What is CMS Up To? Quality, Quality, Quality

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MDS 3.0
Casper
QIS
Quality
Medicare 5 Star
5 Star
Special Focus Facilities
Life Safety Code
QAPI
Disaster Preparation
QI-QMMS
It’s not our grandmothers’ nursing home!
Quality Care or Compliance?
Is This Your Facility?

• “Last year they looked at...”
• “The deficiency of the month is...”
• “The Surveyor said ....”
• “They were just over at...”
• “Let the chips fall. We can’t really prepare.”
• No staff preparation
• Totally reactive
• Like waiting for a pathology report...
Compliance vs. Quality

- Compliance
  - Floor is the goal
  - Crisis management
  - High stress
  - High costs
  - Turn around effect
  - Staff turnover
  - Short-term improvement

- Quality
  - Goals increasing/change
  - Success is planned
  - Manageable challenge
  - Recruitment and retention
  - Team
  - Improvements are sustained
CMS Pressure

- Culture Change
- Use of Technology
- SNFs
- Quality and Transparency
- Aging Population
- Accountability
- Value
Quality Is...

- Product or service meets its specifications
- This can be problematic for long term health care systems
  - Natural tension between business needs, everyone's expectations, and government quality requirements (safety, efficiency, reliability, etc.)
  - Some quality requirements are difficult to specify in an unambiguous way – quality of life
  - Often the specifications for care are incomplete and inconsistent because of human nature.
Quality Management

- Quality management must deliver bottom-line
  - Measure true impact of time and investment
- Quality is everyone’s job
  - Practices and understanding of the continuous nature of quality
- Quality management will increasingly be absorbed in each of our jobs
  - Moving from ‘doing’ quality to coaching for quality
- Customer expectations are increasing
  - Customers are accustomed to speed, efficiency, and excellent customer service will demand that of long term care too
Quality Standards

- 1987 Nursing Home Reform Amendments (OBRA ’87)
- State licensure
- State Medicaid standards
- Medicare 5 Star rating
- Professional standards
- Risk group or preferred provider group
- Facility policy and procedures
- Your personal standards or code of ethics
What is Culture Change?

Culture change in long-term care is an ongoing transformation in the physical, organizational and psycho-social-spiritual environments that is based on person-centered values such as respect.
Culture Change ???

• Eden Alternative, Green Houses, Small Houses and Pioneer initiatives

• Or the superficial displays of culture change:
  – Having mailboxes and front doors yet no one knocks or takes seriously the privacy it is meant to offer
  – Fin, fur and feathers
  – Food line buffet
  – Memory boxes
  – Brag board

• All these efforts are important but these do not deliver culture change
Team Discussion

1. Describe the artifacts of culture change developed by CMS
2. What are the underlying values and culture that these artifacts represent?
3. What are the strengths and weaknesses of this culture?
4. Is there a gap between where the organization is and where it would like to be?
5. If you were to attempt culture change, how would you go about it?

Memorandum Summary

• Preview of Nursing Home QAPI materials: The Centers for Medicare & Medicaid Services (CMS) will make a core set of introductory materials available on the CMS QAPI website by February 2013. Prior to that release, CMS is making QAPI at a Glance available in draft form for advance previewing by Quality Improvement Organizations (QIOs), State Survey Agencies, and Regional Offices;

• QAPI at a Glance: QAPI at a Glance is a step-by-step guide that provides tools and resources to help nursing homes establish a foundation for QAPI;

• ACA Provision: Section 6102(c) of the Affordable Care Act directs the Secretary to provide technical assistance and promulgate regulations for each nursing home to implement a QAPI system, and permits the Secretary to sequence these actions so the technical assistance is available prior to the regulations.
QAPI

• Significantly expands the level and scope of required Quality activities
  – Ensure that facilities *continuously identify and correct* quality deficiencies as well as *sustain* performance improvement”

• QA: QUALITY ASSESSMENT
  – How are we doing compared to our industry?

• PI: PROCESS IMPROVEMENT
  – Making it better
QAPI

• Design and Scope
  – Ongoing and comprehensive
  – Includes all departments and functions

• Governance and Leadership
  – Administration leads with input from facility staff, as well as from residents and their families

• Feedback, Data Systems and Monitoring
  – Systems to monitor care and services

• Performance Improvement Projects (PIPs)
  – Performance Improvement Projects

• Systematic Analysis and Systemic Action
  – Data driven
  – Systematic approach to determine problem, its causes, and implications of a change.
Uses of Data

1. Uncover problems that might otherwise remain invisible.
2. Convince the need for change.
3. Can confirm or discredit assumptions
4. Prioritize vulnerabilities
5. Can help evaluate program effectiveness
7. Give the ability to respond to accountability questions.
8. Can build a culture of inquiry and continuous improvement.
SNF Metrics

- Skilled Nursing Facilities Quality of Care measured in many different formats
  - Survey citations per regulation
  - Nursing Home Compare Scores
  - Facility Quality Indicator/Quality Measure Reports
  - CASPER
  - Resident Satisfaction Surveys
  - Fiscal Responsibility
  - Public Perception
Tools for RCA

Brainstorming

Pareto Chart

Fishbone Diagram

Scatter Diagram

Run Chart

Histogram

Control Charts

Flowchart

Tree Diagram

Design of Experiments
Brainstorming Rules

• Non-judgmental communications
• Encourage wild and exaggerated ideas.
• Quantity counts at this stage, not quality.
• Build on the ideas put forward by others.
• Every person and every idea has equal worth.
Root Cause Analysis

• Finding the real cause of the problem and dealing with it rather than simply continuing to deal with the symptoms
• Asks why, why, why at each level
• Interdisciplinary- involves those closest to the situation
• Identifies changes that need to be made
• Identifies risks and how they contributed
• Leads the team to potential process improvements
• Move beyond a culture of blame
Resident fell last night

It was dark and tripped going to bathroom

Needs to go to bathroom every night

Resident pushed called light and no one came to help

Resident always just gets up even though not steady

Therapist told resident to be more independent

**Root Cause(s)**

1. Dark bathroom
2. Strength training
3. Toileting and staff response
Now What???

- Have active and effective QAPI program
- Auditing, rounding and accountability
- William Deming
  - Plan, Do, Study and Act
    - Planning is the identifying of hazards and risk
    - Do is the implementing of interventions to reduce risks and hazards
    - Study is the monitoring of effectiveness
    - Act is the effectiveness and modifying as necessary
The PDSA Cycle

Act
• What changes are to be made?
• Adapt? Adopt? or Abandon?
• Next cycle?

Plan
• Objective
• Questions and predictions (why)
• Plan to carry out the cycle (who, what, where, when)

Study
• Complete the analysis of the data
• Compare data to predictions
• Summarize what was learned

Do
• Carry out the plan
• Document problems and unexpected observations
• Begin analysis of the data
What Will We Do Today?

• What is a fall?
• Who is at risk?
• What could the causes be?
• Ideas for investigation
• What interventions/care planning could help?
• Possible ways to approach falls as a facility
• Ideas for assuring that interventions are in place
• When will you re-evaluate the resident?
• How will you know that your program is working?
Falls With Injuries

• The issue is falls and residents experiencing serious injuries
  – Who should the team be?
  – What is the problem?
  – What is the source of the problem?
  – What is the goal?
  – What do you really want to improve?
  – Develop plan, change policies, procedures, conduct training, alter paperwork
  – DID IT WORK???
What is the PDSA Cycle?

Plan
• Objective
• Questions and predictions (why)
• Plan to carry out the cycle (who, what, where, when)

Your PLAN and should answer WHO; WHAT; WHEN; WHERE; HOW
PLAN

1. What are we testing?
2. On whom are we testing the change?
3. When are we testing?
4. Where are we testing?

• Data - What data do we need to collect?

• Falls numbers, days of the week, time of day, location, possible reasons, contributing factors, etc.

1. NF’s falls mgt. policy and procedure
2. Nursing home residents
3. At all times
4. Throughout the facility to see if facility procedures reduce falls.
What is the PDSA Cycle?

**Do**
- Carry out the plan
- Document problems and unexpected observations
- Begin analysis of the data
DO

1. What was actually tested?

2. What happened?

3. Success or failures?

1. Procedure tested for an entire month. The facility census was stable though we did admit/discharged 9 residents

2. There were 19 falls involving 14 residents. One resident experienced a serious injury

A. Total number of falls increased

B. One resident sustained a serious injury – hip fracture

C. Three residents fell more than twice in the month but that is half as many as month before

D. Nurses completed investigations more timely and correctly

E. Interventions such reducing meds seems to help some
What is the PDSA Cycle?

**STUDY:** should be a reflection of what the team learned by what they DID as they had PLANNED to meet the OBJECTIVE. It is the conclusion you draw based on the data and should tell you whether or not you met your objective.

**Stud**
- Complete the analysis of the data
- Compare data to predictions
- Summarize what was learned
Study

• Analysis of data to determine what changed, improved or didn’t

—Our initial feeling was that the facility had a good policy and procedure but it turned out that we don’t. There is now a sense of urgency to revise our processes to improve.
What is the PDSA Cycle?

ACT (WRITTEN IN FUTURE TENSE): should describe what your next steps will be to meet the objective based on what you learned from what you did according to the plan to meet the objective.

- What changes are to be made?
- Next cycle?
ACT

1. What adjustments to the change or method of testing should we make before the next cycle?
   – Team will redraft policy and procedures, risk assessment, investigation tools, QA review tool

2. What will the next test cycle be?
   – Next months data related to falls will begin test our ability to successively revise policy and procedure.

1. Are we ready to implement the change we tested?
   – Total facility reeducation
**Medicare.gov**

**5-Star Quality Rating**

![Image: You've Got Mail]

**S&C Memo**

12-37-NH

**June 22, 2012**

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**FROM:** Director  
Survey and Certification Group

**SUBJECT:** Redesign Updates to the Nursing Home Compare Website

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<table>
<thead>
<tr>
<th>Memorandum Summary</th>
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</table>
| - *Nursing Home Compare:* The Centers for Medicare & Medicaid Services (CMS) will launch a re-designed *Nursing Home Compare* website on July 19, 2012.  
- *New Information:* Website will add new MDS 3.0 quality measures, detailed inspection reports (CMS 2567s), nursing home ownership information, and additional staffing data. |

The CMS will launch the re-designed *Nursing Home Compare* website on July 19, 2012. In designing the site, CMS adopted industry best practices for design and usability while incorporating a considerable amount of new information. The result of this effort will be increased transparency and web usability for consumers.

CMS launched *Nursing Home Compare* in 1998 as part of a number of initiatives to improve nursing home quality of care. Since that time, CMS has added information on staffing, quality measures, enforcement actions and complaints to the existing survey results. In 2008, CMS added the *Five Star Nursing Home Quality Ratings to Nursing Home Compare*. The ratings...
5-Star Rating

- Tool for consumers and caregivers to compare nursing homes
- Summarizes information into an easy-to-understand rating system
  - Overall Rating
  - Health Inspections
  - Quality Measures
  - Staffing
**Overall Rating**

- **Step 1:** Start with the Health Inspection Rating.
- **Step 2:** Add one star if the Staffing rating is 4 or 5 stars and also greater than the Health Inspection Rating. Subtract one star if the Staffing rating is 1 star. The rating cannot go above 5 stars or lower than 1 star.
- **Step 3:** Add one star if the Quality Measure rating is 5 stars; subtract one star if the Quality Measure is 1 star. The rating cannot go above 5 stars or lower than 1 star.
- **Step 4:** If the Health Inspection rating is 1 star, then the Overall Quality rating cannot be upgraded by more than one star based on the Staffing and Quality Measure ratings.
- **Step 5:** If a nursing home is a Special Focus Facility that has not graduated, the maximum Overall Quality rating is 3 stars.
SNF Survey

• 3 most recent annual inspections – weighted in favor of most recent surveys (1/2 + 1/3 + 1/6)
  – All complaint health inspections
  – Revisits have points after first

• The rating considers the number and the scope and severity of deficiencies
  – More serious, wide spread deficiencies have a lower rating
  – Less serious, isolated deficiencies have a higher rating
  – Extra points for SQC deficiencies
<table>
<thead>
<tr>
<th>Severity</th>
<th>Isolated</th>
<th>Pattern</th>
<th>Widespread</th>
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<tbody>
<tr>
<td>Immediate jeopardy to resident health or safety</td>
<td>J (50 points)</td>
<td>K (100 points)</td>
<td>L (150 points)</td>
</tr>
<tr>
<td>Actual harm that is not immediate jeopardy</td>
<td>G (20 points)</td>
<td>H (35 points)</td>
<td>I (45 points)</td>
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<tr>
<td>No actual harm with potential for more than minimal harm that is not immediate jeopardy</td>
<td>D (4 points)</td>
<td>E (8 points)</td>
<td>F (16 points)</td>
</tr>
<tr>
<td>No actual harm with potential for minimal harm</td>
<td>A (0 point)</td>
<td>B (0 point)</td>
<td>C (0 point)</td>
</tr>
</tbody>
</table>

Note: Figures in parentheses indicate points for deficiencies that are for substandard quality of care. Shaded cells denote deficiency scope/severity levels that constitute substandard quality of care if the requirement which is not met is one that falls under the following federal regulations: 42 CFR 483.13 resident behavior and nursing home practices; 42 CFR 483.15 quality of life; 42 CFR 483.25 quality of care. * If the status of the deficiency is “past non-compliance” and the severity is Immediate Jeopardy, then points associated with a 'G-level' deficiency (i.e., 20 points) are assigned.
Staffing Data

- Number of hours of care on average provided to each resident each day (case mix adjusted)
- Two Ratings:
  - Total Nursing Staff: RN, LPN/LVN & CNA
  - RN Staff
<table>
<thead>
<tr>
<th>RN rating and hours</th>
<th>Total staffing rating and hours (RN, LPN and aide)</th>
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<tbody>
<tr>
<td></td>
<td>1</td>
</tr>
<tr>
<td>1</td>
<td>&lt;0.283</td>
</tr>
<tr>
<td>2</td>
<td>0.283 – 0.378</td>
</tr>
<tr>
<td>3</td>
<td>0.379 – 0.512</td>
</tr>
<tr>
<td>4</td>
<td>0.513 – 0.709</td>
</tr>
<tr>
<td>5</td>
<td>≥0.710</td>
</tr>
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</table>

Note: Adjusted staffing values are rounded to three decimal places before the cut points are applied.
Quality Measures

• Uses subset of MDS 3.0-based QMs
• Includes 7 long stay and 2 short stay measures
• Calculation utilizes the three most recent quarters for which data are available
Short Stay

1. Self-Reported Moderate to Severe Pain
2. New/Worsened Pressure Ulcers
   - Influenza vaccine
   - Pneumococcal vaccine
   - Use of antipsychotics
Long Stay

3. Self-Reported Moderate to Severe Pain
4. High-Risk Residents with Pressure Ulcers
5. Physical Restraints
6. Falls with Major Injury
7. Need for Help with ADLs Has Increased
8. UTI
9. Catheter Inserted and Left in Bladder

• Depressive symptoms
• Excessive Weight Loss
• Influenza vaccine
• Pneumococcal vaccine
• Use of antipsychotics
• Low-Risk Residents Who Lose Bowel/Bladder Control
The QIS Process

• The Quality Indicator Survey process is a revised survey process that changes how surveyors determine a facility's compliance

• Phase I
  – Collected comprehensive set of resident sampling data consisting of standardized questionnaires, specific observations and record reviews which is used to determine a facilities Quality Indicators

• Phase II
  – Once the quality indicators are determined surveyors investigate items which exceed CMS thresholds

• Goes beyond previous traditional survey process by measuring quantified quality of life aspects of care
Tools For Quality Improvement

- Family and staff interviews
- Resident interviews, observations and record reviews
- 150+ Quality Indictors
- Facility level investigations Mandatory and triggered
- Care pathway investigations
Survey is Survey...

- Facility appearance & what surveyors see, hear, feel and smell is important
- Residents with obvious unmet needs
- Resident interactions
- Activities
- Dining experience
- Personal items stored & labeled
- Data that we collect needs to be accurate
  - Weights & skin sheets
- Splints and restorative care
- Wheelchairs and lifts
- Therapy gym

Remember: survey is about the basics
QIS Updates

• Checklist for reviewing care and services for residents with dementia
  – Usual patterns, how resident communicates needs such as food and water
  – Care planning, monitoring and highest practicable level of functioning

• Strategies for Surveyor Success with Resident Interviews
Average Number of Citations/Survey:
- 7.8
- 6.9%
- 10.6%
Leading Deficiencies

- Quality of Care F309
- Accident/ Hazards F323
- Unnecessary Meds F329
- Infection Control F441
- Food Handling F371
- Care Planning F279
- Resident Abuse F225&26
- Dignity F241
- Notify of change F 157
- Assessment F272
- Prof Standards F282
- Pressure Sores F314
- Bowel/Bladder F315
- Environment F253
- Staffing F353
“Trigger” Responses and Stage II Investigations

QIS rates for:

- Family Interview 19.6%
- Resident Interview 19.4%
- Staff Interview 18.6%
- Admission Clinical Record 17.8%
- Resident Observation 16.6%
- Census Clinical Record 15.2%
<table>
<thead>
<tr>
<th>Care Area</th>
<th>Trigger %</th>
<th>Citation %</th>
</tr>
</thead>
<tbody>
<tr>
<td>Accidents</td>
<td>99%</td>
<td>27%</td>
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<tr>
<td>Pressure Ulcers</td>
<td>77%</td>
<td>21%</td>
</tr>
<tr>
<td>Community Discharge</td>
<td>77%</td>
<td>11%</td>
</tr>
<tr>
<td>ADLs</td>
<td>60%</td>
<td>11%</td>
</tr>
<tr>
<td>Nutrition</td>
<td>58%</td>
<td>16%</td>
</tr>
<tr>
<td>Rehabilitation</td>
<td>58%</td>
<td>2%</td>
</tr>
<tr>
<td>Urinary Incontinence</td>
<td>56%</td>
<td>0%</td>
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<tr>
<td>Dental</td>
<td>55%</td>
<td>23%</td>
</tr>
<tr>
<td>ROM</td>
<td>46%</td>
<td>15%</td>
</tr>
<tr>
<td>Abuse</td>
<td>43%</td>
<td>22%</td>
</tr>
<tr>
<td>Admis/ Transfer</td>
<td>41%</td>
<td>11%</td>
</tr>
<tr>
<td>Environment Observations</td>
<td>41%</td>
<td>63%</td>
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## Triggered vs. Deficiency Care

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<thead>
<tr>
<th>Care Area</th>
<th>Trigger%</th>
<th>Citation %</th>
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<tbody>
<tr>
<td>Dignity</td>
<td>40%</td>
<td>15%</td>
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<tr>
<td>Choices</td>
<td>40%</td>
<td>17%</td>
</tr>
<tr>
<td>Activities</td>
<td>40%</td>
<td>27%</td>
</tr>
<tr>
<td>Personal Funds</td>
<td>38%</td>
<td>17%</td>
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<tr>
<td>Staffing</td>
<td>36%</td>
<td>6%</td>
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<tr>
<td>Personal Property</td>
<td>35%</td>
<td>8%</td>
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<tr>
<td>Hydration</td>
<td>26%</td>
<td>8%</td>
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<tr>
<td>Catheter Use</td>
<td>21%</td>
<td>12%</td>
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<td>Participation in Care Planning</td>
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<td>16%</td>
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<tr>
<td>Hospitalization</td>
<td>15%</td>
<td>0%</td>
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<td>Restraints</td>
<td>15%</td>
<td>35%</td>
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<tr>
<td>Skin Conditions</td>
<td>15%</td>
<td>32%</td>
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</table>
## Triggered vs. Deficiency

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<tr>
<td>Food Quality</td>
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<td>Pain Management</td>
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<td>18%</td>
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<td>Privacy</td>
<td>9%</td>
<td>9%</td>
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<tr>
<td>Notification of Change</td>
<td>8%</td>
<td>22%</td>
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<tr>
<td>Positioning</td>
<td>1%</td>
<td>38%</td>
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<td>Social Services</td>
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<td>Behavior Emotion Status</td>
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<tr>
<td>Infections</td>
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<td>Vision</td>
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# Stage II Investigations

<table>
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<tr>
<th>Task</th>
<th>Triggered</th>
<th>Task</th>
<th>Triggered</th>
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<tbody>
<tr>
<td>Extended Surveys</td>
<td>62%</td>
<td>Personal Funds</td>
<td>18%</td>
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<td>Environment</td>
<td>58%</td>
<td>Dining</td>
<td>17%</td>
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<tr>
<td>Unnecessary Med</td>
<td>40%</td>
<td>Med. Admin</td>
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<tr>
<td>Infection Control</td>
<td>33%</td>
<td>Liability Notices</td>
<td>5%</td>
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<tr>
<td>Kitchen</td>
<td>26%</td>
<td>Staffing</td>
<td>5%</td>
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<tr>
<td>Abuse Prohibition</td>
<td>24%</td>
<td>QA &amp; A</td>
<td>4%</td>
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<tr>
<td>Med Storage</td>
<td>23%</td>
<td>Resident Council</td>
<td>4%</td>
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</table>

Average number of tasks triggered = 12.1
Off-site to Entrance

- Review facility history including the CASPER, past survey history and *patterns of repeat deficiencies*
- Contact ombudsman
- Conduct entrance conference with Administrator
  - 1 surveyor meets with administrator
  - 2 surveyors begin tour plus the kitchen
  - 1 surveyor completes reconciliation
- Provide resident census
- Medicare beneficiaries of last six months sampled from MDS data for review of Liability Notice and Beneficiary Appeal Rights review
Entrance Activities

- QIS brochure is provided
- Given the CMS 671 and CMS 672
- Resident lists:
  - PASRR II Services
  - Ventilator
  - Dialysis
    - Unit, Peritoneal, Home
  - Certified Medicare Hospice
  - Comfort/ End of Life care
- One Resident will be chosen from each care area during stage II
Initial Tour

• Characteristics of the facility, special care areas, staff – resident interactions, response to resident requests, behaviors

• Ask nursing assistants questions, such as
  – How many residents are under your care today?
  – Who determines the assignment?
  – Is there enough time to complete your assignment?
  – What happens if you do not get your assignment completed?
  – What steps do you take when the fire alarm sounds?
  – What is RACE?
Census and Admission Sample

• Census and Admission sample drawn from MDS sample plus census reconciliation
• Thresholds are broken into categories ‘small’ and ‘not small’. Small would be when there are 35 or fewer residents
• **Census sample – random sample current residents**
  – Resident interviews and observations
  – Staff and family interviews
  – Record reviews
• **Admission sample – random sample of up to 30 discharged residents**
  – Record review
Sentinel QIs
QIS indicators set at 0-1% threshold

1. Abuse
2. Dangerous device use
3. Fall/Fracture
4. Activities
5. ADL Assist
6. Admission process
7. Exercise Rights
8. Death
9. Dehydration
10. Hydration
11. Notification of family
12. Personal Funds
13. Privacy
14. Medicaid costs
15. Range of Motion
16. Oral health status
17. Comfortable Temperatures
18. Pest control
19. Electric cords & outlets
20. Ambulation, therapy equip.
21. Bathing safety
22. Call light
23. Chemical-Hazard
24. Unsafe hot water
25. Sufficient staff
26. Participate in care plan
27. PU @ stage 3 or 4
28. Presence - incontinence
Admission Sample Record Review

- Up to 30 residents
- Only closed records reviewed
- Targets residents with vulnerabilities
- Pressure Sores – developed within first 30 days, admitted with and worsening?
- Weights and height
Census Sample Record Review

- **Stability of condition**
- Pressure sores
- Unnecessary medications
- Weights and height
Unnecessary Medications
Sampling Algorithm for QIS

• Census Sample residents are chosen for the Unnecessary Medications
• Residents receive a score based on the medications that they receive
• Algorithm scores range from 0 to 18.
• 5 residents with the highest scores are included in the sample
Unnecessary Medication Scoring

- Residents with diagnosis of dementia or Alzheimer's AND receiving Antipsychotic
  - 3 points
- Residents who have a fall or fracture AND receiving:
  - Antipsychotic
  - Antianxiety
  - Antidepressant
  - Hypnotic
  - Mood Stabilizer
  - Diuretic
  - 2 points
- Resident score point(s) for receiving each of the following:
  - Antipsychotic (excluding Alzheimer’s/dementia diagnosis)
  - Antianxiety
  - Antidepressant
  - Hypnotic
  - Mood Stabilizer
  - Anticoagulant
  - Insulin
    - Up to 7 points
- Residents receive an additional points when they receive med above and a marked as sedated, weight loss, 2 or more of these meds, Alzheimer's/dementia and/or falls
  - 1 point for each
Unnecessary Medication Algorithm

Unnecessary Medications Sampling Algorithm for QIS

The table below shows the Unnecessary Medications sample selected by the new sampling algorithm, using illustrative Census Sample Stage 1 results. In this example, the resident named Cindy (last on the list, with an overall score of 2) was selected so that Insulin would be represented in the sample. One of the residents with a score of 6 (i.e., Dana, Michelle or Jack) was dropped from the sample when Cindy was pulled in.

| Score | Sampled | Name  | Active Diagnosis (from MDS) | Antipsychotic | Antianxiety | Antidepressant | Hypnotic | Mood Stabilizer | Anticoagulant | Antibiotic | Diuretic | Insulin | Sedated | Falls QP26.5 | Weight Loss QP20.1 | Weight Loss QP10.3 |
|-------|---------|-------|-----------------------------|---------------|------------|---------------|---------|----------------|---------------|------------|---------|---------|--------|---------|----------------|------------------------|---------------------|
| 9.5   | ✓ Oscar | dementia | X | X | X | X | ✓ | ✓ | X | X | X | X | X | X | X | X | X |
| 8.5   | ✓ Dennis | Alzheimer’s | X | X | X | X | ✓ | ✓ | X | X | X | X | X | X | X | X | X |
| 8     | ✓ Rick  | Alzheimer’s | X | X | X | X | ✓ | ✓ | X | X | X | X | X | X | X | X | X |
| 6     | Dana    | dementia | X | X | X | X | ✓ | ✓ | X | X | X | X | X | X | X | X | X |
| 6     | ✓ Ryan  | dementia | X | X | X | X | ✓ | ✓ | X | X | X | X | X | X | X | X | X |
| 6     | Michello| dementia | X | X | X | X | ✓ | ✓ | X | X | X | X | X | X | X | X | X |
| 6     | Jack    | dementia | X | X | X | X | ✓ | ✓ | X | X | X | X | X | X | X | X | X |
| 2     | ✓ Cindy |         | X | X | X | X | ✓ | ✓ | X | X | X | X | X | X | X | X | X |

- QIS software will select 5 resident based on surveyor responses to selected questions in the Census Sample resident observation, record review, and staff interview components of the QIS.
- Scores range from 0 to 18.
- The five residents with the highest scores are included in the sample.
Resident Interview & Observation

Key surveyor interview and observation tool

- Surveyor makes final decision after talking with each individual resident
- The BIMS is used to determine Interviewablity
  - Score $\geq 8$, resident is interviewable
  - Score $\leq 7$ or 99, resident is non-interviewable and set to family interview status
Participation in Care Plan:
• Physician orders a change in your medications and RESIDENT is made aware of the change?
• If the physician is contacted about you, are you made aware of the results?
• Does staff tell you the results of tests like lab work or x-rays?
• If you need to have an appointment scheduled (for instance with an outside physician), are you informed of the appointment?
• Have you brought questions or concerns about your care to the attention of facility’s staff? If so, what happened as a result?
ABUSE questions have been reworded

Physical Restraints are triggered from an observation of the potential presence of a restraint.
## Resident Interview & Resident Observation

### Resident Interview

<table>
<thead>
<tr>
<th>N</th>
<th>Oral Health</th>
<th>QP254</th>
<th>QP256</th>
</tr>
</thead>
<tbody>
<tr>
<td>1)</td>
<td>Do you have mouth/facial pain with no relief?</td>
<td>No</td>
<td>Yes</td>
</tr>
<tr>
<td>2)</td>
<td>Do you have any chewing or eating problems (could be due to: no teeth, missing teeth, oral lesions, broken or loose teeth)?</td>
<td>No</td>
<td>Yes</td>
</tr>
<tr>
<td>3)</td>
<td>Do you have tooth problems, gum problems, mouth sores, or denture problems?</td>
<td>No</td>
<td>Yes</td>
</tr>
<tr>
<td>4)</td>
<td>Does staff help you as necessary to clean your teeth?</td>
<td>No</td>
<td>Yes</td>
</tr>
<tr>
<td></td>
<td>N/A, do not need assistance (Skip to O)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>5)</td>
<td>How often are your teeth/dentures/mouth cleaned (routine oral hygiene)?</td>
<td>Daily</td>
<td>Weekly</td>
</tr>
<tr>
<td></td>
<td>Monthly</td>
<td>Never</td>
<td></td>
</tr>
<tr>
<td>O</td>
<td>Privacy</td>
<td>QP204</td>
<td></td>
</tr>
<tr>
<td>1)</td>
<td>Does staff provide you privacy when they work with you, changing your clothes, providing treatment?</td>
<td>No</td>
<td>Yes</td>
</tr>
<tr>
<td>2)</td>
<td>Do you have privacy when on the telephone?</td>
<td>No</td>
<td>Yes</td>
</tr>
<tr>
<td></td>
<td>N/A, do not use telephone</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3)</td>
<td>If you would have a visitor, do you have a private place to meet?</td>
<td>No</td>
<td>Yes</td>
</tr>
</tbody>
</table>

### Resident Observation

<table>
<thead>
<tr>
<th>M</th>
<th>Resident's Room</th>
</tr>
</thead>
<tbody>
<tr>
<td>1)</td>
<td>Were any of the following observed? (Mark all that apply)</td>
</tr>
<tr>
<td></td>
<td>A: Odor in resident's room QP221</td>
</tr>
<tr>
<td></td>
<td>B: Walls, floors, ceilings, drapes, or furniture are not clean or are in disrepair QP222</td>
</tr>
<tr>
<td></td>
<td>C: Environment does not accommodate individual needs and preferences QP147</td>
</tr>
<tr>
<td></td>
<td>D: Lighting levels are inadequate or uncomfortable QP223</td>
</tr>
<tr>
<td></td>
<td>E: Room temperatures are uncomfortable or unsafe QP224</td>
</tr>
<tr>
<td></td>
<td>F: Sound levels are uncomfortable QP225</td>
</tr>
<tr>
<td></td>
<td>G: Bedrooms are not equipped to assure full privacy (i.e., curtains, moveable screens, private rooms, etc.) QP151</td>
</tr>
<tr>
<td></td>
<td>H: Clean bed/bath linens are not available or are in poor condition QP152</td>
</tr>
<tr>
<td></td>
<td>I: Evidence of insects or rodents in bedrooms or bathrooms QP226</td>
</tr>
<tr>
<td></td>
<td>J: None of the above</td>
</tr>
</tbody>
</table>

**Comments:**

| 2) | Were any of the following observed? (Mark all that apply) |
|     | A: Electric cords, extension cords, or outlets are in disrepair or used in an unsafe manner QP228 |
|     | B: Bed and linens are visibly soiled with stool or urine QP260 |
|     | C: Resident care equipment is unclean, in disrepair or stored in an improper or unhygienic manner QP140 |
|     | D: Ambulation, transfer or therapy equipment are unclean or in unsatisfactory condition QP229 |
|     | E: Safety equipment in bed or bathroom is inadequate (i.e., grab bars, slip surface) QP230 |
|     | F: Call system in room or bathroom is not functioning QP231 |
|     | G: Call light not within reach for residents capable of using it QP267 |
|     | H: Accessible chemicals or other hazards in bed or bathroom QP255 |
|     | I: Unsafe hot water in room QP269 |
|     | J: Hot water is too cool QP270 |
|     | K: Room not homelike QP271 |
|     | L: None of the above |

**Comments:**
The surveyor may need to ask probing questions to help determine if the resident understands the difference between a commercial bank account and the facility’s...

**Sleeping Resident?**
Staff Interview

- Staff interviews are conducted with licensed staff, either the RN or LPN
  - Catheter Use
  - Nutrition
  - Skin care/ Pressure Ulcers
  - Side Rails
  - Contractures
  - Falls or fractures

“I’ve been telling you those things will kill you for damn near eighty years! When are you gonna listen?!”
Facility Level Investigations

- Resident Council President/ Representative interview
- Dining observation
- Kitchen/ food service Infection control
  - No second probe
- Liability Notice and Beneficiary Appeal Rights
- Quality assessment and assurance review
- Infection Control
- Medication Pass
  - CMS policy change to reduce from 50 to 25 opportunities
Transition - Stage I to Stage II

• Software calculates the indicators and compares results to national rates
  – Determine what stage II facility level tasks have been triggered and require an in-depth investigation is required
• Stage II sample selected by software
  – Fewest residents with most issues
• Normally three residents - each triggered area
• Triggered Tasks
  – Environmental review
  – Resident Funds
  – Admission, Transfer, and Discharge
  – Sufficient Staff
  – Abuse prohibition review
Critical Element Pathway

• Each CE Pathway is set up with the same basic format
  – Assessment (F272)
  – Care planning (F279)
  – Professional Standards of care (F281)
  – Provision of care and services (F281)
  – Care plan revision (F280)
  – Concerns with structure, process and/or outcomes related to process of care

• Guides surveyors through investigation

• Each pathway suggest specific F-tags that should be considered plus additional areas to consider/investigate
Critical Element Pathways

- Activities
- ADLs/ ROM
- Behavioral and emotional status
- Incontinence, Catheters, UTIs
- Communication and sensory problems
- Dental status and services
- Dialysis
- General
- Hospice-Paliative Care
- Hospitalization or death

- Pain management
- Physical restraints
- Pressure ulcers
- Psychoactive medications
- Rehabilitation and community discharges
- Unnecessary Meds
- PASARR
- Hydration
- Ventilator dependent residents
- Tube feeding status
- Dementia (2014)
Dementia Investigation F309

• Assess behavior (onset, duration, intensity, possible precipitating events or environmental triggers, etc.) and related factors (appearance, alertness, etc.) I

• Staff assess the underlying cause of behaviors

• When there is a suspected change in condition or worsening from baseline, did staff contact the attending physician/practitioner immediately for a medical evaluation

• If medical causes are ruled out, did staff attempt to establish other root causes of the behavior using individualized knowledge about the person and when possible, information from the resident, family, previous caregivers and/or direct care staff?

• As part of the comprehensive assessment did facility staff evaluate:
  – The resident’s usual and current cognitive patterns, mood and behavior, and whether these present a risk to the resident or others?
  – How the resident typically communicates a need such as pain, discomfort, hunger, thirst or frustration?
  – Prior life patterns and preferences customary responses to triggers such as stress, anxiety or fatigue, as provided by family, caregivers, and others who are familiar with the resident before or after admission?
Resident Care

• If during the survey a concern is identified that an antipsychotic medication is given by staff for purposes of discipline or convenience and not required to treat the resident’s medical symptoms, **review F222 – § 483.13(a)**.

• If the physician does not respond to the notification, does staff contact the medical director for further review? If the medical director was contacted, does he/she respond and intervene as needed?

• *Did the facility provide the necessary care and services for a resident with dementia to support his or her highest practicable level of physical, mental and psychosocial well-being in accordance with the comprehensive assessment and plan of care? If No, **cite F309***
Regulatory Compliance

• Potential citations are agreed too and statement of deficiency is developed by with integration of findings
• Combine stage I and II findings across residents by F-tag
  – Identify deficiencies
  – Scope and severity
• Exit conference
CMS

Disaster Rule

Life Safety Code 2012

Healthcare Code 2012
Reasons for Increased Oversight

- Fires over the past 100 years
- GAO reports on Disaster Planning Nursing Home Fire Safety
  - Building is not sprinklered
  - Fire originates in patient sleeping area
  - Door to room of fire origin is not closed or is reopened during the fire
  - Patient known to be outside the danger area during the fire found dead inside the danger zone after the fire
  - All facilities are required to be sprinkled 8/13/13
Miami Shores of Moraine
Basic Principles of LSC

- Residents within health care facilities are presumed to be incapable of self-preservation.
- Safety depends on an appropriate combination of in-place fire and life safety features along with an acceptable staff response.
- The basic concept of safety is ‘defend-in-place’ is based on compartmentalization
- Facilities are subdivided into a minimum of two compartments, thus safety from fire means that is residents can be moved without having to leave the building or change floors.
- The basic features of health care fire protection, therefore, involve a limited amount of patient movement.
Inspection, Testing and Maintenance and Record Keeping

• A majority of the citations of the TOP 10 deficiencies are a result of inspection, testing or maintenance issues, with many involving just record keeping

• Record Keeping and Documentation of everything you do and your contractor does is key to success

• If deficient issues are discovered by Contractor’s testing or inspection report, you must fix it immediately
Leading Deficiencies

• K11 Fire Barriers
• K17 Corridor Walls
• K 18 Corridor doors
• K 29 Hazardous Areas
• K 38 Exit Access
• K 39 Exit
• K46 Emer. Illumination
• K48 Fire Safety Plan

• K50 Fire Drills
• K-54 Fire Alarm
• K62 Sprinkler System
• K73 Flammable Furnishings and Decorations
• K 144 Generator
• K 147 Electrical
CMS Announcement

Life Safety Code©

  – Promulgated by the National Fire Protection Association (NFPA) (not a government agency)

• Life Safety Code is not the only code facilities must meet but one of many i.e. International Building Code (IBC), STATE Fire Code, STATE Building Code, Uniform Building Code), Local Codes and ordinances etc.

• It is NOT a building code. It focuses on safety of all persons in a building by protecting them from fire, smoke and toxic fumes
Organization of the LSC

• Introductory chapters, definition and applications
• Core chapters
  – Means of egress
  – Construction
  – Building services/ equipment
  – Finishes and contents
• Occupancy chapters
  – Healthcare chapters 18 and 19
• Annex
  – Further explains code but is not agreed to by consensus so is not ‘part of the code’
The NFPA 99 has now been upgraded from a “Standard” to a “Code”. This will put it in the same light as NFPA 101 Life Safety Code.

The code is now intended to be law in its entirety versus simply a reference.
NFPA 99 Chapters

1. Administration
2. Referenced Publications
3. Definitions
4. Fundamentals
5. Gas and Vacuum Systems
6. Electrical Systems
7. Information Technology & Communications Systems*
8. Plumbing*
9. Heating, Ventilation and Air Conditioning
10. Electrical Equipment
11. Gas Equipment
12. Emergency Management*
13. Security Management*
14. Hyperbaric Facilities
15. Fire Protection

*NOT SLATED to apply to long term care facilities
Move to 2012

• Partial adoption of specific items
• Survey and Certification letters
  – March 9, 2012
  – August 30, 2013
Culture Change

• Allows for facilities that have enhanced their environments to obtain a waiver until CMS accepts the 2012 Life Safety Code

• Facility must comply with **ALL** the requirements of the 2012 LSC for each waiver
  – You do not have to document financial hardship
  – You do not have to document alternative protection
  – The waived requirements apply to both new and existing buildings
CMS Waiver Letter
S&C-12-21-LSC

– Means of Egress – Corridor storage
– Cooking Facilities – Nursing unit location
– Fireplaces
– Combustible Decorations
Open Kitchens
Cooking Facilities
Chapters 18/19.3.2.5

• Nursing unit kitchen not hazardous & allowed to be opened to the corridor, provided:
  • Only one open kitchen per smoke zone
  • No deep fat fryers
  • Include shut off device for fuel supply
  • Grease baffles installed in exhaust system
  • No solid fuel (i.e. charcoal)
  • Additional cooking area must be in protected room similar to hazardous area
Cooking Facilities
Chapters 18/19.3.2.5

• Nursing unit containing the open kitchen must be separated from all other areas by a smoke barrier.
• Residential hood system can be used
• A manual shut off switch to all cook tops with access to staff only and an automatic shut off not exceeding 120 minutes
• Compliance with NFPA 96 for all inspection, testing and maintenance of the range hood and duct system.
• Smoke detectors in the kitchen located no closer than 20 ft from the cook top or range.
Means of Egress
Chapters 18/19.2.3 & 2.3.4
Means of Egress
Chapters 18/19.2.3 & 2.3.4

• Previously restricted items would now allowed:
  – Wheeled equipment parked in corridor, provided there is 6 feet of clearance (patient lifts & transport equipment)
  – Fixed Furniture – bench seating (limited to 2 feet deep)
  – Fixed seating in the corridors permitted where corridor is at least 8 ft. in width
    • Fixed furniture does not reduce the clear width of the corridor to less than 6 ft.
    • On same side, not more than 50 sq. ft area, 10 feet between benches

• Corridors are protected by a smoke detection
Wheeled Items

- The wheeled equipment does not reduce the clear width of the corridor below 60”
- The wheeled equipment is limited to:
  - Equipment and carts in use.
  - Medical emergency equipment not in use
  - Patient lifts and transport equipment
- The fire safety plan and staff training program addresses the relocation of the wheeled equipment during an emergency.
Fireplaces
Fireplaces
Chapters 18/19.5.23(2), (3), (4)

• Direct vent gas fireplaces allowed in smoke compartments containing patient sleeping rooms
• Not allowed inside a patient room
• Carbon monoxide monitors are required
• Solid fuel burning fireplaces in areas other than patient sleeping areas, with one hour rated barrier between fireplace and sleeping rooms
• The smoke compartment the fireplace is located must be protected with quick response sprinklers
• The fireplace shall have a sealed glass front with wire mesh panel or screen
Combustible Decorations
Combustible Decorations Chapters 18/19.7.5 & ( ).7.5.6

- Decorations such as photographs, paintings and other art are attached to the walls, ceilings and non required fire rated doors in accordance with the following:
  - Decorations on doors do not interfere with the operation or any required latching of the doors
  - Decorations do not exceed 30% of the wall, ceiling or door areas inside any space or room in a smoke compartment that is fully sprinklered

• Categorical LSC Waivers

• CMS has identified several areas of the 2000 edition of the LSC and NFPA 99 that may result in unreasonable hardship on a large number of healthcare facilities and for which there are alternative approaches that provide equal level of protection (2012 NFPA 101)
Categorical Waivers

• There are options for facilities to request waivers at the state of annual survey.
• Facility policy and procedures are updated
• Meet all 2012 code requirements
  – Openings in Exit Enclosures
  – Emergency Generators and Standby Power System
  – Doors
  – Suites
  – Clean Waste - Recycling
Emergency Generators

• Diesel powered generators have had a requirement per NFPA 110 for an load bank test if monthly load bank tests fell below 30% of load.
• (OLD 2000) 2 hour load bank test of 25% first 30 minutes, 50% next 30 minutes, and 75% for 60 minutes
• (NEW 2012) Now 90 minute test is allowed with 50% for first 30 minutes and 75% for next hour
• Reference: Section 8.4.2.3 of the 2010 edition of NFPA 110
Door Locking Arrangements

• 2000 edition of NFPA 101 only allowed for clinical needs (Psychiatric, Alzheimer, Dementia Units)
• Now will also allow for security risks (such as newborn nursery or pediatric units) and patients needing specialized protective measures for their safety
• Delayed egress locks were limited to one in exit pathway
• Now more than one delayed egress lock allowed
• Reference: Sections 18/19.2.2.2.2 thru 18/19.2.2.2.2 and 18/19.2.2.2.4 of 2012 edition of NFPA 101
Clean Waste & Patient Record Recycling Containers

• Past limit of 32 gallon trash container outside of hazardous storage area and not attended
• 96 gallon size recycling containers now permitted for clean waste or patient records awaiting destruction
• Reference: 18/19.7.5.7.2 of the 2012 edition of NFPA 101
CMS

Disaster Rule

Life Safety Code 2012

Healthcare Code 2012
Where Are We Today?

- World has changed
- Disasters can happen anytime, so remember your are always in pre-event mode
- Disaster will exceed the facility’s capacity and external services may be required
Emergencies Present In 2 Ways...

Unanticipated and/or Without Warning

Oklahoma City Bombing
Tornado
Northridge Earthquake

Anticipated and/or With Warning

Hurricane Katrina
Midwest Floods
Pandemic Flu

The Amount of Time We’re Given To Pre-Organize People and Pre-Stage Equipment Can Drastically Change Our Response Effectiveness
“Most Likely”

Man-made
• Fires
• Explosive devices
• Firearms
• Power outage
• Structural collapse
• Transportation event
  – Air, Rail, Roadway, Water
• Industrial HAZMAT

Natural
• Fires
• Extreme weather
• Tornado
• Earthquake
• Tornado
• Hurricanes, floods
“Disaster” Definition

• Disaster- dis·as·ter n.
  a. An occurrence causing widespread destruction and distress; a catastrophe.
  b. A grave misfortune.
  c. Informal- A total failure

• A disaster is present when need exceeds resources!

Disaster = Need > Resources
Katrina & Sandy

- All experienced problems, whether they evacuated or sheltered in place
- Plans were often missing/not up to date
- Lack of familiarity with plans
- 73% of Hurricane Katrina-related deaths in New Orleans area were among persons age 60 and over, although they comprised only 15%
- Uncertainty of access to community resources
- Shortages of supplies
- Power disruptions (2 hours—4 weeks)
- Generators taxed
- Psychological stress
Long Term Care Challenge

• SNFs serve the medically fragile, who may be more severely impacted by disasters
• Outdated plans with no annual review of protocols and practices
• NH no typically included in community preparedness coalitions
• Sheltering-in-place concept not well understood
• Evacuations are based upon nature of threat, impact of threat, and acuity of residents
• Lacking systems to track residents, meds, belongings
• Limited security management plan in place
CMS Actions

• On December 20th CMS released draft disaster rule, Emergency Preparedness Standards for Medicare and Medicaid Participating Providers and Suppliers

• Develop comprehensive disaster management program: Mitigation, Preparedness, Response and Recovery
Disaster Cycle

**Mitigation** - Minimizing the effects of disaster. Examples: building/LSC: risk/vulnerability analyses

**Preparedness** - Planning how to respond. Examples: preparedness plans; emergency exercises/training; warning systems

**Response** - Efforts to minimize the hazards; Examples: search and rescue; emergency relief

**Recovery** - Returning the community to normal; providing care, rebuilding, return to normal or better
All Hazards Approach

• Create an All Hazards Plan to consider various hazards and disaster scenarios
• Risk/Hazards Analysis is the possibility of loss, damage or any other undesirable event.
• Process used to identify hazards
  – Which hazards get attention
  – Priorities
  – Resources
• Maintaining Life Safety Code
• People – Assignments/tasks
  – Triage
  – Tracking
  – Transport
  – Treatment
Highlights of CMS Disaster Rule

1. There are four core elements integral to a healthcare facility's emergency preparedness program:
   - Risk assessment/planning
   - Policies and procedures
   - Communication plan
   - Training/testing

2. Use an "all-hazards" approach in their emergency preparedness. This means providers would have to adopt an approach that covers a "broad range of related emergencies."
CMS Highlights

3. Determine alternate cites for evacuation
4. Maintenance of certain amount of food and drink
   - Alternative sources of energy
   - Sewage and waste management
   - Policy to track the location of residents during and after an emergency
5. Communication planning
   - Identify names and contact information for all pertinent employees, physicians, others hospitals and volunteers.
   - Method for sharing information and medical data within the bounds of HIPAA.
6. Annual review of plan
7. Applies to 17 certified entities
CMS Proposes…  
DECEMBER 2013 CMS released draft of Disaster rule  
Effective emergency preparedness system that must be addressed by healthcare organizations.

- Risk assessment and planning  
- Policies and procedures  
- Communication  
- Training and testing

---

DRAFT - Survey & Certification - DRAFT  
Emergency Preparedness & Response Plan

<table>
<thead>
<tr>
<th>HEALTH CARE FACILITY CHECKLIST FOR EFFECTIVE EMERGENCY PLANNING</th>
</tr>
</thead>
<tbody>
<tr>
<td>Tasks</td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td>• <strong>Develop Emergency Plan:</strong> Gather all available relevant information when developing the emergency plan. This information includes, but is not limited to:</td>
</tr>
<tr>
<td>✓ Copies of any state and local emergency planning regulations or requirements</td>
</tr>
<tr>
<td>✓ Facility personnel names and contact information</td>
</tr>
<tr>
<td>✓ Contact information of local and state emergency managers</td>
</tr>
<tr>
<td>✓ A facility organization chart</td>
</tr>
<tr>
<td>✓ Building construction and Life Safety systems information</td>
</tr>
<tr>
<td>✓ Specific information about the characteristics and needs of the individuals for whom care is provided</td>
</tr>
</tbody>
</table>

| • **All Hazards Plan:** Develop a plan for all potential hazards (hurricanes, floods, tornadoes, fire, bioterrorism, pandemic, etc.) that could affect the facility |
Development Emergency Plan

• Gather all available relevant information when developing the emergency plan. This information includes, but is not limited to:
  – Copies of any state and local emergency planning regulations or requirements
  – Facility personnel names and contact information
  – Contact information of local and state emergency managers
  – A facility organization chart
  – Building construction and Life Safety systems information
  – Specific information about the characteristics and needs of the individuals for whom care is provided
Continuity of Operations Plan (COOP)

- Develop a continuity of operations business plan using an all-hazards approach (e.g., hurricanes, floods, tornadoes, fire, bioterrorism, pandemic, etc.) that could potentially affect the facility directly and indirectly within the particular area of location. Indirect hazards could affect the community but not the facility and as a result interrupt necessary utilities, supplies or staffing. Determine all essential functions and critical personnel.
COOP Planning Objectives

• Ensuring continued performance of essential functions.
• Reducing loss of life and minimizing damage.
• Ensuring succession to office of key leaders.
• Reducing or mitigating disruptions to operations.
• Protecting essential assets.
• Achieving a timely recovery and reconstitution.
• Maintaining a test, training and exercise program for program validation.
NH Incident Command System

A standardized, all-hazard approach to incident management; usable to manage all types of emergencies, routine or planned events, by establishing a clear chain of command

- Organization
- Safety
- Achievement of objectives
- Effective use of resources
NHICS Functions

- Identified Command structure
- Management by objectives
  - Command (Leader)
  - Operations (Doers)
  - Planning (Planners)
  - Logistics (Getters)
  - Finance/Administration (Money)
- Common terminology
- Resource management
- Integrated communications
Collaboration

- **Local EMA**
  - local emergency management agencies to ensure the development of an effective emergency plan.

- **Healthcare Coalitions**
  - Work with different types of healthcare providers (e.g. hospitals, nursing homes, hospices, home care, dialysis centers etc.) at the State and local level to integrate plans of and activities of healthcare systems into State and local response plans to increase medical response capabilities.
Hazard Vulnerability Analysis

• The purpose is a prioritization process that will result in a risk assessment for “all hazards”
• The tool includes consideration of multiple factors
• The focus is on organization planning and resources and/or the determine that no action may be required. This is an organization decision
\[ V = Pb + S - Pr \]

- Process of evaluating risk associated with a specific hazard and defined in terms of:
  - probability & frequency of occurrence
  - magnitude & severity
  - exposure & consequences
  - preparedness

Vulnerability equals hazard/threat probability, plus severity minus prepared response
## Hazard Vulnerability Analysis

### Hazard and Vulnerability Assessment Tool

**Naturally Occurring Events**

<table>
<thead>
<tr>
<th>EVENT</th>
<th>PROBABILITY</th>
<th>HUMAN IMPACT</th>
<th>PROPERTY IMPACT</th>
<th>BUSINESS IMPACT</th>
<th>PREPAREDNESS</th>
<th>INTERNAL RESPONSE</th>
<th>EXTERNAL RESPONSE</th>
<th>RISK</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Likelihood this will occur</td>
<td>Possibility of death or injury</td>
<td>Physical losses and damages</td>
<td>Interruption of services</td>
<td>Proplanning</td>
<td>Time, effectiveness, resources</td>
<td>Community, Mutual Aid staff</td>
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<tr>
<td>Hurricane</td>
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<td>0</td>
<td>0</td>
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<tr>
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<td>Severe</td>
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<td>2</td>
<td>2</td>
<td>2</td>
<td>2</td>
<td>50%</td>
</tr>
<tr>
<td>Thunderstorm</td>
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<td>2</td>
<td>2</td>
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<td>2</td>
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<td>1</td>
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</tr>
<tr>
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<td>2</td>
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<td>2</td>
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<td>50%</td>
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<tr>
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<tr>
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<td>2</td>
<td>3</td>
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<td>2</td>
<td>3</td>
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<td>2</td>
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<tr>
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<td>2</td>
<td>3</td>
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<td>1</td>
<td>1</td>
<td>56%</td>
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<tr>
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<td>2</td>
<td>2</td>
<td>2</td>
<td>2</td>
<td>1</td>
<td>56%</td>
</tr>
</tbody>
</table>

**Average Score**

|             | 0.33 | 0.65 | 0.51 |

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*Risk = Probability * Severity*
Collaborate with Suppliers/Providers

- Collaborate with suppliers and/or providers who have been identified as part of a community emergency plan or agreement with the health care facility, to receive and care for individuals. A surge capability assessment should be included in the development of the emergency plan. Similarly, evidence of a surge capacity assessment should be included if the supplier or provider, as part of its emergency planning, anticipates the need to make housing and sustenance provisions for the staff and or the family of staff.
Criteria for Executing Plan

• Incident Command or something else... lines of authority

• Determine who at the facility level will be in authority to make the decision to execute the plan to evacuate or shelter in place (even if no outside evacuation order is given) and what will be the chain of command

• Establish contingencies for the facility communication infrastructure in the event of telephone failures (e.g., walkie-talkies, ham radios, text messaging systems, etc.).
Shelter-in-Place Plan

• Due to the risks in transporting vulnerable patients and residents, evacuation should only be undertaken if sheltering-in-place results in greater risk.
  – Develop an effective plan for sheltering-in-place, by ensuring provisions for the following are specified
  – Procedures to assess whether the facility is strong enough to withstand strong winds, flooding, etc.
  – Measures to secure the building against damage (plywood for windows, sandbags and plastic for flooding, safest areas of the facility identified
  – Procedures for collaborating with local emergency management agency, fire, police and EMS agencies regarding the decision to shelter-in-place.
Evacuation Planning

• Develop an effective plan for evacuation, by ensuring provisions for the following are specified:
  – Identification of person responsible for implementing the facility evacuation plan
  – Multiple pre-determined evacuation locations (contract or agreement) with a “like” facility with at least one facility being 50 miles away.
    • A back-up may be necessary if the first one is unable to accept evacuees.
  – Evacuation routes and alternative routes have been identified, and the proper authorities have been notified. Maps are available and specified travel time has been established
  – Adequate food supply and logistical support for transporting food is described.
Facility Reentry Plan

- Can we operate facility after the disaster?
  - What do we need to do to get back into operation?
  - Do we have adequate insurance coverage?
- Have a copy of your policy and read it to determine coverage
  - Money needed to continue based on loss of revenue
  - Staff coverage (all, some or none)
  - Other items i.e. direct, indirect, utilities and administration cost that need continued
Resident Identification

• Determine how residents will be identified in an evacuation identifying information such as:
  – Name
  – Social security number
  – Photograph
  – Medicaid or other health insurer number
  – Date of birth
  – Diagnoses
  – Current medication, treatment and diet regimens
  – Name and contact information for next of kin/responsible person/Power of Attorney
  – Determine how this information will be secured

• How will medical records and medications will be transported so they can be matched to the resident
Conduct Staff Education and Exercises

- All staff must be trained on potential roles in competency-based emergency management.
- All should be familiar with EOP, location of procedures, activation processes, etc.
- Those expected to perform NHICS functions must be trained in system
You can’t control what comes your way. You can only control how prepared you will be

- Leadership: How well you work together
- Resources: How well stocked you are and what plans you have for resupply
- Collaboration: What relationships you have with outside resources
- Communication: Back up plans when all else fails
- Know your greatest risks and prepare for them
Final Thoughts

• Quality is like eating this burger
  – ONE BITE AT A TIME!
• Establish Key Indicators across all department/systems
• Establish expectations or tolerances
• Retention is better than recruitment
• Mentor your staff rather than Manage them
• Education and training
  – Customer service
  – Critical thinking
  – Time management
Kenneth Daily, LNHA
Elder Care Systems Group
kenn@qissurvey.com
• Consulting and education focusing on quality improvement, survey compliance, and facility management.
• Comprehensive Traditional and QIS technical assistance, Mock surveys and audits
  – Standard/traditional and QIS preparation
  – Directed Plan of Correction development and implementation
• Immediate Jeopardy Assistance
• Quality/Performance Improvement Program development and implementation
  • Corp Compliance Plans