

Quality Measure/ Indicator Utilization Process Indicator



Approaches based on “best practices”

- Developed by professionals in geriatrics and nursing home care
- Steps detailed in easy-to-use checklist

Brought to you by the Best Practices Process Indicators Workgroup representing these agencies and institutions:

- Arkansas Innovative Performance Program
- Arkansas Health Care Association
- Arkansas Office of Long Term Care
- Nursing Home Quality Initiative (NHQI)



Working together to enhance quality of care in Arkansas nursing homes.

QUALITY MEASURE / INDICATOR REPORT UTILIZATION PROCESS INDICATOR

OVERVIEW

In 1984, the Institute of Medicine (IOM) began a two-year study of nursing home quality. The 1986 report, Improving the Quality of Care in Nursing Homes, resulted in Congress mandating in the Omnibus Reconciliation Act of 1987, several provisions intended to improve nursing home care. These provisions included developing the Minimum Data Set for Resident Assessment and Care Screening (MDS), mandating routine use of the MDS and its companion care planning process for all nursing home residents, and requiring that a quality assurance and assessment process be used in all nursing homes to improve quality of care. This standardized resident assessment process was envisioned to improve resident care through the formulation of a resident-specific care plan: to provide nursing home management with resident level data for monitoring case mix, staffing, and quality of care performance; and to provide regulators with data for case mix, sampling for survey processes, monitoring resident outcomes and utilization review for Medicare or Medicaid eligibility.

The Centers for Medicare & Medicaid Services offers a quality measure / indicator (QM/QI) report for use by facilities as the foundation for continuous quality improvement. These reports are a way to review processes and outcomes. Processes are the steps or actions used to arrive at a predetermined goal. An outcome is the result of applying the process. The QM/QI reports provide very valuable information about the outcomes of care in the facility. They offer a snap shot of your facility at a point in time and allow you to compare your QM/QI scores to other facilities in the state and the nation.

QM/QI reports are also used in the survey process. They are not definite measures of quality of care, but are “pointers” that indicate potential problem areas that need further review and investigation. The QM/QIs are not absolute measurements of quality. They are findings that point to potentially poor care or identify potentially good care.

The key to analyzing the facility’s data regarding the QM/QIs is in the understanding of definitions. Each QM/QI has its own unique definition based on the MDS item response(s) from which it is derived. In some cases, the definition would seem to be obvious on the face of it, but further investigation reveals that it is important not to make assumptions about definitions. The keys to success with the QM/QIs, clearly, are accurate MDS data and resident care systems that foster excellent outcomes.

The process that surveyors use during the licensing and certification survey can be a sound basis for QI activities in the facility. The initial sample is selected via the QM/QI reports during off-site preparation, although changes may be made at the facility. For the initial selection, surveyors must focus on any Sentinel Health Event, any other QM/QI that is at the 90th percentile, and any QM/QI at 75th percentile or greater. In the process, MDS items are checked for accuracy to verify that the resident’s condition is accurately represented. At least two QM/QIs for each resident must be verified using the QM/QI definitions and chart documentation.

With the 2005 merger to the QM/QI reporting system, a total of seven reports are available through the Certification and Survey Provider Enhanced Reporting (CASPER) system. Surveyors utilize these reports on the off-site preparation phase of the survey as one source of information about the facility's resident population and about possible resident care problems. Nursing homes should also utilize these reports to identify potential areas of concern for Quality Improvements action and to identify and select a resident sample for quality improvement review.

MDS QM/QI Package Report

- Facility Quality Measure/ Indicator Report
- Resident Level Quality Measure/Indicator Report: Chronic Care Sample
- Resident Level Quality Measure/Indicator Report: Post Acute Care Sample
- Resident Listing Report: Chronic Care Sample
- Resident Listing Report: Post Acute Care Sample
- Facility Characteristic Reports
- Quality Measure/Indicator Monthly Trend Report (New)

Facility Quality Measure/Indicator Report

This report shows each QM/QI, the facility percentage and how the facility compares with other facilities in the state and the nation.

- Numerator: The number of facility residents who actually triggered a QM/QI. These are the residents who “have” the QM/QI.
- Denominator: The number of facility residents who could have triggered the QM/QI.
- Observed Percent: The numerator divided by the denominator multiplied by 100.
- Percentile: A facility's state rank, expressed as a percentage, on a given QM/QI. If a facility's state percentile is 85%, it means that 85% of the facilities in the state had a QM/QI less than or equal to the facility's score.
- Incidence Measures are conditions that have developed over the course of two assessments – a comparison of two assessments. This type of measures compares two points in time.
- Prevalence Measures are based upon a single assessment (rather than a change across two assessments – actual number. This type of measure/indicator provides information about a specific point in time.
- Thresholds: A set point for each QM/QI at which the likelihood of a problem is sufficient to warrant emphasis or at least investigation by the facility or a survey team. Measures that exceed these thresholds are “flagged” with an asterisk on the Facility Quality Measure/Indicator Report. The logic is as follows:

Sentinel events are flagged if the numerator is greater than zero. All other measures / indicators are flagged if their state percentile is greater than or equal to 90. This does not mean that there is an automatic assumption of a problem. It only means that here is a concern that should be investigated to see whether a problem exists and how it is being addressed.

- **Sentinel Health Events** are QM/QI's that should occur very infrequently, if at all, in a facility. The nature of these indicators is serious enough to warrant investigation, even if it occurs only once.

There are three Sentinel event measures:

- Prevalence of Fecal Impaction
 - Prevalence of Dehydration
 - Prevalence of Pressure Ulcer occurring in a Low Risk Population.
- Technically not all residents are used in the QM/QI calculation on the Facility Quality Measure/Indicator Report.
Admission assessments are used on Incidence BUT NOT on Prevalence QM/QI's, since conditions present on admission are not likely to reflect care in the facility.
 - Residents who were physically restrained ONLY includes trunk restraints, limb restraints, or a chair that prevents rising. Side Rails are NOT included in this percentage.
 - Residents who lose too much weight measure exclude hospice residents.
 - Some facilities have a higher number of residents who are frailer and sicker. In order to take this fact into account, some of the QM/QI's are "risk adjusted", taking into consideration other health characteristics.

These are:

- Residents who have/had a catheter inserted and left in bladder
- Residents who have moderate to severe pain
- Residents whose ability to move in and around their room got worse
- Short-stay residents with delirium
- Short-stay residents with pressure ulcers

Statistics reported on QM/QI reports are updated weekly. Because the date report can be generated for sequential time frames, they are useful to track trends.

BEST PRACTICE:

- Carefully Review the Following Reports
- Customize Report Period for Past Three Months.

Resident Level Quality Measure/Indicator Report: Chronic Care Sample

This report contains data for those residents who are included in the chronic care sample, because they have an OBRA assessment (AA8a) in the report period given in the header or requested.

- It is possible for residents to be included in both the chronic care and post acute care samples if they have a qualifying OBRA and post-acute assessments during the target period.
- This report can be used in two ways:
 - To identify residents that trigger a particular QM/QI
 - To identify residents who trigger multiple QM/QIs. Such residents may merit consideration or more intensive review.
- Review all residents with clinically linked QM/QIs to identify negative outcomes. (i.e., Depression No Tx/Weight Loss, Mod/Severe Pain/Pressure Ulcer, Restraints/Little Activity/Decline in ROM, etc...)

Resident Level Quality/Measure Indicator Report: Post Acute Care Sample

Contains data for residents who had a 14-day SNF PPS assessment during the target period, otherwise it parallels the chronic care report.

Resident Listing Report: Chronic Care Sample

This report lists those residents who are in the chronic care sample, because they have an OBRA assessment during the requested period.

- This report can be utilized to identify assessments that are not timely OR LATE!
 - Report period must be requested for the previous six month time frame. If only pulled for a three month period, late assessments would not be included because they would not have been completed in the requested report period.
 - Example : Report Period 03/01/2006 – 09/01/2006
 - Resident has Target Assessment date of 04/01/2006 in A3a
 - Report period ended 09/01/2006
 - Resident has no Discharge Date Identified!
- This would indicate that this resident has not had an assessment completed since April and the report period ended in September. The assessment on this resident should have been completed prior to July. One of two things has occurred, the assessment was obviously not submitted, may have transmitted but not accepted, or if the resident has been discharged, then no Discharge Tracking Assessment was completed and submitted. One key point to remember is to compare your Resident Listing Report: Acute Care Sample to identify a PPS Assessment that could have been completed on this resident, however, the Chronic Care Report would also show this under AA8a/AA8b column.

MDS schedules MUST BE MERGED – OBRA AND PPD, (Regulatory and Medicare), if necessary they should be DUALY CODED!

Resident Listing Report: Post Acute Care Sample

This report parallels the chronic care Resident Listing Report described above. It lists the residents who had a 14-day SNF PPS assessment during the requested period.

Facility Characteristics Report

Facilities characteristics may indicate a need to concentrate a review on certain resident groups. Examples:

- A very old population.
- An unusually high percentage of male residents.
 - Activities are not adequate for this gender.
- A higher than average percentage of Medicare residents, indicating an emphasis on rehab or a more acutely ill population.
- A higher than average percentage or psychiatric and mentally retarded residents.
- A higher than average percentage of residents receiving hospice care.
- A higher than average percentage of admission assessments or significant change assessments.
ALSO, if low, could signal lack of change of condition identification.

Quality Measure / Indicator Monthly Trend Report

This report lists those residents who are included in the chronic care sample, because they have an OBRA assessment during the requested period.

FACILITY QM/QI REVIEW PROCESS

Step 1 Review the QM/QI reports and select measures to review, looking for areas that are out of range. (Remember low scores are good, so give yourself credit for hard work.)

Areas to consider:

- Review should be conducted by the ICP Team members who have a clear understanding of the QM/QI calculation and the implications of the scores themselves.
- The percentile rank and comparison group facility percentages. (QM/QI scores at the 75th percentile or above.) The facility needs to be proactive to anticipate problem areas and improve performance prior to a change in the QM/QI percentage report.
- Clinically linked QM/QIs to identify facility wide areas for review.
- Areas identified on previous regulatory survey as deficiencies.
- All sentinel events should be selected for further analysis of scores that are trending upward.
- Verify MDS coding is correct

Step 2 Select a separate sample of residents for each QM/QI that will be reviewed for potential problems from the Resident Level Quality Measure/Indicator Report. This is crucial in order to carry out the next step in the review which will be a detailed chart review to verify accuracy of the MDS coding that contributed to the QM/QI. This is a crucial step because the resident outcomes can be the very best, but if the MDS data is not accurate, the QM/QI scores can tell a very different story.

- Residents from all units
- Residents with several flagged QM/QIs
- Residents with clinically linked QM/QIs
- Select at least five residents, if possible, to determine if there is a pattern

Step 3 Once the accuracy of the MDS is validated and it is determined that the resident did have the QM/QI condition, the focus must shift to the care of the resident.

- Review the care for each of the selected residents.

Step 4 Analyze findings about the quality of care for each resident and QM/QI reviewed.

Step 5 Decide if there is a facility-wide QM/QI problem after reviewing the care for each of the residents.

- If undesirable outcomes are identified, were they a result of actions by individual staff members or are improvements needed in the processes of care related to the QM/QI condition.

Step 6 Report findings of the review to the QA & A Committee to develop an action plan to address the problems. In most cases, implementation of your plan of action will begin by educating your staff about the problem and the needed changes.

Step 7 Evaluate the effectiveness of the improvement plan based on continuous, ongoing review of subsequent QM/QI reports. Update policy and procedure manuals to reflect the improvement, if indicated. Remember, quality improvement is a process not an end result. Systems will constantly need to be evaluated and changed to allow for the best resident outcomes. And, while, it is very important to monitor and analyze the QM/QI

data in order to identify opportunities to continuously improve care and services, it is important to note that the QM/QIs always are looking back in time. It is perhaps even more important to have effective monitoring systems in place to be able to identify that a problem is starting – before it becomes a trend that shows up on the QM/QI reports.

ASSESSMENT – Accuracy and Decision Making

- The MDS for each resident must match all items in the QM/QI reports.
- The resident’s condition must be verified by evidence other than the MDS.
- If the assessment information is inaccurate, is the quality of care for this resident affected?

CARE PLANNING/ RAPs

- Is the condition on the QM/QI addressed in the resident’s care plan, if not has the decision to not intervene been documented (RAP statement).
- Is there a problem with the care plan interventions for this resident related to the QM/QI?

IMPLEMENTATION

- Are interventions being implemented that are described in the resident’s care plan?
- Is there interdisciplinary understanding and input?

EVALUATION AND MONITORING

- Has the resident’s care plan been changed as needed to promote the best outcome for the resident based on an accurate and current assessment?

FACILITY LEVEL REVIEW

- Was there a pattern of inaccuracy with the QM/QI Reports?
- Considering the entire sample, is there a problem across the facility with an issue identified by this review?
- Are there urgent problems that need immediate action?

CONCLUSION

Remember, that just because a QI has flagged (exceeded a threshold) does not mean that there is an automatic assumption of a problem. It means that the information suggests that there is a concern that should be reviewed to see whether a problem exists and how it is being addressed. Also remember, just because a facility does not flag does not mean that there is no problem with the quality of care in that area. You need to consider all of the information provided, and use your best clinical judgment. The QI information is only one of many tools for surveyors and facility staff to use. It is not used exclusively for quality assurance/improvement activities or to make assumptions about care.

QM/QI Utilization Review Checklist

Assessment Data	Yes	No	N/A
1. Specific QM/QI's selected for review?			
2. A minimum of five sample residents selected?			
3. Detailed chart review of sample residents completed?			
4. Accuracy of MDS on sample residents validated?			
5. Reviewed care of each of the sample residents?			
6. Identify any problem areas from review process?			
7. Does a facility-wide problem exist?			
8. Findings reported to QA & A Committee?			
9. If appropriate, the effectiveness of the Quality Improvement Plan evaluated?			
10. Subsequent reviews completed as indicated?			



RESOURCES

www.afmc.org

www.ahca.org

www.qtso.org

www.chrsa.wisc.edu

www.cms.hhs.gov

www.amda.org

www.ahrq.gov

www.medicare.gov/Nhcompare/Home.asp

www.cms.hhs.gov/NursingHomeQualityInits/20_NHQIMDS20.asp#TopOfPage