Long-Term Care Survey Alert

QUALITY MEASURES: Get A Jumpstart On The New Quality Measures

This 4-point plan will put your facility ahead of the pack.

Your facility will soon be facing round two of the Nursing Home Quality Initiative's publicly reported quality measures, and that means you'd better be focusing on the new QA targets - and be ready to explain out-of-range scores to consumers and surveyors.

The QMs are expected to go into effect in January, a **Centers for Medicare & Medicaid Services** official confirmed for **Eli** near press time. The measures will essentially be the same as the ones endorsed by the **National Quality Forum**, according to the agency spokesperson.

Yet specifications for some of the measures, such as the exact MDS coding, still have to be completed, according to **David Gifford, MD, MPH**, chief medical officer for the Rhode Island quality improvement organization, one of the QIOs involved in the NHQI. (Check with your state QIO for information about the revised quality measures, including a new user's manual, which the QIOs are putting together in time for the QM debut.)

Target These 4 Areas Now

While CMS never intended the QMs to be survey tools like their quality indicator counterparts, you can bet any surveyor worth his salt will look at your last scores before a survey. But you can stay ahead of the quality improvement curve by tackling these QM areas:

1. **Pressure ulcer healing.** A new post-acute measure looks at the percentage of residents whose pressure ulcers have not gotten better from the 5-day to the 14-day assessments. This measure is causing some concern, considering that the assessment reference dates for those two assessments can be as little as three days apart, notes **Rena Shephard**, president of **RRS Healthcare Consulting** in San Diego, and chair of the **American Association of Nurse Assessment Coordinators** in Denver. "For example, the ARD for the 5-day assessment can be as late as day 8 of the resident's post-acute stay (including the grace days) and the ARD for the 14-day MDS, as early as day 11," Shephard notes.

That's where aggressive wound care protocols come into play. Many stage 1 and 2 ulcers can heal in a few days with the appropriate pressure relief and other nursing care, notes Gifford.

Don't penalize your facility by over-coding wounds as pressure ulcers. For example, the August 2003 MDS update eliminated the word "injury" from the definition of a pressure ulcer. "So if a skin tear is caused by injury (the resident fell and suffered a skin tear to his elbow), then you don't code that as a pressure-related skin tear or a pressure ulcer," counsels **Christine Twombly, RNC**, chief clinical consultant with **Reingruber & Company** in St. Petersburg, FL.

The MDS also does not take into account a palliative or terminal wound, which is a definite wound category and considered unavoidable in a dying patient. Surveyors might count such a wound as a pressure ulcer if staff don't know what they are describing or how to treat it, says **Mary Foot**, a wound care specialist and principal of **Wound Care on Wheels** in Napier, IL.

2. **Worsening depression and anxious mood.** A new chronic care measure will report the percentage of chronic-stay residents whose depression or anxiety has increased from the previous MDS to the target assessment. "The QM could prompt facilities to prescribe more anti-anxiety and antidepressant medications," says **Beth Klitch**, president of **Survey Solutions** in Columbus, OH.

But it's important not to be too quick to resort to pharmaceutical solutions, Klitch cautions. Instead, look for the causes of anxiety, such as loss of roles, fear of health crises and abandonment - and too much change in the environment. "Provide security and reassurance, as well as activities and interpersonal interventions to combat the loneliness and boredom that lead to depression and anxiety," Klitch suggests.

Tip: Are you using the Geriatric Depression Scale or a similar instrument to screen residents for depression? Consider repeating the screen at quarterly assessments. "The risk for depression sometimes grows with the length of stay and physical decline," Klitch notes. Then be prepared to show surveyors how you're on top of potential depression.

3. Urinary tract infections. A new chronic-care measure will look at UTIs in chronic-care residents. (The chronic-care infection QM has fallen by the wayside.) Facilities can improve their performance on the new measure by addressing common risk factors for UTI. "Dehydration puts residents at risk for UTI, for example," Klitch says, "as does fecal incontinence because it exposes the urethral area to E. Coli." Immobility also predisposes residents to UTI. **Tip:** Encourage bedfast residents to sit as upright as possible to empty their bladders.

Make sure you're not over-coding the MDS for UTI, which will artificially inflate your QM scores. (Review the criteria on p. 136 of the Resident Assessment Instrument user's manual at www.cms.hhs.gov/medicaid/mds20/rai1202ch3.pdf.)

Are you using cranberry juice or supplements for residents with recurrent UTIs? Cranberry extract in gel caps is preferable to juice in preventing recurrent UTI, according to new guidance on caring for residents with MS in the nursing homes (see our special supplement in this issue "Best Practices"). The gel caps can be opened and added to applesauce or pudding for residents with dysphagia, or flushed into gastrostomy tubes.

4. Urinary and bowel incontinence. The new QMs also include the percentage of residents with indwelling urinary catheters to see if facilities are using more Foleys to sidestep incontinence. To address urinary incontinence, keep in mind that it's a symptom, says **Clare Hendrick, CRNP, RN**, vice president of education and clinical development for **HealthEssentials Inc.** in San Clemente, CA. "And the question should be: Why is this person incontinent?" Once you pin down the type of incontinence and any aggravating dietary factors or medications, then tailor a comprehensive care plan to address the problem. Toileting programs, good hydration and diets that eliminate or reduce caffeine and improve bowel health help patients stay dry, according to presenters at the recent **National Association of Directors of Nursing Administration in Long Term Care** conference in Cincinnati (for state-of-the art incontinence management, see the August 2003 Long-Term Care Survey Alert).