THE LINGERING ALBATROSS:

OVERSHADOWING EFFECTS FACING QUALITY MEASURES

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Providers are taking a closer look at CASPER and Five-Star reports, and the results from a post-COVID world are devastating. The industry continues to be in a staffing crunch, and often the Nursing Assessment Coordinator (NAC) is pulled from completing MDS's to provide other responsibilities. Documentation has become a source of further stress for staff and is often not provided in its intended framework with an eye for detail. We are witnessing inexperienced staff that may have minimal training, providing care or understanding the depth of accuracy with timely documentation, which impacts Quality Measures. Almost three years have passed since the onset of COVID, and it has certainly left a permanent imprint on the healthcare industry.

During the early days of COVID, residents were in isolation, causing them to be socially separated, and only allowed limited movement within their rooms. Residents no longer walked the halls, ate in dining rooms, or attended activities. These new internal changes resulted in an increase in the number of residents that triggered quality measures (QM) related to Mobility and ADLs. The QMs tell us the quality of patient care for residents and inform the public on the quality of care that is provided in facilities.

Quality Measures are supported by MDS 3.0, with data to complete MDS 3.0 being documented by front-line staff. Due to COVID and staffing shortages, facilities have been unable to deliver in-depth orientation programs, which aim to train CNAs in proper care and supportive, accurate documentation. Combined with NAC's being pulled to provide additional resident care, the MDS completion is usually not completed timely or accurately.

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The two Long-Stay QMs related to MOBILITY and SELF-CARE are calculated using Section G of the MDS. This section of the MDS records information related to the functional abilities of the resident. Let's take a closer look at these two particular QM's in greater detail:

THE PERCENT OF RESIDENTS WHOSE ABILITY TO MOVE HAS WORSENED reports the percent of long-stay residents (those in the facility 101 days or more) who experienced a decline in independence of locomotion when compared to the prior assessment. This measure uses Locomotion on Unit item G0110E1 (self-performance) to calculate the percentage of residents who have lost mobility. The MDS definition for Locomotion on Unit is the ability of the resident to move between locations in their room and the adjacent corridor on the same floor or if the resident is wheelchair bound, the information is recorded based on wheelchair mobility once the resident is in the wheelchair. This item uses the rule of three for coding on the MDS, and during the 7-day look back, the self-performance of locomotion on the unit is documented by the caregiver each time it occurs. If the resident did not perform the activity or there is no documentation to support the assist level during the look back period, the NAC must code that the activity did not happen, and the MDS will recode the resident status to Total Dependence. If this happens and the resident was not dependent for Locomotion on Unit on the prior MDS, this resident will trigger on the QM. If there is If a patient with an actual decline in their ability to move around in their room, then the assistance required results in an increase in coding points (requires more assistance), and the resident will trigger the QM indicating they had a decline in mobility. In the QM calculation, there are items that will exclude the resident from the QM calculation: if on the prior assessment, the resident is comatose (MDS Section BO100), there is a prognosis of less than 6 months (MDS Sections J1400 or O0100K2), or if the resident was dependent for locomotion on unit. Any of these items will exclude, or remove, the resident from the denominator, or roster, and they will not be counted for the QM.

THE PERCENT OF RESIDENTS WHOSE NEED FOR HELP WITH DAILY ACTIVITIES HAS INCREASED reports the percent of long-stay residents whose need for help with late-loss Activities of Daily Living has increased when compared to the prior assessment. This measure uses four items from Section G of the MDS 3.0 for calculations. The QM uses self-performance in Bed Mobility item G0110A1, Transfers GO110B1, Eating GO110H1 and Toileting GO110O1. The MDS definition for these four areas is as follows:

- Bed mobility is how a resident moves to and from lying position, turns side to side,

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and positions body while in bed or alternate sleep furniture.

- Transfers is how a resident moves between surfaces including to or from: bed, chair, wheelchair, standing position but excludes to/from bath/toilet.

- Eating is how a resident eats and drinks. It includes intake of nourishment by tube feeding, TPN and IVE fluids but does not include eating or drinking during the medication pass.

- Toilet use includes multiple items related to toileting, how the resident uses the toilet, bedpan, or urinal, includes transfers on/off the toilet as well as how the resident cleanses self after elimination, changes a pad or manages an ostomy or catheter and adjusts clothing.

The NAC, using this documentation applies the rule of three and codes the MDS for each of the four items. If the resident did not perform the activity or there is no documentation to support the assist level during the look back period, the NAC must code the activity did not happen and the MDS will recode the resident status to Total Dependence. For the resident to trigger on this QM, they must have an increase in assistance in two or more coding, or assistance, points in one of the ADL items OR 1 coding point increase in two or more of the late-loss items. In the QM calculation, the items that will exclude the resident from the QM calculation include if on the target assessment, the resident is comatose (MDS Section BO100), there is a prognosis of less than 6 months (MDS Sections J1400) or on hospice (MDS Section O0100K2). The resident will also be excluded from the QM if on the prior assessment, the resident was totally dependent for all four of the late-loss items or dependent in three of the items and extensive assistance on the 4th ADL item.

SOLUTIONS

1. Review the CASPER Facility Level report to see what the facility looks like in comparison to peers in the state and nation. If the percentage is above 75%, an action plan must be put in place; however, if the number is not one that you would want customers or potential customers to see, it should become a focus for the facility.

2. The action plan will start with the CASPER Resident Level Report using the same dates as the Facility Level Report. This will ensure that the residents that trigger are the same residents reporting in the QM percentile.

3. For each resident that triggered on the report, check coding on the MDS for accuracy. Supportive documentation should be reviewed to confirm the resident status at the time of the MDS. It is also important to review the prior MDS as both QM's rely on comparison between current and prior assessments.

4. Identify the MDS that triggered the QM, as this will be the starting point to make improvement for the measure as the next MDS to be completed will directly be compared to that MDS. For the resident to drop off the CASPER QM report for these QM's, there will need to be a series of MDS's that do not show a change between the current and the prior

5. Therapy should complete screens and/or evaluations to determine the accurate assist levels for each resident that triggers. This information will provide the baseline status for the resident. Because Section G looks back 7 days from the ARD and uses the rule of three, nursing and CNA documentation will be the primary source of data to support the codes on the MDS. If there are discrepancies between the rehab baseline status and the CNA/Nursing documentation, query the staff to determine the true status.

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For both QM's, a low percentage of occurrence in the facility is favorable, meaning that residents do not lose function or self-care abilities while living in the facility. While improvement in direct provision of care is key, there are additional factors that directly affect the percentages on CASPER reports.

Getting back to basics and normalizing the process of quality care in facilities with a multi-prong approach will help minimize the workload on any one person, who may already be wearing many hats, as staffing continues to plague the industry.

Each of these two QM's impact Five-Star Quality Measure ratings. In addition, they are both available for public review on Care Compare. Getting back to basics and assessing resident status will help demonstrate the quality of care in the facility. QMs function as a guide to help focus on QAPI and action planning infrastructures. Preferred Therapy Solutions (PTS) developed a strategic platform in educational webinars to strengthen the many layers associated with Quality Measures and Five-Star Quality Measures. Contact Jim MacManus to learn how the PTS program can help your facility break free from the overshadowing QM albatross. Jim can be reached at jmacmanus.preftherapy.com.

SOLUTIONS

6. Therapy and nursing should work together and perform Resident Rounds on a weekly basis with a focus on each resident prior to the ARD on the upcoming MDS. By completing rounds timely in the MDS cycle, therapy will have time to provide evaluations and treatments to potentially minimize a decline in mobility or self-care.

7. Education on accuracy for coding directly impacts the QM. Make sure that all staff understand how to document the resident self-performance for the late-loss ADLS and mobility. Notification of subtle changes in regular performance will help therapy get involved with the resident early to minimize declines.

8. Stability in the NAC position is a primary area that impacts MDS coding. Ensuring the NAC has the documentation and time to code the MDS correctly will certainly benefit the facility in the QM.

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