Long-Term Care Survey Alert

Adverse Events: Care Planning And Medication Missteps: Expect Renewed Surveyor Scrutiny In 2015

New OIG report highlights preventable adverse events and hospital readmissions.

Will a new report foster meaningful quality improvement in the post-acute setting or simply provide surveyors with a new plan of attack?

While the leaders of several groups representing long-term care providers suggest that the report presents an opportunity for partnerships that could pay off in real and continued quality improvement, the feds, so far, remain focused squarely on the survey process so step up your defenses now.

The report, Adverse Events in Skilled Nursing Facilities: National Incidence Among Medicare Beneficiaries, released February 27 from the **HHS Office of Inspector General** (OIG), relays that "an estimated 22 percent of Medicare beneficiaries experienced adverse events during their SNF stays, (and) an additional 11 percent of Medicare beneficiaries experienced temporary harm events during their SNF stays." Furthermore, more than half (59 percent) of those adverse events were preventable, the report concludes.

The report attributes much of the preventable harm to:

- Substandard treatment,
- Inadequate resident monitoring, and
- Failure or delay of necessary care.

Must know: The OIG call on the **Centers for Medicare & Medicaid Services** (CMS) to "instruct State agency surveyors to review nursing home practices for identifying and reducing adverse events," adding that both CMS and the **Agency for Health Care Quality** concur with the OIG recommendations.

That means that surveyors will be scrutinizing your efforts to prevent adverse events from medication errors to care planning processes.

To improve care and save yourself at survey time, revisit efforts to minimize the types of shortcomings cited in the report. Professional groups, including **The Society for Post-Acute and Long-Term Care Medicine** (AMDA) offer tools designed to strengthen care.

AMDA urges providers to focus on evidence-based care, according to the group's immediate past president **Jonathan M. Evans, MD, CMD**, of Charlottesville, Virginia. Toward that goal, AMDA has developed evidence-based care competencies for physicians working in long-term/post-acute care settings. A curriculum designed to teach the competencies is due out this year.

Medication Missteps

In addition, providers should respond with greater attention to the possibility of medication-related errors. The OIG report focuses in particular on a "lack of compliance with CMS standards regarding the use of atypical antipsychotic drugs." So expect survey scrutiny on that front in the coming year.

Watch list: Among medication-related adverse events labeled in the report as "likely preventable" are the following: Fall associated with inappropriately prescribed atypical antipsychotic (quetiapine) resulting in femur fracture resulting in hospitalization, a fall associated with inappropriately prescribed opiates for pain (hydromorphone, hydrocodone/APAP,

tramadol) resulting in rib fracture, and a fall associated with inappropriately prescribed antipsychotics (haloperidol decanoate and risperidone) resulting in hematoma.

The report also calls attention to the care of residents with diabetes. Cited as "likely preventable" were these immediate jeopardy events: Hypoglycemic episode characterized by blood glucose of 38 resulting in hospitalization and contributing to the resident's death, and hypoglycemic episode characterized by a blood glucose of 20 resulting in hospitalization and contributing to the resident's death, and diabetic ketoacidosis due to insufficient administration of insulin resulting in hospitalization.

Alpesh Amin, MD, MBA, professor of medicine, business, public health, and nursing science at the **University of California**, Irvine, also coaches nursing homes on identifying typical medication transition failures. Many missteps have to do with insufficient oversight of the medication lists, he says. Situations that are an immediate red flag for adverse event potential: possible interactions of medications from multi-prescribers are not assessed, an incoming resident's medication list is outdated, or the electronic medical record doesn't match the list of medications the resident is actually taking.

Tool: The Advancing Excellence in America's Nursing Homes Campaign now offers an Excel-based Medication Tracking Tool that providers can download to better understand how their facility uses antipsychotic prescriptions. The tool helps users track behavioral and symptom changes and implement gradual dose reductions, among other features. To access the tool, go to www.nhqualitycampaign.org/star_index.aspx and search for "Medication Tracking Tool."

Dementia Care Defense

Dementia especially undiagnosed adds to the complexity of care, and can also lead to adverse events. To help ensure your approach is on track, consider employing free online professional development courses launched last December by AMDA.

The goal: The program aims to decrease the inappropriate use of antipsychotic medications for nursing home residents and improve the overall quality of care given to persons with dementia. Since launching last December, the training website has had 2,271 unique visitors, and 543 total users, reports **Perry Gwen Meyers**, AMDA communications manager. To access the program, go to https://amda-training.com/.

You may also want to get in the head of the surveyor to stave off F309 citations. For insights about what surveyors are likely to scrutinize, check out the three online training modules available at surveyortraining.cms.hhs.gov/pubs/AntiPsychoticMedHome.aspx.

Spotlight on Readmissions

The OIG Adverse Events report also stokes the fire already burning over nursing homes' role in preventing unnecessary hospital readmissions. "Over half of the residents who experienced harm returned to a hospital for treatment, with an estimated cost to Medicare of $208 million in August 2011," says the report. "This equates to $2.8 billion spent on hospital treatment for harm caused in SNFs in FY 2011."

The report's findings about hospital readmissions follow close on the heels of a CMS update in January regarding the federal Initiative to Reduce Avoidable Hospitalizations among Nursing Facility Residents, which launched last year and runs through September 2016.

Follow the leaders: CMS reported that all seven organizations participating in that initiative have chosen to use the INTERACT program (developed by **Joseph G. Ouslander, MD, and Mary Perloe, MS, GNP**, at the **Georgia Medical Care Foundation** with the support of CMS) in their quality improvement work with partnering nursing homes.

That kind of high-level buy-in suggests that the training program and tools are probably a sound investment for any post-acute provider. To learn more, go to http://interact2.net/.

CMS will also soon be beefing up its Quality Assurance Process Improvement website, which was created in response to new requirements in the Affordable Care Act. In 2014, expect guidance related to clinical care and resident safety and

the addition of a list of defined "adverse events," a list of potential adverse events that can be used to educate staff on the "range of harm that residents can experience, strategies for detecting and measuring adverse events, and best practices for improving staff recognition and reporting of adverse events."

Beyond-basics training: Look for opportunities focused on improving care transitions essential for post-acute care providers competing for Medicare Part A stay admissions and the recognition of hospital case managers. The **Institute for Healthcare Improvement** (IHI), an independent not-for-profit organization based in Cambridge, Massachusetts, is holding an in-person training event in April that is targeting post-acute providers among others (Reducing Avoidable Readmissions by Improving Transition in Care); go to www.ihi.org/education/Pages/default.aspx.

DIY: IHI also offers free tools that can help facilities track their improvements in patient safety (for example, Percent of Admissions with an Adverse Event) as well as tout what they are doing right by creating customizable graphics that can be used to highlight progress you have made. Go to app.ihi.org/Workspace/tools/ to learn more.

Bottom line: "Many of the events that we identified were preventable," conclude the OIG report authors. "Our study confirms the need and opportunity for SNFs to significantly reduce the incidence of resident harm events."

Go to the source: Inform future decisions about quality improvement with an in-depth reading of the OIG report. It is available at oig.hhs.gov/oei/reports/oei-06-11-00370.asp.