Quality Measures Tip Sheet

1 star = 299-975
2star = 976-1170
3 star = 1171-1342
4 star = 1343-1522
5 star = 1523-2300

Simple LTC- Simple LTC will tell you how many points you are away from the next cutoff , red arrows mean going down in points , green arrows mean going up in points >>> The numbers will change often base on MDS submissions for the quarter , so QM's should be reviewed at least monthly. Simple LTC gives you the name of the residents triggering in the category , if you click on the residents name it will give you the target assessment

Increase Help with ADLs	1. Review Section GG for accuracy prior to closing assessment. Ensure staff interviews have been completed. 2. In addition, review the last assessment for accuracy 3. Review Life Expectancy and Hospice, ensure if appropriate, it is documented by the physician (exclusion) 3. Upon closing of MDS review past assessments for change in function and verify accuracy. If decline is accurate review in 46 days for potential new assessment that indicates no further decline and set assessment to clear trigger. If has returned to prior level, set an ARD to clear trigger
Walk Independently Worsened	1. Review Section GG for accuracy prior to closing assessment. Ensure staff interviews have been completed. 1. Review Life Expectancy and Hospice, ensure if appropriate, it is documented by the physician (exclusion) 2. Upon closing of MDS review past assessments for change in function and verify accuracy. If decline is accurate review in 46 days for potential new assessment that indicates no further decline and set assessment to clear trigger. If has returned to prior level, set an ARD to clear trigger.
UTI	1. Verify meets McGreer criteria. Should also match on infection control log. DX alone does not indicate UTI According to the original McGreer criteria, the definition of symptomatic UTI for residents without an indwelling catheter includes at least 3 of the following signs and symptoms: -Fever (≥38°C) or chills -New or increased burning pain on urination, frequency, or urgency -New flank pain or suprapubic pain or tenderness -Change in character of urine -Worsening mental or functional status 2. Set ARD for 30 days after tx ends to clear UTI
Antipych Medications (L)	1. Check MAR during target assessment look back to see what med they're on and confirm it is a true Antipsych med 2. Look at dx to see why they are taking Antipsych, Bipolar is appropriately treated with Antipsych meds however it is not recognized as an exclusion for QM measure. Any kind of dementia is not an appropriate diagnosis. Schizoaffective can be counted as schizophrenia which is an exclusion. Huntington and Tourette's are both exclusions but it is rare you will see these. 3. If you don't see an appropriate dx for Antipsych use, check PRI for dx that may have been missed upon admission. Refer to psych if no appropriate dx is found. 4. Make sure for short termers that psych meds were not missed on the initial assessment 5. Consult with Psychiatrist for potential reduction or use of a mood stabilizer 6. Set ARD 7 days after discontinuation of antipsychotic medications
Antipych Medications (S)	1. Review first assessment for accuracy of section N coding- Ensure that if patient is on Antipsych it is included.

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Pressure Ulcer	1. Check QM card to see what ard for target assessment and initial assessment 2. See what stage pressure ulcer is recorded on both. (SS) 3. Check MDS against the wound notes, sometimes nursing notes do not match, inconsistent 4. Look at initial MDS and make sure wound was coded appropriately upon admission (SS) 5. MDS coding tips- Intact Blisters are technically a st.2 for MDS purposes, granulation tissue only seen in stage 3&4, no reverse staging as wound heals, IF UNSTAGEABLE ON ADMISSION AND THEN LATER BECOMES STAGEABLE STILL CODE "PRESENT ON ADMISSION"! 6. If coding is accurate, schedule an assessment upon healing of the wound
Falls with Major Injury	1. Fall with major injury includes: fracture, dislocations, CLOSED head injuries with loss of consciousness, subdural hematoma. If they fall and hit head it is not automatically a major injury 2. Track ARD of capture of major injury and assessment can be schedule 276 days later to remove from triggering
Catheter	1. Check look back for target assessment to see if they had indwelling catheter. 2. If they have a nephrostomy or suprapubic cath there is going to be a diagnosis that falls under the 2 exclusions either neurogenic bladder or obstructive uropathy. 3. If it is an indwelling catheter (foley) find out for what diagnosis- common reasons: BPH – obstructive uropathy, MS, Parkinson's, Diabetes, stroke, spinal cord injury- neurogenic bladder. **Find reason behind urinary retention if that is only reason (urinary retention dx itself is not an exclusion and usually has another dx causing it unless it is from a medication side effect) find dx behind urinary retention- either blockage which is an obstructive uropathy or nerve problems which is neurogenic bladder 4. Check MD notes to see what dx MD put for indwelling catheter use. 5. If no medical diagnosis is found, then why do they have it? If for wound healing then this will count against you for QM. See if indwelling can be switched to a condom cath 6. Schedule an assessment 7 days after Catheter is Discharged
Vaccine Management	1. Check the immunizations tab. Nurses may document "not eligible" for reason being "previously had" . For MDS coding purposes you will need to code this as "received outside of facility". Coding not eligible on MDS should be saved only for those that cannot receive the vaccines for medical reasons. 2. If no immunization info check PRI, Review Hospital or transfer records for vaccine status 3. FLU season typically starts in October and last until March of the following year (so 2020-2021 is the upcoming flu season) unless otherwise indicated by the CDC. If the shot was given once in the year, it should be coded through the subsequent quarters until the next season. 4. If vaccine status cannot be determined speak to the physician as the vaccines can still be administered according to the standards of clinical practice. 5. Remember to interview not only the resident but the family as well, ask other disciplines for assistance, ie: admissions, social service, and the concierge
Weightloss	1. Check to make sure weight documented is the most recent weight in the last 30 days. 2. With large discrepancies, work with IDT on having the patient re-weighed
New or Worsened Incontinence of Bowel and Bladder	1. Triggers if newly incontinent of Bowel or Bladder, or a decline from 1 level to another in frequency of incontinence 2. Interview staff for accuracy of continence coding 3. If resident has an indwelling catheter, condom catheter, ostomy, or no urine output MDS should be coded "9- not rated" this should not be coded as incontinent. 4. If returns to prior level of continence, set ARD to clear trigger