MDS Tips and Clinical Pearls

VOLUME.9
ISSUE.4

IN THIS ISSUE

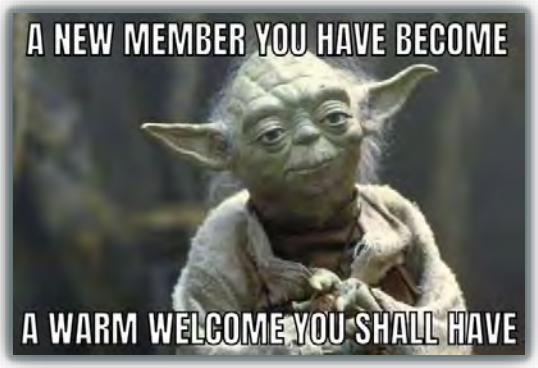
Another Gem Added to Our Team!

Tyler Czarnecki, BS, LNHA, CDP, QCP, IP ✶ QIPMO Leadership Coach

Hi, my name is

Tyler Czarnecki

and I'm the newest member of the QIPMO team! I'm now serving as your Leadership Coach for St. Louis city and some of St. Charles county (regions 5 and 7).



I was born and raised in St. Louis, beginning my career there as well. It's been wonderful to return home and see so many familiar people. I fell in love with long-term care throughout my high school years. Working with seniors while in college convinced me that my next step would be to become a Licensed Nursing Home Administrator. I worked as the Assistant Executive Director of a 189-bed nursing facility and had numerous *incredible mentors*. I worked for that company for nearly nine years, most recently as the Vice President of Operations for seven of their Skilled Nursing Facilities spread across many states.

I've been on the Governing Body of many nursing facilities throughout the years, helping to improve quality and regulatory compliance. I am deeply committed to assisting facilities in transitioning from an institutional care model to a person-centered care one. Furthermore, I enjoy evaluating **data** to create quality improvement programs for facilities. At the University of Missouri-St. Louis, I received a Bachelor of Science in Economics. I've also finished the National Council of Certified Dementia Practitioners' Certified Dementia Practitioners (CPD) program, the CDC's Infection Preventionist (IP) program, and the American Association of Post-Acute Care Nursing's QAPI Certified Professional (QCP).

Outside of work, I enjoy spending time at home. I reside on a small hobby farm and like beginning a variety of projects. If I'm not at the farm, I like all outdoor activities, including fishing and whitewater rafting, to mention a few.

I'M EXCITED TO MEET EVERYONE AND LOOK FORWARD TO HELPING MISSOURI FACILITIES!

For more information on QIPMO Clinical Education, Leadership Coaching, and ICAR visit us at www.nursinghomehelp.org

Monkeypox - Good News or Bad News First?

Wendy Boren, BSN, RN, IP ☠ QIPMO Clinical Educator

So, the *good* news is that while the news may be blowing up with talks about Monkeypox, there are, so far, no cases being reported in long-term care (good thing too since they'd probably ask us to report it in NHSN!) The *bad* news... it can travel into long-term care.

Let me give you a little background. Monkeypox is member of the *smallpox* viral family. It was discovered in the late 1950s on monkeys being used for research in Africa. Outbreaks have continued through the years mostly in western and central Africa and is only seen outside that area in travelers.

According to the CDC, symptoms of Monkeypox can include:

- ⋆ Fever
- ⋆ Headache
- ⋆ Muscle aches and backache
- ⋆ Chills
- ⋆ Exhaustion
- ⋆ Swollen lymph nodes

The rash starts out like pimples then graduates to papules, lesions, and finally to flaky-looking bug bites, lasting anywhere from 2-4 weeks. The rash can show up on the face, inside the mouth, hands, feet, chest, genital area, and anus.

Monkeypox is a contact-borne infectious disease and can be spread from person-to-person through:

- ⋆ direct contact with the infectious rash, scabs, or body fluids
- ⋆ respiratory secretions during prolonged, face-to-face contact, or during intimate physical contact, such as kissing, cuddling, or sex
- ⋆ touching items (such as clothing or linens) that previously touched the infectious rash or body fluids
- ⋆ pregnant people can spread the virus to their fetus through the placenta

Another piece of *good* news? There is a vaccine, and it has been around for several years! And if you get Monkeypox, there are a few viral treatments that have been shown to be effective if you are at high-risk for illness due to comorbidities.

There are currently just ↓ under ↓ 1,000 cases in the United States (2022 U.S. Map & Case Count | Monkeypox | Poxvirus | CDC). So, while there may be a lot of hype, there's not a lot of reason to worry. At this point, just be vigilant. Do your admission assessments. Know the signs and symptoms and reach out to the primary care physician if concerns occur. That goes for your staff too! If you suspect anything out of the ordinary, put on that PPE and isolate.

Source: U.S. Monkeypox Outbreak 2022: Situation Summary | Monkeypox | Poxvirus | CDC

ICAR Corner Q&A

Q. What *IS* an ICAR assessment?

A. ICAR stands for **I**nfection **C**ontrol and **A**ssessment and **R**esponse. It is a standardized assessment of infection control and prevention (IPC) processes and practices, focusing on highly transmittable infectious diseases. The Infection Control Assessment Tools were developed by CDC to *assist health departments* in assessing infection prevention practices and guide quality improvement activities (e.g., by addressing identified gaps). After the assessment, you will receive a feedback report with recommendations, resources, and tools to use as part of ongoing quality improvement initiatives, survey preparation, and even more importantly enhance resident safety.

Q. Who *needs* an ICAR?

A. Any residential care, assisted living, intermediate care, and skilled nursing facility in Missouri should get an ICAR.

Q. Why should *I* schedule an ICAR? Our facility hasn't had any COVID cases in a long time.

A. As CDC recommendations change, an ICAR is a great way to **stay current**. The absence of an outbreak is an opportune time to ensure your policies, procedures, and practices are up to date with current CDC, CMS, and DHSS recommendations for the **best protection** of your residents, staff, and visitors.

Q. Is this something that matters on my *survey*?

A. Yes! CMS Phase 3 regulations have focus on infection prevention. The IP role is seen as **critical** to mitigating infectious diseases through an effective infection prevention and control program.

Q. How *long* does an ICAR assessment take?

A. ICAR assessments take between 1½-2 hours. It can be completed either onsite or virtually via Zoom.

Q. Who should *attend* the ICAR assessment?

A. It is up to the facility who attends, but those with IPC responsibilities are key 🗝 - such as the infection preventionist, administrator, and DON.

Q. Who will *see* the results of my ICAR assessment?

A. ICAR is ***non-regulatory***, so the assessment is for your leadership to use to enhance current IPC policies and practices.

Q. What is the *cost* of an ICAR?

A. It's ☞ **FREE** ☜

Q. *How* do I schedule an ICAR?

A. You can schedule your ICAR assessment today by emailing us at musonicarproject@missouri.edu. Please include your name, title, and facility!

Visit our website for more information: nursinghomehelp.org/icar-project/

WANT ON OUR E-MAIL LIST? SEND YOUR E-MAIL, NAME, TITLE, AND FACILITY INFORMATION TO MUSONQIPMO@MISSOURI.EDU!

Coming Soon to A Survey Near You

New Surveyor Guidance: The Countdown to October 24, 2022 Implementation

Nicky Martin, MPA, LNHA, QCP, CDP, IP ✶ QIPMO Leadership Coach, Team Leader

On June 29, 2022, CMS released an advanced copy of Appendix PP revised surveyor guidance as well as revised the guidance in Chapter 5 relating to facility reported incidents (FRI).

And that's not all… the Psychosocial Outcome Severity Guide was revised to clarify the reasonable person concept and provides examples across the different severity levels. *PHASE 2 GUIDANCE* was updated relating to abuse and neglect, admission, transfer, and discharge, and improving care for individuals with mental health or substance use disorder as well as the addition of using PBJ data to help identify staffing concerns.

CMS identifies significant revisions to the SOM in the following areas:

- Abuse and Neglect
- Admission, Transfer, and Discharge
- Mental Health/Substance Use Disorder (SUD)
- Payroll Based Journal/Nurse Staffing
- Resident Rights
- Potential Inaccurate Diagnosis and/or Assessment
- Pharmacy Services
- Infection Control
- Arbitration Requirements
- Other revisions:
  - Trauma Informed Care
  - Compliance and Ethics,
  - Quality Assurance Performance Improvement (QAPI)

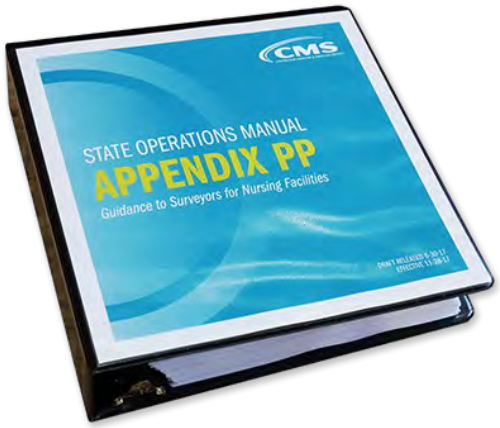
CMS also revised Chapter 5, Complaint Procedures, and Exhibits 358 and 359 provide sample templates that may be used for FRIs. *This revised guidance will be incorporated into the Long-Term Care Survey Process beginning on October 24, 2022.*

All of this information and more can be found in QSO-22-19-NH.

Don't worry, the QIPMO team will be here to navigate the Phase 3 guidance implementation as well as assist you with the necessary tasks that come along with it.

Things you need to consider are policy, procedure, and program reviews in the areas above as well as ensuring you are meeting the staff training requirements that will accompany them. Speaking of training, you can access the surveyor training at the Quality, Safety, and Education Portal (QSEP) website.

The October 24, 2022 implementation date will be here in the blink of an eye; contact us now for implementation assistance!



Sinclair School of Nursing
University of Missouri Health System

The Role of Gradual Dose Reduction (GDR) in Psychotropic Medication Management

Debbie Pool, BSN, RN, LNHA, QCP, IP ↓ QIPMO Clinical Educator

CMS launched the NATIONAL PARTNERSHIP TO IMPROVE DEMENTIA CARE IN NURSING HOMES in 2012 with the goal of *reducing the inappropriate use of antipsychotics* **and** *improving dementia care and behavioral health approaches in managing dementia*. Public reporting of quality measures linked to antipsychotic use and updated survey and certification standards aligned with these efforts.

In 2017, CMS identified a cohort of nursing homes that had not demonstrated improvements, calling them "late adopters." These late adopters were asked to ↓ reduce ↓ antipsychotic use by 15% in 2019. Data for 2020 Q2 demonstrated a reduction to 16.4%, a 23.3% reduction, exceeding the 2019 goal. In Missouri, we have fifty-two late adopters with a rate of 18.3% in 2020 Q2 (Late Adopter Antipsychotic Use by State 2021Q2 [Excel file.]) An analysis of recent Missouri MDS data shows antipsychotic use has steadily ↑ increased ↑ in Missouri long-stay residents since January 2020 from *17.06%* to *19.02%*.

So, what does this mean for your residents?

The regulatory guidance of F757 Drug Regimen Free from Unnecessary Drugs and F758 Free from Unnecessary Psychotropic Meds/PRN Use clearly addresses the definitions of unnecessary drugs, psychotropic medications, and PRN limitations. Although CMS has limited *appropriate* use of antipsychotics to the treatment of Schizophrenia, TOURETTE'S syndrome, and HUNTINGTON'S disease, this does not mean psychotropic medications may not be prescribed for other diagnoses. A resident must receive a comprehensive assessment identifying the specific, diagnosed, and documented condition(s), benefit to the resident, along with monitoring and documentation of the resident's response to the medication. As part of the monitoring process, AIMS testing should be completed, and the resident evaluated for a gradual dose reduction (GDR) and behavioral interventions. It is important for the interdisciplinary team to implement non-pharmacological interventions designed to meet the individual needs of the resident with inclusion in the care plan.

Within the *first year* in which a resident is admitted on a psychotropic medication or after the prescribing practitioner has initiated a psychotropic medication, the facility must attempt a GDR in two separate quarters (with at least one month between the attempts), unless *CLINICALLY CONTRAINDICATED*. After the first year, a GDR must be attempted *annually*, unless *CLINICALLY CONTRAINDICATED*. For any individual who is receiving a psychotropic medication to treat expressions or indications of distress related to dementia or to treat a disorder that may cause psychosis (for example, schizophrenia, bipolar mania, depression with psychotic features, or another medical condition, the GDR may be considered *CLINICALLY CONTRAINDICATED* (refer to SOM Appendix PP pages 523-24 for additional guidance).

Documentation from all disciplines should clearly show the indication for the medication, multiple attempts to implement care planned non-pharmacological approaches, and an ongoing evaluation of the effectiveness of the interventions. It is not enough for nursing to document the "resident is aggressive or acting out." The note should describe how the resident is expressing their behaviors. The physician needs to provide a reasonable explanation for not agreeing to the GDR, i.e., additional dose reduction will cause impairment, psychotic instability, or exacerbate the underlying psychiatric disorder.

Your consultant pharmacist can become your best friend in this process. During the performance of the monthly medication regimen review, those due for a GDR should be identified. Once the form is completed requesting a medication reduction, the next step is getting the physician to review and respond in a *timely* manner. It may be time to assess who is responsible for ensuring the physician reviews the request and a response is returned. Timely follow-up is a key to success. Once the response is received, the form should be added to the medical record. Surveyors will be looking for the paper trail as they assess your compliance with these regulations.

Keep the GDR process simple! Start low, go slow, and taper slow. Periodically evaluate, at least quarterly, targeted behaviors, effectiveness of the medication and non-drug therapy, undesirable effects, and consider a gradual dose reduction.

Coaching Skills

Mark Francis, MS, LNHA, IP 🏆 *QIPMO Leadership Coach*

The following is an exceptionally useful and practical article from Gallup about coaching. Whether you are still wondering exactly what coaching is or have been using a coaching approach for several years, I think you will find this interesting and helpful.

Don't Overcomplicate the Best Management Practice: **Coaching**

By Rohit Kar and Allan Watkinson

Historically, command-and-control styles have been the name of the game for managers -- *bosses* who gave ↑ top-down ↓ orders.

But the world has changed. Today's employees want a manager who is invested in their personal and professional development. They want frequent feedback -- and opportunities to do more of what they do best. They want to consistently grow as they pursue a compelling purpose.

In this new world, the best path to an exceptional employee experience -- not to mention, high performance -- is for employees to have a *coach*, not a *boss*.

Today's employees want a manager who is invested in their personal and professional development.

What is coaching, *really*?

Coaching, at its core, hinges on the following behaviors.

Being more curious

Coaching starts with *asking more and telling less* -- becoming more inquisitive about employees as human beings. What do employees **NEED**? What are their strengths? What are their goals?

The best coaches display a genuine interest in the individual by asking coach-like questions on a regular basis. For example, in a 10-minute conversation, a manager might ask an employee, "What's going well for you today (and what isn't)? How can I best support you?"

Then, the best coaches listen to understand. They listen to truly comprehend employees' circumstances, goals, challenges and needs.

Showing support through natural conversations

Coaches are curious for a reason: They use discoveries about employees' motivations, concerns and aspirations to demonstrate care and dismantle barriers to performance and engagement.

Making these discoveries doesn't require sophisticated coaching models or a prefabricated agenda of questions. Rather, meaningful coaching conversations are often informal and flow naturally depending on the employee's needs. For example, a coach might ask about a recent success -- "What are you most proud of about that achievement (and why)?" -- then use that information to help the individual apply their natural gifts more often.

The point is to have an authentic, ongoing dialogue with the individual to identify their top concerns and show support accordingly.

Focusing on performance, strengths and engagement

Coaching isn't about "taking it easy" on employees or abandoning performance standards. Just the opposite: Coaches set clear expectations and performance goals, and they hold employees accountable for those targets. Coaches are *future focused* when it comes to performance -- whereas bosses typically look for ✕ errors ✕ and punish performance mistakes.

continued on page 7

continued from page 6

Great coaches also focus on each worker's one-of-a-kind strengths, which helps them individualize their leadership style. By emphasizing employees' strengths, coaches cultivate employees' natural abilities and position teams for excellence.

The best coaches also prioritize individual and team engagement -- knowing that their role is to create an environment that **energizes** and **inspires** employees. To this end, great coaches track their employees' workplace needs and respond with action and accountability.

At every turn, coaches emphasize *what's possible*, which fuels development and encourages employees to take ownership for their engagement and performance.

People join companies, but they leave managers. Because today's employees demand something different from their job, coaching is a must for managers. Plus, coaching creates an environment of high development, which is the most productive type of culture for your business and your employees. Coaching accelerates everything from collaboration and agility to performance and productivity.

But coaching shouldn't feel intimidating. It should be simple, practical, rewarding -- and even *fun*. The good news is: Coaching becomes approachable when managers have access to proven development. As one Boss to Coach participant remarked, her experience was "unlike any other training program" because it shifted her perspective on coaching and taught her how to coach "in the context of being a manager."

Best of all, coaches have a ripple effect that extends beyond bottom-line measures like turnover.

When managers serve as coaches, they can improve employees' lives and wellbeing.

Workplace September 24, 2021

Author(s)

Rohit Kar is a Managing Consultant at Gallup. Allan Watkinson is a Managing Consultant at Gallup. Bailey Nelson contributed to this article.

Out with The OLD And In with The NEW

Medicaid Value-Based Purchasing Incentive

Crystal Plank, BSN, RN, RCA-CTA, IP — QIPMO Clinical Educator

AS of **July 1, 2022**, Medicaid reimbursement has moved from a flat-based rate to a CASE MIX index. CASE MIX index is a measure that CMS uses to determine reimbursement for Medicare with our PDPM methodology. As of July 1, Medicaid residents in Missouri in skilled nursing facilities will be reimbursed with a CASE MIX index under RUG-IV methodology. The purpose of CASE MIX is to represent the diversity, complexity, and severity of resident illness and care at a skilled nursing facility. The higher the CASE MIX value, the greater the number of complexity and resources that are needed to take care of the resident, so the skilled nursing facility is reimbursed at a higher rate.

In Missouri, there are seven long-stay quality measures (QM) that will be used to ↑ increase ↑ the possibility of obtaining a higher reimbursement for Medicaid residents in the skilled nursing facility. These include:

- High risk/unstageable pressure ulcer
- Falls with major injury
- Antipsychotic medications
- Urinary tract infection
- Catheter inserted and left in the bladder
- Increase assistance with ADLs
- Moving independently has worsened

Missouri Medicaid will also take in consideration if 40 % of the resident population is diagnosed

continued on page 8

continued from page 7

with schizophrenia or manic/hipolar on the MDS, they will receive an additional $5 per day add-on. Finally, some good news for homes that dedicate their care to residents with mental health illnesses!

The per diem adjustment for each QM performance threshold that is met, will receive up to a maximum of $7. The threshold for each QM is based on the Five Star Rating System by CMS based on national cut-points. The Value Based Purchasing incentive is complex, mathematically and with its methodology. However, January 1 of each year, the skilled nursing facility's Medicaid CASE MIX Index will be updated using the *average* of the preceding July 1 through October 1 quarterly Medicaid CASE MIX Index calculations. Effective for dates of service beginning July 1 of each ear, each facility's Medicaid CASE MIX Index will be updated using the average of the preceding January 1 and April 1 quarterly Medicaid Case Mix Index. Each facility's **mental illness** diagnosis data will be re-evaluated semi-annually, and the add-on rate will be adjusted. This will be updated based on November 15 data for January 1 adjustment and May 15 for the July 1 rate adjustment.

For homes that are nervous about receiving less reimbursement with the new Medicaid CASE MIX Index on July 1, the facility will receive the greater of the two rates, either the rate on June 30, 2022, or the new rate on July 1, 2022, which ever is greater. So, this is *good news* as we educate and transition from our old to our new reimbursement model for our Medicaid residents.

What can we do?

Educate MDS coordinators and the leadership team on what is involved in the RUG IV model and quality measures paying close attention to those measure involved in Medicaid value base purchasing.

Involve the IDT team in documentation on all aspects that impact reimbursement under Medicaid including areas under RUG IV and quality measures.

Educate the frontline staff on accurate documentation on ADL (Section G of the MDS) and the impact the care and documentation that they do everyday and why it is so important.

Ensure leadership responsible for the Brief Interview for Metal Status (BIMS) are trained to complete this interview accurately and the impact it makes on reimbursement.

Review and update your current Restorative program because it also impact RUG IV.

QIPMO will be doing virtual and in-person trainings coming up in the near future on the different aspects of Medicaid CASE MIX. Homes may also contact their QIPMO team members for individualized training also.

**Long stay measures are for residents who have been in the skilled nursing facility 101 days or longer.*