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NEW QUALITY MEASURES - ADLS CLARIFIED

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In April 2016, CMS began posting data for six new quality measures (QMs) on Nursing Home Compare, which was implemented July, 2016.

These measures include the following:

1) Percentage of short-stay residents who were successfully discharged to the community (Claims-based)
2) Percentage of short-stay residents who have had an outpatient emergency department visit (Claims-based)
3) Percentage of short-stay residents who were re-hospitalized after a nursing home admission (Claims-based)
4) Percentage of short-stay residents who made improvements in function (MDS-based)
5) Percentage of long-stay residents whose ability to move independently worsened (MDS-based)
6) Percentage of long-stay residents who received an antianxiety or hypnotic medication (MDS-based)

Clarifying information for these new QMs are available at URL:
https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/CertificationandComplianc/Downloads/Improvements-NHC-April-2016.pdf

and (technical specifications)

https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/CertificationandComplianc/Downloads/New-Measures-Technical-Specifications-DRAFT-04-05-16-.pdf

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This article reviews the primary differences between the three QMs related to ADLs.

Q) We already have a QM for ADLs, "Percentage of long-stay residents whose need for help with daily activities has increased." Yet, we see two new QMs related to ADLs. How do these QMs differ?

A) First, the QM "Percentage of long-stay residents whose need for help with daily activities has increased" is a Long Stay QM. Long Stay QMs are those based on residents whose cumulative days in the facility (CDIF) is greater than 100 days for the episode of the target assessment in the sample. Additionally, this QM is based on the "Late Loss" ADLs (Bed Mobility, Transfers, Toileting, and Eating), where an "increase" is defined as an increase in two or more coding points in one of the Late Loss ADLs or an increase in one ADL coding point in two of the Late Loss ADLs.

The QM, "Percentage of short-stay residents who made improvements in function" is a Short Stay QM (target assessment for resident episodes with a CDIF < 100 days). This QM is based on self-performance in three mid-loss ADLs (MLADLs), transfers, locomotion on the unit, and walking in the corridor. Additionally, this QM is calculated as the percent of short-stay residents with improved mid-loss ADL functioning from the 5-day assessment to the discharge assessment and is based on a discharge assessment at which return to the nursing home is not anticipated. The sum of coding points for these MLADLS is compared on the 5-day assessment with the Discharge Return Not Anticipated assessment and if the sum decreases (negative) score, the target assessment is included in the numerator for the sample.

Next, the QM, "Percentage of long-stay residents whose ability to move independently worsened" (again) is a Long Stay QM. The numerator for this measure is the number of long-stay residents who had a decline in locomotion on the unit: self-performance since their prior MDS assessment. A decline is identified by an increase of one or more points on the "locomotion on unit: self-performance" item (G0110E1) between the target assessment and the prior assessment, with 7s (activity occurred only one or twice) and 8s (activity did not occur) recoded to 4s (total dependence).

If you have any questions please feel free to contact Nathan Shaw, RN, BSN, MBA, LHRM, RAC CT- 3.0, Vice President of Clinical Reimbursement & Analytics for RB Health Partners, Inc. (copyright ©) at nathan@rbhealthpartners.com or Robin Bleier at robin@rbhealthpartners.com or call 727.786.3032.

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Robin Bleier is a senior healthcare executive and the President of RB Health Partners, Inc., a national Clinical Risk Medicare Operations Consultancy Firm based in Tampa Bay, Florida. Robin has over 30 years of progressive experience with increasing levels of responsibilities focused in LTC to include post-acute & skilled nursing, assisted living, independent, and continuing care facilities. Robin is experienced in acute care and home health to include care management which allows her to integrate such services into her interdisciplinary company's team to meet their client's needs.

Infection Prevention and Control Programs: Expanded Scope and the CMS's Phased-In Approach for Updated Regulations for Nursing Homes

Prepared by:
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The Centers for Medicare and Medicaid Services (CMS) published their updated rules and regulations for nursing homes in the Federal Register Published on October 4, 2016. CMS is requiring implementation of new requirements in three phases; Phase 1 requirements effective November 28, 2016, Phase 2 requirements effective November 28, 2017, and Phase 3 requirements are effective November 28, 2019. In short, nursing homes need to have an infection prevention and control program (IPCP) that follows accepted national standards by November 28, 2016. The updated regulations include a few subtle differences that are required to be implemented in Phase 1. For example, the regulations now call for a more robust surveillance system that is designed to identify possible communicable disease and infections before it can spread to other persons in the facility and more specific policies on isolation precautions. Policies will need to specify the type and duration of isolation depending upon the infectious agent or organisms involved and that the least restrictive option possible under the circumstances for isolation precautions is implemented. In addition, nursing homes will need to have a system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. This may be facilitated by integrating the IPCP into QAPI as well as the application of quality assurance and performance improvement practices for infection prevention and control. Lastly, facilities are required to review their IPCP annually and update as needed.

Influenza and pneumococcal immunization requirements are also included under § 483.80 Infection Control. Phase 1 requirements include that each resident is to be offered the influenza immunization October 1 - March 31 each year and the pneumococcal immunization is to be offered to those who are not vaccinated or contraindicated, residents and or their representative is educated on the benefits and potential side effects of both the influenza and pneumococcal immunizations, and that the resident medical record reflects when education was offered and if the resident has or has not been immunized. If a resident declines immunization, the reason for declination and or contraindication must also be documented in the resident's medical record.

The more substantial changes to infection control requirements are not required to be implemented until Phases 2 and 3. Beginning in Phase 2, nursing homes are required to conduct an annual facility assessment to determine what resources are needed to ensure competent care for its residents (noted in § 483.70 Administration). The evaluation of infection prevention and control practices, resources, and risks need to be a part of the facility assessment process to support the implementation of a system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases that is based on evaluation of risk and need specific to the facility's resident population. Also in Phase 2, nursing homes are required to have an antibiotic stewardship program that includes antibiotic use protocols and a system to monitor antibiotic use. In Phase 3, CMS requires nursing homes to designate who serves as an Infection Preventionist (IP) for the facility. Facilities may have more than one infection preventionist and it is the IP(s) who are responsible for the IPCP. The IP(s) must work in the facility at least part-time and have primary professional training in nursing, medical technology, microbiology, epidemiology, or another related field. The IP may be qualified by education, training, experience, or certification and must have completed specialized training in infection prevention and control. Lastly, the IP is required to be a part of the QAPI committee.

CMS has not updated their regulations since 1991 and much has changed since then in terms of technology and advances in practice standards. The focus of the updated regulations are to support competency based, quality care reflective of current practice standards and guidelines in addition to aligning requirements with the Affordable Care Act. RB Health Partners, Inc. has developed a 2-day intensive training to assist nursing homes with implementing an infection prevention and control program that is consistent with national standards and the updated CMS requirements. For more information about Infection Prevention & Control, to learn about the RB Health Partners, Inc. two- day Infection Prevention and Control Program Training, or other services, please contact A.C. Burke at ac@rbhealthpartners.com or contact Robin A. Bleier at robin@rbhealthpartners.com. Both can also be reached at 727-786-3032.

CMS Skilled Nursing Facility Quality Reporting Program

Prepared by:
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With the data collection for the three new Skilled Nursing Facility Quality Reporting Program (SNF QRP) quality measures in effect as of October 1, 2016, facilities will need to assess current evaluation and documentation processes to ensure that data coded on the MDS is supported. This has always been best practice, however with the advent of the new quality measures now having impact on a facility's annual payment update (APU), it becomes even more important. As a reminder, data collected during October 1, 2016 - December 31, 2016 for any resident admitted on October 1, 2016 with a Medicare A stay will impact APU for FY 2018. Currently, the three areas of focus are: Functional Abilities and Goals, Falls, and Pressure Ulcers.

MDS Section GG (Functional Abilities) is a new section that assesses the resident's usual ability to perform specific functional ability over a three-day assessment period. Performance is coded based on each resident's performance of activity and use of any helper(s), if necessary, to ensure activity is completed safely. Unlike Section G, this section is coded based on resident's usual performance, not the most dependent performance. It should also not be coded based on most independent performance.

To ensure accuracy of coding for MDS Section GG it will be important that Nursing and Therapy work closely together and communicate each resident's functional status in terms as defined by the RAI 3.0 Manual. Identifying current terms used by each discipline and determining how these terms can be related to MDS Section GG will aid in the communication process. As a reminder, the evaluation for MDS Section GG should be based on a three-day observation period. Any observations or interviews with resident, family or staff to gather data should be documented in the medical record. While many of the therapy electronic records systems have updated evaluations and/or discharge summaries to reflect the additional items under MDS Section GG, their documentation is only part of the observation period. Residents often perform at different levels throughout the day and it is important to capture these changes in functional ability to accurately code MDS Section GG.

MDS Section J (Falls) item J1900 - Number of Falls Since Admission/Entry or Reentry or Prior Assessment (OBRA or Scheduled PPS) will impact a facilities QMs. Each fall should be coded to the highest level of injury obtained. To ensure accuracy of coding injury level resulting from fall. The assessor may need to look beyond the ARD to obtain information. Integrating the definitions of falls from the RAI 3.0 Manual within a facilities risk management program for tracking and trending falls is advisable. Doing so can assist with facility auditing to assure the accuracy of coding of falls on the MDS. It is important to accurately code falls, thus when information is obtained after an MDS has been accepted into the QIES-ASAP system that would result in a change of the coding for section J1900, the MDS must be modified to capture those changes. MDS Section M (Pressure Ulcers) Item M0300 is used to calculate the percentage of residents with pressure ulcers that are new or worsening. Determining if pressure ulcer(s) were Present on Admission (POA) is a key component to the accurate coding of section M0300. Facilities with a robust wound care program that includes complete, thorough, and accurate documentation and monitoring of pressure ulcers will have an advantage when coding this section. Remember, that only a physician, or physician extender, may diagnosis which includes the diagnosis of pressure ulcers. So, obtaining accurate provider documentation is important. If working with a wound care physician or company it is important to monitor documentation and if necessary, educate providers regarding the definitions related to pressure ulcers and staging found in the RAI 3.0 Manual.

CMS Awards Five New Contracts For Its RAC Program

Important Reprint From:
Provider Daily
A Provider Magazine Publication

McKnight's Long Term Care News (11/1, Mongan, 921) reports the Centers for Medicare & Medicaid Services "has awarded five new contracts for its recovery audit contractor program [RAC], a move one expert suggests reflects the agency's renewed efforts to cut improper payments in Medicare." Four contracts were awarded "to identify and correct improper Medicare Part A and Part B payments through post-payment reviews," and a fifth contract "was given [to] a company to review payments for medical equipment, home health and hospice claims." The RAC program "has recovered an estimated $10 billion in improper payments, and extended Medicare's solvency by two years," according to the Council for Medicare Integrity.

Modern Healthcare (11/1, Dickson, Subscription Publication, 241K) adds the contracts were awarded to Performant Recovery, Cotiviti, and HMS Federal Solutions.

Regulatory Changes Now and on the Horizon ...Melding the 'new' and 'old' in Florida

Prepared by:
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President

As stated, the only constant is change and seemingly never more noted than now! In the past, several months if we use our starting point, we have implemented the federal Payroll Based Journal (PBJ), state Pre-Admission Screening and a Resident Review (PASRR), a new 3008-5000 (Continuity of Care Form), have the new federal Emergency Preparedness requirements to analyze, our state is facing a change in our Medicaid payment system (no change yet...) Prospective Payment System (PPS), and of course we now have the new federal Rules of Participation.

In this article, we will look at our new federal Rules of Participation and specifically at the Adverse Event (federal) as opposed to the Adverse Incident (state). Please be advised that until there is specific guidance from CMS no one can speculate on how the regulators will survey for an Adverse Event or other areas in the new federal Rules of Participation. To better understand the impetus of the Adverse Event (federal), it is encouraged that providers read or re-read the February 2024 OIG report entitled “Adverse Events in Skilled Nursing Facilities: National Incidence Among Medicare Beneficiaries" (OEI-06-11-00370), as this was the basis for including Adverse Events in the new rule.

To define, *an **Adverse Event** is an untoward, undesirable, and usually unanticipated event that causes death or serious injury, or the risk thereof.* There is currently no set report for an Adverse Event.

An ***Adverse Incident*** *(state) can be reviewed to reflect in section 5., (a) An event over which facility personnel could exercise control and which is associated in whole or in part with the facility's*

intervention, rather than the condition for which such intervention occurred, and which results in one of the following:

1. Death
2. Brain or spinal damage;
3. Permanent disfigurement;
4. Fracture or dislocation of bones or joints;
5. A limitation of neurological, physical, or sensory function;
6. Any condition that required medical attention to which the resident has not given his or her informed consent, including failure to honor advanced directives;
7. Any condition that required the transfer of the resident, within or outside the facility, to a unit providing a more acute level of care due to the adverse incident, rather than the resident's condition prior to the adverse incident; or
8. An event that is reported to law enforcement or its personnel for investigation; or
9. Resident elopement, if the elopement places the resident at risk of harm or injury.

While it was noted that an Adverse Event in it of itself is not federally reported, based on the federal guidelines the circumstances could result in a resident being involved in a matter that has one or more required reports based on our existing reporting guidelines. Thus, it is key that providers have a clear understanding of each possible reportable circumstance based on state and federal laws. As one can see, the melding of the 'new' and the 'old' is important and so we are advised to review our current guidelines to be prepared to adapt to any new ones. As always in risk management it is by far better to stay out of trouble then it is to get out of trouble.

Robin A. Bleier is the President of RB Health Partners, Inc. a Clinical Risk Medicare & Operations Consultancy Firm. We partner with clients to assist them to reach their goals. To ask questions pertaining to this article or to learn more about how we can assist you, please call 727.786.3032 or email robin@rbhealthpartners.com.

OUR MISSION

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