

Florida's Agency for Health Care Administration 2014 Joint Training for Skilled Nursing Facilities



Tuesday, February 4, 2014 – Orlando
Thursday, February 6, 2014 – Tampa
Monday, February 24, 2014 – Davie/Ft. Lauderdale
Thursday, February 27, 2014 – Tallahassee

Approved for 6 hours of continuing education – FHCA Provider Number 50-720:

Florida Board of Nursing Home Administrators

Florida Board of Nursing

Florida Board of Clinical Social Work, Marriage and Family Therapy and Mental Health Counseling

Florida Board of Occupational Therapy

Florida Board of Speech-Language Pathology & Audiology

FHCA does not have NAB approval for this program

Event Overview

The 2014 Joint Training for skilled nursing facilities is a forum for the Agency for Health Care Administration and leading long term care experts to brief providers, advocates and state surveyors on regulatory compliance with enforcement provisions explained. This training will highlight the implementation of managed care, critical compliance topics and problematic care areas with guidance for quality outcomes. The Life Safety section will address recent physical plant citations across Florida and how to avoid negative survey outcomes.

Schedule of Events

7:30 a.m.	Registration
8:30 a.m.	Welcome and Introductions
8:45 to 9:45 a.m.	Medicaid Managed Care LTC Program Update for Skilled Nursing Facilities <i>Beth Kidder, AHCA</i> Beth Kidder will provide an update on the Statewide Medicaid Managed Care Long-term Care program implementation and discuss how Florida will ensure the managed care system for long term care provides quality services to individuals with long term care needs.
9:45 to 10:00 a.m.	Break
10:00 a.m. to 12:00 p.m.	Top 10 Deficiencies and Hot Topics - Including Life Safety Citations, F 309, Transfer/Discharge and Resident Rights <i>Polly Weaver and Eddie Alday, AHCA</i> The Florida State Survey Director will discuss the major areas of deficiencies. Concerns with transfer and discharge decision-making, residents' rights and other issues in the determination of levels of care and placements will be addressed. Life Safety enforcement will also be a topic of discussion, with opportunities for Q & A.
12:00 to 1:15 p.m.	Lunch
1:15 to 3:15 p.m.	Successful Practice Guidelines for Quality Outcomes <i>Deborah Afasano, Avante Group, Inc.</i> Successful clinical care practices will be highlighted within the framework of a facility's Quality Assurance and Performance Improvement (QAPI) and the partnership with Advancing Excellence.
3:15 to 3:30 p.m.	Break
3:30 to 4:30 p.m.	Survey Enforcement and Civil Money Penalties <i>Polly Weaver and Kimberly Smoak, AHCA</i> Florida has one of the highest CMP collections in the nation, linked to costly immediate jeopardy citations. This session will discuss the importance of regulatory compliance in critical areas of enforcement.

*6 total contact hours can be earned

Target Audience

Nursing home administrators, nurse leaders, charge nurses, social workers, therapists, activity directors, consultants, ARNPs, Physician Assistants, Medical Directors and dietary staff. Additional stakeholder audiences include state surveyors.

Faculty:

Polly Weaver has over 25 years of regulatory experience and has served as the Chief of Field Operations for the Division of Health Quality Assurance, Agency for Health Care Administration (Agency) since 1995. Her responsibilities include management of the eight field offices located throughout Florida, which are responsible for the certification, survey functions and enforcement activities of the health care facilities licensed by the Agency. In addition, she oversees the staff training and quality assurance program as well as complaint administration activities.

Eddie Alday has been with the Agency for Health Care Administration since December 2012. Currently, he is a Government Analyst II with the Survey & Certification Support Branch located in the Division of Health Quality Assurance. He is responsible for preparing and monitoring the Medicare and Medicaid Services and CLIA budgets for Field Operations. He also provides oversight, instruction and development of quality assurance activities for the Life Safety Survey Program.

Deborah Afasano, BSN, CDONA, HCRM, ELNEC is Vice President of Clinical Services for Avante Group, Inc. She is an end-of-life trainer through ELNEC, MDS 3.0 resident assessment coordinator through AANAC and a licensed health care risk manager. Her diverse nursing background spans 30-plus years in acute and long term care settings. Ms. Afasano also serves as Chair of the FHCA Quality Foundation Senior Clinicians Council.

Beth Kidder is the Assistant Deputy Secretary for Medicaid Operations at the Agency for Health Care Administration. She oversees Medicaid policy development and quality initiatives. She has 15 years of experience working for state Medicaid programs, beginning in North Carolina, and including 11 years with Florida Medicaid. Ms. Kidder holds a Bachelor's Degree from the University of Florida and a Master of Public Policy Degree from Duke University.

Kimberly Smoak, QDDP, MSH has been with the Agency for Health Care Administration (Agency) for over 18 years. Currently, she is the Manager of the Survey & Certification Support Branch located in the Division of Health Quality Assurance (Division). As the Manager of the Survey & Certification Support Branch, she is responsible for monitoring quality improvement/quality assurance indicators for the Division, training of survey staff and other Division staff, data management and support functions. She develops and implements strategies to improve consistency among the field offices and the program units as those functions relate to the Survey and Certification functions of the Agency under contract with the federal Centers for Medicare and Medicaid Services (CMS), in addition to monitoring state requirements and timeframes. She provides technical assistance regarding programmatic issues and assists in interpreting rules, policies and standards.

February 4, 2014

**Radisson Resort
Orlando-Celebration**
2900 Parkway Boulevard
Kissimmee, FL 34747
(407) 396-7000

Room rate: \$99
Cut-off: January 15

Parking is complimentary

February 6, 2014

**Embassy Suites Hotel
USF/Busch Gardens**
3705 Spectrum Boulevard
Tampa, FL 33612
(813) 977-7066

Room rate: \$129 single
\$139 double

Cut-off: January 17

Parking is complimentary

February 24, 2014

Signature Grand
6900 State Road 84
Davie, FL 33317
(954) 424-4000 (directions
only)

Parking is complimentary

*Hotel reservations can be
made at the Holiday Inn
located at 2540 Davie
Road, Davie, FL 33317 by
calling (954) 585-7071.*

*Room Rate: 15% Discount
on published room rates
when you mention
Signature Grand Event*

February 27, 2014

**Tallahassee Automobile
Museum**
6800 Mahan Drive
Tallahassee, FL 32308
(850) 942-0137 (directions
only)

Parking is complimentary

*If you need suggestions
on hotel accommodations,
contact FHCA at
(850) 224-3907.*

Florida's Agency for Health Care Administration

2014 Joint Training for Skilled Nursing Facilities

Program Objectives:

After completion of this program, the attendee will be able to:

- describe the most up-to-date Medicaid Managed Care implementation processes for long term care;
- recognize the methods through which Florida's Medicaid Program will ensure quality services to individuals with long term care needs;
- identify the major areas of deficiencies, including transfer and discharge, resident rights and life safety, and methods for compliance;
- outline best-practices for developing a QAPI plan integrated into all care and service areas of an organization;
- identify strategies to influence safe transitions of care, advanced care planning and reduced re-hospitalizations; and
- summarize methods for successful regulatory compliance to avoid costly immediate jeopardy citations and penalties.

Presenter Bios:

Beth Kidder is the Assistant Deputy Secretary for Medicaid Operations at the Agency for Health Care Administration. She oversees Medicaid policy development and quality initiatives. She has 15 years of experience working for state Medicaid programs, beginning in North Carolina and including 12 years with Florida Medicaid. Beth holds a Bachelor's Degree from the University of Florida and a Master of Public Policy Degree from Duke University.

Deborah Afasano, BSN, RNC, CDONA, HCRM, is a certified Director of Nurses, a certified end-of-life ELNEC trainer and a health care risk manager on faculty for the USF Health Care Risk Management Program. Her diverse nursing background spans over 30 years in acute and LTC settings. Debbie is currently the VP of Clinical Services for the Avante Group with skilled nursing and assisted living facilities in three states. She is a former governor appointee to the Florida Center for Nursing, and the founding and current chair of the FHCA Senior Clinicians' Council. Debbie is the 2011 recipient of the NADONA Spirit of Nursing Presidents Award and an inductee into the Sigma Theta Tau National Honor Society.

Eddie Alday has been with the Agency for Health Care Administration since December 2012 where he currently serves as Government Analyst II with the Survey & Certification Support Branch located in the Division of Health Quality Assurance. His responsibilities include preparing and monitoring the Medicare & Medicaid Services and CLIA budgets for Field Operations. He also provides oversight, instruction and development of quality assurance activities for the Life Safety Survey Program. Eddie holds a Master Certification for Code

Enforcement from the University of Georgia, Associates Businesses Management from Vincennes's University, attended classes for Construction Management at Clayton University and Valdosta State College and received his Fire Inspector I certification from the Florida State Fire College. Previously, he served 24 years as a US Army Engineer and has worked the past 12 years as a Building Official, Planning and Zoning Administrator, Building Inspector for Commercial and Residential, Third Party Construction Consultant and Contractor.

Kimberly Smoak has been with the Agency for Health Care Administration for over 18 years. Currently, she is the Manager of the Survey & Certification Support Branch located in the Division of Health Quality Assurance. She is responsible for monitoring quality improvement/quality assurance indicators for the Division, training of survey staff and other Division staff, data management and support functions. She develops and implements strategies to improve consistency among the field offices and the program units as those functions relate to the Survey and Certification functions of the Agency under contract with the Federal Centers for Medicare and Medicaid Services (CMS), in addition to monitoring state requirements and timeframes. She provides technical assistance regarding programmatic issues and assists in interpreting rules, policies and standards.

Polly Weaver has over 25 years of regulatory experience and, since 1995, has served as the Chief of Field Operations for the Division of Health Quality Assurance, Agency for Health Care Administration. Her responsibilities include management of the eight Agency for Health Care Administration field offices located throughout Florida, overseeing the staff training and quality assurance program, as well as complaint administration activities.

Shevaun Harris is the Bureau Chief for Medicaid Services at the Agency for Health Care Administration. She has over 10 years of experience in the health and human services field, working with children and adults with HIV/AIDS, chronic conditions and behavioral health issues. She has worked at the Agency for Health Care Administration since 2005 and has held several progressively responsible positions. In her current role with the Agency, Shevaun is responsible for managing a staff of over 65 employees and responsible for the development, coordination and implementation of Medicaid program policies and procedures (with the exception of pharmacy services) and is responsible for the administration of the program's medical authorization functions. She received her Bachelor's degree in Psychology and a Master's degree in Social Work from Florida State University and most recently earned another Master's degree in Business Administration from Quinnipiac University.

Presentations and Descriptions:

8:45 to 9:45 a.m.

Medicaid Managed Care LTC Program Update for Skilled Nursing Facilities

Beth Kidder, AHCA (Orlando and Tallahassee) or Shevaun Harris (Tampa and Davie)

Description:

AHCA representatives will provide an update on the Statewide Medicaid Managed Care Long-term Care program implementation and discuss how Florida will ensure the managed care system for long term care provides quality services to individuals with long term care needs.

10:00 a.m. to 12:00 p.m.

Top 10 Deficiencies and Hot Topics - Including Life Safety Citations, F 309, Transfer/Discharge and Resident Rights
Polly Weaver and Eddie Alday, AHCA

Description: The Florida State Survey Director will discuss the major areas of deficiencies. Concerns with transfer and discharge decision-making and residents' rights and other issues in the determination of levels of care and placements will be addressed. Life Safety enforcement will also be a topic of discussion, with opportunities for questions and answers.

1:15 to 3:15 p.m.

Successful Practice Guidelines for Quality Outcomes
Deborah Afasano, Avante Group, Inc.

Description: Successful clinical care practices will be highlighted within the framework of a facility's Quality Assurance and Performance Improvement (QAPI) and the partnership with Advancing Excellence.


3:30 to 4:30 p.m.

Survey Enforcement and Civil Money Penalties
Polly Weaver and Kimberly Smoak, AHCA

Description: Florida has one of the highest CMP collections in the nation, linked to costly immediate jeopardy citations. This session will discuss the importance of regulatory compliance in critical areas of enforcement.

The Statewide Medicaid Managed Care Program & Florida Nursing Facilities

Beth Kidder / Shevaun Harris
Agency for Health Care Administration




Why are changes being made to Florida's Medicaid program?

- Because of the Statewide Medicaid Managed Care (SMMC) program, the Agency is changing how a majority of individuals receive most health care services from Florida Medicaid.

Statewide Medicaid Managed Care program


Long-term Care program
(implementation Aug. 2013 – March 2014)

Managed Medical Assistance program
(implementation May 2014 – August 2014)



The SMMC program does not/is not:

- The program ***does not*** limit medically necessary services.
- The program ***is not*** linked to changes in the Medicare program and does not change Medicare benefits or choices.
- The program ***is not*** linked to National Health Care Reform, or the Affordable Care Act passed by the U.S. Congress.
 - It does not contain mandates for individuals to purchase insurance.
 - It does not contain mandates for employers to purchase insurance.
 - It does not expand Medicaid coverage or cost the state or federal government any additional money.



General Eligibility and Enrollment Information

- All Medicaid recipients will be enrolled in a managed care plan unless specifically exempted under Chapter 409, Florida Statutes
 - Approximately 85% of Medicaid recipients will receive their services through a managed care plan once the SMMC program is implemented
 - The majority of the remaining 15% of Medicaid recipients who are exempted from enrollment are only eligible for limited Medicaid benefits
- Each Medicaid recipient will have a choice of plans and may select any available plan unless that plan is restricted by contract to a specific population that does not include the recipient.



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Choice Counseling & Outreach



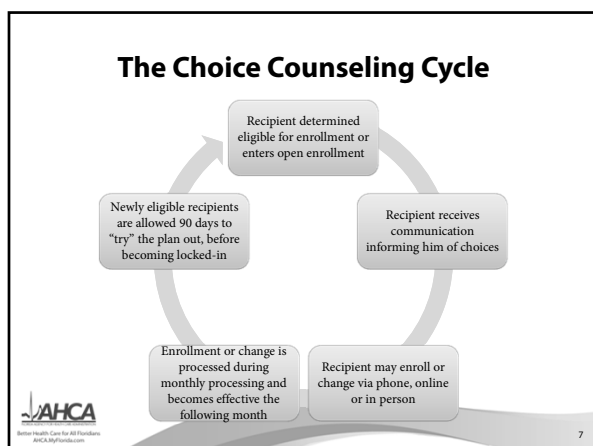
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Choice Counseling

- Choice counseling is a service offered by the Agency, through a contracted enrollment broker, to assist recipients in understanding:
 - managed care
 - available plan choices
 - plan differences
 - the enrollment and plan change process.
- Counseling is unbiased and objective.



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A Closer Look at the Choice Counseling Cycle

- **Newly Eligible Letters:**
 - Approximately 60 days prior to the plan begin date, recipients will receive a letter and a packet of information detailing their choice of plans and how to choose a plan.
 - Letter
 - Brochure that provides plan information specific to the recipient's region
 - Information on how to make a plan choice
 - The plan to which they'll be assigned if they don't make a choice.

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A Closer Look at the Choice Counseling Cycle

- **Reminder Letter:** Reminds fully eligible recipients of their need to make an enrollment choice by a specific cut-off date, (this information was also included in the original letter).
- **Confirmation Letter:** Mailed after a voluntary plan choice or change to confirm the recipient's selection and to inform of next steps and rights.
- **Open Enrollment:** Mailed 60 days prior to the recipient's plan enrollment anniversary date to remind them of the right to change plans.

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A Closer Look at the Choice Counseling Cycle

Individuals may enroll or change their plans using one of the following methods:

- Online at: www.flmedicaidmanagedcare.com
- By contacting the call center at **1-877-711-3662** and speaking with a counselor to complete enrollment or to request a face-to-face meeting.



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Helping your Residents Make Choices

- When individuals call to make a managed care choice or change they must first be able to verify information about themselves to confirm their identity.
- If you are calling on behalf of your residents you must:
 - Have this identity information
 - Explain how you are authorized to make a choice or change on their behalf
 - Submit -proof of authorization after the choice is made.
 - An optional form is at <http://ahca.myflorida.com/smmc>
 - Select LTC tab, then Recipients tab



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Refresher on the Statewide Medicaid Managed Long-term Care Program



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Who is Required to Participate?

Individuals who fit into one of the following categories may be eligible for the LTC program:

- 65 years of age or older **AND** need nursing facility level of care (LOC)*

OR

- 18 years of age or older **AND** are eligible for Medicaid by reason of a disability **AND** need nursing facility level of care.*

* Nursing facility level of care means that someone meets the medical eligibility criteria for Institutional Care Programs (ICP), as defined in Florida Statute.



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What Services are Covered?

Adult companion care	Hospice
Adult day health care	Intermittent and skilled nursing
Assisted living services	Medical equipment and supplies
Assistive care services	Medication administration
Attendant care	Medication management
Behavioral management	Nursing facility
Care coordination/Case management	Nutritional assessment/Risk reduction
Caregiver training	Personal care
Home accessibility adaptation	Personal emergency response system (PERS)
Home-delivered meals	Respite care
Homemaker	Therapies, occupational, physical, respiratory, and speech
Transportation, non-emergency	



Each recipient will not receive all services listed. Recipients will work with a case manager to determine the services they need based on their condition.

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Selecting Long-term Care Plans

- AHCA selected Long-term Care plans through a competitive bid process.
- The state is divided into 11 regions that coincide with the existing Medicaid areas and the Department of Elder Affairs Planning and Service Areas.
- Plans will provide services by region:
 - Five year contracting period for LTC plans.
 - Penalties for plan withdrawals.



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Contracting with a Long-term Care Plan




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During the first year of the program, each selected plan must offer a network contract to:

- Nursing Facilities
- Hospices
- Aging network services providers in their region

After 12 months of active participation in a health plan's network, the plan may exclude any of the providers listed above from the network for failure to meet quality or performance criteria.



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Two Types of Long-term Care Plans


The LTC program has two types of plans:

Health Maintenance Organizations (HMOs)

Are only capitated

Provider Service Network (PSN)

Can be fee-for-service for up to two years, then must be capitated



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Differences in Types of LTC Plans

– Payment:

- If the LTC plan is capitated, then network providers will be paid by the plan.
- If the LTC plan is fee-for-service, then providers will be paid by the Agency after claims are submitted to the LTC plan for authorization.

– Network providers for a fee-for-service provider service network must be fully enrolled in Medicaid.



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When Should I Have a Contract with a LTC Plan?

Nursing facilities should be contracting **now** with the long-term care plans in their region.



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LTC Plan Contact: Provider Networks


Plan Name	Regions of Operation	Contact
American ElderCare	1 through 11	Brenda Evans Phone: 561-496-4440 Email: brevans@americaneldercare.com
Amerigroup	10 and 11	Victoria McMath Phone: 800-950-7679 ext 77429 Email: victoria.mcmath@amerigroup.com
Coventry	6, 7, 9, and 11	Mariangeli Cataluna Phone: 305-222-3012 Email: mecataluna@cctr.com
Humana	4, 10, and 11	Grace Rodriguez Phone: 888-234-6401 Email: graciaronso@lhahealth.com
Molina Healthcare	5, 6, and 11	Lisa Schwendel Phone: 1-888-562-5442, ext. 223694 Email: lisa.schwendel@molinahealthcare.com
Sunshine State Health Plan	1, 3, 4, 5, 6, 7, 8, 9, 10, and 11	Susan McCurry Phone: 850-595-5116 Email: Sunshinecontracting@centene.com
United Healthcare	2, 3, 4, 5, 6, 7, 8, 9, and 11	Sue Kiver 1-850-932-5786 Primary Email: ELI_ltc_network@uhc.com Secondary Email: sue_a_kiver@uhc.com



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Contracting vs. Participating

- Nursing facilities do not have to **contract** with every long-term care plan in their region.
- However, Florida law requires that they must **participate** with every long-term care plan in their region (see s. 409.982(2), F.S.).
- If a nursing facility resident chooses a long-term care plan with which the nursing facility does not contract, the nursing facility and long-term care plan will need to work together to determine how to handle payment for the nursing facility services provided to that resident.




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Contracting vs. Participating

If a nursing facility notifies a resident that he or she will have to move because the facility is not contracted with that resident's plan or cannot reach a payment agreement with that plan, the Agency would consider that the nursing facility is **not participating** with the LTC plan.


All remedies, including termination from Medicaid, will be considered if the nursing facility does not immediately remedy the situation.



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Nursing Facility & Hospice Rates

- The LTC plans are required to pay nursing facilities an amount equal to the nursing facility-specific payment rates set by the Agency.
 - Higher rates mutually acceptable to the plan and the provider may be negotiated for medically complex care.
- The LTC plans must pay hospice providers through a prospective system for each enrollee an amount equal to the per diem rate set by the Agency.



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Incentives Shift to Community-Based Services & Recipient Safeguards


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Incentives Shift to Home & Community Based Care Services

- The law requires that managed care plan rates be adjusted annually to provide an incentive to shift services from nursing facilities to community based care.
- Payment incentives will be in place until no more than 35% of the plan's enrollees are in nursing facilities.


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Recipient Safeguards

- Recipients residing in a nursing facility can choose to remain in that facility, as long as they meet nursing facility level of care.
- Recipients may choose any plan in their region.
- Recipients may choose any provider in their plan's network.
- After the initial LTC plan choice or assignment, enrollees have 90 days to voluntarily disenroll and select another plan.
- After 90 days, plan changes may be made for good cause.



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Recipient Safeguards

- Nursing facilities and hospices must participate with all LTC plans in their region, meaning that they cannot discharge a recipient because of his or her plan choice.
- The nursing facility/hospice and LTC plan will need to work together to determine how to handle payment for the nursing facility/hospice services provided to that recipient.


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Successes & Issues


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Program Implementation

The overarching goals for the Long-term Care program implementation are:

- 1) Ensuring that enrollees have no break in services, and
- 2) Ensuring skilled nursing facility and assisted living facility residents do not have to move to another facility.
 - Both of these goals continue to be met for the implementation to date.
 - Transitioned waiver recipients are receiving services as outlined on their pre-transition care plans until the LTC plans complete the person-centered planning process, and residents of assisted living facilities and skilled nursing facilities have not had to move to another facility since the transition.


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Recipient's Address & Enrollment

- The basis of Medicaid recipient enrollment is the recipient's Residence County in the Florida Medicaid Management Information System (FMMIS).
- If the recipient's address is incorrect in the Medicaid system, the recipient must contact the agency that determined their eligibility.
- This would be either the Department of Children and Families (DCF) or the Social Security Administration (SSA).
 - The recipient will need to request both an address and county change.

Recipient's Address & Enrollment

<http://ahca.myflorida.com/smmc>



If the recipient's address is correct in the Medicaid system, but his *county* is incorrect:

- Report it online at: <http://ahca.myflorida.com/smmc>
- Select the blue "Report a Complaint" button.
- AHCA will work with DCF or SSA to resolve the issue and correct the person's enrollment.

Billing

Fee-for-service Provider Service Network (PSN)

Type of Bill codes nursing facilities providers must use to submit claims.

Type of Bill Codes

- Medicaid is expanding the number of the Type of Bill codes that are valid for nursing facility providers.
- The charts below contain a list of the valid nursing facility Type of Bill codes.
- The UB-04 paper claim form requires a four digit number.
 - The first digit of the Type of Bill code is always a zero.
 - Refer to the appropriate billing instructions regarding the Type of Bill code when submitting claims electronically or through Web Portal applications; the first digit for the leading zero is not always required.



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Type of Bill Codes

- When a recipient is enrolled in Statewide Medicaid Managed Care, nursing facilities must submit claims to the recipient's managed care plan in compliance with the Type of Bill requirements of that managed care plan.
- Effective March 1, 2014, nursing facilities must use the required Type of Bill codes to submit claims directly to the Medicaid fiscal agent.
- Until February 28, 2014, nursing facilities may submit fee for service claims directly to the Medicaid fiscal agent using the Type of Bill codes that are being discontinued:
 - 0251 (original claim); 0257 (adjustments); 0258 (voids); 0261 (original claim); 0267 (adjustments); 0268 (voids).



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Type of Bill Codes


Nursing facility provider types #9 (hospital-based skilled unit) and #10 (nursing facility)		
0211	Admit-Through-Discharge Claim	One claim for an entire stay. Date of admission: the same as the first date of service. Date of discharge: the same as the last date of service.
0212	Interim—First Claim	First claim for a continued stay. Date of admission: a date prior to the first date of service. Date of discharge: none, continued to reside in facility.
0213	Interim—Continuing Claim	Interim claim for a continued stay. Date of admission: a date prior to the first date of service. Date of discharge: none, continued to reside in facility.
0214	Interim—Last Claim	Last claim for a continued stay. Date of admission: a date prior to the first date of service. Date of discharge: the same as the last date of service.
0215	Late Charges Only Claim	Dates of service billed are after the date of discharge billed on a previous claim TOB 0211 (entire stay) or 0214 (last claim).
0217	Replacement of Prior Claim	Completely replaces a previous claim; the original bill is considered null and void.
0218	Void/Cancel of a Prior Claim	Eliminates and cancels a previous claim.



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Type of Bill Codes


Nursing facility provider types #13 (rural hospital swing bed)		
0281	Admit-Through-Discharge Claim	One claim for an entire stay. Date of admission: the same as the first date of service. Date of discharge: the same as the last date of service.
0282	Interim—First Claim	First claim for a continued stay. Date of admission: a date prior to the first date of service. Date of discharge: none, continued to reside in facility.
0283	Interim—Continuing Claim	Interim claim for a continued stay. Date of admission: a date prior to the first date of service. Date of discharge: none, continued to reside in facility.
0284	Interim—Last Claim	Last claim for a continued stay. Date of admission: a date prior to the first date of service. Date of discharge: the same as the last date of service.
0285	Late Charges Only Claim	Dates of service billed are after the date of discharge billed on a previous claim TOB 0281 (entire stay) or 0284 (last claim).
0287	Replacement of Prior Claim	Completely replaces a previous claim; the original bill is considered null and void.
0288	Void/Cancel of a Prior Claim	Eliminates and cancels a previous claim.

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Type of Bill Codes


- The Florida Medicaid UB-04 Reimbursement Handbook and the Florida Medicaid Management Information System (FMMIS) 837 Institutional Health Care Claim and Institutional Encounter Claim Companion Guide will be updated in the near future to reflect this change in nursing facility Type of Bill codes.
- Please contact your Medicaid area office for questions about the Florida Medicaid UB-04 Reimbursement Handbook.
- Please contact the Medicaid fiscal agent's Electronic Data Interchange (EDI) Unit for questions about the FMMIS 837 Institutional Health Care Claim and Institutional Encounter Claim Companion Guide. (1-866-586-0961)

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Bed Hold & Leave of Absence

- The LTC program carries forward the bed hold and leave of absence policies contained in the current Medicaid Nursing Facility Services handbook.
- The handbook is online at <http://mymedicaid-florida.com/>
Select:
 - Public Information for Providers
 - Provider Support
 - Handbooks
- The LTC plan will pay nursing facilities for bed hold and leave of absence days that comply with Medicaid policy.

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Medicare Coinsurance

- Nursing facilities will bill the LTC plans for Medicare Part A coinsurance for individuals who are dually eligible for Medicare and Medicaid.
- The LTC plan must adjudicate Medicare deductibles and co-insurance payments made by the providers or enrollees according to Medicaid guidelines referenced in the Florida Medicaid Provider General Handbook.
 - *Except for patient responsibility, the plan members should have no costs to pay or be reimbursed*
- LTC plans are responsible for nursing facility services, durable medical equipment, home health, and therapies (occupational, physical, speech or respiratory) related crossover payments for their plan members.



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Medicare Coinsurance

- Dually eligible recipients requiring Medicare-funded rehabilitation in a nursing facility may use a facility not contracted with their Medicaid plan.
- Nursing facilities will need to establish an agreement with the Medicaid Long-term care plan in order to bill the plan for the Medicare Part A coinsurance crossover and receive reimbursements or zero payment notifications for the bad debt process.



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Patient Responsibility

- All capitated and fee-for-service LTC plans will be responsible for collecting their enrollee's patient responsibility.
- The LTC plan may transfer the responsibility for collecting its enrollee's patient responsibility to the residential facilities and compensate the facilities net of the patient responsibility amount.



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Patient Responsibility

- If the plan transfers collection of patient responsibility to the provider, the provider contract must specify complete details of both parties' obligations for collection of patient responsibility.
- The plan must either collect patient responsibility from all of its providers or transfer collection to all providers.
- The LTC plans can check the amount of patient responsibility for an enrollee by going to the Florida Medicaid Management Information System, accessing the secure site "DCF Provider View" and then viewing the Patient Responsibility tab.



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Additional Information About Patient Responsibility

Please email the appropriate Department of Children and Families Customer Call Center if you have any questions about a Medicaid recipient's patient responsibility.

- Jacksonville - NFCC_Providers@dcf.state.fl.us
- Tampa - sr_call_center@dcf.state.fl.us
- Miami - SN_Providers_SCFCC@dcf.state.fl.us



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Nursing Facility Transition

- LTC plans will assess their enrollees in nursing facilities about the choice to transition to an assisted living facility, adult family care home, or other community living arrangement.
- Like the former Medicaid Nursing Home Transition Program, transition cannot occur prior to a continuous 60 day stay in the nursing facility.
- LTC plans will coordinate and track these transitions with the enrollees and the assisted living facilities in the LTC plan network. The LTC Managed Care Plan or Comprehensive LTC Managed Care Plan shall notify DCF of the date of nursing facility/ALF admission/discharge prior to the respective admission/discharge date.
- At the time of transition, LTC plans report the change in living arrangement to DCF on Form 2515 within five calendar days after the plan becomes aware of nursing facility discharge.



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Nursing Facility Transition

- Enrollees in the LTC program who are eligible will, as plans become available in their region, choose and enroll in a Managed Medical Assistance (MMA) plan. If an MMA enrollee is eligible and requires long-term care services, he will also choose and enroll in a LTC plan.
- There may be instances where an MMA enrollee suffers an injury or illness that results in a short-term nursing facility or rehab stay.
- In these cases, the enrollee's MMA plan is responsible for coordinating the nursing facility service and paying for the service.
- After the enrollee recovers, the MMA plan is responsible for the coordination of the enrollee's discharge planning from the nursing facility, including planning his post-discharge care back to his home.



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Transitioning to LTC Program Services

- If the MMA enrollee leaves the nursing facility and wants or needs home and community-based services and supports, the enrollee must be assessed by the CARES program to determine if he meets nursing home level of care and must be assessed by his local Aging and Disability Resource Center for placement on the LTC program waitlist.
- If the enrollee meets nursing facility level of care and satisfies other financial requirements, the enrollee is eligible to enroll in the Long-term Care portion of the SMMC program, which will provide him with an array of home and community-based services in his home.



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Changes to the CHOW Process

- If the nursing home rates are not ready by the effective date of the nursing facility CHOW, Medicaid will issue the new provider number effective the date of the CHOW and load the previous owner's nursing home rates to the new owner's provider rate file.
- Therefore the new owner will bill under its own provider number effective the date of the CHOW.
 - The new owner will no longer bill under the previous owner's provider number.
- When the new owner's nursing facility rates are ready, Medicaid will notify the provider and load the new rates into the system.
- The appropriate retro-rate adjustment process will take place, as applicable, after the new nursing facility rates have been loaded to the new owner's provider rate file.



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Quality Measures for Nursing Facilities


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Quality Measures for Nursing Facilities

Each managed care plan shall monitor the quality and performance of each participating provider using measures adopted by and collected by the agency and any additional measures mutually agreed upon by the provider and the plan.

-s. 409.982(3), Florida Statutes


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Quality Measures for Nursing Facilities

- The Agency engaged in discussions with a workgroup comprised of nursing facilities and Medicaid Long-term Care plans to shape the Agency's measures.
- The performance measures established for nursing facility participation in Statewide Medicaid Managed Care Long-term Care plans are based on the data from the Centers for Medicare and Medicaid Services (CMS) Nursing Home Compare website
<http://www.medicare.gov/nursinghomecompare>.


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Quality Measures for Nursing Facilities

- Nursing facilities will meet the Statewide Medicaid Managed Care Long-term Care program's performance measure when their CMS Nursing Home Compare overall rating is:
 - Two or more stars; or
 - One star with a two or more star rating for quality measures and less than the statewide average percentage for long-term care residents that received antipsychotic medication.



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Navigating the CMS Nursing Home Compare Website

Start by going to the CMS Nursing Home Compare Web site and entering Florida in the Location search criteria: <http://www.medicare.gov/nursinghomecompare/search.html>



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Navigating the CMS Nursing Home Compare Website

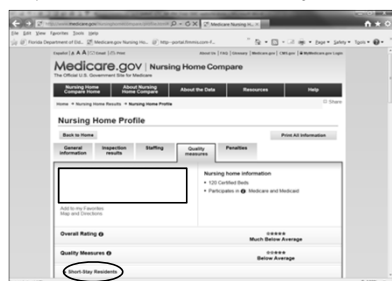
- There are 687 nursing facilities in Florida. To narrow the results, select the relevant county and then select 'Update Results.'



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Navigating the CMS Nursing Home Compare Website

- Select each facility with an 'Overall Rating' of one star. Next, select the Quality Measures tab and then select 'Short Stay Residents' to minimize that data (our focus is long-term care).



Navigating the CMS Nursing Home Compare Website


- Now you can scroll through the facility's data for 'Long-Stay Residents' and locate the relevant data about the facility.

Measure	Facility	National Average
Percent of long-stay residents who were physically restrained	4.7%	2.0%
Percent of long-stay residents who were restrained for 30 days or more	10.0%	10.0%
Percent of long-stay residents who have low body weight	4.7%	9.7%
Percent of long-stay residents who have depressive symptoms	2.0%	2.0%
Percent of long-stay residents assessed and given appropriate, non-restrictive restraints	10.0%	10.0%
Percent of long-stay residents assessed and given appropriate, non-restrictive restraints	17.1%	10.0%
Percent of long-stay residents who received appropriate, non-restrictive restraints	20.0%	20.0%

Quality Measures for Nursing Facilities

- After 12 months of active participation in a MCP's network, the plan **may** exclude any nursing homes, hospices, or aging network service providers for failure to meet quality or performance criteria.
s. 409.982(1), Florida Statutes
- If a nursing facility does not meet the quality criteria, the plan has the option to exclude the nursing facility from its network.


Introducing the Managed Medical Assistance Program



61

Who MAY participate?


- The following individuals may choose to enroll in program:
 - Individuals who have other creditable health care coverage, excluding Medicare;
 - Individuals age 65 and over residing in a mental health treatment facility meeting the Medicare conditions of participation for a hospital or nursing facility;
 - Individuals in an intermediate care facility for individuals with intellectual disabilities (ICF-IID); and
 - Individuals with developmental disabilities enrolled in the home and community based waiver pursuant to state law, and Medicaid recipients.



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Who is excluded from participating?

- Women who are eligible only for family planning services
- Women who are eligible for Medicaid only because they have breast or cervical cancer
- Persons who are eligible for emergency Medicaid for aliens
- Children receiving services in a prescribed pediatric extended care center (PPEC)



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Managed Medical Assistance Services

Minimum Required Covered Services: Managed Medical Assistance Plans

Advanced registered nurse practitioner services	Laboratory and imaging services
Ambulatory surgical treatment center services	Medical supplies, equipment, prostheses and orthoses
Assistive care services	Mental health services
Birth center services	Nursing care
Chiropractic services	Optical services and supplies
Dental services	Optometrist services
Early periodic screening diagnosis and treatment services for recipients under age 21	Physical, occupational, respiratory, and speech therapy
Emergency services	Physician services, including physician assistant services
Family planning services and supplies (some exception)	Podiatric services
Healthy Start Services (some exception)	Prescription drugs
Hearing services	Renal dialysis services
Home health agency services	Respiratory equipment and supplies
Hospice services	Rural health clinic services
Hospital inpatient services	Substance abuse treatment services
Hospital outpatient services	Transportation to access covered services



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Expanded Benefits

List of Expanded Benefits	Alone group	Better	Country	East Coast	Havana	Integral	Maine	Preferred	Prestige	SPCO	Sunlife	Statewell	Sunshine	United
Adult dental services (Expanded)	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
Adult hearing services (Expanded)	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
Adult vision services (Expanded)	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
Art therapy	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
Equine therapy	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
Home health care for non-pregnant adults (Expanded)	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
Influenza vaccine	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
Medically related lodging & food	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
Newborn circumcisions	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
Nutritional counseling	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
Outpatient hospital services (Expanded)	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
Over the counter medication and supplies	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
Pet therapy	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
Physician home visits	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
Pneumonia vaccine	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
Post-discharge meals	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
Prenatal/Perinatal visits (Expanded)	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
Primary care visits for non-pregnant adults (Expanded)	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
Shingles vaccine	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
Waived co-payments	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y

NOTE: Details regarding scope of covered benefit may vary by managed care plan.

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Where will recipients receive services?

- Several types of health plans will offer services through the MMA program:
 - Standard Health Plan
 - Health Maintenance Organizations (HMOs)
 - Provider Service Networks (PSNs)
 - Specialty Plans
 - Comprehensive Plans
 - Children's Medical Services Network
- Health plans were selected through a competitive bid for each of 11 regions of the state.



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Managed Medical Assistance Program Implementation

- The Agency has selected 14 companies to serve as general, non-specialty MMA plans.
- Five different companies were selected to provide specialty plans that will serve populations with a distinct diagnosis or chronic condition; these plans are tailored to meet the specific needs of the specialty population.
- The selected health plans are contracted with the Agency to provide services for 5 years.



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Plans Selected for Managed Medical Assistance Program Participation (General, Non-specialty Plans)

Note: Formal protest pending in Region 11 for MMA Standard Plans

Region	MMA Plans													
	Amerigroup	Better Health	Coventry	First Coast Advantage	Humana	Integral	Molina	Preferred	Prestage	SFCN	Simply	Sunshine State	United Healthcare	Staywell
1		X			X									
2									X					X
3									X			X	X	X
4				X								X	X	X
5	X								X			X		X
6	X	X			X	X			X			X		X
7	X						X		X			X	X	X
8						X			X			X		X
9					X		X		X			X		
10		X		X						X		X		
11	X		X		X		X	X	X		X	X	X	X



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Plans Selected for Managed Medical Assistance Program Participation (Specialty Plans)

Region	MMA Plans							
	Positive Healthcare Florida	Magellan Complete Care	Freedom Health, Inc.	Freedom Health, Inc.	Freedom Health, Inc.	Freedom Health, Inc.	Clear Health Alliance	Sunshine State Health Plan, Inc.
	HIV/AIDS	Serious Mental Illness	Cardiovascular Disease	Chronic Obstructive Pulmonary Disease	Conjunctive Heart Failure	Diabetes	HIV/AIDS	Child Welfare
1							X	X
2		X					X	X
3			X	X	X	X	X	X
4		X						X
5		X	X	X	X	X	X	X
6		X	X	X	X	X	X	X
7		X	X	X	X	X	X	X
8			X	X	X	X	X	X
9		X	X	X	X	X	X	X
10	X	X	X	X	X	X	X	X
11	X	X	X	X	X	X	X	X



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What providers will be included in the MMA plans?

- Plans must have a sufficient provider network to serve the needs of their plan enrollees, as determined by the State.
- Managed Medical Assistance plans may limit the providers in their networks based on credentials, quality indicators, and price.



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Managed Medical Assistance Program Roll Out Schedule

Regions	Enrollment Date	Projected Enrollment
2, 3 and 4	May 1, 2014	681,108
5, 6 and 8	June 1, 2014	811,372
10 and 11	July 1, 2014	828,486
1, 7 and 9	August 1, 2014	750,205



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Rates & Continuity of Care

- MMA plans are responsible for reimbursing nursing facilities and hospices based upon a mutually agreed upon rate between the plan and the provider (with the exception of continuity of care periods).
 - During the continuity of care period, MMA plans are required to continue services until the enrollee's primary care physician or behavioral health provider reviews the enrollee's treatment plan which must be within 60 days after the enrollee's date of enrollment
 - During the continuity of care period, MMA plans are responsible for paying for an enrollee's prior authorized course of treatment, without any form of authorization and without regard to whether such services are being provided by participating or non-participating providers
- Medically fragile children residing in nursing facilities are required to enroll in an MMA plan. However, their nursing facility services will be reimbursed on a fee-for-service basis
 - The MMA plans will be responsible for covering any services that are not included in the per diem



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Hospice Patients

- Nursing home room and board payments will continue to “pass through” the hospice to the nursing home.
- Hospices will bill the MMA plan and then pay the nursing facility the room and board rate.



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Resources



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Statewide Medicaid Managed Care

[Click Here to download the "Authorized Representative Form"](#)
[Click Here to ENROLL ONLINE](#)

Choose Your Language

Welcome!
 Click here to learn more about the program.

iBienvenidos!
 Haga "clic" aquí para obtener más información sobre el programa.

Bienvini!
 Klike la pou aprann plis de pwogram la.

Information on the LTC plans available in each region and on how to choose an LTC plan are available on the Choice Counseling website at:
www.flmedicaidmanagedcare.com

Updates about the SMMC program and upcoming events and news can be found on the SMMC website at:
<http://ahca.myflorida.com/smmc>

Florida Medicaid

Home | News and Events | Long Term Care | Managed Medical Assistance | Federal Authorities

Statewide Medicaid Managed Care Program

In 2011 the Florida Legislature created Part IV of Chapter 408, Florida Statutes, directing the Agency to create the Statewide Medicaid Managed Care (SMMC) program. The SMMC program has two components: the Managed Medical Assistance program and the Long Term Care program.

Choose a link below to view guidance statements and specific information regarding the Long Term Care and Managed Medical Assistance programs.

Choose an arrow below to view general information about the program.

- Program Overview and Summary
- Advanced Savings Rebate Rule

Report Medicaid Fraud Online or 866-966-7226 REPORTE FRAUDE DE MEDICAID

AHCA
 Better Health Care for All Floridians
 AHCA.myflorida.com

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Keep up to date on information by signing up to receive program updates by visiting the SMMC website at:
<http://ahca.myflorida.com/smmc>

Florida Medicaid

Would you like to receive email updates about this program?

Sign up by entering your information below.

Email

First Name

Last Name

* = Required Field

Submit

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State Code: <http://ahca.myflorida.com/smmc>

Florida Statewide Medicaid Managed Care Program Complaint Reporting

If you have a complaint about Medicaid Managed Care services, please complete the information below.

*Required Fields
 For each complaint, please provide:

Your name

Your email

Your phone number

City

County

What is the complaint about?

Name of provider (if applicable)

Did Care, SMC, or Medicaid C or M?

What type of Managed Care Plan is the complaint about?

What is the name of the Managed Care Plan?

What date did the complaint occur?

Please describe:

In electronic format?

Submit

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- Report a Complaint**
- If you have a complaint, or issue about Medicaid Managed Care services, please complete the online form found at:
<http://ahca.myflorida.com/smmc>
 - Click on the "Report a Complaint" blue button.
 - If you need assistance completing this form or wish to verbally report your issue, please contact your local Medicaid area office.
 - Find contact information for the Medicaid area offices at:
<http://www.mymedicaid-florida.com/>

Sample Asked Questions

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Review the SMMC
*Frequently Asked
Questions* document
which is posted at:

<http://ahca.myflorida.com/smmc>

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Stay Informed



- Participate in webinars regarding implementation activities.
- The direct link to the webinars is: <http://ahca.myflorida.com/LTCwebinars>

Stay Connected



[Youtube.com/AHCAFlorida](https://www.youtube.com/AHCAFlorida)



Facebook.com/AHCAFlorida



Twitter.com/AHCA_FL



[SlideShare.net/AHCAFlorida](https://www.slideshare.net/AHCAFlorida)

Agency for Health Care Administration 2014 Joint Training for Skilled Nursing Facilities

Polly Weaver
Chief, Field Operations
Eddie Alday
Life Safety Code Quality Assurance Lead



Objectives

- Review frequently cited deficiencies and discuss strategies to improve compliance in these areas.
- Provide an update on Federal and state initiatives that involve nursing homes.
- Present strategies for implementation of Quality Assurance and Performance Improvement processes.



2

Top Ten Health Deficiency Citations January 1, 2013 - December 31, 2013

Rank	Tag	Count	Description
1	F0371	259	Food Procure, Store/Prepare/Serve - Sanitary (483.35(I) C.F.R.)
2	F0441	259	Infection Control, Prevent Spread, Linens (483.65 C.F.R.)
3	F0282	242	Services By Qualified Persons/Per Care Plan (483.20(K)(3)(ii) C.F.R.)
4	F0309	213	Provide Care/Services For Highest Well Being (483.25 C.F.R.)
5	F0431	200	Drug Records, Label/Store Drugs & Biologicals (483.60(B), (D), (E) C.F.R.)
6	F0253	194	Housekeeping & Maintenance Services (483.15(H)(2) C.F.R.)
7	F0323	189	Free Of Accident Hazards/Supervision/Devices (483.25(H) C.F.R.)
8	F0329	184	Drug Regimen Is Free From Unnecessary Drugs (483.25(L) C.F.R.)
9	F0241	177	Dignity And Respect Of Individuality (483.15(A) C.F.R.)
10	F0279	125	Develop Comprehensive Care Plans (483.20(D), 483.20(K)(1) C.F.R.)

Note: The entire description of each deficiency can be found at:
http://ahca.myflorida.com/MCHQ/Current_Regs.shtml

(Data Draw January 3, 2014)

3

**Common Health Complaint Investigation Citations
January 1, 2013 – December 31, 2013**

Rank	Tag	Count	Description
1	F0309	131	Provide Care/Services For Highest Well Being (483.25 C.F.R.)
2	F0282	119	Services By Qualified Persons/Per Care Plan (483.20(K)(3)(ii) C.F.R.)
3	F0441	101	Infection Control, Prevent Spread, Linens (483.65 C.F.R.)
4	F0323	98	Free Of Accident Hazards/Supervision/Devices (483.25(H) C.F.R.)
5	F0226	77	Develop/Implement Abuse/Neglect, Etc Policies (483.13(C) C.F.R.)
6	F0514	76	Res Records-Complete/Accurate/Accessible (483.75(L)(1) C.F.R.)
7	F0157	74	Notify Of Changes (Injury/Decline/Room, Etc) (483.10(B)(11) C.F.R.)
8	F0425	61	Pharmaceutical Svc - Accurate Procedures, Rph (483.60(A),(B) C.F.R.)
9	F0225	55	Investigate/Report Allegations/Individuals (483.13(C)(1)(i)-(iii), (C)(2) - (4) C.F.R.)
10	F0166	51	Right To Prompt Efforts To Resolve Grievances (483.10(F)(2) C.F.R.)

Note: The entire description of each deficiency can be found at:

http://ahca.myflorida.com/MCHQ/Current_Regs.shtml

(Data Draw January 16, 2014)

4

**Common Health Deficiencies Recited On Revisit Surveys
January 1, 2013 – December 31, 2013**

Rank	Tag	Count	Description
1	F0520	10	QAA Committee-Members/Meet Quarterly/Plans (483.75(O)(1) C.F.R.)
2	F0225	8	Investigate/Report Allegations/Individuals (483.13(C)(1)(i)-(iii), (C)(2) - (4) C.F.R.)
3	F0226	8	Develop/Implement Abuse/Neglect, Etc Policies (483.13(C) C.F.R.)
4	F0323	7	Free Of Accident Hazards/Supervision/Devices (483.25(H) C.F.R.)
5	F0490	7	Effective Administration/Resident Well-Being (483.75 C.F.R.)
6	F0441	6	Infection Control, Prevent Spread, Linens (483.65 C.F.R.)
7	F0282	5	Services By Qualified Persons/Per Care Plan (483.20(K)(3)(ii) C.F.R.)
8	F0253	4	Housekeeping & Maintenance Services (483.15(H)(2) C.F.R.)
9	F0309	4	Provide Care/Services For Highest Well Being (483.25 C.F.R.)
10	F0314	4	Treatment/Svcs To Prevent/Heal Pressure Sores (483.25(C) C.F.R.)

Note: The entire description of each deficiency can be found at:

http://ahca.myflorida.com/MCHQ/Current_Regs.shtml

(Data Draw January 16, 2014)

5

F329 Unnecessary Drugs

- Antipsychotic Drugs.

Based on a comprehensive assessment of a resident, the facility must ensure that:

- Residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record.
- Residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.

F329 Unnecessary Drugs

- The intent of this requirement is that each resident's entire drug/medication regimen be managed and monitored to achieve the following goals:
 - Promote or maintain the resident's highest practicable mental, physical, and psychosocial well-being, as identified by the resident and/or representative(s) in collaboration with the attending physician and facility staff.
 - Each resident receives only those medications, in doses and for the duration clinically indicated to treat the resident's assessed condition(s).



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F329 Unnecessary Drugs

- Goals continued:
 - Non-pharmacological interventions (such as behavioral interventions) are considered and used when indicated, instead of, or in addition to, medication.
 - Clinically significant adverse consequences are minimized.
 - The potential contribution of the medication regimen to an unanticipated decline or newly emerging or worsening symptom is recognized and evaluated, and the regimen is modified when appropriate.



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F329 Investigative Protocol

- Potential Tags for Additional Investigation
 - Notification of Change – F157
 - Notice of Rights and Services, and Free Choice – F154, F155
 - Comprehensive Assessment – F272
 - Comprehensive Care Plans – F279*, F280
 - Quality of Care – F309*
 - Decline in ADL – F310



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F329 **Investigative Protocol**

- Potential Tags Continued...
 - Urinary Incontinence – F315
 - Mental and Psychosocial functioning – F319, F320
 - Nutritional Parameters – F325
 - Hydration – F327
 - Physician Supervision – F385
 - Physician visits – F386
 - Medication Regimen Review – F428
 - Medical Director – F501



10

CMS Surveyor Guidance Revisions

- S&C 13-35–ALL (May 24, 2013)
 - National Partnership to Improve Dementia Care In Nursing Homes
 - Revision to Appendix P of State Operations Manual (traditional survey process resident sample)
 - Revisions to Appendix PP of State Operations Manual
 - F309 Quality of Care
 - F329 Unnecessary Drugs



11

F309 **§483.25 Provision of Care and Services for Highest Well-being**


- 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, in accordance with the comprehensive assessment and plan of care.



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Dementia Care Principles


- Fundamental principles of care of a resident with dementia include an interdisciplinary approach focuses on the needs of the resident as well as needs of other residents in the nursing homes.



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Dementia Care Principles


- Person Centered Care
- Quality and Quantity of Staff
- Thorough Evaluation of New or Worsening Behaviors
- Individualized Approaches to Care



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Dementia Care Principles

- Critical Thinking Related to Antipsychotic Drug Use
- Interviews with Prescribers
- Engagement of Resident and/or Representative in Decision Making



15

Care Process for a Resident with Dementia

- Recognition and Assessment
 - How the resident communicates physical needs;
 - The residents usual and current cognitive patterns, mood and behavior and whether these present a risk to the resident or others;
 - How the resident displays personal distress such as anxiety or fatigue.



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Care Process for a Resident with Dementia

- Cause Identification and Diagnosis
 - Physical
 - Functional
 - Psychosocial
 - Environmental
 - Other potential causes of behavior and related symptoms



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Care Process for a Resident with Dementia

- Development of Care Plan
 - Baseline and ongoing details of common behavioral expressions and expected response to interventions;
 - Specific goals for and monitoring of all interventions for effectiveness in responding to target behaviors/expresses of distress;
 - For any medications, indication/rationale for use, specific target behaviors and expected outcomes, dosages, duration and monitoring.



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Care Process for a Resident with Dementia

- Individualized Approaches and Treatments
 - Identify and document specific target behaviors, expressions of distress and desired outcomes;
 - Implement appropriate, individualized, person-centered interventions and document the results;
 - Communicate and consistently implement the care plan, over time and across various shifts



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Care Process for a Resident with Dementia

- Monitoring, Follow-Up and Oversight
 - Staff monitors and documents the implementation of the care plan, identifies effectiveness of interventions relative to target behaviors and/or psychological symptoms and changes in a resident's level of distress or emergence of adverse consequences;
 - Staff adjusts interventions based on the effectiveness and/or adverse consequences



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Care Process for a Resident with Dementia

- Quality Assessment and Assurance (QAA)
 - Resident care policies reflect the facility's overall approach to the care of residents with dementia including a clearly outlined process for their care;
 - How the facility monitors whether staff follow related policies and procedures in choosing and implementing individualized interventions for the care of the resident with dementia;



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Care Process for a Resident with Dementia

- Quality Assessment and Assurance (QAA)
 - Whether the facility has trained staff in how to communicate with and address behaviors in residents with dementia;
 - Whether there is sufficient staff to implement the care plan for residents with dementia;
 - Whether staff collect and analyze data to monitor the pharmacological and non-pharmacological interventions;
 - How the committee helps the facility monitor responses to the issues and concerns identified through the consultant pharmacist medication regimen review



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Training Opportunities

- Hand-in-Hand Video
 - Mailed to all Nursing Homes in December, 2012
 - Contact Michele.Laughman@cms.hhs.gov
- Surveyor Training
 - <http://surveyortraining.cms.hhs.gov>
 - “I am a Provider”
 - Reduction in Unnecessary Medications in Nursing Homes



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Corrective Action Plan

- Section 7304.4 State Operations Manual
 - Address residents found to have been affected by the deficient practice;
 - Address other residents having the potential to be affected by the same deficient practice;
 - Address what measures that will ensure that the deficient practice will not recur;
 - Indicate how the facility plans to monitor; and
 - Include dates when corrective action will be completed.



24

Quality Assessment and Assurance

- F520
 - Must maintain QAA Committee
 - Meet quarterly
 - Develop and implement appropriate plans of action to correct quality deficiencies
 - Potential markers of quality
 - Area of improvement
 - Internal assessment and is not limited to State Survey Agency survey results



25

Compliance with QAA

- QAA Review is a “Mandatory Task” in the QIS process
- Each survey includes review of compliance with QAA Committee requirement
 - Composition
 - DON, physician and 3 members of facility staff
 - Meeting requirements
 - Minimum of quarterly meetings



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Compliance with QAA

- Surveys where quality deficiencies are identified additional review of QAA is conducted
 - How are issues identified by the Committee?
 - Methods used by the Committee to develop and implement action plans
 - Are staff aware of how to bring issues to the Committee?
 - Are facility practices consistent with facility protocols and reflective of issues identified through the QAA process?
 - Are staff able to demonstrate how they developed, implemented and revised appropriate corrective actions in response to identified concerns?



27

Quality Assessment and Assurance vs. Quality Assurance and Performance Improvement

- Quality Assurance is reactive and retrospective
 - Activities tend to end once the standard is met
- Performance Improvement is pro-active and continuous
 - Intent to improve processes
 - Result in making good quality even better



28

Nursing Home Quality Assurance and Performance Improvement (QAPI)

- Survey and Certification Memo:13-05-NH and 13-37-NH
 - QAPI Website
 - <http://go.cms.gov/Nhqapi>
- QAPI at a Glance
- Video – *Nursing Home QAPI – What's in it for you?*



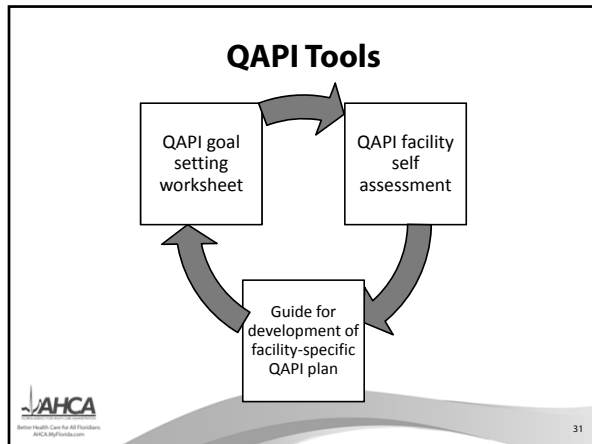
29

QAPI at a Glance

- Detailed guide that enables nursing homes to understand QAPI principles
- Provides details of the fundamental components of QAPI
- Provides tools and resources that nursing homes may use in development of QAPI systems



30



Review Regulatory Requirements

- Review investigative protocols or CE pathways
 - Assists with developing plan
 - Guides investigation
 - Assists with determining compliance.
- Consider Quality Improvement strategies regardless of compliance determination.

32

Mr. Tobias

- 68 year old male
- Retired truck driver
- Diagnosis of Alzheimer's Disease
- Wife had been the care giver until her death
- Subsequent to his wife's death Mr. Tobias was found wandering in his neighborhood
- Court ordered placement two years ago
- Admission orders- "constant supervision to prevent elopement"

33

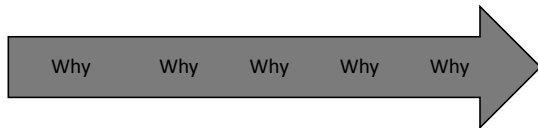
Mr. Tobias

- Wanders throughout the facility
- Wanders into resident rooms
- Other residents losing patience with the intrusion into their room
- Exhibiting signs of aggression
- While wandering, exhibits shortness of breath and is wringing his hands
- At about 7AM falls while walking through area being mopped by housekeeping staff



34

Internal Investigation



35

Mr. Tobias

As the state survey team enters the nursing home, they observe Mr. Tobias wandering in an agitated manner throughout the facility.....



36

Mr. Tobias

- *As the survey progresses, the survey team notices Mr. Tobias continue to wander and that one of his shoes is untied and that he has a small laceration above his left eye.*
- *At approximately 12:30 PM on the day of the survey, a surveyor sees Mr. Tobias leave a resident's room and dishes from the lunch tray tossed out the door toward Mr. Tobias with facility staff in the area indicating no response to the exchange.*
- *Resident and staff interviews are conducted in response to these observations.*



37

Mr. Tobias

Resident interviews reflect frustration at what is perceived as Mr. Tobias' intrusive behavior.



38

Mr. Tobias

- *Staff interviews include statements that Mr. Tobias:*
 - *Is "a bit clumsy"*
 - *Shoes are often untied*
 - *Means no harm*
 - *"Just wanders" and "does not hurt anyone"*
 - *Does not participate in activities other than wandering*
 - *No review of Mr. Tobias' medications has occurred because he seems to be doing "ok"*



39

Facility Concerns

What components of the facility operation are contributing to potential noncompliance based on these findings?



40

Potential Noncompliance

- F157—Notification of Change
 - Failed to notify physician of change in behavior & injury resulting from fall.
- F224—Prevent Neglect
 - Failed to provide adequate supervision to keep resident free from potential mistreatment from other residents due to his wandering behavior.
- F248—Activities
 - Failed to provide an activities program that meets needs of residents who need one-on-one programming. Not involved in activities, left to wander facility.



41

Potential Noncompliance Continued...

- F250—Social Services
 - Failed to provide social services in response to poor quality shoes & declining mental & psychosocial functioning (delusions, increased behavior symptoms & wandering).
- F272—Comprehensive Assessments
 - Failed to conduct comprehensive assessments of psychosocial well-being, mood symptoms, behaviors (wandering, symptoms directed towards others, rejection of care), potential risk for accidents & activity needs.



42

Potential Noncompliance Continued...

- F282—Provide Services per Care Plan*
 - Failed to provide supervision per care plan.
- F319—Mental/Psychosocial Difficulties
 - Failed to provide services to address his restless wandering & prevent decline in psychosocial functioning.
- F323—Accidents/Supervision*
 - Failed to provide adequate supervision & safe environment for resident's wandering.



43

Potential Noncompliance Continued...

- F329—Unnecessary Drugs*
 - Failed to define therapeutic indication of psychoactive medications (Risperdal & Xanax). Failed to attempt a dose reduction & did not conduct behavior monitoring.
- F428—Drug Regimen Review
 - Failed to identify therapeutic intent for psychoactive medication. No attempt at a dose reduction & no behavior monitoring.



44

Potential Noncompliance Continued...

- F501— Medical Director
 - Failed to identify, evaluate and address health care issues related to the quality of care including non-pharmacological interventions or implement an effective system to monitor the performance and practices of care givers.
- F520— Quality Assessment and Assurance
 - Failed to include known concerns in the QAA process for development of an effective action plan.



45

Top Ten Life Safety Code Deficiency Citations January 1, 2013 - December 31, 2013

Rank	Tag	Description
1	K147/49	Electrical Safety (NFPA 101 – LSC 2000 & 2009)
2	K062	Sprinkler Inspection - Testing(NFPA 101 – LSC 2000 & 2009)
3	K067	HVAC Equipment(NFPA 101 – LSC 2000 & 2009)
4	K076	Medical Gas (NFPA 101 – LSC 2000 & 2009)
5	K51/ 52	Fire Alarm Testing(NFPA 101 – LSC 2000 & 2009)
6	K038	Exit Accessibility(NFPA 101 – LSC 2000 & 2009)
7	K050	Fire Drills(NFPA 101 – LSC 2000 & 2009)
8	K069	Cooking Equipment(NFPA 101 – LSC 2000 & 2009)
9	K018	Corridor Doors(NFPA 101 – LSC 2000 & 2009)
10	K109/ 108	Emergency Generator Maintained(NFPA 101 – LSC 2000 & 2009)

1. K147/K49 Electrical Safety

- **NFPA 99**
- **4.4.4.1.2 Maintenance and Testing of Circuitry.**
 - **4.4.4.1.2.1*** Circuit Breakers. Main and feeder circuit breakers shall be inspected annually and a program for periodically exercising the components shall be established according to manufacturer's recommendations.

1. K147/K49 Electrical Safety Cont.

- **4.4.4.1.3 Maintenance of Batteries.** Batteries for on-site generators shall be maintained in accordance with NFPA 110, Standard for Emergency and Standby Power Systems.
- **4.4.4.2 Recordkeeping.** A written record of inspection, performance, exercising period, and repairs shall be regularly maintained and available for inspection by the authority having jurisdiction.

Electrical Safety -Continued

- Power Strips
- State Operation Manual, F323, Power strips may not be used as a substitute for adequate electrical outlets in a facility. Power strips may be used for a computer, monitor, and printer. Power strips are not designed to be used with **medical devices** in patient care areas.



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Electrical Safety -Continued

- Receptacle testing for polarity and tension is required.
- NFPA 99 4.3.3.2 Receptacle Testing in Patient Care Areas.
 - 4.3.3.2.1 The physical integrity of each receptacle shall be confirmed by visual inspection.
 - 4.3.3.2.2 The continuity of the grounding circuit in each electrical receptacle shall be verified.



50

Electrical Safety -Continued

- 4.3.3.2.3 Correct polarity of the hot and neutral connections in each electrical receptacle shall be confirmed.
- 4.3.3.2.4 The retention force of the grounding blade of each electrical receptacle (except locking-type receptacles) shall be not less than 115 g (4 oz.).



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Compliance Issues

- Missing Documentation
- Inspections not being performed
- Not testing/inspecting the Main and Feeder Breakers
- Not testing receptacles and appliances
- Unserviceable devices (hair dryers, receptacles, panels, cords etc.)
- Missing junction box covers (live wires exposed)
- Emergency backup batteries not maintained
- Power strips in patient care areas



52

2. K-62 Sprinkler Systems Testing

- All automatic sprinkler and standpipe systems required by NFPA 101 Life Safety Code shall be inspected, tested, and maintained in accordance with NFPA 25 (2008 edition Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems). NFPA 101 Life Safety Code
- Issues
 - Quarterly Inspections (flow alarm test)
 - Five year obstruction investigation
 - Annual inspection overdue
 - Painted Heads
 - Mixed Heads



53

3. K-67 HVAC/Ventilation Systems Fire & Smoke Damper Testing

- NFPA 101 (2000) 8.5.5.4.2 Smoke dampers and combination fire and smoke dampers shall be inspected, tested, and maintained in accordance with NFPA 105, Standard for the installation of Smoke Door assemblies and Other Opening Protectives.
- Nursing Homes – 4 years
- Hospitals – 6 years



54

K-67 HVAC/Ventilation Systems Fire & Smoke Damper Testing Cont.

- NFPA 72 (2007), 6.16.5 HVAC Systems.
 - 6.16.5.1 The provisions of 6.16.5 shall apply to the system interfaces with the HVAC systems.
 - 6.16.5.2* If connected to the fire alarm system serving the protected premises, all detection devices used to cause the operation of HVAC systems smoke dampers, fire dampers, fan control, smoke doors, and fire doors shall be monitored for integrity in accordance with 4.4.7.



55

K-67 HVAC/Ventilation Systems Fire & Smoke Damper Testing Cont.

- Survey Issues
 - Inspection Documentation missing
 - Dampers not being maintained
 - Dampers not inspected/tested
 - Fusible Links not inspected/tested



56

4. K-76 Medical Gas

- NFPA 101 - 19.3.2.4 Medical Gas. Medical gas storage and administration areas shall be protected in accordance with NFPA 99, Standard for Health Care Facilities.
- NFPA 99, (2005), 5.3.3.3.1
Cylinders in service and in storage shall be individually secured and located to prevent falling or being knocked over.
- 5.3.13.1.3 Cylinders shall be protected from damage. Specific procedures shall include the following: (11) Freestanding cylinders shall be properly chained or supported in a proper cylinder stand or cart.



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Survey Issues

- Full and empty cylinders are stored together
- Cylinders not in racks
- Empty cylinder valves not closed
- Proper signage is not posted
- Hazardous storage room is not rated (door, walls, etc.)



58

5. K51/K52 Fire Alarm System

- K051
 - An electrically supervised fire alarm, which provides emergency forces notification, is available to warn occupants, and operate protective systems shall be provided in accordance with 9.6. 2000 NFPA 101 Life Safety Code 18.3.4 & 19.3.4 & 9.6.



59

5. K51/K52 Fire Alarm System Cont.

- K052
 - The fire alarm system is installed, tested, and maintained in accordance with NFPA 72 (National Fire Alarm Code 2007 edition), and NFPA 70 (National Electrical Code 2008 edition). 2009 NFPA 101 Life Safety Code 18.3.4.1, 19.3.4.1, 9.6.1.3 & NFPA 72 (2007 edition), 7-3.2.
- Survey Issues
 - Alarms not tested correctly
 - Trouble signals not monitored as required
 - Documentation is incomplete



60

6. K38 Exit Access

- Exits and exit access shall be arranged to be readily accessible at all times.
- 7.5.1. Every aisle, passageway, corridor, exit discharge, exit location, and access shall be in accordance with chapter 7, unless otherwise modified by 18.2.2 thru 18.2.11, and 19.2.2 thru 19.2.11. NFPA 101 Life Safety Code 18.2.1 & 19.2.1.



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Definitions

- 3.3.76 Exit Access. That portion of a means of egress that leads to an exit.
- 3.3.161* Means of Egress. A continuous and unobstructed way of travel from any point in a building or structure to a public way consisting of three separate and distinct parts: (1) the exit access, (2) the exit, and (3) the exit discharge.



62

Survey Issues


- Carts, wheelchairs, gurneys, trash cans, etc., located in the exit path while not in use (more than 30 minutes.)
- Doors and locks not operating properly
- No clear path to a public way



63


7. K-50 Fire Drills

- NFPA 101
- 19.7.1 Evacuation and Relocation Plan and Fire Drills
- 19.7.1.1 The administration of every health care occupancy shall have, in effect and available to all supervisory personnel, written copies of a plan for the protection of all persons in the event of fire, for their evacuation to areas of refuge, and for their evacuation from the building when necessary.
- 19.7.1.2 All employees shall be periodically instructed and kept informed with respect to their duties under the plan required by 19.7.1.1.


64


K-50 Fire Drills Continued

- 19.7.1.3 A copy of the plan required by 19.7.1.1 shall be readily available at all times in the telephone operator's location or at the security center.
- 19.7.1.5 Infirm or bedridden patients shall not be required to be moved during drills to safe areas or to the exterior of the building.
- 19.7.1.7 When drills are conducted between 9:00 p.m. (2100 hours) and 6:00 a.m. (0600 hours), a coded announcement shall be permitted to be used instead of audible alarms


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Survey Issues

- Drills are not being conducted as required
- All employees are not participating
- New employees are not being informed of their duties during a drill
- Signatures are missing from the log


66

8. K-69 Cooking Equipment

- NFPA 101 Life Safety Code 18.3.2.5, 19.3.2.5, 9.2.3 & NFPA 96
- Commercial cooking equipment shall be protected in accordance with 9.2.3. Where domestic cooking equipment is used for food warming or limited cooking, protection or separation of food preparation facilities shall not be required. The design, installation, and use of commercial cooking equipment shall be in accordance with **NFPA 96 (Standard for ventilation Control and Fire Protection of Commercial Cooking Operations)**, unless such installations are approved existing installations, which shall be permitted to be continued in service.



67

Cooking Equipment Continued

- NFPA 96 8.3* Replacement Air. 8.3.1 Replacement air quantity shall be adequate to prevent negative pressures in the commercial cooking area.
 - 3.3.11 Cleaning. For kitchen exhaust systems and cooking equipment, the act of removing grease, oil deposits, and other residue.



68

Survey Issues

- Exhaust Hood
 - Failure to inspect every six months and/or clean as necessary
 - Wrong filters or orientation
 - Documentation of the last two inspections
- Hood Suppression System
 - Failure to service every six months
 - Improper auto fuel shutoff interconnect
 - Improper K-Extinguisher & signage
- Improper Hood Coverage
 - After cleaning, the appliance is not returned to correct location



69

9. K-18 Corridor Doors

- Corridor doors shall be 1 3/4 inch solid bonded wood core doors or they shall have a 20 minute fire resistive rating. There shall be no impediment to the closing of the door, and latching devices shall be provided which keep the door tightly closed in the frame.
- For NEW doors, roller latches are prohibited. NFPA 101 Life Safety Code 18.3.6.3 & 19.3.6.3.



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Survey Issues

- Doors not serviceable (Damaged)
- Not rated
- Not latching
- Gap too large
- Not closing properly (Self Closing)



71

10. Emergency Generator K109/K108


- K-109
 - Emergency generator maintenance and testing shall meet the standards in NFPA 101 Life Safety Code 9.1.3. NFPA 110 8.3.8, (A fuel quality test shall be performed at least annually using tests approved by ASTM standards.)
- K-108
 - Alarm, communication, and generator set illumination power are provided per standards of NFPA 101 Life Safety Code 18.2.9, 19.2.9 & 7.9. NFPA 99



72


Survey Issues

- Fuel test
- Load bank test
- Documentation
- Services
- Emergency lighting


73


CMS-Region IV Comparative Survey Findings

- Most common areas cited on Federal comparative Fire Life Safety surveys:
 - K-51 Fire Alarm Testing
 - K-50 Fire Drills
 - K-38 Exit Accessibility
 - K-18 Corridor Doors
- Alarm panel testing was the most common concern noted by the Federal surveyor(s)


74

Survey and Certification Fire Life Safety Updates

- S&C: 14-03-NH/LSC F 454- Physical Environment
 - This tag has been removed from ASPEN
 - Noncompliance is cited under Life Safety Code requirements


75

Survey and Certification Fire Life Safety Updates

- **S&C: 13-58-LSC** - 2000 Edition National Fire Protection Association (NFPA) 101* Life Safety Code (LSC) Waivers provides a list of categorical waivers to reduce the burden on facilities.
- **Several Categorical LSC Waivers Permitted:** The Centers for Medicare & Medicaid Services (CMS) has identified several areas of the 2000 edition of the LSC and 1999 edition of NFPA 99 that may result in unreasonable hardship on a large number of certified providers/suppliers and for which there are alternative approaches that provide an equal level of protection.
- The State of Florida (AHCA) will follow CMS guidelines for these categorical waivers.



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Waiver Requirements

- Providers and Suppliers Must Elect to Use the Waiver:
- Individual waiver applications are not required, but providers and suppliers are expected to have written documentation that they have elected to use a waiver and must notify the survey team at the entrance conference for any survey assessing LSC compliance that it has elected the use of a waiver permitted under this guidance and that it meets the applicable waiver requirements.



77

Background Screening Care Provider Background Screening Clearinghouse

- Provides a single data source for background screening results of persons required to be screened by law for employment in positions that provide services to children, the elderly, and disabled individuals.
- Allows the results of criminal history checks to be shared among specified agencies when a person has applied to volunteer, be employed, be licensed, or enter into a contract that requires a state and national fingerprint-based criminal history check.



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Background Screening Clearinghouse

- Seven state agencies will participate in the Clearinghouse
 - Agency for Health Care Administration (AHCA)
 - Department of Health (DOH)
 - Department of Children and Families (DCF)
 - Department of Juvenile Justice (DJJ)
 - Department of Elder affairs (DOEA)
 - Agency for Persons with Disabilities (APD)
 - Vocational Rehabilitation (DOE-VR)
- To be entered into the Clearinghouse a person screened must:
 - Undergo Level 2 screening and have finger prints retained by FDLE, and
 - Have a photograph taken at the time of screening, and
 - Sign a privacy policy



79

Benefits of the Clearinghouse

- Allows the results of criminal history checks to be shared among specified state agencies, thereby reducing duplicative screenings for individuals requiring screening across multiple state agencies.
- Applicants will now have their fingerprints retained for five years
 - The retention of fingerprints enables a provider to be notified of an arrest of their employee as soon as the information is reported to the Agency by FDLE.
 - The retention of fingerprints will also provide a cost savings for those employees that are in the Clearinghouse but have had a lapse in employment greater than 90 days. After a 90 day lapse in employment, these applicants would only be required to pay for a new national criminal history check (currently \$16.50).



80

Benefits of the Clearinghouse

- Provides a photo of the applicant taken at the time of screening.
 - The provider can verify that the person who applied for the position is the same person that had their background screening completed.



81

Employee Roster

According to section 435.12(2)(c), F.S., an employer of persons subject to screening by a specified agency must register with the Clearinghouse and maintain the employment status of all employees within the Clearinghouse. Initial employment status and any changes in status must be reported within 10 business days.

- You must add an employee to your employee roster to receive arrest and criminal registration notifications. Please remember, per section 435.06(2)(b), F.S., if an employer becomes aware that an employee has been arrested for a disqualifying offense, the employer must remove the employee from contact with any vulnerable person that places the employee in a role that requires background screening.
- Even though the requirement is only for employees/contractors with a Clearinghouse screening, it is highly recommended that ALL employees/contractors are added to the employee roster. By doing so the provider will receive email notifications of employment status changes for all employees.



82

How do I, as a provider, ensure I am receiving all of the benefits of the Clearinghouse?

Initiating screenings through the website is now required per section 59A-35.090(2)(a), Florida Administrative Code (F.A.C.).

- During the initiation process, you will be seamlessly connected with approved Livescan service providers, so that you may enter applicant information, as well as schedule and pay for appointments through one system.

By initiating the screening through our website you will:

- Enter applicant demographic information once (no need to use both the Clearinghouse and a service provider website)
- Reduce duplicative/unnecessary screenings costs
 - The first step to initiate a screening requires you to search the database for an existing screening. By checking for an existing screening first, you will be able to use the existing screening, thereby reducing your screening costs.



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Initiating Screenings Through The Website Continued


- Receive a Florida criminal history report
 - Initiating providers will receive a public record of the applicant's Florida criminal history report.
- Be able to track a screening through the entire screening process and receive email notifications
 - You will be able to see a status at each stage of the screening process, including Fingerprints Submitted, Fingerprints Received from FDLE, Fingerprints Rejected, Fingerprints Rejected 2nd – NCO requested, etc.
 - Each time an applicant's status is updated, you will receive an email notification, reducing the time needed to search the system for updates.
- Screenings in process and screening results will be displayed on their own page, reducing the need to search the entire database.



84

Clearinghouse Statistics


- From January 1, 2013 to December 31, 2013:
 - 2,154 individuals arrested AFTER they were screened (rap backs)
 - **660 individuals went from Eligible to Not Eligible for offenses including:**
 - Grand Theft
 - Battery and Assault
 - Sex Offenses
 - Exploitation of the Elderly


85

Agency for Health Care Administration Background Screening Resources

Background Screening Website
<http://ahca.myflorida.com/backgroundscreening>


Questions/Comments/Issues
bgscreen@ahca.myflorida.com


86

Contact Information

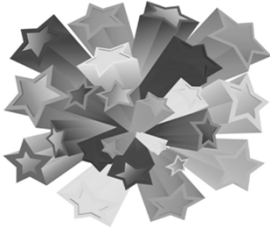
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87

Mobilizing Operational and Clinical Excellence

**Safe Care Transitions
Something to QAPI About**



*Debbie Ayasano
VP of Clinical Services
Avante Group*

Objectives

- Identify strategies to influence safe transitions of care
- Discuss available tools and resources
- Provide suggestions for collaborative Quality Assurance and Performance Improvement initiatives

**Old Quality Paradigm
(Re-Active)**

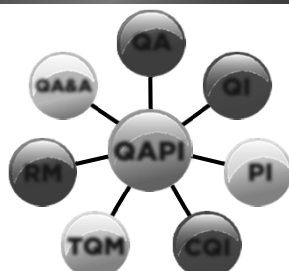
**Risk Management
& Quality Assurance**

**After the fact*



New Paradigm (Pro-Active)





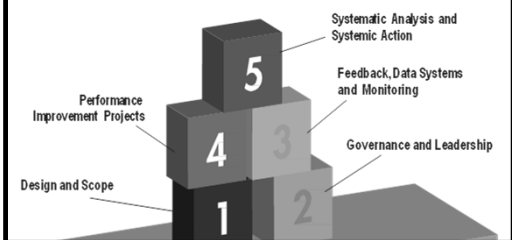
Quality Assurance/Performance Improvement (QAPI): The merger of two complementary approaches to quality, Quality Assurance (QA) and Performance Improvement (PI). QAPI is a data-driven, proactive approach to improving the quality of life, care, and services in nursing homes. The activities of QAPI involve members at all levels of the organization who identify opportunities for improvement; address gaps in systems or processes; develop and implement an improvement or corrective plan; and continuously monitor effectiveness of interventions. (Source: CMS Glossary, www.cms.gov)

Five Elements of QAPI

- **Design & Scope:** Comprehensive Plan; all departments and functions
- **Governance & Leadership:** Buy in; training climate, resources, sustainability
- **Feedback, Data Systems and Monitoring:** Multiple sources, benchmarking, reaching targets, managing adverse events
- **Performance Improvement Projects (PIPs):** Prioritize improvement opportunities, drive the change through a team, apply PDCA
- **Systematic Analysis & Systemic Action:** Understand why! Root cause applications, systems approach and thinking, systematic changes as needed

Safe Transitions and Re Hospitalization: The Perfect QAPI

CMS has identified five strategic elements that are basic building blocks to effective QAPI. These provide a framework for QAPI development.



Sample QAPI provided as handout

QAPI Should Allow For

- Lower Operational Cost and Enhanced Profitability
- Positive Clinical, Operational, Regulatory Outcomes
- Higher Census
- Improved Satisfaction
- Culture Change
- Way of Doing Business

The Focus on Rehospitalization

- Provides a venue for review of programs and services
- Advanced care planning
- Moving, as appropriate to a Palliative model when comfort takes precedence over cure
- Who can you collaborate with?

Rehospitalization Effect on Resident

“Relocation Stress Syndrome” “A consequence of the stress and emotional shock caused by an abrupt relocation of a resident from one location to another.”

Symptoms include:

- Increased dependence on staff
- Delirium, depression, anger, withdrawal
- Change in behavior
- Change in sleep pattern
- Insecurity
- Loss of trust
- Weight loss
- Falls
- Did it help or hinder? Did it promote highest practicable? Could the facility worked towards the same goal without rehospitalization?



Element 1: Design and Scope

A QAPI program must be ongoing and comprehensive AND Address clinical care, quality of life, resident choice, and care transitions

- How do we support Transitional Excellence?
- (What is Your Scope of Care) Who Knows?
- What are the Programs and Services offered at your facility? Have you evaluated staff skills?

Aims for safety and high quality

- What are the indicators of quality related to safe transitions of care? What are the goals we hope to reach?

Element One

- The steering committee has overall responsibility to develop and modify the plan, review information, and set priorities for PIPs.
- The steering committee must learn and use systems thinking—a nursing home has many competing interests and needs.
- Top leadership such as the Administrator and the Director of Nursing must be part of this structure, along with the Medical Director.

Establish permanent and time-limited workgroups that report to it. You might have a QAPI group addressing safe transitions, rehospitalizations and advance care planning

QAPI Element One

- Establish a climate of open communication and respect : Make quality a priority across the continuum
 - Have an open-door policy to communicate and knock on partners doors!
 - Emphasize communication across shifts and between department heads and with external partners.
 - Create an environment (s) where people feel free to bring quality concerns forward without fear of reprisal

Element 2: Governance and Leadership

- The governing body and/or administration of the nursing home develops a culture that involves leadership
- Seeks input from facility staff, residents, and their families and/or representatives.
- Provides adequate resources; champions
- Facility-wide training on QAPI and ensures staff time, equipment, and technical training as needed
- QAPI is a priority and is ensures staff accountability
- Accountability sustains the gains and keeps it going!

Element Two: Governance and Leadership

Leadership and stakeholders are engaged and informed

Seek input from facility staff (and include feedback from partner employees)

What is the community perception on how your facility coordinates care?

Residents /families and/or representatives.

Keep the QAPI integration adequately resourced and sustained over time

Quality Begins Before the Admission

Promoting Safe Transitions is part of the INTERACT QAPI

Establish Collaborative Partnerships

Identify mutual goals of care

Facilitate Advanced Care Planning

Physical, Mental, Psychosocial
needs is a QUALITY focus



Governance and Leadership

Gather data to build relationships with referral sources

- Analyze processes & procedures
- Calculate readmission rates
- Root cause and share readmission reasons
- Act on your findings
- Prevent complications (pressure ulcers; urosepsis; falls, Weight gain & loss, Quality Measure oversight)
- Use the QM's and data from Point Right to build on whatever leads to positive outcomes

Strengthen a "Good admission" : upfront

Strengthen handoffs

Collaborate to Understand What is Occurring With Transitions

Look for areas of improvement and trends

- What are the deficient areas in the transfer of information and the resident ?
- Analyze each one for ideas regarding how it could have been prevented...
- Share the data (Suggest a Quarterly QAPI between facility and hospital, facility and SNF, SNF and Homehealth)with co-developed agenda's

Engaging Partners

- Safe Transitions require two or more partners
- The best sending is relevant only if the receiver uses the right information (Examine the environment in which discharge/admission activity occurs. Quiet zones?)
- Consider a follow up call (72 hours post discharge/admission) Nurse Navigators?
- Identify readmission champions at hospital and SNF/ALF: Verify contact information; Make contact!
- Invite partners to a Safe Transitions Team QAPI for shared opportunities (Handoffs, missing information, medication reconciliation, pain management, advanced directives and care planning at transfer?)
- Suggest a Quarterly review with a mutually beneficial agenda

Ideas...

- Work with hospitals and partners to address short and long term goals of care and advance directives early on with the patient and family to help determine the appropriate next level of care.
- Work with hospitals; Facilitate discussion before transfers on: "What would make his/her stay at the SNF/NF more comfortable? What is the patient's expectation for the SNF/NF stay?"
- Collaborate to ensure the sending and receiving professionals should have reliable contact information for each other (e.g., phone, pager, fax).
- Consider using INTERACT family teaching tools for Palliative decision making
- Adopt similar collaborative teaching tools: Join Palliative teams

Scope

QAPI thinking is integrated into all care and service areas of your organization; It is a way of thinking
How are specific departments assisting care transitions in your facility? Brainstorm to identify roles/responsibilities/opportunities

- Admissions
- Nursing
- SS
- Administration
- Physicians and Extenders
- Therapy
- Housekeeping and Activities
- Others:

Hospital/SNF AHA's: WHO ARE THE PREADMISSION COMMUNICATORS? Nurse to nurse, or discharge planner to Admissions Coordinator?

Describe

- How will the QAPI plan will address Transitional Needs:
 - Clinical care: More transparent Communication Systems, Nurse Navigators or Transitional Nurses, Permanent assignments, STOP and WATCH, Staff huddles, morning reviews
 - Quality of life: Increased resident participation in Advance care Planning, shared emphasis on advance directives and goals of care, utilization of data, weekly QOL meetings that are interdisciplinary and review QM, change in condition, adv directives
 - Resident choice (i.e., individualized goals for care) Implementation of INTERACT advance care planning and resources, 72 hour care plan

Facilitate Realistic Expectations

- Education, communication, and engagement of patients and family as to the reason(s) for transfer, goals and next steps in care (Beware of the Myths of Medicare).
- Prior to discharge identify and discuss:
 - Nature and severity of their conditions
 - Appropriate health care provider contact information for problem solving
 - Optimization of the actual location of care to meet patient-specific needs. (Know what facilities have what capabilities)

More Essential Information: AMDA

- A formal, dictated discharge summary from the sending facility or a brief medical care summary (This is often not available)
- Recent vital signs, (normal baseline; related parameters)
- Baseline mental status, fall risk, pulse oximetry
- Last bowel movement , voiding patterns (CAUTI goals and discontinuation of catheters is helpful)
- Outstanding laboratory or diagnostic studies; Cultures and sensitivities, biopsy results, or imaging studies. *Process for obtaining results of outstanding studies.
- Pending studies/consults for follow up

What Do We Do? Who Knows?

- Primary Care and Physician Services**, (Frequency of visits)
(physicians, extenders, consultant support: Psychiatry, Cardiology, Pulmonary, Wound Care, Other)
- Diagnostic testing**: Stat services, EKG, Bladder ultrasound, etc.
- Social Services/Psychology and/or Mental health support**
- Therapy** availability
- Nursing Capabilities and Interventions**: IV initiation and maintenance, IV ABT/meds (Lasix?), PICC/Management of PICC, Trach, Analgesic Pumps, etc. **(on or off site availability)**
- Scope of Care** (And have data ready on success rates e.g. LOS, return to hospital rates)
- Pharmacy Services**: delivery systems, reliability, other/

Nursing Home Capabilities List

INTERACT
Nursing Home

This list is for hospital emergency rooms, hospitalists, and case managers, and for physicians, NPs, and PAs who take off-hours call for the facility to assist with decisions about hospital admission or return to the facility.

Facility: _____
Address: _____
Tel: () _____ Fax: () _____
Code: 00 for yes or 01 for no to indicate the availability of each item in your facility

Capabilities	Yes	No	Capabilities	Yes	No
Primary Care Physician Services			Nursing Services		
Internal Medicine, NP or PA on site	Y	N	Present all shifts (e.g. 4 day 20/2)	Y	N
Internal Medicine, NP or PA on call	Y	N	Obstetrical and gynec (100 monitoring)	Y	N
Internal Medicine, NP or PA on call	Y	N	Daily weights	Y	N
Diagnostic Testing			Accessories for glucose at least every shift	Y	N
Onsite tests with turnaround less than 8 hours	Y	N	ROP	Y	N
Onsite tests with turnaround less than 8 hours	Y	N	Coagulation	Y	N
BP	Y	N	Helicopter treatments	Y	N
Bladder Ultrasound	Y	N	Intensive care unit	Y	N
Arterial Oxygen	Y	N	Intensive care unit (ICU)	Y	N
Cardiac Rehab	Y	N	ICU (Intensive Care Unit)	Y	N
Catheter Suites	Y	N	ICU (Intensive Care Unit)	Y	N
Consultations			ICU (Intensive Care Unit)	Y	N
Psychiatry	Y	N	ICU (Intensive Care Unit)	Y	N
Cardiology	Y	N	ICU (Intensive Care Unit)	Y	N
Pulmonary	Y	N	ICU (Intensive Care Unit)	Y	N
Wound Care	Y	N	ICU (Intensive Care Unit)	Y	N
Other Physician Specialty Consultations	Y	N	ICU (Intensive Care Unit)	Y	N
ICU (Intensive Care Unit)	Y	N	ICU (Intensive Care Unit)	Y	N
Social and Psychology Services			ICU (Intensive Care Unit)	Y	N
Unassisted Social Worker	Y	N	ICU (Intensive Care Unit)	Y	N
Psychological Evaluation and Consultation	Y	N	ICU (Intensive Care Unit)	Y	N
Therapist on site	Y	N	ICU (Intensive Care Unit)	Y	N
Occupational	Y	N	ICU (Intensive Care Unit)	Y	N
Physical	Y	N	ICU (Intensive Care Unit)	Y	N
Respiratory	Y	N	ICU (Intensive Care Unit)	Y	N
Speech	Y	N	ICU (Intensive Care Unit)	Y	N

A Good Admission:

- Planned for in advance
- Medical information, hx, goals of care are known and applied
- Meds and Tx within scope; needed supplies are on site
- Nurse to nurse transfer of info
- Comfort is a collaborative goal for sending and receiving
- What are the first and the last impressions?

Transitional First Impressions Influenced By The Right Advance Info

- Specific equipment needs prior to transfer: specialty beds, intravenous (IV) pumps, wound care supplies, or enteral feeding supplies.
- Provide the most current, complete and accurate list possible of meds
- Evaluate each drug to ensure there is a solid reason for its use, and a good reason not to discontinue it (Especially psycho actives) (MARS, last dose given when?)
 - Advance medication information includes: antibiotics, inhaled/nebulized meds, analgesics, the effect of the Pain Management Plan (especially Schedule II controlled substances)

Transitional Care and Comfort

- Comfort at transfer: Helpful to give pain medication prior to transfer.
- Advance information will promote readiness, and help alleviate patient/family anxiety about the transfer.*

Medication Reconciliation Good Areas for review at a QAPI Meeting

Medication Reconciliation Worksheet for Post-Hospital Care



Part 1: Hospital Recommended Medications Needing Clarification

Medications Recommended by Hospital of Discharge for which Clarification Needed	Clarification Needed*	Resolution for Post Medication Orders (Continue, Stop, Change)

*Examples of clarifications needed: medication dose or route of administration, drug name, full parameters, add-on needed for monitoring, dose different than before hospitalization, medication duplication

Part 2: Medications Prior to Hospitalization Needing Clarification

Medications Taken Before Hospitalization that Currently are Hospital Recommended	Comments (e.g. reason for the medication before hospitalization and/or reason for hospital admission)	Resolution for Post Medication Orders (Continue, Stop, Change)

Resident's Name _____

Date _____

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SMART GOALS

- Specific: What do we want to accomplish?
- Who will be involved/affected?
- Where will it take place?
- Measureable: What is the measure you will use?
- What is the current data figure, count, percent rate for that measure?
- What do you want to increase/decrease that number to?
- Attainable: Define the rationale
- Did you base the measure figure you want to attain on a particular best practice/average score/benchmark
- Does the goal require stretch without being unreasonable?
- Relevant: Briefly describe how the goal being set will address the problem stated
- Timebound: Describe the timeline for achieving it? What is the target date?it will

Element 3: Feedback, Data Systems and Monitoring

- Systems to monitor care and services, drawing data from multiple sources.
- Feedback systems
- Performance Indicators
- Benchmarks
- Tracking, investigating, and monitoring
- Action plans implemented

Integration- Element 3



Describe how your caregivers will become and remain proficient with process improvement tools and techniques related to their level of proficiency regarding SAFE TRANSITIONS OF CARE?

- Indicate the plan for developing leadership and facility-wide training on QAPI
- **Example:**
- **Establish monthly staff meetings at set times for all shifts.**
- **Include QAPI time on each meeting agenda, involve C.N.A. staff in care plans, include QAPI initiatives into daily shift report...)**

STOP and WATCH CLINICAL FAIRS around admission process

Integration

- Describe how QAPI is integrated into the responsibilities and accountabilities of top-level management
- Describe how QAPI will be adequately resourced: (**Designated champion/co-champion and team members to include external community partners**)

Integration

Indicate how you will determine if resources are adequate for a Safe Transitions QAPI.

- *Example: Determine with the team and as part of staff meetings what resources might be needed such as:*

Supplies and equipment: Advanced Care Planning Resources, updated vital sign monitoring equipment, Evaluation on equipment and on site needs based on Scope of Care

- *Education and training materials: Acuity Management, Advance Care Planning*
- *Budget for training: education, STOP and WATCH skills fairs*
- *External resources/Protocols and tools*

Feedback, Data Systems, and Monitoring

- Overall system that will be put in place to monitor care and services
- Identify the sources of data that you will monitor through QAPI: Input from caregivers, residents, families, and others
- ***Integrate into daily care reviews, weekly at risk/QOL meetings, care planning, interviews, physician feedback, QIS and QM data analysis, formal discussions with members of the team, staff, stakeholders and community partners***

Daily Information

Daily Monitoring and Alerts

Considered and Review: For the information displayed in this report, the Resident Response Indicator (RRI) is used to indicate the level of concern. The RRI is a color-coded indicator that ranges from Green (Low) to Red (High).

Open Alert Overview

The Resident RRI is a color-coded indicator that ranges from Green (Low) to Red (High). The RRI is a color-coded indicator that ranges from Green (Low) to Red (High).

Alerts

The Resident RRI is a color-coded indicator that ranges from Green (Low) to Red (High). The RRI is a color-coded indicator that ranges from Green (Low) to Red (High).

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The Resident RRI is a color-coded indicator that ranges from Green (Low) to Red (High). The RRI is a color-coded indicator that ranges from Green (Low) to Red (High).

Indicator Sources

- Census/Mix/Referrals
- Discharges
- Rounds
- Incidents
- Business Office
- HR
- Dashboard
- Maintenance
- QIS

Data Elements

Data Elements

The Data Elements are the specific data points that are used to calculate the Resident Response Indicator (RRI). The Data Elements are the specific data points that are used to calculate the Resident Response Indicator (RRI).

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Indicator Sources

- Dining Services
- Activities
- SS
- MDS
- Dashboard
- Clinical
- Therapy

Stop and Watch Early Warning Tool



If you have identified a change while caring for or observing a resident, please **circle** the change and notify a nurse. Either give the nurse a copy of this tool or review it with her/him as soon as you can.

- STOP and WATCH**
- Seems different than usual
 - Talks or communicates less
 - Overall needs more help
 - Pain – new or worsening; Participated less in activities
 - Ate less
 - No bowel movement in 3 days; or diarrhea
 - Drank less
 - Weight change
 - Agitated or nervous more than usual
 - Tired, weak, confused, or drowsy
 - Change in skin color or condition
 - Help with walking, transferring, toileting more than usual

Name of Resident

Your Name

Reported to

Date and Time (am/pm)

Nurse Response

Date and Time (am/pm)

Nurse's Name

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Stop and Watch Log

Date	Resident & Reported Change	Action Taken	Attached and noted on 24 hour report

Put the Tool to Good Use

- It can be used to communicate changes noted by many people:
- C.N.A. staff
- Food Service Staff
- Therapists
- Nursing Staff
- And why not SS, Activities, and even families?
- Tip: Bring a copy to care plan when meeting with families/RP's
- Have a unit to unit contest: Which unit has the most Stop and Watch observations over a Quarter with the most improvement in quality measures such as falls, UTI's, etc.)



Feedback Systems Quality of Life Details

Weekly Quality of Life/Risk Meeting
Confidential and Privileged. Not to be distributed or divulged to anyone except the intended recipient(s) without Legal Counsel's approval (24c, one copy)
Part of the Facility OMA

Sample handout tool

Detail for QLF members to prepare/participate for the QLF meeting
Members: Director of Nursing (Nursing), Program Manager, MDS Coordinator, CNA, Director of Social Services, Activities Director, Administrator and other meeting personnel (as appropriate)

Weekly Meeting: The QLF meeting (see Weekly Quality of Life/Risk Meeting guidelines) is regularly scheduled (weekly) to discuss change in condition, individual or risk, and intervene through internal communication systems, QLF audits, internet, and facility OMA(s) to influence positive outcomes for residents. To this effect, it is imperative that members of the QLF prepare appropriately in order to facilitate a productive meeting. This guideline is an extension of the QLF as well as each member's preparation responsibilities (not necessarily all included) for the QLF. Use of these guidelines in conjunction with the Weekly Quality of Life/Risk Meeting guidelines will assist your QLF in achieving the desired outcome.

Please keep in mind the rules of effective and efficient meetings:

Start on time/End on time/Participants/Stop on Topic/End on Time

Member Responsibilities: Each member of the QLF:

- Review the resident's QLF (as it relates to their discipline) to ensure that all components are current and complete (i.e., assessments, notes, care plans, QLFs, goals & interventions, Kardex, weight entry, behaviors, pain, admission orders, labs, etc.)
- Review QLF interview and observations (as it relates to their discipline) for concerns and/or potential issues
- Assess Risk Right & Review the Risker Report/QLF Reports (as it relates to their discipline) to identify residents with clinical and risk concerns. If the resident triggers for clinical and/or risk concerns determine if there can be reports, observations, or responses to the current care plan to try to influence a positive outcome (as prepared to discuss in the QLF meeting).

Opportunity: Advance Care Planning

- Provide staff and stakeholders with the challenges at hand regarding advance care planning and advance directives
- Evaluate internal and external resources for the development or expansion of palliative care concepts
- Review re hospitalizations and root cause the length of stay, the integrity of information on admission, and any opportunities for improvement in advance care planning and realistic goals of care

Barriers

- Delayed access to palliative and hospice care
- Rules and regulations
- Fear of litigation
- Regulation of controlled substances
- Issues related to access to care
- Denial
 - Poor communication
 - Reluctance to take away hope

Identification of High Risk Residents for Dying

- Selected Dx: CHF, Dementia, COPD, Cancer
- Those at high risk: Frequent ER, Sudden major decline in functional status with no identified reversible cause
- Met Cancer with chronic pain, poor ADL, not on chemo, Semi comatose/comatose with no identified reversible causes
- Inability/difficulty with oral meds
- Minimal oral intake (receiving continuous or intermittent IV hydration)
- Mottling of extremities related to poor oral intake and/or volume depletion

Who Could Be Managed From a Palliative Approach?

Those with:

- Compatible goals
- Compatible physicians plan of care
- Terminal illness, End-stage disease
- Far advanced and progressive illness
- Extreme Frailty and Functional Disability
- Pain Syndromes

PIP Considerations

- Improve Safe Transitions of Care hospital to SNF, SNF to AL/Home Health reporting of essential information
- Improve safe transitions shift to shift reporting & IDT documentation
- Standardize facility communication systems
 - Stop and Watch and related systems
 - Morning clinical meetings
 - How information is gathered, interpreted and managed
- Use systems to better identify “at risk” residents (Daily, weekly, monthly)
- Improve communication with Physicians and extenders
- Adopt practices such as SBAR
- Review readmissions in a timely manner
- Identify what makes a GREAT admission
- Implement or enhance quality improvement & benchmarking processes

Element 5: Systematic Analysis and Systemic Action

- Systematic approach when in-depth analysis is needed to fully understand the problem, its causes, and implications of a change.



Systematic Analysis

- Describe the process you will use to ensure you are getting at the underlying causes of issues, rather than applying quick fixes that address symptoms only.
- **Examples: Root case analysis with the fish bone and related tools the reasons behind re hospitalization with a target area of advance directives, ethical issues**
- **Identify the number of residents/patients admitted with advance directives or DNR documentation**
- **use of brainstorming techniques and coordination of a diverse representation of people to offer varying perspectives; include hospice, Palliative experts, and assess current education for decision making**
- **analysis of the data with feedback to community partners and related stakeholders**

Quality Improvement Tool For Review of Acute Care Transfers		INTERACT Nursing AB Test												
Resident Characteristics	<p>The INTERACT QI Tool is designed to help you analyze hospital transfers and identify opportunities to reduce transfers that might be preventable. Complete this tool for each or a representative sample of hospital transfers in order to conduct a root cause analysis and identify common reasons for transfers. Examining trends in these data with the INTERACT QI Summary Tool can help you focus educational and care process improvement activities.</p> <p>SECTION 1: Describe Resident Characteristics</p> <p>Resident ID: _____ Age: _____</p> <p>Date of most recent admission to nursing home: ____/____/____</p> <p>a. Major diagnosis at admission:</p> <table border="0"> <tr> <td><input type="checkbox"/> Conditions that put the resident at risk for hospital admission or readmission:</td> <td><input type="checkbox"/> DNR</td> </tr> <tr> <td><input type="checkbox"/> Hospitalization within the last 6 months</td> <td><input type="checkbox"/> Confusion or delirium (acute or chronic)</td> </tr> <tr> <td><input type="checkbox"/> Dementia</td> <td><input type="checkbox"/> Multiple comorbidities (e.g. CHF, COPD, etc.)</td> </tr> <tr> <td><input type="checkbox"/> Polypharmacy (e.g. for more medications)</td> <td><input type="checkbox"/> Multiple or multiple acute diagnoses</td> </tr> <tr> <td><input type="checkbox"/> Change of condition</td> <td><input type="checkbox"/> Other (describe): _____</td> </tr> <tr> <td><input type="checkbox"/> Fracture</td> <td></td> </tr> </table> <p>b. Resident hospitalized in the past 30 days? <input type="checkbox"/> No <input type="checkbox"/> Yes (for dates and reasons): _____</p> <p>c. Resident hospitalized in the past 12 months? <input type="checkbox"/> No <input type="checkbox"/> Yes (for dates and reasons): _____</p> <p>SECTION 2: Describe the Acute Change in Condition and Other Non-Clinical Factors that Contributed to the Transfer</p> <p>a. Date the change in condition first noticed: ____/____/____</p> <p>b. Briefly describe the change, symptom, sign or other factors that led to the transfer and then check each box below that applies:</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>(continued on reverse side)</p> <p><small>©2011 Interact Health Services. All rights reserved. This document is confidential and may not be reproduced or transmitted without written permission of Interact Health Services.</small></p>		<input type="checkbox"/> Conditions that put the resident at risk for hospital admission or readmission:	<input type="checkbox"/> DNR	<input type="checkbox"/> Hospitalization within the last 6 months	<input type="checkbox"/> Confusion or delirium (acute or chronic)	<input type="checkbox"/> Dementia	<input type="checkbox"/> Multiple comorbidities (e.g. CHF, COPD, etc.)	<input type="checkbox"/> Polypharmacy (e.g. for more medications)	<input type="checkbox"/> Multiple or multiple acute diagnoses	<input type="checkbox"/> Change of condition	<input type="checkbox"/> Other (describe): _____	<input type="checkbox"/> Fracture	
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Quality Improvement Tool For Review of Acute Care Transfers (cont'd)		INTERACT Nursing AB Test																																																																																																																												
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Briefly describe how the changes in Section 2 were evaluated and managed and check each box that applies:</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>i. Check all that apply</p> <table border="0"> <tr> <td>Tests Used</td> <td>Medical Evaluation</td> <td>Timing</td> <td>Interventions</td> </tr> <tr> <td><input type="checkbox"/> Bloodwork</td> <td><input type="checkbox"/> Telephone only</td> <td><input type="checkbox"/> Before transfer</td> <td><input type="checkbox"/> New medication</td> </tr> <tr> <td><input type="checkbox"/> Imaging and tests</td> <td><input type="checkbox"/> On-site or in lab</td> <td><input type="checkbox"/> After</td> <td><input type="checkbox"/> Other (describe): _____</td> </tr> <tr> <td><input type="checkbox"/> Care history</td> <td><input type="checkbox"/> MD visit</td> <td><input type="checkbox"/> Urinalysis and/or urine culture</td> <td><input type="checkbox"/> Oxygen</td> </tr> <tr> <td><input type="checkbox"/> Change in condition</td> <td><input type="checkbox"/> Other (describe): _____</td> <td><input type="checkbox"/> Urine dipstick</td> <td><input type="checkbox"/> Other (describe): _____</td> </tr> <tr> <td><input type="checkbox"/> Skin Care</td> <td></td> <td><input type="checkbox"/> EKG</td> <td></td> </tr> <tr> <td><input type="checkbox"/> Transfer/Discharge</td> <td></td> <td><input type="checkbox"/> Other (describe): _____</td> <td></td> </tr> <tr> <td><input type="checkbox"/> Resident Care history</td> <td></td> <td></td> <td></td> </tr> <tr> <td><input type="checkbox"/> Form or an equivalent</td> <td></td> <td></td> <td></td> </tr> <tr> <td><input type="checkbox"/> Resident Care</td> <td></td> <td></td> <td></td> </tr> <tr> <td><input type="checkbox"/> Planning Tools</td> <td></td> <td></td> <td></td> </tr> <tr> <td><input type="checkbox"/> Other (describe): _____</td> <td></td> <td></td> <td></td> </tr> <tr> <td><input type="checkbox"/> Other (describe): _____</td> <td></td> <td></td> <td></td> </tr> </table> <p>(continued)</p> <p><small>©2011 Interact Health Services. 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<input type="checkbox"/> Emotional status	<input type="checkbox"/> Difficulty swallowing	<input type="checkbox"/> ABG (Arterial Blood Gas)																																																																																																																												
<input type="checkbox"/> Change in condition	<input type="checkbox"/> Incontinence	<input type="checkbox"/> Pulse oximetry																																																																																																																												
<input type="checkbox"/> Skin or wound	<input type="checkbox"/> Confusion or worsening cognitive function	<input type="checkbox"/> Urinalysis or urine culture																																																																																																																												
<input type="checkbox"/> Other (describe): _____	<input type="checkbox"/> Constipation	<input type="checkbox"/> Urine dipstick																																																																																																																												
	<input type="checkbox"/> Change	<input type="checkbox"/> EKG																																																																																																																												
	<input type="checkbox"/> Dehydration	<input type="checkbox"/> Other (describe): _____																																																																																																																												
	<input type="checkbox"/> Flushing/syncopal																																																																																																																													
	<input type="checkbox"/> Fall																																																																																																																													
	<input type="checkbox"/> Fever																																																																																																																													
	<input type="checkbox"/> Head																																																																																																																													
	<input type="checkbox"/> Hypertension																																																																																																																													
	<input type="checkbox"/> Urinary symptoms or incontinence																																																																																																																													
	<input type="checkbox"/> Other (describe): _____																																																																																																																													
Tests Used	Medical Evaluation	Timing	Interventions																																																																																																																											
<input type="checkbox"/> Bloodwork	<input type="checkbox"/> Telephone only	<input type="checkbox"/> Before transfer	<input type="checkbox"/> New medication																																																																																																																											
<input type="checkbox"/> Imaging and tests	<input type="checkbox"/> On-site or in lab	<input type="checkbox"/> After	<input type="checkbox"/> Other (describe): _____																																																																																																																											
<input type="checkbox"/> Care history	<input type="checkbox"/> MD visit	<input type="checkbox"/> Urinalysis and/or urine culture	<input type="checkbox"/> Oxygen																																																																																																																											
<input type="checkbox"/> Change in condition	<input type="checkbox"/> Other (describe): _____	<input type="checkbox"/> Urine dipstick	<input type="checkbox"/> Other (describe): _____																																																																																																																											
<input type="checkbox"/> Skin Care		<input type="checkbox"/> EKG																																																																																																																												
<input type="checkbox"/> Transfer/Discharge		<input type="checkbox"/> Other (describe): _____																																																																																																																												
<input type="checkbox"/> Resident Care history																																																																																																																														
<input type="checkbox"/> Form or an equivalent																																																																																																																														
<input type="checkbox"/> Resident Care																																																																																																																														
<input type="checkbox"/> Planning Tools																																																																																																																														
<input type="checkbox"/> Other (describe): _____																																																																																																																														
<input type="checkbox"/> Other (describe): _____																																																																																																																														
Actions, Evaluation, Management																																																																																																																														

Quality Improvement Tool
For Review of Acute Care Transfers (cont'd)

INTERACT
Version 4.0 Text

4. Have advance care planning or advance directives (cont'd) been considered in evaluating/monitoring the change? (e.g., orders for Do Not Resuscitate (DNR), Do Not Intubate (DNI), palliative or hospice care) ☐ No ☐ Yes
If yes, were the relevant advance directives: ☐ Identified as a result of the change in clinical condition? ☐ Identified as a result of the change in clinical condition?
☐ Identified as a result of the change in clinical condition?
☐ Identified as a result of the change in clinical condition?

Describe _____

SECTION 4: Describe the Hospital Transfer

a. Date of transfer: ____/____/____ Day _____ Time (am/pm) _____
b. Decision authorizing transfer: ☐ Primary MD ☐ Consulting MD ☐ NPI or PA ☐ Other
c. Reason for transfer: ☐ CPE not only ☐ Healthier observation ☐ Admitted to hospital as inpatient
Hospital diagnosis(es) if available: _____
d. Resident died in ED or hospital: ☐ No ☐ Yes ☐ Unknown

SECTION 5: Identify Opportunities for Improvement

a. In retrospect, does your team think this transfer might have been prevented? ☐ No ☐ Yes (check all that apply and describe below)
☐ The way signs, symptoms, or other change might have been identified earlier
☐ Changes in the resident's condition might have been communicated better among NPI staff, with MD/NPI/PA, or with IR staff
☐ The condition might have been managed earlier in the facility with available resources
☐ Resources were not available to manage the change in condition safely or effectively (check all that apply)
☐ On-site primary care clinician ☐ Testing ☐ Lab or other diagnostic tests
☐ Changing priorities
☐ Resident and family preferences for hospitalization might have been discussed earlier
☐ Advance directives and/or palliative or hospice care might have been put in place earlier
☐ Other (describe) _____

b. In retrospect, does your team think this resident might have been transferred earlier? ☐ No ☐ Yes (if yes, describe) _____

c. After review of how this change in condition was evaluated and managed, has your team identified any opportunities for improvement? ☐ No ☐ Yes (describe specific changes your team can make to your care process and related outcomes as a result of this transfer) _____

Name of person completing form: _____ Date of completion: ____/____/____

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Quality Improvement
Summary Worksheet

INTERACT
Version 4.0 Text

This Worksheet is a guide to learning from individual root cause analyses of hospital transfers. It can be used to summarize findings documented on INTERACT Quality Improvement (QI) Tools to determine if there are common factors involved in your hospital transfers. Identifying these common factors will help focus your education and care process changes in order to further improve care and reduce potentially preventable hospital transfers. An Excel template of Summary Worksheet is also available on the INTERACT website. There are several steps involved, which are outlined below.

STEP 1: Document the number and timeframe of completed QI Tools included in this summary

a. Number of completed QI Review Forms included in this summary: _____

STEP 2: Compare the answers across each section of the QI Review Tools. Circle "Yes" for the same or similar answers across a majority of the completed QI Tools.

A. Resident characteristics

1. Age of resident transferred to the hospital (e.g., are most over 65)? ☐ Yes ☐ No
2. Length of stay prior to hospital transfer? (e.g., less than 7 days) ☐ Yes ☐ No
3. Bed status for hospitalization? (note which ones) _____
A. Expenses associated with hospitalization? ☐ Yes ☐ No
(Note which ones) _____

B. Changes to condition that led to transfer ☐ Yes ☐ No
(Note which ones) _____

C. Actions taken prior to the transfer

a. Tools that were used to manage the change in condition prior to the transfer? ☐ Yes ☐ No
b. Tools that might have been used but were not? ☐ Yes ☐ No
c. Size of medical evaluation conducted prior to the transfer? ☐ Yes ☐ No
d. Timing of advance care planning discussions with resident and/or family? ☐ Yes ☐ No
Findings: _____

(continued)

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Quality Improvement
Summary Worksheet (cont'd)

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B. Hospital transfer and contributing factors

1. Day of the week of hospital transfer? ☐ Yes ☐ No
2. Time of day of hospital transfer? ☐ Yes ☐ No
3. MD/NPI/PA authorizing the transfer? ☐ Yes ☐ No
a. Non-clinical factors that contributed to the hospital transfer?
b. Resident preferred or insisted on transfer? ☐ Yes ☐ No
c. Family members preferred or insisted on transfer? ☐ Yes ☐ No
d. Resources needed to provide care in IR not available? ☐ Yes ☐ No
e. Facility policies do not support providing care in IR? ☐ Yes ☐ No
Findings: _____

E. Transfers noted as potentially preventable

a. Factors related to transfers noted as preventable? ☐ Yes ☐ No
b. Reasons provided for preventable transfers? ☐ Yes ☐ No
Findings: _____

STEP 3: Summarize Common Factors Across

a. What factors were most common and similar across QI Tools?

b. Based on this summary what areas would you target for:
a. Staff education: _____
b. Care process changes: _____
c. Other improvement efforts: _____

Submit to Monthly QAA as part of your QAPI

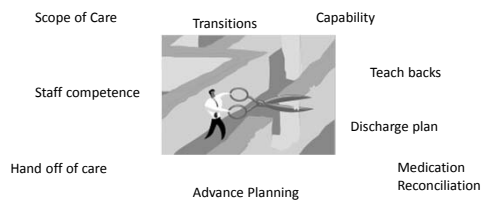
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QI Summary

- Summarize findings from individual QI reviews
- Identify common factors >drive care process changes and education
- **Step One:** Number of QI forms in this summary and established time frame
- Compare the answers: Resident characteristics, (LOS, risk factors, diagnoses associated with hospitalizations)
- Actions taken prior to transfer: Tools used or should have been used, medical evaluation, timing of advance care planning
- Compare answers: Time, physician, staff, resident/family, resources, policies
- Number of those potentially preventable
- What factors were most common/similar across QI tools?
- Identified target areas

Mobilize Quality

- Reevaluate systems of care
- Begin at the beginning
- Know the before, during, and after's of care
- Know the Resident



Resident Wishes

- The facility must ensure compliance with federal and state requirements regarding advance directives.
- If a resident has an advance directive or executes one upon admission, it is important for the facility staff to communicate the resident's wishes to the resident's direct care staff and physician
- Identify the primary decision-maker (e.g., assess the resident's decision-making capacity) and be alert to changes as noted via Stop and Watch, etc.)
- Identify an appropriate legal representative for when the resident is or becomes unable to make relevant health care decisions)

Be Aware of Resident Wishes

- Know the resident
- Advance Care Planning: Starts at Admission (Know the tools)
- Involve your IDT with changes in condition
- Use the care planning process to understand resident wishes: When does the goal of care shift from cure to comfort?
- Care Plan Agenda
- Pay attention to frequent re hospitalizations, significant changes on the MDS, and advance directives...
- Connect the dots of decline in ADL to high risk Dx?
- Weekly systems of care? Thursday Triage?

Be Inquisitive and Innovative

- Have a process for Advance Directives review from Admissions to the clinical record/unit.
- Identify medical records process for readmission: is the record closed and a new one started with key documents pulled forward? (Advance directives, surrogate appointment, DNR), or is the original record maintained?
- Reconcile Adv Directive wishes with readmissions; reenact DNR orders as appropriate
- If the resident or the resident's legal representative has executed one or more advance directive(s): Ask for copies and incorporate them into the resident's medical record (verify as part of am meeting)
- Implement Advance Care Planning tracking tools from Interact within the first week. Consider new admission interim care plan review at 72 hours

Define, Clarify, Communicate, Advocate

- Define and clarify medical issues and present the information regarding relevant health care issues to the resident or his/her legal representative, as appropriate;
- Identify and assess medical issues where life-sustaining treatments are potential options and implement choices related to health care decisions;
- Review the resident's condition and existing choices and continue or modify approaches, as appropriate;
- If a resident's refusal of treatment brings about a significant change in condition, the facility should reassess the resident, determine decision making capacity, and modify the care plan as appropriate. **Use weekly "At risk /QOL" meetings to address**
- The Global Deterioration Scale is a valuable tool for identification of expected decline in Alzheimer's

Care Planning

Suggested actions:

- Meet new resident/family ASAP post admission
- Verify decision making, update face sheets as part of care planning
- Reinforce: The advance care planning process is an integral aspect of the facility's comprehensive care planning process. *Assure re-evaluation of the resident's desires on a routine basis and when there is a significant change in the resident's condition.*
- Set up information system for DNR status and keep with crash cart with weekly audit or as needed per status change. Review as part of care planning
- Implement Care plan agenda, Thursday triage to stay on top of acute changes

Educate

- **Provide education to residents** via resident council, care planning, or other venues
- The facility must provide education for the resident community regarding the right to formulate an advance directive and the facility's written policies and procedures regarding the implementation of this right
- Various formats (e.g., written materials, video and audio tapes) may be used to provide such education. (INTERACT Handouts/Hard Choices book) advance directive;
- Reinforce consistent assignments (**Advancing Excellence as a Resource**)
- Advancing Excellence has Advanced care planning tracking tools



ADVANCE CARE PLANNING TRACKING FORM

RESIDENT NAME: _____

Residents and/or their responsible health care decision makers should be provided the opportunity to discuss advance care planning with appropriate staff members and medical providers within the first few days of admission to the facility, at times of change in condition, and periodically for routine updating of care plans.

The purpose of this form is to provide a tool to document that these discussions are taking place. Improving advance care planning is a goal of the **Advancing Excellence in America's Nursing Homes** Campaign. This form has been adapted from the campaign's website: http://www.chauillcare.org/files/interact/AdvanceCarePlanning_Tool_Guide.pdf

AT ADMISSION (within about a week of admission or readmission)

Check one of the following:

☐ Resident and/or responsible party do NOT want to have this discussion

☐ Discussion about advance care planning held with (check one or both of the following):

____ Resident

____ Resident's surrogate; name: _____

Staff or healthcare provider completing this form:

Name: _____ Title: _____

Signature: _____

Date of Discussion: ____ / ____ / ____

Location of Advance Care Plan documentation (i.e., medical record, plan of care, progress notes): _____

Use Continuation Pages to document additional Advance Care Planning Reviews and Discussions

60201-002

- Within a few days of admission
- At times of change in condition
- During routine updates with care plans
- Page One of Two

INTERACT Advance Planning Guide

Advance Care Planning Communication Guide: Overview



The INTERACT Advance Care Planning Communication Guide is designed to assist health professionals who work in nursing homes to initiate and carry out conversations with residents and their families about goals of care and preferences at the time of admission, at regular intervals, and when there has been a decline in health status.

The Guide can be useful for education, including role playing exercises and simulation training.

Communicating about advance care planning and end-of-life care involves all facility staff.

The guide must conversations with residents and families about advance directives, and about how to be able to communicate about goals of care, preferences, and end-of-life care.

This Guide should therefore be useful for:

- Nursing staff
- Family care programs, nurse practitioners, and physician assistants
- Social workers and care team designers
- Administrators and others who discuss goals of care with residents and family

The Guide may be helpful in discussions on:

- Advance Directives: such as a Durable Power of Attorney for Health Care document, Living Will, and POLST and other similar documents
- Plans for care when a resident's health is gradually deteriorating: such as a stroke, heart attack, pneumonia, or cancer
- Plans for care when a resident's health is gradually deteriorating: such as progression of Alzheimer's disease or other dementia, weight loss without an obvious medical cause, and worsening of congestive heart failure, kidney failure, or chronic lung disease
- Establishing a palliative or comfort care plan or enrolling in a respite program

< In the kit and on the website at www.interact2.net

Starting Difficult Conversations

- Set the stage (INTERACT Advance Planning Tools)
Private environment, Get the facts, agenda with the right people, adequate time
- Initiate the conversation: what is the understanding and goals of care
- Provide information on artificial hydration/nutrition, CPR, Palliative Care
- Know the resources: "Hard Choices for Loving People" (Dunn), INTERACT resources on DNR and Enteral Feeding Decisions
- Resources: Coalition for Compassionate Care, POLST, MOLST, Five Wishes

Communicate & Educate

- There are risks and benefits to hospitalization
- Prevention of rehospitalization depends on resident condition, ability of staff to prepare care to meet the needs, and resident wishes
- Risks of hospital care include:
 - New/worsening confusion
 - More time in bed: risk of blood clots, pressure ulcers, loss of function, muscle weakness, and other complications
 - Less sleep and rest (Noise, monitoring, tests)
 - New infections
 - Depression, reduced socialization: social isolation

Education on CPR for Residents and Families



The Problem

Many health problems are so serious that they cause your heart to stop beating. This is called cardiac arrest. When this happens, you also stop breathing.

The heart pumps blood to all organs in your body to give them oxygen. When your heart stops beating, your body and brain do not get enough oxygen for you to live.

Treatment

There is only one treatment when your heart stops beating. That treatment is cardiopulmonary resuscitation or CPR. CPR is done to try to restart the heartbeat and breathing. It is the only treatment that could save your life when your heart stops beating.

CPR involves gently pushing on your chest, and placement of a tube through the mouth into the lungs to directly help you breathe. Sometimes electric shocks are given using a device called a defibrillator. Once started, CPR is continued until your heart restarts or it is clear beyond a doubt that your heart cannot be restarted.

CPR can be started in the nursing home, but as soon as possible, you will be transferred to the hospital, often an intensive care unit, for additional treatment and monitoring.



Your Choice

CPR is a choice – it is not a treatment that everyone must have. Some people believe that when their time comes or their heart or breathing stops, nothing more should be done to keep them alive. Other people want everything done to keep them alive. Neither of these choices is right or wrong. It is your choice.

You should understand, however, that if you choose not to have CPR, your choice will not affect any other aspect of your care. All of your other treatments and care will continue.

The only thing that will change is that if you are found without a pulse or heartbeat (as cardiac arrest), CPR will not be done.



(continued on next page)

Education on Tube Feeding for Residents and Families



The Problem

Many health problems may cause you to lose more and more of your mental and physical abilities. The problems may become so serious that you may no longer be able to eat all the food your body needs. Also, some conditions, such as stroke, Parkinson's disease, Alzheimer's disease, and other forms of dementia, may make it difficult to swallow, allowing food to go into your lungs. This can cause pneumonia.

Nurses or others can feed you, but you may still continue to have trouble eating and swallowing properly, and you may not be able to get all the food and fluids your body needs to maintain your health.

Treatment

Sometimes a speech therapist may be able to help you improve your swallowing ability. A change in the consistency of the food you eat may also be helpful. If these do not help, another treatment for eating and swallowing problems is to have a feeding tube placed into your stomach. You would be fed liquids through the tube which provide nutrition and fluids.

A feeding tube can be used temporarily for a few days if you become suddenly sick and unable to eat or drink. The tube would be put through your nose and down your throat into your stomach and you would receive liquid food several times per day. If you regain the ability to feed yourself, then the tube could be removed.

If a feeding tube is needed for longer than a week, it can be placed into your stomach. If you regain the ability to eat on your own, this tube could be removed.

In order to have the long term feeding tube placed in your stomach, you would need a short operation that usually lasts less than an hour. You would be given medication to make you comfortable while the doctor makes a small cut in your skin so that the feeding tube can go into your stomach. This operation is usually safe and has been done often.

Your Choice

Feeding tubes are not used for everyone. You have a choice about whether or not you want this treatment. Feeding tubes may be used for a short time or for the rest of your life, and can be removed at your request or by the request of your health care decision maker. You should understand, however, that if you choose not to have a feeding tube, your choice will not affect any other aspect of your care. All of your other treatments and care will continue.



(continued on next page)

Dying In Institutions: Do we...



- Provide a "Homelike environment"?
- Avoid abrupt changes in setting
- Discuss status, realistic goals, the role of the physician, and the team
- Consider a specialized unit or area
- Reinforce signs and events of the dying process
- Recognize personal, cultural, religious rituals
- Provide ongoing education, information, & support
- Recognize the onset of an unavoidable decline?

Principles of Care

1. Offer continuity of care.
2. Provide access to therapy, which may realistically be expected to improve the patient's quality of life.
3. Respect the right to refuse treatment.
4. Respect the physicians professional responsibility to discontinue some treatments when appropriate, with consideration of both patient and family preferences.
5. Promote clinical-evidence based research on providing care at the end of life

Principles of Care

1. Respect the dignity of both patients and caregiver.
What is important to them?
2. Be sensitive to and respectful of the patient's and families wishes.
Meaning and purpose is influenced by social interactions
3. Use of the most appropriate measures consistent with patient choices.
The Interdisciplinary team must remain connected with the physician
4. Alleviate pain and other physical symptoms.
 1. Fear of pain is a key concern. Do not judge the pain!
5. Assess and manage psychological, social, spiritual, and religious concerns.

Let's Grow Together and Have Something to QAPI About

Questions? Ideas?

Call me, I am glad to be your partner in quality!

- Debbie Afasano, BSN, CDONA, LHCRM
- VP of Clinical Operations Avante group
- dafasano@avantegroup.com
- 954-299-8362

CMS Partnership to Improve Dementia Care in Nursing Homes

RESOURCES

Updated 6/28/2012

CMS Launches Partnership to Improve Dementia Care in Nursing Homes

On March 29, via a video streaming event, CMS launched a new initiative aimed at improving behavioral health and safeguarding nursing home residents from unnecessary antipsychotic drug use. As part of the initiative, CMS is developing a national action plan that will use a multidimensional approach including public reporting, raising public awareness, regulatory oversight, technical assistance/training and research. The action plan will be targeted at enhancing person-centered care for nursing home residents, particularly those with dementia-related behaviors. [Watch the CMS video.](#)

CMS' Partnership to Improve Dementia Care in Nursing Homes:

[Clive Ballard's Presentation on Management of Behavioral and Psychological Symptoms in People with Dementia Living in Care Homes: A UK Perspective](#)

From Dr. Peter Rabins:

[Assessment Form for Residents with Dementia](#)

Additional Resources from Advancing Excellence Partners

Alzheimer's Association

Massachusetts/New Hampshire Chapter

From Dr. Paul Raia:

[Sleuthing Troublesome Behaviors](#)

[Habituation Therapy: A New Starscape](#)

http://www.alz.org/professionals_and_researchers_dementia_care_practice_recommendations.asp

Contact:

Cyndy Cordell

cyndy.cordell@alz.org

The American Geriatrics Society (AGS)

<http://www.americangeriatrics.org>

American Health Care Association (AHCA)

http://www.ahcancal.org/QUALITY_IMPROVEMENT/QUALITYINITIATIVE/Pages/default.aspx

Contact:

Sandy Fitzler

sfitzler@AHCA.org

202-898-6307

American Medical Directors Association (AMDA)

[Psychopharmacologic Interdisciplinary Medication Review](#)

[Sample Psychotropic Medication Policy](#)

Contact:

Karyn Leible

kleible@jewishseniorlife.org

585-784-6405

AMDA's Clinical Practice Guidelines

[Dedicated to Long Term Care Medicine: Excerpt from AMDA Dementia Clinical Practice Guideline](#)

<http://www.amda.com/advocacy/brucbs.cfm>

American Society of Consultant Pharmacists

<http://www.ascp.com/antipsychotic>

Contact:

Arnold Clayman

aclayman@ascp.com

703-739-1300

California Advocates for Nursing Home Reform (CANHR)

<http://www.canhr.org/stop-drugging>

Contact:

Michael Conners

Michael@canhr.org

Contact:

Anthony Chicotel

tony@canhr.org

The Consumer Voice

Long Term Care Ombudsmen Resource Center Issue Overview

<http://www.theconsumervoice.org/advocate/antipsychotic-drugs>

Fact Sheet including guidance to residents and advocates regarding individualized assessment where an individual has behavioral symptoms

http://www.theconsumervoice.org/sites/default/files/advocate/advocacy-groups/INDIVIDUALIZED_ASSESSMENT_with_Behavior_Symptoms.pdf

Contact:

Janet Wells

jwells@theconsumervoice.org

Person-centered Care Planning

<http://www.theconsumervoice.org/sites/default/files/resident/nursing-home/assessment-and-care-planning.pdf>

Department of Veterans Affairs

<http://www.ncbi.nlm.nih.gov/books/NBK54971>

The Eden Alternative

The Eden Alternative has created a webpage that summarizes new groundbreaking educational offerings designed to introduce providers to fundamental and advanced techniques in person-directed care proven to reduce the off-label use of antipsychotic drugs.

<http://www.edenalt.org/how-we-serve/reduce-the-use-of-antipsychotic-medications-in-people-living-in-long-term-care-settings>

Contact:

Meredith Burrus

Education Coordinator

The Eden Alternative

(615) 785-1600

(585) 461-3951

education@edenalt.org

LeadingAge

<http://www.leadingage.org/Newsletter.aspx?id=4694&pv=t>

Contact:

Cheryl Phillips, M.D.

cphillips@leadingage.org

National Gerontological Nursing Association (NGNA)

<http://www.ngna.org>

The National Long-Term Care Ombudsman Resource Center

Person-centered Care Planning

http://www.ltombudsman.org/ombudsman-support/training#Training_Programs_and_In-services

Quality Improvement Organizations

Alliant | GMCF

[Reducing Inappropriate Use of Antipsychotics in Nursing Homes - part 1](#)

[Reducing Inappropriate Use of Antipsychotics in Nursing Homes - part 2](#)

Advance Care Planning Communication Guide: *Overview*

The INTERACT Advance Care Planning Communication Guide is designed to assist health professionals who work in nursing homes to initiate and carry out conversations with residents and their families about goals of care and preferences at the time of admission, at regular intervals, and when there has been a decline in health status.

The Guide can be useful for education, including role-playing exercises and simulation training.

Communicating about advance care planning and end-of-life care involves all facility staff

- Physicians must communicate with residents and families about advance directives, but all staff need to be able to communicate about goals of care, preferences, and end-of-life care

This Guide should therefore be useful for:

- Nursing staff
- Primary care physicians, nurse practitioners, and physician assistants
- Social workers and social work designees
- Administrators and others who discuss goals of care with residents and family

The Guide may be helpful in discussions on:

- Advance Directives – such as a Durable Power of Attorney for Health Care document, Living Will, and POLST and other similar directives
- Plans for care when a sudden, life-threatening condition is diagnosed – such as a stroke, heart attack, pneumonia, or cancer
- Plans for care when a resident's health is gradually deteriorating – such as progression of Alzheimer's disease or other dementia; weight loss without an obvious medical cause; and worsening of congestive heart failure, kidney failure, or chronic lung disease
- Considering a palliative or comfort care plan or enrolling in a hospice program

Advance Care Planning Communication Guide

Part 1: Tips for Starting & Conducting the Conversation

Set the Stage

1. Get the facts – understand the resident's conditions and prognosis.
2. Choose a private environment.
3. Determine an agenda for the meeting and who should be present.
4. Allow adequate time – usually these discussions take at least 30 minutes.
5. Turn cell phone or beeper to vibrate to avoid interruptions and demonstrate full attention.
6. If the resident is involved, sit at eye level with her or him.
7. Have tissues available.

Initiate the Discussion

1. Describe the purpose of the meeting.
2. Identify whether the resident wants or already has a spokesperson and who it is.
3. Ask what the resident and/or family understand about advance care planning.
4. Ask about their goals for care
 - Most nursing home residents and their families are more concerned about comfort than life prolongation. This opens the door to discuss palliative care and comfort care plans.
 - Attempt to understand underlying rationale for the goals (*i.e. "I've lived long enough, now I'm ready to meet God," or "I want to keep on living until my granddaughter graduates college next spring."*). This provides insight into specific decisions that are made.

Initiate the Discussion

1. Use simple language.
2. Briefly discuss:
 - Cardiopulmonary arrest and CPR*
 - Artificial Hydration/Nutrition (*tube feeding***)
 - Palliative care, comfort care orders*** and hospice if appropriate.

Cardiopulmonary Arrest and CPR*

1. Initiate discussion of Cardiopulmonary Resuscitation (CPR).
 - e.g. "Sometimes when peoples' hearts stop, doctors and nurses try to delay the dying process... have you considered whether you would want this or not?"
2. Discuss some facts:
 - Cardiopulmonary arrest is the final common pathway for everyone when they die. Not all deaths should involve CPR.
 - The possibility of surviving CPR in a nursing home is very low, and CPR often results in broken ribs and the need for a respirator (*'breathing machine'*) in an intensive care unit.
 - A request to not perform CPR (*a Do Not Resuscitate (DNR) Order*) **does not alter care** – it only prevents CPR if the resident is found without a heart beat or not breathing.

* See INTERACT Education on CPR

** See INTERACT Education on Tube Feeding

*** See INTERACT Comfort Care Orders

(continued)

Advance Care Planning Communication Guide

Part 1: Tips for Starting & Conducting the Conversation

(continued)

Artificial Hydration/Nutrition (tubefeeding)**

1. Initiate discussion of feeding tubes:
 - “Many nursing home residents gradually lose the ability to eat, drink, and swallow. In this situation a tube can be placed in the stomach to provide water and nutrition. Have you considered whether you would want this or not?”
2. Discuss some facts:
 - Feeding tubes have not been shown to prevent pneumonia or prolong life for most nursing home residents.
 - Placement of a tube requires minor surgery, and can have some complications.
 - A request to not place a tube **does not alter care** – residents will be provided oral fluid and nourishment as long as it is comforting for them.
 - People who do not get feeding tubes generally gradually slip into a comfortable coma within a few days and die comfortably.

Palliative Care and Comfort Care Orders

1. Review overall goals for care and the importance of comfort and quality of life regardless of advance directives
2. If the goal of care is comfort:
 - Offer to provide and review educational materials on palliative care.
 - Describe examples of comfort care orders.***
 - Discuss limiting hospitalization only for the purpose of improving comfort, not to prolong life.
 - If appropriate, provide information about palliative and/or hospice care.

End the Discussion

1. Ask: “Do you have any questions?”
2. Emphasize that the role of the nursing home is to ALWAYS provide comfort no matter what the goals of care.
3. Offer to have a follow-up meeting if indicated.
4. Stand – an effective way to end the conversation.

** See INTERACT Education on Tube Feeding

*** See INTERACT Comfort Care Orders

Advance Care Planning Communication Guide

Part 2: Communication Tips

Tips	Examples
Establish Trust	
Encourage residents and families to talk	<p><i>"Tell me what you understand about your illness."</i></p> <p><i>"Help me get to know you better – tell me about your life before you came to this nursing home."</i></p> <p><i>"How are you coping with your illness?"</i></p>
Recognize resident and family concerns, but do not put down other health care providers	<p><i>"I understand that you didn't feel heard by other doctors/nurses. I'd like to make sure you have a chance to voice all of your concerns."</i></p> <p><i>"It sounds like Dr. X left you very hopeful for a cure. I'm sure he really cares for you, and it would have been wonderful if things would have gone as well as he/she wished."</i></p>
Acknowledge mistakes	<i>"You are absolutely right. Four days was too long to wait for that [test or procedure]."</i>
Be humble	<i>"I really appreciate what you have shared with me about the medication we prescribed. It is clear that it is not right for you."</i>
Demonstrate respect	<i>"I am so impressed by how involved you have been with your [relative] throughout this illness. I can tell how much you love her/him."</i>
Do not force decisions	<i>"We've just had a very difficult conversation, and you and your family have a lot to think about. Let's schedule another meeting and see how you feel about things then."</i>
Attend to Emotions	
Attend to the emotion	<i>"Is talking about these issues difficult for you? Making these decisions is not easy."</i>
Identify loss	<i>"I bet it's hard to imagine life without your [relative] – I can see how close you are to her/him."</i>
Legitimize feelings	<p><i>"It's quite common for someone in your situation to have a hard time making these decisions – it can feel like an enormous responsibility."</i></p> <p><i>"Of course talking about this makes you feel sad – it wouldn't be normal if it didn't."</i></p>
Explore	<i>"You've just told me you feel scared. Can you tell me more about what scares you most?"</i>
Offer support	<i>"No matter what the road holds ahead, I'm going to be there with you."</i>
Communicate Hope	
Hope for the best, but prepare for the worst	<p><i>"Have you thought about what might happen if things don't go as you wish? Sometimes having a plan to prepare for the worst makes it easier to focus on what you hope for most."</i></p>
Reframe hope	<i>"I know you hope your illness will improve. Are there other goals you want to focus on?"</i>
Focus on the positive	<p><i>"Some treatments are really not going to help and may make you feel worse or uncomfortable. But there are a lot of things we can do to help you – let's focus on those."</i></p> <p><i>"What sorts of things are left undone for you? Let's talk about how we might be able to make these happen."</i></p>

Advance Care Planning Communication Guide

Part 3: Helpful Language for Discussing End-of-Life Care

Issue	Helpful Language
Identify other decision makers	<i>"Is there anyone you rely on to make important decisions?"</i>
Define goals for care	<i>"What do you hope for most over the next few months?" "Is there anything that you are afraid of?"</i>
Reframe goals	<i>"I wish we could guarantee you will be alive for your [event], but unfortunately we can't. Perhaps we can work on a letter to read on that day, so people will know you are there in spirit in case you cannot be there."</i>
Identify needs for care?	<i>"What types of treatments do you think will help you the most?"</i>
Summarize and link goals with care needs	<i>"I think I understand that your main goals are to be comfortable and alert enough to spend time with your family. We have several ways we can help you."</i>
Introduce palliative or comfort care and/or hospice	<i>"One of the best ways to meet your needs would be a comfort care plan." "One of the best ways to give you help is a program called hospice. The hospice program can provide extra support and the hospice has a lot of experience in caring for seriously ill people."</i>
Acknowledge response	<i>"You seem surprised to learn how sick you are." "I can see it is not easy for you to talk about end-of-life care."</i>
Empathize	<i>"I can imagine how hard this is for all of you to talk about – you care about each other so much."</i>
Explore concerns	<i>"Tell me what is upsetting you the most."</i>
Explain comfort care or hospice goals	<i>"Comfort or hospice care does not help people die sooner – it helps people die naturally." "Comfort and hospice care helps people live as well as they can for as long as they can."</i>
Reassure	<i>"The goal of comfort and hospice care is to improve your quality of life as much as possible for whatever time you have left." "Comfort and hospice care can help you and your family make the most of the time you have left."</i>
Reinforce commitment to care	<i>"Why don't you think this over? I think comfort or hospice care is the best choice for you right now, but the decision is yours. You know we will continue to care for you whatever you decide."</i>

Advance Care Planning Communication Guide

Part 4: The Resident or Family Who Want Everything Done

Resident/Family Concern	How They Say It	How You Can Respond
Abandonment	<i>"Don't give up on me."</i>	<i>"What worries you the most?"</i>
Fear	<i>"Keep trying for me."</i>	<i>"What are you most afraid of?"</i>
Anxiety	<i>"I don't want to leave my family."</i>	<i>"What does your doctor say about your condition?"</i>
Depression	<i>"I'm scared of dying."</i>	<i>"What is the most frightening to you?"</i>
Incomplete Understanding	<i>"I do not really understand how sick I am."</i>	<i>"What are your most important goals?"</i>
Wanting reassurance that best medical care has been given	<i>"Do everything you think is worthwhile."</i>	<i>"What is your understanding of your condition?"</i>
Wanting reassurance that all possible life-prolonging treatment is given	<i>"Don't leave any stone unturned." "I really want every possible treatment that has a chance of helping me live longer." "I will go through anything, regardless of how hard it is."</i>	<i>"What have others told you about what is going on with your illness?" "What have they said the impact of these treatments would be?" "Tell me more of what you mean by 'everything'?"</i>
Vitalism	<i>"I value every moment in life, regardless of the pain and suffering (which has important meaning for me)."</i>	<i>"Does your religion (faith) provide any guidance in these matters?"</i>
Faith in God's Will	<i>"I will leave my fate in God's hands; I am hoping for a miracle; only He can decide when it is time to stop."</i>	<i>"How might we know when God thinks it is your time?"</i>
Differing perceptions	<i>"I cannot bear the thought of leaving my children (wife/husband)."</i>	<i>"How is your family handling this?"</i>
Children or dependents	<i>"My family is only after my money." "I don't want to bother my children with all of this."</i>	<i>"Have you made plans for your children (other dependents)?" "Have you discussed who will make decisions for you if you cannot?" "Have you completed a will?"</i>

References

This guide contains information adapted from the following sources:

1. "The Palliative Response – Sharing the Bad News," the Birmingham/Atlanta VA Geriatric Research, Education and Clinical Center
2. Tulsky, JA. Beyond Advance Directives – Importance of Communication Skills at the End of Life. JAMA 2005; 294:359-365.
3. Casarett, DJ and Quill, TE. "I'm Not Ready for Hospice": Strategies for Timely and Effective Hospice Discussions. Ann Intern Med 2007; 146:443-449.
4. Quill, TE, Arnold, R, and Back, AL. Discussing Treatment Preferences with Patients Who Want "Everything." Ann Intern Med 2009; 151:345-349.

Additional Resources for Staff and Families *(available free on the internet)*

1. American Association for Retired Persons
2. The Coalition for Compassionate Care
3. The Conversation Project
4. Closure.org
5. Caring Connections of the National Hospice and Palliative Care Organization

Acute Care Transfer Document Checklist

Resident Name _____

Facility Name _____ Tel _____

Copies of Documents Sent with Resident (*check all that apply*)

Documents Recommended to Accompany Resident

_____ Resident Transfer Form

_____ Face Sheet

_____ Current Medication List or Current MAR

_____ SBAR and/or other Change in Condition Progress Note (*if completed*)

_____ Advance Directives (*Durable Power of Attorney for Health Care, Living Will*)

_____ Advance Care Orders (*POLST, MOLST, POST, others*)

Send These Documents ***if indicated:***

_____ Most Recent History and Physical

_____ Recent Hospital Discharge Summary

_____ Recent MD/NP/PA and Specialist Orders

_____ Flow Sheets (*e.g. diabetic, wound care*)

_____ Relevant Lab Results (*from the last 1-3 months*)

_____ Relevant X-Rays and other Diagnostic Test Results

_____ Nursing Home Capabilities Checklist (*if not already at hospital*)

Emergency Department:

Please ensure that these documents are forwarded to the hospital unit if this resident is admitted. Thank you.

Amulance Driver Signature (*optional*) _____

Education on CPR for Residents and Families

The Problem

Many health problems are so serious that they cause your heart to stop beating. This is called cardiac arrest. When this happens, you also stop breathing.

The heart pumps blood to all organs in your body to give them oxygen. When your heart stops beating, your body and brain do not get enough oxygen for you to live.

Treatment

There is only one treatment when your heart stops beating. That treatment is cardio-pulmonary resuscitation or CPR. CPR is done to try to restart the heartbeat and breathing. It is the only treatment that could save your life when your heart stops beating.

CPR involves rapidly pushing on your chest, and placement of a tube through the mouth into the lungs to directly help you breathe. Sometimes electric shocks are given using a device called a defibrillator. Once started, CPR is continued until your heart restarts or it is clear beyond a doubt that your heart cannot be restarted.

CPR can be started in the nursing home, but as soon as possible, you will be transferred to the hospital, often an intensive care unit, for additional treatment and monitoring.

Your Choice

CPR is a choice – it is not a treatment that everyone must have. Some people believe that when their time comes or their heart or breathing stops, nothing more should be done to keep them alive. Other people want everything done to keep them alive. Neither of these choices is right or wrong. It is your choice.

You should understand, however, that if you choose not to have CPR, your choice will not affect any other aspect of your care.

All of your other treatments and care will continue.

The only thing that will change is that if you are found without a pulse or heartbeat (*in cardiac arrest*) CPR will not be done.



(continued on reverse)

Education on CPR for Residents and Families (cont'd)

Making the Decision: CPR or DNR

Many people make a decision in advance about whether or not they want CPR. You can choose between having CPR and asking for a 'Do Not Resuscitate (DNR)' order. If you choose the DNR order, CPR will not be done if your heart stops beating. You are unlikely to be able to make this decision for yourself at the time your heart stops beating. Making the decision in advance will help make sure that your wishes are carried out.

The decision whether or not to have CPR can be a difficult one. You may want to discuss it with your family, doctor, nurse, social worker, or a religious leader.

Understanding the benefits and risks of CPR is important when you make your decision. The chart below explains the benefits and risks of CPR.



Benefits of CPR

If your heart stops beating, CPR is the only treatment that could save your life. However, you should also know that the rate of surviving CPR is low.

- On average less than 1 in 10 people who receive CPR outside of a hospital survive.
- The chances of surviving CPR are even lower in people of advanced age, and in people with serious medical problems such as advanced forms of cancer and diseases of the heart, kidneys, and liver.

Risks of CPR

Although in some cases CPR can save your life, CPR itself can cause bodily harm. For example:

- Many people, especially older people with thin bones, suffer broken ribs as a result of CPR.
- There is a small chance that if you survive CPR, you can have severe brain damage or be in a coma for some time or even the rest of your life

Help in Making Your Decision

There are many resources available to you in making this decision. Organizations such as the American Association for Retired Persons, the Coalition for Compassionate Care, the Conversation Project, Closure, and Caring Connections of the National Hospice and Palliative Care Organization, as well as many others



have information available in print and on their websites that may be helpful to you.

In addition, most states have standard forms for documenting your decisions in advance ('Advance Directives'), and many are recommending completing an order form in advance, such as Physicians Orders for Life Sustaining Treatment ('POLST') or other similar forms.

Comfort Care Interventions

Examples

Some nursing home residents and/or their families are reluctant to enroll in hospice but would like a comfort care plan. The examples of comfort care orders below may be helpful for these residents, who will not have hospice order sets.

Order Type	Examples and Helpful Tips
Diet	<ol style="list-style-type: none"> 1. Order a diet (<i>it may improve the desire to taste food</i>) 2. Full rather than clear liquid if liquid diet necessary 3. May have food brought in by family 4. Allow resident to sit up for meals
Activity	<ol style="list-style-type: none"> 1. Allow resident to sit in chair and use a bedside commode if capable and desired 2. Other activities as tolerated 3. Allow family to stay in room
Vital Signs	<ol style="list-style-type: none"> 1. Minimum frequency allowed by policy <ol style="list-style-type: none"> a. Frequent monitoring and numbers can alarm resident and family b. Limit MD/NP/PA notification parameters
IV Orders	<ol style="list-style-type: none"> 1. If IV fluids are needed, use a time limited trial, (<i>e.g. 1000cc of D5 ½ Normal Saline over 6 hrs</i>) <ol style="list-style-type: none"> a. Starting IV is often difficult and painful – and usually of limited benefit 2. Subcutaneous injections of small volumes of medicines using a small butterfly needle under the skin of the thigh or abdomen may avoid the need for IV therapy
Orders for Dyspnea and Shortness of Breath	<ol style="list-style-type: none"> 1. Oxygen 2 - 4 L by nasal cannula; avoid mask if possible 2. Avoid monitoring oxygen saturations 3. Blow air on face with a bedside fan or open window 4. Nebulizers may be helpful 5. Consider steroids if wheezing present 6. Use opioids for persistent dyspnea 7. Use antibiotics if a bacterial infection is exacerbating dyspnea and treatment may improve symptoms
Hygiene	<ol style="list-style-type: none"> 1. Avoid bladder (Foley) catheter if possible <ol style="list-style-type: none"> a. May be helpful in selected residents who are immobile and have pain with toileting or movement 2. Check regularly for stool impaction <ol style="list-style-type: none"> a. Suppositories may be helpful 3. Monitor for oral thrush 4. Petroleum jelly to lips may be helpful for dry mouth 5. Allow family to cleanse mouth with sponge sticks

Comfort Care Interventions

Examples (cont'd)

Order Type	Examples and Helpful Tips
Pain and Dyspnea	<ol style="list-style-type: none"> 1. Opioids usually most effective 2. Use small, frequent doses as needed for opioid-naïve residents 3. Consider stopping sustained preparations and switching to immediate release Morphine concentrate 20 mg/ml 4. Start with equivalent dose as previous regimen – at least 5 mg PO every 2 hrs 5. Offer routinely, and let the resident refuse 6. Use short-acting benzodiazepine if anxiety is present
Anorexia, Asthenia, Fatigue, Depression, Pain, Dyspnea	<ol style="list-style-type: none"> 1. Corticosteroids can have beneficial effects <ol style="list-style-type: none"> a. Use Dexamethasone 4 - 8 mg PO or subcutaneous at breakfast and lunch (<i>avoids the mineralocorticoid effects of Prednisone</i>) 3. Employ sleep hygiene measures to facilitate optimal nighttime sleep
Nausea and Delirium	<ol style="list-style-type: none"> 1. Review underlying cause(s) of delirium and nausea, and eliminate if possible 2. Haloperidol 0.25 - 2 mg PO or 0.5 - 1 mg subcutaneous every 2 hrs for 3 doses or until symptoms relieved, then every 4 hours PRN
Anxiety and Seizures	<ol style="list-style-type: none"> 1. Lorazepam for anxiety 0.5 - 2 mg PO or subcutaneous every 6 - 8 hrs <ol style="list-style-type: none"> a. Must be given IV or subcutaneous for seizures
Sleep	<ol style="list-style-type: none"> 1. Trazodone 25 - 100 mg PO or Zolpidem 5 - 10 mg PO qhs
Skin, Pruritus, Wounds	<ol style="list-style-type: none"> 1. Keep skin moist; use moisturizing soap or lotions 2. Hydrocortisone creams may be helpful 3. Benadryl 25 - 50 mg PO ever 4 hours for pruritus 4. Lidocaine 2% gel PRN to painful wounds
'Death Rattle'	<ol style="list-style-type: none"> 1. Keep back of throat dry by turning head to the side 2. Stop IV fluids or tube feedings 3. Use a Scopolamine patch; Atropine drops 2 - 3 in the mouth every 4 hrs until patch is effective <ol style="list-style-type: none"> a. Use glycopyrrolate, 1 - 2 mg PO or 0.1 - 0.2 mg IV or subcutaneous every 4 hrs; or 0.4 - 1.2 mg/day continuous infusion is an alternative 5. Avoid deep suctioning 6. Allow family to cleanse mouth with sponge sticks
Comfort, Counseling, Safety	<ol style="list-style-type: none"> 1. Sit with resident and talk to avoid isolation 2. Reposition and massage regularly 3. Avoid sensory overload (<i>e.g. loud TV</i>); use soft music 4. Avoid use of restraints, bedrails, and alarms 5. Religious counseling should be considered if acceptable

Identifying Residents who may be Appropriate for Hospice or Palliative/Comfort Care Orders

I. Residents with Selected Diagnoses who may be Appropriate for Hospice

Congestive Heart Failure

- Symptoms of CHF at rest (*New York Heart Association class IV*)
- Serum sodium level < 134 mmol/L or creatinine level > 2.0 mg/dL due to poor cardiac output
- Intensive care unit admission for exacerbation

Chronic Obstructive Pulmonary Disease

- Cor pulmonale (*right-sided heart failure associated with COPD*)
- Intensive care unit admission for exacerbation
- New dependence in two activities of daily living (ADLs) due to COPD symptoms
- Chronic hypercapnia ($PaCO_2 > 50$ mm Hg)

Dementia

- Dependence in all ADLs, language limited to just a few words, and inability to ambulate
- Acute hospitalization (*especially for pneumonia or hip fracture*)
- Difficulty swallowing with recurrent aspiration
- Has feeding tube due to dementia or swallowing difficulty related to dementia

Cancer

- Poor physical performance status as a result of cancer (*dependence in multiple ADLs*)
- Multiple tumor sites
- Metastatic cancer involving liver or brain
- Bowel obstruction due to cancer
- Pericardial effusion due to cancer

II. Residents at High Risk of Actively Dying who Should be Considered for Palliative or Comfort Care Orders (*if not already on Hospice*)

- Frequent Emergency Room visits and/or hospitalizations over the last 6 months
- Sudden, major decline in functional status with no identified reversible causes
- Primary diagnosis of metastatic cancer with chronic pain and/or poor ADL function, not on chemotherapy
- Semi-comatose or comatose state with no identified reversible causes
- Inability or difficulty taking oral medicines
- Minimal oral intake (*or receiving continuous or intermittent IV hydration*)
- Mottling of extremities related to poor oral intake or volume depletion

Nursing Home to Hospital Transfer Data List

This list is intended to provide guidance on key data elements critical for safe and effective care at the time of transition to an acute care hospital. It is not intended to be comprehensive. The INTERACT **Nursing Home – Hospital Transfer Form** illustrates an example of how these data can be formatted so that the data are readily accessible for receiving clinicians.

Information to be Sent Immediately at the Time of Transfer

Contact Information

- ☐ Resident name
- ☐ DOB
- ☐ Language
- ☐ Date of admission
- Type of stay
 - ☐ Long term care
 - ☐ Skilled nursing facility
- ☐ Primary diagnosis for admission

Facility Information

- ☐ Name of hospital sent to
- ☐ Date of transfer

Nursing Home Information

- ☐ Contact person at nursing home
- ☐ Phone number

Contact Person Information

- Relationship
 - ☐ Relative
 - ☐ Health care proxy
 - ☐ Guardian
- ☐ Contact number

Primary Care Clinician in Nursing Home

- ☐ Name
- ☐ Contact number

Code status

- ☐ Full Code
- ☐ DNR (Do Not Resuscitate)
- ☐ DNI (Do Not Intubate)
- ☐ DNH (Do Not Hospitalize)
- ☐ Comfort Care Only
- ☐ Uncertain

Key Clinical Information

- ☐ Reason for Transfer
 - Primary reason for transfer diagnostic testing only:
 - ☐ Yes
 - ☐ No

Relevant Diagnoses

- ☐ CHF
- ☐ CODP
- ☐ CRF
- ☐ DM
- ☐ Ca (*active treatment*)
- ☐ Dementia
- ☐ Other

Vital Signs

- ☐ BP
- ☐ HR
- ☐ RR
- ☐ Temperature
- ☐ O2 Saturation
 - ☐ Time taken
- ☐ Most recent pain level
 - ☐ Pain location
- ☐ Most recent pain med
 - ☐ Date given
 - ☐ Time given

Usual Mental Status

- ☐ Alert, oriented, follows instructions
- ☐ Alert, disoriented, but can follow simple instructions
- ☐ Alert, disoriented, cannot follow simple instructions
- ☐ Not Alert

Usual Functional Status

- ☐ Ambulates independently
- ☐ Ambulates with assistive device
- ☐ Ambulates only with human assistance
- ☐ Not ambulatory

Additional Clinical Information

- ☐ SBAR Acute Change in Condition Note included
- ☐ Other clinical notes included
- ☐ Date of last tetanus (*for residents with lacerations/wounds*)

Devices and Treatments

- ☐ Oxygen
 - ☐ Liters per minute
- ☐ Nasal cannula
- ☐ Mask
 - ☐ Chronic
 - ☐ New
- ☐ Nebulizer Therapy
 - ☐ Chronic
 - ☐ New
- ☐ CPAP
- ☐ BiPAP
- ☐ Pacemaker
- ☐ IV
- ☐ PICC line
- ☐ Bladder (Foley) Catheter
 - ☐ Chronic
 - ☐ New
- ☐ Internal Defibrillator
- ☐ Enteral Feeding
- ☐ TPN
- ☐ Other

Isolation Precautions

- ☐ MRSA
 - ☐ Site
- ☐ VRE
 - ☐ Site
- ☐ C. difficile
- ☐ Norovirus
- ☐ Respiratory virus/flu
- ☐ Other

Allergies

- ☐ Yes
- ☐ No

Risk Alerts

- ☐ Anticoagulation
- ☐ Falls
- ☐ Pressures ulcer(s)
- ☐ Aspiration
- ☐ Seizures
- ☐ Harm to self or others
- ☐ Restraints
- ☐ Limited/non-weight bearing:
 - ☐ Left/Right
- ☐ May attempt to exit
- ☐ Swallowing precautions
- ☐ Needs medications crushed
- ☐ Other

Personal Belongings Sent with Resident

- ☐ Eyeglasses
- ☐ Hearing Aid
- ☐ Dental Appliance
- ☐ Jewelry
- ☐ Other

Form Completed By

- ☐ Name
- ☐ Title
- ☐ Signature

Report Called By

- ☐ Name
- ☐ Title

Report Called To

- ☐ Name
- ☐ Title
- ☐ Date
- ☐ Time

Nursing Home to Hospital Transfer Data List

Information Not Critical for Emergency Room Evaluation: Can be forwarded later if unable to complete at time of transfer

Nursing Home Contact

- ☐ Name
- ☐ Title
- ☐ Phone number

Social Worker

- ☐ Name
- ☐ Phone Number

Family and Other Social Issues

- ☐ Yes
- ☐ No

Behavioral Issues and Interventions

- ☐ Yes
- ☐ No

Primary Goals of Care at Time of Transfer

- ☐ Rehabilitation and/or Medical Therapies with intent of returning home
- ☐ Chronic long-term care
- ☐ Palliative or end-of-life care
- ☐ Receiving hospice care
- ☐ Other

Treatments and Frequency

- ☐ Dialysis
- ☐ Chemotherapy
- ☐ Transfusions
- ☐ Radiation
- ☐ TPN
- ☐ Other

Diet

- ☐ Needs assistance with feeding
- ☐ Trouble swallowing
- ☐ Special Consistency
- ☐ Enteral Feeding
 - ☐ Formula
 - ☐ Rate

Skin/Wound Care

- ☐ Pressure Ulcers
 - ☐ Stage
 - ☐ Location
 - ☐ Appearance
 - ☐ Treatments

Immunizations

- ☐ Influenza
 - ☐ Date
- ☐ Pneumococcal
 - ☐ Date

Physical Rehabilitation Therapy

- Resident is receiving therapy with goal of returning home
 - ☐ Yes
 - ☐ No
- Physical Therapy
 - ☐ Yes
 - ☐ No
- Occupational Therapy
 - ☐ Yes
 - ☐ No
- Speech Therapy
 - ☐ Yes
 - ☐ No

ADLs

- ☐ Bathing
- ☐ Toileting
- ☐ Dressing
- ☐ Eating
- ☐ Transfers
- ☐ Can ambulate independently
- ☐ Assistive device
- ☐ Needs human assistance to ambulate

Impairments General

- ☐ Cognitive
- ☐ Speech
- ☐ Hearing
- ☐ Vision
- ☐ Sensation
- ☐ Other

Impairments Musculoskeletal

- ☐ Amputation
- ☐ Paralysis
- ☐ Contractures
- ☐ Other

Continence

- ☐ Bladder
- ☐ Bowel
 - ☐ Date of last BM

Additional Relevant Information

- ☐ Yes
- ☐ No

Form Completed by

- ☐ Name
- ☐ Title
- ☐ Date
- ☐ Time
- ☐ Signature



Transforming the lives of nursing home residents through continuous attention to quality of care and quality of life

API

at a Glance:

A Step by Step Guide to Implementing Quality Assurance and Performance Improvement (QAPI) in Your Nursing Home



UNIVERSITY OF MINNESOTA




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Introduction: Why This Guide?

As you use this guide, please take note of the following:

- The term “Caregiver” refers to individuals who provide care in nursing homes.
- The tool icon:  indicates that there is a QAPI tool associated with that concept in Appendix A of this guide. Click the tool icon to access the corresponding QAPI tool.
- Words underlined in **bold blue** are defined in Appendix B. Click the underlined word icon to be automatically linked to the definitions listed in Appendix B.

Effective Quality Assurance and Performance Improvement

(QAPI) is critical to our national goals to improve care for individuals and improve health for populations, while reducing per capita costs in our healthcare delivery system. We have the opportunity to accomplish these goals in each local nursing home with the aid of QAPI tools and the establishment of an effective QAPI foundation. Nursing homes are in the best position to assess, evaluate, and improve their care and services because each home has first-hand knowledge of their own organizational systems, culture, and history. Effective QAPI leverages this knowledge to maximize the return on investments made in care improvement. This *QAPI at a Glance* guide is a resource for nursing homes striving to embed QAPI principles into their day to day work of providing quality care and services.



Nursing homes in the United States will soon be required to develop QAPI plans. QAPI will take many nursing homes into a new realm in quality—a systematic, comprehensive, data-driven, proactive approach to performance management and improvement. This guide provides detailed information about the “nuts and bolts” of QAPI. We hope that *QAPI at a Glance* conveys a true sense of QAPI’s exciting possibilities. Once launched, an effective QAPI plan creates a self-sustaining approach to improving safety and quality while involving all nursing home caregivers in practical and creative problem solving. Your QAPI results are generated from your own experiences, priority-setting, and team spirit.

The Affordable Care Act of 2010 requires nursing homes to have an acceptable QAPI plan within a year of the promulgation of a QAPI regulation. However, a more basic reason to build care systems based on a QAPI philosophy is to ensure a systematic, comprehensive, data-driven approach to care. When nursing home leaders promote such an approach, the results may prevent adverse events, promote safety and quality, and reduce risks to residents and caregivers. This effort is not only about meeting minimum standards—it is about continually aiming higher. Many nursing homes are already demonstrating leadership in developing and implementing effective QAPI plans.

We encourage nursing home leaders to use *QAPI at a Glance* as a reference as they examine their own activities in the context of the goals and expectations for QAPI and sustainable improvement. You can also visit the QAPI website at <http://go.dms.gov/Nhqapi>, which we will update regularly as new materials and resources become available.

WHAT IS QAPI?

QAPI is the merger of two complementary approaches to quality management, Quality Assurance (**QA**) and Performance Improvement (**PI**). Both involve using information, but differ in key ways:

- QA is a process of meeting quality standards and assuring that care reaches an acceptable level. Nursing homes typically set QA thresholds to comply with regulations. They may also create standards that go beyond regulations. QA is a reactive, retrospective effort to examine why a facility failed to meet certain standards. QA activities do improve quality, but efforts frequently end once the standard is met.
- PI (also called Quality Improvement - QI) is a pro-active and continuous study of processes with the intent to prevent or decrease the likelihood of problems by identifying areas of opportunity and testing new approaches to fix underlying causes of persistent/systemic problems. PI in nursing homes aims to improve processes involved in health care delivery and resident quality of life. PI can make good quality even better.

The chart below was adapted from the Health Resources and Services Administration (HRSA)¹ and shows some key differences between QA and PI efforts.

	QUALITY ASSURANCE	PERFORMANCE IMPROVEMENT
Motivation	Measuring compliance with standards	Continuously improving processes to meet standards
Means	Inspection	Prevention
Attitude	Required, reactive	Chosen, proactive
Focus	Outliers: “ <i>bad apples</i> ” Individuals	Processes or Systems
Scope	Medical provider	Resident care
Responsibility	Few	All

QA + PI = QAPI

QA and PI combine to form QAPI, a comprehensive approach to ensuring high quality care.

QAPI is a data-driven, proactive approach to improving the quality of life, care, and services in nursing homes. The activities of QAPI involve members at all levels of the organization to: identify opportunities for improvement; address gaps in systems or processes; develop and implement an improvement or corrective plan; and continuously monitor effectiveness of interventions.

¹ U.S. Department of Health and Human Services, Health Resources and Services Administration. Quality Improvement adapted from <http://www.hrsa.gov/healthit/toolbox/HealthITAdoptiontoolbox/QualityImprovement/whatarediffbtwqina.html>

WHY QAPI IS IMPORTANT

Once QAPI is launched and sustained, many people report that it is a rewarding and even an enjoyable way of working. The rewards of QAPI include:

- Competencies that equip you to solve quality problems and prevent their recurrence;
- Competencies that allow you to seize opportunities to achieve new goals;
- Fulfillment for caregivers, as they become active partners in performance improvement; and
- Above all, better care and better quality of life for your residents.

Being new at QAPI is like being a new driver...

A new driver must coordinate so many actions and pay attention to so many cues that driving feels awkward, confusing, and almost impossible at first. Yet when it suddenly comes together, it becomes automatic and ushers in new horizons for that driver. In the same way, once you get some QAPI experience, it will come together, seem automatic, and will take you to new places in your quality management.



In the following pages, we discuss QAPI and its inter-related components (QA and PI), and emphasize how it can readily fit into your nursing home. Launching QAPI is not necessarily easy or quick, but it has a compelling logic and it is feasible for all nursing homes, beginning wherever your nursing home is right now.

QAPI Builds on QA&A

QAPI is not entirely new. It uses the existing QA&A, or Quality Assessment and Assurance regulation and guidance as a foundation. Maybe you recognize some of the statements below as things you are already doing:

- You create systems to provide care and achieve compliance with nursing home regulations.
- You track, investigate, and try to prevent recurrence of adverse events.
- You compare the quality of your home to that of other homes in your state or company.
- You receive and investigate complaints.
- You seek feedback from residents and front-line caregivers.
- You set targets for quality.
- You strive to achieve improvement in specific goals related to pressure ulcers, falls, restraints, or permanent caregiver assignment; or other areas; (for example by joining the Advancing Excellence Campaign).
- You are committed to balancing a safe environment with resident choice.
- You strive for deficiency-free surveys.
- You assess residents' strengths and needs to design, implement, and modify person-centered, measurable and interdisciplinary care plans.

You are already partly there. All of this is part of QAPI.

QAPI Features

QAPI includes components that may be new for many nursing homes. It emphasizes improvements that can not only elevate the care and experience of all residents, but also improve the work environment for caregivers. With QAPI, your organization will use a systems approach to actively pursue quality, not just respond to external requirements. Look at the following list of QAPI features. How many are you already using?

“Not all change is improvement, but all improvement is change.”

*Donald Berwick, MD
Former CMS Administrator*

- Using data to not only identify your quality problems, but to also identify other opportunities for improvement, and then setting priorities for action
- Building on residents’ own goals for health, quality of life, and daily activities
- Bringing meaningful resident and family voices into setting goals and evaluating progress
- Incorporating caregivers broadly in a shared QAPI mission
- Developing Performance Improvement Project ([PIP](#)) teams with specific “charters”
- Performing a [Root Cause Analysis](#) to get to the heart of the reason for a problem
- Undertaking systemic change to eliminate problems at the source
- Developing a feedback and monitoring system to sustain continuous improvement

Illustrating QAPI in Action

The scenario below illustrates how a QAA committee might develop a plan of correction in response to deficiencies identified during an annual survey. The example shows how facilities often react to regulatory non-compliance with a “band-aid” approach. The activities described are representative of the types of plans of corrections that are often submitted to Survey Agencies and accepted. It addresses the immediate problem, and then takes steps assumed to prevent recurrence of the problem.

Scenario 1

The Issue: Your nursing home, Whistling Pines, received deficiencies during their annual survey because residents had unexplained weight loss, and weights and food intake were not accurately and consistently documented.

What Whistling Pines did: The QA Committee developed a Plan of Correction, which contained the following components: Re-weighing all residents, and updating the weight records for the affected residents; in-servicing the Nursing Department on obtaining and documenting weights and intake. They stated they would conduct 3 monthly audits of weight and intake records, with results reported to the QA committee.

This plan of correction was accepted by the State Survey Agency.

The next case study shows a facility with effective QAPI systems in place to identify issues proactively, before trends become serious problems. A nursing home chooses a limited number of PIP projects in “high-risk, high volume, problem-prone” areas.

Scenario 2

The Issue: During the monthly QAPI meeting at Whistling Pines, staff discovered a trend of unexplained weight loss among several residents over the last two months. During the discussion, a representative from dining services noted that there had been an increase in the amount of food left on plates, as well as an increase in the amount of supplements being ordered. Although other issues and opportunities for improvement were identified at the meeting, the QAPI Steering Committee decided to launch a Performance Improvement Project (PIP) on the weight loss trend because unexplained weight loss posed a high-risk problem for residents.

What Whistling Pines did: The QAPI Steering Committee chartered a PIP team composed of a certified nursing assistant (CNA), charge nurse, social worker, dietary worker, registered dietitian, and a nurse practitioner. The team studied the issue, and then performed a root cause analysis (RCA) to help direct a plan of action. The RCA revealed several underlying factors, which included:

- No process existed for identifying and addressing risks for weight loss such as dental condition, diagnosis, or use of appetite suppressing medications;
- No system existed to ensure resident preferences are honored;
- Staff lacked an understanding of how to document food intake percentages; and
- Residents reported the food was not appetizing.

Based on the identified underlying causes, the PIP team recommended the following interventions:

- Development of a protocol for identifying residents at risk for weight loss to be done on admission and with each care plan. This protocol included a review of medications (appetite suppressants), new diagnoses, and resident assessments, including dental issues;
- Development of standing orders for residents identified as “at risk” for weight loss. These would include bi-weekly weights, referral to attending physician and dietitian for assessment, and documentation of meal percentages;
- Development of a new program for CNAs to be “Food Plan Leads” for at risk residents. The program would include identification of food preferences and accurate documentation of meals - laminated badge cards with pictures of meal percentages were distributed to all CNAs; and
- Revision of the menu to focus on favorite foods, adding finger foods and increasing choices outside of mealtimes.

The interventions were implemented in one area of the building that was home to 25 residents. The PIP team collected data from dietary (food wasted and supplement use), CNAs (observation of resident satisfaction and meal percentages), residents (satisfaction surveys), and weights.

After 3 months, they found that 5 residents gained weight, 15 remained stable, and 5 lost weight, but the weight loss was not unexpected and consistent with their clinical condition. Food costs did not increase and supplement costs decreased by 12%.

Whistling Pines decided to adopt and expand the changes to other areas of the facility. They received no deficiencies in the areas of nutrition on their annual survey. Using QAPI allowed them to identify and correct developing issues before they escalated to larger problems.

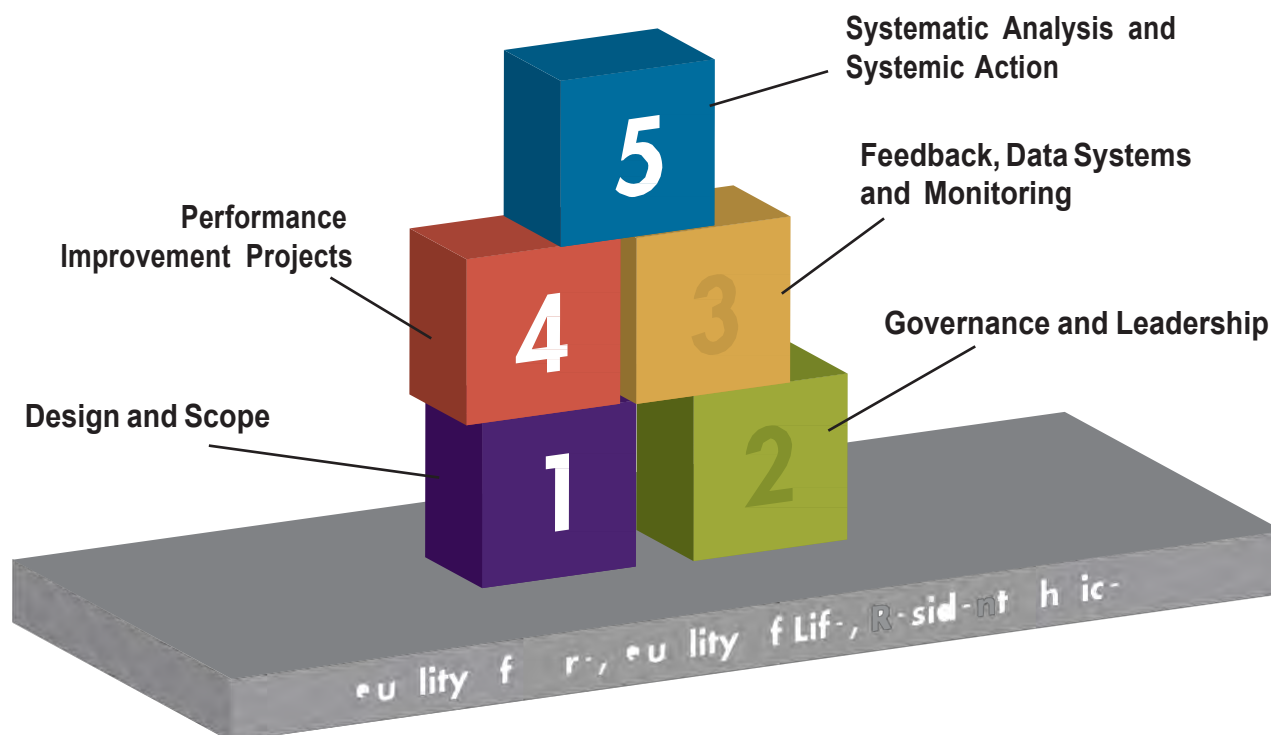
Many of the QAPI action steps discussed in this guide are found in the second scenario. Here are some of the key highlights:

- The facility had a structured Steering Committee for directing the QAPI activities (Step 1).
- The facility established performance measures and was conducting routine monitoring (Step 6).
- The facility used data to identify gaps or opportunities for improvement (Step 8).
- The QAPI Steering Committee used prioritization to decide when to conduct PIPs (Step 9).
- The QAPI Steering Committee created an interdisciplinary team, and as seen in this example, each discipline in the team brought a unique perspective that contributed to a balanced and comprehensive analysis (Step 2).
- The QAPI Steering Committee gave each team member real responsibility to study the issue, analyze the data, and recommend corrective actions (Step 2).
- The PIP team explored the issue, and designed interventions using a Plan-Do-Study-Act (PDSA) model (Steps 9 and 10).
- The PIP team's investigation revealed several underlying systemic issues and made recommendations that addressed those systems, rather than focusing on individual behavior (Step 12).



Five Elements for Framing QAPI in Nursing Homes

CMS has identified five strategic elements that are basic building blocks to effective QAPI. These provide a framework for QAPI development.



The 5 elements are your strategic framework for developing, implementing, and sustaining QAPI. In doing so, keep the following in mind:

- Your QAPI plan should address all five elements.
- The elements are all closely related. You are likely to be working on them all at once—they may all need attention at the same time because they will all apply to the improvement initiatives you choose.
- Your plan is based on your own center's programs and services, the needs of your particular residents, and your assessment of your current quality challenges and opportunities.

THE FIVE ELEMENTS ARE:

■ Element 1: Design and Scope

A QAPI program must be ongoing and comprehensive, dealing with the full range of services offered by the facility, including the full range of departments. When fully implemented, the QAPI program should address all systems of care and management practices, and should always include clinical care, quality of life, and resident choice. It aims for safety and high quality with all clinical interventions while emphasizing autonomy and choice in daily life for residents (or resident's agents). It utilizes the best available evidence to define and measure goals. Nursing homes will have in place a written QAPI plan adhering to these principles.

■ Element 2: Governance and Leadership

The governing body and/or administration of the nursing home develops a culture that involves leadership seeking input from facility staff, residents, and their families and/or representatives. The governing body assures adequate resources exist to conduct QAPI efforts. This includes designating one or more persons to be accountable for QAPI; developing leadership and facility-wide training on QAPI; and ensuring staff time, equipment, and technical training as needed. The Governing Body should foster a culture where QAPI is a priority by ensuring policies are developed to sustain QAPI despite changes in personnel and turnover. Their responsibilities include, setting expectations around safety, quality, rights, choice, and respect by balancing safety with resident-centered rights and choice. The governing body ensures staff accountability, while creating an atmosphere where staff are comfortable identifying and reporting quality problems as well as opportunities for improvement.

■ Element 3: Feedback, Data Systems and Monitoring

The facility puts in place systems to monitor care and services, drawing data from multiple sources. Feedback systems actively incorporate input from staff, residents, families, and others as appropriate. This element includes using Performance Indicators to monitor a wide range of care processes and outcomes, and reviewing findings against benchmarks and/or targets the facility has established for performance. It also includes tracking, investigating, and monitoring Adverse Events that must be investigated every time they occur, and action plans implemented to prevent recurrences.

■ Element 4: Performance Improvement Projects (PIPs)

A Performance Improvement Project (PIP) is a concentrated effort on a particular problem in one area of the facility or facility wide; it involves gathering information systematically to clarify issues or problems, and intervening for improvements. The facility conducts PIPs to examine and improve care or services in areas that the facility identifies as needing attention. Areas that need attention will vary depending on the type of facility and the unique scope of services they provide.

■ Element 5: Systematic Analysis and Systemic Action

The facility uses a systematic approach to determine when in-depth analysis is needed to fully understand the problem, its causes, and implications of a change. The facility uses a thorough and highly organized/ structured approach to determine whether and how identified problems may be caused or exacerbated by the way care and services are organized or delivered. Additionally, facilities will be expected to develop policies and procedures and demonstrate proficiency in the use of Root Cause Analysis. Systemic Actions look comprehensively across all involved systems to prevent future events and promote sustained improvement. This element includes a focus on continual learning and continuous improvement.

Action Steps to QAPI

The next few sections detail action steps that may help you on your road to implementing QAPI. They do not need to be achieved sequentially, but each step builds on other QAPI principles.

The most important aspect of QAPI is effective implementation. Learning and understanding the principles is just the first step.

STEP 1: Leadership Responsibility and Accountability

Creating a culture to support QAPI efforts begins with leadership. Support from the top is essential, and that support should foster the active participation of every caregiver. The administrator and senior leaders must create an environment that promotes QAPI and involves all caregivers.

Executive leadership sets the tone and provides resources. Their challenge is to help leadership flourish in each home.

Put a Personal Face on Quality Issues

Leadership should:

- give residents, family and staff the opportunity to meet board members and executive leaders to generate support for QAPI.
- tour the organization regularly, meeting with residents and caregivers where they live and work.
- choose the person or persons who will be the QAPI lead in conjunction with top management—QAPI needs champions.

Here are some ways leadership can take action:

- Develop a steering committee, a team that will provide QAPI leadership:
 - The steering committee has overall responsibility to develop and modify the plan, review information, and set priorities for PIPs. The steering committee charts teams to work on particular problems. It reviews results and determines the next steps. The steering committee must learn and use systems thinking—a nursing home has many competing interests and needs. Top leadership such as the Administrator and the Director of Nursing must be part of this structure.
 - It is also important to have a medical director who is actively engaged in QAPI. It is possible to adapt your Quality Assurance committee to become your “Steering committee” to oversee QAPI. For this to work, the QA Committee may need to meet more often, include more people, and establish permanent and time-limited workgroups that report to it.
- Provide resources for QAPI—including equipment and training:
 - Caregivers may need time to attend team meetings during working hours, requiring others to cover their clinical duties for a period of time.
 - Equipment might include anything from additional computers, to low-cost supplies like posters to create story boards, or multiple copies of resource books or CDs.
 - Leadership may want to consider sending one or more team members to a specialized training.

- Establish a climate of open communication and respect. Leadership may wish to consider:
 - Having an open-door policy to communicate with staff and caregivers.
 - Emphasizing communication across shifts and between department heads.
 - Creating an environment where caregivers feel free to bring quality concerns forward without fear of punishment.
 - Understand your home's current culture and how it will promote performance improvement:
 - Create the expectation that everyone in your nursing home is working on improving care and services.
 - Establish an environment where caregivers, residents, and families feel free to speak up to identify areas that need improvement.
 - Expect and build effective teamwork among departments and caregivers.

STEP 2: Develop a Deliberate Approach to Teamwork

Teamwork is a core component of QAPI and too often it is taken for granted. You will hear and read that you should discuss a situation with “your team,” or that the opinion of “everyone on the team” is valued. The word “teamwork” may have different meanings. Many people work together without being a designated or formal “team.”



Characteristics of an effective team include the following:

- Having a clear purpose
- Having defined roles for each team member to play
- Having commitment to active engagement from each member

The roles of team workers may grow out of their original discipline (e.g., nurse, social worker, physical therapist) or their defined job responsibilities.

QAPI relies on teamwork in several ways:

- Task-oriented teams may be specially formed to look into a particular problem and their work may be limited and focused.
- PIP teams are formed for longer-term work on an issue.
- When chartering a PIP, careful consideration must be given to the purpose of the PIP and type of members needed to achieve that purpose. Here are some examples:
 - A PIP team with the goal of helping residents go outside more often decided that grounds personnel needed to be on that team so that procedures for snow removal, sun protection, and outdoor seating could be considered.
 - Another PIP team working at simplifying medication regimens included a pharmacist, even though the time needed to be added to the consultant contract.
 - After a PIP team began working on the problem of anxiety among residents, the members realized that many of the affected residents reported reassurance from the pastor and asked the QA committee to add him to the team that was planning the approach.
 - A PIP team working on reducing falls asked that the housekeeping department be involved as it considered root causes of falls and realized that equipment in the corridors and clutter in the bathrooms contributed.

Note: Generally, each team should be composed of interdisciplinary members. For example, a concern with medication administration should include nursing and pharmacy team members. However, even other disciplines or family members may bring a different perspective to understanding this issue and should be considered for this type of team.

- Family members and residents may be team members, though for confidentiality reasons, they may not review certain data or information that identifies individuals.
- PIP teams need to plan for sufficient communication—including face-to-face meetings to get to know each other and plan the work. The team should also plan for the way each team member will review information that emerges from the PIP.
- Leadership needs to convey that being on a PIP team is an important part of the job—not something to put aside if other things come up. They must also support this idea through action and resources to enable staff to complete daily assignments, provide clinical care and also participate on QAPI teams.

STEP 3: Take your QAPI “Pulse” with a Self-Assessment

In order to establish QAPI in your organization, it is helpful to conduct a self-assessment in your organization. As you continue implementing the action steps outlined in this guide, you should periodically evaluate QAPI in your organization – see how far you’ve come.

To get you started, we’ve developed a self-assessment tool to take your QAPI “pulse.” It will assist you in evaluating the extent to which components of QAPI are in place within your organization and identifying areas requiring further development. It will help you determine how you really know whether QAPI is taking hold.

You may use the self-assessment tool as you begin work on QAPI and then for annual or semiannual evaluation of your organization’s progress. You should complete the tool with input from the entire QAPI team and organizational leadership. This is meant to be an honest reflection of your progress with QAPI. The results of this assessment will direct you to areas you need to work on in order to establish QAPI in your organization.

[*Click here to go to the QAPI Self-Assessment Tool in Appendix A*](#)



STEP 4: Identify Your Organization’s Guiding Principles

It is important to lay a foundation that will help you think about what principles will guide your decision making and help you set priorities.

Nursing homes are complex organizations, with numerous departments performing different functions that interact with and depend on each other. Establishing a purpose and guiding principles will unify the facility by tying the work being done to a fundamental purpose or philosophy. These principles will help guide your facility in determining programmatic priorities.

Use the Guide for Developing Purpose, Guiding Principles, and Scope for QAPI to establish the principles that will give your organization direction. The team completing this assignment should include senior leadership. Taking time to articulate the purpose, develop guiding principles, and define the scope will help you to understand how QAPI will be used and integrated into your organization. This information will also help your organization to develop a written QAPI plan.

[*Click here to go to the Guide for Developing Purpose, Guiding Principles, and Scope for QAPI in Appendix A*](#)



STEP 5: Develop Your QAPI Plan

Your plan will assist you in achieving what you have identified as the purpose, guiding principles and scope for QAPI. This is a living document that you may revisit as your facility evolves.

A written QAPI plan guides the nursing home's quality efforts and serves as the main document to support implementation of QAPI. The plan describes guiding principles that will be used in QAPI as well as the scope QAPI will have based on the unique characteristics and services of the nursing home. The QAPI plan should be something that is actually used and not viewed as a task that must be completed. You should continually review and refine your QAPI plan.

- Tailor the plan to fit your nursing home including all units, programs, and resident groups (for example, your sub-acute care unit, your dementia care unit, or your palliative care program). Think also of the range of residents. Do you have some younger residents? You may need to consciously develop a distinct plan to create quality of life for those residents.
- Some large organizations or corporations may choose to develop a general plan for all nursing homes in the group—in fact many multi-home organizations already have a corporate quality plan. Flexibility must be built in because individual nursing homes must have a plan that works for them. Leaders at the facility level need flexibility to develop plans for the priorities that fit their needs.

You may use the Guide for Developing a QAPI Plan to help you create a comprehensive plan that addresses the full range and scope of care and services provided by your organization.

[Click here to go to the Guide for Developing a QAPI Plan in Appendix A](#)



STEP 6: Conduct a QAPI Awareness Campaign

COMMUNICATE WITH ALL CAREGIVERS

- Let everyone know about your QAPI plan—often and in multiple ways.
- Plan ongoing caregiver education beyond single exposures—the goal is widespread awareness of QAPI initiatives.
- Train through dialogue, examples, and exercises. Transform the material in this guide into smaller pieces and easily understood ideas. Use your home's own experiences with certain caregivers or residents as part of the learning materials.
- Convey the message that QAPI is about systems of care, management practices, and business practices—systems should support quality and/or acceptable business practices, or they must change. Use examples to get the message across, and ask caregivers to think of examples of their own.
- Be sure consultants, contractors, and collaborating agencies are also aware of your QAPI approach. Maybe you have several hospice organizations coming in and out of your home. You may work with a podiatrist who visits regularly. They each have a role in your system.
- Convey the message that any and every caregiver is expected to raise quality concerns, that it is safe to do so, and that everyone is encouraged to think about systems.

- Discuss the hard questions—what is meant by a culture of safety here in our nursing home? How does the nursing home try to balance issues of safety and resident choice/autonomy? These types of questions often do not have easy answers but QAPI opens up these types of issues for discussion and deeper thinking.

Try this:

An exercise where groups that cross disciplines and roles brainstorm the various ways their work influences the work of others. For example, activities personnel may find that their events are cut short because no one is available to help residents to and from activity areas. Also seek examples where resident choice did not prevail. For instance, evening caregivers may say residents cannot be up and out of their rooms after 9:30 pm because no one will be able to help them to bed after 10:00 pm. Brainstorm how to solve problems like these, even if jobs and routines would change.

If systems don't exist, they may need to be developed. If systems impede quality, they must be changed.

COMMUNICATE WITH RESIDENTS AND FAMILIES

- Make sure all residents and families know that their views are sought, valued, and considered in facility decision-making and process improvements by announcing and discussing QAPI in resident and family councils and other venues.
- Ask residents and family members to tell you about their quality concerns. Many facilities today are using some type of customer-satisfaction survey—results should be used to identify opportunities for improvement that will proactively have an impact on all residents and their families.
- Try to view concerns through residents' eyes. For example, getting back to a resident in 10 minutes may seem responsive, but may feel like an eternity to the resident. How would that feel to a resident waiting an answer to a call light or for help to the bathroom?
- Consider including QAPI information in routine communications to families.



Family and resident complaints are often underused, and yet they are a valuable way of identifying more general problems.

STEP 7: Develop a Strategy for Collecting and Using QAPI Data

Your team will decide what data to monitor routinely. Areas to consider may include:

- Clinical care areas, e.g., pressure ulcers, falls, infections
- Medications, e.g., those that require close monitoring, antipsychotics, narcotics
- Complaints from residents and families
- Hospitalizations and other service use
- Resident satisfaction
- Caregiver satisfaction
- Care plans, including ensuring implementation and evaluation of measurable interventions
- State survey results and deficiencies
- Results from MDS resident assessments
- Business and administrative processes—for example, financial information, caregiver turnover, caregiver competencies, and staffing patterns, such as permanent caregiver assignment. Data related to caregivers who call out sick or are unable to report to work on short notice, caregiver injuries, and compensation claims may also be useful.

This data will require systematic organization and interpretation in order to achieve meaningful reporting and action. Otherwise, it would only be a collection of unrelated, diverse data and may not be useful.

Compare this to an individual resident's health—you must connect many pieces of information to reach a diagnosis. You also need to connect many pieces of information to learn your nursing home's quality baseline, goals, and capabilities.

- Your team should set targets for performance in the areas you are monitoring. A target is a goal, usually stated as a percentage. Your goal may be to reduce restraints to zero; if so, even one instance will be too many. In other cases, you may have both short and longer-term goals. For example, your immediate goal may be reducing unplanned rehospitalizations by 15 percent, and then subsequently by an additional 10 percent. Think of your facility or organization as an athlete who keeps beating his or her own record.
- Identifying benchmarks for performance is an essential component of using data effectively with QAPI. A benchmark is a standard of comparison. You may wish to look at your performance compared to nursing homes in your state and nationally using Nursing Home Compare (www.medicare.gov/nhcompare); some states also have state report cards. You may compare your nursing home to other facilities in your corporation, if applicable. But generally, because every facility is unique, the most important benchmarks are often based on your own performance. For example, seeking to improve hand-washing compliance to 90 percent in 3 months based on a finding of 66 percent in the prior quarter. After achieving 90 percent for some period of time, the benchmark can be raised higher as part of ongoing, continuous improvement.
- It may be helpful to monitor what happens when residents leave the nursing home or come back, including discharges to the hospital or home. You may examine discharge rates from your post-acute care area, preventable hospitalizations (i.e., hospitalizations that can be avoided through good clinical care), and what happens after the resident returns from the hospital.

- You'll want to develop a plan for the data you collect. Determine who reviews certain data, and how often. Collecting information is not helpful unless it is actually used. Be purposeful about who should review certain data, and how often—and about the next steps in interpreting the information.

STEP 8: Identify Your Gaps and Opportunities

This step involves reviewing your sources of information to determine if gaps or patterns exist in your systems of care that could result in quality problems. Or, are there opportunities to make improvements?

Potential areas to consider when reviewing your data:

- MDS data for problem patterns.
- Nursing Home Compare (provides quality information about every certified nursing home in the country).
- State survey results and plans of correction.
- Resident care plans for documented progress towards specified goals.
- Trends in complaints.
- Resident and family satisfaction for trends.
- Patterns of caregiver turnover or absences.
- Patterns of ER and/or hospital use.

During this step, you may decide to spend more time discussing the quality themes you have identified with residents and caregivers. They may pick up patterns you have not yet identified, and they may have ideas about what is at the root of the problem. Consider hosting a series of small group meetings with your caregivers, and arrange to meet with your Resident Council. You may wish to provide refreshments and have an informal discussion.

This step should lead to the next steps involving PIPs. Such projects are expected to be chosen to deal with “high risk, high volume, problem-prone areas” related to quality of care or quality of life. Take time to notice the things you are doing well—that’s important too, and deserves recognition.

But while you are celebrating accomplishments, you can also begin to set priorities for improvement around issues that the team identifies.

STEP 9: Prioritize Quality Opportunities and Charter PIPs

Prioritizing opportunities for improvement is a key step in the process of translating data into action.

As you continue to implement QAPI, you and your team will:

- Prioritize opportunities for more intensive improvement work. Problems versus opportunities are a matter of perspective and often require discussion.
- Choose problems or issues that you consider important (consider if the issue is high risk, high frequency, and/or problem prone). Remember that problems affecting psychosocial well-being and the ability of residents to exercise choice should also be considered as they may lead to resident suffering.
- Consider which problems will become the focus for a PIP.

- All identified problems need attention—and usually from more than one person, but they do not all require PIPs.
- Begin some PIPs with problems you think you can solve relatively easily. A quick win is worthwhile.

Charter PIP teams:

We use the word “charter” on purpose. A PIP is more than a casual effort - it entails a specific written mission to look into a problem area. The PIP team should include people in a position to explore the problem (usually direct caregivers, such as nursing assistants, are needed). If the problem being addressed involves, for example, dietary choices, then someone from the dietary department should also be on the PIP team.

Chartering implies that the team has been entrusted with a mission, and that it reports back to the Steering Committee at intervals. Being part of a formally chartered PIP team must be interpreted as an important assignment that team members and their supervisors must take seriously. The development of a charter adds strength, importance, and formality to the PIP process. The team typically has a leader—either chosen in the charter or by the team itself. Soon after it begins its work, the PIP should develop a proposed time line, and indicate the budget that is needed.

Use the Goal Setting Worksheet to help your PIP team establish appropriate goals for organizational quality measures, informal improvement initiatives, and PIPs.

[Click here to go to the Goal Setting Worksheet in Appendix A](#)

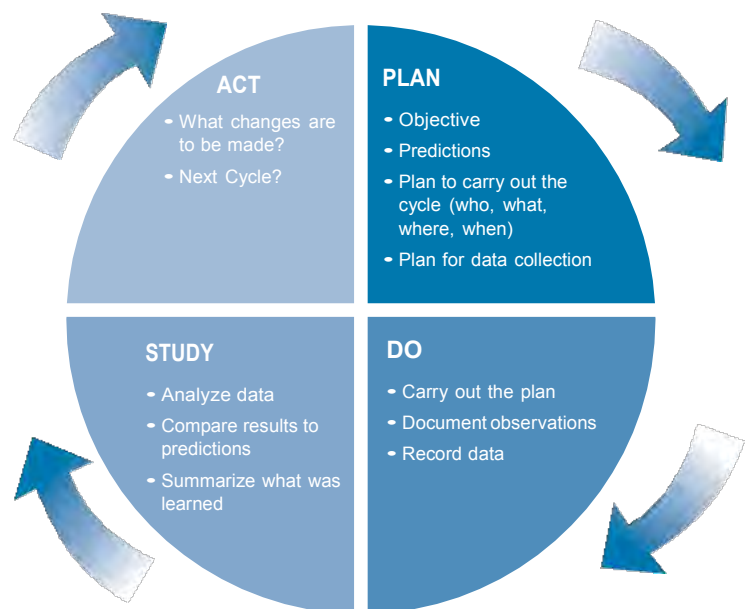


STEP 10: Plan, Conduct and Document PIPs

Careful planning of PIPs includes identifying areas to work on through your comprehensive data review which are meaningful and important to your residents. It is important to focus your PIPs by defining the scope, so they do not become overwhelming.

You and your team may:

- consider each PIP a learning process.
- determine what information you need for the PIP.
- determine a timeline and communicate it to the Steering Committee.
- identify and request any needed supplies or equipment.
- select or create measurement tools as needed;
- prepare and present results.
- use a problem solving model like PDSA (Plan-Do-Study-Act).
- report results to the Steering Committee.



PDSA MODEL

PLAN-DO-STUDY-ACT (PDSA) CYCLE

During a PIP you will try out some changes and then see whether or not they made a difference in the area you were trying to improve. In the PLAN stage, the team learns more about the problem, plans for how improvement would be measured, and plans for any changes that might be implemented. In the DO stage, the plan is carried out, including the measures that are selected. In the STUDY phase, the team summarizes what was learned. In the ACT phase, the team and leadership determine what should be done next. The change can be adapted (and re-studied), adopted (perhaps expanded to other areas), or abandoned. That decision determines the next steps in the cycle.

STEP 11: Getting to the “Root” of the Problem

A major challenge in process improvement is getting to the heart of the problem or opportunity.



There is danger in starting with a solution without thoroughly exploring the problem. Multiple factors may have contributed, and/or the problem may be a symptom of a larger issue. What seems like a simple issue may involve a number of departments.

Root Cause Analysis (RCA) is a term used to describe a systematic process for identifying contributing causal factors that underlie variations in performance. This structured method of analysis is designed to get to the underlying cause of a problem—which then leads to identification of effective interventions that can be implemented in order to make improvements.

RCA helps teams understand that the most immediate or seemingly obvious reason for the problem or an event may not be the real reason that an event occurred. The RCA process leads to digging deeper and deeper—looking for the reasons behind the reasons. This process will generally lead to the identification of more than one root cause. The root cause(s) and any contributing factors can then be sorted into categories to facilitate the identification of various actions that can be taken to make improvements.

RCA focuses primarily on systems and processes, not individual performance.

The RCA process takes practice, but can be a valuable tool for performance improvement. In order to get familiar with RCA you and your team may consider:

- studying case examples of RCA.
- applying RCA to an adverse event and discussing this technique with the team.
- building RCA examples into training opportunities.

STEP 12: Take Systemic Action

Identifying root causes is only the first step in improving performance. Next you will want to implement changes or corrective actions that will result in improvement or reduce the chance of the event recurring. This is often the most challenging step in the process. Common solutions such as providing more training/education or asking clinicians to “be more careful” do not change the process or system. These proposed solutions are based on two assumptions: lack of knowledge contributed to the event, and if a person is educated or trained, the mistake won’t happen again.

Choosing actions that are tightly linked to the root causes and that lead to a system or process change are considered to have a higher likelihood of being effective. Actions that simply support the current process are considered “weaker” and should not be selected as the sole intervention. The goal is to make changes that will result in lasting improvement. Avoiding quick fixes and weak actions is vital to achieving that goal.

To be effective, interventions or corrective actions should target the elimination of root causes, offer long term solutions to the problem, and have a greater positive than negative impact on other processes. In addition, interventions must be achievable, objective, and measurable.

Pilot Test:

Think about testing or “piloting” changes in one area of your facility before launching throughout. Some changes have unintended consequences.

The Department of Veterans Affairs National Center for Patient Safety’s Hierarchy of Actions²—classifies corrective actions as:

Weak: Actions that depend on staff to remember their training or what is written in the policy. Weak actions enhance or enforce existing processes.

Examples of weak actions:

- double checks
- warnings/labels
- new policies/procedures/memoranda
- training/education
- additional study

Intermediate: Actions are somewhat dependent on staff remembering to do the right thing, but they provide tools to help staff to remember or to promote clear communication. Intermediate actions modify existing processes.

Examples of intermediate actions:

- decrease workload
- software enhancements/modifications
- eliminate/reduce distraction
- checklists/cognitive aids/triggers/prompts
- eliminate look alike and sound alike
- read back
- enhanced documentation/communication
- build in redundancy

²U.S. Department of Veterans Affairs. National Center for Patient Safety Root Cause Analysis Tools. Retrieved from <http://www.patientsafety.gov/CogAids/RCA/index.html#page+page-1>.

Strong: Actions that do not depend on staff to remember to do the right thing. The action may not totally eliminate the vulnerability but provides strong controls. Strong actions change or re-design the process. They help detect and warn so there is an opportunity to correct before the error reaches the patient. They may involve hard stops which won't allow the process to continue unless something is corrected or gives the chance to intervene to prevent significant harm.

Examples of strong actions:

- physical changes: grab bars, non slip strips on tubs/showers
- forcing functions or constraints: design of gas lines so that only oxygen can be connected to oxygen lines; electronic medical records – cannot continue charting unless all fields are filled in
- simplifying: unit dose

Prevent future problems by developing and testing strong actions.

QAPI Principles Summarized

- All of QAPI may not be new to your facility. You already have a Quality Assessment and Assurance program—consider beginning by evaluating or re-evaluating that program and then conducting a self evaluation using the QAPI Self Assessment Tool.
- QAPI leadership starts at the top with executive management and the Board of Directors, Owners, or Trustees, and includes top management in each home.
- Three important principles of QAPI are Systems, Systems, and Systems. Start using systems thinking as you assess your own QAPI efforts, and develop a QAPI plan moving forward. Think of your entire center or community as you plan for monitoring, as you conduct PIPs, and particularly as you think about the way problems might be caused and how care is organized.
- Involve the people directly working in a process in order to improve that process. These are the people who really know what happens at any point in the process. It is crucial to focus on organization-wide inclusion, not for the sake of inclusion, but to truly understand what is going on in any given process.
- Communication about QAPI should be continuous throughout the whole organization. QAPI principles and ongoing training should be built into a facility-wide educational effort that involves all caregivers, residents, and families.
- Residents' perspectives need to be considered in setting QAPI priorities. Solicit residents' viewpoints and talk to residents and families about quality as they experience it.
- Two important components of your QAPI plan will be setting priorities and chartering PIP teams. Everyone should have an opportunity to participate in these activities.
- Create a record of QAPI activities. Consider using past experience as a resource as you move ahead. Keeping an ongoing record of QAPI achievements may help to sustain the improvements regardless of crises or changes in leadership. Build it into your plan.
- Celebrate and reward successes.

How to Learn More

Our QAPI website: <http://go.cms.gov/Nhqapi>

An excellent resource on QAPI in Nursing Homes is CMS' QAPI website. It contains a number of tools and resources including:

- Learning modules complete with videos, QAPI Process Tools and how to use them, case study examples, best practices information, sections to help engage consumers, and much more
- Downloadable QAPI process tools with instructions for their use
- Best practice examples organized by topic
- QAPI tools for specific topics and purposes with links to many related resources
- Special resources for you in your particular practice role in the “Communities of Practice” section
- News Briefs on QAPI implementation



QAPI Tools and Related Resources

QAPI PROCESS TOOLS

These are tools that help make QAPI processes work. They may include:

- checklists
- templates
- flow charts
- reporting forms or outlines
- worksheets

QAPI process tools are important to:

- organize multiple tasks.
- enhance communication within and across teams.
- help generate ideas and reach decisions.
- keep information organized and accessible.
- track successes and challenges using data.

QAPI is largely about well-functioning and tightly coordinated systems that can identify, solve, and prevent problems effectively. Using QAPI can improve diverse aspects of care and services as well as resident, family, caregiver, and staff experience and satisfaction. **TOOLS CAN HELP.**

QAPI TOPIC TOOLS

QAPI Topic Tools are used to study and improve particular topic areas. Many tools are available to assess care processes and outcomes and to allow you to follow progress in areas you want to track and/or improve. Topic tools can take many forms, ranging from simple to complex, and they use multiple sources of information.

- Checklists or audits completed by caregivers and practitioners. Checklists can be used to review records of various kinds to determine that all steps have been taken. For example, an admission or fall prevention checklist.
- Rating forms completed by caregivers. For example, residents' mood states are rated when residents cannot respond to direct questions.
- Structured observation (e.g., observations of interactions among residents and caregivers or of physical environments). Observations are objective and made at specific times and places; later they may be summarized into a score.
- Direct interviews with residents and family. Such tools, sometimes called resident self-report tools, may be related to single areas of functioning.
- Protocols to guide caregivers' behavior to improve quality in a particular area. Such protocols may include procedures and forms meant to shape caregiver behavior around pressure ulcer prevention, respecting residents' rights, etc. This comprehensive set of tools could be considered a QAPI process toolkit as well.

Nursing homes may wish to select established tools that have been tested and use them consistently.

QAPI RESOURCES FOR PROVIDERS

Each state is served by a Quality Improvement Organization that offers resources and tools for nursing homes. To find your Quality Improvement Organization, visit <http://www.qualitynet.org/dcs/ContentServer?c=Page&pagename=QnetPublic%2FPage%2FQnetTier2&cid=1144767874793>

RESOURCES AND TOOLS AVAILABLE THROUGH QIOS

Oklahoma Foundation for Medical Quality

Provides tools and resources for nursing homes.

<http://www.ofmq.com/nhtoolsandresources> Improvement basics for nursing homes, Change management, and Facilitating group agreement.

Stratis Health

The following recorded webinars cover some basic principles of QI and can be used for caregiver education: <http://www.stratishealth.org/events/recorded.html>

WEBSITES ON SELECTED QUALITY TOPICS

Advancing Excellence in America's Nursing Homes

Supported by CMS, the Commonwealth Fund, and others, The Advancing Excellence Campaign provides tools and resources to improve nursing home care in clinical and organizational areas.

<http://www.nhqualitycampaign.org/>

Agency for Healthcare Research and Quality

The Department of Defense and the Agency for Healthcare Research and Quality developed the Team STEPPS program to optimize performance among teams of healthcare professionals and improve collaboration and communication. The Long-Term Care version addresses issues specific to nursing homes:

<http://www.hrq.gov/professionals/education/curriculum-tools/teamstepps/ltc/index.html>

Department of Veterans Affairs

National Center for Patient Safety supports and leads the patient safety activities for all VA medical centers and has developed tools including Root Cause Analysis investigations: <http://www.patientsafety.gov/CogAids/RCA/>

Getting Better All the Time: Working Together for Continuous Improvement

The Isabella Geriatric Center and Cobble Hill Health Center have developed a web manual on quality improvement approaches as a guide for nursing home caregivers. This is a particularly practical and lively resource that explains and illustrates performance monitoring and improvement approaches in ways that are understandable to most nursing home caregivers. *Getting Better All the Time* was written by Ann Wyatt, a social worker and nursing home administrator; it aims to present a model of quality improvement that integrates quality of care and quality life.

<http://www.usanwehrymd.com/files/gettingbetterall-the-time.pdf>

Interact II

An example of a more extensive set of tools, INTERACT II is a system of tools to improve how nursing home caregivers communicate around change in resident condition. This comprehensive set of tools could be considered a QAPI process toolkit as well. www.interact2.net

Institute for Health Care Improvement (IHI)

IHI uses the Model for Improvement as the framework to guide improvement work. The Model for Improvement, developed by Associates in Process Improvement, is a simple, yet powerful tool for accelerating improvement. Learn about the fundamentals of the Model for Improvement and testing changes on a small scale using Plan-Do-Study-Act (PDSA) cycles.

<http://www.ihi.org/knowledge/Pages/HowtoImprove/default.aspx>

WEBSITES ON PERSON-CENTERED CARE

Implementing Change in Long-Term Care: A Practical Guide to Transformation

This resource was prepared by Barbara Bowers and others with a grant from the Commonwealth Fund to the Pioneer Network. Although it deals with implementing culture change (not QAPI), it is a good resource on the change process.

http://www.pioneernetwork.net/Data/Documents/Implementation_Manual_ChangeInLongTermCare%5B1%5D.pdf

Picker Institute Publications

These include a *Long-Term Care Improvement Guide*, commissioned in 2010 and a *Patient-Centered Care Improvement Guide*, commissioned in 2008, both by Susan Frampton and others. The website also carries information on current books related to person centered care that Picker Institute recommends.

<http://pickerinstitute.org/publications-and-resources/>



Appendix A: QAPI Tools



Disclaimer: Use of these tools is not mandated by CMS for regulatory compliance nor does their completion ensure regulatory compliance.

Directions: Use this tool as you begin work on QAPI and then for annual or semiannual evaluation of your organization's progress with QAPI. This tool should be completed with input from the entire QAPI team and organizational leadership. This is meant to be an honest reflection of your progress with QAPI. The results of this assessment will direct you to areas you need to work on in order to establish QAPI in your organization. You may find it helpful to add notes under each item as to why you rated yourself a certain way.

Date of Review: _____ Next review scheduled for: _____

Rate how closely each statement fits your organization	Not started	Just starting	On our way	Almost there	Doing great
<p>Our organization has developed principles guiding how QAPI will be incorporated into our culture and built into how we do our work. For example, we can say that QAPI is a method for approaching decision making and problem solving rather than considered as a separate program.</p> <p>Notes:</p>					
<p>Our organization has identified how all service lines and departments will utilize and be engaged in QAPI to plan and do their work. For example, we can say that all service lines and departments use data to make decisions and drive improvements, and use measurement to determine if improvement efforts were successful.</p> <p>Notes:</p>					
<p>Our organization has developed a written QAPI plan that contains the steps that the organization takes to identify, implement and sustain continuous improvements in all departments; and is revised on an ongoing basis. For example, a written plan that is done purely for compliance and not referenced would not meet the intent of a QAPI plan.</p> <p>Notes:</p>					
<p>Our board of directors and trustees (if applicable) are engaged in and supportive of the performance improvement work being done in our organization. For example, it would be evident from meeting minutes of the board or other leadership meetings that they are informed of what is being learned from the data, and they provide input on what initiatives should be considered. Other examples would be having leadership (board or executive leadership) representation on performance improvement projects or teams, and providing resources to support QAPI.</p> <p>Notes:</p>					

Rate how closely each statement fits your organization	Not started	Just starting	On our way	Almost there	Doing great
QAPI is considered a priority in our organization. For example, there is a process for covering caregivers who are asked to spend time on improvement teams. Notes:					
QAPI is an integral component of new caregiver orientation and training. For example, new caregivers understand and can describe their role in identifying opportunities for improvement. Another example is that new caregivers expect that they will be active participants on improvement teams. Notes:					
Training is available to all caregivers on performance improvement strategies and tools. Notes:					
When conducting performance improvement projects, we make a small change and measure the effect of that change before implementing more broadly. An example of a small change is pilot testing and measuring with one nurse, one resident, on one day, or one unit, and then expanding the testing based on the results. Notes:					
When addressing performance improvement opportunities, our organization focuses on making changes to systems and processes rather than focusing on addressing individual behaviors. For example, we avoid assuming that education or training of an individual is the problem, instead, we focus on what was going on at the time that allowed a problem to occur and look for opportunities to change the process in order to minimize the chance of the problem recurring. Notes:					
Our organization has established a culture in which caregivers are held accountable for their performance, but not punished for errors and do not fear retaliation for reporting quality concerns. For example, we have a process in place to distinguish between unintentional errors and intentional reckless behavior and only the latter is addressed through disciplinary actions. Notes:					

Rate how closely each statement fits your organization	Not started	Just starting	On our way	Almost there	Doing great
<p>Leadership can clearly describe, to someone unfamiliar with the organization, our approach to QAPI and give accurate and up-to-date examples of how the facility is using QAPI to improve quality and safety of resident care. For example, the administrator can clearly describe the current performance improvement initiatives, or projects, and how the work is guided by caregivers involved in the topic as well as input from residents and families.</p> <p>Notes:</p>					
<p>Our organization has identified all of our sources of data and information relevant to our organization to use for QAPI. This includes data that reflects measures of clinical care; input from caregivers, residents, families, and stakeholders, and other data that reflects the services provided by our organization. For example, we have listed all available measures, indicators or sources of data and carefully selected those that are relevant to our organization that we will use for decision making. Likewise, we have excluded measures that are not currently relevant and that we are not actively using in our decision making process.</p> <p>Notes:</p>					
<p>For the relevant sources of data we identify, our organization sets targets or goals for desired performance, as well as thresholds for minimum performance. For example, our goal for resident ratings for recommending our facility to family and friends is 100% and our threshold is 85% (meaning we will revise the strategy we are using to reach our goal if we fall below this level).</p> <p>Notes:</p>					
<p>We have a system to effectively collect, analyze, and display our data to identify opportunities for our organization to make improvements. This includes comparing the results of the data to benchmarks or to our internal performance targets or goals. For example, performance improvement projects or initiatives are selected based on facility performance as compared to national benchmarks, identified best practice, or applicable clinical guidelines.</p> <p>Notes:</p>					
<p>Our organization has, or supports the development of, employees who have skill in analyzing and interpreting data to assess our performance and support our improvement initiatives. For example, our organization provides opportunities for training and education on data collection and measurement methodology to caregivers involved in QAPI.</p> <p>Notes:</p>					

Rate how closely each statement fits your organization	Not started	Just starting	On our way	Almost there	Doing great
<p>From our identified opportunities for improvement, we have a systematic and objective way to prioritize the opportunities in order to determine what we will work on. This process takes into consideration input from multiple disciplines, residents and families. This process identifies problems that pose a high risk to residents or caregivers, is frequent in nature, or otherwise impact the safety and quality of life of the residents.</p> <p>Notes:</p>					
<p>When a performance improvement opportunity is identified as a priority, we have a process in place to charter a project. This charter describes the scope and objectives of the project so the team working on it has a clear understanding of what they are being asked to accomplish.</p> <p>Notes:</p>					
<p>For our Performance Improvement Projects, we have a process in place for documenting what we have done, including highlights, progress, and lessons learned. For example, we have project documentation templates that are consistently used and filed electronically in a standardized fashion for future reference.</p> <p>Notes:</p>					
<p>For every Performance Improvement Project, we use measurement to determine if changes to systems and process have been effective. We utilize both process measures and outcome measures to assess impact on resident care and quality of life. For example, if making a change, we measure whether the change has actually occurred and also whether it has had the desired impact on the residents.</p> <p>Notes:</p>					
<p>Our organization uses a structured process for identifying underlying causes of problems, such as Root Cause Analysis.</p> <p>Notes:</p>					

Rate how closely each statement fits your organization	Not started	Just starting	On our way	Almost there	Doing great
<p>When using Root Cause Analysis to investigate an event or problem, our organization identifies system and process breakdowns and avoids focus on individual performance. For example, if an error occurs, we focus on the process and look for what allowed the error to occur in order to prevent the same situation from happening with another caregiver and another resident.</p> <p>Notes:</p>					
<p>When systems and process breakdowns have been identified, we consistently link corrective actions with the system and process breakdown, rather than having our default action focus on training education, or asking caregivers to be more careful, or remember a step. We look for ways to assure that change can be sustained. For example, if a policy or procedure was not followed due to distraction or lack of caregivers, the corrective action focuses on eliminating distraction or making changes to staffing levels.</p> <p>Notes:</p>					
<p>When corrective actions have been identified, our organization puts both process and outcome measures in place in order to determine if the change is happening as expected and that the change has resulted in the desired impact to resident care. For example, when making a change to care practices around fall prevention there is a measure looking at whether the change is being carried out and a measure looking at the impact on fall rate.</p> <p>Notes:</p>					
<p>When an intervention has been put in place and determined to be successful, our organization measures whether the change has been sustained. For example, if a change is made to the process of medication administration, there is a plan to measure both whether the change is in place, and having the desired impact (this is commonly done at 6 or 12 months).</p> <p>Notes:</p>					



Guide for Developing Purpose, Guiding Principles, and Scope for QAPI

Directions: Use this tool to establish the purpose, guiding principles and scope for QAPI in your organization. The team completing this worksheet should include senior leadership. Taking time to articulate the purpose, develop guiding principles, and define the scope will help you to understand how QAPI will be used and integrated into your organization. This information will also help your organization to develop a written QAPI plan. Use these step-by-step instructions to create a separate document that may be used as a preamble to your QAPI plan.

STEP 1. LOCATE OR DEVELOP YOUR ORGANIZATION'S VISION STATEMENT

A **vision statement** is sometimes called a picture of your organization in the future; it is your inspiration and the framework for your strategic planning. Consider involving staff in the development of your vision statement. Post it for everyone to view.

For example, the vision of the Good Samaritan Society is to create an environment where people are loved, valued and at peace.

STEP 2. LOCATE OR DEVELOP YOUR ORGANIZATION'S MISSION STATEMENT

A **mission statement** describes the purpose of your organization. The mission statement should guide the actions of the organization, spell out its overall goal, provide a path, and guide decision-making. It provides the framework or context within which the company's strategies are formulated. As above, get caregivers involved in establishing your organizations mission.

For example, Meadowlark Hills is each resident's home. We are committed to enhancing quality of life by nurturing individuality and independence. We are growing a value-driven community while leading the way in honoring inherent senior rights and building strong and meaningful relationships with all whose lives we touch.

STEP 3. DEVELOP A PURPOSE STATEMENT FOR QAPI

A **purpose statement** describes how QAPI will support the overall vision and mission of the organization. If your organization does not have a vision or mission statement, the purpose statement can still be written and would state what your organization intends to accomplish through QAPI.

For example, the purpose of QAPI in our organization is to take a proactive approach to continually improving the way we care for and engage with our residents, caregivers and other partners so that we may realize our vision to [reference aspects of vision statement here]. To do this, all employees will participate in ongoing QAPI efforts which support our mission by [reference aspects of mission statement here].

STEP 4. ESTABLISH GUIDING PRINCIPLES

Guiding Principles describe the organization's beliefs and philosophy pertaining to quality assurance and performance improvement. The principles should guide what the organization does, why it does it and how.

For example:

- Guiding Principle #1: QAPI has a prominent role in our management and Board functions, on par with monitoring reimbursement and maximizing revenue.
- Guiding Principle #2: Our organization uses quality assurance and performance improvement to make decisions and guide our day-to-day operations.
- Guiding Principle #3: The outcome of QAPI in our organization is the quality of care and the quality of life of our residents.
- Guiding Principle #4: In our organization, QAPI includes all employees, all departments and all services provided.
- Guiding Principle #5: QAPI focuses on systems and processes, rather than individuals. The emphasis is on identifying system gaps rather than on blaming individuals.
- Guiding Principle #6: Our organization makes decisions based on data, which includes the input and experience of caregivers, residents, health care practitioners, families, and other stakeholders.
- Guiding Principle #7: Our organization sets goals for performance and measures progress toward those goals.
- Guiding Principle #8: Our organization supports performance improvement by encouraging our employees to support each other as well as be accountable for their own professional performance and practice.
- Guiding Principle #9: Our organization has a culture that encourages, rather than punishes, employees who identify errors or system breakdowns.

Add any additional Guiding Principles that may be important to your nursing home. Review the five QAPI elements to ensure you identify and capture guiding principles for your organization.

STEP 5. DEFINE THE SCOPE OF QAPI IN YOUR ORGANIZATION

The **Scope** outlines what types of care and services are provided by the organization that impact clinical care, quality of life, resident choice, and care transitions. Be sure to incorporate the care and services delivered by all departments.

For example:

Post-acute care
Dementia care and services
Dietary
Dining

Once the list of care and service area has been identified, you can determine how each will use QAPI to assess, monitor and improve performance on an ongoing basis.

STEP 6. ASSEMBLE DOCUMENT

Once you've completed steps 1-5, assemble the vision and mission statements, guiding principles, and scope of QAPI into a separate document that may be used as a preamble to your QAPI plan. This document will help you articulate the goals and objectives of your organization; QAPI will help you get there. Consider posting for all to see.

The next step is to develop a written QAPI plan that will meet your purpose, guiding principles and comprehensive scope described above. See *"Guide for Developing a QAPI Plan."*



Guide for Developing a QAPI Plan

DIRECTIONS

The QAPI plan will guide your organization's performance improvement efforts. Prior to developing your plan, complete the *Guide to Develop Purpose, Guiding Principles, and Scope for QAPI*. Your QAPI plan is intended to assist you in achieving what you have identified as the purpose, guiding principles and scope for QAPI, therefore this information is needed before you begin working on your plan. This is a living document that you will continue to refine and revisit. Use these step-by-step instructions to create your QAPI plan. This plan should reflect input from caregivers representing all roles and disciplines within your organization.

(This document has been revised into a word format with the ability to enter information into it as part of your QAPI. I have provided examples within the document for an INTERACT based QAPI of Re hospitalization.)

D. Afasano, VP of Clinical Services, Avante Group

I. QAPI Goals

Based on the *Guide to Develop Purpose, Guiding Principles, and Scope for QAPI*, indicate the QAPI goals that your plan will strive to meet. Goals should be specific, measurable, actionable, relevant, and have a time line for completion. (See *Goal Setting Worksheet*).

Goals: Reduce unplanned re hospitalizations by 15 % over the next year
Work with collaborative partners on identification of process improvements to influence mutually safe transitions of care and safe handoff of information with transfers
Work with community partners to enhance the application of advanced care planning and the development of a Palliative model to meet the needs of those we serve when comfort takes precedence over cure.

Opportunity Statement: We have an opportunity to reduce unplanned hospitalizations beginning with knowing our baseline and analyzing retrospective data related the root causes behind discharges, and ending with defined criteria on tour scope of care and our current capabilities. (INTERACT FACILITY CAPABILITIES) and PIP's based on analysis of re hospitalization data. This is important to work on now so that our programs and services, educational programs and competencies, equipment and supply readiness, communication structures, and advance care planning align with the individuals we provide care to, and result in a reduction in unnecessary hospitalizations.

II. Scope

a. Describe how QAPI is integrated into all care and service areas of your organization

How are specific departments assisting with unplanned re hospitalization:

Therapy: Participation in daily clinical review/PPS; Care planning, Standard of Care meetings, and referral oversight through frontline staff (Stop and Watch)

SS: Transitioning of the new admission; discharge planning. Orientation for new resident/family within 72 hours; advance care planning

Admissions: Preadmission evaluation; review with discharge planners the facility Capabilities list

Nursing: Preadmission screen; oversight of hand off information and structures to examine unplanned re hospitalizations

Administration: Support of a facility Re hosp team

Physicians and Extenders: Participation in SBAR and pathway education

Housekeeping and Activities (Example: Using Stop and Watch and reporting)

Others:

b. Describe how the QAPI plan will address:

i. **Clinical care: Examples include use of STOP and WATCH, staff huddles, morning reviews, Point Right Care dashboard management, Safe Transitions Team, QM review, etc.**

ii. **Quality of life: QM review; utilization of Point Right Data; weekly QOL meetings that are interdisciplinary (See attached agenda) Advanced Care Planning first week of admit with ongoing review; highlighted advance directive component on care plan agenda**

iii. **Resident choice (i.e., individualized goals for care) Examples include tracking and trending of resident and family feedback from QIS interviews and Observations (See attached documents), person centered care plans, consistent staff, formal and informal satisfaction reviews...**

c. Describe how QAPI will aim for safety and high quality with all clinical interventions while emphasizing autonomy and choice in daily life for residents (or resident's agents). **Example: We will promote person centered care and advance care planning from the point of admission, with ongoing oversight as a part of daily reviews, weekly QOL and discharge planning as pertinent to the goals of care**

d. Describe how QAPI will utilize the best available evidence (e.g., data, national benchmarks, published best practices, clinical guidelines) to define and measure goals.

Unplanned Re hospitalization data will be tracked and trended and compared to peer groups and national data through data sources such as INTERACT, Advancing Excellence, CMS, Point Right, AHCA and FHCA, and FMDA resources

III. Guidelines for Governance and Leadership

- a. Describe how QAPI is integrated into the responsibilities and accountabilities of top-level management and the Board of Directors (if applicable).

Examples: Designated Safe Transition Team, Regional and Corporate wide Quality Calls, 5 Star analysis and reviews, benchmarking of data...

- b. Describe how QAPI will be adequately resourced.

- i. Designate one or more persons to be accountable for QAPI leadership and for coordination.

Designated champion/co-champion:

Team members to include external community partners: Hospice, hospitals

- ii. Indicate the plan for developing leadership and facility-wide training on QAPI: **(Attach meeting meetings as applicable). Examples: Participation in the National Partnership to Improve Dementia Care, Facility wide INTERACT training with on demand education and resources...**

- iii. Describe the plan to provide caregivers time, equipment, and technical training as needed for QAPI. **Example: Establish monthly staff meetings at set times for all shifts. Include QAPI time on each meeting agenda, build discussion on QAPI initiatives into daily shift report and observe that shift huddles occur, periodic Stop and Watch Skills Fair based on QM review and rehospitalization data analysis...)**

- iv. Indicate how you will determine if resources are adequate for QAPI.

Example: Determine with the team and as part of staff meetings what resources might be needed:

Supplies and equipment: Inventory of vital sign equipment and equipment checks

Education and training materials: Review resources as noted through Advancing Excellence, Interact, State Association

Budget for training: Work into Strategic Plan

External resources: Request assistance from Physicians and extenders on SBAR and communication

Protocols and tools: Interact, AMDA, State Association, Advancing Excellence, Pioneer Network

- v. **Review resource needs as part of budget planning activities**

- vi. Describe how your caregivers will become and remain proficient with process improvement tools and techniques. How will you assess their level of proficiency?

Examples: Establish a timeline for an Educational plan; include integration into orientation with the use of facility on demand INTERACT sessions

Ensures Resources are on each unit: Stop and Watch, Care Pathways, etc.

Integration into monthly meetings:

Reinforcement with shift huddles

Competency observations and audits

Other: Stop and Watch Hands on Skills Fairs that reemphasize the Stop and Watch tool

c. QAPI Leadership

- i. While everyone in the organization is involved in QAPI, you will likely have a small group of individuals who will provide the backbone or structure for QAPI in your organization. Who will be part of this group? Many of these individuals may be on your current QAA committee.

Are there other workgroups involved in key elements within the PIP: **“Admissions Transitions Team”**

Refer to guidelines for governance section b

- ii. Describe how this group of people will work together, communicate, and coordinate QAPI activities. **This could include but is not limited to:**

- **Establishing a format and frequency for meetings**

Designated time and place:

Develop a team agenda (See example)

- **Establishing a method for communication between meetings**

Who will oversee minutes?

How will staff be informed? (Staff meetings, shift updates, Storyboard of the PIP, etc.)

- **Establishing a designated way to document and track plans and discussions addressing QAPI.**

Example: run charts from the INTERACT Transfer log data that is uploaded into the excel file

- iii. Describe how the QAPI activities will be reported to the governing body; i.e., Board of Directors, owner. Best Practice sharing, newsletters, training

IV. Feedback, Data Systems, and Monitoring

- a. Describe the overall system that will be put in place to monitor care and services, drawing data from multiple sources.

- b. **Example: Weekly QOL reviews with integration into facility IDT “Safe Transitions Team...”**

- c. Identify the sources of data that you will monitor through QAPI

- i. Input from caregivers, residents, families, and others

Examples: This will be integrated into care planning, QIS interviews, physicians, members of the team, staff, stakeholders to include community partners:

- ii. Adverse events:

- iii. Performance indicators: **30 day rates, QM data, etc.**

- iv. Survey findings: **Examples: We will track Casper data; evaluate QM, Manage 5 Star outcomes...**

- v. Complaints: **Examples: Grievance oversight, proactive use of QIS interview data...**

- d. **Describe the process for collecting the above information. Daily, weekly, QAA meetings**

e. Describe the process for analyzing the above information, including how findings will be reviewed against benchmarks and/or targets established by the facility. Use of Casper reports, Point Right, Interact data, customer feedback, QIS data
f. Describe the process to communicate the above information. What types of reports will be used? Examples: INTERACT Quality Summary, QM outcome data, INTERACT data from trending, root cause analysis of individual transfers, Medical Director and physician feedback, other: One way to accomplish this is to use a dashboard or dashboards for individual performance improvement projects.
g. Identify who will receive this information (i.e., executive leadership, QAPI leadership, resident/ family council, and a center's caregivers), in what format, and how frequently information will be disseminated.

V. Guidelines for Performance Improvement Projects (PIPs)

a. Describe the overall plan for conducting PIPs to improve care or services <ul style="list-style-type: none"> i. <u>Indicate how potential topics for PIPs will be identified.</u> Examples: Through data reviews by the designated Safe Transitions Team, through the facility QAA and QM evaluations, Point Right data, Casper data, Focus groups, QIS interviews and observations, customer feedback
ii. Describe criteria for prioritizing and selecting PIPs: areas important and meaningful for the specific type and scope of services unique to the facility, requires a concentrated effort on a particular problem in one area of the facility or facility wide. Examples: What are the most high risk and problem prone areas: This may be retrieved via INTERACT data, re hospitalization reviews, customer and stakeholder feedback, outcome analysis, OTHER:
iii. Indicate how and when PIP charters will be developed: They will be discussed as part of the formalized weekly QOL meetings and channeled to the QAPI Steering group as part of the facility QAA
iv. Describe the process for reporting the results of PIPs. Identify who will receive this information (i.e., quality committee, resident/family council, and a center's caregivers), in what format, and how frequently information will be disseminated. v. Monthly meetings, story boards, educational events, newsletters
b. Describe how to designate PIP teams and establish and describe a process for assembling teams to work on specific PIPs. Discussion through weekly quality of life, QAA. Team discussion of who would be good team members and offer diversity and perspective

- c. Define the required characteristics for any PIP team. This may include that the team be interdisciplinary (i.e., representing each of the job roles affected by the project), that it include resident representation (as appropriate), and that a qualified team leader is selected (i.e., ability to coordinate, organize and direct all activities of the project team). Describe how PIP teams should document and report their work.

- d. Describe your process for documenting PIPs, including highlights, progress, and lessons learned. For example, what project documentation templates will you use consistently and file electronically in a standardized fashion for future reference.

Examples: Use of this report over time, storyboards, INTERACT data and graphs, QM measures,

VI. Systematic Analysis and Systemic Action

- a. Any change that is made has the potential to have broader impact than intended. If you are trying to make a change to a specific system or process, it is important to recognize any “unintended” consequences of your actions.

Describe how your organization will identify these consequences which may be either positive or negative.

Data must be used to analyze expected and unexpected consequences. For example, it is important that staff use critical thinking and hospitalize in a timely manner if it is indicated. A review of hospitalizations as a whole will be done and reviewed to ensure the quality outcomes are positive

- b. Describe the process you will use to ensure you are getting at the underlying causes of issues, rather than applying quick fixes that address symptoms only.

Examples: Root case analysis with the fish bone and related tools; use of brainstorming techniques and coordination of a diverse representation of people to offer varying perspectives; analysis of the data with feedback to community partners and related stakeholders (Example: how effective if the handoff of information between hospitals and SNF's? Are the communication tools used consistently and effectively?)”

- c. Describe how you will monitor to ensure that interventions or actions are implemented and effective in making and sustaining improvements

Examples: Ongoing structure for review of data, Inspect what you expect, ensuring the culture supports this as a key goal; Use of QIS Observation tools, IDT rounds, post admission reviews, discharge planning oversight...”

VII. Communications

Outline the audiences for QAPI communications and the frequency and format of these communications.

Examples of Stakeholders include:

Hospitals

Home Health Hospice

Physicians

Family, FHCA

Residents

Staff

Community:

Ancillary providers

VII. Communications, cont.

QIO, FHCA, Health Care Associations

Quality and Collaborative workgroups

Surveyors/Regulators

Consumers

Others;

VII. Evaluation

- a. Describe the process for assessing QAPI in your organization on an ongoing basis. (See *QAPI Self-Assessment Tool*.)

VIII. Establishment of Plan

- a. Date your plan.

- b. Determine when you will revisit the plan (i.e., at least annually

- c. Determine how you will track revisions or updates to the plan.

Summary:

Submitted to QAA as part of QAPI by:

Date:

Process Guidance Considerations for Unplanned Hospitalizations: Applying the concepts of QAPI

D. Afasano

Five Elements of an acceptable QAPI plan

Element 1: Design and Scope

- A QAPI program must be ongoing and comprehensive: **Reducing Unnecessary Rehospitalization**
- Deal with full range of services offered by the facility, including the full range of departments. (What is the Scope of Care, what are the Programs and Services? What are departmental roles?)
- Address clinical care, quality of life, resident choice, and care transitions
- Aims for safety and high quality

Element 2: Governance and Leadership

- Leads a QAPI program that involves leadership working with input from facility staff, as well as from residents /families and/or representatives.
- The governing body assures the QAPI program is adequately resourced to conduct its work. (Appoint a champion)
- Develop leadership and facility-wide training on QAPI; and ensuring staff time, equipment, and technical training as needed for QAPI.
- Establishing policies/protocols to sustain the QAPI program despite changes in personnel and turnover.
- Setting priorities for the QAPI program and building on the principles identified in the design and scope
- Setting expectations around safety, quality, rights, choice, and respect by balancing both a culture of safety and a culture of resident-centered rights and choice.
- Ensures that while staff are held accountable, there exists an atmosphere in which staff are not punished for errors and do not fear retaliation for reporting quality concerns.

Element 3: Feedback, Data Systems and Monitoring : The facility puts in place systems to monitor care and services, drawing data from multiple sources

- Feedback systems actively incorporate input from staff, residents, families, and others as appropriate.
- Performance Indicators to monitor a wide range of care processes and outcomes, and reviewing findings against benchmarks and/or targets the facility has established for performance.
- Tracking, investigating, and monitoring Adverse Events that must be investigated every time they occur, and action plans implemented to prevent recurrences.

Element 4: Performance Improvement Projects (PIPs)

- The facility conducts Performance Improvement Projects (PIPs) to examine and improve care or services in areas that are identified as needing attention.
- A PIP project typically is a concentrated effort on a particular problem in one area of the facility or facility wide; it involves gathering information systematically to clarify issues or problems, and intervening for improvements.

Element 5: Systematic Analysis and Systemic Action

- The facility uses a systematic approach to determine when in-depth analysis is needed to fully understand the problem, its causes, and implications of a change.
- The facility uses a thorough and highly organized/ structured approach to determine whether and how identified problems may be caused or exacerbated by the way care and services are organized or delivered.
- Facilities will be expected to develop policies and procedures and demonstrate proficiency in the use of Root Cause Analysis.
- Systemic Actions look comprehensively across all involved systems to prevent future events and promote sustained improvement. This element includes a focus on continual learning and continuous improvement.

Applying the Concepts

Scope and Design: Performance Improvement is Leadership Driven. Performance Improvement MUST be driven by the leadership of the facility and must be clearly identified as a priority.

- It must reflect a wide range of facility services. The INTERACT tool for determining facility capabilities is an example of a resource that can be integrated into this QAPI.

Governance and Leadership: Promotes clinical care, quality of life, resident choice, and care transitions and aims for safety and high quality of care. The facility may do this by establishing a team. The appointed “**Unplanned Hospitalization Team**”, or “**Safe Transitions Team**”, should be multidimensional and may include residents, families, and community representatives.

- The team MUST be committed to wanting to understand “why” and commit to the process of “root cause analysis”, and not fixing the same issues again and again.
- The team should meet on a regular basis, and be supported by the Administration.

Element Three: Thorough Feedback, Data Systems and Monitoring, the facility has systems to monitor care and services. Through Interact, that could include the use of tools such as the:

- Acute care Transfer Log Worksheet: Enter transfers onto sheet as part of the am meeting and then transfer to the spreadsheet that can be uploaded off the Interact site at <http://www.interact2.net>; Calculating rates info sheet
- Interact QI tool for review: Do this as close to when the transfer occurred as possible

QI Summary: Aggregate the 30 day data and summarize the findings of the individual reviews; calculate the return rate, and submit to monthly QAA as part of your Re hospitalization QAPI. The facility puts in place systems to monitor care and services, drawing data from multiple sources, and establishes performance indicators. This can include QM data, re hospitalization data, customer satisfaction data and survey outcome data. Probes as part of Root Cause Analysis could include things such as:

Why do we have an increase in unplanned hospitalizations on weekends on 3-11?

Why are we seeing a high number of CHF/Heart Failure readmissions within the first 72 hours?

Why do we not have the right information on admission?

Why do we not share the right information between shifts?

Why do we not provide physicians with the right clinical information to make the right treatment decisions?

Communication is a key factor: Problems arise when tasks are handed off between people and departments. Poor handoff can occur internally and externally (Hospital to LTC and vice versa, Nurse to physician, shift to shift, department to department, facility to resident/family, etc.)

- Creating a culture of safety reinforces the idea that people do not fail but systems often do.
- Use data to develop **Performance Improvement Plans**. Drive change e.g. Education, Advance Directives oversight and implementation, Clinical competencies, etc. Performance Improvement is Process Oriented and a **process** is a series of steps that that when put all together leads to an end product.

Example: The process for accepting new admissions and channeling necessary information from intake> to the team >to the unit and >to the people that will manage the admission.

Safe Transitions are rooted in the handoff process. The INTERACT QAPI provides excellent tools for communication of information across the continuum.

Element Four: Performance Improvement

PI is Customer Driven and Data driven. The team must have a clear understanding of who the customers are. Internal customers are those in the work setting: Resident, all staff and departments. External customers include Families, Hospitals, Physicians, Home Health, Lab, X ray, etc.

Key Points to QAPI Success include knowing that data by itself is data and numbers. Data applied is valuable information. Trending data and summarizing the results is the foundation for process improvements.

- **What are the key data and indicators? Return to hospital rates, admission rates, staffing rates, etc.** Utilize data to understand the beginning and end outcomes of systems being monitored. Know where you are in the beginning of problem solving to have goals set for end. As a starting point it would be beneficial to have a baseline for the prior 6 months of unplanned Re hospitalizations.
- **Performance Improvement needs a systematic method to guide stages of improvement:** Each meeting should have a standing agenda that is managed. There should be a report, and minutes must be kept for all meetings. Meeting examples include: Formal Morning meetings for clinical and operational review, Weekly SOC/AT Risk, Unplanned Hospitalizations Team

Element Five: Systematic Oversight; sustain the gain; ensure it is working. This should be a function of the QAPUI Steering Committee as part of the facility QAA

FOCUS on the Problem: Part of PI and Systematic Oversight

FIND AND PROCESS TO REVIEW (F)

- i. Brainstorm (rapid succession of thoughts going around the room)
- ii. Look at cause and effect categories: Preadmission, Admission, People, Equipment and Supplies, Operations, Advance Directives, etc.

PIP should meet the following criteria:

- High Risk: New admission clinical assessments are not comprehensive and accurate or Hospital transfer information is missing medication history, H&P, etc.
 - High Volume: Occurs frequently (assessments not completed, or hand off information is not complete)
 - Problem Prone creates inconsistency and disruption (Risk identification is inconsistent; Assessments and interim care plans are incomplete; High number of Re hospitalization within first 72 hours)
- iii. Sources of data
 - Hospital records
 - Medication records
 - Unplanned hospitalization data
 - Chart reviews, (Focus on high risk Ds)
 - Internal Audit Tools
 - Physician feedback
 - Quality Measures/MDS
 - QIS data
 - Adverse reports
 - Survey History
 - Score Card Results
 - Customer Satisfaction surveys (Internal and external)
 - Grievance and facility reported events analysis
 - Facility Infection Control Surveillance Reports

ORGANIZE A TEAM THAT KNOWS THE PROCESS (O)

- The team should have a goal statement or opportunity /Mission statement that describe a problem to be studied, or an improvement opportunity.
Yes? ____ No? ____
 - Keep the team manageable; Recommendations are 4 to 6 members to the team; Select people that can be champions and buy in to the concept of improving the admission process and care management of the new admissions.
 - Consider times when decisions have been made that directly affected you. Think of a prior time you were not involved but had great ideas? How did you feel?
- iv. Create a mission or opportunity statement for the team, what you wish them to look at (system) and reason (process failure).
Improve (what outcome?)... Through (what process change?)

Opportunity Statement: We have an opportunity to reduce unplanned hospitalizations beginning with knowing our baseline and analyzing retrospective data related the root causes behind discharges, and ending with defined criteria on our scope of care and our current capabilities. (INTERACT FACILITY CAPABILITIES) and PIP's based on analysis of rehospitalization data. This is important to work on now so that our programs and services, educational programs and competencies, equipment and supply readiness, communication structures, and advance care planning align with the individuals we provide care to, and result in a reduction in unnecessary hospitalizations.

- v. Identify the champion, co-champion.
- vi. Set an agenda and rules for the team
 - Assign someone to record minutes and report to the QA&A Committee
- vii. Assign a facilitator, time keeper, timekeeper

CLARIFY YOUR CURRENT KNOWLEDGE (C)

- viii. Brainstorm why this process is a new project priority

Examples:

- It is a CMS and hospital target area and impacts on quality of life and care
- Physicians are complaining about nurse communication methods and bounce backs
- Census is suffering related to clinical management and hospital reluctance to use the facility as a provider of choice, etc.

- ix. Determine what is the current process

- x. How do we coordinate care pre, post admission, and throughout the stay?

- Do not jump to a solution or conclusion
- Determine the flawed steps or opportunity for improvement or the process will continue to be “broken”

How does the team currently manage Changes in condition? How are they identified, reported, triaged? Is Stop and Watch used?

- xi. What can be measured? When should it be measured?

- (Unplanned hospitalization data? Vs. Planned Discharges) Patient LOS, Post discharge to home outcomes, etc.)

- xii. Tools to help refine the process: e.g. flow hart of how it should work

- xiii. Goals should be set for the completion of the process. Set goals or thresholds for indicators chosen for measurement of improvement carefully as most people will rise to the expectations set of them.

UNDERSTANDING THE ROOT CAUSES OF PERFORMANCE (U)

- xiv. Where is the variation in how we manage new admissions? And what is causing it?

S: Select the Improvement and Establishment the Goal: If we do... (XYZ... identify the change) we expect... (This- what outcome?).

Element Five: Systemic Action: Oversee the change

1. STEPS IN PDCA: PLAN, DO, CHECK, ACT

Step 1: Plan the ACTION, test or observation, including a plan for collecting data.

- a. State the objective of the test. What are you trying to accomplish?
- b. Make predictions about what will happen and why.
- c. Develop a plan to test the change. (Who? What? When? Where? What data need to be collected?)
 - a. **Select an important problem to attack (bounce backs in first 72 hours, how admissions are selected and managed)**
 - b. Select an improvement team, and agree on working ground rules
 - c. Gather improvement ideas from the team
 - d. Pick an idea to test and clearly define that idea
 - e. Identify a good test of the change you want to make from the idea.

Step 2: Do

- a. Try it out the test on a small scale. Maybe one unit. (**Schedule a Transitional Nurse to oversee admissions on busy days and reevaluate nursing model**)
- b. Carry out the test
- c. Document problems and unexpected observations.

Step 3: Check

- a. Set aside time to analyze the data and study the results.
- b. Complete the analysis of the data.
- c. Compare the data to your predictions.
- d. Summarize and reflect on what was learned.

Step 4: Act

- a. Refine the change, based on what was learned from the test.
- b. Determine what modifications should be made.
- c. Prepare a plan for the next test.
- d. If successful, spread the change and begin planning to test another change
- e. Or modify the change and retest, or if the test was not successful, move to test another idea

Safe Transitions Quality Team Meeting

Part of the Facility QAPI

Date _____

Time: _____

Place _____

Content

Objective: Understand our current baseline for unplanned hospitalizations, Provide root cause analysis of those transferred, and identify action steps to positively influence the future

1. Review Roles and Assign Responsibilities:

Champion or Co-Champion/Leader _____

Recorder _____

Timekeeper _____

(Have interdisciplinary representation)

2. The designated Leader reviews the Agenda

3. Work through the Agenda:

A. Welcome and Introductions

B. Review the goals of the team/QAPI initiatives or PIP's

: Reduce unplanned re hospitalizations by 15 % over the next year

- o Work with collaborative partners on identification of process improvements to influence mutually safe transitions of care and safe handoff of information with transfers

- o Work with community partners to enhance the application of advanced care planning and the development of a Palliative model to meet the needs of those we serve when comfort takes precedence over cure.

4. Provide the results of last 30 days of transfer data

i. Discuss identified trends/root cause findings from the retrospective review and INTERACT Summary

Clinical

Family/Advance Directives

Physician or nurse driven

Acuity

Equipment

Other:

ii. Identify any shared opportunities between collaborative partners (Integrity of information sent or received, advance care planning/directives, medication reconciliation, patient concerns on admission to or from, other

iii. Action steps/needs and person responsible:

5. Acute change in condition review/ selected QM review/results of Point Right Radar report

A. Review INTERACT 111 Log and QA tools that will be used; set up INTERACT Training calendar

6. Review the meeting record

7. Evaluate the Meeting

Daily Morning Meeting Detail Agenda

Confidential and Privileged, Not to be distributed or Divulged to anyone except the Intended Recipient(s) without Legal Counsel's Approval (QA Use Only) *** 30 Minutes MAX, then PPS to follow *******
Operational Discussions

Admissions:

Dashboard: ADT and discussion of appropriateness of admission during clinical review

Date: _____ **Q Mix** _____ / _____

- | | |
|--|-------------------------------|
| - Current Census as of midnight _____ | Residents LOA/bed holds _____ |
| - Budgeted Census _____ | # of Discharges _____ |
| - # of Private/Respite _____ | UPHD _____ |
| - # of Medicare VS Budgeted _____ / _____ | # of Medicaid _____ |
| - # of Insurance VS Budgeted _____ / _____ | # of Managed Care _____ |
| - # of Hospice _____ | # of Conversions: _____ |
| - # of Referrals _____ | # Medicaid Pending _____ |
| - Anticipated Admissions _____ | |
| - Anticipated Discharges _____ | |

Administrator: General comments/updates

QAPI Updates

Rounds- results and resolutions/audits or QIS audits pending, (Guardian Angel)

- **QIS- interviews completed:**
 - o Review results and interventions; Document positive interventions in the record
 - o Schedule as part of forthcoming MDS/Care Plan as possible
- **Reportable Incidents/ERMA updates and trends**
- Customer Service Survey Results/Resolutions
- Central Supply Management:
- Equipment Needs/Rental equipment
- **Any ADR requests/needs and status of completion**

Business Office: Updates

Human resources: **Department PPDs**

- Kronos Scheduler Report updates
- Open Positions (F/T, P/T, PRN and department)
- Resignations/Terminations
- Light Duty
- Education Compliance/Orientation or Competency reviews
- New Hires (pre-employment requirements completed)

Medical Records:

Dashboard: Physician Visits, visit schedule, anticipated visit schedule

- Records compliance
- Record request
- Cert/Recert: Have notebook available for periodic am meeting confirmation of compliance

Maintenance/House keeping: TELS task for the day:

- Report on prior days TELS task
- Projects/ jobs pending completion (brief)
- Rooms/Offices scheduled for deep cleaning
- Discharged rooms ready
- **Infection Control Concerns**

Dietary:

- Meal for the day and alternates
- Dining Experience Issues/Concerns
- QIS Observation Review (Dining)
- Kitchen Observations (weekly)
- Food First Initiatives
- **Weight Reviews (New admissions, weights pending, reweights, areas for follow up)**

DSM is to provide the following Reports at Facility Morning Meeting

- ❖ Resident Listing Report
- ❖ Resident Care Level Report....Nectar Thick Liquids
- ❖ Resident Care Level Report....Honey Thick Liquids
- ❖ Resident Care Level Report....Pudding Thick Liquids
- ❖ 3 copies of each Report are required: DON>2 copies, Activities >1 copy

Activities: Activities for the day; special events or outings

Social Service:

- Grievances and status of resolution (logs, resolution within 5 days)
- Upcoming discharges; Status of Equipment, Home health, Resident/Family teaching, etc. (discharge plan)
- Resident Status (**New Admissions, behaviors, etc.**)
- Room Changes/notifications (pending/requested)
- **Confirm status of new admission advance directives; DNR, surrogate**
- **Advance Directives/ADVANCE Care Planning Needs**

MDS: (computer required for updates)

Dashboard: Care plan review (overdue or due in the next seven days, incomplete care plans, review in progress list)

- Outstanding MDS completions and/or signatures needed
- **Care Plan meeting schedule or updates or special reviews**
- ADL/Kardex Review (Check new admissions)

Clinical:

- **Staffing/PPD/Special Needs**

Dashboard: Medication Report- (orders on hold, orders review/clarification, med pass 24 hours for red areas, (exclude current shift) orders pending confirmation, missing meds, errors, review all new orders)

Dashboard: Immunization Issues: pneumonia, influenza, Hep C, two step

- **Vent or Dialysis Needs/Weaning Schedules, change in status, other**

Changes in condition: Per “24 hr report” or Stop and Watch/other: include: new/change pressure ulcers, wt + or-, acute medical changes, Pain, new abnormal or critical labs, PT/INR: Coumadin checks, Stat Labs or tests, etc.

Falls/Interventions or Incident/Accidents (Check for alerts on dashboard)

- New Admission Chart Review (Admission Checklist completion): Check the MDS is opened for new admit
- Restorative Nursing Update (case load, referrals)
- Appointments

Therapy:

- Equipment Needs
- Home visits
- Schedule Issues
- Staffing
- Part B Referrals (based on declining ADLs, falls, pain, swallow , other) **Screens**
- SEE ART/Question of the Day

Stop and Watch

Early Warning Tool

If you have identified a change while caring for or observing a resident, please **circle** the change and notify a nurse. Either give the nurse a copy of this tool or review it with her/him as soon as you can.

S
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W
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H

Seems different than usual

Talks or communicates less

Overall needs more help

Pain – new or worsening; Participated less in activities

Ate less

No bowel movement in 3 days; or diarrhea

Drank less

Weight change

Agitated or nervous more than usual

Tired, weak, confused, or drowsy

Change in skin color or condition

Help with walking, transferring, toileting more than usual

Name of Resident

Your Name

Reported to

Date and Time (am/pm)

Nurse Response

Date and Time (am/pm)

Nurse's Name



Incubator Phase of the National Learning Collaborative on Using the MDS 3.0 as the Engine for High Quality Individualized Care

Shift Huddles Tip Sheet

What It Is:

A **Huddle** is a quick meeting to share and discuss important information. **Start of Shift and End of Shift Huddles** provide a way to share information about each resident as everyone starts work and to recap any information at the end of the shift that needs to be shared with the next shift. They can be done in a stand-up meeting or as room to room walking rounds with the charge nurse and CNAs together checking on each resident. It helps to have other disciplines join in to share their information and to hear information that can help them contribute to the team caring for residents.

Why Do It:

A shift huddle reinforces teamwork and allows everyone to hear about every resident so staff can provide help to residents not on their assignment. Communication of essential information cannot be left to chance. When it is shared in a group, everyone hears **EXACTLY** the same information and can share what they know. The group can problem-solve any issues on the spot.

Who Participates:

Shift Huddle is a gathering of the nurses and CNAs working together by unit and shift. It is good to include housekeeping, social work, activities, and therapy or to huddle again quickly later in the shift when these others can participate.

When To Do It:

Shift huddle should occur at the beginning and at the end of the shift. If there is a paid shift overlap, it can be done with staff from both shifts. Huddles can also occur at other times as needed, such as before staff go on break, when a new resident arrives, when an issue arises that needs the team to come together, or when other departments can participate in a short discussion.

How Long:

Start and end of shift huddles should take no more than 15 minutes. In-the-moment huddles can often complete business in less than 5 minutes but may take longer.

How To Do It:

This needs to be a positive mutual exchange of information needed to care for each resident on the hall. Standing Agenda Items may include:

- **Resident by resident report by exception**, focused on *risks and opportunities, including quality of life and quality of care*, using MDS areas of functional status, mood, and customary routines as a guide. INTERACT^{II} *Stop and Watch* is an excellent tool to focus the end of shift exchange.
- Anyone due for their **MDS** (in their **Assessment Reference Date - ARD**)
- **Changes in Census – people coming in or leaving**



Incubator Phase of the National Learning Collaborative on Using the MDS 3.0 as the Engine for High Quality Individualized Care

- **Information about new residents**, including social history, family information, medical needs, customary routines and special needs
- **Reportable Events, Incidents, Accidents** for any resident
- **Complaints and Compliments** for any resident
- **Follow-up on any issues** raised for which the loop needs to be closed
- Any **clinical area** that is being worked on (e.g., pressure ulcers)
- **News from any department** requiring staff knowledge or coordination
- Introduction of and check-in with **new employees**

Keys to Success:

Be on time, this is a short meeting. It needs to start and end on time. **Everyone** needs to be there on time and be prepared to share.

Process:

This is an exchange among CNAs and with the charge nurse and other staff. At the end of the shift, **CNAs share information** for each resident on their assignment. At the start of shift, nurses give information provided by CNAs and nursing from the previous shift's end of shift report. Other staff may add relevant information about that resident.

Report is **by exception**, focused on risks and opportunities in **quality of care and quality of life**. For example if someone is at risk for pressure ulcers, discussion will include how well they ate and drank, and any positioning issues. If someone has been depressed, the discussion will include their interactions and participation in activities. If a resident does not seem to be oneself that day, this is noted and discussed. See **INTERACT^{II} Stop and Watch** for good examples of issues to note.

Critical Thinking:

To be successful shift huddles have to be valuable to the participants. These are not rote reports. They are opportunities for critical thinking and problem-solving together to ensure the best care for each resident.

Provide Support:

It is optimal to have the support of nursing management answering lights and meeting residents' needs while CNAs and the charge nurse are rounding or having stand-up so that they can have uninterrupted time.

Huddles should be supportive, not negative. Provide mentoring to those nurses who need help on how to facilitate positive team building huddles.

For a short video How-to on Shift Huddles go to
www.BandFConsultingInc.com/WhatYouDoMatters

Weekly Quality of Life/At Risk Meeting

Confidential and Privileged, Not to be distributed or divulged to anyone except the Intended Recipient(s) without Legal Counsel's Approval (QA Use Only)

Part of the Facility QA&A

Detail for IDT members in preparation/participation for/in QOL meeting

Members: Director of Nursing (Nursing), Program Manager, MDS Coordinators, CDM, Director of Social Services, Activities Director, Administrator and other nursing personnel (as appropriate)

Weekly Meeting: The QOL meeting (see Weekly Quality of Life/At Risk Meeting guidelines) is regularly scheduled (weekly) to discuss change in condition, individuals at risk, and referrals through internal communication systems, QIS audits, Interact, and facility QM/QI to influence positive outcomes for residents. To this effect, it is imperative that members of the IDT prepare appropriately in order to facilitate a productive meeting. This guideline is an overview of the IDT's as well as each member's preparation accountabilities (not necessarily all inclusive) for the QOL. Use of these guidelines in conjunction with the Weekly Quality of Life/Risk Meeting guidelines will assist your IDT in achieving the desired outcome.

Please keep in mind the rules of effective and efficient meetings:

Start on time...Come prepared...Participate...Stay on Topic...End on Time

Member Responsibilities: Each member of the IDT:

- Review the resident's EHR (as it relates to their discipline) to insure that all components are current and complete: i.e., assessments, notes, care plans (focus, goals & interventions), Kardex, weight entry, behaviors, pain, physician orders, labs, etc.
- Review QIS interviews and observations (as it relates to their discipline) for concerns and/or potential issues
- Access Point Right & Review the Radar Report/QM Reports (as it relates to their discipline) to identify residents with clinical and risk concerns. If the resident triggers for clinical and/or risk concerns determine if there can be referrals, interventions, or revisions to the current care plan to try to influence a positive outcome (be prepared to discuss in the QOL meeting).

Below is the thumbnail overview of **RADAR/QM Reports** and the information provided by each:

RADAR is a Web-based, resident-level clinical and predictive risk management tool.

RADAR includes:

Resident Profile Scores

Quality Measures (QM) Alerts

Resident historical data presented from MDS history RADAR Benefits:

Provides a high level overview of all current residents

- Identifies residents with clinical and risk concerns

- Drill down for more details

- Risk management

- Care planning

The QM Report:

Provides resident-specific details for the CMS

Quality Measures (QM)

Displays Short Stay and Long Stay Measures with drill-down capability

- Surveyor Measures are included

Enables a proactive approach to quality improvement incorporating QM data

[Within Point Right there are tutorials available to assist you with utilizing the various reports]

Accountabilities: In addition to the above overall review of the EHR, some specific accountability's by discipline are listed below, again, not necessarily all inclusive...(Each discipline should review the Weekly Quality of Life/At Risk Meeting guidelines regarding additional information they may need to review/provide as it relate to residents to be reviewed in the weekly meeting):

- Nursing (Director of Nursing)
 - Bring & review current 802
 - List of residents with restraints, alarms (as they relate to residents in the weekly review)
 - ERMA falls/incidents (as they relate to residents in the weekly review)
 - Pressure Wound Reports (as they relate to residents in the weekly review)
 - Psychotropic Drug List (as they relate to residents in the weekly review)
 - Hospice List (as they relate to residents in the weekly review)
 - Infection Control (as they relate to residents in the weekly review)
 - Discharge Review (as they relate to residents in the weekly review)
 - INTERACT communication tools (as they relate to residents in the weekly review) for change of condition, change in ADLs/Restorative
- CDM
 - GFS weight reports (reflective of triggers for significant loss/gain)
 - Unavoidable Weight Loss/Gain forms (as they relate to residents in the weekly review)
- MDS
 - Casper Reports (most recent 6 months) with numerator defined resident list: this allows you to see trends before the results are promulgated.
 - Review of Point Right Data: residents triggering in the QM/RADAR (all areas, i.e., weights, psychotropic, ADLs, pressure wounds, etc.), noting their historical coding on the MDS and if there is a possible means to provide a positive outcome via referrals, interventions, or revisions to the current care plan
 - Review calendar for scheduling of residents at least 8 weeks out from their next assessment
- Program Manager
 - Therapy reviews of residents with restraints, assistive devices, etc. (as they relate to residents in the weekly review)
 - List of residents referred to therapy (as they relate to residents in the weekly review)
 - Referrals to OT for splints/braces (as they relate to residents in the weekly review)

- Social Services
 - Review of Advance Directives and code status for accuracy (as they relate to residents in the weekly review)
 - Review for emerging behaviors (as they relate to residents in the weekly review)
- Activities
 - Participation records (as they relate to residents in the weekly review)
 - Review for emerging behaviors (as they relate to residents in the weekly review)

With the preparation complete, the IDT is ready for the QOL meeting. As indicated in the Weekly Quality of Life/At Risk meeting guidelines, the IDT will discuss clinical concerns identified from daily communication systems, QM/QI integration and their preparation information. The categories (outlined in the guideline) should be looked at comprehensively in regards to individual resident QM triggers. If the resident triggers for clinical and/or risk concerns determine if there can be referrals, interventions, or revisions to the current care plan to try to influence a positive outcome. Within each category are critical thinking points for review/discussion as applicable. Action steps for the IDT will be recorded for follow up and these will be reviewed at the next QOL to insure their completion. The attached log can be used as a tool for follow up. QOL activities should be summarized as part of the Monthly QAA/QAPI.

1/28/2014

Weekly Quality of Life/At Risk Meeting

Confidential and Privileged, Not to be distributed or Divulged to anyone except the Intended Recipient(s) without Legal Counsel's Approval (QA Use Only)

Part of the Facility QAA

Standard: As part of the facility QAA, the facility will regularly schedule QOL reviews (weekly) to discuss change in condition, individuals at risk, and referrals through internal communication systems, QIS audits, Interact, and facility QM/QI.

Purpose: To enhance communication systems, and facilitate timely reporting and interventions for potential changes in condition.

Guidance: On a regular schedule members of the IDT will meet and discuss clinical concerns identified from daily communication systems and QM/QI integration. Action steps will be recorded for follow up

The following are categories for review, the categories should be looked at comprehensively in regards to individual resident QM triggers. Within each category are critical thinking points for review/discussion as applicable.

Preparation:

1. Bring the most current copy of the 802 and any high risk lists (Keep an 802 current and updated as part of the morning meeting).
2. Identify residents for review within QM categories:
 - Prior to the meeting, access the **Point Right** /QM Resident Roster, and also reference the Radar report for the frailty index. This is obtained by going to the **Avante Portal**>select Point Right> select Products>select RADAR>Frailty Index. **QM Report:** select Products>select QM> select summary, trend or resident roster (print all three)
 - Bring the most recent 6 month Casper Report with numerator defined resident list: this allows you to see trends before the results are promulgated.
3. Bring the projected Care Plan Meeting calendar for the next quarter. Use the projected calendar to develop a weekly review of residents that will fall into their assessment time frame within the next 8 weeks. Review all residents regardless of triggers. **Those that are triggering, determine if there can be referrals, interventions, or revisions to the current care plan to try to influence a positive outcome.**
4. Bring recently noted changes in condition through daily operations meetings, and INTERACT QAPI activity for discussion as indicated.
 - In preparation of the meeting all disciplines should review QIS related interviews and observations, appropriate sections of care plans for designated at risk residents for current approaches and accuracy.
 - Verify INTERACT communication tools have been referred for discussion
 - Review that dietary, activity and SS notes are current and reflect interventions pertinent to behaviors, pain, weight loss, etc. (Bring the current GFS report for weights)

Falls/Incidents : (Weekly)

- Review falls in past 7 days; Ensure fall analysis has occurred post fall X 72hrs and no evidence of new onset of pain is evident, Care Plan/Kardex are updated to reflect current interventions and line staff are aware of changes to the resident care plan.
- Review past week(s) falls for intervention continuation or need for change.

Restraints/Alarms : (Monthly)

- Review facility QM/Point Right for long term residents who are physically restrained
- List of all residents with restraints or devices: Identify the type, reason, diagnosis and documented attempt at reduction (MD Communication Form completed at least quarterly and upon change)
- Review of interdisciplinary interventions e.g. diversional approaches through Activities, etc.
- Documentation of each residents review of w/c and bed alarms for continued need
- Discuss Alarm reductions/SR reductions, and any revisions or updates to care plans.
- Validate consent forms for restraints and Side Rails/Grab Bars

Weights : (Weekly)

- Review residents triggered in the QM/Point Right; reference coordinating triggers
- CDM pulls weights from GFS to reflect triggers for significant loss/gain.
- Nursing brings PCC weight report for all residents for a 90 day period.
- Generate referrals to RD for review as needed based on both PCC and GFS reports.
- Oversight and entry of weights per Dialysis
- Evidence of referrals to dietary and related Weight committee notes ; Evidence that MD and families aware of unanticipated weight loss and gains (Physician Communication Form)
- Unavoidable Weight Loss/Gain form is initiated by Nursing and Clinical RD prior to referring to MD.

Pressure Ulcers : (Weekly)

- Review facility QM/Point Right report
- Review residents triggered in the QM/Point Right; reference coordinating triggers
- **Weekly Wound report summary:** Identify new wounds and those with decline or failure to show improvement
- Review avoidable and unavoidable status as identified: Unavoidable pressure ulcers must show risk assessment, management of risk and conditions and ongoing changes to the care plan as indicated.
- Verify evidence of physician and family notification for change in condition (Physician Communication Forms/Progress notes)
- Verify Pain is managed with pretreatment medication (as indicated) with observation during rendering of treatment to maintain comfort.

Psychotropic Drug Use (As per 60-90 day MDS Schedule)

Review for pharmacy and physician oversight and GDR

Review facility QM/Point Right report; residents triggered in the QM

- Review for AIMS test per schedule and monitoring for adverse effects
- Review CNA ADL sheets for behaviors, last RX note, etc.
- Review percent of residents per QM that have depressive features (failure to thrive, review also for psychoactive use/antidepressant use or mental health referrals
- Root cause for the reason why behind the behavior: Internal/external factors, medical issues, Pain/sleep hygiene, etc

Pain Management (As per 60-90 day MDS Schedule)

- Review facility QM for Short Stay residents on a scheduled pain medication on admission who self-report increases in pain intensity or frequency
- Cross reference other triggered QM's as indicated (Ex; Behaviors)
- Review percent of residents who self report moderate to severe pain in short/long stay residents
- Review all residents on a routine pain management plan for efficacy of the plan; Verify pain scales are current and medication is reassessed as indicated
- Physician Pain Communication forms for updates as part of review
- Verify potential side effects are noted in the care plan e.g. constipation, altered mental status and risk for falls/injury; Have residents that are resistant to care been evaluated for pain?
- Document attempt reduction; monitor for resident behaviors, what is resident attempting to do? What are alternatives to alarms? A reduction plan should be in place

Infection Control (week to week)

- Review facility QM/Point Right both Short and Long Stay residents assessed appropriately and given the seasonal Influenza vaccine and the Pneumococcal vaccine: Pull PCC reports for Vaccination; **Check admission EMARS for TB test and readings during morning meeting/verify it is current**
- Review facility QM and identify per log listings percent of residents that received the vaccine(s), percent that were offered and refused the vaccine(s), and percent who did not receive the vaccination(s) due to medical contraindication: Is information appropriately categorized to "historical" option.
- Review facility QM/Point Right for Percent of residents with a UTI
- Review the listing of infection logs and trending reports for types of infections and location of infection trends within facility
 - Review rates for pneumonia and if it is Nursing Home Acquired versus Hospital acquired. Identify type e.g. aspiration, bacterial, viral;
 - For aspiration pneumonia, verify if aspiration precautions were in place; evidence that precautions were being followed? Noted on care plan? Are they observed for compliance on a regular schedule?
- Discuss any environmental/infection control trends or threats noted during environmental/infection control rounds)
- Review new ABT orders, trends with UTI/URI or potential overuse of ABT or side effects related to ABT (C Diff?)
- Surveillance includes awareness of employee illness trends.

Change in ADL's/Restorative (week to week)

- Review per facility QM percent of long stay residents whose need for help with Activities of Daily Living has increased
- Review per QM percent of long stay residents with a decline in ambulation to the bathroom
- List of current on program, # of referrals and # discharged from program
- List of residents referred to therapy
- STOP and WATCH referrals for the week
- Review medications for potential side effects as applicable
- Review advance directives as applicable to the degree of the decline(s)

Splint and Brace Oversight (week to week)

- New OT referrals/Orders
- Verification of use and appropriate monitoring
- OT oversight for periodic screens
- Application and removal oversight; Care plan integration

Discharge Review (week to week)

- Unplanned Hospitalization
- Root cause analysis results
- Review all unplanned discharges for areas of prevention, align education for improvement in prevention and medical management.

Hospice/End of Life care (week to week)

- Current list on program and review continued appropriateness
- Ensure IDT notes are current
- Review Advance Directives and DNR status for accuracy
- Review residents for referral to include unavoidable weight loss, change in condition and chronic decline.
- Review both Hospice and facility Care Plans align in goals and interventions.

Oxygen (all residents quarterly)

- Each resident reviewed for continued need of current O2 by RT or MD
- Consider assessment: D/C any PRN not used, decrease # of Liters, off during daytime and apply at HS, etc...

Elopement/Wander Risk (all residents quarterly)

- Maintain list of those at risk for elopement with photo ID
- Review list and risk assessments of new admissions for accuracy and completion
- Suggest an elopement book is kept on each unit as applicable with resident photo and related resident identification
- Update with declines in cognition/emerging behaviors

The Campaign: Circle of Success



Agency for Health Care Administration 2014 Joint Training for Skilled Nursing Facilities

Kimberly Smoak, MSH, QIDP
Bureau of Field Operations
Survey & Certification Support Branch



1

Objectives

- Overview of Online Licensing
- Discuss Nursing Home Enforcement
- Top Ten Immediate Jeopardy Citations



2

Online Licensing

- Effective January 7, 2014
 - Nursing Homes can now submit their license renewal applications online instead of using the paper forms.
 - Providers will continue to be notified when their renewal is due and when the online renewal is available.
 - The online system is a user-friendly electronic renewal application. After completing the application form, providers can upload supporting documentation and pay licensure fees, fines or assessments.



3

Online Licensing

- The online system will save time and reduce errors by pre-populating the application form with information that has been filed with the Agency in past applications. Use of the online will also allow providers to review the status of their applications during the licensure process.
- For more information about the online renewal process, please visit our website http://ahca.myflorida.com/MCHO/Health_Facility_Regulation/index.shtml#OL or call the Long Term Care Unit at (850) 412-4303.



3

Nursing Home Enforcement History

- Started July 1995
 - Remedies Included:
 - Plan of Correction (PoC)
 - Directed Plan of Correction (DPoC)
 - Temporary Management
 - Termination
 - Denial Payment for New Admissions (DPNA)
 - Discretionary Denial Payment for New Admissions (DDPNA)
 - Civil Money Penalties (CMP)



5

Nursing Home Enforcement

- Chapter 7- Survey and Enforcement Process for Skilled Nursing Facilities and Nursing Facilities
 - Implements nursing home survey, certification and enforcement regulations.
 - Establishes three expectations:
 - Providers remain in substantial compliance with Medicare/Medicaid program requirements as well as State law,
 - All deficiencies will be addressed promptly, and;
 - Residents will receive the care and services they need to meet their highest practicable level of functioning.



6

Factors to Consider When Imposing a Remedy

- Statement of Deficiencies is reviewed in its entirety
- Three year history of facility is reviewed
- If IJ this year, but last year facility had harm level tags
- Substandard Quality of Care



7

Factors to Consider When Imposing a Remedy continued

- Regulatory Groupings
- Repeat Deficiency
- The facility's degree of culpability
 - **Culpability** includes, but is not limited to, neglect, indifference, or disregard for resident care, comfort or safety. The absence of culpability is not a mitigating circumstance in reducing the amount of the penalty.



8

Imposition of Remedies

- Not guaranteed opportunity to correct before remedies are imposed
- Harm or higher identified the remedy will go back to the date of the incident, not exit date
- CMP Ranges- \$3,050 to \$10,000 per day for IJ
- CMP Ranges- \$50 to \$3,000 per day of non-IJ
- Per Instance- \$1,000 to \$10,000 for each deficiency



9

Imposition of Remedies continued

- Directed Plans of Correction
- Directed In-Services
- Regional Office IV Consistent use of CMP pre-decisional Tool since 2006
- April 2013 all 10 CMS Regional Offices are required to use the pre-decisional tool
 - Repeat deficiencies and
 - Substandard Quality of Care



10

Civil Money Penalties

- Effective 2012
 - CMP's held in escrow account
 - Facilities **must** pay CMP's in full even if hearing is requested
 - If facility prevails, CMP's are reimbursed-including interest.
 - CMP paid and closed out, posted on Nursing Home Compare



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Civil Money Penalties

- Survey & Certification Memo 13-57-NH: Escrow and Independent Informal Dispute Resolution Process for Nursing Homes-Applicable to All Civil Money Penalties
 - Effective 10/1/2013 CMP's imposed to all standard or complaint surveys that initiate enforcement action in which a CMP is imposed where the highest level of deficiency is **less than a "G" level**, will be subject to collection and escrow.



12

Enforcement Reminders

- When a notice of imposition is sent from the state agency or CMS it is critical the providers;
 - Review the entire notice
 - Respond timely to meet deadlines outlined in the notice



13

QAPI

- Facilities need to get on board with QAPI
 - Achieve Compliance
 - Sustain Compliance
 - Reach out to the QIO
 - Advancing Excellence



14

Top Ten Federal Health Immediate Jeopardy Deficiency Citations January 1, 2013 - December 31, 2013

Rank	Tag	Description
1	F0490	Effective Administration (483.75)
2	F0281	Services Provided Meet Professional Standards (483.20(K)(3)(I))
3	F0224	Prohibit Mistreatment/Neglect/Misappropriation (483.13 (C))
4	F0226	Develop/Implement/Abuse/Neglect Policies (483.13(C))
5	F0520	Quality Assessment and Assurance (483.75(O))
6	F0155	Resident Right to an Advance Directive (483.10(b)(4))
7	F0225	Investigate allegations of Abuse/Neglect (483.13(C))
8	F0323	Accidents and Supervision (483.25(H)(1) and (2))
9	F0156	Notice of Rights, Rules, Services and Charges (483.10(b))
10	F0282	Services Provided by Qualified Persons in accordance with Care Plan (483.20(K))



15

Immediate Jeopardy Findings

- Failure to initiate CPR when resident found unresponsive
- Failure to monitor residents Coumadin levels and conduct PT/INR
- Infection Control
- Accidents and Supervision



16

Contact Information

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