Learning Session 2
for the Ohio Nursing Home Quality Care Collaborative II (NHQCC II) and the Clostridium difficile Infection (CDI) Initiative

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Warm-Up Activity
Today’s Objectives

- Describe the Ohio NHQCC and the CDI Initiative.
- Identify and share effective strategies to improve some of your Quality Measure (QM) scores.
- Identify and review the new Nursing Home Facility Assessment tool from The Centers for Medicare & Medicaid Services.
- Identify and review common issues that affect the National Healthcare Safety Network (NHSN).
What is a QIN-QIO?

- Funded by the Centers for Medicare & Medicaid Services (CMS)
  - QIN-QIO in each state
  - Dedicated to improving health quality at the community level
  - Ensures people with Medicare get the care they deserve, and improves care for everyone
New National QIN-QIO Structure
Nearly 25 percent of the nation’s Medicare beneficiaries

HSAG is the Medicare QIN-QIO for Arizona, California, Florida, Ohio, and the U.S. Virgin Islands.
CMS separated medical case review from quality improvement work creating two separate structures:

- **Medical Case Review**
  - Beneficiary Family Centered Care-QIOs (BFCC-QIOs)

- **Quality Improvement**
  - Quality Innovation Network-QIOs (QIN-QIO)
QIN-QIO Areas of Focus
Patient is at the center of care

- Cardiac Health
- Disparities in Diabetes
- Transforming Clinical Practice
- Antibiotic Stewardship in Communities
- Coordination of Care
- Behavioral Health
- Healthcare-Acquired Conditions in Nursing Homes
- Adult Immunizations
- Support of Clinicians in the Quality Payment Program
- Improve Hand Hygiene and Injection Practices in ASCs*
Patient is at the center of care

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- Improve Hand Hygiene and Injection Practices in ASCs*

*ASCs: Ambulatory Surgery Centers
Improve Nursing Home Quality

• All Ohio nursing homes are invited to join Medicare’s NNHQCC.
  – An “all-teach, all-learn” quality improvement effort designed to ensure residents receive the highest quality of care.
  – Collaborate with peer nursing homes and expert speakers through face-to-face meetings and webinars while earning no-cost continuing education units (CEUs).
Improve Nursing Home Quality

- The Ohio National Nursing Home Quality Care Collaborative (NNHQCC) II

- *Clostridium difficile* Infection (CDI) Initiative
Ohio NNHQCC II

- Improve resident mobility.
- Integrate QAPI* practices.
- Reduce antipsychotic medication use.
- Decrease QM composite scores.

*QAPI=Quality Assurance & Performance Improvement
Ohio NHQCC *Go for the Gold* Program

- Structure for quality improvement
- Recognition for homes’ hard work
- Recognized by ODH/ODA* as an acceptable quality improvement program

(http://aging.ohio.gov/ltcquality/nfs/qualityimprovementprojects.aspx)

*ODH/ODA=Ohio Department of Health/Ohio Department of Aging*
Ohio NHQCC *Go for the Gold* Standings

**Go for the Gold!**

Ohio NHQCC Recognition Program

<table>
<thead>
<tr>
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<tbody>
<tr>
<td>• Join NHQCC</td>
<td>• Meet Bronze-Level Criteria</td>
<td>• Meet Silver-Level Criteria</td>
<td>• Meet Gold-Level Criteria</td>
</tr>
<tr>
<td>• Team Roster</td>
<td>• QAPI Self-Assessment</td>
<td>• 6 percent or lower Composite Score (rolling 6 months)</td>
<td>• 6 percent or lower Composite Score (calendar quarter)</td>
</tr>
<tr>
<td></td>
<td>• Discovery Form</td>
<td>• Summary Form</td>
<td></td>
</tr>
</tbody>
</table>

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16
Ohio NHQCC QAPI Self-Assessment Trends

- Have not started: 8
- Just starting: 71
- Doing great: 183
- On their way: 197
- Almost there (average response): 262
- Completed self-assessment: 721
CDI Initiative

- 185 participating nursing homes in Ohio
- NHSN enrollment
- 10-month data collection for baseline
- Quality improvement
  - Starting in early 2018
Ohio NHQCC II and CDI Initiative Timeline

Ohio Nursing Home Quality Care Collaborative II Structure

Learning Session

ACT

PLAN

STUDY

DO

Action Period occurs between learning sessions

Outcomes Congress: August–September 2018

Learning Session 1 April–June 2017

Learning Session 2 Sept.–Nov. 2017

Learning Session 3 April–June 2018
Quality Measure Composite Score
COM•POS•ITE
kəmˈpæzət
ADJECTIVE;
Made up of various parts or elements.
QMs in the Composite Score

1. Percent of residents with one or more falls with major injury
2. Percent of residents with a urinary tract infection
3. Percent of residents who self-report moderate to severe pain
4. Percent of high-risk residents with pressure ulcer
5. Percent of low-risk residents with loss of bowels or bladder
6. Percent of residents with catheter inserted or left in bladder
7. Percent of residents physically restrained
8. Percent of residents whose need for help with activities of daily living has increased
9. Percent of residents who lose too much weight
10. Percent of residents who have depressive symptoms
11. Percent of residents who received antipsychotic medications
12. Percent of residents assessed and appropriately given flu vaccine
13. Percent of residents assessed and appropriately given Pneumococcal vaccine
Quality Measure Review

Take a closer look!
Antipsychotic Medications
**MDS 3.0 Measure: Percent of Long-Stay Residents Who Received An Antipsychotic Medication**

<table>
<thead>
<tr>
<th>MEASURE DESCRIPTION</th>
<th>MEASURE SPECIFICATIONS</th>
<th>COVARIATES</th>
</tr>
</thead>
<tbody>
<tr>
<td>CMS: N031.02 NQF: none</td>
<td><strong>Numerator</strong>&lt;br&gt;Long-stay residents with a selected target assessment where the following condition is true: antipsychotic medications received. This condition is defined as follows:&lt;br&gt;- For assessments with target dates on or before 03/31/2012: N0400A = [1].&lt;br&gt;- For assessments with target dates on or after 04/01/2012: N0410A=[1,2,3,4,5,6,7].</td>
<td>Not applicable.</td>
</tr>
<tr>
<td></td>
<td><strong>Denominator</strong>&lt;br&gt;All long-stay residents with a selected target assessment, except those with exclusions.</td>
<td></td>
</tr>
<tr>
<td></td>
<td><strong>Exclusions</strong>&lt;br&gt;1. The resident did not qualify for the numerator and any of the following is true:&lt;br&gt;- 1.1. For assessments with target dates on or before 03/31/2012: N0400A = [-].&lt;br&gt;- 1.2. For assessments with target dates on or after 04/01/2012: N0410A=[-].&lt;br&gt;2. <strong>Any</strong> of the following related conditions are present on the target assessment (unless otherwise indicated):&lt;br&gt;- 2.1. Schizophrenia (I6000 = [1]).&lt;br&gt;- 2.2. Tourette’s Syndrome (I5350 = [1]).&lt;br&gt;- 2.3. Tourette’s Syndrome (I5350 = [1]) on the prior assessment if this item is not active on the target assessment and if a prior assessment is available.&lt;br&gt;- 2.4. Huntington’s Disease (I5250 = [1]).</td>
<td></td>
</tr>
</tbody>
</table>

Source: MDS 3.0 RAI Manual<br><br>www.goo.gl/qUuwgo
MDS—Section N: Medications

N0410A, Antipsychotic: Record the number of days an antipsychotic medication was received by the resident at any time during the seven-day look-back period (or since admission/entry or re-entry if less than seven days)

• This measure will trigger for residents receiving an antipsychotic drug without a diagnosis of Schizophrenia, Tourette’s syndrome, or Huntington's disease.
Antipsychotic Medications: Areas to Consider

- Coding
- Underlying conditions
- Basic needs
- Activities
- Environmental
- Medication management
- Behavior documentation
- Gradual dose reductions (GDRs)

- Root cause analysis of the behavior
- Staff and resident interaction
- Qualifying diagnosis
- Pharmacy and therapeutic drug meeting
- Education needs
Strategies From NNHQCC Nursing Homes

- **Ensure** proper diagnoses of Schizophrenia, Tourette’s syndrome, or Huntington’s disease are captured in chart and MDS.
- **Engage** consulting pharmacist in Performance Improvement Plan (PIP) team.
- **Perform** GDRs where possible.
- **Eliminate** antipsychotics prescribed only as needed.
- **Update** attending physicians on F329 and facility data.
- **Educate** residents, families, and staff members on:
  - Pathophysiology of various dementia types.
  - Approved uses and contraindications of antipsychotics.
- **Customize** care plans to meet each resident’s needs.
Change Package Strategies

Five-Point Bundle

1. Design and create a calming environment.
2. Create meaningful relationships.
3. Provide meaningful activities.
4. Identify and treat physical and mental conditions.
5. Define a consistent approach to minimize the use of antipsychotic medications.
Create a calming environment
Design and Create a Calming Environment

• Eliminate loud or competing noises.
• Have a place for everything and everything in its place (reduce confusion and stress).
• Eliminate patterns in carpet or other furnishings that could be confusing.
• Include private personal spaces that are comforting and soothing to residents.
• Respect each resident’s private space.
Foster meaningful relationships
Create Meaningful Relationships

- Implement consistent assignment.
- Establish familiar faces, with a goal of developing trust and familiarity.
Encourage meaningful activities and daily routines
Provide Meaningful Activities

• Identify opportunities for individuals to contribute to daily routine (e.g., laundry, meal prep, feeding pets, etc.).

• Encourage decision making throughout the day (issues that impact the individual).

• Engage individuals in conversations.

• Promote and encourage mobility throughout every day.
Find the physical and mental source of behaviors
Identify and Treat Physical and Mental Conditions

- Identify practitioners in the community that are skilled at working with individuals with dementia and willing to provide on-site care.
- Educate staff members on assessment of behaviors (considering behaviors as signs of unmet needs) and possible non-pharmacologic interventions.
- Educate all staff on the signs and symptoms of delirium as well as appropriate interventions.
Strive for gradual dose reduction of antipsychotics
Define a Consistent Approach to Minimize the use of Antipsychotic Medications

• Engage pharmacy consultants to identify opportunities for changing or eliminating medications to maximize benefit and minimize side effects.

• Use the medical director to communicate between the interdisciplinary team (IDT) and attending physicians to align goals and practices with regard to providing improved care for persons with dementia.
Define a Consistent Approach to Minimize the use of Antipsychotic Medications (cont.)

- Prior to initiation of any new antipsychotic medication for a resident, implement a policy that key leaders must sign off on the plan for initiation and monitoring of the medication.
- Use data to identify and track who is taking an antipsychotic medication and why.
- Identify residents that are appropriate for gradual dose reductions.
- Establish a clear plan for the dose reduction, incorporating a plan for monitoring and reassessing the resident’s response to the reduction.
Antipsychotic Medication Reduction
Resident Prioritization Tool Part 1

The actions in the pink hexagons are intended to be addressed before moving to Part 2.

Box 1: MDS-Referenced Diagnosis
- Schizophrenia
- Schizoaffective disorder
- Tourette syndrome
- Huntington disease
Consult MDS for more information.

Box 2: Common Low or Starting Dose
- Quetiapine (Seroquel) 12.5-25mg
- Olanzapine (Zyprexa) 2.5-5mg
- Risperidone (Risperdal) 0.25-0.5mg
- Aripiprazole (Abilify) 2-5mg
- Ziprasidone (Geodon) 20-40mg

*https://goo.gl/uuyqRh*
Antipsychotic Medication Reduction
Resident Prioritization Tool Part 2

Use this ONLY to evaluate residents after completing Part 1 (other side)

List Residents | Target Symptom
--- | ---

Non-Aggressive Target Symptom Absent

Rank residents in order of who has been symptom-free the longest (longest is #1)

<table>
<thead>
<tr>
<th>Rank</th>
<th>Resident</th>
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<tbody>
<tr>
<td>1</td>
<td></td>
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<tr>
<td>2</td>
<td></td>
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<tr>
<td>3</td>
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<tr>
<td>4</td>
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</table>

Target Symptom absent for less than three months**

Time it took to become free of target symptom (shortest time is #1)

<table>
<thead>
<tr>
<th>Rank</th>
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<tbody>
<tr>
<td>1</td>
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<td>2</td>
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<tr>
<td>3</td>
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<td>4</td>
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</tbody>
</table>

Non-Aggressive Target Symptom Persists**
Hallucinations, delusions (do not mistake delusions for memory problems)

Dose of medication (highest dose is #1)

<table>
<thead>
<tr>
<th>Rank</th>
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<tbody>
<tr>
<td>1</td>
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<td>2</td>
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<td>3</td>
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</table>

Aggressive Target Symptom*
Behavior that causes physical or emotional harm to others or one’s self, or threatens to.

How long resident has been on medication (longest time is #1)

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<tr>
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<th>Resident</th>
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</thead>
<tbody>
<tr>
<td>1</td>
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<td>3</td>
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<tr>
<td>4</td>
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</tbody>
</table>

Target Symptoms Where Antipsychotic Treatment May Be Inappropriate
Wandering, not being social or friendly, poor self-care, restlessness, uncooperativeness without aggression. Consult provider.

Add up points for each resident in the green boxes above (#1 is 1 point etc.)

Resident | Points
|---------|-------
|         |       |
|         |       |
|         |       |
|         |       |

These lists are not comprehensive and are intended to be used only as guidance.

- This flowchart was developed in part utilizing documentation with permission from Dr. Thomas Magnuson of the University of Nebraska Medical Center published article “Reductions in Antipsychotics in Long Term Care”
- Always consult the provider
- Dose reductions should be approached with awareness and caution for symptoms of withdrawal
- Documentation is key for target symptom management and outcomes tracking
- In aggressive residents, six months of stability may be needed.
- In non-aggressive residents, three months of stability is reasonable before a reduction is attempted.

The resident with the LOWEST point total should be considered first for dose reduction.

https://goo.gl/uuyqRh
MULTIDISCIPLINARY MEDICATION MANAGEMENT COMMITTEE

ANTIPSYCHOTIC USE IN DEMENTIA ASSESSMENT

RESIDENT NAME: _______________ ROOM: _______________ PHYSICIAN: _______________

ASSESSMENT DATE: _______ □ Initial assessment □ Continuation assessment
PHQ-9 Score/date: ___________ BIMS/CPS Score/date: ___________

A. ANTIPSYCHOTIC (name/dosage/directions):
   □ Start Date: ___________ Last Dosage Change: ___________ (Decrease/Increase)

B. OTHER CONCURRENT CLINICAL CONCERNS:

   □ Pain □ Infection □ Constipation □ Weight loss
   □ Falls □ Parkinson's □ Depression □ Insomnia
   □ Other: _______________

C. REASON FOR ANTIPSYCHOTIC INITIATION:
   □ Dementia illness with associated behavioral symptoms
   □ Dementia alone
   □ Other: _______________
   □ No Indication Identified

D. TARGETED SYMPTOMS OR BEHAVIORS (why it was started):

______________________________

E. NONPHARMACOLOGICAL INTERVENTIONS:

______________________________

F. BEHAVIORAL TRENDS SINCE LAST ASSESSMENT (documentation):
   □ Behavioral symptoms Decreased □ Behavioral symptoms increased
   □ No Change in Behavioral symptoms

SUMMARY:

______________________________

G. ADVERSE EFFECT MONITORING (changes from baseline functioning) [AIMS: date ______]

   □ Dizziness, palpitations or confusion □ Nausea or loss of balance
   □ Falls □ Constipation
   □ Mural ptyalism □ Unintentional weight gain □ Tachycardia □ Vision changes

______________________________

M3 COMMITTEE SUMMARY OF BEHAVIORAL TRENDS & ANTIPSYCHOTIC USAGE:

______________________________

Page 1 of 2
High Risk Residents w/Pressure Ulcers
## MDS 3.0 Measure: Percent of High-Risk Residents With Pressure Ulcers (Long Stay)

<table>
<thead>
<tr>
<th>MEASURE DESCRIPTION</th>
<th>MEASURE SPECIFICATIONS</th>
<th>COVARIATES</th>
</tr>
</thead>
</table>
| **Numerator**       | All long-stay residents with a selected target assessment that meets **both** of the following conditions:  
1. Condition #1: There is a high risk for pressure ulcers, where “high-risk” is defined in the denominator definition below.  
2. Condition #2: Stage II-IV pressure ulcers are present, as indicated by **any** of the following three conditions:  
   2.1 M0300B1 = [1, 2, 3, 4, 5, 6, 7, 8, 9] or  
   2.2 M0300C1 = [1, 2, 3, 4, 5, 6, 7, 8, 9] or  
   2.3 M0300D1 = [1, 2, 3, 4, 5, 6, 7, 8, 9]. | Not applicable. |

| **Denominator**     | All long-stay residents with a selected target assessment who meet the definition of high risk, except those with exclusions. Residents are defined as high-risk if they meet **one or more** of the following three criteria on the target assessment:  
1. Impaired bed mobility or transfer indicated, by **either or both** of the following:  
   1.1 Bed mobility, self-performance (G0110A1) = [3, 4, 7, 8].  
   1.2 Transfer, self-performance (G0110B1) = [3, 4, 7, 8].  
2. Comatose (B0100 = [1])  
3. Malnutrition or at risk of malnutrition (I5600 = [1]) (checked). | |

| **Exclusions**      | 1. Target assessment is an admission assessment (A0310A = [01]) or a PPS 5-day or readmission/return assessment (A0310B = [01, 06]).  
2. If the resident is not included in the numerator (the resident did not meet the pressure ulcer conditions for the numerator) AND **any** of the following conditions are true:  
   a. M0300B1 = [-]  
   b. M0300C1 = [-]  
   c. M0300D1 = [-]. | |

Source: MDS 3.0 RAI Manual  
[www.goo.gl/qUuwgo](http://www.goo.gl/qUuwgo)
M0100 Determination of Pressure Ulcer Risk/M0300 Stage 2, 3, and 4 Pressure Ulcer

• Assessment is based on highest stage of existing ulcer(s) at its worst; do not reverse staging.
• Determination of pressure ulcer risk
• Current number of unhealed pressure ulcers and stage of each
• Dimensions of unhealed stage 3 or 4 pressure ulcers or eschar
• Most severe tissue type (epithelial, granulation, slough, eschar, or none)
• Worsening in pressure ulcer since prior assessment
• Were pressure ulcers present on admission?
Pressure Ulcers: Areas to Consider

- Coding
- Completion of risk assessments
- Admission protocols
- Timeliness of interventions
- Criteria for different interventions
- Communication between caregivers and nursing management
- Competency evaluation
- Weekly reviews for at-risk residents
Pressure Ulcers: Facility Acquired Pressure Ulcer Investigation Form

Facility Acquired Pressure Ulcer Investigation Form

Resident name: ____________________________________________________________
Room number: __________________________________________________________

Date pressure ulcer identified: ___________________________ Time/shift identified: ___________________________

Stage of pressure ulcer: ___________________________ Second nurse assessment to verify staging: ___________________________

<table>
<thead>
<tr>
<th>Investigation</th>
<th>Five ‘Why’s’ to Uncover the Root Cause</th>
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<tbody>
<tr>
<td></td>
<td>Resident develop a pressure ulcer?</td>
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<tr>
<td></td>
<td>Why?</td>
</tr>
<tr>
<td></td>
<td>Why?</td>
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<td></td>
<td>Why?</td>
</tr>
<tr>
<td></td>
<td>Why?</td>
</tr>
<tr>
<td></td>
<td>What prevention strategies were in place when the pressure ulcer was identified:</td>
</tr>
</tbody>
</table>

Root Cause Analysis

Identification/results: ____________________________________________________________
Plan of action: ____________________________________________________________

Skin Team Members: ___________________________ Medical Director: ___________________________
Administrator: ___________________________
Pressure Ulcers: HSAG Tip Sheet

Quality Measure Tip Sheet: Pressure Ulcers—Long Stay

Quality Measure Overview

- This measure captures the percentage of long-stay, high-risk residents with stage II-IV pressure ulcers.
- This measure will trigger if the resident presents as having a Stage II, III, or IV pressure ulcer and if the resident is considered high risk for pressure ulcers. (This is the numerator.)
- A high-risk resident is identified as meeting one or more of the following three criteria of the target assessment:
  1. Impaired bed mobility or transfer indicated by either or both of the following:
     - Bed mobility self-performance (G0110A1), transfer self-performance (G0110B1) [8], [4], [7], [8]
     - Comatosis (80100)
     - Malnutrition or at risk for malnutrition (15600) is checked
- MDS Coding Requirements

  - Provide base assessment on highest stage of existing ulcer at its worst; do not use reverse-staging.
  - Determine the resident’s pressure ulcer risk.
  - Document the current number of unhealed pressure ulcers and the stage of each.
  - Indicate the dimensions of any unhealed Stage III or IV pressure ulcers or eschar.
  - Indicate the most severe tissue type (e.g., epithelial, granulation, doughy, eschar, or nonnal).
  - Note any worsening in pressure ulcers since prior assessment.
  - Indicate if the pressure ulcers were present on admission.

Exclusion:
- Target assess is an admission assessment, PPS 5-day, readmission/return assessment.
- Resident does not meet the pressure ulcer conditions for the numerator, and any of the following are coded as [8] M0900081, M09000C3, or M09000D1.

Ask These Questions ... 

- Was the MDS coded per Resident Assessment Instrument (RAI) requirements?
- Are risk assessments completed per policy (usually on admission, quarterly, and after a change in condition); and, based on the score, are interventions implemented for prevention?
- Does a criteria guide exist for the type of interventions to use, and is it accessible to floor nurses?
- Are the interventions communicated to front-line staff members; does a quality-rounding process exist to ensure application of devices?
- Are nurses evaluated for competency in wound evaluation?
- Are certified nursing assistants evaluated for proper wound care conditions and interventions?

https://goo.gl/9RE5Kg
Falls With Major Injury
## Falls With Major Injury: MDS 3.0

### MDS 3.0 Measure: Percent of Residents Experiencing One or More Falls with Major Injury (Long Stay)

<table>
<thead>
<tr>
<th>MEASURE DESCRIPTION</th>
<th>MEASURE SPECIFICATIONS</th>
<th>COVARIATES</th>
</tr>
</thead>
<tbody>
<tr>
<td>CMS: N013.01 NQF: 0674</td>
<td><strong>Numerator</strong> Long-stay residents with one or more look-back scan assessments that indicate one or more falls that resulted in major injury (J1900C = [1, 2]).</td>
<td>Not applicable.</td>
</tr>
<tr>
<td></td>
<td><strong>Denominator</strong> All long-stay nursing home residents with a one or more look-back scan assessments except those with exclusions.</td>
<td></td>
</tr>
<tr>
<td></td>
<td><strong>Exclusions</strong> Resident is excluded if one of the following is true for <strong>all</strong> of the look-back scan assessments: 1. The occurrence of falls was not assessed (J1800 = [-]), OR 2. The assessment indicates that a fall occurred (J1800 = [1]) AND the number of falls with major injury was not assessed (J1900C = [-]).</td>
<td></td>
</tr>
</tbody>
</table>
J1900: Number of falls since admission/entry, reentry, or prior assessment (OBRA* or scheduled PPS**), whichever is more recent

- This measure is a look-back scan measure.
- This measure is triggered if the event/condition occurred any time during a one-year period.
- Fall history is obtained with a look-back scan of up to six months prior to admission.
- Exclusions:
  - Occurrence of fall was not assessed.
  - Assessment indicates a fall occurred, but the number of falls with major injury (e.g., bone fractures, joint dislocations, closed-head injuries with altered consciousness, and subdural hematoma) was not assessed.

*Omnibus Reconciliation Act
**Prospective Payment System
Falls With Major Injury: Areas to Consider

• Coding
• Root cause analysis
• Assessments and scoring
• Preventive devices
• Environmental precautions
• Medication management
• Comfort
• Therapy involvement
• Restorative maintenance
• Quality rounding for safety
• Safety committee
• Monitoring of safety devices

• Gait belts
• Staff member competency with transfers and positioning
• Pain management
• Proper resident positioning
• Strong activity department
• Bowel and bladder management
• Monitoring of safety devices
Falls With Major Injury: HSAG Tip Sheet

Quality Measure Tip Sheet: Falls With Major Injury—Long Stay

Quality Measure Overview
- This measure is a look-back scan measure. If the resident had one or more falls with a major injury on one or more of the look-back scan assessments, it will trigger the measure.
- This measure triggers if the event/condition occurred any time during a one-year period.
- Fall history is obtained with a look-back of up to six months prior to admission.

Exclusions:
- The occurrence of fall was not assessed.
- The assessment indicates a fall occurred and the number of falls with major injury was not assessed.

MDS Coding Requirements
- In the Minimum Data Set (MDS):
  - Include fall history on admission/entry or re-entry.
  - Include number of falls since admission/entry, re-entry, or prior assessment (Omnibus Reconciliation Act (SORRA) or scheduled Medicare Prospective Payment System assessment), whichever is more recent.
  - Indicate major injuries for:
    - Bone fractures
    - Joint dislocations
    - Closed head injuries with altered consciousness
    - Subdural hematomas

Ask These Questions ...
- Was the MDS coded as per the Resident Assessment Instrument requirements?
- Was a fall risk assessment completed on admission, quarterly, and with changes to identify appropriate risk?
- Was a process in place based on fall score to initiate preventive devices?
- Were preventive devices communicated to direct-care staff members?
- Are interventions monitored for placement and function?
- Are gait belts accessible for transfers?
- Do the nurses demonstrate competence for assessing fall risk?
- Are the direct-care staff members proficient in transfers and mobility functions?
- Are fall precautions taken if the resident is on anticoagulants, antidepressants, antiepileptics, antihypertensives, antiparkinson agents, benzodiazepines, diuretics, monoclonal anti-inflammatory agents, psychotropics, vasodilators, laxatives, glycemic medications, tranquilizers, or hypnotics/sedatives?
- Are vision issues addressed?
- Is appropriate footwear utilized?
- Is the resident appropriately positioned?
- Are pain and comfort issues addressed? Are rest periods provided?
- Are activity programs individualized for the resident to meet his or her needs/preferences?
- Is continence managed?

For guidance on your quality measures, reach out to Health Services Advisory Group (HSAG).

https://goo.gl/MCK1fw
Nursing Home Collaborative Change Package

CHANGE PACKAGE

A curated collection of great ideas & practices to create lasting change in your nursing home

https://goo.gl/a9iauG
References: On the Web

**HSAG**

- QM Tip Sheet: Antipsychotic Medication (L-S)

- QM Tip Sheet: Pressure Ulcers (L-S)
  [https://www.hsag.com/globalassets/providers/resources-nh/qualitymeasuretipsheet-pressureulcers.3.30.16.final.pdf](https://www.hsag.com/globalassets/providers/resources-nh/qualitymeasuretipsheet-pressureulcers.3.30.16.final.pdf)

- QM Tip Sheet: Falls with Major Injury (L-S)

**CMS**

- MDS 3.0 Quality Measures User’s Manual
Nursing Home Facility Assessment Tool

Requirement
Nursing facilities will conduct, document, and annually review a facility-wide assessment, which includes both their resident population and the resources the facility needs to care for their residents (§483.70(e)).

The requirement for the facility assessment may be found in Attachment 1.

www.hsag.com/facility-assessment-tool
NH Facility Assessment Tool: Purpose

Used to determine what resources are necessary to care for residents competently during day-to-day operations and emergencies. It may be used to make decisions about direct care staff member needs as well as capabilities to provide services to the residents in your facility.
NH Facility Assessment Tool: Introduction

• Requirement
• Purpose
• Overview of the tool
• Guidelines for conducting the assessment
• Table to capture when the assessment was completed/updated, and those involved
NH Facility Assessment Tool: Overview

Introduction

Main Body (3 parts)
1. Resident profile and factors that impact care and support needs
2. Services and care offered based on resident needs
3. Facility Resources needed to provide competent care for residents

Attachments (2)
1. References to the facility assessment in the October 2016 Centers for Medicare & Medicaid Services Final Rule-Reform of Requirements for Participation for Long-Term Care Facilities (LTCFs)
2. Sample process for conducting the assessment
NH Facility Assessment Tool Introduction: Guidelines for Conducting the Assessment

- Use data from a variety of sources
- Plan for an inclusive process that includes your customers
- Conduct at the facility level
- Review and update annually or when there are significant changes
- Use as a record to understand reason for staffing and resource decisions
- Understand how the assessment may be used in the survey process
- See Attachment 2 for a suggested process for conducting the assessment
## FACILITY ASSESSMENT TOOL

<table>
<thead>
<tr>
<th>Facility Name</th>
<th>Administrator:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Persons (names/titles) involved in completing assessment</td>
<td>Director of Nursing:</td>
</tr>
<tr>
<td></td>
<td>Governing Body Rep:</td>
</tr>
<tr>
<td></td>
<td>Medical Director:</td>
</tr>
<tr>
<td></td>
<td>Other:</td>
</tr>
<tr>
<td>Date(s) of assessment or update</td>
<td></td>
</tr>
<tr>
<td>Date(s) assessment reviewed with Quality Assessment &amp; Assurance /Quality Assurance &amp; Performance Improvement (QAA/QAPI) committee</td>
<td></td>
</tr>
</tbody>
</table>

1. Resident Profile and factors that impact care and support needs
2. Services and care offered based on resident needs
3. Facility Resources needed to provide competent care for residents
Resident Profile:

• The Numbers; licensed bed, average daily census, persons admitted/discharged
• Common Issues; diseases/conditions, physical and cognitive disabilities
• Decisions regarding care for residents with conditions that you do not commonly see
• Acuity–ID potential implications regarding the intensity of care and services needed
• Ethnic, culture, religious, or other factors that may affect the care provided
Services and Care:

- Listing of resident support and care needs based on what your resident population requires
- The purpose is to help identify and reflect on resources needed to provide these types of care
- Sample list provided (pages 6–7) to be modified based on your facility’s population
Facility Resources Needed to Provide Competent Care

- Staff type (sample list provided on page 9)
- Staffing plan (your general approach to staffing)
  - See attachment 2, 7.b
- Individual staff assignment
- Staff training/education and competencies (sample lists provided on pages 10–11)
- Policies and procedures for provision of care
- Working with medical practitioners
- Physical environment and building/plant needs
- Other: Contracts, MOU*, HIT** resources, infection prevention (IP) program, miscellaneous assessments, etc.

*MOU=Memorandum of understanding
**HIT= Health information technology
Regulatory Mentions of Facility Assessment:
• Reference only
• Not inclusive
Sample Process for Conducting the Assessment:

• Plan for the assessment
• Complete the assessment
• Synthesize and use the findings
• Evaluate your process and plan for future assessments
• Nursing homes can use or adapt this optional tool
• CMS: “Due to the significant variations in the types of LTC facilities, resident populations, and resources among the LTC facility facilities, we believe that the facilities need the flexibility to determine the best way for each facility to comply with this requirement...and conduct that assessment, as long as it addresses or includes the factors or items set forth in §483.70(e).” We have not required any specific methodology for facilities to use for the facility assessment.”
• Your feedback is appreciated.

www.hsag.com/facility-assessment-tool
QM, QAPI Questions?

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Trish Borntrager, RN  
QI Specialist  
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Frequently Asked Questions Regarding the National Healthcare Safety Network (NHSN)

Ohio NHQCC II Learning Session 2
First, What is NHSN?

• National Healthcare Safety Network (NHSN)
• Operated by the Centers for Disease Control and Prevention (CDC)
• Currently utilized by hospitals
• Secure federal mainframe
  – Need for Secure Access Management Services (SAMS) card
Question 1: How do I calculate the Total Resident Days for summary data?

Answer: It’s the sum of each day’s facility census for the reporting month.

Remember: You do not include bed-hold days.
Question 2: How do I know if the resident type for an event is Long-stay or Short-stay?

Short-stay: Resident has been in facility for less than or equal to 100 days from date of first admission.

Long-stay: Resident has been in facility greater than 100 days from date of first admission.
Question 3: We have reported our summary data but did not have any cases of in-house CDI for the month. How do we report this?

Answer: For the given month check the “Report No Events” box in NHSN.
Question 4: How do I report a resident who was admitted with *C. difficile*?

**Answer:** A resident who is admitted with *C. difficile* is only counted in your summary data.

**Remember:** If the resident came from a hospital, they would report the event on their end.
Question 5: The NHSN Facility Administrator will be leaving the facility. How does someone else take over reporting CDI events?

**Answer:** Another person must go through the process of acquiring a SAMS card, and then gain rights.

**Remember:** HSAG and the CDC recommend all nursing homes have at least 2 individuals within the facility with a SAMS card.
NHSN Questions?

Angila Anderson, BSHA, LPN
QI Specialist
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General Resources

Ohio NHQCC II Learning Session 2
Advancing Excellence is now the National Nursing Home Quality Improvement Campaign

Same goals. New resources!
Are You Receiving Monthly Email Updates?

Email us to be added!

ohnursinghome@hsag.com

The Ohio Nursing Home Quality Care Connection

The QCC Newsletter is your monthly Nursing Home Quality Care Collaborative (NHQCC) Ohio member update that provides information on the latest activities. It is a quick reference for information on upcoming learning events, links to improvement tools, resources, news, best practices, and success stories.

The Centers for Medicare & Medicaid Services (CMS) recently released Interpretative Guidance update for Phase II of the Requirements of Participation. A QCC Certification and Survey Memo dated June 30, 2017, outlines the Revised Interpretative Guidance for Survey Agnists, revised F-tags, a revised survey process, training resources for surveyors and Long Term Care (LTC) providers and enforcement, and Nursing Home Comparisons considerations for Phase II. Phase II requirements are scheduled to take effect November 28, 2017.

Encourage Resident Mobility

Mobility is a term that includes physical strength, flexibility, balance, and endurance, according to the National Nursing Home Quality Improvement Campaign. It includes important activities that require movement, such as turning over in bed, getting up, standing, walking, or using a device. Not all residents are equally mobile; however, being able to move helps improve physical function and psychological well-being. For example, improved mobility can improve sleep, appetite, and independence during activities of daily living.

To help nursing homes encourage resident mobility, the National Nursing Home Quality Care Collaborative Change Package includes a six-point change bundle to help multidisciplinary quality improvement team support function and well-being of residents. The six points are as follows:

1. Define mobility for each unique individual.
2. Provide a place or space to move.
3. Provide supportive equipment.
4. Train staff and residents.
5. Support and encourage.
6. Address physical and psychological needs that inhibit mobility.

You can find specific action items for each of these six points in Attachment 3 of the NHQCC Change Package (April 2017 V2.2).

Quality Measure Tips: Activities of Daily Living (ADL)

The ADL quality measure reports the percentage of residents whose need for help with ADLs has increased when compared with the prior assessment. The seven-day, look-back measure involves four tasks: ADLs, mobility, transferring, eating, and toileting. When you are working with your staff members, you may want to consider the following questions:

- Is the staff member's coding documentation accurate?
- Has the root cause for the decline been determined and treated?
- Is pain management managed?
- Is the resident receiving appropriate assistance from staff members?

If you would like more improvement tips and MDS coding insight, download the HSAG ADL quality measure tip sheet. Please contact ohnursinghome@hsag.com if you have any questions.
Visit www.hsag.com/ohnursinghome

Ohio Nursing Homes

Our New Website

The new Ohio NHQCC website is your one-stop shop for the latest collaborative news, events, announcements, and resources you need to continue providing high-quality care to your residents.

Welcome to the Ohio Nursing Home Quality Care Collaborative (NHQCC)

Providing the highest quality care to nursing home residents is a mission shared by all nursing home professionals. The work done in each nursing home—from preventing pressure ulcers to appropriately using antipsychotic drugs—has a profound effect on improving the lives of Ohio’s 79,000 nursing home residents.

With the Ohio NHQCC, Health Services Advisory Group will work with nursing homes to identify opportunities for improvement using a data-driven, proactive approach to improve quality.

About the Collaborative

Nursing Homes

- Collaborative Description
- The Composite Score
- Quality Assurance & Performance Improvement
HSAG NHSN Resources

www.hsag.com/nh-nhsn-resources
Resources to Improve Re-hospitalization Rate

Alliant Zone Tools:

- Heart failure
- Pneumonia
- COPD
- UTI
- Diabetes
- Total hip replacement

http://www.alliantquality.org
Resources to Improve Re-hospitalization Rate

Avoidable Hospital Readmission
Organizational Assessment

Resources to Improve Re-hospitalization Rate

Hospital Readmission from Skilled Nursing Facility Report

Contact the Readmission Team Representative Nearest You.
Readmission Team Contact Information

- Caitlin Mocarski, MPH
  cmocarski@hsag.com
  614.653.5455

- Erica Stanton, BSAS
  estanton@hsag.com
  614.301.1874

- Rosi McGinnis, MS RN
  rmcginnis@hsag.com
  614.307.1715

= Top readmitting hospitals
## Upcoming Events

### Upcoming HSAG Webinars

<table>
<thead>
<tr>
<th>Event</th>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Elements of Antibiotic Stewardship and the CDI Initiative</td>
<td>November 7</td>
</tr>
<tr>
<td>Learning Session 3</td>
<td>May 2018</td>
</tr>
</tbody>
</table>


### Ohio Person-Centered Care Coalition Conference

- Navigating The Future: Partner in Person-Centered Care– November 9  
  (visit [www.centeredcare.org](http://www.centeredcare.org) to register and for more information.)
Questions
Thank you!