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# MDS Alert

## Quality Reporting: Counter These 3 Shortfalls To New Quality Measures

**These strategies will help you tell the 'rest of the story' about your facility's quality of care.**

The **Centers for Medicare & Medicaid Services'** set of "enhanced" 14 quality measures debuted in late January not with a bang or a whimper but with providers scoring very valid points about how some of the newly crafted measures might mislead consumers about the quality of their care.

Here's a rundown of three of providers' and trade groups' top concerns in that regard and suggested ways to cope (see "14 Enhanced Quality Measures" for a list of the QMs).

**Concern #1: Confusion generated by the measures' consumer-friendly language.** For example, the measure "percentage of residents who spend most of time in the bed or chair" is actually looking at the same thing as the bedfast quality indicator, says **Ruta Kadonoff**, senior policy analyst for the **American Association of Homes & Services** for the Aging. "The MDS item (G6a) that defines that measure is the one where the resident either spends 22 hours a day in bed or in a recliner in his/her room," she notes.

**Strategies for Success:** Crosswalk the measures to what they actually measure.  Download and print a convenient chart that does that for you at www.cms.hhs.gov/quality/nhqi/Snapshot.pdf.

Then develop consumer education materials to further define and explain what the measures really mean within the context of your patient population. For example, explain how your rehab program uses restraints as "enablers" to help residents function more independently, if that's the case.

**Concern #2: Misleading connotation that chronic-care residents with "worsening anxiety and depressed mood" have been actually diagnosed with these conditions.**

In reality, that may or may not be true, as the Section E items that drive this measure only capture mood symptoms or indicators; these include signs of crying or tearfulness, motor agitation, negative statements, repetitive health complaints,  repetitive/recurrent verbalizations, etc.

**Strategies for Success:** Do a more in-depth assessment of all residents who trigger on the mood items in Section E and care plan accordingly. "The nurse can work with the primary care practitioner or medical director to do a good depression work-up," suggests **Susan Scanland MSN, GNP, RN**, president of **Geriscan Geriatric Consulting** in Philadelphia.

Look at the diagnostic criteria in the DMS-IV for depression or use the SIGECAP, a mnemonic device that screens for depression and dysthymia (see "SIGECAPS Screening Tool For Depression"). Or use the Geriatric Depression Scale. "In some cases, the work-up may reveal the resident actually has an adjustment reaction or is grieving," Scanland notes. **Play It Safe:** "Make sure to assess residents with depression for suicidal ideation and plans," emphasizes Scanland.

Lower the prevalence of anxiety and depression by addressing its causes, such as loss of roles, fear of health crises and abandonment -- and too much change in the environment, suggests **Beth Klitch**, president of **Survey Solutions Inc**. in Columbus, OH.

**Concern #3: Shortfalls in the risk adjustment for short-stay and chronic care pressure ulcer measures.** By not differentiating between wounds that facilities inherit at admission versus those that develop in-house, the chronic-care pressure ulcer measure "skewers" the very wound care centers of excellence that CMS, on the other hand, seeks to

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promote.

That's how a provider participating in a recent open door forum on the quality measures put it, a sentiment supported to some extent by CMS representatives **Mary Pratt** and **Jean Scott**, who moderated the ODF on the QMs.

Scott noted that the MDS 2.0 has no way to capture information about whether a pressure ulcer is present at admission, a shortfall that CMS is trying to figure out how to address in the MDS 3.0.

**Strategies for Success:** If you admit a lot of residents with serious pressure ulcers, be prepared to show consumers and surveyors the actual numbers and how that impacts your quality measures.

Also give them data to demonstrate how quickly you're healing stage 3 and 4 ulcers, suggests **David Gifford**, chief medical officer for the Rhode Island quality improvement organization.

**Two Other Problems:** The short-stay measures capture the percentage of residents whose pressure ulcers stay the same or worsen from the 5-day to 14-day assessment. Yet the assessment reference dates for these two MDSs can be as little as three days apart. That doesn't give you much time to heal the ulcers.

In addition, the low-risk chronic care pressure ulcer measure includes only those residents who don't have one of the three risk factors for the high-risk QM (malnutrition, comatose or impaired bed mobility or ability to transfer). "That's a pretty limited definition of risk," Kadonoff points out.

**Strategies for Success:** Implement aggressive pressure-relief protocols to heal as many stage 1 and stage 2 ulcers as possible between the 5-day and 14-day assessment. "Facilities forget how quickly these ulcers can heal" with the right intervention, says Gifford.

Perform and document a comprehensive assessment of all of a resident's risk factors for skin breakdown, including comorbidities, such as diabetes mellitus and peripheral vascular disease.

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