussion with family members regarding the predictors of frailty and the need to consider future care planning. These discussions should be conducted by the medical director or attending physician and monitored by the compliance committee for compliance.

Another scale that could be useful in identifying frail residents is the Changes in Health, End-Stage Disease and Symptoms and Signs (CHESS) Scale — *see on page X* — designed to identify health instability in long-term care facilities using the MDS to predict which residents may experience adverse health outcomes including death.^[4] Scores of three or more indicate an increased risk of health instability with issues focusing on changes in the individual's decision-making capacity; changes in Activities of Daily Living (ADL) status; the health conditions of vomiting, peripheral edema, and dyspnea; end-stage disease states; weight loss; inadequate fluid

intake/dehydration; decreased oral intake or evidence that fluid output exceeds intake.

So, where does compliance fit in beyond ensuring physicians, residents, and their loved ones engage in this shared decision-making process? We view the compliance department as a significant player in ensuring the concepts of informed consent, resident rights, and quality care delivery remain paramount. The compliance committee should review clinical outcomes and relevant associated processes (e.g., informed consent) during its meetings; it is critically important to ensure care delivery systems are in place to remedy noncompliant care. The diagnosis of frailty does not relieve providers of the duty to provide appropriate care. The interventions must be tailored to meet the resident’s individualized care goals.

Conclusion

An effective ethics and compliance program must ensure that MDS scores are accurate for billing and care delivery purposes. Frailty scores should be generated to determine an individual resident’s risk for the sequelae—the aftereffect of a disease, condition, or injury—associated with the syndrome of frailty; this will create an opportunity for meaningful discussions with residents and their families. These discussions between clinicians, the patient, and the family could begin as part of the discharge planning process and continue shortly after admission to the facility. Quality Assurance and Performance Improvement (QAPI) projects focusing on identifying frailty from the MDS and generating informed discussions about decline may be beneficial in mitigating regulatory citations regarding weight loss, malnutrition, dehydration, pressure injuries, falls, and the failure to achieve the highest possible level of function. Physicians can easily administer the frailty scales, and nurses and other health professionals can engage with families, identify care goals, educate families and staff, and better manage the inherent risks imposed by a frail population of long-term care residents.

	Frailty Sign	MDS Response
F	Frailty	PHQ–9 responses identify fatigue, depression
R	Resistance	Refers to the amount of assistance needed for transfers
A	Ambulation	The use of assistive devices for ambulating
I	Incontinence	Degree of urinary or fecal incontinence
L	Loss of Weight	Weight loss greater than 5% in 30 days or 10% in 180 days
N	Nutritional Approach	Regular diet, altered consistency or enteral feedings

H	Help with Dressing	Degree to which assistance is required
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Appendix 1– FRAIL SCALE^[5]

	0	1	2
Fatigue	No	Yes	PHQ-9 >10
Resistance	Independent Transfer	Set Up	Physical Help
Ambulation	Independent	[Cane or] Walker	Unable to ambulate or wheelchair used
Incontinence	None	Bladder	Bowel
Loss of Weight	None	Yes	xxxx
Nutritional Approach	Regular Diet	Mechanically Altered	Feeding Tube
Help with Dressing	Independent	Set Up	Physical help
Total			0–13

Appendix 2 – FRAIL–NH Scoring^[6]

Score	Item
0–2, 8	Change in Decision-making ability
0–2, 8	Changes in ADL status

0-4	Health condition-vomiting
0-4	Health condition-peripheral edema
0-3	Health condition-dyspnea
0,1	End-stage disease
0,1	Weight loss
0,1	Insufficient fluid
0,1	Dehydration
0,1	Decrease in food or fluid
0,1	Fluid output exceeds intake

Appendix 3 – CHESS MDS⁴²

Takeaways

- Frailty is characterized as increased vulnerability to the adverse outcomes of geriatric syndromes such as falls, disability, delirium, pneumonia, urinary tract infections, COVID-19, and the failure to return to baseline following a stressful physical or psychological event.
- Frailty syndrome is an emerging concept for providers who care for individuals with significant comorbidities, advanced age, or a decline in functional or cognitive status; the more typical resident receives services in a long-term care facility.
- In general, frailty is a concept that residents or their families do not understand well.
- Accurate Minimum Data Set (MDS) information provides an opportunity to identify several risk factors for frailty.
- An effective ethics and compliance program will monitor risk for frailty and ensure that residents and their responsible parties are engaged in meaningful discussions associated with care goals.

- 1** Centers for Medicare and Medicaid Services, “Minimum Data Set (MDS) 3.0 for Nursing Homes and Swing Bed Providers,” last modified February 16, 2022, <https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/NursingHomeQualityInits/NHQIMDS30>.
- 2** Reuben B. David et al., *Geriatrics at your Fingertips*, 22nd ed., (New York: American Geriatrics Society, 2020), 17.
- 3** Brett H. Shaw et al., *Relationships Between Orthostatic Hypotension, Frailty, Falling and Mortality in Elderly Care Home Residents* (BMC Geriatrics, 2019), 1-14, <https://doi.org/10.1186/s12877-019-1082-6>.
- 4** Jessica A. Ogarek et al., “Minimum Data Set Changes in Health, End-Stage Disease and Symptoms and Signs Scales: A Revised Measure to Predict Mortality in Nursing Home Residents,” *Journal of the American Geriatrics Society* 66, no. 5 (May 2018): 976-981, <https://doi.org/10.1111/jgs.15305>.
- 5** Lauren J. Gleason et al., “FRAIL questionnaire screening tool and short-term outcomes in geriatric fracture patients,” *Journal of the American Medical Directors Association* 18, no. 12 (December 2017): 1082-1086, <https://doi.org/10.1016/j.jamda.2017.07.005>.
- 6** Carey Cowles, “FRAIL-NH Simplifies Frailty Screening,” *Caring for the Ages* 17, no. 11 (2016): 19, [https://www.caringfortheages.com/article/S1526-4114\(16\)30288-8/pdf](https://www.caringfortheages.com/article/S1526-4114(16)30288-8/pdf).
- 7** John P. Hirdes, Dinnus H. Frijters, and Gary F. Teare, “The MDS-CHESS Scale: A new measure to predict mortality in institutionalized older people,” *Journal of the American Geriatrics Society* 51, no. 1 (January 2003): 96-100, <https://doi.org/10.1034/j.1601-5215.2002.51017.x>.

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