

Resource Guide for Quality Improvement Tools Related to New (April 2016) *Nursing Home Compare* Quality Measures¹

Tool Name	Description	Tool Owner/Developer	Publicly Available?
<i>Resources for Systems Approaches to Quality Improvement</i>			
CMS Quality Assurance and Performance Improvement (QAPI) Website	<p>QAPI is the coordinated application of two mutually-reinforcing aspects of a quality management system: Quality Assurance (QA) and Performance Improvement (PI). QAPI takes a systematic, comprehensive, and data-driven approach to maintaining and improving safety and quality in nursing homes while involving all nursing home caregivers in practical and creative problem solving.</p> <ul style="list-style-type: none"> • QA is the specification of standards for quality of service and outcomes, and a process throughout the organization for assuring that care is maintained at acceptable levels in relation to those standards. QA is on-going, both anticipatory and retrospective in its efforts to identify how the organization is performing, including where and why facility performance is at risk or has failed to meet standards. • PI (also called Quality Improvement - QI) is the continuous study and improvement of processes with the intent to better services or outcomes, and prevent or decrease the likelihood of problems, by identifying areas of opportunity and testing new approaches to fix underlying causes of persistent/systemic problems or barriers to improvement. PI in nursing homes aims to improve processes involved in health care delivery and resident quality of life. PI can make good quality even better. 	CMS	https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/QAPI/NHQAPI.html
QAPI Process Tool Framework	In a collaborative effort with the University of Minnesota and Stratis Health, subject matter experts, consumer groups, and nursing home stakeholders, CMS created “process” tools that may be used to implement and apply some of the basic principles of QAPI. A Process Tool Framework has been created to crosswalk each CMS Process Tool to the QAPI Five Elements. This framework includes a description of the purpose or goal for each tool that is hyperlinked within the framework	CMS	https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/QAPI/Downloads/ProcessToolFramework.pdf
Performance Improvement Plan Launch Check List	A check list to ensure important steps in launching a performance improvement project (PIP) have been executed. This tool is intended to be used by the staff member leading a PIP, and incorporates guidance on project stakeholders, resources, and processes.	CMS	https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/QAPI/downloads/PIP_LaunchChecklistdebits.pdf
Baldridge Excellence Framework for Health Care	The Baldridge framework helps manage the components of an organization as a unified whole, so that plans, processes, measures, and actions are consistent. The Baldridge framework is based on core values and concepts including: systems perspective, visionary leadership, patient-focused excellence, valuing people, organizational learning and agility, focus on success, managing for innovation, ethics and transparency, and delivering values and results	National Institute of Standards and Technology at the US Department of Commerce	Available for purchase here: http://www.nist.gov/baldridge/publications/hc_about.cfm

¹ For measure specifications, please see <https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/CertificationandCompliance/Downloads/New-Measures-Technical-Specifications-DRAFT-04-05-16-.pdf>

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Quality and Safety Education For Nurses (QSEN) Project: KSA – Knowledge, Skills, Attitude	The overall goal for the Quality and Safety Education for Nurses (QSEN) project is to meet the challenge of preparing future nurses who will have the knowledge, skills, and attitudes (KSAs) necessary to continuously improve the quality and safety of healthcare systems within which they work.	Quality and Safety Education for Nurses (QSEN) Project	http://qsen.org/competencies/graduate-ksas/
Pioneer Network Shift Huddles	A huddle is a quick meeting to share and discuss important information. Shift huddle is a gathering of the nurses and CNAs working together in one area. Start of Shift and End of Shift huddles provide ways to share information about each resident as everyone starts work, and to recap and pass along to the next shift new information.	Pioneer Network	Information available here: https://www.pioneer-network.net/Providers/StarterToolkit/Step1/HuddlesTipSheet
Circle of Success	Advancing Excellence has selected nine goals and developed new resources to help start quality improvement projects. These goals focus on issues that are meaningful to nursing homes, leadership, staff, and residents. The Circle of Success provides a step-by-step framework, starting with selecting goals, that will guide staff through any quality improvement project.	Advancing Excellence	https://www.nhqualitycampaign.org/circleOfSuccess.aspx
Consistent Assignment	Consistent assignment of nurse aides can improve quality of care by building relationships between residents and their caregivers. Advancing Excellence provides a number of best practice tools on their website to help providers get started with consistent assignment.	Advancing Excellence	https://www.nhqualitycampaign.org/goalDetail.aspx?g=CA#
National Nursing Home Quality Care Collaborative Change Package	The National Nursing Home Quality Care Collaborative (NNHQCC) Change Package is a menu of strategies, change concepts, and specific actionable items that nursing homes can choose from to begin testing for purposes of improving residents' quality of life and care. The Change Package was originally intended for nursing homes participating in the National Nursing Home Quality Care Collaborative led by CMS and the Medicare Quality Improvement Organizations (QIOs), to improve care for the millions of nursing home residents across the country. The Change Package was developed from a series of ten site visits to nursing homes across the country, and the themes that emerged regarding how they approached quality and carried out their work. It focuses on the successful practices of high performing nursing homes.	CMS	https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/QAPI/Downloads/NNHQCC-Package.pdf
Resources for Antianxiety or Hypnotic Medication Measure			
A Guide to Reducing Antipsychotic Drugs While Enhancing Care for Persons with Dementia A Competency-Based Approach	A framework outlining necessary actions to reduce antipsychotic drugs from a competency-based perspective	AHCA/NCAL Quality Initiative	http://www.sdhca.org/files/7614/0493/2290/Guide_to_Reducing_Antipsychotic_Drugs_AHCA2013.pdf
Hand in Hand	This mission of the Hand in Hand training toolkit is to provide nursing homes with a high-quality training program that emphasizes person-centered care in the care of persons with dementia and the prevention of abuse.	CMS	http://www.cms-handinhandtoolkit.info/Index.aspx

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Beers Criteria	Beers Criteria for Potentially Inappropriate Medication Use in Older Adults	American Geriatrics Society	http://www.americageriatrics.org/files/documents/beers/2012AGSBersCriteriaCitations.pdf
Improving Antipsychotic Appropriateness in Dementia Patients	Information and resources to help clinicians, providers, and consumers better understand how to manage problem behaviors and psychosis in people with dementia using evidence-based approaches.	University of Iowa Geriatric Education Center	https://www.healthcare.uiowa.edu/igec/iaadapt/
National Partnership on Dementia Care	The CMS is partnering with federal and state agencies, nursing homes, other providers, advocacy groups, and caregivers to improve comprehensive dementia care. CMS and its partners are committed to finding new ways to implement practices that enhance the quality of life for people with dementia, protect them from substandard care and promote goal-directed, person-centered care for every nursing home resident. The Partnership promotes a multidimensional approach that includes public reporting, state-based coalitions, research, training and revised surveyor guidance.	CMS	https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/SurveyCertificationGenInfo/National-Partnership-to-Improve-Dementia-Care-in-Nursing-Homes.html
Resources for Mobility Measures (Short stay and long stay)			
Continuing Care Activity Measure	Performance-based measure of gross motor function and mobility developed for long-term care. Higher scores reflect higher level of function. Takes approximately 20 minutes to administer.	Advancing Excellence	https://www.nhqualitycampaign.org/files/ccam.pdf
Timed Up and Go (TUG) Test	Widely used performance-based measure of functional mobility in community-dwelling older adults. Quick and easy method to describe and monitor functional mobility. Consists of timing an individual as he or she stands, walks 3 meters, turns 180 degrees, returns to the chair, and sits down. The score on the test is the time it takes (in seconds) to complete the task.	Mathias S, Nayak USL, Isaacs B.	http://www.rheumatology.org/I-Am-A/Rheumatologist/Research/Clinician-Researchers/Timed-Up-Go-TUG_and http://www.cdc.gov/steadi/pdf/tug-test-a.pdf
Change Bundle to Encourage Nursing Home Residents' Mobility	The bundle of actions represents the practices described by nursing homes participating in the National Nursing Home Quality Care Collaborative to maintain and improve mobility.	CMS Quality Improvement Organizations – Lake Superior Quality Improvement Network	https://www.lsqin.org/wp-content/uploads/2015/10/Change-Package-bundle-mobility.pdf
Restorative Care Nursing for Older Adults (\$\$)	Educational program in restorative care for nurses and other caregivers with practical suggestions for activities to enhance function, and strategies for motivating older adults and caregivers to engage in restorative care.	AHCA	http://www.ahcapublications.org/ProductDetails.asp?ProductCode=8399
Promoting Mobility, Reducing Falls and Alarms	This tool contains practices that nursing homes can implement to promote safe mobility while reducing alarms and falls among residents.	Pioneer Network	http://www.pioneer-network.net/Providers/StarterToolkit/Step2/MobilityTipSheet/
Resources for Emergency Department Visits and Rehospitalization Measures			
INTERACT Hospital Rate Tracking Tool	Used to calculate hospital transfer outcomes (unplanned admissions, 30-day readmissions, emergency department visits without admission) using standard definitions and identifying trends.	INTERACT	http://interact2.net/tools_v4.html

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INTERACT Nursing Home Capabilities List	A tool that nursing homes can provide to hospital emergency rooms, hospitalists, and case managers, and for physicians, NPs, and PAs who take off-hours calls for the facility to assist with decisions about hospital admission or return to the facility.	INTERACT	http://www.avoidreadmissions.com/wwwroot/userfiles/documents/286/interact-nursing-home-capabilities-list-dec-29-2012.pdf
Go to the hospital or stay here: A decision guide for residents and families (booklet) English Version	A guide to help residents and families understand how decisions about transfers to the hospital are made and how to be involved in the decision.	Florida Atlantic University with funding from the Patient-Centered Outcomes Research Institute (Ruth Tappen Princ. Investigator)	http://pubweb.fau.edu/media/hospitalguides/Decision%20Guide%20Booklet_ENGLISH.PDF
Go to the hospital or stay here: A decision guide for residents and families (booklet) Spanish Version	As above.	As above	http://pubweb.fau.edu/media/hospitalguides/PCORI%20Decision%20Guide_SPANISH.PDF
Go to the hospital or stay here: A decision guide for residents and families (trifold brochure)	As above.	As above	http://www.decisionguide.org/english/pdf/Decision%20Guide%20Trifold_ENGLISH.pdf
Advancing Excellence's Seven Steps to Reducing Hospitalizations	Advancing Excellence provides nursing home teams with seven steps and multiple resources to decrease resident hospitalizations. Included among the tools is a useful tool that allows for calculation of rates of 30-day and 90-day readmissions, hospital admissions, emergency room transfers, and transfers resulting in observation stay. It also has features that allows for tracking patterns and processes impacting these rates.	Advancing Excellence Campaign	https://www.nhqualitycampaign.org/goalDetail.aspx?g=hosp
Geri-EM: Personalized e-learning in Geriatric Emergency Medicine	Older people with complex medical and surgical problems move through our EDs every day. Emergency physicians can readily manage medical problems but often have difficulty with cognitive, functional, psycho-social assessment of the older patient. To plan ED discharges that are safe and durable, patient assessment needs to be complete. This module follows three patients to the ED – all straightforward on the face of things, but complex upon a deeper examination. The authors suggest a framework, some tools, and strategies for assessing ALL the components of the older patient's presentations, along with some best practices for the most complicated of transitions – the ED to nursing home.	Geri-EM	http://geri-em.com/
Involving Nursing Home Residents and Families in Acute Care Transfer Decisions (\$\$)	Resident and family insistence on transfer is a major factor in the occurrence of potentially avoidable transfers from nursing homes (NHs) to acute care. The purpose of this study was to explore resident, family, and staff preferences regarding transfer to acute care.	PCORI	http://www.pcori.org/research-results/2012/involving-nursing-home-residents-and-families-acute-care-transfer-decisions

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Improving Patient Safety in Long-Term Care Facilities	These educational materials are intended for use in training front-line personnel in nursing homes and other long-term care facilities and are organized into three modules: Module 1: Detecting Change in a Resident's Condition. Module 2: Communicating Change in a Resident's Condition. Module 3: Falls Prevention and Management.	AHRO	http://www.ahrq.gov/professionals/systems/long-term-care/resources/facilities/ptsafety/index.html
Sharing advanced INTERACT Success! Recorded On April 22, 2014 (60 minutes)	In this session, participants will have the opportunity to hear how four different organizations advanced the use of INTERACT within their setting. INTERACT has played a key role in helping many organizations reduce unnecessary hospitalizations. Ideas on how to use the INTERACT tools, how to spread them throughout the organization, how to get buy-in, and the results of these determined leaders are some of the stories that are shared in this session.	AHCA	http://webinars.ahcancal.org/session.php?id=13085
Sharing advanced INTERACT Success! (Part 2) Recorded On May 7, 2014 (60 minutes)	This program presents two unique stories of communities in two separate counties, that put INTERACT to work to improve care. The first story is about a community that worked together to develop INTERACT with their local hospital. This story shares how a combined group of nursing centers worked together on implementation despite being competitors. The second group in another county, worked on implementation by creating a change package for a Medicaid Collaborative. Through a mentoring program with an "All Teach, All Learn" structure, those with more advanced skills in using INTERACT tools became mentors to other organizations, helping the community to create better care. This educational program demonstrates that the best way to be successful is to work together!	AHCA	http://webinars.ahcancal.org/session.php?id=13181
Communicating Health Assessments by Telephone (CHATs)	Communicating Health Assessments by Telephone (CHATs) is an on-going quality improvement program designed to enhance telephone communication between nurses and physicians. Each CHAT contains important questions about the status of the patient, checklist of exams, and progress notes for medical records.	AHCA	https://www.ahcancal.org/facility_operations/Clinical_Practice/Pages/CHATs.aspx
How-to Guide: Improving Transitions from the Hospital to Skilled Nursing Facilities to Reduce Avoidable Rehospitalizations	This How-to Guide supports teams in skilled nursing facilities (SNFs) and their community partners in co-designing and reliably implementing improved care processes to ensure that residents have a safe, effective transition into — and are actively received by — the SNF. Visitors to the IHI website will need to register (at no cost) in order to access the How-to Guide.	IHI	http://www.ihi.org/resources/pages/tools/howtoguideimprovingtransitionhospitalsnfstoreducerehospitalizations.aspx
Modified LACE Tool for Assessment of Risk for Readmission	A tool to assess risk of hospital readmission	Health Research & Educational Trust (HRET)	http://www.google.com/url?sa=t&ct=j&q=&esrc=s&source=web&cd=1&ved=0ahUKEwiD0YCUIJfMAhXDwj4KHSS_DccQFggcMAA&url=http%3A%2F%2Fwww.hret-hen.org%2Ftopics%2Freadmissions%2FLACE_tool.doc&usg=AFOjCNEr3HrGskNSE9Ec4p_m1SxAgOIC4g

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Hospital Engagement Network 2.0 Resources	Health Research & Educational Trust (HRET) has made available an extensive compilation of resources to assist hospitals with preventing readmissions. While the primary focus of the resources is on acute care providers, nursing home providers will likely find many of them useful and pertinent to the post-acute care (PAC) setting.	Health Research & Educational Trust (HRET)	http://www.hret-hen.org/topics/readmissions.shtml
Resources for Community Discharge Measure			
MATCH (Medications at Transitions and Clinical Handoffs) Toolkit for Medication Reconciliation	Medication reconciliation is a complex process that impacts all patients as they move through healthcare settings. The process involves comparisons of a patient's current medication regimen against a physician's admission, transfer or discharge orders to identify discrepancies. Study data show that an effective process can detect and avert most medication discrepancies, potentially avoiding a large number of adverse drug events and related costs for care of affected patients. This toolkit incorporates the experiences and lessons learned by the health care facilities that have implemented MATCH strategies to improve their medication reconciliation processes.	AHRQ	http://www.ahrq.gov/professionals/quality-patient-safety/patient-safety-resources/resources/match/index.html
The Patient Education Materials Assessment Tool (PEMAT) and User's Guide	The Patient Education Materials Assessment Tool (PEMAT) is a systematic method to evaluate and compare the understandability and actionability of patient education materials. It is designed as a guide to help determine whether patients will be able to understand and act on information.	AHRQ	http://www.ahrq.gov/professionals/prevention-chronic-care/improve/self-mgmt/pemat/index.html
Know-It-All™ system	AMDA's <i>Know-It-All™</i> system is designed to maximize quality care and avoid unnecessary emergency room visits and hospitalizations. This system enhances teamwork and mutual respect, and encourages team members to be educated about, involved, and working together to reduce avoidable transitions. These tools help achieve these goals and enable practitioners and nursing staff to communicate in a way that ensures a seamless continuum of care.	AMDA	http://www.paltc.org/product-store/know-it-all%20A2-series This is publicly available, but has a nominal fee.
Discharge Planning Checklist	A discharge planning checklist for patients and their caregivers preparing to leave a hospital, nursing home, or other care setting	CMS	https://www.medicare.gov/Pubs/pdf/11376.pdf
Next Step in Care	Next Step in Care provides easy-to-use guides to help family caregivers and health care providers work closely together to plan and implement safe and smooth transitions for chronically or seriously ill patients.	United Hospital Fund	http://www.nextstepincare.org/
Always Use Teach-back!	The purpose of this toolkit is to help all health care providers learn to use teach-back—every time it is indicated—to support patients and families throughout the care continuum, especially during transitions between health care settings. The toolkit combines health literacy principles of plain language and using teach-back to confirm understanding, with behavior change principles of coaching to new habits and adapting systems to promote consistent use of key practices.	Unity Point Health Picker Institute Des Moines University Health Literacy Iowa	http://www.teachbacktraining.org/
Health Literacy Universal Precautions Toolkit	This toolkit provides step-by-step guidance and tools for assessing practice and making changes to better connect with individuals of all literacy levels.	NC Program on Health Literacy	http://nchealthliteracy.org/toolkit/