MOMENTUM
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LeadingAge Ohio

Moving Quality Outcomes Through Collaboration

September 1, 2022

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Fiscal Year 2022, one-quarter of facilities statewide were excluded from the QIP, which translated to hundreds of thousands in losses for some organizations.

- For example, a 100-bed nursing home operating at the state average of 60% Medicaid occupancy whose QIP score fell into the bottom quartile would have lost over $260,000 in Medicaid payments over the year.

LeadingAge Ohio worked to make sure members had the knowledge and skills they needed to boost their scores-- and their revenue. LeadingAge Ohio launched a six-month intensive that brought together finance, clinical and operations experts from across the state to boost QIP scores.

Medicaid Quality Incentive Payment

Ohio Legislature FY20 – FY21 Budget created a new "Quality Incentive Payment" based on four long-stay measures.

- "Quality pool" represented a 5.2% increase to nursing facility reimbursement by the end of the biennium (Est. 2.6% in each FY)
- Providers with occupancy below 80% were excluded UNLESS: 1.) 15+ points OR 2.) significant renovations.

2019 rate was based on CY 2018 Quality Measures. 2020 rate was based on CY 2019 measures.

***Committee will be created at the legislative level to discuss and provide recommendations for QIP going forward**

Medicaid Quality Incentive Payment

Ohio Legislature FY22 – FY23 Budget passed with increases to Quality Incentive Payment (QIP), which could mean significant revenue for providers

- 100-bed nursing home operating at the state average of 60% Medicaid occupancy whose QIP fell into the bottom quartile would have lost $260,000
- 25% of providers are excluded from the QIP based the Quality Measures
  - Cut-off points for FY22 are 9.5 points

July 2021 & 2022 rates based on latest-available four-quarter average.

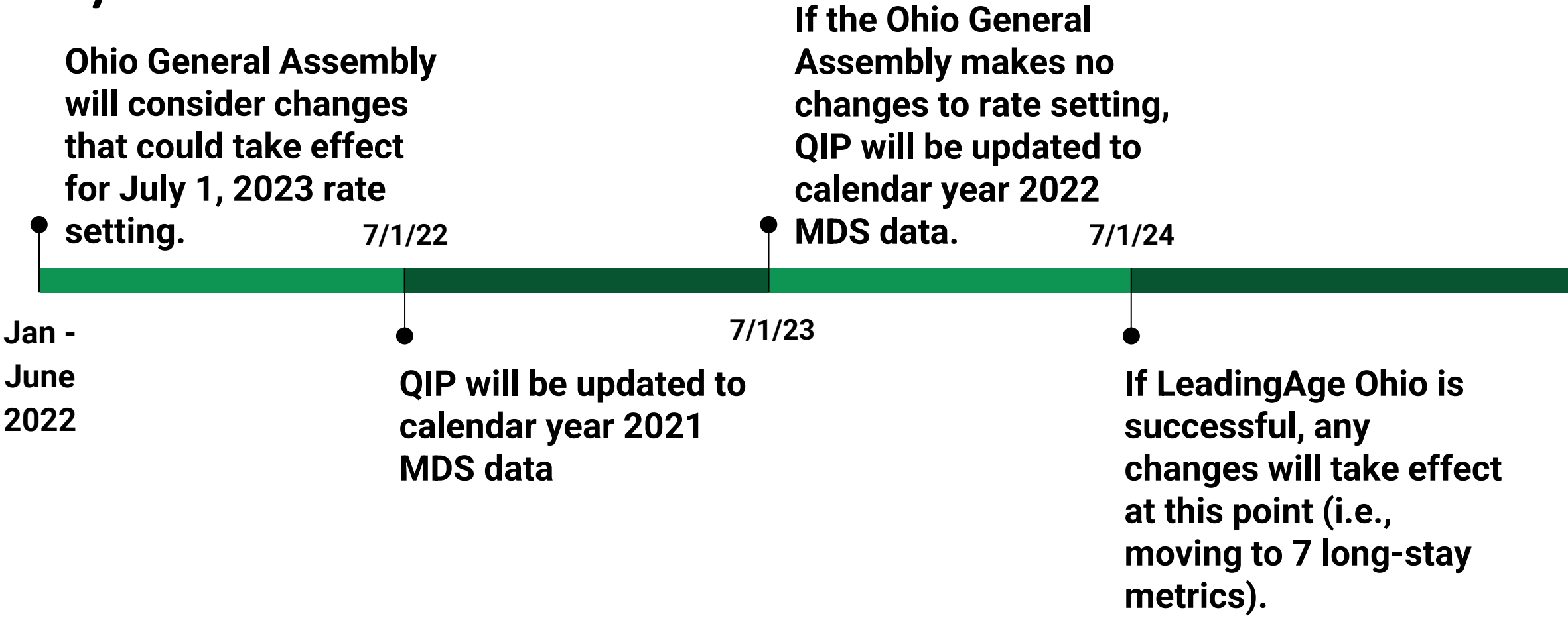
***Committee will be created at the legislative level to discuss and provide recommendations for QIP going forward**

Medicaid Quality Incentive Payment

QIP is calculated using CMS assigned points for four long-stay measures

- Four Long Stay Measures
  - UTI, High Risk Pressure Ulcers, Catheters, Mobility Decline
- CMS assigned points are divided by 20, for max points of 22.5
  - UTI – 100/20 = 5 points
  - Mobility Decline – 150/20 = 7.5 points
  - Catheters – 100/20 = 5 points
  - High Risk Pressure Ulcers – 100/20 = 5 points
- Providers in the lowest percentile based on points assigned by CMS would receive zero points for each QM

Key Dates


Ohio General Assembly will consider changes that could take effect for July 1, 2023 rate setting.
7/1/22
If the Ohio General Assembly makes no changes to rate setting, QIP will be updated to calendar year 2022 MDS data.
7/1/24
Jan - June 2022
7/1/23
QIP will be updated to calendar year 2021 MDS data
If LeadingAge Ohio is successful, any changes will take effect at this point (i.e., moving to 7 long-stay metrics).

QIP Collaborative Goals

- Team-based education
- "Everybody teaches, everybody learns"
- Partnership between financial and clinical teams
- Nursing Home providers learned:
  - How the Quality Incentive Payment (QIP) is calculated for Ohio Medicaid reimbursement
  - How to manage and improve the quality measures to improve their reimbursement opportunities.
  - Financial measures and tools to improve processes and outcomes that will impact the quality measures.
  - Best practices and useful tips, tactics and resources.

Results

- Total of 36 participating facilities
- 27 facilities improved their financial impact
- $4,012,836 financial gain
  - A couple facilities had significant events impacting their ability to fully participate
- Overall gain in knowledge across the clinical and financial teams
- Improvement in quality measures impacts five star ratings and survey risk
- Changes in processes that drive quality outcomes
- Shared learning from best practices

OVERALL NET FINANCIAL IMPACT FOR COLLABORATIVE

$4 MILLION DOLLARS

Participate Results

	TWIN TOWERS		
	- % - 2020Q1 - 2020Q4	Total CMS Points	Total OHIO Points
LONG-STAY (Based upon zeroed out lowest percentile)			
High Risk Pressure Ulcers (long-stay)	3.6%	100	5.0
Catheter (long-stay)	4.8%	20	-
Urinary Tract Infection (long-stay)	10.5%	20	-
Mobility decline (long-stay)	20.2%	60	3.0
TOTAL POINTS		200	8.0
		QIP Rate	$ -

	TWIN TOWERS		
	- % - 2021Q1 - 2021Q4	Total CMS Points	Total OHIO Points
LONG-STAY (Based upon zeroed out lowest percentile)			
High Risk Pressure Ulcers (long-stay)	5.7%	80	4.0
Catheter (long-stay)	0.4%	100	5.0
Urinary Tract Infection (long-stay)	1.5%	80	4.0
Mobility decline (long-stay)	11.5%	120	6.0
TOTAL POINTS		380	19.0
		QIP Rate	$ 34.58

$34.58 QIP Rate Add-On

Focus on the OPPORTUNITY!!

	MAX POSSIBLE "BASE" POINTS	- % - 2021Q4	Points	- % - Four Quarter Average	CMS Points	QIP Points	2021Q4 - Opportunity / Risk: OPPORTUNITY No. of Residents	OPPORTUNITY % of Residents	RISK No. of Residents	RISK % of Residents	Opportunity / Risk
LONG-STAY											
High Risk Pressure Ulcers (long-stay)	100	0.0%	100	6.0%	60	3.0	0.3	5.8%	2.2	7.8%	Opportunity
Catheter (long-stay)	100	0.0%	100	0.0%	100	5.0	-	0.0%	0.7	0.5%	Risk
Urinary Tract Infection (long-stay)	100	0.0%	100	0.6%	[illegible]	5.0	1.0	0.0%	0.1	0.7%	Risk
Mobility decline (long-stay)	150	3.5%	150	24.2%	30	1.5	0.3	23.9%	4.0	27.5%	Opportunity
					290	14.5					

Collaborative Impact

First Meeting October 21, 2021 – Avg Points for the Collaborative –

9.7

Year End January 20, 2022 – Avg Points for the Collaborative –

12.1

25% Improvement

Average Points for 1st Quarter 2022 – **12.8**

Return on Investment

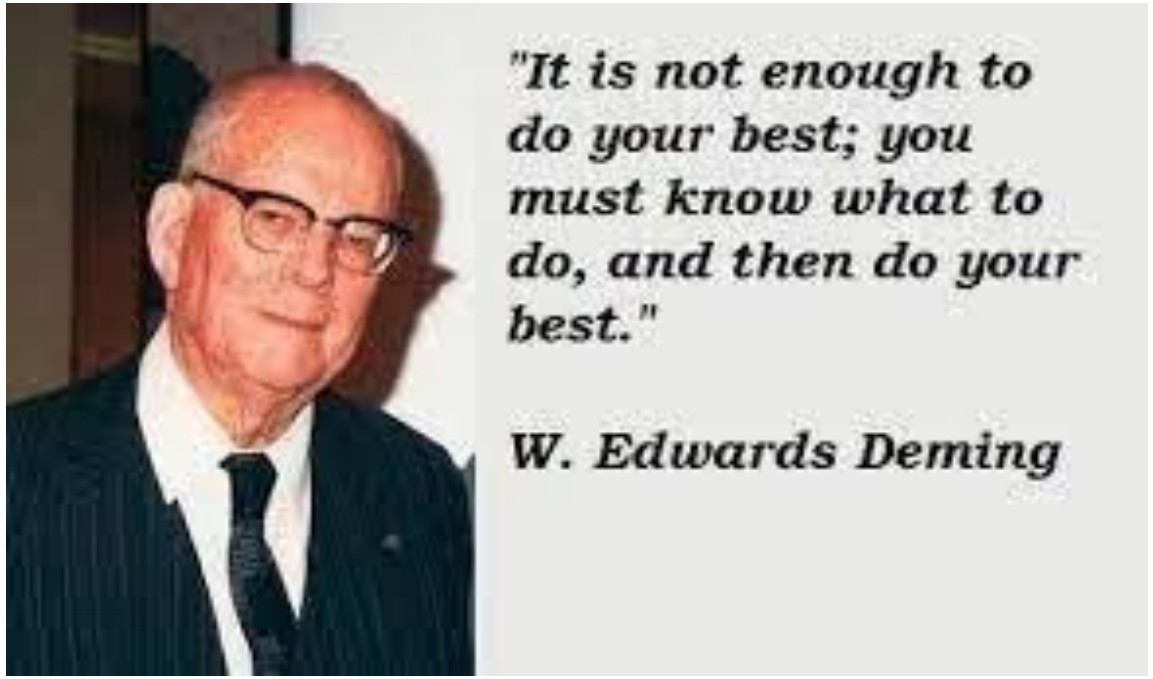
So how many points do I need to improve in order to get the return on my investment???

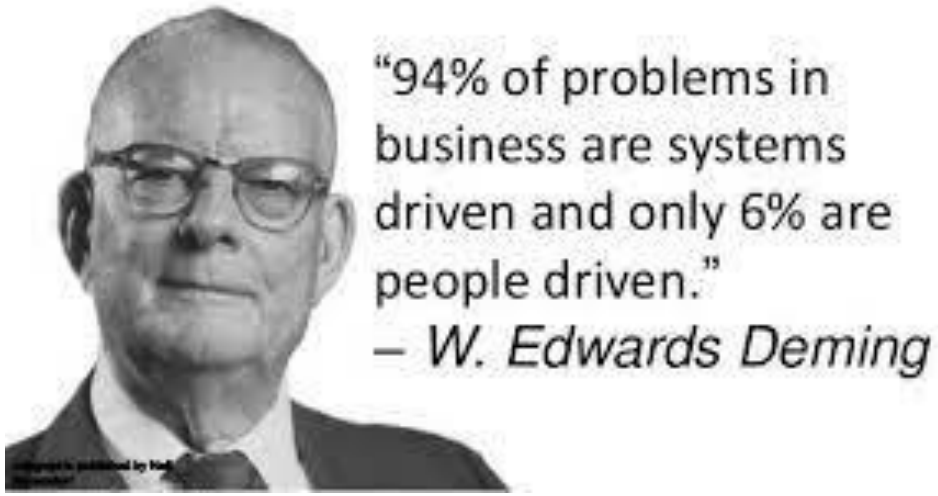
Provider Name	Quality Incentive Points 2020	Quality Incentive Points 2021	Increase/ (Decrease)	Financial Impact
Example Facility	15.0	15.5	0.5	15,561

Improvement of .5 (1/2 a point) resulted in a net financial impact of $15,561, an initial investment of $1,500 would be 10% of that result.

Provider Experience
THE WHY

Quality Assurance Performance Improvement





QAPI Work

- Identify residents triggering for the four QM's in the 4th quarter (10/1/2021 – to date)
  - Would the resident still trigger if a new MDS was completed?
    - Ensure there is >45 days between assessments.
- Identify which residents will have an MDS assessment by 12/31/21 (ARD on or before 12/31/21).
  - Determine if they previously triggered one of the four QM's
  - Identify if they still will trigger
  - Evaluate if an earlier ARD is better. Example – A resident with a history of recurrent UTI last had UTI in September. ARD is scheduled for 12/31/21. Consider scheduling ARD sooner.
- For any new resident triggering one of the four QM's in the 4th quarter, complete a thorough team review using the next steps document that was the 5 page word document you sent to Stephanie DeWees before the November call.

QAPI Work

Follow-up from opportunities identified from completing page 2-5 of the QIP Next Steps QAPI from that was submitted to Stephanie DeWees before the November call.
Remember, you would have investigated the following items for each of the four QM's.

- Where is all the supporting documentation located in the medical record?
- Who all is part of documenting and are they competent or need additional training?
- Who is coding the MDS and should others be part of the discussion?
- Were you able to validate the MDS and if not, what was the issue?
- Was there another time when the resident wouldn't have triggered?
- What was learned?
- Based on your above responses, what do you want to do?

How many new residents have you had trigger any one of the four measures that did not trigger in the 4th quarter?

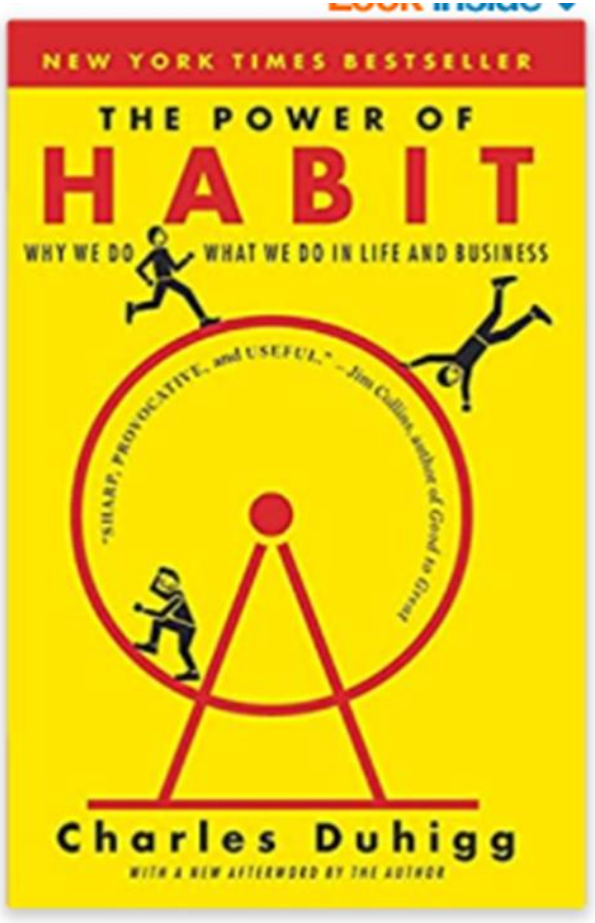
What did you learn when you completed the in depth root cause analysis?

“Learned the importance of the drill down and prevention.”

“If you always do what you’ve always done, you’ll always get what you’ve always got.”

– Henry Ford

Power of Habits



CUE + ROUTINE + REWARD = HABIT

Track QM List

- Audit for accuracy & keep a list
- Run QM monthly, review the QM weekly & discuss needs during MDS meeting
- Continually monitor documentation with weekly benchmarks, daily review of progress notes and orders.
- Infection preventionist will send list of all residents that had UTI's each month.
- MDS will review and schedule MDS earlier or later to avoid capturing UTI.
- Anyone with indwelling catheters, unit managers will monitor for proper diagnosis or try to get catheter discontinued.

Track QM List

- Daily QM meeting in morning meeting-
- Audits before signing MDS – compare previous 45 day MDS
- QM drill down report
- IDT team meets bi-weekly to review all residents who are triggering for each QM
- Develop MDS binder to track residents, kept in MDS office, monitored weekly to identify if resolved and if yes, then identify date when they hit greater than 45 days
- Add to our weekly UR meeting to review our residents that would trigger, have acute concerns, and set new ARD dates to complete assessment and determine the date needed for a follow-up assessment.

Quality Measure Coding

UTI (I2300 = 1)

- ❑ Target Assessment
- ❑ When did it occur
- ❑ Criteria to code

RAI Manual - 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.

Where documented?
Who documents?
Who coding MDS?
Able to validate?
Doesn't trigger?
What was learned?

RAI Manual

— If the diagnosis of UTI was made prior to the resident's admission, entry, or reentry into the facility, it is not necessary to obtain or evaluate the evidence-based criteria used to make the diagnosis in the prior setting. A documented physician diagnosis of UTI prior to admission is acceptable. This information may be included in the hospital transfer summary or other paperwork.

— When the resident is transferred, but not admitted, to a hospital (e.g., emergency room visit, observation stay) the facility must use evidence-based criteria to evaluate the resident and determine if the criteria for UTI are met AND verify that there is a physician-documented UTI diagnosis when completing I2300 Urinary Tract Infection (UTI).

McGeer Criteria, 3 important conditions should be met when applying these surveillance definitions:

All symptoms must be new or acutely worse. (urinary urgency)

Alternative noninfectious causes of signs and symptoms (eg, dehydration, medications) should generally be considered and evaluated before an event is deemed an infection.

Identification of infection should not be based on a single piece of evidence but should always consider the clinical presentation and any microbiologic or radiologic information that is available. Microbiologic and radiologic findings should not be the sole criteria for defining an event as an infection. Similarly, diagnosis by a physician alone is not sufficient for a surveillance definition of infection and must be accompanied by documentation of compatible signs and symptoms.

UTI - Opportunity for Improvement

Resources for evidence-based UTI criteria:

- Loeb criteria:

https://www.researchgate.net/publication/12098745_Development_of_Minimum_Criteria_for_the_Initiation_of_Antibiotics_in_Residents_of_Long-Term-Care_Facilities_Results_of_a_Consensus_Conference

- Surveillance Definitions of Infections in LTC (updated McGeer criteria):

https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3538836/

- National Healthcare Safety Network (NHSN):

https://www.cdc.gov/nhsn/ltc/uti/index.html

QAPI Work

UTI - We are calling all Infection Preventionist to do a deep dive into the challenges of using evidenced-based criteria and help develop solutions that everyone in the collaborative can incorporate. Below will get you started but we hope you will expand beyond these points.

o What action steps do you already have in place that supports your work in this area?

- Our infection preventionist completes all needed follow up with staff for clarification and documentation
- UDA assessment with criteria, solid foundation with attending practitioners who are in-line with our goals and onboard with evidence based practice.
- Placing hydration carts on halls around 10 am
- Infection preventionist to attend morning meeting with team to catch any new infections.

Action Steps Already in Place

- Educate staff on criteria for UTI
- Infection line listing- ability
- Continuing to educate on symptoms
- Continued education and hydration cart
- SBAR
- Staff development provides education on UTI's
- Bowel and bladder assessments
- Toileting schedule
- Peri care audits to ensure proper technique
- Following Mcgeer criteria, tracking them monitoring for trends
- Spoken with the physician to follow up on what is needed to help educate nurses.

QAPI Work

UTI - We are calling all Infection Preventionist to do a deep dive into the challenges of using evidenced-based criteria and help develop solutions that everyone in the collaborative can incorporate. Below will get you started but we hope you will expand beyond these points.

o What action steps will you add to your plan?

- Continued education
- More staff education
- Offer additional fluids during meals
- Educate nurses to monitor Urine C&S and to call physicians with any negative results to obtain order to D/C antibiotics.
- Continued use of infection line listing and following criteria through ability program
- Continue to educate staff
- Education
- Audits

Rate your team on how well you are currently monitoring residents who trigger? On a scale of 1-10. Ten being all QIP team members are reviewing who is triggering, in-depth review, root cause, action step, monitoring plan, consistently discussed as planned. If your entire QIP team is not part of this discussion, meaning only the MDS nurse is doing it, then rate yourself below a 5.

"Coming together is a beginning, staying together is progress, and working together is success."

– Henry Ford

UTI

What gap or opportunity for improvement did your team identify?

Lack of supporting documentation when a urinalysis is ordered because family requests and no symptoms present.

UTI - Opportunity for Improvement

Where does the problem begin?

Who all is involved?

What training have they had to handle this situation?

UTI - Opportunity for Improvement

- If a resident is discharged to the hospital with a UTI it is captured on the d/c MDS. Many times when a resident is admitted from the hospital the discharge paperwork has UTI as a diagnosis. Unsure how to address those issues if there's not enough time remaining in the quarter to complete another MDS

UTI - Opportunity for Improvement

- Team identified documentation of s/s of uti is the biggest gap and prevention of uti's
- Set ARD for another assessment in order to avoid capture of UTI if possible.
- We learned if a resident would trigger for UTI, it may be best to open outside of the look back window for UTI if possible. Also, if MD did not dx, and no urinary symptoms are present, it is not a true UTI.
- Educating the direct care staff on their impact on the Quality Measures.

UTI - Action Steps

Have you been able to initiate action steps/plan of action? If not, what are you planning to do?

- MDS to do a thorough review of document and staff being educated in the required criteria for doing a urinalysis and how to educate the family on why we do not want to do testing if it is not necessary.
- Added health care academy for nurses- s/s of uti's that are significant and other possible causes for symptoms
- Added health care academy for stna's - peri care and uti prevention
- Moved ARD of resident with recurrent UTI
- Set another MDS - Will start implementing in 4th quarter.

UTI - Action Steps

- Continue to talk about new UTI's in daily clinical meeting to evaluate McGeers criteria, evaluate if they are going to trigger on the MDS and determine if a new MDS is needed to remove.
- We have initiated reviews at the end of each quarter with the MDS nurse and other IDT members. Reviews include the following: Exclusions and Covariates for the UTI, section I of the MDS to ensure accuracy, review the criteria from the RAI manual to ensure it should be coded and should another MDS be scheduled (if applicable) to remove the UTI
- We are talking with staff development to outline education that will be presented to the direct care staff.
- If you didn't have a resident trigger, the team still needs to do a root cause analysis of the facility's protocols to proactively identify gaps.

Gaps and Opportunities

- Education and understanding
- Understanding criteria- documentation,
- Knowledge of criteria needed
- Initiated dip sticks
- Infection assessment
- More consistent staffing needed
- Medical director/physician education
- More detailed documentation to identify a concern prior to U/A results. The nurse's attention to identify the need to push fluids as a resident is beginning to have uti symptoms.

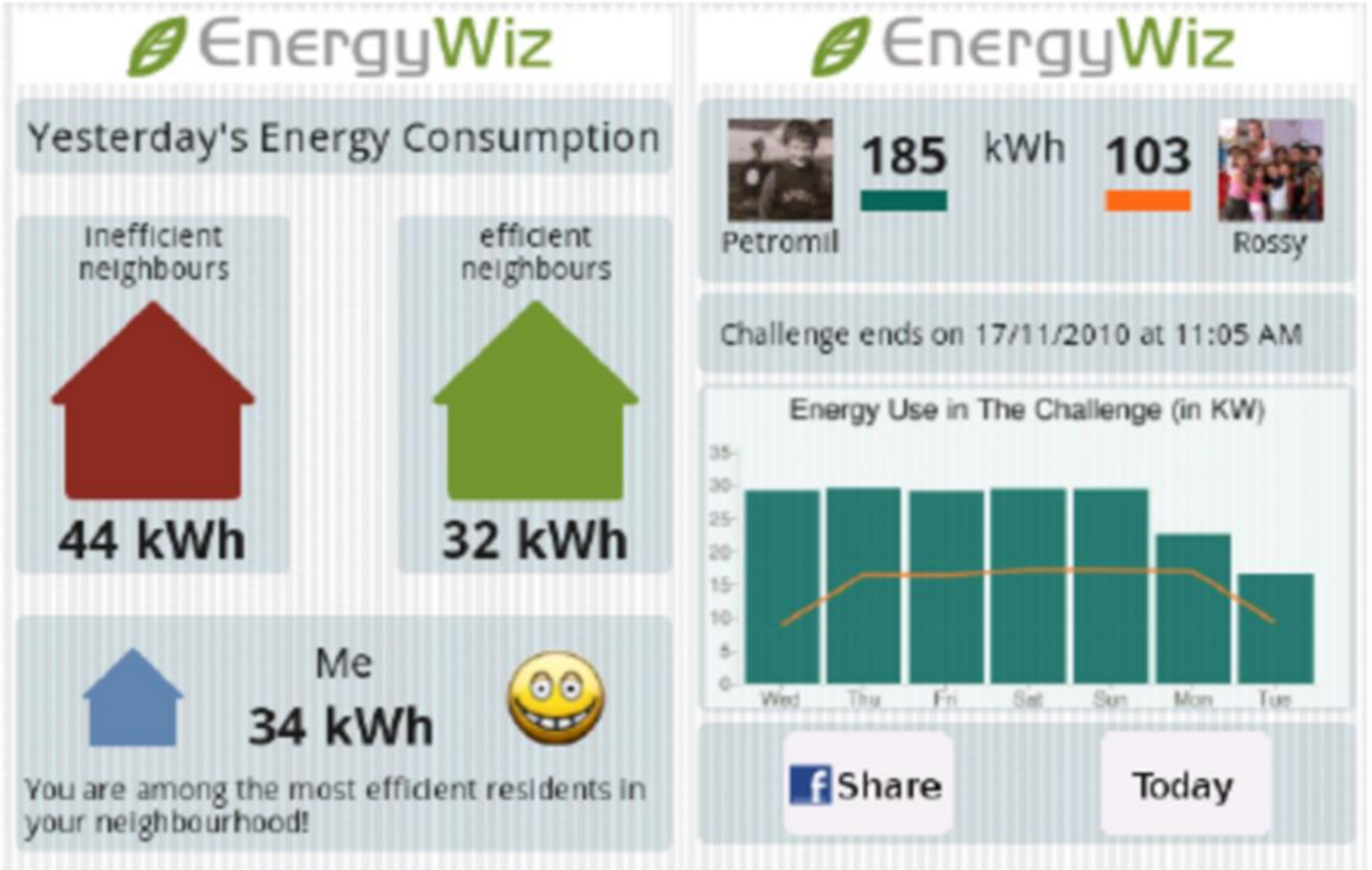
Gaps and Opportunities

- Obtaining the correct documentation from nursing staff
- We have a lot of new staff, training them to the expectation and documentation requirements. Educating families on pushing fluids and other causes of confusion.
- Staff shortage related to COVID, agency staff, lack of consistent staff
- Education- documentation
- Resident non-compliance, new infection assessments
- Lack of understanding of McGeer criteria
- Not investigating other reasons for infection, staff's first response is UA

Gaps and Opportunities

- Documentation related to suspected UTI
- Family request
- Staff understanding of importance of Nurses and STNA attention to slight changes in residents mood, urine output, skin,etc.
- The physician not directing the nurses to push fluid and encourage routine toileting for the resident with mild s/s of UTI, and going ahead and ordering a U/A and C & S.

Power of Habits



THANK YOU For Hydrating Our Resident's!!!

Keep Up the Good Work and Continue to ensure they drink plenty of fluids!

Provide fresh ice water every shift!

After hearing the examples on February's call, what additional work did you do with your lead measure for UTI's?

Following mcgeers criteria

Preventative interventions

Fluid inventions

Peri care audits

Hand washing audits & education

Nurse meetings, education

Visual cues for UTI prevention

Visual cues for pressure ulcer prevention.

Observation of hydration carts

Observation of activity programming

Audit to ensure SBAR before MD notification

End of quarter reviews

UTI's continued

Monitor intake and output, develop alert system in EMR to identify high risk for recurrent UTI.

Monitoring LTC residents that seem to have recurrent UTI's, pushing fluids and toileting programs.

Make sure we are following through with our hydration program to ensure adequate hydration.

The lead measure is # residents with s/sx of UTI.

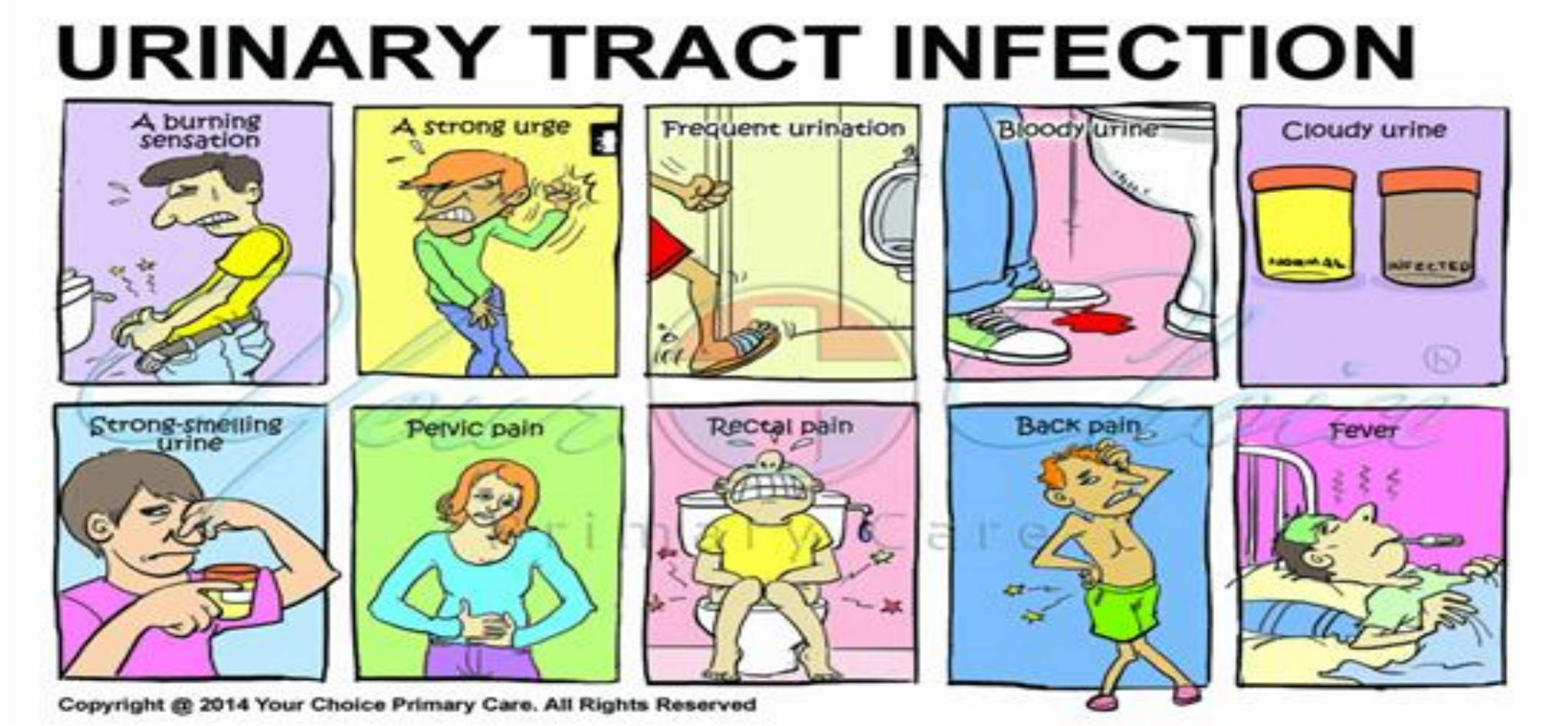
The habit is reviewing every day for the completion of a McGeers, any new order for antibiotic for UTI, and progress notes to look for residents exhibiting s/sx of UTI, so we can add the residents next ARD to the daily clinical follow up sheet to evaluate if criteria is met and if it will impact the MDS or if the ARD can be moved.

The visual cue is a dashboard set up in excel that is shared daily at clinical meeting

UTI's continued

Provided visual signs for residents room to drink more water and also monitored how much water was consumed with individuals at risk for UTIs before a UA was collected.

Initiation of hydration carts. Twice a day the kitchen brings hydration cart to end of hall to prompt STNA to pass fluids to the hall. Each resident offered cranberry, apple or water for additional fluid intake. Overall impact has been noted improvement and residents appear to love this!


URINARY TRACT INFECTION
A burning sensation
A strong urge
Frequent urination
Bloody urine
Cloudy urine
NORMAL
INFECTED
Strong-smelling urine
Pelvic pain
Rectal pain
Back pain
Fever
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Warning Signs of a Urinary Tract Infection

Urinary Tracy Infections (UTIs), while easy to cure, are often harder to diagnose in the senior citizen population and can be potentially life-threatening to elderly individuals if left untreated. And because they can often cause behavioral changes that mimic those of dementia and Alzheimer's disease, it is important to know and be able to spot the warning signs of a UTI to avoid misdiagnosis.

Certain UTI symptoms are easier to detect in seniors than others. The following are some common symptoms and behaviors that often accompany UTIs in elderly persons:

- Agitation
- Hallucinations
- Falling
- A confused, or delirium-like state
- Other behavioral changes
- Poor motor skills or dizziness

Additionally, there are some UTI symptoms that may be present, but often go unreported by elderly individuals, including:

- Strong-smelling urine
- Pelvic pressure
- Fever
- Pain with urination
- Night sweats
- Cloudy or bloody urine

(NOTE: A fever may not be present in some seniors with UTIs due to a weakened immune system.)

How do seniors develop UTIs?
According to the National Institutes of Health, the following conditions make the elderly more susceptible to UTIs than younger people:

- Diabetes
- Use of a catheter
- Enlarged prostate
- Kidney stones
- An inability to fully empty the bladder
- Bowel incontinence
- Immobility

If any of these symptoms are noted, bring them to the attention of the person's physician immediately, as an untreated UTI can lead to dangerous health complications. **Live Free Home Health Care** provides in-home care services that can help prevent UTIs such as health monitoring, preparing healthy, bladder-friendly meals, and encouraging fluid intake throughout the day.

Live Free Home Health Care, LLC

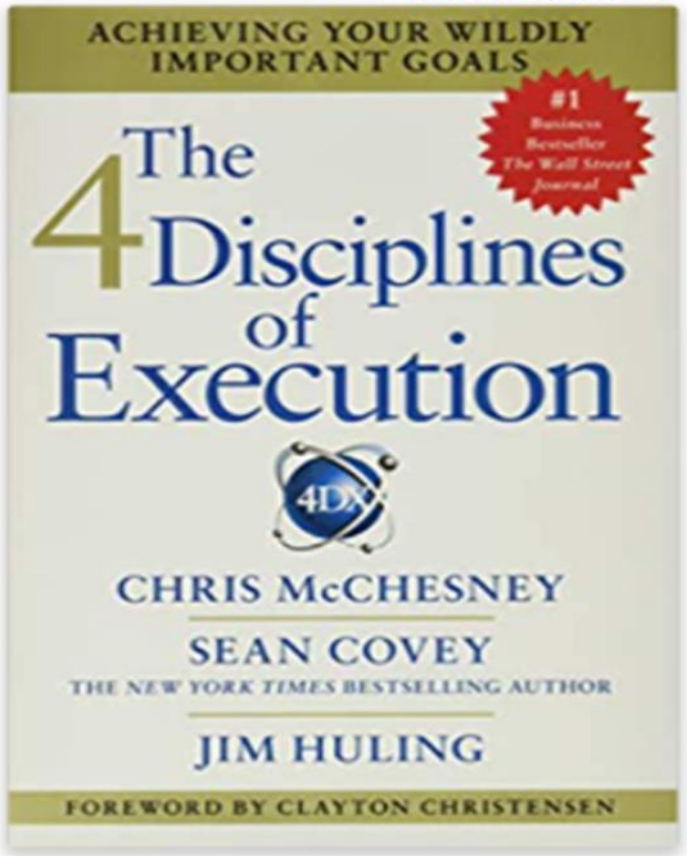
Supporting Independence at Home

438 NH Route 104 • New Hampton, NH 03256 • (603) 217-0149 • www.LiveFreeHomeHealthCare.com

When someone is suspected of a possible UTI please review and implement the following interventions.

1. Increase fluids (water/cranberry juice)
2. Any change in toileting recently? Incontinent? Urgency?
3. Any change in bathing? Bubble bath or scented products?
4. Review peri care with staff/ audit (clean front to back)
5. Contact Doctor

Lead vs Lag Measures



While a lag measure tells you if you've achieved the goal, a lead measure tells you if you are likely to achieve the goal.

Lead measures track the critical activities that drive, or lead to the lag measure. They predict success of the lag measure and are influenced directly by the team.

Lead Measures

Hi-Risk Residents with Pressure Ulcers

- The interdisciplinary team is conducting the audits and each have a basket of giveaways they can use to thank the staff for floating the heels.
- At the end of each week, any unit that meets the 85% gets new treats placed in their nurses station basket.
- Before we began the project we huddled with staff about the goal and rationale for the project.
- We put up fun boards on each unit that spoke to the goal.

Building Upon the Results

- Ohio will continue paying for quality
  - Proposed plan to expand quality measures used from 4 to 7
- CMS updating quality measure thresholds
- Teams want to continue to build upon success
- Support QAPI process
- Trains new leadership team members
- Learn best practices from the entire collaborative
- Mitigate survey risk
- Improve systems that drive quality

Thank You

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