Quality Measures, Five Star and QAPI

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VP of Reimbursement and Education

Objectives

1. Identify how MDS data is used to develop Quality Measures
2. Discuss the importance of validating MDS data.
3. Recognize the 3 components that populate your Five Star Rating
4. Identify the data sources (MDS, PBJ, etc.) and how they are used to populate your star rating
5. Describe a system which incorporates the Five Star components into your QAPI process to ensure continual monitoring and continuous survey readiness
What are Quality Measures?

• The nursing home Quality Measures (QMs) come from MDS resident assessment data routinely collected at specified intervals.

• Quality Measures on the Nursing Home Compare website allow consumers, providers, states and researchers to compare information on nursing homes.

• Many nursing homes use this information to guide quality improvement efforts and monitor progress.

How important are the QMs?

1. Drives our QA&A process.
2. Provides state surveyors with survey process guidance.
4. Pay for Performance/Value Based Purchasing.
5. NYS Nursing Home Quality Initiative (NHQI).
6. Accountable Care Organizations (ACO) and Bundled Payment initiative participation.
QM Reporting Mechanisms

1. CMS Nursing Home Compare / Five Star Rating
   - 24 Quality Measures reported
   - 17 of those 24 impact Five Star Rating (5 are Claims-Based)

2. CASPER Quality Measures
   - 21 Quality Measures
     3 Measures added 2/2018:
     - Antianxiety/Hypnotic % (LS),
     - Ability to Move Indep Worsened (LS),
     - Improvements in Function (SS)
   1 New Measure added 1/2019
     - Hi-risk/Unstageable Pres Ulcer (L)
   - QM Reports are available from CASPER (QIES Portal)

3. QRP (Nursing Home Quality Reporting Program)
   - Data is available now to the public on some QRP measures through link on NHC
CASPER QMs

**Long Stay**
1. Increased Help w/ ADL
2. Pressure Ulcer (High Risk)
3. Unstageable Pressure Ulcer (High Risk)
4. Catheters
5. Restraints
6. UTI
7. Mod/Severe Pain
8. Falls *
9. Falls w/ Major Injury
10. Antipsychotics
11. Anti-Anxiety/Hypnotic Prevalence
12. Anti-Anxiety/Hypnotic %
13. Behavior Sx Affecting Others *
14. Depression
15. B&B Incontinence (low risk)
16. Weight Loss
17. Ability to Move Indep. Worsened

* Surveyor Measures (Appendix E)

**Short Stay**
1. Pressure Ulcers (new/worse)
2. Mod/Severe Pain
3. New Antipsychotic Use
4. Improvement in Function

Pulling Reports from QIES
Facility Characteristics Report

Facility ID: [Enter Facility ID here]

Begin Date (mm/dd/yyyy): 10/01/2018
End Date (mm/dd/yyyy): 03/31/2019
Comparison Group: 08/01/2018-01/31/2019
Data was calculated on: 04/01/2019
Facility Level QM Report

Resident Level QM Report
Glossary

Which MDSs are used to calculate QMs?

Glossary of Terms

Definitions

❑ **Target Period** – The span of time that defines the QM reporting period (i.e., a calendar quarter)

❑ **Stay** - The period of time between a resident’s entry into a facility and either (a) a discharge, or (b) the end of the target period, whichever comes first. A stay is also defined as a set of contiguous days in a facility. The start of a stay is either:
  ▪ An admission entry (A0310F = [01] and A1700 = [1]), OR
  ▪ A reentry (A0310F = [01] and A1700 = [2]).

❑ The end of a stay is the earliest of the following:
  ▪ Any discharge assessment (A0310F = [10, 11]), OR
  ▪ A death in facility tracking record (A0310F = [12]), OR
  ▪ The end of the target period.
Definitions

❑ **Episode** - A period of time spanning one or more stays. An episode begins with an admission (defined below) and ends with either (a) a discharge, or (b) the end of the target period, whichever comes first. An episode starts with:
   ▪ An admission entry (A0310F = [01] and A1700 = [1]).

❑ The end of an episode is the earliest of the following:
  ▪ A discharge assessment with return not anticipated (A0310F = [10]), OR
  ▪ A discharge assessment with return anticipated (A0310F = [11]) but the resident did not return (A0310F = [10]) within 30 days of discharge, OR
  ▪ A death in facility tracking record (A0310F = [12]), OR
  ▪ The end of the target period.

Definitions

❑ **Admission** - An admission entry record (A0310F = [01] and A1700 = [1]) is required when *any one of the following occurs*:
  ▪ resident has never been admitted to this facility before; OR
  ▪ resident has been in this facility previously and was discharged return not anticipated; OR
  ▪ resident has been in this facility previously and was discharged return anticipated and did not return within 30 days of discharge.
Definitions

❑ **Reentry** - A reentry record (A0310F = [01] and A1700 = [2]) is required when *all of the following occurred prior to this entry, the resident was*:
  ▪ discharged return anticipated, AND
  ▪ returned to facility within 30 days of discharge.

Definitions

❑ **Cumulative days in facility (CDIF)** - The total number of days within an episode during which the resident was in the facility. It is the sum of the number of days within each stay included in an episode. If an episode consists of more than one stay separated by periods of time outside the facility (e.g., hospitalizations), only those days within the facility would count towards CDIF. Any days outside of the facility (e.g., hospital, home, etc.) would not count towards the CDIF total.

❑ **Residents on leave of Absence**
  ➢ Residents who leave for a temporary home visit/therapeutic leave
  ➢ Residents who have a hospital observation stay <24 hours and are not admitted
    ▪ Discharge assessment is not completed
    ▪ These residents can trigger for incidents outside the facility (i.e., fall w/ fracture)
  ➢ LOA days still count towards resident’s CDIF
Definitions

❑ **Short Stay** - quality measures include all residents in an episode whose CDIF is <100 days at the end of the target period.

❑ **Long Stay** - quality measures include all residents in an episode whose CDIF is >101 days at the end of the target period.

❑ **Target date** - The event date for an MDS record, defined as follows:
  ▪ For an entry record (A0310F = [01]), the target date is equal to the entry date (A1600).
  ▪ For a discharge record (A0310F = [10, 11]) or death-in-facility record (A0310F = [12]), the target date is equal to the discharge date (A2000).
  ▪ For all other records, the target date is equal to the assessment reference date (A2300).

Definitions

❑ **Target Assessment**
  • Latest assessment which meets criteria in the Target Period.

❑ **Initial Assessment**
  • First assessment following entry record at the beginning of the selected episode.

❑ **Prior Assessment**
  • Latest assessment that is 46 to 165 days before the target assessment.

❖ **Look-back Scan**
  • Scan all assessments within the current episode that have target dates no more than 276 days prior to the target assessment.
Definitions

Numerator = # of residents with event/disease
Denominator = # of persons who are eligible or at risk of being in numerator

Example: # of residents with pressure ulcer stage II, III or IV
# of residents who are long stay residents who are classified as high risk (i.e., impaired bed mobility or transferring, comatose, or malnourished)

NOTE: Exclusions ONLY apply to the Denominator (most exclusions are for missing data)

Risk Adjustment

- Goal is to make denominator similar between facilities.
- Three methods:
  1. Exclusions
  2. Stratification - i.e., high-risk versus low risk (Hi Risk PU (LS), Low risk Bowel & Bladder (LS))
  3. Regression - catheter (LS), pain (LS), New/worse PU (SS), Improved ADL Function (SS), Decline in Locomotion (LS)
     a) Use a set of resident clinical characteristics (termed “covariates”) to adjust for potential differences in residents between facilities
     b) Compare your observed rate to an expected rate, which is based on what an average facility with similar residents to you would have (based on your covariates)
Record Selection

❑ Resident’s span of time in the facility dictates which measures may trigger
  ▪ An OBRA assessment may trigger a Short Stay measure if the resident has \( \leq 100 \) CDIF
  ▪ A PPS assessment may trigger a Long Stay measure if \( \geq 100 \) CDIF (5 Day Assessments are excluded)

Record Selection

❑ Look-Back Scan: used to capture triggering conditions within the episode
  ▪ May not be the most recent MDS

❑ 3 QMs with look-back scans
  ▪ New/Worsening Pressure Ulcers (SS)
    ▪ Looks back up to the beginning of the episode
  ▪ Falls (LS) – Surveyor Measure
  ▪ Falls with Major Injury (LS)
    ▪ Look-back up to a year (275 + 93 days)
Hint

- Resident interview **only** for Pain assessment
  - Residents who were not interviewed excluded from SS and LS measures
  - Reduces denominator size
- New/Worsening Pressure Ulcers
  - Stage 2-4 only
  - Excludes hospital acquired/worsened ulcers

Hint

- Symptoms of Depression
  - Uses either the PHQ-9© resident interview or staff assessment
    - Little interest/pleasure in doing things or feeling down/depressed/hopeless: half or more days
    - **AND**
    - Total severity score > 10
Antipsychotic Measures

- Incidence of Antipsychotic Medication use (SS)
  - Short-stay residents who did not receive antipsychotic on initial assessment and do receive it on target assessment
- Prevalence of Antipsychotic Medication Use (LS)
  - Long-stay residents who receive antipsychotic
- Both measures only exclude residents with Schizophrenia, Tourette’s or Huntington’s
MDS Accuracy

1. Integrate QMs into your QAPI process utilizing a interdisciplinary approach
2. MDS training for staff (initial and ongoing)
3. Review MDS data prior to submission to CMS
   • Software
   • Care Conference
4. If data entry errors are identified, submit a MDS Modification
   • CMS delays use of QMs for 85-90 days to allow for corrections and modifications
MDS Accuracy

5. Ensure staff are trained in MDS interviews
   • i.e. BIMs
6. Know your EMR cannot think!
7. Correct CNA documentation issues with a nursing progress note when in the lookback window
8. Utilize QAPI and root cause analysis for valid quality improvement opportunities
Format will be changing in April

The October 2017 Five-Star ratings provided below will be displayed for your nursing home on the Nursing Home Compare website on October 23, 2017. The Quality Measures CMS rating that will be posted is based on MOS 3.3 quality measures, using data from the first and fourth quarters of 2016 and the second quarter of 2017, and claim-based quality measures through Q4 2015 through Q3 2016. The claim-based quality measures will not be updated for the Oct 23, 2017, update.

The Five-Star website will operate Monday-Saturday, from October 23, 2017 – October 27, 2017. Hours of operation will be from 7:00 a.m. to 6:00 p.m. on Monday through Friday, and from 9:00 a.m. to 6:00 p.m. on Saturday from October 23 to October 28, 2017. During other times, direct contact may be made through the CMS Help Desk at 1-800-570-7784 from 8:00 a.m. to 7:00 p.m. on weekdays and 9:00 a.m. to 10:00 p.m. on weekends.

Procedures that submit no staffing data for the July 1 to September 30, 2017 reporting period by November 14, 2017 will have their overall staffing and RN staffing ratings enforced starting in the December 2017 update of Nursing Home Compare. In addition, 13 facilities with no reported staffing data for an extended number of days will be placed in the provisional category. Final quality scores will be updated in December.

Quality Measures that are included in the QM Rating

For additional assistance with or questions related to the QM registration process, please contact the QM Help Desk at 877-231-4219 or via email at qmhelp@cms.gov.

The CMS national Q3 2017 MOS 3.3 scores will be available beginning October 1, 2017, and will be updated on the Five-Star rating website weekly.

Information about staffing data submissions is available on the CMS website. Go to...

Quality Measures that are included in the QM Rating

<table>
<thead>
<tr>
<th>MOS 3.3 Quality Measures that are not Included in the QM Rating</th>
<th>State</th>
<th>National</th>
</tr>
</thead>
</table>
Pulling your Provider Rating Report from QIES

1. Survey

Survey Results → Staffing → Quality Measures
Survey Results

Each deficiency is weighted by scope & severity

1. 3 Most Recent annual inspections
   - More recent surveys weight more heavily
     - Most recent = ½ of survey score total
     - 1st prior survey = 1/3 of survey score
     - 2nd prior survey = 1/6 of survey score
   - If only 2 standard surveys available
     - 60% weight for most recent
     - 40% weight for prior
   - < 1 survey available
     - Considered not sufficient data
     - No rating is reported for Staffing & QM Domains (even if available)

Survey Results (cont’d)

2. Includes complaint surveys (substantiated findings from last 36 months)
   - Within last calendar year = ½ weight
   - 13-24 months ago = 1/3 weight
   - 25-36 months ago = 1/6 weight

3. Repeat Revisits
   - 1st Revisit = 0 points
   - 2nd Revisit = 50% of health inspection score
   - 3rd Revisit = 70% of health inspection score
   - 4th Revisit – 85% of health inspection score
Most recent NYS Cut Points (Feb 2019); change monthly (based on relative performance within each state due to variations in survey management, state licensure differences and Medicaid policy)

https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/CertificationandComplianc/FSQRS.html
Nursing Home Compare QMs Factoring into 5 Star Rating

**Long Stay**
1. Increased Help w/ ADL
2. Pressure Ulcer (high risk)
3. Catheters
4. UTI
5. Mod/Severe Pain
6. Falls w/ Major Injury
7. Antipsychotics
8. Ability to Move Independent. Worsened
9. Rehospitalizations*
10. ED Transfers*

**Short Stay**
1. Pressure Ulcers (new/worse)
2. Mod/Severe Pain
3. New Antipsychotic Use
4. Improved Function
5. Discharged to Community*
6. Rehospitalizations*
7. ED Transfers*

*Claims Based Measures

https://www.medicare.gov/nursinghomecompare/search.html

Updated Quarterly (Jan, Apr, Jul & Oct)


Rehospitalizations
(Claims Based)

Short-Stay Rehospitalizations

**Description:**

- The percentage of short-stay residents who were re-hospitalized or had an observation stay within 30 days after a nursing home admission or readmission.

- It is risk-adjusted.

- Window includes stays over a 12 month period

- Planned inpatient readmissions are excluded.
Short-Stay Rehospitalizations (continued)

Denominator:
• Medicare fee-for-service enrollees who entered or reentered the nursing home within 1 day of discharge from an inpatient hospital stay

Excluded:
  o Medicare Advantage Plan enrollees (for any part of the stay)
  o Not in both Med A and B (for any part of the stay)
  o Enrolled in hospice during their stay
  o 1st MDS of the stay coded as comatose
  o There was no initial MDS assessment

Numerator:
• The number of nursing home stays where the resident had one or more unplanned inpatient admissions or observation stay claims within 30 days of entry/reentry.
  • Includes inpatient or observation stays occurring after discharge from the nursing home but within the 30 day timeframe.

Note:
  o A stay is defined as a set of contiguous days in a facility. A stay begins when a resident enters a nursing facility (i.e., based on the entry/reentry date from the MDS) and ends when the person leaves the nursing home (based on discharge date from the MDS, regardless of whether the discharge was planned or the resident was anticipated to return to the facility).

\[
\frac{\text{Observed Rate}}{\text{Expected Rate}} \times \text{National Rate} = \text{Risk Standardized Rate}
\]
Long-Stay Rehospitalizations

Description:

• Determines the percentage of admissions or observations stays occurring in the target period for residents > 101 days cumulative days in the facility.

• Window includes stays over a 12 month period.

• It is risk-adjusted.

• Planned inpatient readmissions are excluded.

Long-Stay Rehospitalizations (continued)

Denominator:

• Medicare fee-for-service enrollees > 101 days with a single stay or sequence of stays

• Sum of all LS residents days, after the 100th cumulative day, in the target period divided by 1000.

LS Residents Excluded if:
  o Not a Medicare Beneficiary
  o Enrolled in Medicare Managed Care (between Admission & Discharge, or end of the target period)

LS Days Excluded if:
  o Days while enrolled in Hospice
  o Days not in the nursing home for any reason during the episode
    o an inpatient facility or other institution, or days temporarily residing in the community
Long-Stay Rehospitalizations (continued)

**Numerator:**
- The number of LS residents admitted for an inpatient stay or observation

**LS Residents are Excluded if:**
- Enrolled in hospice
- Admitted for a planned admission (identified using principal discharge diagnosis and procedure codes on hospital claim)

\[
\frac{\text{Observed Rate}}{\text{Expected Rate}} \times \text{National Rate} = \text{Risk Standardized Rate}
\]
Short-Stay ED Visits

Description

• Determines the percentage of all new admissions or readmissions to a nursing home from a hospital where the resident had an outpatient ED visit within 30 days of entry or re-entry.
• It is risk-adjusted.
• Window includes stays over a 12 month period

Denominator:
• Medicare fee-for-service enrollees who entered or reentered the nursing home within 1 day of discharge from an inpatient hospital stay

Excluded:
- Medicare Advantage Plan enrollees (for any part of the stay)
- Not in both Med A and B (for any part of the stay)
- Enrolled in hospice during their stay
- 1st MDS of the stay coded as comatose
- There was no initial MDS assessment
Short-Stay ED Visits (continued)

Numerator:
• Number of SS stays where the resident had one or more outpatient claims for an ED visit within 30 days of entry/reentry that did not result in an inpatient admission or observation stay.
• This includes outpatient ED visits occurring after discharge from the nursing home but within the 30 day timeframe.

\[
\frac{\text{Observed Rate}}{\text{Expected Rate}} \times \text{National Rate} = \text{Risk Standardized Rate}
\]

Long-Stay Rehospitalizations

Description:
• Determines the percentage of ED visits occurring in the target period for residents > 101 days cumulative days in the facility.
• Window includes stays over a 12 month period.
• It is risk-adjusted.
Long-Stay Rehospitalizations (continued)

Denominator:
- Medicare fee-for-service enrollees ≥ 101 days with a single stay or sequence of stays
- Sum of all LS residents days, after the 100th cumulative day, in the target period divided by 1000.

**LS Residents Excluded if:**
- Not a Medicare Beneficiary
- Enrolled in Medicare Managed Care (between Admission & Discharge, or end of the target period)

**LS Days Excluded if:**
- Days while enrolled in Hospice
- Days not in the nursing home for any reason during the episode
  - an inpatient facility or other institution, or days temporarily residing in the community

Numerator:
- The number of LS residents who had an ED Visit that did not result in an inpatient admission or observation stay

**LS Residents are Excluded if:**
- Enrolled in hospice

\[
\frac{\text{Observed Rate}}{\text{Expected Rate}} \times \text{National Rate} = \text{Risk Standardized Rate}
\]
Improvement Strategies

- Use data to steer improvement opportunities
- Ongoing education on the health care service delivery capabilities of the Nursing Home to physicians
- Communication to physicians/nurse practitioners at the time of change in status (SBAR)
- Build prevention into every day practice
- Risk Assessments
- Early Intervention
- Assessment of the Resident
- Family and Caregiver Education
- Clinical Competencies

% of Short-Stay Residents Who Were Successfully Discharged to the Community (Claims Based)
% of Short-Stay Residents Who Were Successfully Discharged to the Community

Description:

• It reports the percentage of all new admissions to a nursing home from a hospital where the resident was discharged to the community within 100 calendar days of entry and for 30 subsequent days:
  ➢ they did not die,
  ➢ were not admitted to a hospital for an unplanned inpatient stay,
  ➢ and were not readmitted to a nursing home.

• Note that lower values of the short-stay successful community discharge measure indicate worse performance on the measure.

Numerator:

• The number of nursing home episodes where the resident was discharged to the community within 100 calendar days of entry, and the resident did not die, did not have a claim for an unplanned inpatient admission, and did not enter/reenter a nursing home within 30 days of discharge to the community.

Note:

- Note that an episode is defined as a period of time spanning one or more stays in a facility. An episode begins when a resident is admitted to a nursing facility and ends when the person is discharged from the nursing home and did not return for at least 30 days.
% of Short-Stay Residents Who Were Successfully Discharged to the Community

Denominator:
- Medicare fee-for-service enrollees who entered the nursing home from a hospital
- were not a resident of the nursing home in the previous 30 days
- were not enrolled in hospice during their nursing home stay
- who were not identified as comatose based on the MDS admission assessment.

Excluded:
- Medicare Advantage Plan enrollees (for any part of the stay)
- Not in both Med A and B (for any part of the stay)
- If the “from” and “thru” dates on hospice claims overlay the nursing home stay, then the stay is excluded

Improvement Strategies

Strategies:
- Role of Rehab Team
- Community partnerships/relationships
- Engage families and caregivers
- Discharge teaching
- Post discharge follow-up
Format will be changing in April

The October 2017 Five-Star rating provided above will be displayed for your nursing home on the Nursing Home Compare website on October 25, 2017.

The Quality Measure CMS Rating that will be posted is based on MIPS 3.0 quality measures, using data from the first and fourth quarters of 2016 and the second quarter of 2017, and claim-based quality measures from July 1, 2015 through September 30, 2016. The claim-based quality measures will not be updated for this year.

The Five-Star website will be updated Monday, October 9, 2017 through Sunday, October 29, 2017. Hours of operation will be Monday through Friday, 9AM to 5PM ET. The site will be temporarily unavailable on Friday, October 6, 2017.

The Five-Star website will be updated on Tuesday, November 21, 2017. During other times, direct inquiries to BetterHospitals.com, Inc. at (800) 570-4725, or email at info@betterhospitals.com. The website will be temporarily unavailable on Monday, November 27, 2017.

The CMS will release its annual updates to the Five-Star website on November 21, 2017. The updates will reflect data from the most recent years.

The quality measures that are included in the Five-Star ratings are based on the quality measures that were used to calculate the Five-Star ratings during the most recent year. The quality measures that are included in the Five-Star ratings for the nursing home are based on the quality measures that were used to calculate the Five-Star ratings during the most recent year.

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The quality measures that are included in the Five-Star ratings for the nursing home are based on the quality measures that were used to calculate the Five-Star ratings during the most recent year.
QM thresholds update every 6 months. The QM thresholds will increase by 50% of the average rate of improvement in QM scores every six months. For example, if the average rate of improvement is 2% for functional improvement, the thresholds for functional improvement will increase by 1%. This is to reduce the need to have large adjustments in the future.

### QM Score Table

<table>
<thead>
<tr>
<th>QM Rating</th>
<th>Long-Stay QM Rating Thresholds</th>
<th>Short-Stay QM Rating Thresholds</th>
<th>Overall QM Rating Thresholds</th>
</tr>
</thead>
<tbody>
<tr>
<td>★</td>
<td>175 – 524</td>
<td>167 – 541</td>
<td>342 – 1066</td>
</tr>
<tr>
<td>☆☆</td>
<td>525 – 619</td>
<td>542 – 638</td>
<td>1067 – 1258</td>
</tr>
<tr>
<td>★☆☆</td>
<td>620 – 704</td>
<td>639 – 714</td>
<td>1259 – 1419</td>
</tr>
<tr>
<td>☆☆☆</td>
<td>705 – 799</td>
<td>715 – 805</td>
<td>1420 – 1605</td>
</tr>
<tr>
<td>☆☆☆☆</td>
<td>800 – 1250</td>
<td>806 – 1250</td>
<td>1606 – 2500</td>
</tr>
</tbody>
</table>

Note: the short-stay QM rating thresholds are based on the adjusted scores (after applying the factor of 1250/900 to the unadjusted scores).
Staffing

3 Calculations

1. Actual Staffing Hours Per Patient Day (PPD)
2. Case Mix Staffing Hours PPD
3. Adjusted Staffing Hours PPD

CASPER Employee & Census Report
Pulling Staffing Reports from QIES

State: NY

* Facility ID:

Find By Name Add Facility ID

Date Criteria:
- Prior Fiscal Quarter
- from (mm/dd/yyyy): 01/01/2019
- thru (mm/dd/yyyy): 03/31/2019

Report Output: CSV/Excel PDF

Filter By Include In Results
- All
- Contractor
- Exempt
- Non Exempt

Sort By Descending
- Staffing Hours

* To select multiple items, hold down the Ctrl key and click the desired items
Actual Staffing Hours PPD

Actual Staffing Hours = PBJ Hours / 90 days / Avg Qtr Census in PBJ

1. RN Hours PPD: DNS (5); RN Admin Duties (6); RN (7)
2. Total Nursing Hours PPD: RN (5, 6, 7) + LPN (8, 9) + Nurse Aides (10,12)

<table>
<thead>
<tr>
<th>Position</th>
<th>Hours Worked</th>
<th># of Days</th>
<th>Census</th>
<th>HRD</th>
</tr>
</thead>
<tbody>
<tr>
<td>RN</td>
<td>4,500</td>
<td>90</td>
<td>100</td>
<td>.5</td>
</tr>
<tr>
<td>LPN</td>
<td>7,500</td>
<td>90</td>
<td>100</td>
<td>.833</td>
</tr>
<tr>
<td>Nurse Aide</td>
<td>17,400</td>
<td>90</td>
<td>100</td>
<td>1.933</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>29,400</strong></td>
<td><strong>90</strong></td>
<td><strong>100</strong></td>
<td><strong>3.266</strong></td>
</tr>
</tbody>
</table>

Case Mix Hours

Case Mix Hrs = Sum of nsg time (minutes) connected to each Resident's RUG / # of rdnts included / 60 minutes

- RUG IV score on most recent MDS for each active resident on the last business day of the PBJ quarter
  - Active = on day data is pulled, do not have a Discharge MDS & most recent MDS transaction is less than 180 days old
  - Utilization of CMS STRIVE Study results for staffing thresholds
- Utilizes percentile ranking compared to nation
- Higher acuity is expected to have higher staffing levels
Adjusted Staffing Hours PPD

*Case Mix Adjusted based on RUG Categories*

**Adjusted Hours** = Hours Reported (PBJ)/Case Mix Hours (RUGs/Strive) * Hours National Average

<table>
<thead>
<tr>
<th>Type of staff</th>
<th>National average expected hours per resident per day</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total nursing staff (Aides + LPNs + RNs)</td>
<td>3.2285</td>
</tr>
<tr>
<td>Registered nurses</td>
<td>0.3804</td>
</tr>
</tbody>
</table>

- National Hours Average (updated quarterly)
  
  [https://data.medicare.gov/data/nursing-home-compare](https://data.medicare.gov/data/nursing-home-compare)
### CMS Staffing Data File (calculations updated quarterly)

<table>
<thead>
<tr>
<th>Staffing Category</th>
<th>Mean Annual Report Hours</th>
<th>Standard Deviation</th>
<th>Minimum Hours</th>
<th>Median Hours</th>
<th>Maximum Hours</th>
</tr>
</thead>
<tbody>
<tr>
<td>nursed - Staffing</td>
<td>140.61</td>
<td>47.92</td>
<td>120</td>
<td>140.50</td>
<td>160</td>
</tr>
<tr>
<td>licensed practical nurse - Staffing</td>
<td>45.74</td>
<td>15.31</td>
<td>30</td>
<td>45.50</td>
<td>60</td>
</tr>
<tr>
<td>nurse aide - Staffing</td>
<td>18.25</td>
<td>9.82</td>
<td>0</td>
<td>18.30</td>
<td>25</td>
</tr>
<tr>
<td>physician - Staffing</td>
<td>4.29</td>
<td>2.35</td>
<td>0</td>
<td>4.29</td>
<td>6</td>
</tr>
<tr>
<td>physical therapist - Staffing</td>
<td>3.74</td>
<td>2.16</td>
<td>0</td>
<td>3.70</td>
<td>5</td>
</tr>
<tr>
<td>respiratory therapist - Staffing</td>
<td>3.08</td>
<td>1.87</td>
<td>0</td>
<td>3.01</td>
<td>4</td>
</tr>
<tr>
<td>occupational therapist - Staffing</td>
<td>2.41</td>
<td>1.47</td>
<td>0</td>
<td>2.20</td>
<td>3</td>
</tr>
<tr>
<td>social worker - Staffing</td>
<td>2.21</td>
<td>1.33</td>
<td>0</td>
<td>2.16</td>
<td>3</td>
</tr>
<tr>
<td>physical therapist - Staffing</td>
<td>3.74</td>
<td>2.16</td>
<td>0</td>
<td>3.70</td>
<td>5</td>
</tr>
<tr>
<td>occupational therapist - Staffing</td>
<td>2.41</td>
<td>1.47</td>
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<td>2.20</td>
<td>3</td>
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<td>2.21</td>
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<td>2.16</td>
<td>3</td>
</tr>
</tbody>
</table>

### Five Star Staffing Calculation uses the Adjusted Staffing

The Five Star Staffing Calculation uses the Adjusted Staffing, which is calculated by multiplying the adjusted number of hours by the number of days in a year (365) and dividing by the number of nursing days (250). This results in a staffing score that reflects the adequacy of staffing for each category.

### Note:

- Adjusted staffing values are rounded to the nearest decimal place before the cut points are applied.
- Calculations are updated quarterly.
Scoring Exceptions

1 Star Rating will be issued for 3 months if:

- Failure to submit staffing data by required deadline
- > 4 days without a RN (job codes 5-7)
- Failure to respond to a CMS accuracy audit request
- Significant discrepancies

Rating Calculation

Health Inspection Rating

Forms Rating

Foundation

Quality Measures Rating

+ 1 star for 5 Star Rating

- 1 star for 1 Star Rating

Staffing Rating

+ 1 star for 4 or 5 Star Staffing

- 1 star for 1 Star Staffing

Note: If the health inspection rating is one star, then the overall rating cannot be upgraded by more than one star based on the staffing and quality measure ratings.
Example

3 stars for survey = 3 Stars

5 stars for QMs = add 1 Star (5 adds a Star)

4 stars for Staffing = add 1 Star (4 or 5 adds a Star)

Example

4 stars for survey = 4 Stars

4 stars for QMs = no Star (5 adds a Star)

1 star for Staffing = removes 1 Star (1 star removes a Star)
**MDS Accuracy**

1. Integrate QMs into your QAPI process utilizing a interdisciplinary approach
2. MDS training for staff (initial and ongoing)
3. Review MDS data prior to submission to CMS
   - Software
   - Care Conference
4. If data entry errors are identified, submit a MDS Modification
   - CMS delays use of QMs for 85-90 days to allow for corrections and modifications

---

**MDS Accuracy**

5. Ensure staff are trained in MDS interviews
   - i.e. BIMs
6. Know your EMR cannot think!
7. Correct CNA documentation issues with a nursing progress note
8. Utilize QAPI and root cause analysis for valid quality improvement opportunities
QAPI Needs to be more than a task!

**QA&A Committee / QAPI**

- Identify your data sources
- Analyze Data (set frequency)
  - Establish benchmarks / variance factors
- Identify Trends & OFIs
- Address gaps in systems or processes
- Continuously monitor effectiveness of interventions

**Q** • Quality

**A** • Assurance

**P** • Performance

**I** • Improvement
Purpose of a QAPI Program

To promote a culture of quality assurance and performance improvement that incorporates:

- Improving the quality of care and services delivered to residents
- Safe clinical practices
- Improving satisfaction
- Meeting the needs and expectations of residents and other stakeholders
- Prevention over correction

Opportunities are found in Data!

Are there system changes needed?
- Policies & Procedures
- Staff communication
- Staff education
- Equipment
- Environment
“What if we don’t change at all ... and something magical just happens?”

If you think the effort involved in quality improvement is not worth it, consider the cost of failure.
Root Cause Analysis

• The most basic reason a problem has (Reactive) or could occur (Proactive) occur...

• Root cause analysis techniques are most often used in reactive mode to uncover the reason(s) for problems that have already occurred.

Root Cause Analysis (RCA)

• RCA is a process to find out:
  • what happened,
  • why it happened, and to
    • determine what can be done to prevent it from happening again
• A RCA focuses primarily on systems and processes, not individual performance
• Identify the underlying function(s) leading to poor outcomes
• Determine the primary cause(s) and contributing factors
• A RCA is generally broken down into the following steps:
  1. Collect data
  2. Analyze data
  3. Develop and evaluate actions, using a Plan-Do-Check-Act cycle
  4. Implement successful corrective actions
The solution to the problem generally lies closest to the problem.

A problem that continues may be the result of poor root cause analysis.

The outcome of a 5 Why’s analysis is one or several root causes that ultimately identify the reason why a problem was originated.
For all the Five Why’s

Ask the full question including the problem or cause behind it. If a resident had a fall, ask.....

“Why did the resident fracture her arm?”

If the answer is she rolled out of bed, ask:

“Why did she roll OOB?”

If we do not follow this approach answers, to the why’s tend to lose focus on the third or fourth why.

“What if, and I know this sounds kooky, we communicated with the employees.”
Systematic Analysis & Systemic Action

- Root Cause Analysis

Examples:
- Five Whys
- Flowcharting
- Fishbone Diagram
**RCA Scenario**

Why did he try to get up?
Social Worker: “He’s upset about not being able to walk anymore.”

Why can’t he walk anymore?
Nurse: “He’s weaker and seems to be getting stiff.”

Why is he weaker?
Dietician: “He had a weight loss of 10% over the last month.”

Why is he stiff?
Nurse: “He is due to see the neurologist soon to assess the changes in his Parkinson’s symptoms.”

Is a medication adjustment needed?
PT: “It may not be a medication issue. Immobility can cause stiffness and muscle weakening.”

Why is he losing weight?
Dietician: “His meal intake has been less than 50% for several weeks.”

Why is he eating less?
CNA: “He has a sore in his mouth and he won’t wear his dentures.”

---

**PDCA: Just like a Care Plan**

**Performance Improvement Plan (PIP) Team Report**

<table>
<thead>
<tr>
<th>Plan</th>
<th>Do</th>
<th>Check</th>
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<tbody>
<tr>
<td>Problem/Cause/Opportunity</td>
<td>Objective Goal</td>
<td>Interventions</td>
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</tbody>
</table>

**Sustained Improvement**
Sustained Improvement

- Updating P&P
- Clearly defining roles & responsibilities for new actions
- Communicate change & purpose
- Identify barriers to new change
- Integrate new change into orientation / competency
- Ensure adequate funding

Ensure Implementation & Effectiveness

- Choose indicators/measures
- Periodic review
- Determine frequency of review
- Analyze measurement & adjust as needed

Another good resource: CMS’ QAPI at a Glance [www.cms.gov]
Encourage Opportunities to be Reported

Table Top Discussion

What have you done so far:

1. What are some of the challenges experienced in developing your QAPI Plan and how did you overcome them?
2. What are some of the successful outcomes produced through QAPI Plan utilization?
3. Did you identify or create any tools to help develop it?
4. Did you include strategic planning, if so, how?
5. If you did not include strategic planning, how do you think you will make this connection moving forward?
Communication is KEY!

...and that is why we lift on three...

OK, there is a small change... red bag has the sandwiches green bag is your parachute.

Communication

Thank You for Joining us Today!

Any Questions?

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Coretactics Healthcare Consulting, Inc.

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