High Risk Pressure Ulcer Quality Measure

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Outline of Presentation…

• What is included in the High Risk Pressure Ulcer Quality Measure

• RAI Manual / Critical Element Pathway Guidance

• Recommended Strategies / Approaches
What is your QAPI Process?

Consider the following questions…

• Does your facility have a process to track and monitor pressure ulcers?

• Does your facility understand the QM specifications for high-risk pressure ulcers?

• Does your appropriate staff understand the importance of correct MDS coding on your publically-reported quality measure for high-risk pressure ulcers?
The primary sources of information for this presentation are...

- CMS’s RAI Version 3.0 Manual
- Pressure Ulcer Critical Element Pathway – QIS Survey
- Surveyor Interpretive Guidelines – Appendix PP of the State Operations Manual (Rev. 12, 10-14-05)

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Numerator ("Triggers")…

The QM is calculated from a "pool" of residents….

- **Numerator**
  
  - "High-Risk" Long-stay residents with a selected target assessment with an unhealed Stage 2, 3 or 4 pressure ulcer present during the 7-day look-back period.
What is “High Risk”?

M0100: Determination of Pressure Ulcer Risk

- A. Resident has a stage 1 or greater, a scar over bony prominence, or a non-removable dressing/device
- B. Formal assessment instrument/tool (e.g., Braden, Norton, or other)
- C. Clinical assessment
- D. None of the above

M0150: Risk of Pressure Ulcers

- Is this resident at risk of developing pressure ulcers?
  - 0. No
  - 1. Yes

Even though there are sections on the MDS specifically speaking to “Pressure Ulcer Risk” that must be coded, they have nothing to do with the pressure ulcer risk determination included with the high-risk pressure ulcer quality measure.
“High Risk” determination …

In the quality measure specifications, “High-Risk” for the development of pressure ulcers is based solely on any of three criteria...

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**Denominator**

All long-stay residents with a selected target assessment who meet the definition of high risk, except those with exclusions. Residents are defined as high-risk if they meet **one or more** of the following three criteria on the target assessment:

1. Impaired bed mobility or transfer indicated, by **either or both** of the following:
   1.1. Bed mobility, self-performance (G0110A1) = [3, 4, 7, 8].
   1.2. Transfer, self-performance (G0110B1) = [3, 4, 7, 8].
2. Comatose (B0100 = [1])
3. Malnutrition or at risk of malnutrition (I5600 = [1]) (checked).
“High Risk” determination …

In the quality measure specifications, “High-Risk” for the development of pressure ulcers is based solely on any of three criteria…

Comatose (B0100 = [1]), Malnutrition or at risk of Malnutrition (I5600 is checked), Impaired bed mobility or transfer as indicated by either or both of the following...

Bed Mobility, Self-Performance (G0110A1) = [3,4,7 or 8]
Transfer, Self-Performance (G0110B1) = [3,4,7 or 8]
“High Risk” determination continued…

This is a very important factor because if your ADLs are not captured accurately, you will have residents excluded from your High-Risk Pressure Ulcer QM calculation.

If your denominator is under-stated and it is not an honest representation of your population, your final High-Risk Pressure Ulcer Quality Measure calculation will be OVERSTATED.
Back to the math…

MDS 3.0 Measure: Percent of High-Risk Residents With Pressure Ulcers (Long Stay)

<table>
<thead>
<tr>
<th>MEASURE DESCRIPTION</th>
<th>MEASURE SPECIFICATIONS</th>
<th>COVARIATES</th>
</tr>
</thead>
<tbody>
<tr>
<td>CMS: N015.01 NQF: 0679</td>
<td></td>
<td>Not applicable.</td>
</tr>
<tr>
<td>This measure captures the percentage of long-stay, high-risk residents with Stage II-IV pressure ulcers.</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Numerator</strong></td>
<td>All long-stay residents with a selected target assessment that meets both of the following conditions:</td>
<td></td>
</tr>
<tr>
<td></td>
<td>1. Condition #1: There is a high risk for pressure ulcers, where “high-risk” is defined in the denominator definition below.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>2. Condition #2: Stage II-IV pressure ulcers are present, as indicated by any of the following three conditions:</td>
<td></td>
</tr>
<tr>
<td></td>
<td>2.1. M0300B1 = [1, 2, 3, 4, 5, 6, 7, 8, 9] or</td>
<td></td>
</tr>
<tr>
<td></td>
<td>2.2. M0300C1 = [1, 2, 3, 4, 5, 6, 7, 8, 9] or</td>
<td></td>
</tr>
<tr>
<td></td>
<td>2.3. M0300D1 = [1, 2, 3, 4, 5, 6, 7, 8, 9].</td>
<td></td>
</tr>
<tr>
<td><strong>Denominator</strong></td>
<td>All long-stay residents with a selected target assessment who meet the definition of high risk, except those with exclusions. Residents are defined as high-risk if they meet one or more of the following three criteria on the target assessment:</td>
<td></td>
</tr>
<tr>
<td></td>
<td>1. Impaired bed mobility or transfer indicated, by either or both of the following:</td>
<td></td>
</tr>
<tr>
<td></td>
<td>1.1. Bed mobility, self-performance (G0110A1) = [3, 4, 7, 8].</td>
<td></td>
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<td>1.2. Transfer, self-performance (G0110B1) = [3, 4, 7, 8].</td>
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</tr>
<tr>
<td></td>
<td>3. Malnutrition or at risk of malnutrition (I5600 = [1]) (checked).</td>
<td></td>
</tr>
</tbody>
</table>

Admission and 5-Day PPS Assessments are **NOT** included in the QM.

The “High Risk” determination piece.
Numerators (Condition 2)...

### M0300. Current Number of Unhealed Pressure Ulcers at Each Stage

<table>
<thead>
<tr>
<th>A: Number of Stage 1 pressure ulcers</th>
</tr>
</thead>
<tbody>
<tr>
<td>Stage 1: Intact skin with non-blanchable redness of a localized area usually over a bony prominence. Darkly pigmented skin may not have a visible blanching; in dark skin tones only it may appear with persistent blue or purple hues</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>B: Stage 2: Partial thickness loss of dermis presenting as a shallow open ulcer with a red or pink wound bed, without slough. May also present as an intact or open/ruptured blister</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Number of Stage 2 pressure ulcers - If 0 → Skip to M0300C, Stage 3</td>
</tr>
<tr>
<td>2. Number of these Stage 2 pressure ulcers that were present upon admission/entry or reentry - enter how many were noted at the time of admission/entry or reentry</td>
</tr>
<tr>
<td>3. Date of oldest Stage 2 pressure ulcer - Enter dashes if date is unknown:</td>
</tr>
<tr>
<td>Month</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>C: Stage 3: Full thickness tissue loss. Subcutaneous fat may be visible but bone, tendon or muscle is not exposed. Slough may be present but does not obscure the depth of tissue loss. May include undermining and tunneling</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Number of Stage 3 pressure ulcers - If 0 → Skip to M0300D, Stage 4</td>
</tr>
<tr>
<td>2. Number of these Stage 3 pressure ulcers that were present upon admission/entry or reentry - enter how many were noted at the time of admission/entry or reentry</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>D: Stage 4: Full thickness tissue loss with exposed bone, tendon or muscle. Slough or eschar may be present on some parts of the wound bed. Often includes undermining and tunneling</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Number of Stage 4 pressure ulcers - If 0 → Skip to M0300E, Unstageable: Non-removable dressing</td>
</tr>
<tr>
<td>2. Number of these Stage 4 pressure ulcers that were present upon admission/entry or reentry - enter how many were noted at the time of admission/entry or reentry</td>
</tr>
</tbody>
</table>
For MDS assessment, initial numerical staging of pressure ulcers and the initial numerical staging of ulcers after debridement, or sDTI that declares itself, should be coded in terms of what is assessed (seen or palpated, i.e. visible tissue, palpable bone) during the look-back period. Nursing homes may adopt the NPUAP guidelines in their clinical practice and nursing documentation. However, since CMS has adapted the NPUAP guidelines for MDS purposes, the definitions do not perfectly correlate with each stage as described by NPUAP. Therefore, you cannot use the NPUAP definitions to code the MDS. You must code the MDS according to the instructions in this manual.
Numerators (Condition 2)...

Unhealed Pressure Ulcers (Stage 2, 3 or 4)

RAI Manual Definitions...

**DEFINITION**

**STAGE 1 PRESSURE ULCER**
An observable, pressure related alteration of intact skin, whose indicators are compared to an adjacent or opposite area on the body may include changes in one or more of the following parameters: skin temperature (warm or coolness), tissue consistency (firm or bouncy), sensation (pain or itching), and/or a defined area of persistent redness in lightly pigmented skin, whereas in darker skin tones, the ulcer may appear with persistent red, blue, or purple hues.

**DEFINITION**

**STAGE 2 PRESSURE ULCER**
Partial thickness loss of dermis presenting as a shallow open ulcer with a red-pink wound bed, without slough. May also present as an intact or open/ruptured blister.

**DEFINITION**

**STAGE 3 PRESSURE ULCER**
Full thickness tissue loss with exposed bone, tendon or muscle. Slough or eschar may be present on some parts of the wound bed. Often includes undermining and tunneling.

**DEFINITION**

**STAGE 4 PRESSURE ULCER**
Full thickness tissue loss with exposed bone, tendon or muscle. Slough or eschar may be present on some parts of the wound bed. Often includes undermining and tunneling.

**DEFINITION**

**SLOUGH TISSUE**
Non-viable, yellow, tan, green or brown tissue; usually moist, can be soft, stringy and mucinous in texture. Slough may be adherent to the base of the wound or present in clumps throughout the wound bed.

**DEFINITION**

**ESCHAR TISSUE**
Dead or devitalized tissue that is hard or soft in nature; usually black, brown, or tan in color, and may appear scab-like, necrotic tissue, and eschar.

**DEFINITION**

**FLUCTUANCE**
Used to describe the texture of wound tissue indicative of underlying unexposed fluid.

**DEFINITION**

**SUSPECTED DEEP TISSUE INJURY**
Purple or maroon area of discolored intact skin due to damage of underlying soft tissue. The area may be preceded by tissue that is painful, firm, mushy, and shiny.

**DEFINITION**

**UNDETERMINING**
The destruction of tissue or ulceration extending under the skin edges (margins) so that the pressure ulcer is larger at its base than at the skin surface.

**DEFINITION**

**TUNNELING**
A passage way of tissue destruction under the skin surface that has an opening at the skin level from the edge of the wound.

**DEFINITION**

**ESCHAR**
Dead or devitalized tissue that is hard or soft in nature; usually black, brown, or tan in color, and may appear scab-like. Eschar is usually firm and adherent to the base of the wound and often the sides/edges of the wound.

**DEFINITION**

**EPITHELIAL TISSUE**
New skin that is pink and shiny (even with darkly pigmented). Only in Stage 2 pressure ulcer tissue is the center and edge of the ulcer. In full thick Stage 3 and 4 pressure ulcers, epithelial advances from the wound.

**DEFINITION**

**HEALED PRESSURE ULCER**
Completely closed, fully epithelialized, covered completely with epithelial tissue, or resurfaced with new skin, even if the area continues to have some surface discoloration.

**DEFINITION**

**GRAANULATION TISSUE**
Red tissue with “cobblestone” or bumpy appearance, bleeds when injured.

**DEFINITION**

**PRESSURE ULCER “WORSENING”**
Pressure ulcer “worsening” is defined as a pressure ulcer that has progressed to a deeper level of tissue damage and is therefore staged at a higher number using a numerical scale of 1-4 (using the staging assessment system classifications assigned to each stage; starting at stage 1, and increasing in severity to stage 4) on an assessment as compared to the previous assessment. For the purposes of identifying the absence of pressure ulcers, zero pressure ulcers is used when there is no skin breakdown or evidence of damage.
There are definite benefits to early detection...

Stage 1 pressure ulcers, though coded on the MDS, are **NOT included** in the calculation for the HR PU QM.

The RAI Manual specifically states for Stage 1 pressure ulcers...

**Coding Instructions for M0300A**
- **Enter the number** of Stage 1 pressure ulcers that are currently present.
- **Enter 0** if no Stage 1 pressure ulcers are present.

**Coding Tips**
- If a resident had a pressure ulcer on the last assessment and it is now healed, complete **Healed Pressure Ulcers** item (M0900).
- If a pressure ulcer healed during the look-back period, and was not present on prior assessment, **code 0.**
Consider both sides of the equation…

Remember that the QM is calculated from a “pool” of residents….

• ANY change in either part of the equation (numerator or denominator) will impact the results!

Consider the following example…
Example…

A facility with 137 “long stay” MDSs submitted...

- 10 of those MDSs triggered with either a Stage 2, 3 or 4 unhealed pressure ulcers.
- The denominator included 83 residents deemed to be “at risk for the development of pressure ulcers” (61% of LS population).

\[
\frac{10}{83} = 12\%
\]

Consider the NY State Average of 8.4% and the National Average of 6.7%

(averages as available July 2015)
Revised Example...

Same facility with 137 “long stay” MDSs submitted...

• Same 10 of those MDSs triggered with either a Stage 2, 3 or 4 unhealed pressure ulcers.

• The denominator included 118 residents deemed to be “at risk for the development of pressure ulcers” (86% of LS population).

10 divided by 118 = 8%

Consider the NY State Average of 8.4%

and the National Average of 6.7%

(averages as available July 2015)
Revised Scenario Results…

• Same 10 of those MDSs triggered with either a Stage 2, 3 or 4 unhealed pressure ulcers.
• Increased capture of self-performance for bed mobility and/or transfer resulted in an increased denominator of “at risk” residents.

• Posted quality measure reduced by 4 percentage points… over 33% adjustment!

For more information on “extensive assistance”, check on our website at www.nursinghomes.ipro.org.
Appendix PP… §483.25(c) Pressure Sores

Based on the comprehensive Assessment of a resident, the facility must ensure that—

- (1) A resident who enters the facility without pressure sores does not develop pressure sores unless the individual’s clinical condition demonstrates that they were unavoidable;

and

- (2) A resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing.
Critical Element Pathway...

5 Pages...

- Observation
  - Wound Care
  - Repositioning
  - Devices
  - Toileting/Incontinent Care
  - Pain
  - Nutrition

- Interviews
  - Resident/Representative
  - “Most Appropriate Direct Care Staff ”
  - Tx/Wound Care Nurse
  - DON, MD, CNP or PA

- Compliance Decisions
  - Five Critical Elements
Five Critical Elements…

• Did the facility comprehensively assess to determine risks and/or underlying causes, presence and stage, current Tx, presence of infection, and impact on function, mood and cognition? If no, cite F272.

• Did the facility develop a plan of care with interventions and measureable goals, in accordance with assessment, wishes and standards of practice to prevent, or if present... the care and treatment? If no, cite F279.

• Did the facility provide or arrange services by qualified individuals in accordance with CP? If no, cite F282.

• Did the facility reassess the effectiveness of the interventions and review/revise the CP to meet the needs of the resident? If no, cite F280.

• Based on observation, interviews and record review, did the facility provide care and services to prevent development and/or promote healing and/or prevent or treat infection? If no, cite F314.

(Plus 26 other Tags and Care Areas to consider....)
Element 3 in the 5 elements in QAPI…

- **Feedback, Data Systems and Monitoring**

  “The facility puts in place systems to monitor care and services, drawing data from multiple sources.”

- Once information has been gathered, you need to organize it in a way that helps your team understand what is happening.

- The **effective** use of data will ensure that decisions are being made based on “fact” and not on an assumption of the truth.

- QAPI Teams and Performance Improvement Project (PIP) Teams need data to ensure they are targeting the right areas.
Monthly Pressure Ulcer Tracking Tool…

- All pressure ulcer data is organized and summarized in one information source.
- The data is organized and displayed in easy-to-understand data summaries and graphs.
- Since the tool is updated every week, the data is real-time and factual.
- The tool summarizes by stage, site, current status and resident “location” (unit, wing, floor).
- Education and treatment strategies may be efficiently targeted.

www.nursinghomes.ipro.org
To Summarize “Key Points”…

• Any Unhealed Stage 2, 3 or 4 pressure ulcers coded on an MDS, other than an admission or 5-Day PPS assessment, for a “high risk” long-stay resident will be included in the HR PU QM.

• Remember that “risk” is determined by any one of 3 criteria as coded on the MDS... Comatose, Dx or risk of Malnutrition, or impaired bed mobility and/or transfer self-performance.

• Remember that “under capture” of the self-performance codes in bed mobility and/or transfer will cause an overstatement of your actual pressure ulcer quality measure statistic and it will not be a true representation of your resident population.

• Remember that since the RAI manual “adapted” the NPUAP definitions, you must follow the definitions and guidance in the RAI manual to correctly code the MDS.
Next Steps…

• Review your “real-time” data for all residents currently “triggering” for the high risk pressure ulcer quality measure.

• Review the documentation of each triggering resident to validate that the wound, or wounds being coded on the MDS are, in fact, due to pressure.

• Review your facility’s policy/procedure and actual processes for measuring, evaluating and documenting every wound.

• Adopt a competency expectation of the RAI Manual’s “adaptation” of the NPUAP definitions to ensure the accurate coding of the MDS.
Next Steps (continued)...

- Adopt a system of tracking all pressure wounds to maintain an accurate record of each wound, its current status and response to treatment. (www.nursinghomes.ipro.org)

- Review your facility’s current capture and documentation process for ADLs... BOTH Self-Performance and Support as collected on the MDS. There must be accurate documentation to reflect any coding for the 7-day look-back period.

- Adopt a competency expectation of the RAI Manual’s definitions of the “self-performance” codes in Section G of the MDS. Pay particular attention to the actual defined difference between “limited” and “extensive” assistance.
The Role of Consistent Assignment...

• Consistent assignment is a key step in giving care that is centered on the resident.

• Staff who work with the same residents most of the time are more likely to notice slight changes in health, mood or routine… including changes in skin.

• Consistent knowledge of every resident’s skin condition to pick up subtle changes will be invaluable in your efforts for the early detection, resolution and prevention of pressure ulcers.

• For more information on consistent assignment – www.nursinghomes.ipro.org
For more information

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