Qsource®

www.qsource.org

Culture of Safety Center 2023 Summit

Ensuring Quality of Care in Nursing Homes.
Protecting Quality of Life for Residents.

Welcome

Disclosures to Participants

- None of the planners for this activity have relevant financial relationship(s) to disclose with ineligible companies.
- Dr. Arif Nazir, Jennifer LaBay, Joel VanEaton, Kelley Tobey, Becky Meyer, or Dr. Prassana Chinthala have no relevant financial relationships to disclose with ineligible companies.
- Criteria for awarding the contact hours:
  - Attendance for entire activity
  - Completion/submission of evaluation form

This program is funded by TN-CMPRP and is approved for Continuing Education (CE) for 5 total participant hours by NAB/NCERS — Approval # 20240802-6-A94892-IN

This nursing continuing professional development activity was approved by the Georgia Nurses Association, an accredited approver by the American Nurses Credentialing Center's Commission on Accreditation. This event has been approved for 5.5 contact hours.

Qsource®

ABODE
CARE PARTNERS

BRIGHTSPRING
HEALTH SERVICES

ENGAGING MEDICAL DIRECTORS FOR MEANINGFUL TEAMWORK

ARIF NAZIR MD CMD

AUG 3, 2023

OBJECTIVES

- Upon completion of this presentation, attendees should be able to:

1. List the regulatory requirements for the medical director role
2. Describe the importance of medical director role in enhancing teamwork in skilled nursing facilities
3. Strategize to operationalize models that promote medical director partnerships in SNFs

Medical Directors in Skilled Nursing Facilities

- 1970: An outbreak of Salmonella in a Maryland nursing home resulting in 34 deaths highlights need for physician presence in SNFs.
- 1973: The American Medical Association published “Guidelines for a Medical Director in a Long-Term Care Facility,” which listed 15 functions of a medical director in order to help ensure the adequacy and appropriateness of the medical care provided to the residents.
- 1974: Regulations were approved, which required as a condition of participation that each skilled nursing facility retain a physician to serve as a medical director on at least a part-time basis.
- 1980: The medical director mandate was deleted. The American Medical Association, the American Geriatrics Society, and a relatively new organization called the American Medical Directors Association, along with 34 other national organizations, protested. The medical director mandate was once again restored in federal regulation for skilled nursing facilities.

https://www.hmpgloballearningnetwork.com/site/altc/article/4782

POLL

- My medical director is highly engaged in enhancing quality of care in my facility

1. Yeah, right!
2. Well, somewhat
3. Absolutely

POLL

- The MOST important reason that I am quite happy with my medical director is because, she/he:

1. Is a nice person
2. Takes proactive interest in quality initiatives and outcomes e.g., hospital prevention
3. Provides me whatever I ask e.g., urine testing, prescriptions

Poll

- If I am hiring a new medical director for my facility, the most important attribute I seek is:

1. Has hospital connections
2. Humility
3. Available 24/7
4. Expert with regulatory frameworks
5. Is a super clinician

Medical Director Facts

Myths	Facts
There is a federal requirement for medical directors in all SNFs and AL facilities	All SNFs are required to have medical directors, but not ALs
QAPI can only be quarterly or monthly	Must attend a QAPI meeting, at least quarterly
Facility can set the medical director hourly rate	Must be paid fair-market value
Medical directors can bill medical director time while performing clinical services e.g., seeing patients for care	To prevent Stark violations, for medical directors a contract and description of administrative services is required; clinical services should not be counted
All medical directors are experts at quality improvement	Many medical directors are not well-versed in regulatory aspects and may or ma not be QI experts
Medical directors should be hired based on their ability to refer patients	Hiring medical directors for their referral ability ONLY is critical violation

"Interdisciplinary interventions had a positive impact on resident outcomes in the SNF setting. Participation of the residents' primary physician and/or a pharmacist in the intervention, as well as team communication and coordination, were consistent features of successful interventions."

How can we engage Medical Directors in interprofessional conduct and Quality Improvement?

Nazir, Arif, et al. "Systematic review of interdisciplinary interventions in nursing homes." Journal of the American Medical Directors Association 14.7 (2013): 471-478.

LEAKY FAUCET

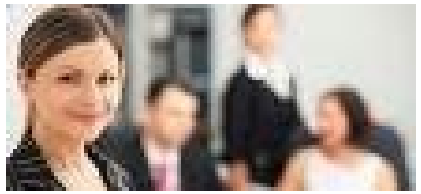
- Your home has a problem
  "Powder room faucet is leaking"
- You need to get it fixed
- You are clueless when it comes to leaky faucets.
- What are the detailed steps for the **BEST** possible outcome?

Fixing the Faucet

- Knowing the exact problem
- Finding the Best plumber
  - Previous experience, Some App, word of mouth, others?
- Explaining the exact job and setting expectations
- Deciding the price
- Reviewing performance and payment

Medical Directors

- Federal regulations specify only two duties:
  - Implementation of resident care policies
  - Coordination of medical care in the facility



13

Medical Director Role: AMDA Guidelines

- The position of the nursing home Medical Director can be identified in terms of the **Role, Functions, and Tasks** hierarchy.
- Roles: the set of behaviors that an individual within an organization is expected to perform and feels obligated to perform.
- Functions: the major domains of activity within a role.
- Tasks: the specific activities that are undertaken to carry out those functions.

The Nursing Home Medical Director: Leader & Manager | AMDA | The Society for Post-Acute and Long-Term Care Medicine (paltc.org)

MEDICAL DIRECTOR **ROLES**

- AMDA has identified four key roles of the long-term care medical director, as follows:
  - **Role 1—Physician Leadership**
- The medical director serves as the physician responsible for the overall care and clinical practice carried out at the facility.
  - **Role 2—Patient Care-Clinical Leadership**
- The medical director applies clinical and administrative skills to guide the facility in providing care.
  - **Role 3—Quality of Care**
- The medical director helps the facility develop and manage both quality and safety initiatives, including risk management.
  - **Role 4—Education, Information, and Communication**
- The medical director provides information that helps others (including facility staff, practitioners, and those in the community) understand and provide care.

MEDICAL DIRECTOR **FUNCTIONS**

- Function 1—Administrative
- Function 2—Professional Services
- Function 3—Quality Assurance and Performance Improvement
- Function 4—Education
- Function 5—Employee Health
- Function 6—Community
- Function 7—Rights of Individuals
- Function 8—Social, Regulatory, Political, and Economic Factors
- Function 9—Person-Directed Care

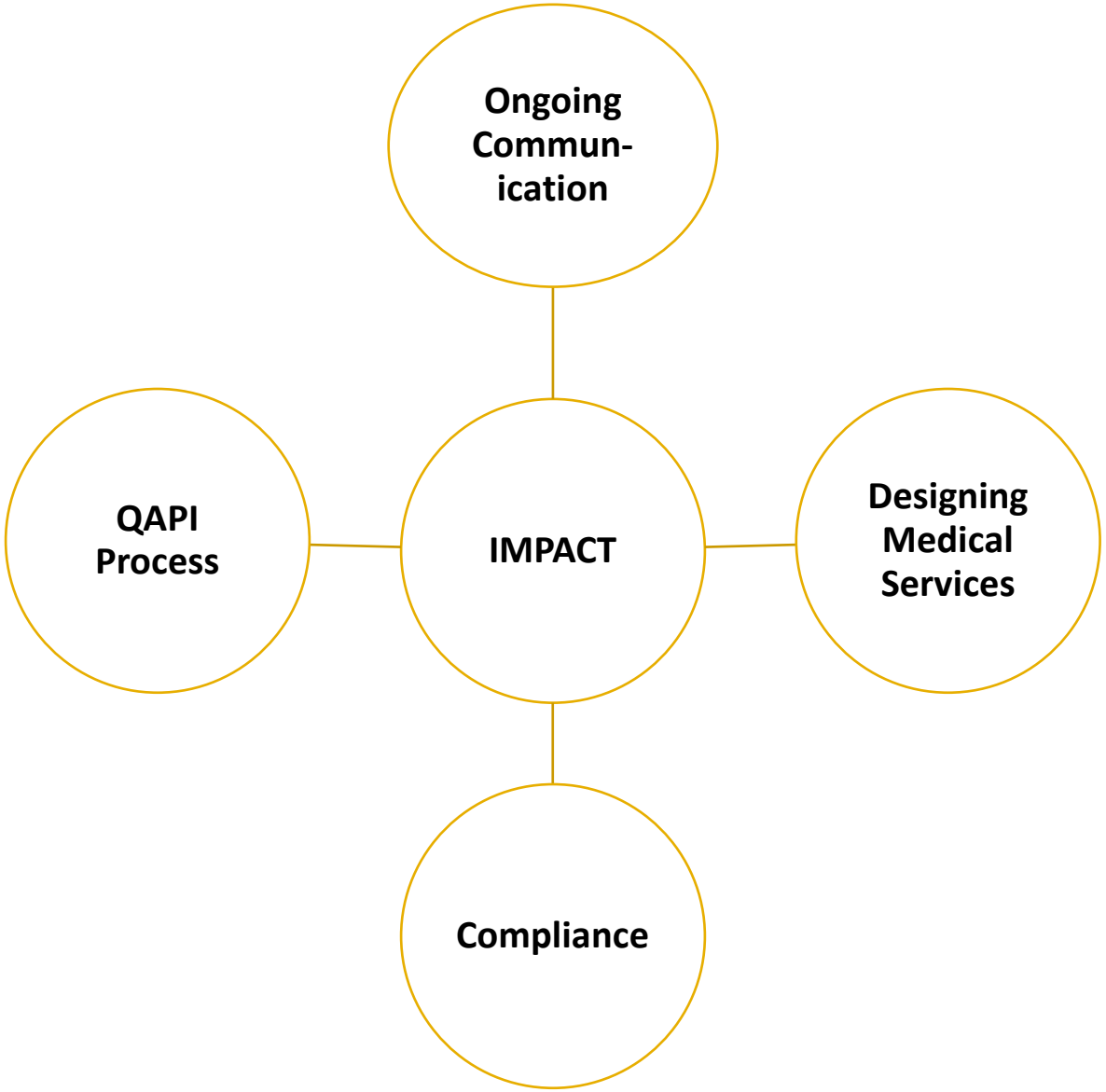
Partnering with the Medical Director

- Understanding facility key needs and challenges
- Seek an “A-Player” (humility, teamwork, clinical expertise, regulatory understanding, QI and solution-oriented)
- “Interview” process with key leaders and the facility staff
- Fair-market value and credentialing
- Onboarding processes (toolkit, training and ongoing communications)

Priority Medical Director Roles

- Quality Assurance meetings
- Utilization and polypharmacy review
- Infection control and antibiotic stewardship
- Chart review for hospital transfers and complex clinical matters
- Survey participation
- Meeting with residents, families, staff, and community liaisons (Ombudsmen, Ethics Committees, Hospitals, etc.)
- Education staff, patients and community

ABODE CARE PARTNERS STRATEGY TO IMPACT PERFORMANCE

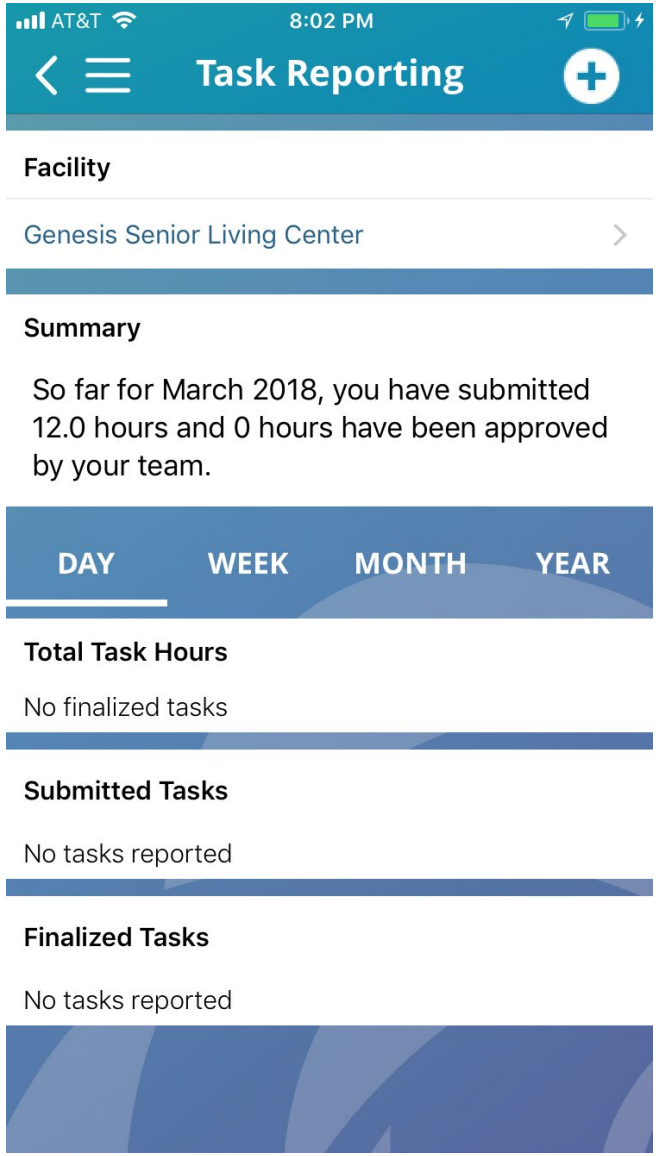


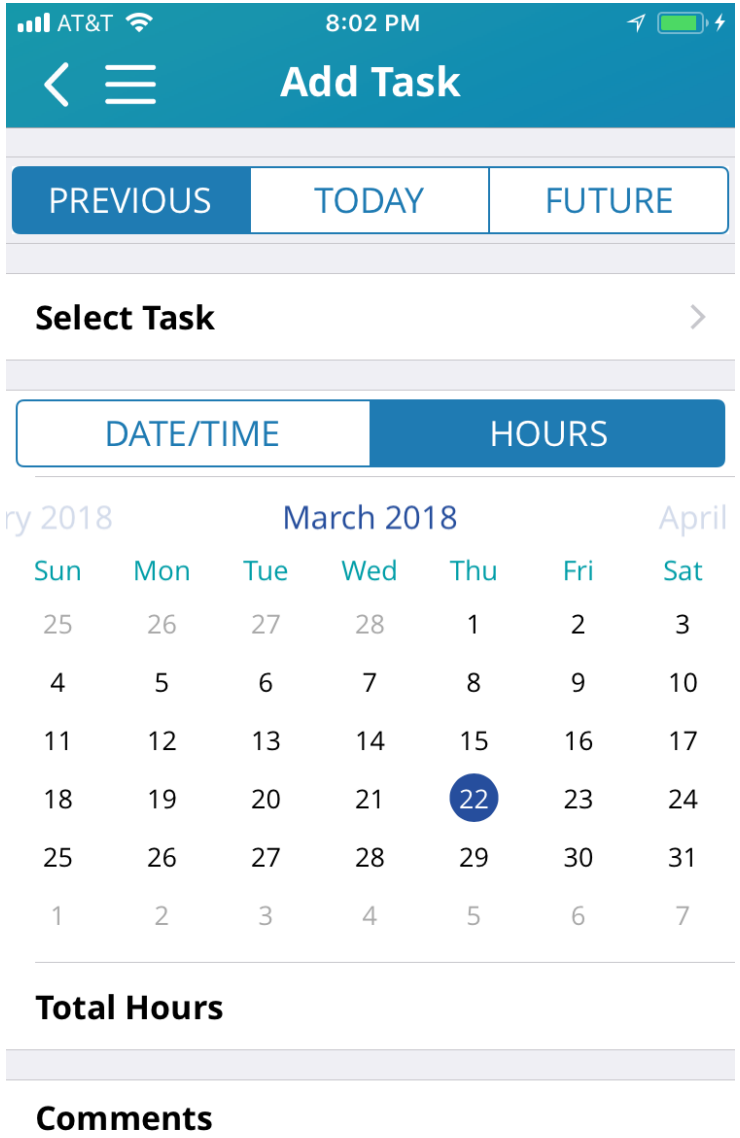
Ongoing Communication with Facility leaders

- Set a cadence
- Agree on agenda
  - Mutual learning
  - Policies and procedures
  - Metrics
  - Strategy
  - Customer service
  - QAPI frameworks

COMPLIANCE

- Assure tightening of compliance to prevent Stark's and Antikickback violations
  - Contract with role clarity
  - Fair Market based hourly rates with reasonable number of hours
  - Clear process to log hours and to keep a record
  - Steer clear from discussions on referring patients
  - Others?
- There is an App for that!
  - Medical director contracts, roles expectations, education, communication, data metrics and feedback


AT&T
8:02 PM
Task Reporting
Facility
Genesis Senior Living Center
Summary
So far for March 2018, you have submitted 12.0 hours and 0 hours have been approved by your team.
DAY
WEEK
MONTH
YEAR
Total Task Hours
No finalized tasks
Submitted Tasks
No tasks reported
Finalized Tasks
No tasks reported


AT&T
8:02 PM
Add Task
PREVIOUS
TODAY
FUTURE
Select Task
DATE/TIME
HOURS
March 2018
Sun Mon Tue Wed Thu Fri Sat
Total Hours
Comments

Medical Services Quality

- Quality of other practitioners, attending physicians and consultants
- Call availability
- Telehealth protocols
- Special programs e.g., heart failure program
- Lead a transfer review protocol, ideally weekly

QAPI FRAMEWORKS

- Partnership and regular meetings between medical director and key departmental leaders e.g., Infection Preventionist, social worker, nursing and others
- Include medical director on setting QAPI agenda at least a week before the meeting
- Medical director role in QAPI e.g., updates on new medications, information on any hospital initiatives, other updates e.g., pandemic
- Besides monthly/ quarterly QAPI, how about other learning structures?

MEDICAL DIRECTOR DASHBOARD

Setting Medical Directors for Success by Focusing on 3Cs

COMMUNICATION

COLLABORATION

CARE

A Day at Squeaky Meadows

- 130-bed SNF with >20 short-stay patients
- On a Friday, new patient admitted with Aspirin, Eliquis (apixaban) and Clopidogrel (Plavix)
- Relatively new nurse manager is concerned about anemia (Hgb 8.9 g/dl) and above three agents
- Director of nursing asks to not call the medical director (also the attending physician) “late on Friday” and to leave the recommendation in the folder
- Two weeks later, patient transferred with coffee-ground stools and dyspnea and Hgb of 5.2 g/dl

Root Cause of the Outcome

Among other things:

Poor communication

Lack of collaboration and trust

Care not delivered

Other Examples of Lack of 3Cs at Squeaky Meadows

- Medical director, who mostly relies on the NP, does most work remotely as he is “too busy” (how does this impact teamwork, staff workflows, and outcomes?)
- Agency staff call the physician without formal assessments e.g., SBAR and many patients unnecessarily hospitalized
- Due to high hospitalization rates, medical director devises an intervention that all residents receive extensive labs on admissions that must be faxed to him
- **Medical director on QAPI meeting remarks that “consultant pharmacy recommendations are silly” and declines to accept any after skimming through them**

Case of Silly Consultant Pharmacists' Recommendations

- Facility NP visits twice a week and rarely over the weekend
- NP and consultant pharmacists never meet in-person
- Perception: Practitioner and the medical director are "unimpressed" by "cookie-cutter and silly" pharmacist recommendations
- Reality: A very engaged CP who invests a lot of time, but due to lack of structured communication with the team, resorts to general recommendations

Assessing the "3C" Issues at Squeaky Meadows

- **Communication:**
  - All around lack of communication
- **Care:**
  - Perception that the NP and the medical director do not prioritize important issues and "don't really care"
  - Director of nursing perceived significant burden and perceived that the "system does not care" for nursing homes
- **Collaboration:**
  - Multiple missed opportunities for simplifying, improving care, and promoting teamwork

Price of “3C” Issues Related to Polypharmacy

- Consultant Pharmacist efforts not resulting in impact
- Director of nursing burnout
- Nursing burnout due to polypharmacy
- Costs of medicines
- Multiple medication adverse effects resulting in medication cascades, ED transfers, and hospitalizations
- Others?

"3C" Framework for Polypharmacy Management

- Director of nursing hears about AMDA, the Society of PALTC medicine campaign "Drive to Deprescribe" (D2D)
- Visits the website: D2D Meeting Archives | AMDA | The Society for Post-Acute and Long-Term Care Medicine (paltc.org)
- Reviews materials on implementing medication optimization and deprescribing at a SNF
- Meets with medical director and consultant pharmacist to set a culture of 3Cs

Implementing Medication Optimization & Deprescribing at Squeaky Meadows

- Director of Nursing and medical director review D2D letters for family and other physicians to inform about the renewed focus on medication optimization

- Consultant pharmacist, practitioner, medical director and director of nursing meet and exchange contact information

- All decide on monthly huddle to review polypharmacy-related issues and to address Consultant Pharmacists' recommendations

New Responsibilities to Promote "3Cs" at Squeaky Meadows

Director of Nursing	Consultant Pharmacist	Medical Director and NP
Join AMDA D2D webinars	Join AMDA D2D webinars	Commit to join AMDA D2D webinars
Educate all staff about medication optimization benefits and inform patients and families	Share cell phone number with NP and medical director	Review weekly polypharmacy data from CP and act to deprescribe and optimize when needed
Add new polypharmacy related metrics to the monthly QAPI meetings	Provide data on average number of scheduled medications and Beer's list medications for long-stay residents and provide list of highest utilizers of medications in the facility	Review all CP recommendations via phone call every month and deprescribe and prescribe, where appropriate
Educate all staff on risks of ASA and anticoagulants	Provide list of all residents on Aspirin and an anticoagulant	Discontinue ASA/anticoagulants where appropriate

NEWS

Bake in success with advanced clinicians in place: BrightSpring Health's Arif Nazir, MD

KIMBERLY MARSELAS

@KIMMARSELAS

JUNE 26, 2023

SHARE

Bake in success with advanced clinicians in place: BrightSpring Health's Arif Nazir, MD (mcknights.com)

SUMMARY

- Physician partnerships are critical to improving outcomes in post-acute and long-term care settings
- We need to establish formal structures of medical director roles to assure engagement and bringing value
- Focus on communication, collaboration and care can improve medical director partnerships
- Health Systems should establish clear medical director priorities and implement data-driven strategies to implement and to gauge success

QUESTIONS

- Arif Nazir MD
- anazir@shcmedicalpartners.com

"A ***Knowledgeable*** and ***Compassionate*** partner"

BROAD RIVER REHAB

Health Equity and Social Determinants of Health

The changing face of patient care

Joel VanEaton, BSN, RN, RAC-CTA, Master Teacher:
Executive Vice President of PAC Regulatory Affairs and Education

Agenda

Health Equity and Social Determinants of Health

- Introduction to SNF QRP and Health Equity/Social determinants of Health
- Introduction to SNF Value Based Purchasing and Health Equity/Social determinants of Health
- Review how Health Equity Intersects Value Based Purchasing
- Literature Review Examples of how to operationalize SDOH and Health Equity Principles

Skilled Nursing Facility Quality Reporting Program (SNF QRP) update

- **SNF QRP Resources:**
  - SNF QRP
  - Reporting tables for FY 2024
  - Reporting tables for FY 2025
  - SNF QRP Technical Specifications and Addendum
  - HAI Draft Specifications
  - COVID-19 Vaccination Among HCP Specifications
  - Influenza Vaccination Coverage Among HCP
  - TOH Measures and SPADEs
  - Claims Based Measures DTC and PPR
  - MSPB
  - Unified PAC Report to Congress
  - MDS 3.0 v1.18.11

IMPACT Act

- On October 6, 2014, the Improving Medicare Post-Acute Care Transformation Act of 2014 (the IMPACT Act) was signed into law.
- The Act requires the submission of standardized data by Long-Term Care Hospitals (LTCHs), **Skilled Nursing Facilities (SNFs)**, Home Health Agencies (HHAs) and Inpatient Rehabilitation Facilities (IRFs).
- Standardized data are to be collected by the commonly used assessment instruments: The Long-Term Care Hospital CARE Data Set (LCDS) for LTCHs, **the Minimum Data Set (MDS) for SNFs**, the Outcome and Assessment Information Set (OASIS) for HHAs, and the Inpatient Rehabilitation Facility Patient Assessment Instrument (IRF PAI) for IRFs.
- The IMPACT Act requires the reporting of standardized patient assessment data with regard to quality measures and standardized patient assessment data elements (SPADEs).
- The Act also requires the submission of data pertaining to measure domains pertaining to resource use, and other domains.
- In addition, the IMPACT Act requires assessment data to be standardized and interoperable to allow for exchange of the data among post-acute providers and other providers.
- The Act intends for standardized post-acute care data to improve Medicare beneficiary outcomes through shared-decision making, care coordination, and enhanced discharge planning.

IMPACT Act QMs

IMPACT Act Domain	IMPACT Act Measure	Source	PAC Setting Adopted
Skin Integrity and Changes in Skin Integrity	Percent of Residents or Patients with Pressure Ulcers that are New or Worsened (Short Stay) replaced with Changes in Skin Integrity Post-Acute Care: Pressure Ulcer/Injury.	Assessment	IRF, LTCH, SNF, HH
Functional Status, Cognitive Function, and Changes in Function and Cognitive Functiony	Application of Percent of LTCH Hospital Patients with an Admission and Discharge Functional Assessment and a Care Plan that Addresses Function	Assessment	IRF, LTCH, SNF, HH
	Change in Self-Care Score for Medical Rehabilitation Patients	Assessment	IRF, SNF
	Change in Mobility Score for Medical Rehabilitation Patients	Assessment	IRF, SNF
	Change in Discharge Self-Care Score for Medical Rehabilitation Patients	Assessment	IRF, SNF
	Change in Discharge Mobility Score for Medical Rehabilitation Patients	Assessment	IRF, SNF
Medication Reconciliation	Drug Regimen Review	Assessment	IRF, LTCH, SNF, HH
Incidence of Major Falls	Application of the Percent of Residents Experiencing One or More Falls with Major Injury (Long Stay)	Assessment	IRF, LTCH, SNF, HH
Transfer of Health Information and Care Preferences when an Individual Transitions	Transfet of Health Information to Provider Transfer of health Information to Patient	Assessment Assessment	IRF, LTCH, SNF, HH
Resource Use Measures, including Total Estimated Medicare Spending Per Beneficiary	Medicare Spending Per Beneficiary	Claims	IRF, LTCH, SNF, HH
Discharge to Community	Discharge to Community	Claims	IRF, LTCH, SNF, HH
All-Condition Risk-Adjusted Potentially Preventable Hospital Readmissions Rates	Potentially Preventable 30-Day Post-Discharge Readmission	Claims	IRF, LTCH, SNF, HH
Meaningful Measure Domain	**IMPACT Act Measure**		**PAC Setting Adopted**
Patient Safety (Meaningful Measures 2.0)	SNF Healthcare Associated infections	Claims	SNF
Patient Safety (Meaningful Measures 2.0)	Influenza vaccination HCP	NHSN	IRF, LTCH, SNF
Patient Safety (Meaningful Measures 2.0)	COVID-19 Vaccination HCP	NHSN	IRF, LTCH, SNF

New Measures

- Discharge Function Score (DC Function) measure FY 2025
- ~~CoreQ: Short Stay Discharge (CoreQ: SS DC) measure FY 2026~~
- COVID-19 Vaccine: Percent of Patients/Residents Who Are Up to Date (Patient/Resident COVID-19 Vaccine) measure FY 2026
- COVID-19 Vaccination Coverage among Healthcare Personnel (HCP COVID-19 Vaccine) measure FY 2026

IMPACT Act

- The Improving Post-Acute Care Transformation (IMPACT) Act of 2014 also requires a report to Congress on unified payment for Medicare post-acute care (PAC).
- Medicare PAC services are provided to beneficiaries by PAC providers defined as skilled nursing facilities (SNFs), inpatient rehabilitation facilities (IRFs), long-term care hospitals (LTCHs), and home health agencies (HHAs).
- Each PAC provider setting has a separate Medicare fee-for-service (FFS) prospective payment system (PPS).
- A goal of unified PAC payment is to base the payment on patient characteristics instead of the PAC setting.
- This framework applies a uniform approach to case-mix adjustment across Medicare beneficiaries receiving PAC services for different types of PAC providers while accounting for factors independent of patient need that are important drivers of cost across PAC providers.
- The unified approach to case-mix adjustment includes **standardized patient assessment data** collected by the four PAC providers.

SNF Quality Reporting Program (QRP)

- The Improving Medicare Post-Acute Care Transformation Act of 2014 (IMPACT Act) requires CMS to develop, implement, and maintain standardized patient assessment data elements (SPADEs) for PAC settings (SNF, HH, LTCH, IRF).
- The goals of implementing cross-setting SPADEs are to facilitate care coordination and interoperability and to improve Medicare beneficiary outcomes.
- The IMPACT Act further requires that the assessment instruments for each PAC setting (MDS, OASIS, LCDS, IRF PAI) be modified to include core data elements on health assessment categories and that such data be standardized and interoperable. HH, IFF and LTCH tools have already been modified to report these SPADEs. **MDS 3.0 v1.18.11 contains the data elements necessary to comply with this mandate.**
- CMS has adopted SPADEs for five categories specified in the IMPACT Act:
  - **Cognitive function** (e.g., able to express ideas and to understand normal speech) and mental status (e.g., depression and dementia)
  - **Special services, treatments, and interventions** (e.g., need for ventilator, dialysis, chemotherapy, and total parenteral nutrition)
  - **Medical conditions and comorbidities** (e.g., diabetes, heart failure, and pressure ulcers)
  - **Impairments** (e.g., incontinence; impaired ability to hear, see, or swallow)
  - **Other categories** as deemed necessary by the Secretary (Social Determents of Health)

SNF Quality Reporting Program (QRP)

- **New Category: Social Determinants of Health (cont.)**
- MDS items have been added and or revised to assess for SDOH:
  - **Ethnicity – MDS item A1005**
  - **Race – MDS item A1010**
  - **Preferred Language – MDS item A1110**
  - **Interpreter Services – MDS item A1110**
  - **Transportation – MDS item A1250**
  - **Health Literacy – MDS item B1300**
  - **Social Isolation – MDS item D0700**

SNF Quality Reporting Program (QRP)

- **Health Equity Update (SNF PPS FY 2024 proposed Rule)**
- CMS is working to advance health equity by designing, implementing, and operationalizing policies and programs that support health for all the people served by CMS' programs and models, eliminating avoidable differences in health outcomes experienced by people who are disadvantaged or underserved, and providing the care and support that beneficiaries need to thrive.
- This initiative is guided by 5 priorities
- **Priority 1:** Expand the Collection, Reporting and Analysis of **Standardized Data**
- **Priority 2:** Assess **Causes of Disparities** Within CMS Programs, and **Address Inequities in Policies and Operations to Close Gaps**
- **Priority 3:** Build Capacity of Health Care Organizations and the Workforce to **Reduce Health and Health Care Disparities**
- **Priority 4: Advance Language Access, Health Literacy** and the Provision of Culturally Tailored Services
- **Priority 5:** Increase All Forms of Accessibility to Health Care Services and Coverage

SNF VBP/QRP Connection: Health Equity

- The CDC defines health equity as, "…the state in which everyone has a fair and just opportunity to attain their highest level of health." "Achieving this requires focused and ongoing societal efforts to address historical and contemporary injustices; overcome economic, social, and other obstacles to health and healthcare; and eliminate preventable **health disparities**."
- The CDC also indicated that, "Achieving health equity requires valuing everyone equally with focused and ongoing societal efforts to address avoidable inequalities, historical and contemporary injustices, and the elimination of health and healthcare disparities." "Achieving health equity also requires addressing **social determinants of health** and **health disparities**."

SNF VBP/QRP Connection: Health Equity

CMS Framework for Health Equity 2022–2032

SNF VBP/QRP Connection: Health Equity

- **New Category: Social Determinants of Health**
  - CMS has identified data elements for cross-setting standardization of assessment for seven social determinants of health (SDOH).
  - **Healthy People 2020 defines SDOH** as, *"…the conditions in the environments where people are born, live, learn, work, play, worship, and age that affect a wide range of health, functioning, and quality-of-life outcomes and risks."*
  - **World Health Organization** – *"Social determinants of health (SDH) are the non-medical factors that influence health outcomes. They are the conditions in which people are born, grow, work, live, and age, and the wider set of forces and systems shaping the conditions of daily life. These forces and systems include economic policies and systems, development agendas, social norms, social policies and political systems. The SDH have an important influence on Health Inequities - the unfair and avoidable differences in health status seen within and between countries. In countries at all levels of income, health and illness follow a social gradient: the lower the socioeconomic position, the worse the health."*
  - *Examples of the social determinants of health, which can influence health equity in positive and negative ways: - Income and social protection – Education - Unemployment and job insecurity – Working life conditions - Food insecurity – Housing, basic amenities and the environment - Early childhood development - Social inclusion and non-discrimination - Structural conflict - Access to affordable health services of decent quality.*

SNF VBP/QRP Connection: Health Equity

- **Health Equity Update SNF PPS FY 2024**
  - CMS' National Quality Strategy identifies a wide range of potential quality levers that can support CMS' advancement of equity, including:
    - (1) establishing a **standardized approach for resident-reported data and stratification**;
    - (2) employing quality and **value-based programs to address closing equity gaps**; and
    - (3) developing **equity-focused data collections, analysis, regulations, oversight strategies, and quality improvement initiatives**.

SNF VBP/QRP Connection: Health Equity

- **Health Equity Update SNF PPS FY 2024**
- CMS is committed to developing approaches to meaningfully incorporate the advancement of health equity into the SNF QRP. One option we are considering is including **social determinants of health (SDOH) as part of new quality measures**.
- CMS is considering whether health equity measures we have adopted for other settings, such as hospitals, could be adopted in post-acute care settings.
- CMS is exploring ways to incorporate SDOH elements into the measure specifications. For example, CMS is considering **a future health equity measure like screening for social needs and interventions**.
- **With 30 percent to 55 percent of health outcomes attributed to SDOH**, a measure capturing and addressing SDOH could encourage SNFs to identify residents' specific needs and connect them with the community resources necessary to overcome social barriers to their wellness.

SNF VBP/QRP Connection: Health Equity

- **Health Equity Update SNF PPS FY 2024**
- CMS could specify a health equity measure using the same SDOH data items that we currently collect as standardized patient assessment data elements under the SNF.
- These SDOH data items assess health literacy, social isolation, transportation problems, and preferred language (including need or want of an interpreter).
- CMS also sees value in aligning SDOH data items across all care settings as we develop future health equity quality measures under our SNF QRP statutory authority.
- This would further the NQS to align quality measures across our programs as part of the **Universal Foundation**.

Skilled Nursing Facility Value-Based Purchasing (SNF VBP) Program

- **Value Based Purchasing**
  - The Centers for Medicare & Medicaid Services (CMS) awards incentive payments to skilled nursing facilities (SNFs) through the SNF VBP Program to encourage SNFs to improve the quality of care they provide to Medicare beneficiaries. Performance in the SNF VBP Program is currently based on a single measure of all-cause hospital readmissions.
  - In Section 215 of the Protecting Access to Medicare Act of 2014 (PAMA), Congress added sections 1888(g) and (h) to the Social Security Act, which required the Secretary of the Department of Health and Human Services (HHS) to establish a SNF VBP Program. The Program began affecting SNF payments on October 1, 2018.
  - PAMA specifies that under the SNF VBP Program, SNFs:
    - Are evaluated by their performance on a hospital readmission measure;
    - Are assessed on both improvement and achievement, and scored on the higher of the two;
    - Receive quarterly confidential feedback reports containing information about their performance; and
    - Earn incentive payments based on their performance.
    - All SNFs paid under Medicare's SNF Prospective Payment System (PPS) are included in the SNF VBP Program. Inclusion in the SNF VBP Program does not require any action on the part of SNFs.
  - As required by statute, CMS withholds 2% of SNFs' Medicare fee-for-service (FFS) Part A payments to fund the program. This 2% is referred to as the "withhold".
  - CMS is required to redistribute between 50% and 70% of this withhold to SNFs as incentive payments. CMS redistributes 60% of the withhold to SNFs as incentive payments, and the remaining 40% of the withhold is retained in the Medicare Trust Fund.

Skilled Nursing Facility Value-Based Purchasing (SNF VBP) Program

- **Value Based Purchasing (Cont.)**
  - In Section 111 of the Consolidated Appropriations Act, 2021, Congress amended Section 1888(h) of the Social Security Act to allow the HHS Secretary to apply up to nine additional measures to the SNF VBP Program for payments for services furnished on or after October 1, 2023 (fiscal year [FY] 2024).
  - In the FY 2023 SNF PPS final rule, CMS adopted two additional measures for use beginning in the FY 2026 SNF VBP Program year: **1)** Skilled Nursing Facility Healthcare-Associated Infections (SNF HAI) Requiring Hospitalization measure; and **2)** Total Nurse Staffing Hours per Resident Day (Total Nurse Staffing) (including Registered Nurse [RN], Licensed Practical Nurse [LPN], and Nurse Aide hours) measure. CMS also adopted one additional measure for use beginning in the FY 2027 SNF VBP Program year: Discharge to Community (DTC)—Post-Acute Care Measure for SNFs (National Quality Forum [NQF] #3481).

Skilled Nursing Facility Value-Based Purchasing (SNF VBP) Program

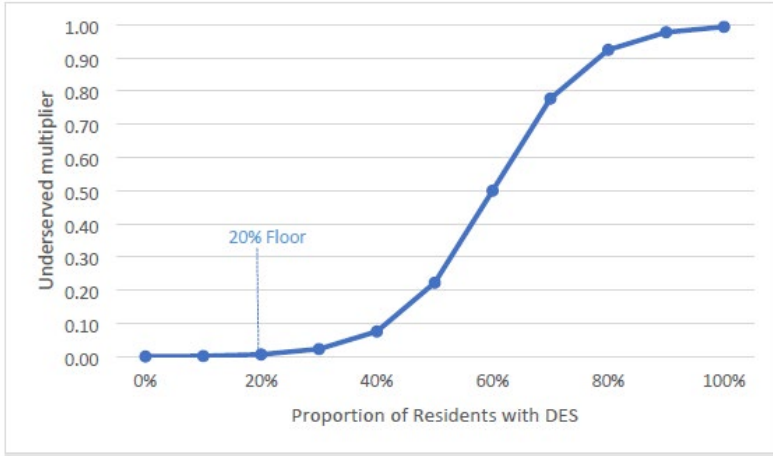
- **Value Based Purchasing Measures**
  - NQF 2510: Skilled Nursing Facility Readmission Measure (SNFRM) Current
  - Skilled Nursing Facility (SNF) Healthcare Associated Infections (HAI) Requiring Hospitalization FY 2026
  - Total Nursing Hours per Resident Day Staffing (Total Nurse Staffing) measure FY 2026
  - Discharge to Community (DTC) FY 2027
  - Nursing Staff Turnover Measure FY 2026 proposed
  - Long Stay Hospitalization Measure per 1000 long-stay resident days FY 2027 proposed
  - Discharge Function Score measure FY 2027 proposed
  - Percent of Residents Experiencing One or More Falls with Major Injury (Long Stay) FY 2027 proposed
  - Skilled Nursing Facility Within Stay Potentially Preventable Readmissions (SNF WS PPR) FY 2028 proposed

Skilled Nursing Facility Value-Based Purchasing (SNF VBP) Program

- **Value Based Purchasing FY 2024 SNF PPS**
  - To prioritize the achievement of **health equity** and the reduction of disparities in health outcomes in SNFs, CMS is adoptingof a Health Equity Adjustment in the SNF VBP Program that rewards SNFs that perform well and whose resident population during the applicable performance period includes at least 20% of residents with dual eligibility status.
  - This adjustment would begin with the **FY 2027 program year and FY 2025 performance year**.
  - CMS is adjusting the scoring methodology to provide bonus points to high-performing facilities (CMS is proposing to define a top tier performing SNF, as a SNF whose score on the measure for the program year falls in the top third of performance, or greater than or equal to the 66.67th percentile) that provide care to a higher proportion of duals.
  - In the FY 2024 SNF PPS rule, CMS is requesting comments about possible future methodologies for selecting and prioritizing quality measures to focus on underserved populations.

Skilled Nursing Facility Value-Based Purchasing (SNF VBP) Program

- **Value Based Purchasing FY 2024 SNF PPS**
  - In addition, CMS will increase the payback percentage policy under the SNF VBP program from current 60% to a level such that the bonuses provided to the high performing, high duals SNFs do not come at the expense of the other SNFs. The estimates for FY 2027 program year is 66.02%.
  - Bonus Scoring Methodology (if 20% DES):
    - **Measure Performance Scaler**: 2 bonus points for each VBP measure scoring in the top 66.67th percentile.
    - **Underserved Multiplier**: the number representing the SNF's proportion of residents with DES out of its total resident population in the applicable program year, translated using a logistic exchange function
    - **HEA bonus points** = measure performance scaler × underserved multiplier



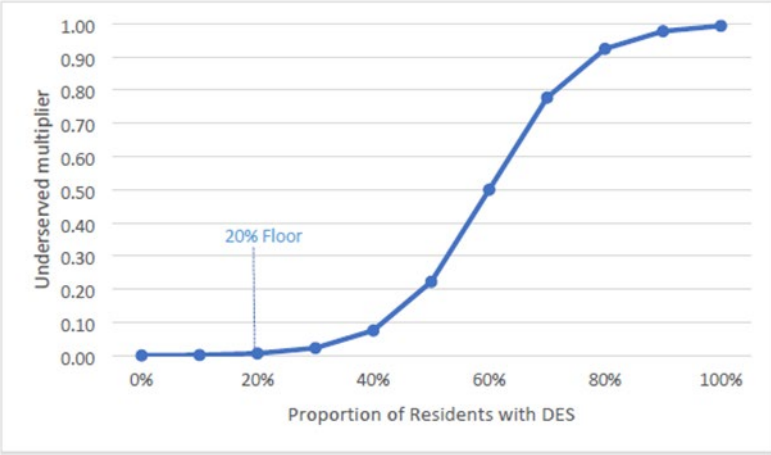
Skilled Nursing Facility Value-Based Purchasing (SNF VBP) Program

TABLE 20: Example of the HEA Bonus Points Calculation

Example SNF	Measure Performance Scaler [A]	Proportion of Residents with DES (%) [B]	Underserved Multiplier [C]	HEA bonus points [D] ([A]*[C])
SNF 1	16	50	0.22	3.52
SNF 2	14	70	0.78	10.92
SNF 3	10	10	0	0
SNF 4	2	80	0.92	1.84

TABLE 21: Example of the HEA Bonus Points Calculation

Example SNF	Normalized Sum of all Points Awarded for each Measure [A]	HEA Bonus Points (Step 3, Column [D]) [B]	SNF Performance Score ([A] + [B])
SNF 1	80	3.52	83.52
SNF 2	65	10.92	75.92
SNF 3	42	0	42.00
SNF 4	10	1.84	11.84



Health Equity/Social Determinants of Health in Practice

- **Health Equity/Social Determinants of Health Application**
  - In a recent column in McKnight's LTC News, it was noted that, "According to the Centers for Disease Control and Prevention"
  - "social isolation can increase a person's risk of premature death from all causes and increases the risk of dementia by 50%."
  - "Social isolation is a lack of social connections. Social isolation can lead to loneliness in some people, while others can feel lonely without being socially isolated."
  - **"Health Risks of Loneliness:** Although it's hard to measure social isolation and loneliness precisely, there is strong evidence that many adults aged 50 and older are socially isolated or lonely in ways that put their health at risk. Recent studies found that:
    - Social isolation **significantly increased a person's risk of premature death** from all causes, a risk that may rival those of smoking, obesity, and physical inactivity.[1]
    - Social isolation was associated with about a **50% increased risk of dementia**.[1]
    - Poor social relationships (characterized by social isolation or loneliness) was associated with a **29% increased risk of heart disease** and a **32% increased risk of stroke.**[1]
    - Loneliness was **associated with higher rates of depression, anxiety, and suicide**.
    - Loneliness among heart failure patients was **associated with a nearly 4 times increased risk of death, 68% increased risk of hospitalization, and 57% increased risk of emergency department visits**.[1]

Health Equity/Social Determinants of Health in Practice

- **Health Equity/Social Determinants of Health Application**
  - Black Americans' High Gout Rate Stems From Social Causes (Medscape): Gout prevalence is more common in Black Americans than white Americans, and the disparity in prevalence is attributable to social determinants of health, according to a recently published article in *JAMA Network Open.*
  - Age-standardized prevalence of gout:
    - 3.5% in Black women and 2.0% in white women.
    - 7.0% in Black men and 5.4% in white men
    - Similar differences were found in the prevalence of hyperuricemia between Black and white Americans.
  - This research concluded that the increased prevalence of gout in Black Americans, compared with white Americans, does not arise from genetics. The conclusion was that it was due to social determinants of health. "When we adjusted for all socio-clinical risk factors, the racial differences in gout and hyperuricemia prevalence disappeared. Importantly, stepwise regression analysis showed **the two biggest drivers of the racial difference in gout prevalence among women were poverty itself, and excess BMI, which can be influenced by poverty.**"
  - The authors suggested that Primary care providers need to adopt a holistic approach to gout management that involves counseling about good nutrition, smoking cessation, regular exercise, and limiting alcohol consumption, in addition to medication adherence.

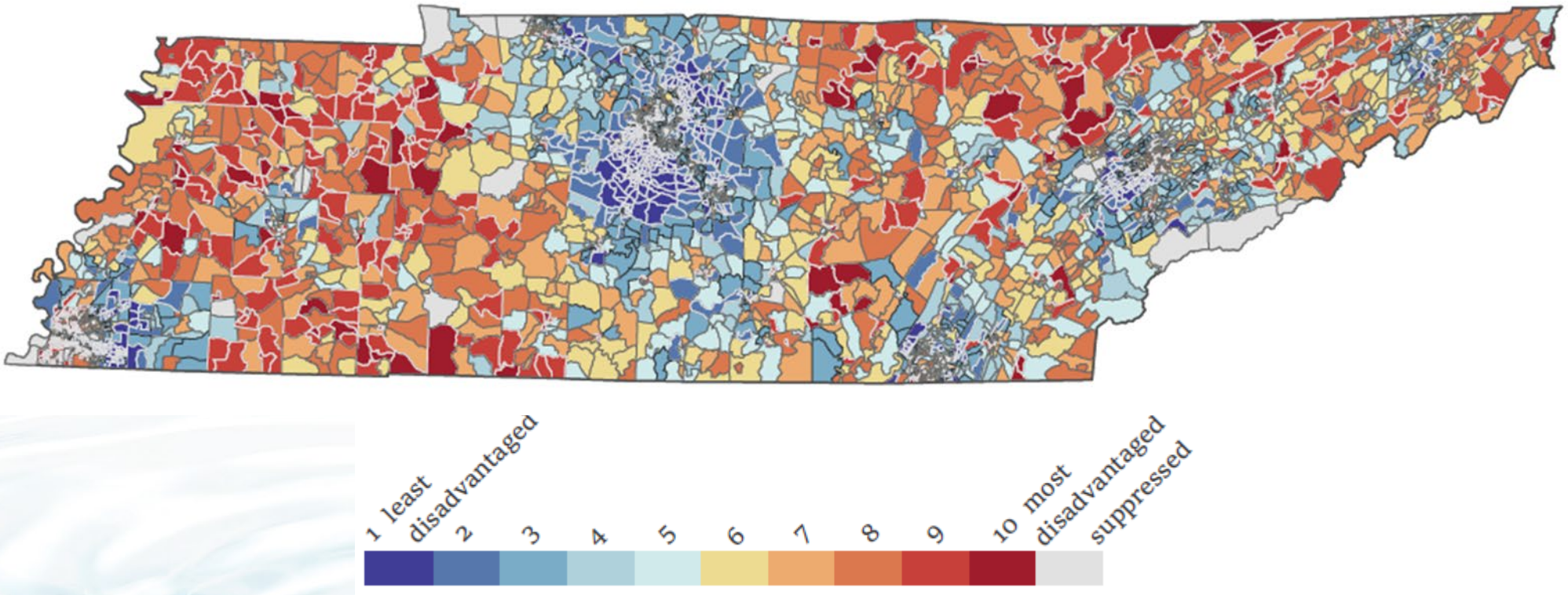
Health Equity/Social Determinants of Health in Practice

- **Health Equity/Social Determinants of Health Application**
  - This research discovered that significantly more black women and men were currently taking diuretics, compared with their white counterparts and therefore, clinicians should give more thought to medical therapies prescribed for conditions like high blood pressure to patients with gout or at risk for gout.
  - One author indicated that diuretic use is a driver of gout and stated, a prescriber "may want to consider different therapies that present a lower risk of gout if someone has hypertension. There could be greater consideration for prescribing alternatives to diuretics."

Health Equity/Social Determinants of Health in Practice

- **Health Equity/Social Determinants of Health Application**
  - Study: Socioeconomic factors influence stroke outcomes: A new study published in *Neurology* reveals that how well you fare after a stroke or other neurological event may come down to where you live.
    - Researchers used three years' worth of Medicare claims to identify nearly a million people aged 65 and older who had been hospitalized for various neurologic conditions like stroke, Alzheimer's disease, Parkinson's disease, epilepsy, coma, multiple sclerosis
    - The address of each of these patients was reviewed using a measurement called the **Area Deprivation Index (ADI)** to determine whether or not they lived in a socioeconomically disadvantaged neighborhood. The ADI takes things like the **housing quality**, **education**, **income** and **employment of neighborhood residents** to assign a score, and neighborhoods that score higher on the index are at a greater disadvantage. The study team then used these scores to look at which Medicare recipients died within a month after their hospitalization for one of the neurological conditions listed.
    - According to the report, 14.6% of stroke victims in the most disadvantaged neighborhoods died within the first month after their stroke, compared to 14.1% in advantaged neighborhoods.
    - For degenerative conditions like Alzheimer's disease and Parkinson's, 9.7% of the patients studied died within a month of hospitalization compared to 8.7% in advantaged neighborhoods.
    - Another 7.7% died within a month of hospitalization for epilepsy in disadvantaged neighborhoods compared to 6.8% in advantaged neighborhoods.
    - The study authors suggest that these results highlight the need for healthcare providers to examine neighborhood level access to care and how it can impact patient outcomes.

Area Deprivation Index Tennessee



Health Equity/Social Determinants of Health in Practice

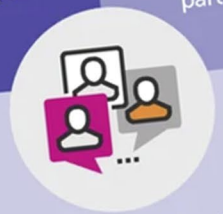
- “Living in a disadvantaged neighborhood has been linked to a number of healthcare outcomes, including higher rates of diabetes and cardiovascular disease, increased utilization of health services, and earlier death. Health interventions and policies that don't account for neighborhood disadvantage may be ineffective.” https://www.neighborhoodatlas.medicine.wisc.edu/
- **The Area Deprivation Index (ADI) …**allows for rankings of neighborhoods by socioeconomic disadvantage in a region of interest (e.g., at the state or national level). It includes factors for the theoretical domains of income, education, employment, and housing quality. It can be used to inform health delivery and policy, especially for the most disadvantaged neighborhood groups.

TOP 6 STRATEGIES TO UNDERSTAND AND ADDRESS SDOH

1 Start with member/patient experience to identify data about SDOH and implement interventions. Invest in a strategy that reveals gaps in data about SDOH. A data strategy that incorporates standard terminology and coding structures to compare third-party data, such as DMV records, prison records, dental records and credit bureaus, can help Medicaid MCOs and care delivery organizations learn more about the social factors impacting members. Partnering with companies like Aveus, a division of Medecision, can help organizations devise a strategy by understanding market demographics, leveraging data to create focus, identifying funding and grant opportunities, building community partnerships, and designing operational and cultural change plans.

2 Build collaborative care teams. Care team collaboration is important for ensuring that SDOH are addressed across multiple inpatient, ambulatory and community-based settings. Assign a central point-of-contact to support transitions in care and fill in the gaps.

3 Partner with community organizations. Community partners can help support members and assist them in finding housing, transportation, employment, food and other resources. Some health plans are even placing navigators in the community to support SDOH and interact with community partners—a new role for many plans.



4 Leverage technology. Use technology tools such as Aerial™, Medecision's HITRUST CSF®-certified, SaaS solution, which brings payers, providers and community-based organizations together to address SDOH as an integrated team.

5 Involve individuals, caregivers and supports. When people are connected to and educated on the resources and social supports they need, they will be more engaged in their care.

6 Measure your impact. Having measurable KPIs, such as health outcomes, utilization of healthcare services and medication adherence, can help determine success and help organizations identify areas for improvement.

Conclusion

- Health equity and Social determinants of health are now embedded into CMS' expectations for how we care for our residents.
- New MDS items have been added to begin the conversation, don't ignore them!
- New Quality measures for both SNF QRP and SNF VBP are also resident focused and can be used to address SDOH and Health Equity.
- Include a focus on SDOH and Health Equity in your CAAs, care pathway development and discharge planning.
- Consider that this is a significant opportunity to approach our residents from a new perspective.
- Embrace these changes!

QUESTIONS?

Find Out More

Contact Us:

Tricia Wood: Vice President, Business Development (Southern US)
twood@broadriverrehab.com
(919) 844-4800

Jeff Moyers: Vice President, Business Development (Southern US)
jmoyers@broadriverrehab.com
(828) 319-9618

Sign up for our Blog www.broadriverrehab.com

Ask an Expert https://www.broadriverrehab.com/expert/

Broad River Rehab Reflections are the third Thursday of each month. In August we will breakdown the FY 2024 SNF PPS Final Rule.

Qsource®

www.qsource.org

Culture of Safety Center 2023 Summit

Ensuring Quality of Care in Nursing Homes.
Protecting Quality of Life for Residents.

Lunch Break 11:15am-12:15pm

Qsource

www.qsource.org

Culture of Safety Center 2023 Summit

Ensuring Quality of Care in Nursing Homes.
Protecting Quality of Life for Residents.

Culture of Safety Project Overview

CSC Team

August 3, 2023

Qsource Long-Term Care Team

Linzie Bugg
Quality Improvement Advisor
lbugg@Qsource.org

Koreen Edwards
Quality Improvement Advisor
kedwards@Qsource.org

Amanda Odom
Quality Improvement Advisor
aodom@Qsource.org

Santana Mullins
Lead QI Advisor
smullins@Qsource.org

Tina Webster
Quality Improvement Advisor
twebster@Qsource.org

Kimberly Snyder
LTC Quality Specialist
ksnyder@Qsource.org

Jennifer Goodpaster
LTC Quality Director
jgoodpaster@Qsource.org

Jonathon Pouliot
Consultant Pharmacist
jpouliot@qsource.org

Qsource®

Objectives

- CSC Project Overview
- Outcomes Review
- Targeted Measures
- Success Story

Qsource®

Who We Are

Qsource has nearly 50 years of experience working with healthcare providers, Medicare and Medicaid.

Currently operate in 11 states overseeing ESRD, EQRO and QIO activities.

Serves as the Medicare Quality Innovation Network-Quality Improvement Organization (QIN-QIO) for Indiana.

Qsource®

Civil Monetary Penalties

Civil monetary penalties are penalties imposed by the Centers for Medicare & Medicaid Services (CMS) on nursing homes for failing to meet federal regulations.

90% of funds are then returned to the State to improve the quality of life and care.

Qsource®

Source: www.tn.gov/health/health-program-areas/nursing-home-civil-monetary-penalty--cmp--quality-improvement-program.html

Top Citations in 2022

1. F-689 Free of Accident Hazards/Supervision/Devices
2. F-880 Infection Prevention & Control
3. F-812 Food Procurement, Store/Prepare/Serve-Sanitary
4. F-600 Free from Abuse and Neglect
5. F-609 Reporting of Alleged Violations
6. F-656 Develop/Implement Comprehensive Care Plan
7. F-657 Care Plan Timing and Revision
8. F-684 Quality of Care
9. F-550 Resident Rights/Exercise of Rights
10. F-610 Investigation/Prevention/Correction of Alleged Violation of Abuse

Qsource®

The Culture of Safety Center (CSC)

The Culture of Safety Center (CSC) is a coordinated collaborative effort in Tennessee to improve resident safety and quality of life in skilled nursing facilities (SNFs).

Aims:

Annual Summit

Nursing Home Regional Collaboratives

Qsource®

Project Summary

Driving Forces

- Continuous Learning
- Tests of Change
- Innovation
- Spread
- Action
- Data

Annual Summit

Led by Project Lead Advisory Council

Who
National Experts
Key Stakeholders
SNFs
Residents

What
Key Skills
Core Competencies
Best Practices

Regional Collaboratives

Led by Qsource QIAs

Who
Key Stakeholders
Recruited SNFs
Residents
TDH

What
Priority-focused Application of Skills (e.g. PDSA)

Technical Assistance

Led by Qsource QIAs

Who
SNF PIP Team
SNF Leadership
Mentors
Residents

What
Local Application of Skills by Priority (e.g. PDSA)

Qsource®

Benefits of Participating in CSC Collaborative

- New skills
- Troubleshoot challenges
- Share best practices
- Improve Quality Measure Scores and fulfill federal requirements
- Technical assistance
- Data analysis

Qsource®

Outcomes Review

- Recruited **42** SNFs
- Create **3** Collaboratives
- Target Measures
  - Falls
  - Staffing
  - Psychotropics
  - Pressure Injuries

- **100%** Root Cause Analysis Completed
- **100%** Technical Assistance to all
- **100%** Performance Improvement Project Completed
- Training Modules and Tools Offered
- Regional Collaborative Meetings Held

Qsource®

Facility Feedback

By participating in the Culture of Safety Center project with Qsource, we improved our outcome measures and learned new quality improvement techniques. We enhanced our culture of safety through the expertise gained from Qsource Advisors and shared experiences from the regional collaborative.

- Generations of Spencer; Year 1

Our QI Advisor has provided so many great tools for use and have guided our community, down the path to success as set goals to see reduction in falls and have achieved that month after month. Our facility team also worked with the Quality Improvement Advisor to help enhance our QAPI program. Additional education was provided to our administrative team, and they became much more knowledgeable about the QAPI process. Our QAPI meetings became more meaningful and productive.

-Community Care of Rutherford; Year 2

Qsource®

Facility Feedback (cont.)

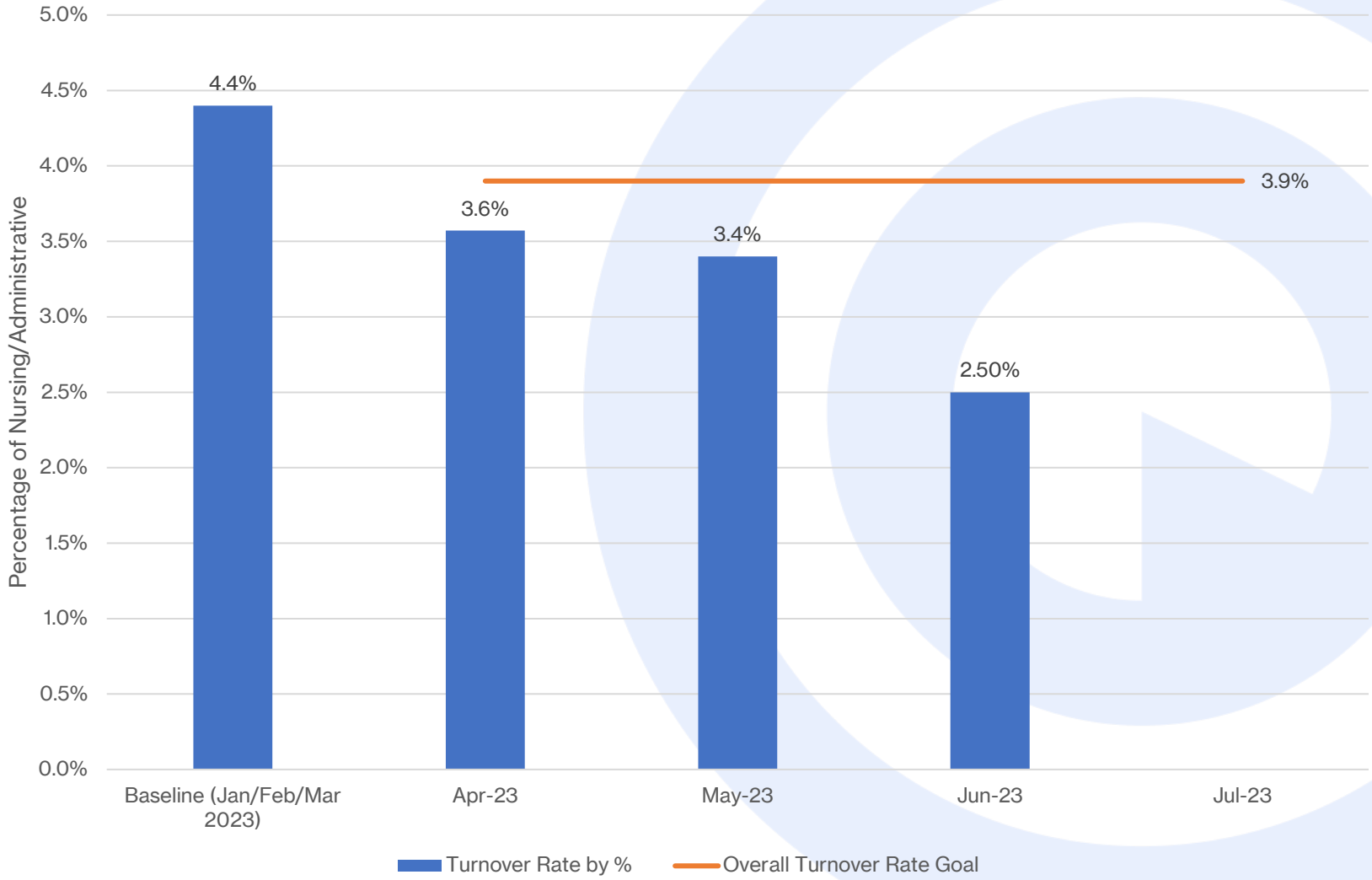
I cannot say enough good things about this program. We have worked on psychotropic reduction which is right in line with the state requirements. This group has helped me with a patient each month this year to reduce the usage for that patient. They brought in a pharmacist each meeting to help also. Our psych rate has been reduced because of this program. Last year was a tremendous help with fall reduction. I am looking forward to another successful year next year with this good group. Thank you for all you do.

-Briarwood Community Living Center; Year 3

Qsource®

Percentage of Overall Nursing & Administrative Staff Who Were Terminated/Resigned during the Month Baseline and Goal (10% RIR)

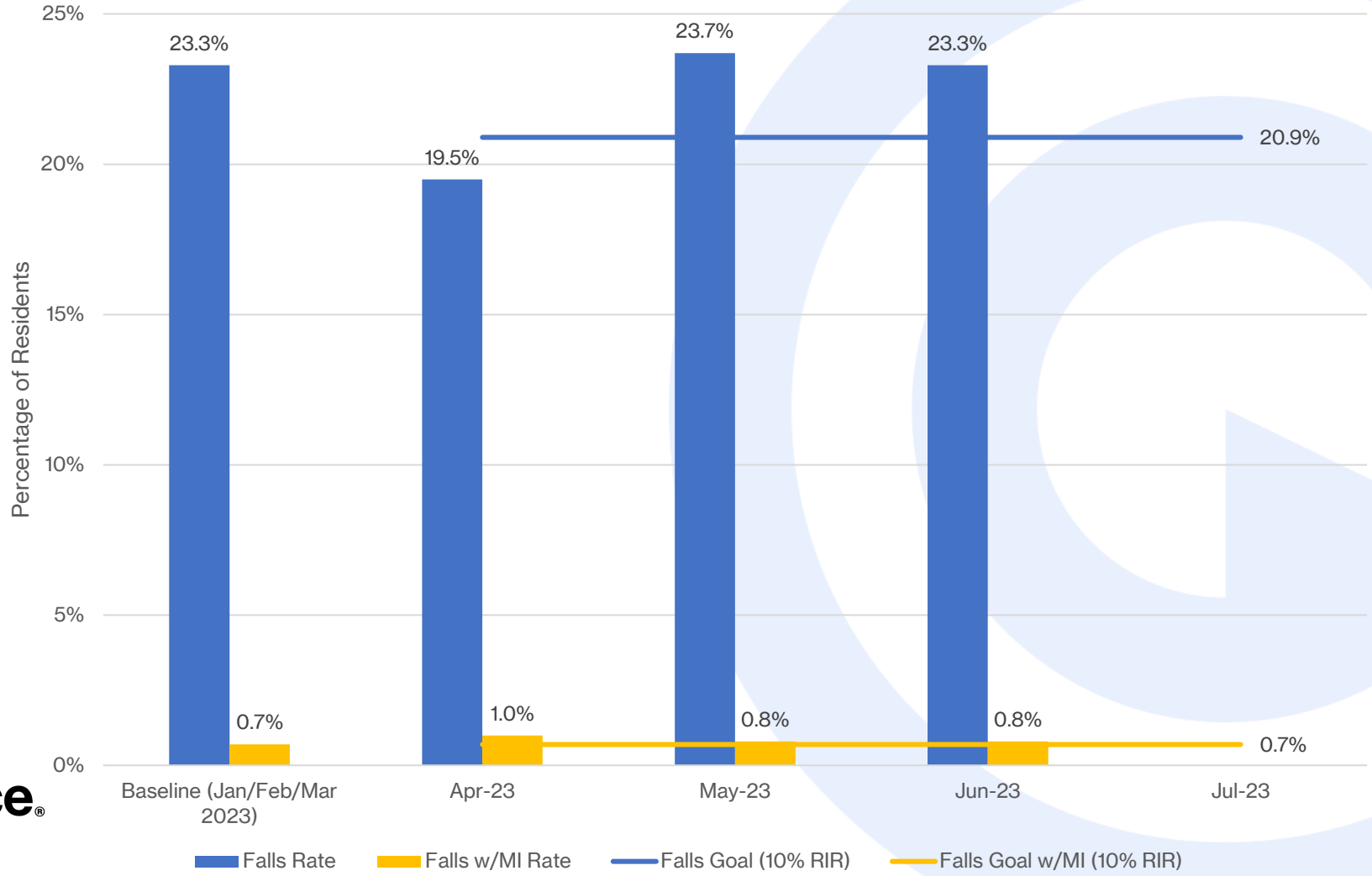
(Lower percentage indicates better performance)



Qsource®

Percentage of Falls and Percentage of Falls with Major Injury Baseline and Goal (10% RIR)

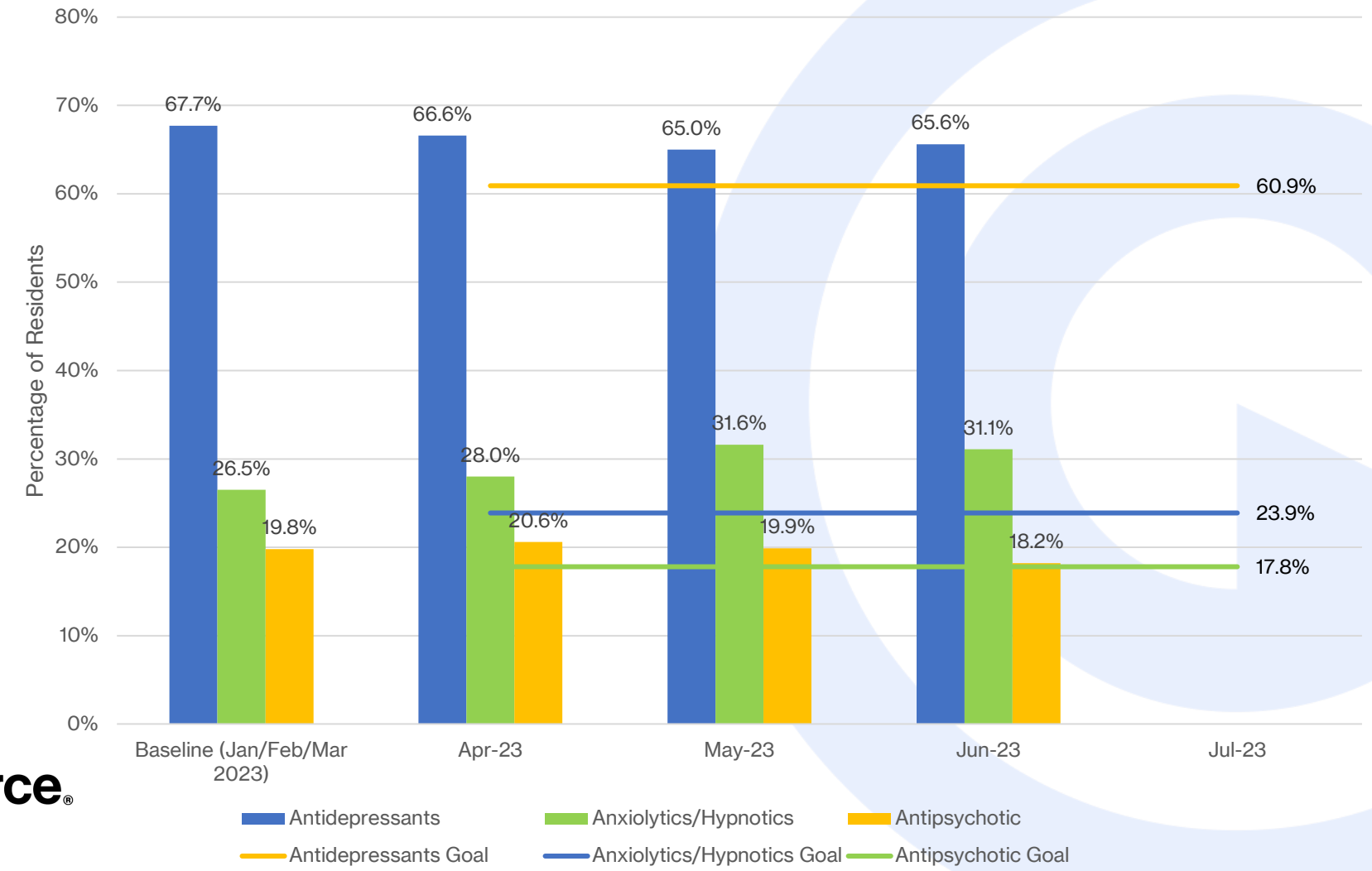
(lower percentage indicates better performance)



Qsource®

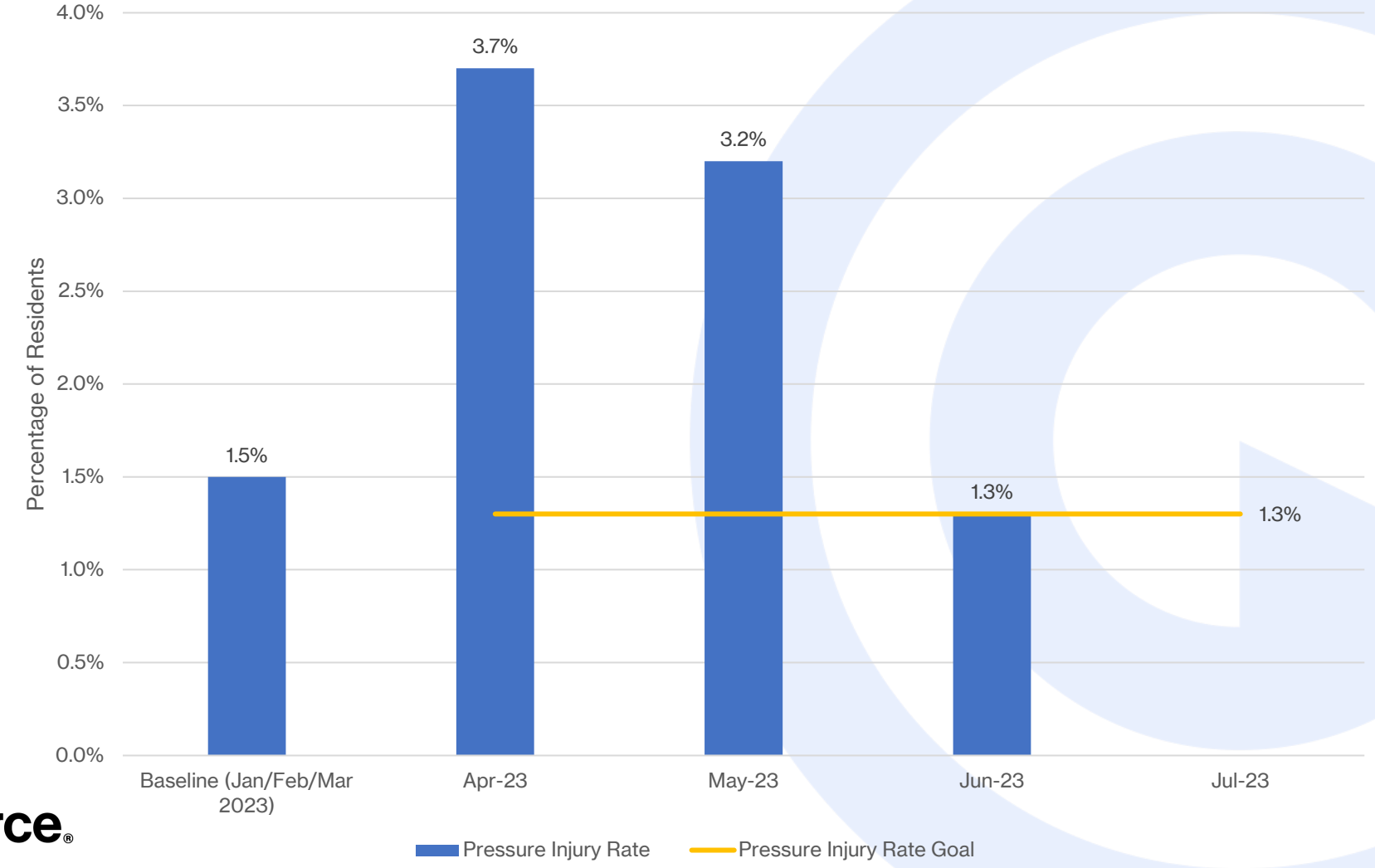
Percentage of Residents Who Received any Psychotropic Medication Baseline and Goal (10% RIR)

(lower percentage indicates better performance)



Qsource®

Percentage of Pressure Injuries Baseline and Goal (10% RIR) (lower percentage indicates better performance)



Qsource®

Success Story

Elk River Health & Nursing Center
Fayetteville, TN

Maggie Jewell, Director of Nursing

Lisa Veteto, Administrator

Qsource®

Qsource®

www.qsource.org

Culture of Safety Center 2023 Summit

Ensuring Quality of Care in Nursing Homes.
Protecting Quality of Life for Residents.

Break 12:45pm-1:00pm

Department of Health

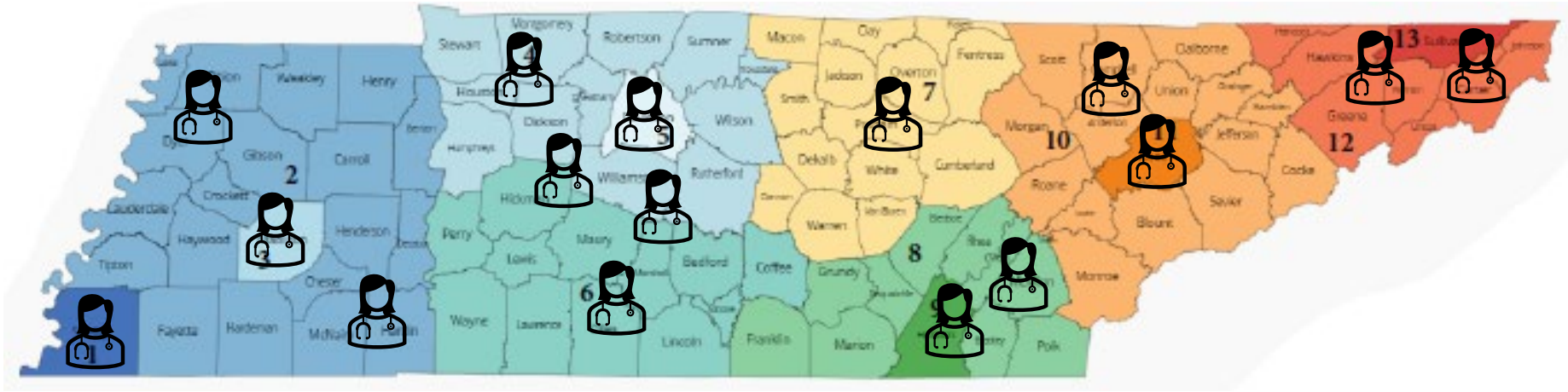
Legionellosis in Healthcare

Water Management, Infection Control, and Outbreak Response

Kelley Tobey MPH, BSN, RN, CIC | Infection Prevention Specialist 2
Becky Meyer MPH, CIC | Infection Prevention Specialist 1

HAI/AR IP
Team Introduction

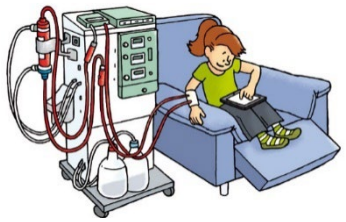
HAI (Healthcare-Associated Infections)
Infection Prevention Specialist Network



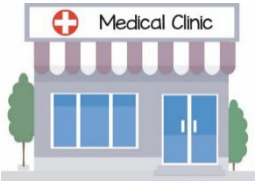
Diverse, Multi-Disciplinary Team

- 310 + years cumulative nursing experience
- 196 + years cumulative IPC experience
- 13 years epidemiology experience
- Dialysis, Emergency Medicine, Trauma-Critical Care, Med Surg, PACU, Public Health, NICU, Pediatrics, Labor & Delivery, Organ Transplantation, Surgery, Cardiology, Home Health/Hospice, Dental Hygiene, Critical Care, Microbiology, Inpatient Rehabilitation, LTCF, and Project Management
- 12 – Certification In Infection Control & Epidemiology (CIC)
- 2- Certification in Infection Control for LTCF (CIC-LTC)
- 6 – Past/Present APIC Officers or Board Members

Facilities Served



- Acute Care/Critical Access Hospitals
- Nursing Homes
- Assisted Living Facilities
- Residential Homes for Aged
- Substance Abuse Treatment Facilities
- Outpatient Clinics/Providers
- Public Health Clinics
- Ambulatory Surgery Centers
- Group Homes
- Long Term Acute Care Hospitals
- Skilled Nursing Facilities (Ventilators)
- Dialysis Centers
- Regional/Local Health Departments
- Health Care Coalitions
- Rehab facilities
- Dental Clinics
- Podiatry



Consultants only, non-regulatory

- Support ALL Healthcare Facilities
  - HAI.Health@tn.gov
  - Regional/Local Health Departments & Clinics

✗ Surveyors

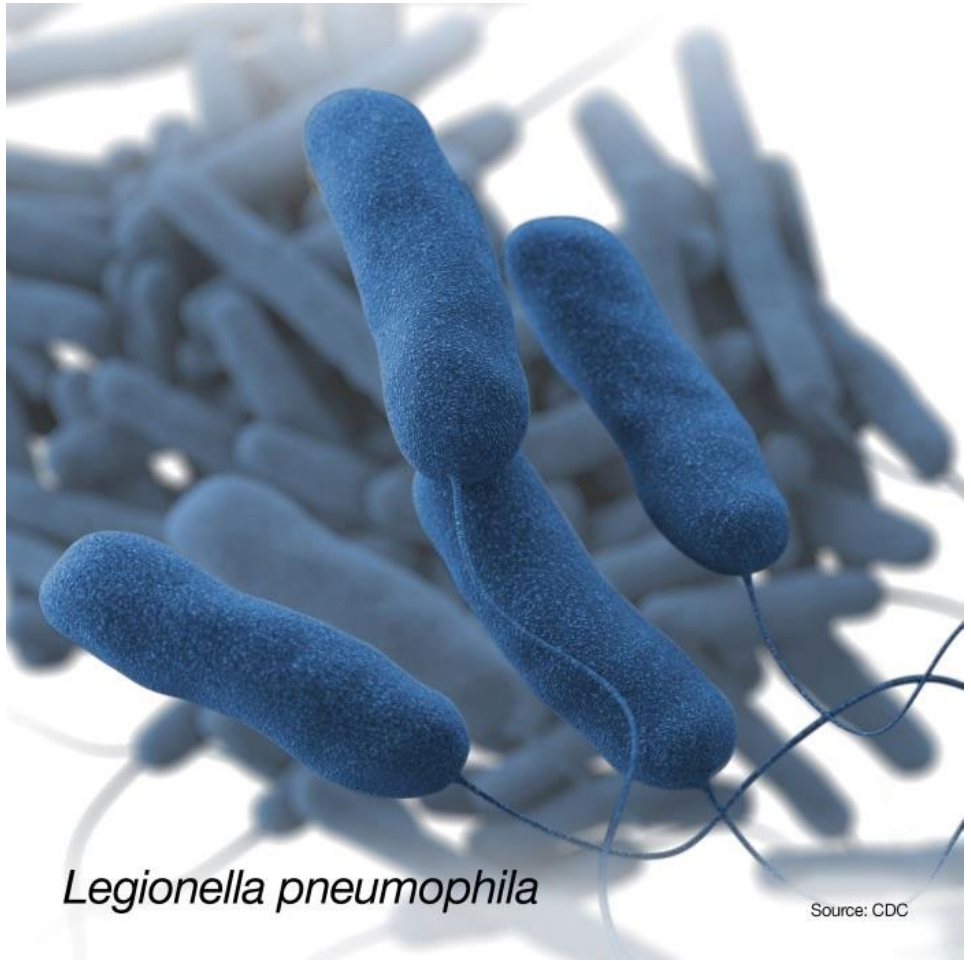
✗ Regulatory

✓ **Provide resources, guidance, and support**

Legionella Background

Legionella bacteria

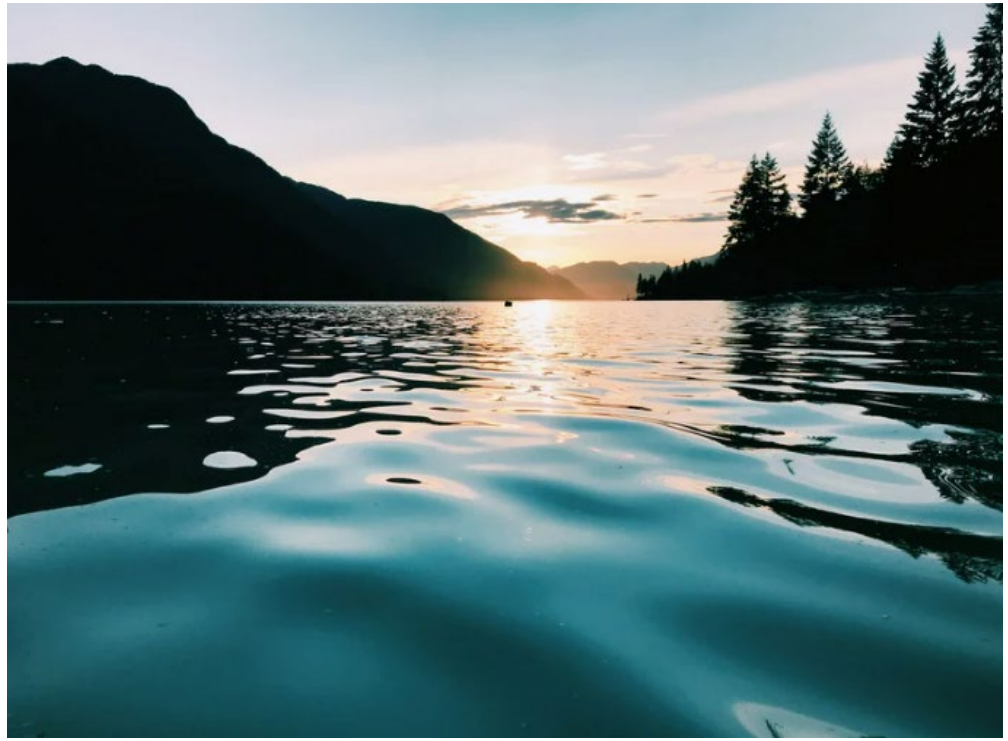
- 52 *Legionella* bacteria species
- *L. pneumophila* serogroup 1 responsible for the majority of human illness



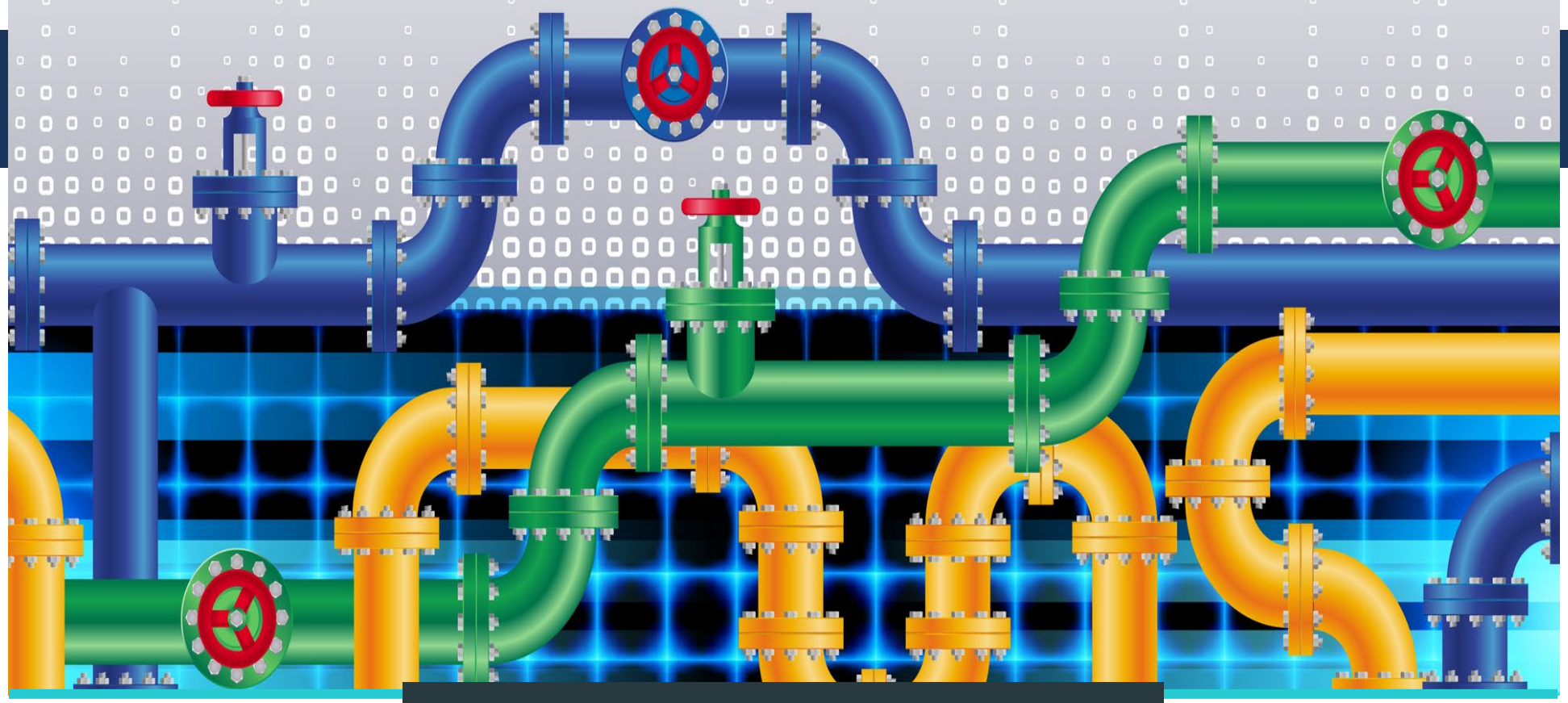
About Legionnaires Disease and Pontiac Fever | CDC

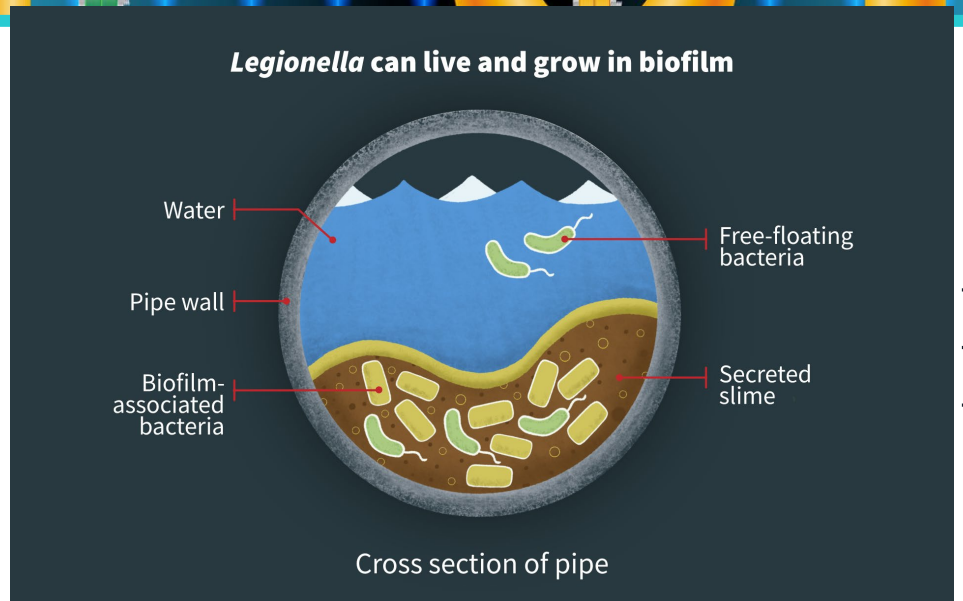
Legionella bacteria

- Exists naturally in the environment in lakes, rivers, streams, and soil



About Legionnaires Disease and Pontiac Fever | CDC

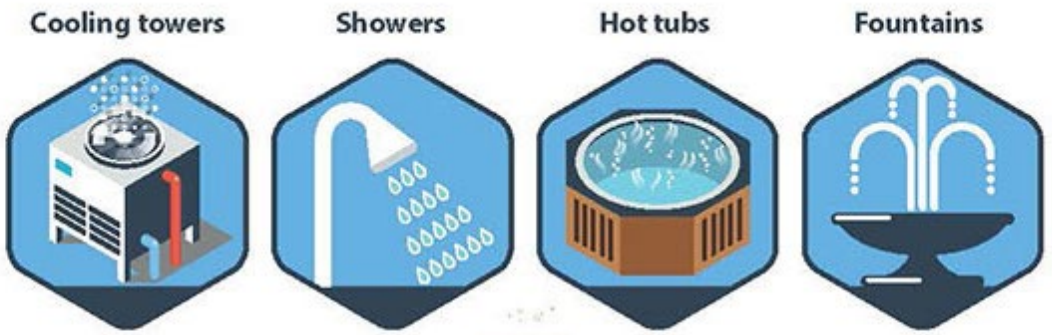




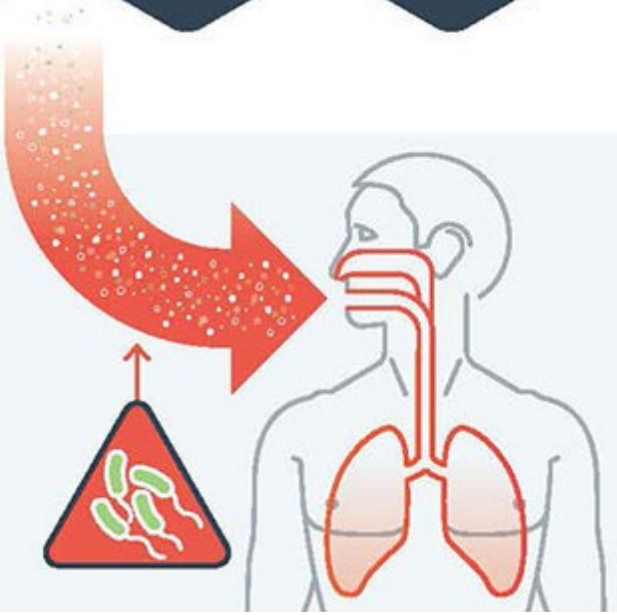
NIST Identifies Critical Needs for Improved Plumbing | NIST

How Legionella Affects Building Water Systems and People

Water containing *Legionella* is aerosolized through devices.



People can get sick when they breathe in small droplets of water or accidently swallow water containing *Legionella* into the lungs. Those at increased risk are adults 50 years or older, current or former smokers, and people with a weakened immune system or chronic disease.



How Legionella Affects Building Water Systems and People Infographic | CDC

Additional Transmission Routes in Healthcare

- Splashing from sink drains
- Preparing injections / medications near sinks
- Improper oral care in immunocompromised patients
- Using poor quality water for immunocompromised patients (e.g., contaminated ice)

See Infographic Here: https://www.cdc.gov/hai/prevent/environment/water.html

Legionnaires' Disease : Clinical Features

- Wide range of illness severity
- Symptoms: fever, cough, shortness of breath, gastrointestinal symptoms (diarrhea, nausea, vomiting, abdominal pain), malaise, neurologic signs
- Abnormal radiographic findings on chest x-ray
- Incubation period: 2-14 days
- Case Fatality Rate: ~10%

Fever/Chills

Cough/Dyspnea

Vomiting/Diarrhea

Confusion/AMS

https://www.cdc.gov/legionella/clinicians/clinical-features.html

Healthcare Settings are High Risk

- Complex water systems
- Serve vulnerable population

Knowledge Check 1

The optimal temperature growth range for *Legionella* is:

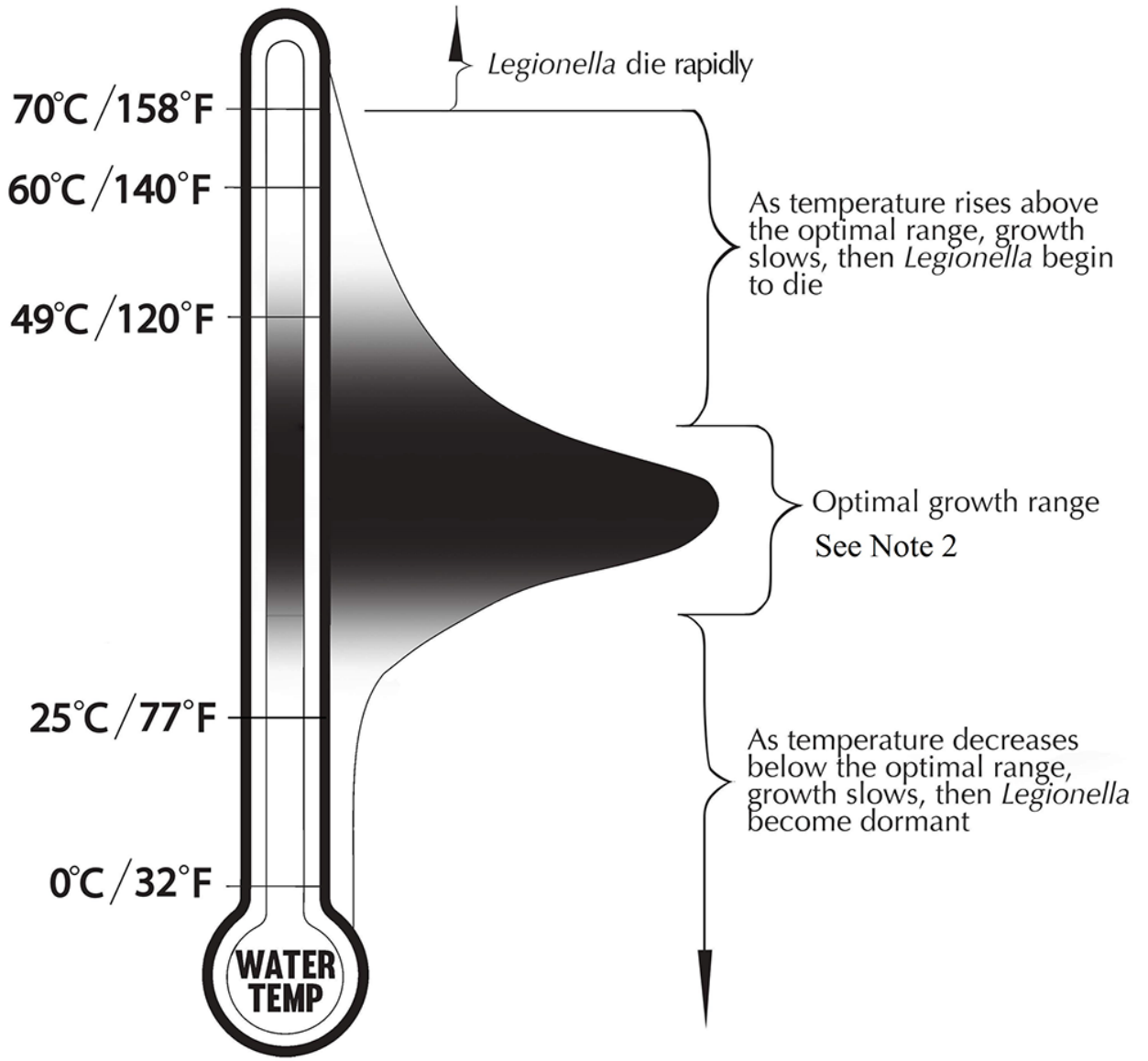
a. 0 °F – 32 °F
b. 32 °F - 77 °F
c. 77 °F - 113 °F
d. 120 °F - 140 °F

Knowledge Check 1

The optimal temperature growth range for *Legionella* is:

a. 0 °F – 32 °F
b. 32 °F - 77 °F
c. 77 °F - 113 °F
d. 120 °F - 140 °F

Knowledge Check 1 - Rationale



ASHRAE Guideline 12-2020

Legionella Outbreaks Occur in Healthcare Facilities

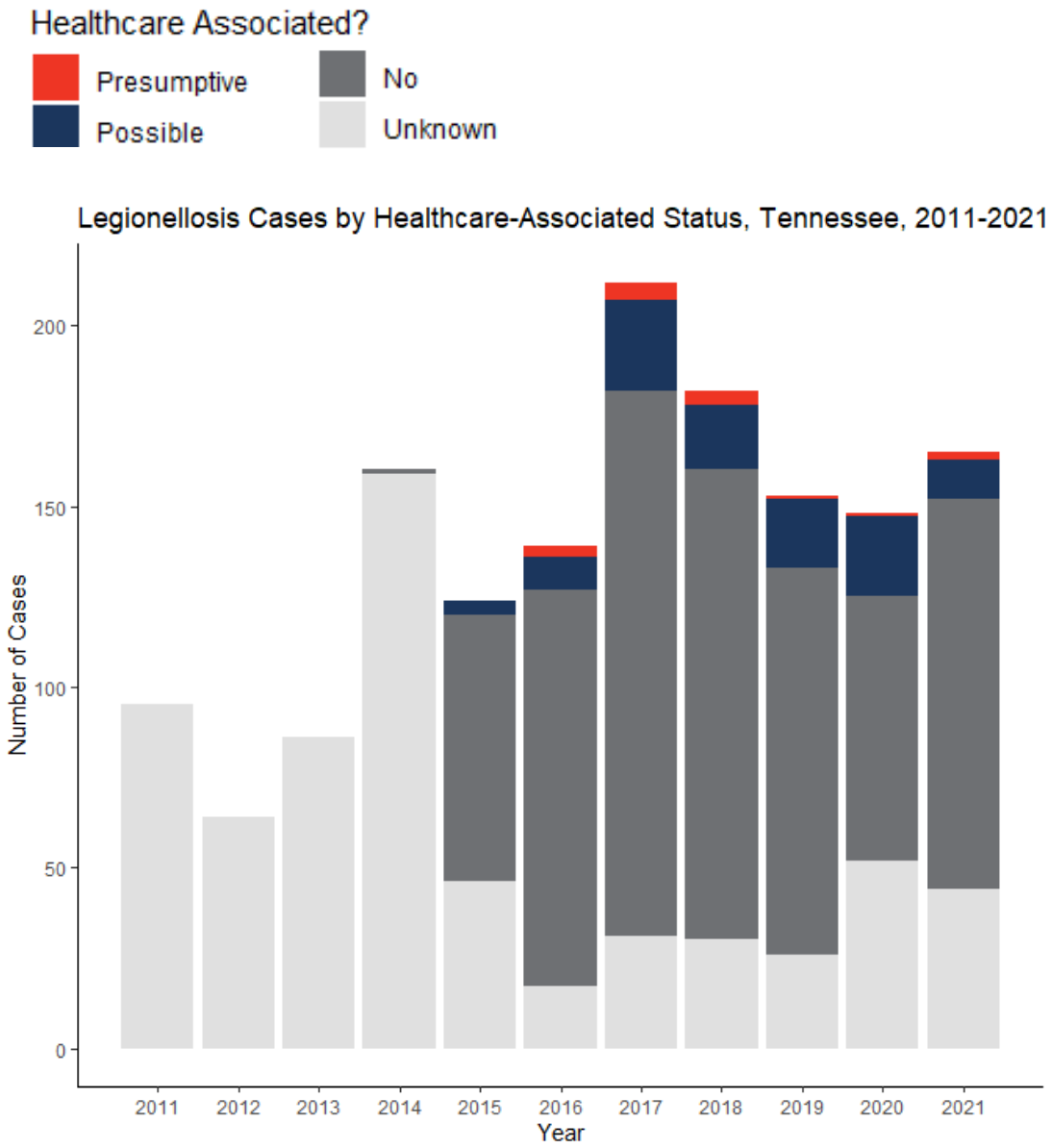
Healthcare-Associated Legionnaire's Disease

- **Possible healthcare-associated case**: Patient **spent a portion of the 14-day incubation period** in one or more healthcare facilities

- **Presumptive healthcare-associated case:** Patient spent **≥10 days of continuous stay** at a healthcare facility during their 14-day incubation period

- **Cluster/Outbreak:** Two or more people with Legionnaires' disease exposed to *Legionella* at the same place at about the same time (Per TDH Waterborne Team)

Are Healthcare-Associated Cases Common?



2022 Legionellosis Cases	
112 YTD	
HC-Associated Legionellosis Cases	
12 **Possible** (<10 days in facility before onset)	5 **Presumptive** (≥10 days in facility before onset)

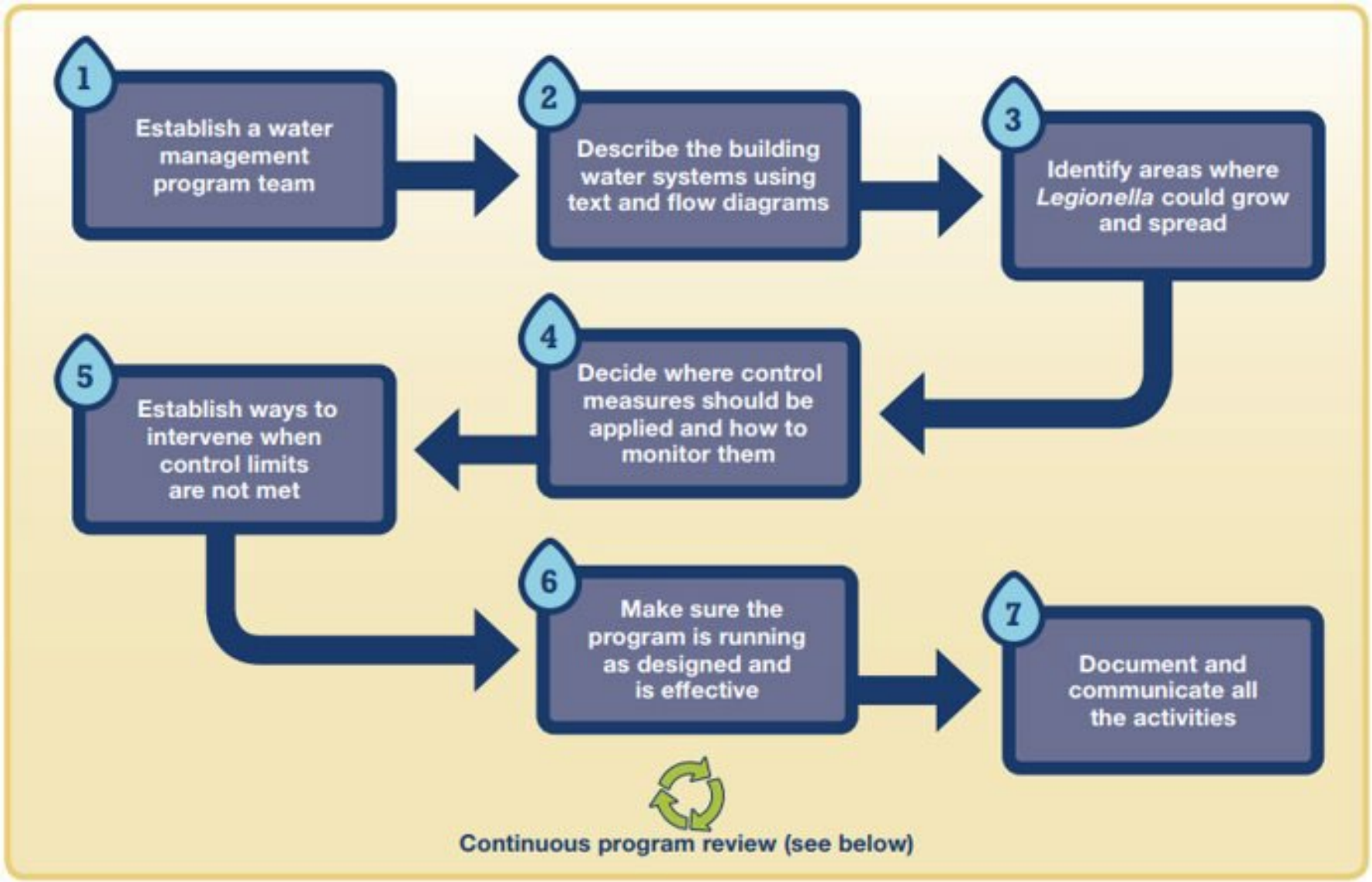
Water Management Plan – Content and Development

Water Management Program

Water management programs identify hazardous conditions and take steps to minimize the growth and transmission of *Legionella* and other waterborne pathogens in building water systems.

Steps for Development of a Water Management Program

https://www.cdc.gov/legionella/downloads/toolkit.pdf



Outbreak Prevention

9 in 10

CDC investigations show almost all outbreaks were caused by problems preventable with more effective water management.

What causes the Legionnaires' disease outbreaks that CDC investigates?

- About 1 in 2 (48%) are due to **more than one** of the following problems.
- About 2 in 3 (65%) are due to **process failures**, like not having a *Legionella* water management program.
- About 1 in 2 (52%) are due to **human error**, such as a hot tub filter not being cleaned or replaced as recommended by the manufacturer.
- About 1 in 3 (35%) are due to **equipment**, such as a disinfection system, not working.
- About 1 in 3 (35%) are due to **changes in water quality** from reasons external to the building itself, like nearby construction.

Legionnaires' Disease | VitalSigns | CDC

Knowledge Check 2

- Which of these devices do *not* pose a risk for Legionella growth?

a. Electric A/C units
b. Low-flow shower fixtures
c. Ice machines
d. Dental waterlines
e. Windshield wiper fluid tank of a vehicle

Knowledge Check 2

- Which of these devices do *not* pose a risk for Legionella growth?

a. **Electric A/C units**
b. Low-flow shower fixtures
c. Ice machines
d. Dental waterlines
e. Windshield wiper fluid tank of a vehicle

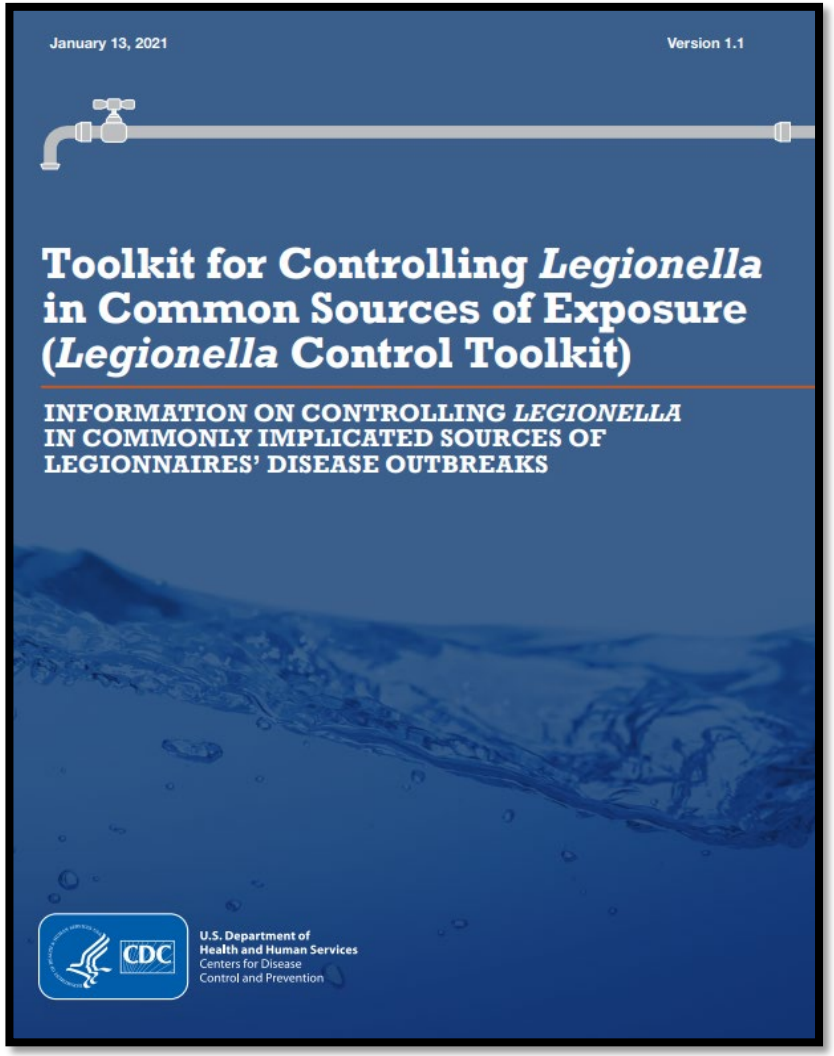
Knowledge Check 2 Rationale

ASHRAE Guideline 12 Lists the following devices as having the potential to grow *Legionella*:

- Sink faucets
- Shower heads
- Cooling towers
- Evaporative condensers
- Decorative fountains
- Whirlpool spas
- Humidifiers
- Misters
- Respiratory therapy equipment (rinsed with tap water)
- Dental unit water lines
- Ice machines

Guidelines for Environmental Infection Control in Health-Care Facilities

CDC Legionella Control Toolkit - Outbreak



https://www.cdc.gov/legionella/wmp/control-toolkit/index.html

Outbreak Investigation

- Groups involved
  - Local Public Health
  - Environmental Health
  - Waterborne Program
  - Infection Prevention Specialists

- Sampling – determine multiple testing locations and test for chlorine, pH, and temperature. Samples sent in for culture and PCR.

- When to expect results - as long as 2 weeks

- What happens next? - interpretation, review, and remediation

A Word about Remediation

- *"Even when successful, remedial treatment is only a temporary measure.* ***Recolonization is very likely to occur unless the underlying reasons for Legionella colonization are addressed****."*

ASHRAE Guideline 12

Remediation

- What does remediation entail?
  - Varies depending on building age and pipe composition, etc.

- Chemical Shock
  - Used on hot or cold-water systems using chemical disinfectants such as chlorine for a short period (1-24 hours)

- Thermal Shock
  - Use of very high-temperature water for treatment of a hot-water system. Cannot be used on cold-water systems.

Regulation and Standards

CMS Requirement to Reduce Legionella Risk

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop C2-21-16
Baltimore, Maryland 21244-1850

CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES

Center for Clinical Standards and Quality/Survey & Certification Group

Ref: S&C 17-30-*Hospitals/CAHs/NHs*
REVISED 06.09.2017

DATE: **June 02, 2017**

TO: State Survey Agency Directors

FROM: Director
Survey and Certification Group

SUBJECT: Requirement to Reduce *Legionella* Risk in Healthcare Facility Water Systems to Prevent Cases and Outbreaks of Legionnaires' Disease (LD)

Requirement to Reduce Legionella Risk in Healthcare Facility Water Systems to Prevent Cases and Outbreaks of Legionnaires Disease (LD) | CMS

CMS Requirement to Reduce Legionella Risk

- The updated CMS requirements include:
  - Conducting a facility risk assessment
  - Developing a water management program
  - Developing of a protocol for testing control measures, setting ranges and creating a response plan

QSO17-30-18 (cms.gov)

Tennessee State Operations Manual – 2023 Update

State Operations Manual
Appendix PP - Guidance to Surveyors for Long Term Care Facilities

Table of Contents
(Rev. 211, 02-03-23)

Facilities must be able to demonstrate its measures to minimize the risk of Legionella and other opportunistic pathogens in building water systems such as by having a documented water management program. Water management must be based on nationally accepted standards (e.g., ASHRAE (formerly the American Society of Heating, Refrigerating, and Air Conditioning Engineers), CDC, U.S. Environmental Protection Agency or EPA) and include:

- *An assessment to identify where Legionella and other opportunistic waterborne pathogens (e.g., Pseudomonas, Acinetobacter) could grow and spread; and*
- *Measures to prevent the growth of opportunistic waterborne pathogens (also known as control measures), and how to monitor them.*

At this time, CMS does not require water cultures for Legionella or other opportunistic waterborne pathogens as part of routine program validation, although there may be instances when it is needed (e.g., a case of healthcare-associated legionellosis or a potential outbreak of legionellosis in the facility).

State Operations Manual -Appendix PP - Guidance to Surveyors for LTCF

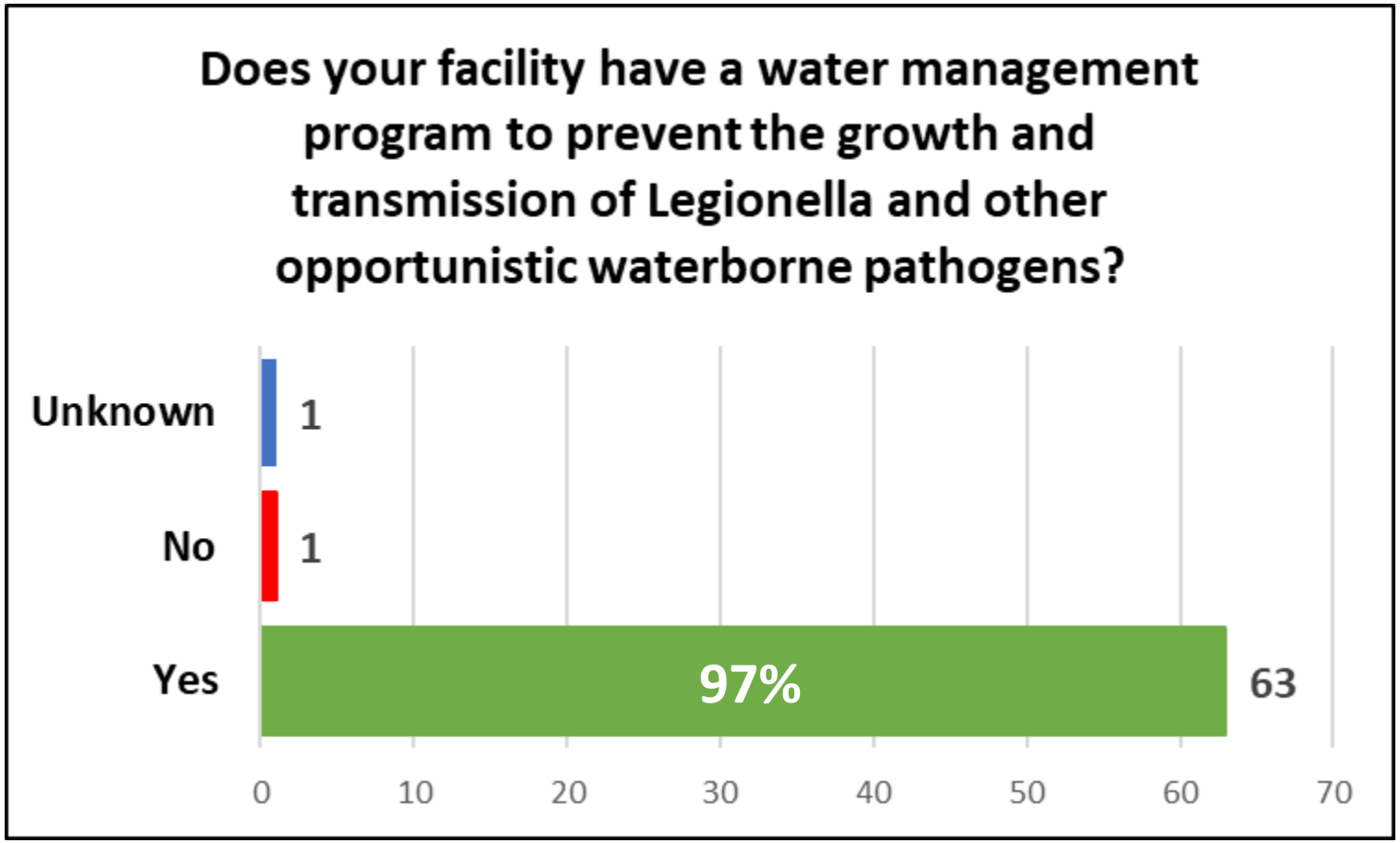
Questions to Expect from Regulatory

1. Does this facility have a water management program?
2. If yes, can we see a copy?
3. Has the facility done a risk assessment?
4. If yes, what were the results?
5. What are your control measures?
6. How do you monitor them, and what is the plan if they're out of range?

Regulatory Finding Examples

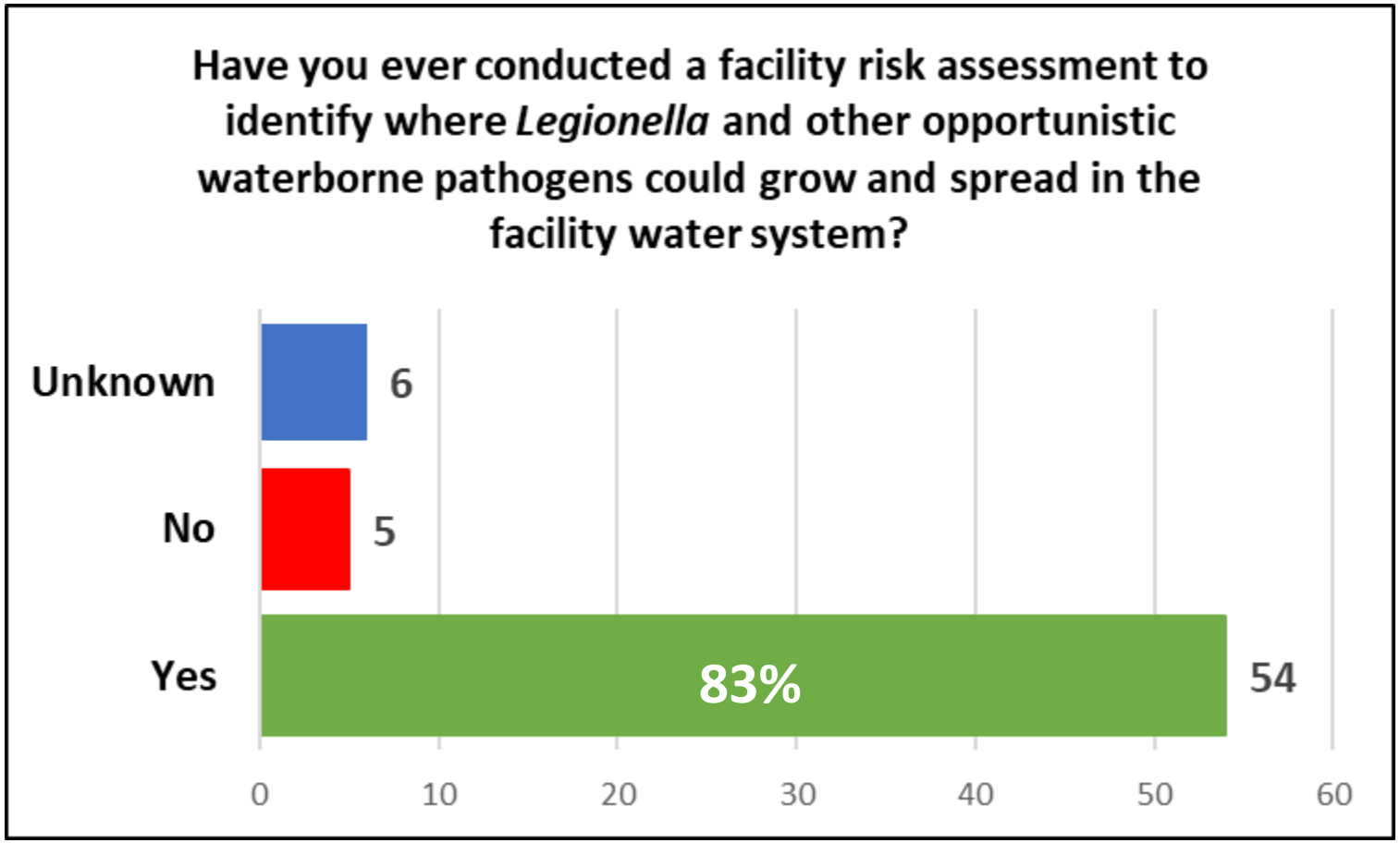
- There were no records to show when the (water management) plan was last reviewed.
- The water management plan did not include an assessment.
- There were no records of any control measures being followed.
- Surveyors interviewed staff to assess familiarity with WMP, facility policy, and Legionella prevention

NHSN LTCF 2022 Data Slide 1



NHSN LTCF Annual Survey Data: Accessed from NHSN Spring 2023

NHSN LTCF 2022 Data Slide 2



NHSN LTCF Annual Survey Data: Accessed from NHSN Spring 2023

NHSN LTCF 2022 Data Slide 3

Who is represented on the water management program team at your facility?

Role	Yes	No
Infection Preventionist	60%	40%
Facilities Manager/Engineer	32%	68%
Maintenance Staff	82%	18%
Risk/Quality Management	18%	82%

NHSN LTCF Annual Survey Data: Accessed from NHSN Spring 2023

NHSN LTCF 2022 Data Slide 4

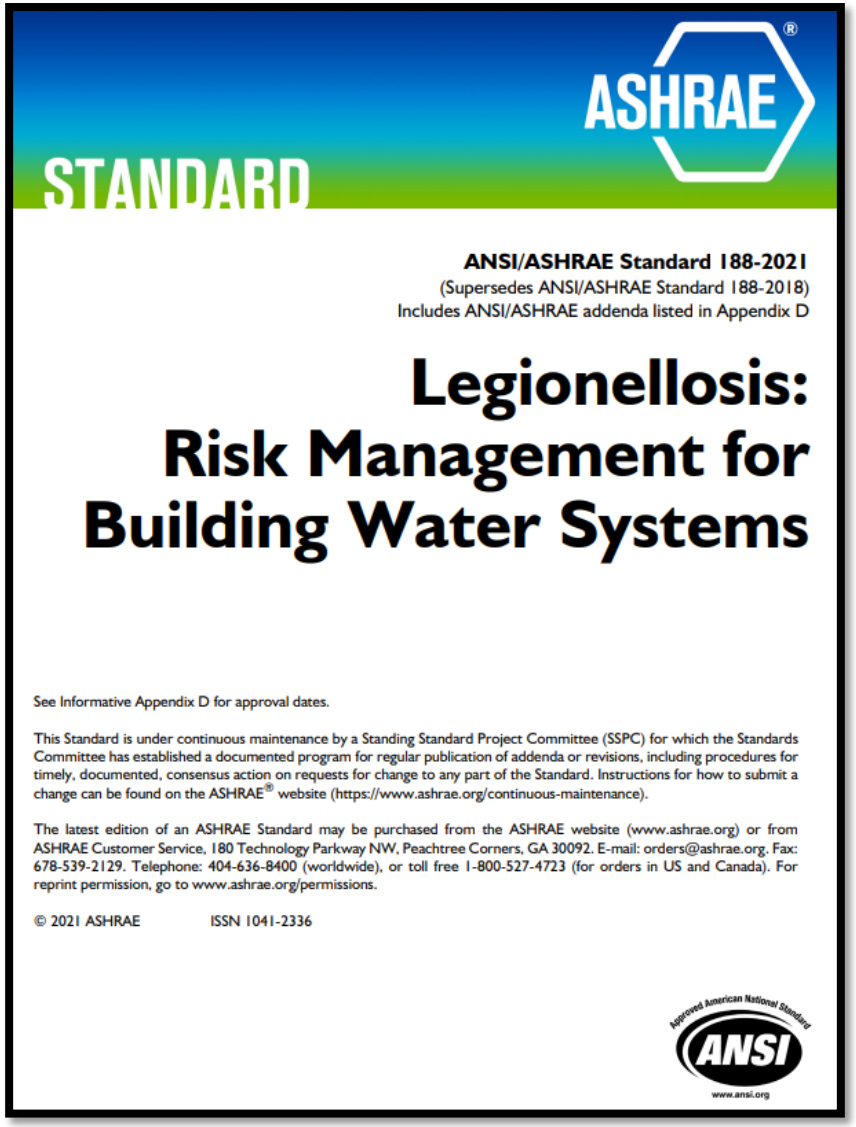
Do you regularly monitor _____ in your building's water system?*

Measure	Yes	No	Unknown
Disinfectant	58%	37%	5%
Heterotrophic Plate Counts	45%	52%	3%
"Specific Tests"	78%	20%	2%
Temperature	94%	5%	2%

*Cumulative totals exceeding 100% are due to rounding

NHSN LTCF Annual Survey Data: Accessed from NHSN Spring 2023

ASHRAE Standard 188



STANDARD

ANSI/ASHRAE Standard 188-2021
(Supersedes ANSI/ASHRAE Standard 188-2018)
Includes ANSI/ASHRAE addenda listed in Appendix D

Legionellosis: Risk Management for Building Water Systems

See Informative Appendix D for approval dates.

This Standard is under continuous maintenance by a Standing Standard Project Committee (SSPC) for which the Standards Committee has established a documented program for regular publication of addenda or revisions, including procedures for timely, documented, consensus action on requests for change to any part of the Standard. Instructions for how to submit a change can be found on the ASHRAE® website (https://www.ashrae.org/continuous-maintenance).

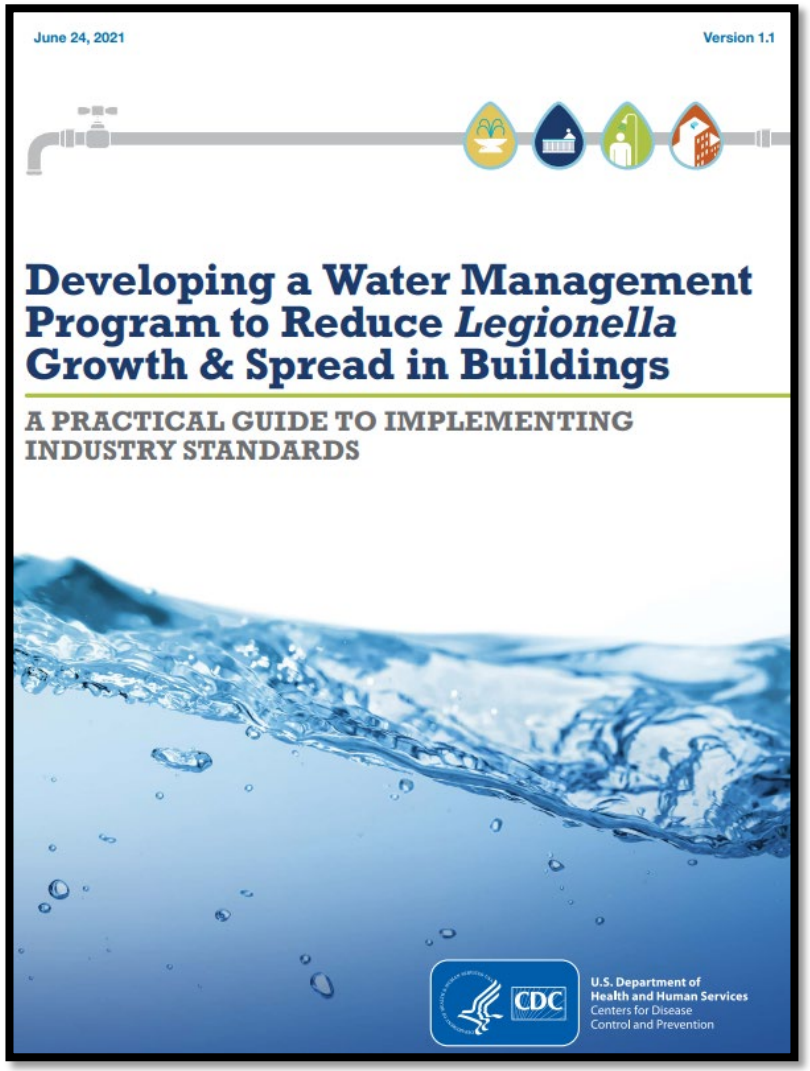
The latest edition of an ASHRAE Standard may be purchased from the ASHRAE website (www.ashrae.org) or from ASHRAE Customer Service, 180 Technology Parkway NW, Peachtree Corners, GA 30092. E-mail: orders@ashrae.org. Fax: 678-539-2129. Telephone: 404-636-8400 (worldwide), or toll free 1-800-527-4723 (for orders in US and Canada). For reprint permission, go to www.ashrae.org/permissions.

 ISSN 1041-2336

Approved American National Standard
ANSI
www.ansi.org

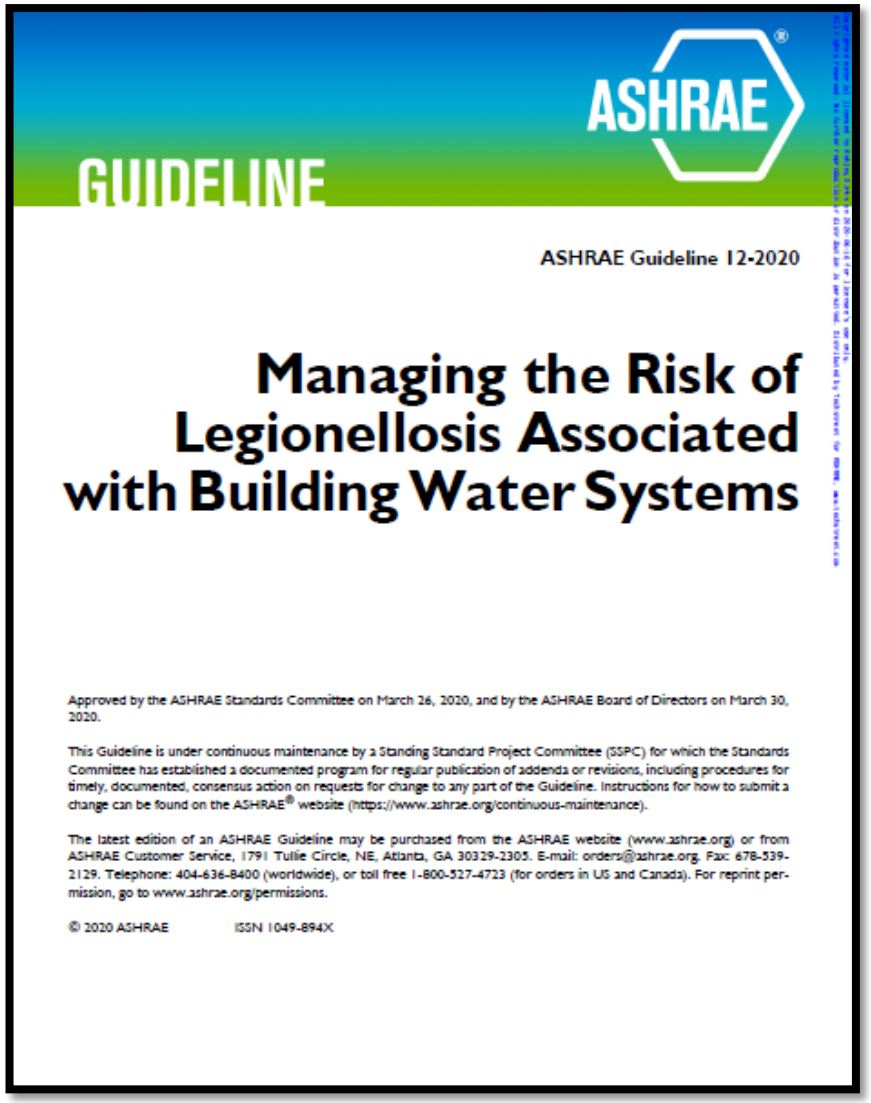
ASHRAE 188-2021

CDC Legionella Toolkit - Prevention



https://www.cdc.gov/legionella/wmp/toolkit/index.html

ASHRAE Guideline 12



Guideline 12-2020

Free Water Management Program Resources

- TDH Webinar Series
- CDC Prevent LD Training
- CDC Toolkit
- CSTE WMP Template

- Legionella.Health@tn.gov
- HAI.Health@tn.gov
- Legionellosis (tn.gov)

Knowledge Check 3

The following are all *Legionella* control measures **EXCEPT**:

a. Temperature control
b. Supplemental disinfection/treatment
c. Filtration
d. Flushing
e. Recirculation
f. Cleaning and maintenance
g. These are all control measures discussed in ASHRAE Guideline 12-2020

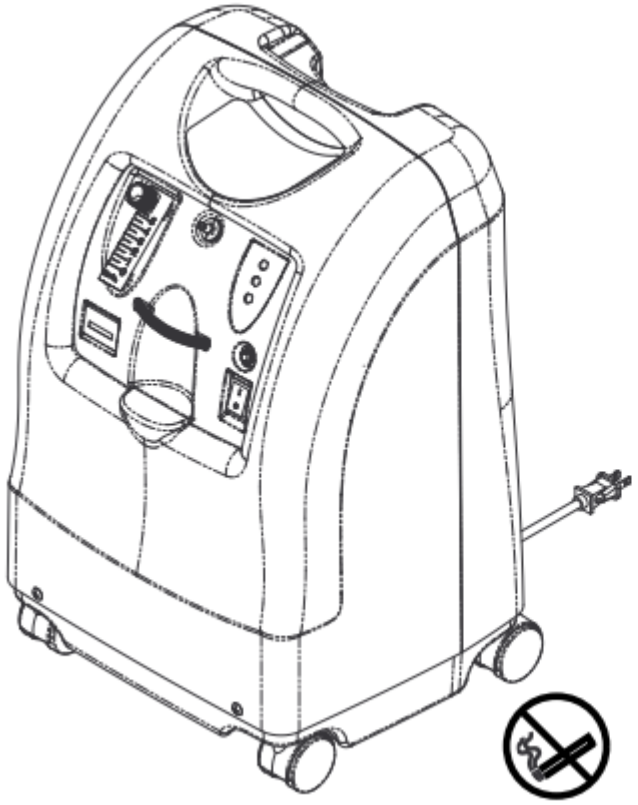
Respiratory Therapy

Knowledge Check 3

The following are all *Legionella* control measures **EXCEPT**:

a. Temperature Control
b. Supplemental disinfection/treatment
c. Filtration
d. Flushing
e. Recirculation
f. Cleaning and Maintenance
g. **These are all control measures discussed in ASHRAE Guideline 12-2020**

Manufacturer's Instructions for Use (IFU)



Invacare® Perfecto₂™ Oxygen Concentrator

IRC5PO2, IRC5PO2W, IRC5P, IRC5PW

en **HomeFill® System Compatible**
User Manual

User Manual
Manual de operación
Manuel d'utilisation

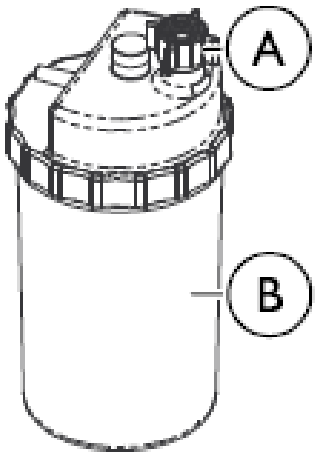
Stratos™ Compact

Compressor Nebulizer System
Model IRC 1710

Cleaning and Disinfection of O2 Concentrator

Invacare® Perfecto$_2$™ Oxygen Concentrator

Humidifier Bottle with Cap



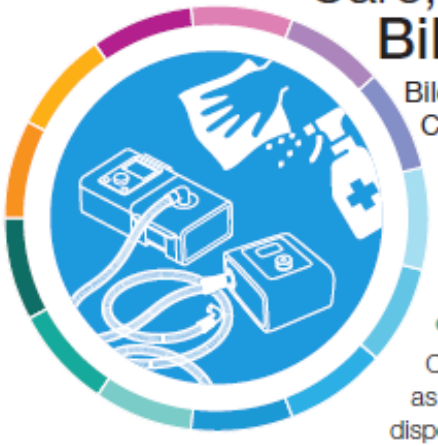
Humidifier Bottle without Cap

1. Remove cap Ⓐ from bottle Ⓑ.
2. Fill humidifier with boiled tap water or bottled water to the level indicated by the manufacturer. Boil tap water for approximately 10 minutes and cool to room temperature prior to use.

CPAP and BiPAP Cleaning and Disinfection

CHECKLIST 3

Care, cleaning and disinfection of **BiPAP/CPAP** devices



Bilevel or two-level Positive Airway Pressure (BiPAP).
Continuous Positive Airway Pressure (CPAP)

During non-invasive ventilation and between patients

Always read and follow the instructions and recommendations of the manufacturer's manual

Consumables associated with oxygen delivery are generally intended as **single use devices**, should be treated as infectious material and disposed of accordingly. Dispose of patient interface and filters, for example, as per facility standard operating procedures for infectious/biohazardous waste management.

DURING NON-INVASIVE VENTILATION (SAME PATIENT)

Before starting any hygiene tasks, please take preventative measures to ensure that:
All electrical medical equipment are disconnected from power supply while tasks are being done; and, activities are performed away from the medical wards, preferably in biomedical workshops.

Task	Description
1. **Humidifier must be washed, rinsed, and disinfected daily**	Oxygen bubble humidifier (non-heated bottle) must be washed, rinsed, and disinfected regularly when used for the same patient and after use between patients. Empty the water from the humidifier. Rinse the humidifier flask under running water. Fill in proper distilled water or cold boiled water within the scale between the top scale line and the lowest one. Do not use tap water (not-boiled), even if it is safe drinkable water. Do not use bottled water, even distilled, which has been stored in warm conditions. (These conditions allow bacterial growth in the water and

Care, cleaning and disinfection of BiPAP/CPAP devices (who.int)

Nebulizers and Inhaler Risk

Nosocomial Legionnaires' Disease and Use of Medication Nebulizers

Timothy D. Mastro, Barry S. Fields, Robert F. Breiman, Joyce Campbell, Brian D. Plikaytis, and John S. Spika

Respiratory Diseases Branch, Division of Bacterial Diseases, Center for Infectious Diseases, Centers for Disease Control, Atlanta, Georgia; Washington State Department of Social and Health Services, Seattle

Guidelines for the prevention of nosocomial pneumonia specify that only sterile fluids should be used for aerosol therapy; however, this recommendation may not be uniformly followed. Thirteen patients with nosocomial pneumonia due to *Legionella pneumophila* serogroup 3 (Lp3) were identified at a community hospital in the period from 1984 through 1988; 12 patients (92%) had chronic obstructive pulmonary disease; and 9 patients (69%) died. An epidemiologic investigation suggested that the use of nebulizers to deliver medication was associated with acquiring legionnaires' disease. The hospital potable water system was contaminated with Lp3, and a survey indicated that tap water was commonly used to wash medication nebulizers. Lp3 in respirable-size droplets was isolated from aerosols generated by a nebulizer containing Lp3 at one-tenth the concentration found in the hospital potable water. These findings support the recommendation that only sterile fluids be used for filling or cleaning respiratory care equipment and suggest that this guideline is not universally followed.

Nosocomial Legionnaires' disease and use of medication nebulizers - PubMed (nih.gov)

Nebulizers and Inhalers Risk

No tap water. Dry thoroughly *away* from sink.

Table 2. Recommendations for Nebulizer Care in the Hospital

Hand-held disposable nebulizers:

1) *After each use*, rinse out the residual volume with sterile water and wipe the mask/mouthpiece with an alcohol pad.
2) Discard the nebulizer every 24 h.

Hand-held reusable/durable nebulizers (home nebulizers):

1) *After each use*, clean, disinfect, rinse with sterile water (if using a cold disinfectant), and air-dry away from the sink.
2) *After each use*, the nebulizer can be reprocessed, such as steam sterilization or autoclave, if the reprocessing is performed according to the manufacturer's instructions and the Cystic Fibrosis Foundation recommendations for home care and if the nebulizer can be returned to the patient in time for the next treatment.

Device Cleaning and Infection Control in Aerosol Therapy

Catherine A O'Malley RRT-NPS

Device Cleaning and Infection Control in Aerosol Therapy

Knowledge Check 5

When determining proper cleaning and disinfection procedures for a piece of respiratory equipment good practice is to first:

a) Ask a coworker
b) Check manufacturer's instructions for use (IFU)
c) Make an educated guess
d) Google it

Knowledge Check 5

When determining proper cleaning and disinfection procedures for a piece of respiratory equipment good practice is to first:

a) Ask a coworker
b) Check manufacturer's instructions for use (IFU)
c) Make an educated guess
d) Google it

Summary and Wrap Up

Summary of Major Take-Aways

- Create a water management plan and program
- Conduct an annual risk assessment:
  Water Infection Control Risk Assessment (WICRA) for Healthcare Settings (cdc.gov)
- Clinical testing for sick residents: Best practice is to obtain both sputum for culture and urine for the urinary antigen test at the same time.
  - https://www.cdc.gov/legionella/downloads/fs-legionella-clinicians.pdf
- Educate staff about respiratory therapy equipment cleaning and disinfection

TDH Waterborne Program Resources

- TDH Webinar Series
  https://www.tn.gov/health/cedep/waterborne-diseases/legionella.html

- CDC Prevent LD Training
  https://www.cdc.gov/nceh/ehs/elearn/prevent-LD-training.html

- CDC Developing a Water Management Program to Reduce Legionella Growth & Spread in Buildings
  https://www.cdc.gov/legionella/wmp/toolkit/index.html

- CSTE Water Management Program Template
  https://www.cste.org/page/Legionnaires

Thank You!

- Questions?
- HAI.Health@TN.gov
-
- Acknowledgements:
  - Marissa Turner, Epidemiologist HAI/AR Program
  - Kelley Tobey, IPS 2 HAI/AR Program
  - Donna Russell, IP Manager HAI/AR Program
  - Katherine Witcher, Education and Outreach Coordinator
  - Cari Simmons, IPS 2 HAI/AR Program

Operationalizing MDS Changes Effective October 2023 – SDOH, TOH Information, and Functional Status

Jennifer LaBay RN, RAC-MT, RAC-MTA, QCP, CRC

American Association of Post-Acute Care Nursing

AAPACN
AMERICAN ASSOCIATION OF POST-ACUTE CARE NURSING

Faculty Disclosures

- No relevant financial relationships exist for any individual in a position to control the content of this educational activity.
- The speaker will not promote any commercial products or services during this presentation.

Learner Objectives

After participating in this presentation, learners will be able to:

- Recognize the social determinants of health (SDOH), transfer of health (TOH) information, and new functional status items that will be added to the MDS effective Oct. 1, 2023
- Provide operational considerations and best practices to prepare the interdisciplinary team for the upcoming changes

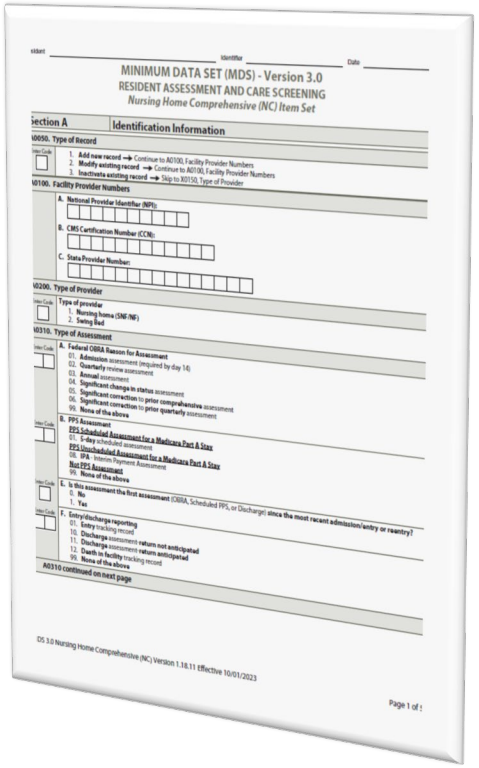
What are SDOH?

- The conditions in the environments where people are born, live, learn, work, play, worship, and age that affect a wide range of health, functioning, and quality-of-life outcomes and risks
  - Healthy People 2030, U.S. Department of Health and Human Services, Office of Disease Prevention and Health Promotion. Retrieved 2.6.23, from https://health.gov/healthypeople/objectives-and-data/social-determinants-health

AAPACN
AMERICAN ASSOCIATION OF POST-ACUTE CARE NURSING

Social Determinants of Health (SDOH) MDS 1.18.11 Effective Oct. 1, 2023

- Ethnicity
  - A1005
- Race
  - A1010
- Language
  - A1110
- Transportation
  - A1250
- Health Literacy
  - B1300
- Social Isolation
  - D0700


MINIMUM DATA SET (MDS) - Version 3.0
RESIDENT ASSESSMENT AND CARE SCREENING
Nursing Home Comprehensive (NC) Item Set

Section A Identification Information

A0050. Type of Record

A0100. Facility Provider Numbers

A. National Provider Identifier (NPI)

B. CMS Certification Number (CCN)

C. State Provider Number

A0200. Type of Provider

A0310. Type of Assessment

A0310 continued on next page

AAPACN
AMERICAN ASSOCIATION OF POST-ACUTE CARE NURSING

Operational Considerations

- New MDS data elements that had not been collected previously, operations managers will likely need to consider how data will be collected, documented tracked, and eventually coded
  - Who will interview the resident and document the data?
  - Where will the data be documented?
  - Who will collect the data and when?
  - What tracking will be needed of the data?
  - Who will be responsible for coding data on the MDS?
  - Who will be responsible for using this data in care planning?
- Interdisciplinary training
  - To ensure an accurate understanding of *RAI User's Manual* Instruction
- Consider policy impact
  - New
  - Revised

A1005 Ethnicity

A1005. Ethnicity

Are you of Hispanic, Latino/a, or Spanish origin?

↓ **Check all that apply**

- ☐ **A.** No, not of Hispanic, Latino/a, or Spanish origin
- ☐ **B.** Yes, Mexican, Mexican American, Chicano/a
- ☐ **C.** Yes, Puerto Rican
- ☐ **D.** Yes, Cuban
- ☐ **E.** Yes, another Hispanic, Latino/a, or Spanish origin
- ☐ **X.** Resident unable to respond
- ☐ **Y.** Resident declines to respond

If "Y" is selected, no other response choices can be checked

- Information gathering must start with the resident
- If the resident is unable to answer, others (family, significant other, or legal guardian) may be asked
- If others are not available, the medical record may be used to determine
- If the **resident declines** to respond, **other resources cannot be used** to answer the question

AAPACN AMERICAN ASSOCIATION OF POST-ACUTE CARE NURSING

A1010 Race

A1010. Race

What is your race?

↓ **Check all that apply**

- ☐ A. White
- ☐ B. Black or African American
- ☐ C. American Indian or Alaska Native
- ☐ D. Asian Indian
- ☐ E. Chinese
- ☐ H. Korean
- ☐ I. Vietname
- ☐ J. Other Asi
- ☐ K. Native Ha
- ☐ L. Guamani
- ☐ M. Samoan
- ☐ N. Other Pa

ese

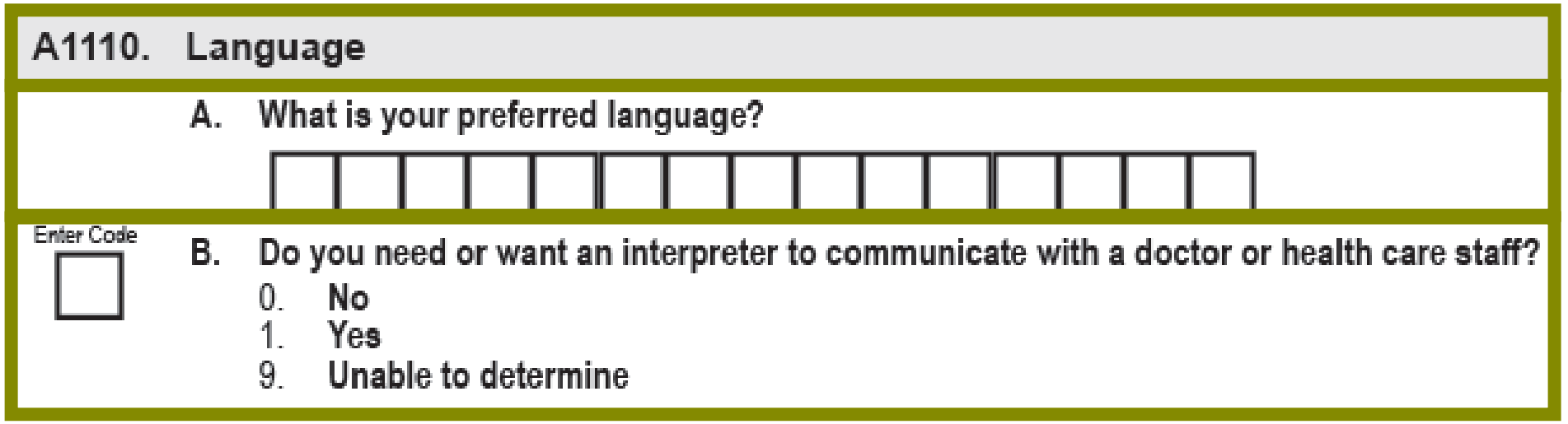
- ☐ X. Resident unable to respond
- ☐ Y. Resident declines to respond
- ☐ Z. None of the above

If "Y" is selected, no other response choices can be checked

- Information gathering must start with the resident
- If the resident is unable to answer, others (family, significant other, or legal guardian) may be asked
- If others are not available, the medical record may be used to determine
- If the **resident declines to respond, other resources cannot be used** to answer the question

AAPACN
AMERICAN ASSOCIATION OF POST-ACUTE CARE NURSING

A1110 Language



A1110. Language

A. What is your preferred language?

Enter Code

B. Do you need or want an interpreter to communicate with a doctor or health care staff?

0. No
1. Yes
9. Unable to determine

- Enter the preferred language the resident primarily speaks or understands after interviewing the resident and family, significant other and/or guardian/legally authorized representative and/or reviewing the medical record
- If the resident, family member, significant other, guardian/legally authorized representative and/or medical record documentation cannot or does not identify preferred language, enter a dash (-) in the first box

Operational Considerations Language

- Facility-wide assessment should identify interpreter needs of the facility
- Consider unmet needs of the resident if an interpreter is not used when needed
- Consider barriers to cultural considerations if interpreter is not used when needed
- May impact:
  - Accurate assessment
  - Care planning
  - Need for an interpreter
  - Current process for assessing language needs

Operational Considerations Ethnicity and Race

- Facility-wide assessment should be used to identify resident population having unique cultural preferences
- Race and ethnicity should be used to identify possible cultural preferences of residents in the facility
  - This information can be used to further investigate and develop a culturally competent care plan
- Identify need to staff training or education based on unique culturally differences of residents in the facility
- May impact:
  - Care planning
  - Current process for gathering data
  - Staff training and education

Care Planning to Address Cultural Preference

- It is important for facilities to be aware of the impact of culture and cultural preferences on the provision of care and have an understanding of the cultural norms and practices of the individuals they care for
- For example, in some cultures, it may be considered taboo to direct care at end of life; or in other cultures care must be provided by caregivers of the same sex as the resident
- Staff must understand the cultural preferences of the individual and how it impacts the delivery of care

-State Operations Manual, Appendix PP

Care Planning to Address Cultural Preference

- There are many aspects of cultural preferences which may impact the delivery of care, such as:
  - Food preparation and choices
  - Clothing preferences such as covering hair or exposed skin
  - Physical contact or provision of care by a person of the opposite sex
  - Cultural etiquette, such as avoiding eye contact or not raising the voice

-State Operations Manual, Appendix PP

Care Planning to Address Cultural Preference

- Consider:
  - Offering **activities that are culturally relevant** to resident populations within the facility
  - Group activities with both sexes may not be permitted or appropriate in some cultures, or the type of programming may be in conflict with his/her cultural preferences
  - Providing reading materials, movies, newspapers **in the resident's preferred language** may help orient a resident to date, times and events
  - Allowing the performance of religious rites at end of life to the extent possible
  - Certain medications, procedures or treatments may be prohibited

-State Operations Manual, Appendix PP

Care Planning to Address Cultural Preference

- Consider:
  - Does the care plan describe interventions that reflect the resident's cultural preferences, values and practices?
  - The facility failed to identify a resident's cultural dietary restrictions related to eating pork. After eating her dinner, upon realization that she had eaten pork, the resident began crying inconsolably and screaming that this was explicitly forbidden in her culture and faith of Islam. The resident remained tearful and inconsolable for several days, and would not eat the food provided by the facility, which resulted in weight loss and serious psychosocial harm

-State Operations Manual, Appendix PP

A1250 Transportation

Completed at the **start** of the Medicare stay (5-Day PPS)

Completed at the **end** of the Medicare stay with a **planned** discharge

Look-back is the past 6 months to a year

A1250. Transportation (from NACHC©)

Has lack of transportation kept you from medical appointments, meetings,

Complete only if A0310B = 01 **or** A0310G = 1 and A0310H = 1

↓	Check all that apply
☐	A. Yes, it has kept me from medical appointments or from get
☐	B. Yes, it has kept me from non-medical meetings, appointme
☐	C. No
☐	X. Resident unable to respond
☐	Y. Resident declines to respond

- Information gathering must start with the resident
- If the resident is unable to answer, others (family, significant other, or legal guardian) may be asked
- If others are not available, the medical record may be used to determine
- If the **resident declines to respond, other resources cannot be used** to answer the question

If "Y" is selected, no other response choices can be checked

A1250 Transportation

Rationale:

- Access to transportation for ongoing healthcare and medication access needs is essential to effective care management
- Understanding resident transportation needs can help organizations assess barriers to care and facilitate connections with available community resources

Operational Considerations Transportation

- Consider developing a new questionnaire or adding a section to current IDT tools to collect the new data
  - Who will ask this question?
  - How and where will it be documented?
  - Who is responsible to use this information in care planning and discharge planning?
- Consider how the local contact agency may be able to assist with transportation barriers with planning for discharge
- May Impact:
  - Discharge planning
  - Care plan
  - Current policy/process

AAPACN
AMERICAN ASSOCIATION OF POST-ACUTE CARE NURSING

B1300 Health Literacy

Item Rationale/Health-related Quality of Life on page B-14

B1300. Health Literacy

Complete only if A0310B = 01 **or** A0310G = 1 and A0310H = 1

Enter Code ☐

How often do you need to have someone help you when you read instructions, pamphlets, or other written material from your doctor or pharmacy?

0. **Never**
1. **Rarely**
2. **Sometimes**
3. **Often**
4. **Always**
7. **Resident declines to respond**
8. **Resident unable to respond**

This is a resident self-report item, no other resource should be used to identify the response even if the resident is unable to respond.

The Single Item Literacy Screener is licensed under a Creative Commons Attribution-NonCommercial 4.0 International License.

DEFINITION:

Health literacy is the degree to which individuals have the capacity to obtain, process, and understand basic health information and services needed to make appropriate health decisions.

Heath Literacy

Rationale:

- Similar to language barriers, low health literacy interferes with communication between provider and resident
- Health literacy can also affect residents' ability to understand and follow treatment plans, including medication management
- Poor health literacy is linked to lower levels of knowledge of health, worse outcomes, the receipt of fewer preventive services, and higher medical costs and rates of emergency department use
- Assessing for health literacy will facilitate better care coordination and discharge planning

Operational Considerations
Health Literacy

- Data collected on social risk factors in order to determine which factors have the biggest impact on health outcomes
- Consider how health literacy data will be used in the transfer of health information to the resident
- Consider how health literacy data will direct the methods used for teaching self-care, medication management, and other discharge planning services
- Consider how health literacy data will be used to coordinator care and discharge planning
- May impact:
  - Current process/policy
  - Care plan
  - Discharge plan

AAPACN
AMERICAN ASSOCIATION OF POST-ACUTE CARE NURSING

Operational Considerations
Health Literacy

- Train staff on how to communicate health material
  - Teach-back methods
  - Skill/level appropriate material
  - Communication methods needs to be resident-centered
- Policies and practices that address health literacy
  - Training for nurses on communication practices
  - How to measure health literacy

D0700 Social Isolation

D0700. Social Isolation	
Enter Code ☐	How often do you feel lonely or isolated from those around you? 0. **Never** 1. **Rarely** 2. **Sometimes** 3. **Often** 4. **Always**
	7. **Resident declines to respond** 8. **Resident unable to respond**

DEFINITION

SOCIAL ISOLATION Refers to an actual or perceived lack of contact with other people, such as living alone or residing in a remote area.

AAPACN
AMERICAN ASSOCIATION OF POST-ACUTE CARE NURSING

Social Isolation

Intent:

- **Social isolation** refers to an actual or perceived lack of contact with other people and tends to increase with age
  - Is a risk factor for physical and mental illness
  - Is a predictor of mortality
  - Is important to assess in order to identify engagement strategies

Operational Considerations
Social Isolation

- Consider how this data will impact care planning and discharge planning
- Consider facility-wide interventions that may be implemented when social isolation or risk of social isolation is identified
- Consider how outside services/groups may reduce the risk of social isolation
  - Pet therapy services, church groups, clubs
- May impact:
  - Current process/policy
  - Care plan

AAPACN
AMERICAN ASSOCIATION OF POST-ACUTE CARE NURSING

Care Planning Considerations for Self-Reported Social Isolation

- Adapted from the National Institute on Aging
  - Find an activity the resident enjoys
  - Help the resident connect with other residents with similar interests
  - Assist the resident to schedule a time to stay in touch with family or friends
  - Identify if an exercise group or restorative nursing program is appropriate to meet the resident's physical activity needs

Discharge Planning Considerations for Self-Reported Social Isolation

- Adapted from the National Institute on Aging
  - Does the resident have family, friend, or neighbor who can regularly check-in or call the resident
  - Identify community-based support options
  - If technology-based communication will be used, provide training to the resident on how use as part of discharge education

A2121 Provision of Current Reconciled Medication List to Subsequent Provider at Discharge

Transfer Of Health Information SNF QRP

A2121. Provision of Current Reconciled Medication List to Subsequent Provider at Discharge

Complete only if A0310H = 1 and A2105 = 02-12

Enter Code ☐

At the time of discharge to another provider, did your facility provide the resident's current reconciled medication list to the subsequent provider?

0. **No** - Current reconciled medication list not provided to the subsequent provider → Skip to A2200, Previous Assessment Reference Date for Significant Correction
1. **Yes** - Current reconciled medication list provided to the subsequent provider

DEFINITION :

Providing the current reconciled medication list at the time of transfer or discharge can be accomplished by any means, including active means (e.g., by mail, electronically, or verbally) and more passive means (e.g., a common electronic health record [EHR], giving providers access to a portal). Page A-45

A1805 Entered From and A2105 Discharge Status

A2105. Discharge Status

Complete only if A0310F = 10, 11, or 12

Enter Code

01. **Home/Community** (e.g., private home/apt., board/care, assisted living, group home, transitional living, other residential care arrangements) → Skip to A2123, Provision of Current Reconciled Medication List to Resident at Discharge
02. **Nursing Home** (long-term care facility)
03. **Skilled Nursing Facility** (SNF, swing beds)
04. **Short-Term General Hospital** (acute hospital, IPPS)
05. **Long-Term Care Hospital** (LTCH)
06. **Inpatient Rehabilitation Facility** (IRF, free standing facility or unit)
07. **Inpatient Psychiatric Facility** (psychiatric hospital or unit)
08. **Intermediate Care Facility** (ID/DD facility)
09. **Hospice** (home/non-institutional)
10. **Hospice** (institutional facility)
11. **Critical Access Hospital** (CAH)
12. **Home under care of organized home health service organization**
13. **Deceased**
99. **Not listed** → Skip to A2123, Provision of Current Reconciled Medication List to Resident at Discharge

Operational Considerations
Entered from and Discharge Status

- Review current applications for admission and make changes as needed
- Assess current referral forms and determine if the additional data can be obtained, or if changes will be needed
- Add data collection items to current tools to include the additional section questions
- Alert team members as to where the data will be kept and how to access
- Cross-check to ensure the status on the Medicare claim matches the status on MDS – add to triple check

A2123 Provision of Current Reconciled Medication List to Resident at Discharge

A2123. Provision of Current Reconciled Medication List to Resident at Discharge

Complete only if A0310H = 1 and A2105 = 01, 99

Enter Code ☐

At the time of discharge, did your facility provide the resident's current reconciled medication list to the resident, family and/or caregiver?

0. **No** - Current reconciled medication list not provided to the resident, family and/or caregiver → Skip to A2200, Previous Assessment Reference Date for Significant Correction
1. **Yes** - Current reconciled medication list provided to the resident, family and/or caregiver

A2121 and A2123 were both added to meet requirements for SNF Quality Reporting Program Transfer of Health Information Measures

Items A2121 and A2123 are asking about a process that has or has not been completed in the facility.

AAPACN
AMERICAN ASSOCIATION OF POST-ACUTE CARE NURSING

Route of Current Reconciled Medication List Transmissions A2122, Subsequent Provider and A2124, Resident

A2122. Route of Current Reconciled Medication List Transmission to Subsequent Provider

Indicate the route(s) of transmission of the current reconciled medication list to the subsequent provider.

Complete only if A2121 = 1

A2124. Route of Current Reconciled Medication List Transmission to Resident

Indicate the route(s) of transmission of the current reconciled medication list to the resident/family/caregiver.

Complete only if A2123 = 1

↓ **Check all that apply**

		Route of Transmission
☐	A.	**Electronic Health Record** (e.g., electronic access to patient portal)
☐	B.	**Health Information Exchange**
☐	C.	**Verbal** (e.g., in-person, telephone, video conferencing)
☐	D.	**Paper-based** (e.g., fax, copies, printouts)
☐	E.	**Other methods** (e.g., texting, email, CDs)

Check all that apply

Operational Considerations
Transfer of Health Information

- Consider health literacy when determining the best route to provide the resident with the health information
  - How will staff determine best route based on this data?
- If the reconciled medication list was not provided, it's a best practice to document why it was not provided
- Consider how direct care staff completing this task will document the process and route to support MDS coding
  - Update current discharge worksheets, new user defined assessments, template to include in nurse's notes
- Likely just the beginning of the data expected to be shared
- May impact:
  - Policies
  - Current process/forms
  - Care plan
  - Discharge planning

GG0115 Functional Limitation in Range of Motion

GG0115. Functional Limitation in Range of Motion

Code for limitation that interfered with daily functions or placed resident at risk of injury in the last 7 days

Coding:

0. **No impairment**
1. **Impairment on one side**
2. **Impairment on both sides**

Enter Codes in Boxes

☐	A. **Upper extremity** (shoulder, elbow, wrist, hand)
☐	B. **Lower extremity** (hip, knee, ankle, foot)

DEFINITION

FUNCTIONAL LIMITATION IN RANGE OF MOTION

Limited ability to move a joint that interferes with daily functioning (particularly with activities of daily living) or places the resident at risk of injury.

GG0115 Functional Limitation in Range of Motion

- Coding for functional ROM limitations is a three-step process:
  - Test the resident's upper and lower extremity ROM
  - If the resident is noted to have limitation of upper- and/or lower-extremity ROM, review GG0130 and GG0170 and/or directly observe the resident to determine whether the limitation interferes with function or places the resident at risk for injury
  - Code GG0115A and GG0115B as appropriate

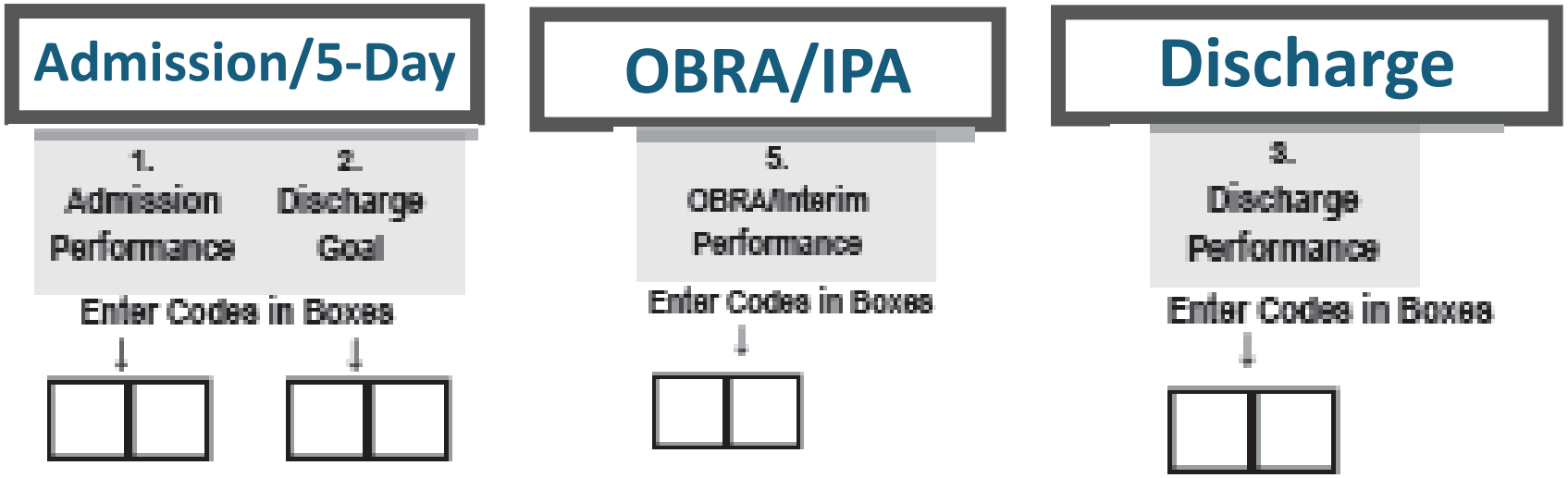
Do not look at limited ROM in isolation. Must determine if limitation interferes with function or places the resident at risk for injury.

GG0120 Mobility Devices

GG0120. Mobility Devices	
Check all that were normally used in the last 7 days	
☐	A. Cane/crutch
☐	B. Walker
☐	C. Wheelchair (manual or electric)
☐	D. Limb prosthesis
☐	Z. None of the above were used

GG0130 Self-Care and GG0170 Mobility

- Usual performance is collected at the start of the stay, with each OBRA assessment, and at the end of the stay
- Discharge goal(s) are established only on the 5-Day PPS Assessment



GG0130 and GG0170 Column 1. Admission Performance Assessment Period

Type of Assessment	Look-Back Period
Standalone Medicare 5-Day PPS assessment	First three days of the stay starting with A2400B
Standalone OBRA Admission assessment	First three days of the stay starting with A1600
Combined Medicare 5-Day PPS assessment and any OBRA assessment (Admission, Quarterly, Annual, Significant Change in Status, Significant Correction)	First three days of the stay starting with A2400B

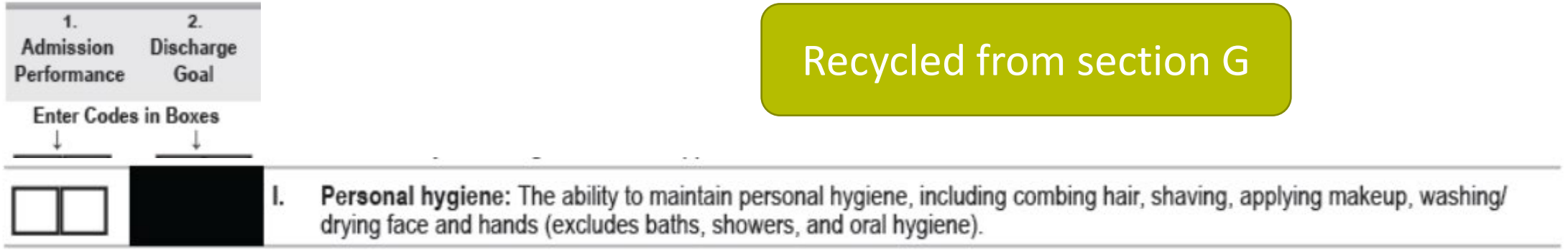
Column 3. Discharge Performance Assessment Period

Type of Assessment	Look-Back Period
OBRA Discharge	Discharge date (A2000) plus two previous calendar days
Part A PPS Discharge	End date of most recent Medicare Part A stay (A2400C) and two previous calendar days
Combined OBRA and Part A PPS discharge	End date of most recent Medicare Part A stay (A2400C) and two previous calendar days

Column 5. OBRA/Interim Performance Assessment Period

Type of Assessment	Look-Back Period
Interim Payment Assessment	Assessment Reference Date (ARD) and two previous calendar days
Standalone OBRA assessment other than Admission (Quarterly, Annual, Significant Change in Status, Significant Correction)	ARD and two previous calendar days

GG0130I Personal Hygiene: New Item

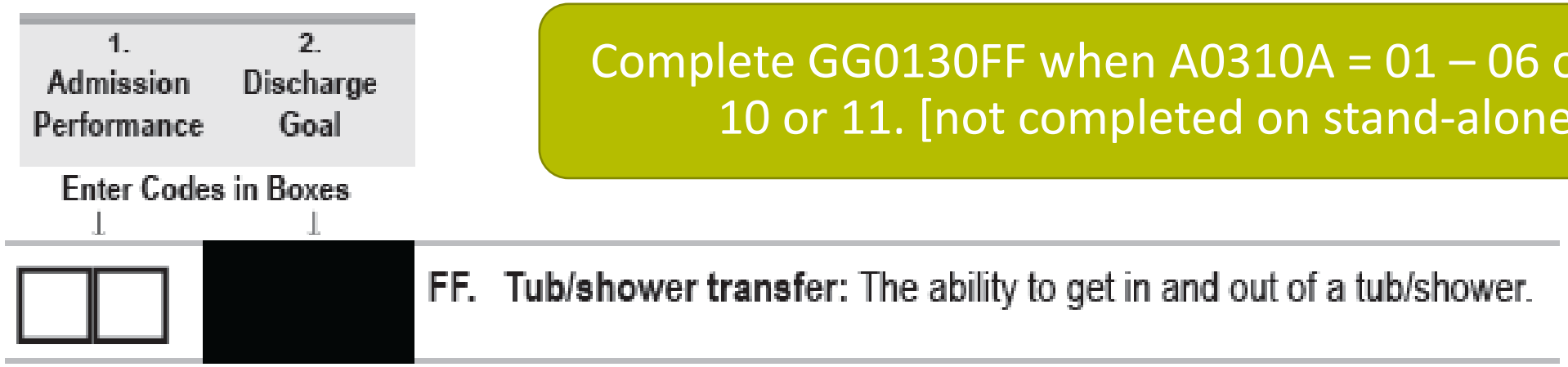


Recycled from section G

Coding Tips

- Complete GG0130I for all OBRA or Discharge assessments (A0310F = 10 or 11). [not completed on stand-alone PPS]
- Personal hygiene involves the ability to maintain personal hygiene, including combing hair, shaving, applying makeup, and washing and drying face and hands (**excludes** baths, showers, and **oral hygiene**)

GG0170FF Tub/shower transfer: New Item



Complete GG0130FF when A0310A = 01 – 06 or A0310F = 10 or 11. [not completed on stand-alone PPS]

Coding Tips

- Tub/shower transfers involve the ability to get into and out of the tub or shower. **Do not include washing, rinsing, drying, or any other bathing activities in this item**
- If the resident does not get into or out of a tub and/or shower during the observation period, use one of the "activity not attempted" codes (07, 09, 10, or 88)

Operational Considerations Functional Status

Update ADL flowsheets

- EMR software will likely have a solution built-in
  - CNA documentation cannot just flow into Section GG
  - Qualified clinician must assess information from all sources to determine usual performance
- Determine how you want the data collected by those involved in resident care
  - CNA, nursing, rehab
  - Interviews with resident, family, and direct care staff
- May impact:
  - Policies
    - Section G language will need to be removed
  - Process
    - Consider the education needed
  - Care plan

Operational Considerations Functional Status Medical Record Documentation

- “Documentation in the medical record is used to support assessment coding of Section GG. Data entered should be consistent with the clinical assessment documentation in the resident’s medical record.” (RAI, Chapter 3, p. GG-21)
- Each facility can decide how to meet this requirement
  - Flow sheets are not a Federal requirement
- MDS scheduling considerations with new section GG assessment periods

Operational Considerations
Functional Status

- Section GG data is likely going to be the basis of many reporting items and comparisons in future
- Ensure accurate and timely data
- Car transfer items may be used to determine the transportation mode
  - Personal car vs. Wheelchair van vs. ambulance

Questions

Email:
jlabay@aapacn.org

AAPACN
AMERICAN ASSOCIATION OF POST-ACUTE CARE NURSING

Resources

- National Center for Chronic Disease Prevention and Health Promotion
  - https://www.cdc.gov/chronicdisease/healthequity/nccdphps-approach-to-health-equity.html
- Healthy People 2030, U.S. Department of Health and Human Services, Office of Disease Prevention and Health Promotion. Retrieved 2.6.23, from https://health.gov/healthypeople/objectives-and-data/social-determinants-health
- Encyclopedia of Public Health
  - https://link.springer.com/referenceworkentry/10.1007/978-1-4020-5614-7_629#:~:text=Cultural%20determinants%20include%20ethnicity%2C%20race,beliefs%2C%20socioeconomic%20class%20and%20education.

Resources

- Home Health Virtual Training – Part 1 Social Determinants of Health
  - https://www.cms.gov/medicare/quality-initiatives-patient-assessment-instruments/homehealthqualityinits/home-health-quality-reporting-training
- State Operations Manual (SOM) Appendix PP
  - https://www.cms.gov/medicare/provider-enrollment-and-certification/guidanceforlawsandregulations/downloads/appendix-pp-state-operations-manual.pdf
- National Institute on Aging
  - https://www.nia.nih.gov/health/loneliness-and-social-isolation-tips-staying-connected?utm_source=partner-social-share&utm_medium=affiliate&utm_campaign=socisolation-toolkit-2021&utm_term=riskfactors

Resources
State Operations Manual, Appendix PP

- The following resources are intended for informational purposes only:
  - The National Center for Cultural Competence
    - https://nccc.georgetown.edu
  - The National Standards for Culturally and Linguistically appropriate Services in Health and Health Care (developed by the Office of Minority Health in HHS)
    - https://www.thinkculturalhealth.hhs.gov/clas/blueprint
  - Office of Minority Health “Think Cultural Health” website
    - https://www.thinkculturalhealth.hhs.gov
  - Georgetown University publication: Cultural Competence in Health Care: Is it important for people with chronic conditions
    - https://hpi.georgetown.edu/agingsociety/pubhtml/cultural/cultural.html

Understanding the Value of the Nurse Assessment Coordinator Role: How to Avoid Financial and Regulatory Risk

Jennifer LaBay RN, RAC-MT, RAC-MTA, QCP, CRC

Curriculum Development Specialist

AAPACN

AAPACN
AMERICAN ASSOCIATION OF POST-ACUTE CARE NURSING

Faculty Disclosures

- There were no relevant financial relationships identified with planners and presenters of this activity.
- I will not promote any commercial products or services during the presentation.

AAPACN
AMERICAN ASSOCIATION OF POST-ACUTE CARE NURSING

Learner Objectives

- Understand the responsibilities of the nurse assessment coordinator (NAC)
- Recognize the consequences of missed or late NAC tasks
- Provide solutions to leadership that they can use to mitigate financial and regulatory risks related to NAC staffing challenges
- Identify which NAC duties can be assigned to non-clinical team members

Commonly Used Acronyms

ARD	Assessment Reference Date	HETS	HIPAA Eligibility Transaction System
ABN	Advanced Beneficiary Notice	ICD-10-CM	International Classification of Diseases, 10th edition, Clinical Modification
BIMS	Brief Interview for Mental Status	IPA	Interim Payment Assessment
BNI	Beneficiary Notices Initiative	iQIES	Internet Quality Improvement and Evaluation System
CMI	Case-Mix Index	IDT	Interdisciplinary Team
CMS	Centers for Medicare & Medicaid Services	MBPM	Medicare Benefit Policy Manual
DC	Discharge	MDS	Minimum Data Set
EHR	Electronic Health Record	NAC	Nurse Assessment Coordinator
HIPAA	Health Insurance Portability and Accountability Act	NOMNC	Notice of Medicare Non-Coverage
HIPPS	Health Insurance Prospective Payment System	NTA	Non-Therapy Ancillary

Commonly Used Acronyms

OBRA	Omnibus Budget Reconciliation Act	QIO	Quality Improvement Organization
OT	Occupational Therapy	QM	Quality Measure
PDPM	Patient-Driven Payment Model	RAI	Resident Assessment Instrument
PHQ	Patient Health Questionnaire	RUGS-IV	Resource Utilization Group, 4th version
PPS	Prospective Payment System	SLP	Speech Language Pathology
PT	Physical Therapy	SNF	Skilled Nursing Facility
QHS	Qualifying Hospital Stay	SOM	State Operations Manual

What does the NAC do?

AAPACN
AMERICAN ASSOCIATION OF POST-ACUTE CARE NURSING

Pre-Admission NAC Tasks

- Review incoming residents for eligibility
  - Qualifying hospital stay (QHS)
  - Days available
- Determination of skill on admission
  - Anticipated daily skilled need
  - Use of Administrative Presumption of Coverage
  - Primary diagnosis that maps to a clinical category
- Beneficiary Notices Initiative (BNI)
  - Administer skilled nursing facility advanced beneficiary notice (SNFABN)
    - Mandatory when admitting to the SNF with no skilled need
    - Voluntary if admitted with a technical ineligibility
      - No QHS, no benefit days available, other primary payer

Risk If Not Managed

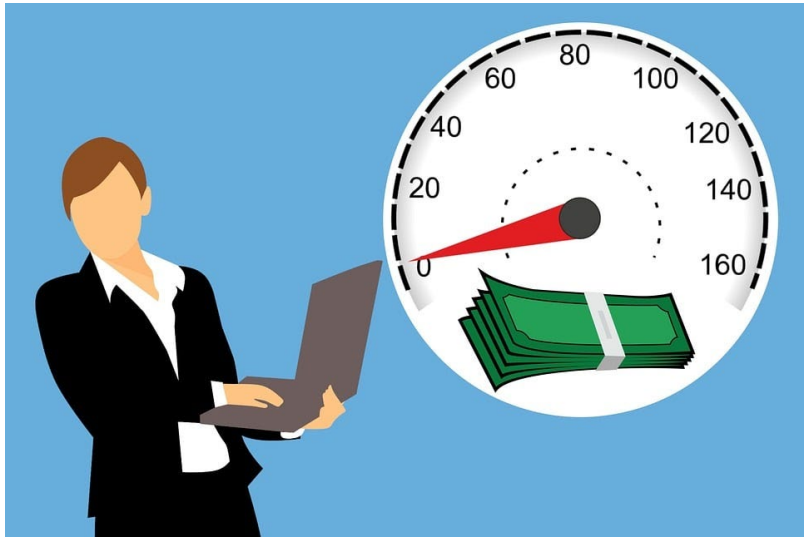
- Review incoming residents for eligibility
  - Qualifying hospital stay miscalculated
    - ✓ Entire stay would not be eligible for payment - PROVIDER LIABLE
  - HIPAA Eligibility Transaction System (HETS) incorrectly calculates when or limited days are available
    - ✓ Payment at default rate or PROVIDER LIABLE

Provider Liable

- When a facility fails to follow all the rules and regulations of Medicare, the facility cannot bill Medicare for the services provided, no other payer can be billed for the services. The facility becomes responsible for paying for those services provided which means the provider is liable for the services provided despite other eligibility or entitlement to Medicare coverage

Default Rate

- Refers to the lowest possible per diem Medicare rate
- Default code under PDPM is ZZZZZ
- Represents the equivalent of billing the following PDPM groups:
  - PT Payment Group: TP
  - OT Payment Group: TP
  - SLP Payment Group: SA
  - Nursing Payment Group: PA1
  - NTA Payment Group: NF



Provider Liable Versus Default

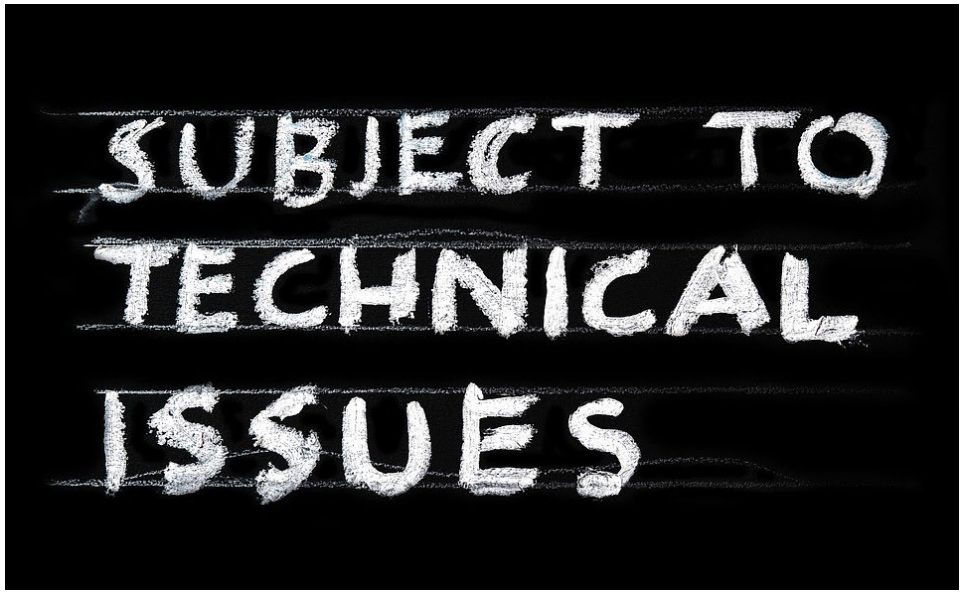
- Provider liable = no money can be collected
  - E.g., missed MDS
    - Six exceptions – chapter 6 *RAI User's Manual* page 6-53
    - Occurrence span 77 on the claim with dates of provider liability
- Default Rate (HIPPS billing code = ZZZZZ)
  - Only the lowest Medicare rate can be collected
    - E.g., late MDS

Management Strategy

- ❑ Assign review of eligibility to admissions or billing staff competent of Medicare regulations
- ❑ Ensure staff are cross-trained on review of qualifying hospital stay and HETS review
- ❑ Interview beneficiary/responsible party about previous SNF stays that may not have been billed to Medicare yet

Caution!

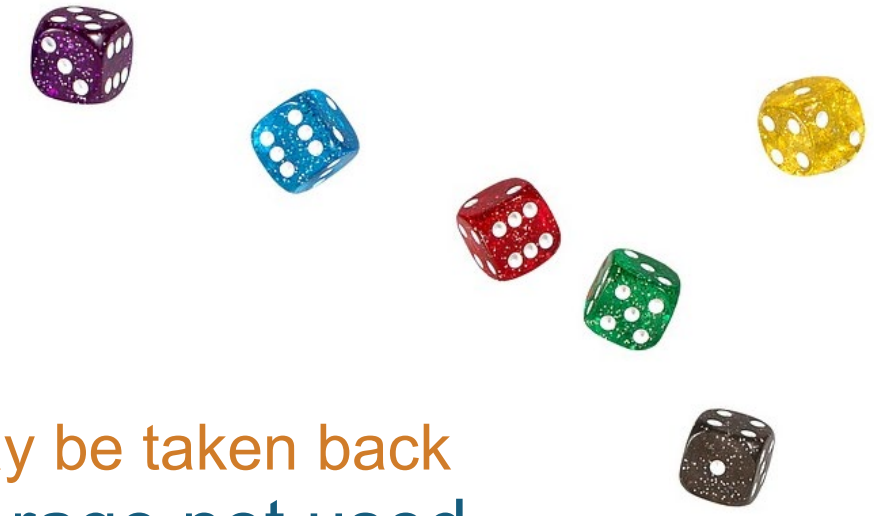
- Sometimes software will show a default rate in the electronic health record billing system when it is truly meant to be billed as provider liable
  - ✓ If this is not managed correctly, the facility could get paid the default rate when there should have been no Medicare payment



Management Strategies

- Staff familiar with the rules of Medicare and *RAI User's Manual* should review all claims to ensure accurate billing and confirm HIPPS codes prior to billing
- Run software reports regularly to ensure assessments and HIPPS codes are appropriately transferred to the claim
- Triple-check meetings should be held at least monthly

Risk If Not Managed



- Determination of skill on admission
  - If no skilled need is present
    - ✓ Upon medical review, the payment may be taken back
  - Administrative Presumption of Coverage not used
    - ✓ Lost opportunity to cover a beneficiary on Medicare that might not otherwise qualify
  - Primary diagnosis return to provider
    - ✓ No HIPPS code will be calculated, MDS will be rejected, Medicare cannot be billed
    - ✓ Inaccurate diagnosis chosen as primary, upon medical review, payment may be adjusted

Management Strategies

- Assign this task to alternate staff, such as admissions nurse, unit manager, admitting nurse, or other nursing leadership roles
- Ensure staff are cross-trained on the definition of skilled services and the Administrative Presumption of Coverage (MBPM, Chapter 8, Section 30.1)
- Ensure staff are knowledgeable on ICD-10-CM coding rules and PDPM clinical categories

Risk If Not Managed

- Beneficiary Notices Initiative (BNI)
  - Administer mandatory SNFABN when admitting to the SNF with no skilled needs
    - ✓ Under medical review, failure to administer notice may result in provider liability for the length of the stay or full 100-day benefit period due to the beneficiary not having reasonable notice that Medicare would not be paying for the stay

Management Strategies

- Assign this task to admissions, social services, or billing office after determination notice is required
- Ensure staff are cross-trained on the instructions for completing the SNFABN
  - https://www.cms.gov/Medicare/Medicare-General-Information/BNI/ABN
  - Medicare Claims Processing Manual, 100-4, Chapter 30 (PDF)

During Stay

- Completion of ICD-10-CM assignment
- Schedule/transmit the MDS
  - Entry tracking
  - Admission assessment/care area assessments/comprehensive care planning
  - Chart review for determination of significant change in status assessment (SCSA) determination
  - Quarterly and annual assessments
  - PPS assessments
  - DC assessments
  - Transmit MDSs to iQIES
- Complete the MDS accurately and timely
- Participate in resident conferences
  - Care planning
  - Discharge planning

Risk If Not Managed

- Completion of ICD-10-CM assignment
  - Completion of ICD-10-CM is a requirement of HIPAA and drives care planning, survey accuracy, PDPM payment, quality measures (QMs)
    - ✓ Missed or untimely diagnoses can lead to inaccurate assessment and care plan, which may lead to survey citations
    - ✓ All five case-mix adjusted PDPM components use diagnosis – inaccuracies may lead to inaccurate payment
    - ✓ Diagnosis can include or exclude a resident from a QM – may also risk adjust. Inaccuracies may lead to a misrepresentation of the quality, either negatively or positively in the measures and Five-Star rating

Management Strategies

- ❑ Ensure staff is cross-trained in ICD-10-CM coding conventions, use of coding guidelines, and proper use of manual
  - Cheat sheets and internet searches should not be used
- ❑ Keep ICD-10-CM coding manuals up to date
- ❑ Query physician/physician extenders to obtain supporting documentation on or before the MDS assessment reference date

Risk If Not Managed

- Schedule/complete MDS Survey Risk
  - F636 - The facility must conduct within 14 days of admission and no less than annually, a comprehensive accurate, standardized, reproducible assessment
  - F637 – Significant Change in Status MDS must be completed within 14 days after the facility determines, or should have determined, that there has been a significant change in the resident's physical or mental condition
  - F638 - Quarterly MDS not less frequently than once every 3 months
  - F639 – 15 months of MDS records, including tracking records, must be maintained in the active medical record

Continued

Risk If Not Managed

- ARD must be set on an MDS form or in MDS software timely
  - ✓Failure to complete required MDS assessments will result in inadequate care planning, multiple survey citations, missed payment, inaccurate QM and Five-Star calculation
    - Census for Five-Star Rating System staffing domain calculated using MDS census data. If discharge assessments or death in facility tracking forms not completed, census may look higher, meaning staffing needs calculated would be higher, and staffing star rating would drop

Management Strategies

- ❑ Cross-train staff to set ARD timely
- ❑ Revamp the OBRA MDS schedule to utilize the federal limits
- ❑ Build in oversight time for MDS schedule
  - For the NAC or utilize regional/corporate supports if available
- ❑ Review assessment due reports in EHR to track missing assessments
- ❑ Value the importance of discharge assessments and tracking records
- ❑ Review the Missing Assessment Report in iQIES

Risk If Not Managed

- Transmit MDS
  - Per F640 the facility must transmit MDSs to the national database via iQIES
    - ✓ Failure to transmit required MDS assessments will result in multiple survey citations, missed payment, inaccurate QM and Five-Star calculation

Management Strategies

- Cross-train ancillary staff to transmit assessments
- Utilize automated transmission through electronic health records (EHR) if available

Risk If Not Managed

F641 - The assessment must accurately reflect the resident's status

- If assessments are not completed accurately
  - ✓ Inaccurate assessments may lead to inaccurate care plans, resulting in poor clinical outcomes, and survey deficiencies
    - Several F tags impacted including resident assessment and comprehensive care plans

Risk if not managed

- If assessments are not completed accurately
  - ✓ Inaccurate payment under PDPM and some state Medicaid payment systems
    - Underpayment or overpayment
    - May lead to additional medical record reviews and audits

Example

Resident experienced coughing at mealtime during the observation period. The untrained MDS assessor did not capture this in K0100 causing the SLP component of PDPM to be calculated at a case-mix group of SA (CMI 0.66) instead of SB (CMI 1.77).

Urban base rate for SLP component = $ 24.66

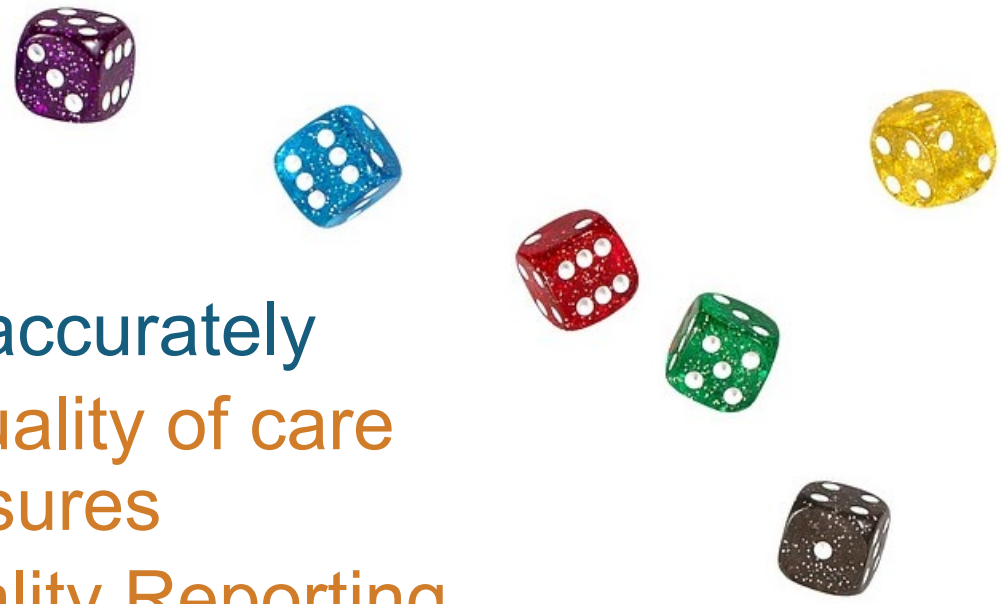
- 0.66 x 24.66 = $16.28 per day
- 1.77 x 24.66 = $43.65 per day

Difference of $27.37 per day

30-day claim period total loss of $821.10!!!

AAPACN
AMERICAN ASSOCIATION OF POST-ACUTE CARE NURSING

Risk If Not Managed



- If assessments are not completed accurately
  - ✓ Inaccurate monitoring of the quality of care using MDS-based quality measures
    - Quality Measures, SNF Quality Reporting Program, Five-Star Rating System
    - Inaccurate representation on Care Compare

Example

Item I2300 Urinary tract infection (UTI):

— The UTI has a look-back period of 30 days for active disease instead of 7 days.

— **Code only if both of the following are met in the last 30 days:**

1. It was determined that the resident had a UTI using evidence-based criteria such as McGeer, NHSN, or Loeb in the last 30 days,

   AND

2. A physician documented UTI diagnosis (or by a nurse practitioner, physician assistant, or clinical nurse specialist if allowable under state licensure laws) in the last 30 days.

- A resident is on an antibiotic for a urinary tract infection (UTI). There is a physician diagnosis within 30 days of the ARD, but the McGeers criteria is not positive for a UTI. The untrained MDS assessor codes UTI on the MDS and the UTI Quality Measure triggers incorrectly.

Both coding criteria from RAI User's Manual must be met in order to code UTI on the MDS.

Risk If Not Managed

- If assessments are not completed accurately
  - ✓ Resident acuity not calculated impacting facility staffing levels and calculation of staffing acuity for the Five-Star Rating System
    - Staffing is partially calculated using case-mix adjusted data from MDS
    - Inaccurate representation on Care Compare

Example

Five-Star nursing staffing level measures are case-mix adjusted based on the distribution of MDS assessment by RUGS-IV. If the assessments did not accurately reflect the true acuity of the residents, the staffing calculation would not be calculated accurately.

Risk If Not Managed

- If assessments are not completed accurately
  - ✓An individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment
  - ✓ An individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than $5,000 for each assessment

Z0400 Signature of Persons Completing the Assessment

I certify that the accompanying information accurately reflects resident assessment information for this resident and that I collected or coordinated collection of this information on the dates specified. To the best of my knowledge, this information was collected in accordance with applicable Medicare and Medicaid requirements. I understand that this information is used as a basis for ensuring that residents receive appropriate and quality care, and as a basis for payment from federal funds. I further understand that payment of such federal funds and continued participation in the government-funded health care programs is conditioned on the accuracy and truthfulness of this information, and that I may be personally subject to or may subject my organization to substantial criminal, civil, and/or administrative penalties for submitting false information. I also certify that I am authorized to submit this information by this facility on its behalf.

Example

A corporate consultant instructs the NAC to code K0510A parenteral fluids on a resident who has documented receipt of IV fluids in the recovery room during the hospital stay to impact Special Care High PDPM calculation. The RAI User's Manual states IV fluids administered as a routine part of an operative or diagnostic procedure or recovery room stay are NOT to be captured on the MDS (p K-12). The NAC questions the accuracy of this advice, but the consultant demands the NAC code IV fluids despite the *RAI User's Manual* instruction.

Management Strategies

- ❑ Ensure full *RAI User's Manual* instructions are followed when completing MDS – not just the instruction listed on the MDS item set
  - Do not code MDS when the *RAI User's Manual* expressly prohibits
- ❑ Utilize alternative methods of MDS completion
  - Incorporate MDS completion into nursing and interdisciplinary team (IDT) assessments
    - Optimize facility software to incorporate RAI language and definitions
  - Per diem MDS nurses
  - Corporate "float" NAC
  - Travel MDS assignments
- ❑ Build in oversight time
  - For the NAC or utilize regional/corporate supports if available
- ❑ Invest in a strong scrubber software

AAPACN
AMERICAN ASSOCIATION OF POST-ACUTE CARE NURSING

Risk If Not Managed

- Participate in resident conferences
  - If the NAC does not attend care planning or discharge planning meetings, there is potential for important resident information to not be carried onto the care plan or added to the MDS assessment
    - ✓ Inaccurate assessment and care planning can lead to survey deficiencies

Management Strategies

- ❑ All staff should maintain updates to the care plan
- ❑ Meetings should be well documented timely in the medical record

Prioritizing Tasks

Crisis Mode: RAI Process Survival Checklist

AAPACN
AMERICAN ASSOCIATION OF POST-ACUTE CARE NURSING

When the RAI process is in crisis mode due to NACs out sick or working full shifts on the floor:

- ☐ Open OBRA and PPS MDS assessments within allowable ARD windows. For Medicare payment, late or missed assessments are identified by ARDs that have not been set timely.
- ☐ Code section GG (Functional Abilities and Goals) in the first three days of the Medicare stay, or alert administration to PDPM and SNF QRP payment implications of having to dash these items.
  - ☐ Think outside the box about who the best person is to take on section GG coding and collaborate with therapy as needed:
    - The NAC?
    - An admission nurse?
    - A unit manager?
- ☐ Code the following resident interview items timely, or alert administration to the multiple implications of having to dash these items (e.g., payment, care planning, Quality Measures, etc.):
  - ☐ The Brief Interview for Mental Status (BIMS) in items C0200 – C0500.
  - ☐ The Resident Mood Interview in D0200 – D0300.
  - ☐ The Interview for Daily Preferences and Activity Preferences in F0400 – F0500.
  - ☐ The Pain Assessment Interview in J0300 – J0600.
    - The RAI User's Manual does not allow staff assessments to be done for interviewable residents. There should be a team decision—based on workload, available personal protective equipment (PPE), and the ability to do training—as to which team members conduct these resident interviews.
- ☐ Complete OBRA and PPS MDS assessments with hard deadlines, or alert administration to survey implications of failure to complete timely.
- ☐ Ensure transmission of OBRA and PPS MDS assessments with hard deadlines, or alert administration to survey and billing implications of failure to submit timely.

AAPACN
AMERICAN ASSOCIATION OF POST-ACUTE CARE NURSING

Prioritizing Tasks

- ☐ Code the following resident interview items timely, or alert administration to the multiple implications of having to dash these items (e.g., payment, care planning, Quality Measures, etc.):
  - ☐ The Brief Interview for Mental Status (BIMS) in items C0200 – C0500.
  - ☐ The Resident Mood Interview in D0200 – D0300.
  - ☐ The Interview for Daily Preferences and Activity Preferences in F0400 – F0500.
  - ☐ The Pain Assessment Interview in J0300 – J0600.
    - The RAI User's Manual does not allow staff assessments to be done for interviewable residents. There should be a team decision—based on workload, available personal protective equipment (PPE), and the ability to do training—as to which team members conduct these resident interviews.
- ☐ Complete OBRA and PPS MDS assessments with hard deadlines, or alert administration to survey implications of failure to complete timely.
- ☐ Ensure transmission of OBRA and PPS MDS assessments with hard deadlines, or alert administration to survey and billing implications of failure to submit timely.

During Stay

- Medicare Part A case management
  - Managing ARDs to capture services and conditions
  - Participate in the review of daily skilled need
    - Including review for interim payment assessment (IPA) determination
  - Physician certification/recertification management
  - Census review for the management of interrupted stay
  - Assist with determination of the end of skilled stay
  - Administer BNI
    - Notice of Medicare Non-Coverage (NOMNC)
    - SNFABN
  - Management of expedited appeals
- Staff development
  - Education of IDT with any RAI/Medicare changes

Risk If Not Managed

- Medicare Part A case management
  - Managing ARDs to capture services and conditions
    - ✓ ARDs must be set on an MDS form or in MDS software on or before day 8 of the Medicare stay – if not set timely may result in default rate or provider liability
    - ✓ Incorrect ARD selection may impact the services or conditions coded on the MDS that impact Medicare revenue up to hundreds of dollars a day

Continued

Examples

- Not capturing cognitive impairment on Brief Interview for Mental Status (BIMS) properly (e.g., ARD is set for day 8 but BIMS was completed day 1)
  - Impacts SLP and Nursing components
- ARD set before physician documentation in place to support ICD-10-CM codes impacting payment
  - Impacts all components
- Not capturing IV fluids or parenteral feeding from the hospital
  - Impacts nursing component

Management Strategies

- ❑ All clinical staff should be aware of basic Medicare requirements
- ❑ Cross-train nursing staff to set ARD on an MDS form or in MDS software on or before day 8 of the Medicare stay
  - ○ Knowledge of PDPM components essential to ensure no items are missed
- ❑ Incorporate PDPM clinical requirements into assessment forms in the electronic health records

Risk If Not Managed

- Medicare Part A case management
  - Participate in the review of daily skilled needs Including review for IPA determination
    - ✓ Daily skilled nursing or rehabilitation services are a Medicare Part A payment requirement. If documentation does not support this need, under medical review, the entire claim could be denied, and the facility would be provider liable for the claim period in question
    - ✓ Although the IPA is not mandatory, additional revenue could be missed due to a lack of specialized review with PDPM components in mind

Continued

Example

- Resident with a 5-Day PPS assessment
  - Acute Neurologic clinical category and function score of 14 - PT/OT = TO (PT CMI 1.51/OT CMI 1.51)
  - Mildly impaired cognition BIMS of 12, no SLP comorbidities, swallowing disorders present - SLP = SH (CMI 2.78)
  - Parkinson's disease with function score 10, PHQ-9 score of 13 – Special Care Low category - Nursing = LBC2 (CMI 1.67)
  - No NTA comorbidities - NTA = NF (CMI 0.70)

Unadjusted Urban Daily Federal Base Rate
$617.39

Continued

AAPACN
AMERICAN ASSOCIATION OF POST-ACUTE CARE NURSING

Example (continued)

Change in case-mix groups qualifiers from 5-Day

- Primary reason for skilled services now acute respiratory infection with MRSA - Medical Management clinical category and function score of 19 - PT/OT = TK (PT CMI 1.48/OT CMI 1.50)
- Mildly impaired cognition BIMS of 14, no SLP comorbidities, no further swallowing disorders present - SLP = SA (CMI 0.66)
- Parkinson's disease stabilized with improved function score 13, PHQ-9 score improved to 9 – Extensive services category (isolation) - Nursing = ES1 (CMI 2.85)
- NTA comorbidities of Multi Drug Resistant Organism, IV meds, infection isolation (7 points) - NTA = NC (CMI 1.79)

Potential IPA Unadjusted Urban Daily Federal Base Rate
$793.11

Continued

AAPACN
AMERICAN ASSOCIATION OF POST-ACUTE CARE NURSING

Example (continued)

- Daily rate difference $175.72 per day for the remainder of the stay
- A total of $5,271.60 missed revenue over a 30-day period if no case-management for IPA

Management Strategy

- All clinical staff should be aware of basic Medicare and PDPM requirements to ensure documentation meets minimum requirements
- Utilize chart checks to ensure daily documentation requirement is met
- Utilize PDPM clinical criteria in nursing assessments
- Cross-train staff in review for appropriateness of IPA and setting ARD

Risk If Not Managed

- Medicare Part A case management - Physician Certification
  - For Part A services to be payable, the physician must certify and recertify, in writing, on an ongoing basis the need for the SNF care
    - ✓ Medicare cannot be billed without certifications in place. If a claim is submitted without certification, upon medical review the claim period, and potentially the entire stay will not be paid, and the facility will be provider liable

Management Strategy

- This task can be assigned to ancillary staff for completion providing there is an appropriate understanding of the requirements and timeframes of completion
- This process should be tracked regularly and be included in the triple-check review process monthly

AAPACN
AMERICAN ASSOCIATION OF POST-ACUTE CARE NURSING

Risk If Not Managed

- Medicare Part A case management - Census review for the management of interrupted stay
  - ✓ If the interrupted stay policy is not followed, this can result in:
    - ✓ A missed 5-Day PPS assessment
      - Resulting in the default rate (if the error is noted while still on Medicare) or provider liability
    - ✓ A duplicate 5-Day PPS assessment that was not required
      - Incorrect payment, may trigger audit

Management Strategy

- Business office or admissions staff may be cross-trained to track the interrupted stay policy and communicate to nursing staff for proper assessment selection if any

AAPACN
AMERICAN ASSOCIATION OF POST-ACUTE CARE NURSING

Risk If Not Managed

- Medicare Part A case management
  - Assist with the determination of the end of the skilled stay and administer BNI (NOMNC/SNFABN)
    - ✓ Failure to identify end of skilled service may result in provider liability
    - ✓ Failure to administer expedited determination or SNFABN may result in provider liability
    - ✓ Failure to complete notices per instructions may result in provider liability
    - ✓ Failure to respond to expedited appeal requests may result in provider liability

Management Strategy

- ❑ All clinical staff should be aware of basic Medicare requirements
- ❑ Determination of end of skilled needs should be discussed in daily PPS meeting and/or weekly Medicare meeting
- ❑ Business office or admissions staff may be cross-trained to complete the BNI notices
  - Includes notices from Medicare Advantage plans
- ❑ All staff must be familiar with expedited appeal requests from QIO via fax and ensure request is addressed timely
- ❑ Back-up staff should be trained to manage appeals requests

Risk If Not Managed

- Staff development
  - Education of IDT with any RAI/Medicare changes
    - ✓ Not providing this information to the IDT may result in inaccurate assessments, care plans, payment, QMs, and Five-Star ratings and may also result in survey deficiencies

Management Strategy

- ❑ All involved staff should review:
  - MDS item sets v1.18.11v2 (https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/NursingHomeQualityInits/MDS30RAIManual)
    - Including Item set change history
  - Draft RAI User's Manual – updated language will be in red (https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/NursingHomeQualityInits/MDS30RAIManual)
- ❑ Attend trainings

Summary

- The NAC has a unique, highly specialized role in the SNF setting with the knowledge that combines clinical, financial, and regulatory compliance information
- Because the position is so specialized, clinical leadership must weigh the risks of utilizing the NAC to cover open nursing positions against the benefits
- While temporarily shifting the NAC to an open spot may solve an immediate problem, it could also negatively impact quality, survey outcomes, reimbursement, and the Five-Star rating

Questions

Thank you!

jlabay@aapacn.org

AAPACN
AMERICAN ASSOCIATION OF POST-ACUTE CARE NURSING

References

- MDS 3.0 RAI User's Manual (V1.17.1) 2019 https://downloads.cms.gov/files/mds-3.0-rai-manual-v1.17.1_october_2019.pdf
- MDS 3.0 RAI User's Manual DRAFT https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/NursingHomeQualityInits/MDS30RAIManual
- CMS State Operations Manual Appendix PP https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/som107ap_pp_guidelines_ltcf.pdf

References

- Medicare Benefits Policy Manual: Ch. 8: *Coverage of Extended Care (SNF) Services Under Hospital Insurance.* http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/bp102c08pdf.pdf
- CMS Beneficiary Notices Initiative https://www.cms.gov/BNI
- Medicare Claims Processing Manual Chapter 30 – Financial Liability Protection (Rev.11210, 01-21-22) https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c30.pdf

DE-PRESCRIBING

Dr. Prasanna Chinthala

Psychotropic Medication in Long Term Care (ECF)

WHEN SHOULD PSYCHOTROPIC MEDICATION BE USED?

WHY SHOULD THEY BE USED?

WHAT SHOULD WE DO BEFORE USING MEDICATION?

Introduction

Dr. Prasanna Chinthala

CEO of A & G Behavioral Health Services

Brittany Modesitt M.S.

Clinical Coordinator of A & G Behavioral Health Services

What to do before considering Psychotropic Medication

- Vitals
- Labs
- Documentation
- Consider environmental and behavioral factors and interventions
- Call psychiatric provider (or provider managing psychotropics in-house)

LAB MONITORING
Acute vs Maintenance

How recent labs need to be for acute issues vs ongoing maintenance

Why is this important?

IMPORTANT LABS TO CONSIDER

- BMP
- CBC
- TSH
- LIPID
- A1C

CONTINUATION OF LABS

- LFTs
- Ammonia
- Vitamin B12
- Folate

CONTINUATION OF LABS

- UA C &S
- Lithium & Depakote Levels

Common side effects of SSRI's

- Hyponatremia (low sodium): clinically presents as increased confusion and falls
- Anemia/GI Bleeds (GIB)
- Cardiac concerns/arrythmias
- Serotonin Syndrome

✓Note: too much serotonin can result in patient being overstimulated/anxious

Selective serotonin reuptake Inhibitor (SSRI's, most common)

- Prozac, Lexapro, Celexa, Zoloft, Paxil and Luvox
- ✓ Frequently used to treat depression, anxiety and obsessive-compulsive symptoms.
- ✓ Please note that for older adult and medically compromised adult patients higher doses of these medications does not increase the efficacy. It only increases risk of side effects and risks.

SEROTONIN NOREPINEPHRINE REUPTAKE INHIBITOR (SNRI's)

- Commonly used SNRI's are Cymbalta and Effexor
- For patients who have hyponatremia and anemia/GIB concerns, this drug class is often safer alternative.

Special considerations when using SNRI's

- Cymbalta

✓ Renal function must be monitored, specifically the patient's GFR (glomerular filtration rate)

✓ This is not the drug of choice for patients with significantly impaired renal functions/progressed CKD (Chronic Kidney Disease)

Tricyclic anti-depressants (TCA's)

Common TCA's are Elavil and Nortriptyline
Safer alternative for patient who cannot tolerate SSRI or SNRI
Common Side Effects:
Anti-cholinergic symptoms (confusion, bladder retention)
Antihistamine side effects (confusion, sedation)
Orthostatic hypotension (fall risk in elder population)
Cardiac toxicity (be careful with underlying cardiac disease.)

Special considerations when using SNRI's

- Effexor

✓ Significant HTN/hypertensive concerns

✓ This drug is not the drug of choice for patients with major HTN concerns

Miscellaneous Anti-depressants

- Remeron

✓ Lowest risk of side effects for older adults/medically compromised patients.

✓ This drug does not impact a patient's sodium, hemoglobin and renal functions.

✓ This medication dose needs to be prescribed at lower dosages due to sedation, fall GI risks if prescribed at higher doses initially.

*This is the only anti-depressant must be prescribed at bedtime.

Miscellaneous Anti-depressants

- Wellbutrin
- Safer alternative for patients who cannot tolerate SSRI's or SNRI's

✓ This drug does not impact a patient's sodium, hemoglobin and renal functions.

✓ CANNOT be used for patients with seizure disorder/patient at risk for seizures.

✓ Not a drug of choice for patients who have significant weight loss concerns

Benzodiazepines

- Most dangerous drug class to be prescribed for older adult/medically compromised patients.
- Known dangers of benzodiazepines for older patients include lethargy, increased confusion, increased risk of falls and fractures, significant impairment of driving skills with increased crash risk, and increased risk of an emergency room visit (Gress, Miller, Meadows, 2020)

Common risks and side effects of Benzodiazepines

- Hypotension
- Falls
- Sedation
- Respiratory suppression
- Paradoxical effects (i.e. increase in agitation/aggression)

Safer Alternatives to Benzodiazepines

Buspar: Alleviates anxiety symptoms without benzodiazepine risks.

Not a medication for patients with hyponatremia concerns, monitoring of sodium is important.

Vistaril: Safer alternative for anxiety/agitation concerns.

This can be administered by capsule or IM (intramuscular injection).

Safer alternatives to Benzodiazepines

Neurontin (off label):
Initially used for seizure disorder, however later on it has been used for mood disorders and anxiety disorders.
It is used in Long Term Care setting for anxiety, mood disorders and restlessness contributing to behaviors and agitation.
Neurontin is excreted by kidney to be used cautiously in patient with reduced kidney function.
Make note: Neurontin is also known to have addiction dependence.

Safer alternatives to Benzodiazepines

SSRI's:

Can be considered as an alternative to benzodiazepines to treat depression, anxiety and obsessive symptoms.

Common Sleep-Aids

- **Trazodone**

✓ Recommended low doses not exceeding 25 mg-50 mg for older adults and geriatric patients due to risk of falls and orthostatic hypotension.

- **Doxepin**:
- Safer alternative to Trazodone

✓ Does not have the orthostatic hypotensive risks as Trazodone

- **Melatonin**

✓ Maximum dose of 10 mg by mouth (PO) at bedtime (QHS)

Common Sleep-Aids

- **Restoril**

✓ Used rarely for older adults

✓ Benzodiazepine risks need to be considered with this drug

- **Ambien**

✓ This drug should be avoided in older adults and medically compromised patients

✓ It should be used short term in acute care settings only

Mood Stabilizers

- Mood stabilizers are anti-seizure medications such as Depakote, Lamictal, and Tegretol.
- Mood stabilizers are generally used for Bipolar disorders, with mania/depression and behavioral disturbances related to any other condition.
- In Long Term Care mood stabilizers are mainly used for aggression, agitation, hostility in addition to mood disorders.

Depakote

- Depakote: Most commonly used mood stabilizer
- Routine lab monitoring is necessary for this drug

✓ Ammonia Level- Concern for ammonia toxicity

❖ Falls

❖ Agitation

❖ Restlessness

Depakote

- ✓ LFT's- concern for liver damage (side effect)
- ✓ CBC- specifically platelet monitoring
- ❖ This medication can cause thrombocytopenia (risk for bleeding)
- ✓ Depakote levels should be routinely monitored every 6 months/as needed, especially when patient is having acute concerns

Anti-psychotics

- These medications are to be considered only after the below have been monitored and evaluated by the treatment team and provider.

✓ Environmental Factors (i.e. staff interactions, proximity of others, area the behavior(s) occurred, behavioral interventions, etc.)

✓ Current vitals obtained?

❖ Abnormal blood sugar and oxygen levels can cause AMS changes/behavioral changes.

Anti-psychotics

Low blood pressure/pulse are important to monitor before medications changes are considered.

Current Labs

If the patient has not had labs for 30-60 days, these are not considered "current" labs.

Documentation: Have these behavioral and/or psychiatric concerns been documented.

Anti-psychotics

Have acute medical concerns been ruled out?

Have possible pain concerns been ruled out and addressed?

Special considerations before Initiating Anti-psychotics

- Even if all of the above issues have been addressed and completed, the following issues need to be considered by the provider before an antipsychotic can be initiated.

✓ Cardiac concerns

❖ QTC concerns/"black box warning"

✓ Blood pressure concerns

❖ Significant risk of orthostatic hypotension concerns with anti-psychotics

Special Considerations before Initiating Anti-Psychotics

- Patients with hypotensive concerns are limited and at times not candidates for anti-psychotics.
- Falls: High risk patients are limited and not candidates for anti-psychotics at times.
- ✓ Metabolic concerns
- A1C
- Lipid Panel
- Excessive weight gain

Haldol and Delirium

- **Delirium**

✓ A disturbance of consciousness and altered cognition. It happens suddenly and usually an acute condition.

✓ Delirium has multifactorial etiology e.g. infection, abnormal labs, hydration, other medical concerns.

Haldol and Delirium

- **Haldol**

✓ Safest drug of choice used at lower doses as needed (PRN) to control moderate to severe agitation and psychosis.

✓ Continuous or prophylactic doses are not recommended. However, if clinical condition persists and the agitation/psychosis is not effective with PRN doses, Haldol can be scheduled for a short period of time.

Anti-psychotics with the least risk for Older Adults

- Please note all antipsychotics should be ~~initiated at the lowest dose possible due to~~ tolerability/risk of side effects and concerns

✓ Zyprexa

✓ Risperdal

✓ Abilify

Extrapyramidal (EPS)

- Describes dystonia, akathisia, pseudo-parkinsonism
- ✓ Dystonia: Involuntary muscle contraction, repetitive twisting movements
- ✓ Akathisia: muscle quivering, restlessness (inability to sit still)
- ✓ Pseudo-Parkinsonism: slowed movement, muscle stiffness, and shuffling gait
- Later onset tardive dyskinesia
- ✓ Tardive Dyskinesia: sucking and smacking lips, jaw movement, involuntary movement of extremities and trunk area

Extrapyramidal (EPS) Concerns

- A physical examination is recommended by a physician for accurate diagnosis of EPS.
- What does this look like in patients?
  - ✓ Joint stiffness/Joint rigidity
  - ✓ Drooling
  - ✓ Abnormal mouth/tongue movement
  - ✓ Tremors/abnormal shaking

EPS Treatment (Anti-Cholinergic drugs)

- Before initiating an additional medication to treat these concerns, a reduction in the medication needs to be attempted first. Since anti-cholinergic medications can cause AMS changes themselves.
- These medications are:
  - ✓ Cogentin
  - ✓ Amantadine
  - ✓ Artane

Psychotropics and Potential Side Effects

- Anytime a staff member, provider, or family questions side effects due to a psychotropic medication, HOLD THE MEDICATION.

✓ If the issue resolve in 72 hours, it was likely the medication.

✓ If the issue(s) continue after the 72-hour window, there is an underlying medical concern/overall decline going on that needs to be addressed.

Summary

- Long Term Care patients need psychotropic medications, but they are to be used cautiously.
- Before considering medications, explore all possible conditions/interventions to avoid medication usage.
- If all of the above fails and medication(s) has to be prescribed, use low doses for shorter periods and use medications with the least amount of side effects.

Questions?

References

- Gress T, Miller M, Meadows C 3rd, Neitch SM. Benzodiazepine Overuse in Elders: Defining the Problem and Potential Solutions. Cureus. 2020 Oct 19;12(10):e11042. doi: 10.7759/cureus.11042. PMID: 33214968; PMCID: PMC7673272.

Qsource®

www.qsource.org

Culture of Safety Center 2023 Summit

Ensuring Quality of Care in Nursing Homes.
Protecting Quality of Life for Residents.

Thank You for Joining Us!