In theory, there is no difference between practice and theory, while in practice there is. — Benjamin Brewster

This month’s column considers the idea of the mandatory Resident Assessment Instrument (RAI) process, as authorized by the 1987 Omnibus Budget and Reconciliation Act (OBRA) and administered by the Centers for Medicare & Medicaid Services. We will distinguish the theory behind it from the reality of its actual use in post-acute and long-term care.

The Theory Behind the Comprehensive Assessment

The comprehensive resident assessment is one of the cornerstones of the OBRA regulations. The simple underlying theory is that gathering and analyzing information about each resident is the basis for appropriate interventions. Before the 1987 OBRA regulations, there was no standardized assessment for nursing home residents, and often no meaningful assessment whatsoever.

To this end, OBRA mandated a set of tools — the RAI — and provided a general process for using those tools to develop a comprehensive care plan, provide the appropriate care and services for each resident, and modify the care plan and care/services based on the resident’s status.

Most of the 1,300-page RAI manual (version 1.17.1. October 2019) is devoted to the technical details of completing and coding the minimum data set (MDS). For example, every data element is covered by detailed instructions about its coding, and comprehensive MDS assessments are required on admission, annually, and for a significant change in status.

A portion of the RAI manual covers subsequent interpretation and use of the MDS. Facilities must use a Care Area Assessment (CAA) process whereby the MDS automatically “triggers” certain areas (Care Area Triggers: CATs) for further review (e.g., falls and dementia/cognitive impairment) that indicate potential or actual problems that may need further assessment and management. Facilities are then supposed to use “current, evidence-based clinical resources” to assess potential problems, identify causes, and determine whether they should initiate or modify aspects of the care plan. The facility must complete a Care Area Summary to summarize where and why it did or did not proceed to care planning.

On paper, it all seems sensible. However, in practice it has been anything but simple. Practice is not necessarily consistent with theory.

The Practice of the Comprehensive Assessment

The principal RAI tool for documenting a comprehensive assessment is the 45-page MDS containing hundreds of data elements. It is defined as a core set of screening, clinical, and functional status elements, including common definitions and coding categories. Therein lies much of the challenge: the MDS loosely combines data into categories (diagnoses, behavior, etc.), but it was never designed to cover all relevant issues, risks, or causes of problems or symptoms, nor does it provide a chronological “story” of symptoms.

After the MDS is completed, confirming causes and identifying links between causes and consequences are key activities to support care planning. For care planning purposes, every finding must be considered and managed in the context of the patient’s entire picture, not in its own silo. Often a care area issue or condition (e.g., falls) has multiple causes; multiple symptoms (e.g., confusion and anorexia) may have common causes. Interventions for each condition may need to be modified depending on their impact on other symptoms and risk factors.

For example, certain items in the MDS will trigger the cognitive loss/dementia CAA. All behavior and psychiatric issues need a systematic approach that covers relevant medical and non-medical issues simultaneously. The problem must be defined precisely (not just “the patient is having behaviors”). Identifying causes of behavior and psychiatric symptoms requires solid reasoning skills using patient-specific evidence.

Pain is another example. The MDS contains some elements about pain such as severity and frequency. However, additional details, an adequate physical assessment, and a “story” of pain and pain treatment over time are all needed to identify causes of pain, select and monitor interventions, and determine the need for, right dosage of, and effectiveness and complications related to analgesics.

Sometimes the pieces all come together and the right conclusions lead to the appropriate interventions. Often, however, conclusions and interventions related to behavior, pain, and other issues are either independent of or inconsistent with patient-specific evidence. For example, a patient may receive opioids for frequent pain of 7/10 as noted in the MDS, but the symptom details and patient history suggest that opioids are not indicated for the likely underlying causes.

Inadvertent Silos of Care

The care delivery process (or CDP, which is briefly discussed and summarized in table 2 of chapter 4 in the CMS RAI manual) is a universal thought process, regardless of time, place, or disciplines involved in the care. In theory, the RAI process should coincide with the CDP. For example, successful completion of CATs and CAs requires individuals who know how to “lump” and “split” (as discussed in Caring for the Ages 2020;[2]:10,11) — but practice and theory often diverge.

Although all disciplines draw conclusions based on data from the MDS, there is huge variation in how well they draw such conclusions, especially in more complex situations. Drawing the right conclusions requires considerable understanding of the CDP and a recognition of personal limitations in knowing the causes of symptoms.

The OBRA regulations and RAI manual emphasize a “comprehensive,” “person-centered” care plan that results from using “evidence-based” approaches. But in a significant self-contradiction, the RAI manual allows facilities to assign specific CAs to one particular discipline to review (e.g., the dietician completes the Nutritional Status and Feeding Tube CAs, if triggered). The RAI manual states that interdisciplinary team (IDT) members should determine which current clinical protocols, tools, resources, research, and standards of practice they will use for assessment and care-planning approaches.

Essentially, facilities and their IDT and practitioners are left to decide whether they will deploy the CDP correctly and completely. The critical element pathways that guide surveyors are not detailed or particularly helpful about how to review the quality and appropriateness of the critical thinking process beyond MDS completion. Although the facility is expected to identify its chosen resources upon request, surveyors rarely request them, are unlikely to know whether the facility’s thought processes were valid, and rarely cite inadequacies in the CDP or the clinical reasoning behind the care plan. CMS quality measures do not adequately address care process quality. Facility staff and practitioners may never receive any meaningful internal or external feedback about how their approaches to clinical reasoning and problem solving affect resident outcomes.

Thus, ironically, MDS implementation in practice has reinforced the silo approach to care, which distorts the original intent of the whole process. It is common practice to distribute symptoms and conditions to various IDT members or consultants, based on the MDS, and allow them to assess and manage the entire thought process about specific issues. For example, social workers and psychiatric consultants get behavior, physical therapists get falls, speech therapists get swallowing, dieticians get weight loss, and hospices get pain.

Ultimately, there must be one unified care plan, which is not the same as one care plan with multiple silos. Except in the simplest situations, each of these areas requires much more than any one person knows or can provide — for example, regarding swallowing issues (J Am Med Dir Assoc 2019;20:952–955).

The required MDS nurse coordinator should not be — but too often is — the principal or sole decision maker about care plan elements and who gets to manage a given symptom or problem. While it is OK for individuals to coordinate documentation of various aspects of care, it is never appropriate to give one individual or one discipline exclusive rights to manage a symptom or condition from start to finish. A care plan that is little more than a loose collection of separately developed conclusions may lead to inadequate, incorrect, and conflicting interventions and less desirable outcomes.

Is More an Improvement? Or Just More?

The OBRA law mandated that the MDS serve multiple purposes, as a foundation for payment, quality assessment, and care. It serves a useful purpose clinically by providing basic information about each resident’s multiple dimensions. However, repeated modifications and additions to the MDS increasingly appear to reflect the notion that more data are somehow better. Beyond a certain point, there is no evidence that this is true. The repeated collection of MDS data is a relatively inefficient way to manage patients beyond a starting point, especially regarding changes of condition. The time could be much better spent in deploying the full CDP, which is too often sacrificed to the pursuit of data gathering and form completion.

PALTC clinicians and medical directors can play a key role in improving care by helping ensure that the IDT follows

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So the medical model is not wrong, but persons once disease has been detected. Frankly, the journey should never end — it should evolve. It is inevitable that that evolution includes the medical model. Anyone working in health care is familiar with the medical model. For providers and nurses, it is the foundation of their training. The processes that keep the business of a nursing home functioning are also founded on the medical model. It is so ingrained in our facility culture that we don’t even think about it. By its structure, this model emphasizes an individual’s diseases and deficits. The medical model in its traditional form is detection of disease through symptoms, examinations, and diagnostic tests. It does not fully address the biopsychosocial needs of persons once disease has been detected. The medical model is not wrong, but it can fall short in addressing the matters most important to residents.

The Centers for Medicare & Medicaid Services alludes to a medical model when it states that facilities “must ensure the resident receives care and treatment in accordance with professional standards of practice.” And consider the revised quality measures from CMS that include rehospitalizations, anti-psychotics, pressure ulcers, falls, functional abilities, catheters, incontinence, weight, depression, antibiotic stewardship, and restraints. From a regulatory perspective, CMS is addressing both quality of care and quality of life, but only the measurable quality of care metrics contribute to reimbursement. Understandably, staff will focus on what gets measured, reported, and reimbursed.

It is more difficult to measure quality of life because it varies by individual. CMS describes quality of life as a “fundamental principle that applies to all care and services” and that “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” (42 CFR § 483.24). Defining and measuring a quality of life that ensures the highest practicable well-being is elusive, which may relegate it to less importance.

In her pivotal book Elderhood (Bloomsbury, 2013), Louise Aronson, MD, wrote, “Our current medical paradigm’s science-first approach has reaped huge benefits for individuals and society, but it has also had disturbing unintended consequences.” She continued, “If we feel the need to use catchphrases like ‘patient-centered care,’ what exactly is medicine? Shouldn’t patients always be the focus of health care? Something is missing in the current system and its underlying paradigm. Something important.”

So are we forever stuck between the proverbial rock and a hard place, between the medical model and person-centered care? Or is there a way to blend the two and create a model of care that recognizes the medical and psychosocial needs of each person? One place to start is our everyday language.

Consider recent conversations with colleagues. Were terms like “wheelchair-bound,” “bed-bound,” “noncompliant with care,” or “exhibits behaviors” part of the dialogue? All those statements reflect a medical model that emphasizes deficits — in other words, what is wrong with a person, their choices or their actions. Most care plans are written with this type of deficit-based mentality. Consider the language you used in a recent history and physical note or progress note. How did you describe the “patient”? Billing requirements and electronic medical record platforms may dictate some of the language we use, but perhaps there is room for increased sensitivity in our conversations and documentation.

How about the words patient and resident? One definition of patient is “a person receiving or registered to receive medical treatment.” The language and definition are clear. It describes a role or relationship between health care provider and receiver. A resident is defined as “a person who lives somewhere permanently or on a long-term basis.” Both are helpful descriptions, but are they necessary? What if we just used a person’s name instead of labeling them as a resident or a patient? Let’s begin to talk about the medical model culture that we work in and that individuals in nursing homes live in. Invite the staff to become aware of the words they use. When speaking and writing, let’s be consistently intentional in putting the person first and their characteristics second. The “wheelchair-bound” individual becomes “[name] who uses a wheelchair for mobility.” The “bed-bound” person becomes “[name] who spends the majority of time in bed.” The diabetic patient becomes “[name] living with diabetes” (or any other diagnosis). Notice the language: living with instead of diagnosed with. Don’t make the mistake of thinking that this is just wordplay. That would be deceptively simple. The culture change we are talking about is much deeper and more profound.

Create an ongoing list of the words and phrases used in your facility. Get residents and families involved! Convene a Language Committee and embark on this change process just as we would any process improvement project. Include resources like “Person-Centered Care: Are We Really Doing It?” by Joan Devine, RN (Caring for the Ages 2019;20(4):18) and “The Language of Culture Change” by Karen Schoeneman, MPA (Pioneer Network, 2009; s:/bit.ly/3btXji). Language is an integral part of every culture, including the culture in each facility. The words people use have power — they can hurt, and they can heal. Let’s be intentional in our use of words, both written and spoken, on our journey to serve some of the most vulnerable adults in our communities. Isn’t that the goal of the medical model and person-centered care?

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After 30 years, the RAI has been useful in many ways. However, more of the same thing cannot move quality in nursing homes any further than it has to date. The quest for true person-centered care that meets the Institute of Medicine’s definition of quality (Crossing the Quality Chasm, National Academies Press, 2001) must involve rethinking the RAI process to improve the convergence of theory and practice.

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