CORE TACTICS™ Healthcare Consulting

Quality Measures, Five Star and QAPI

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VP of Reimbursement and Education

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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

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2

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.

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How important are the QMs?

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

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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

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CASPER Reports

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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

Short Stay

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

* Surveyor Measures (Appendix E)

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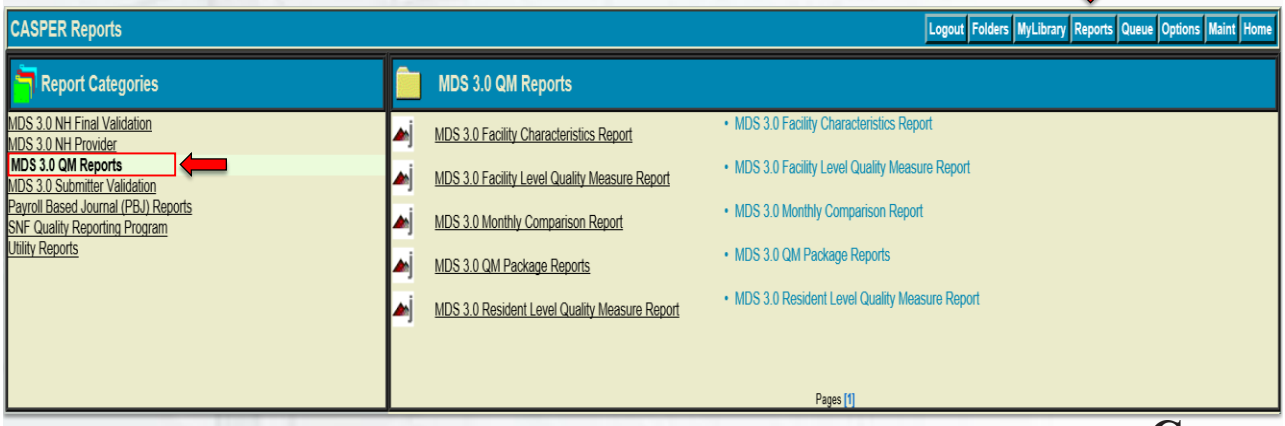
Pulling Reports from QIES



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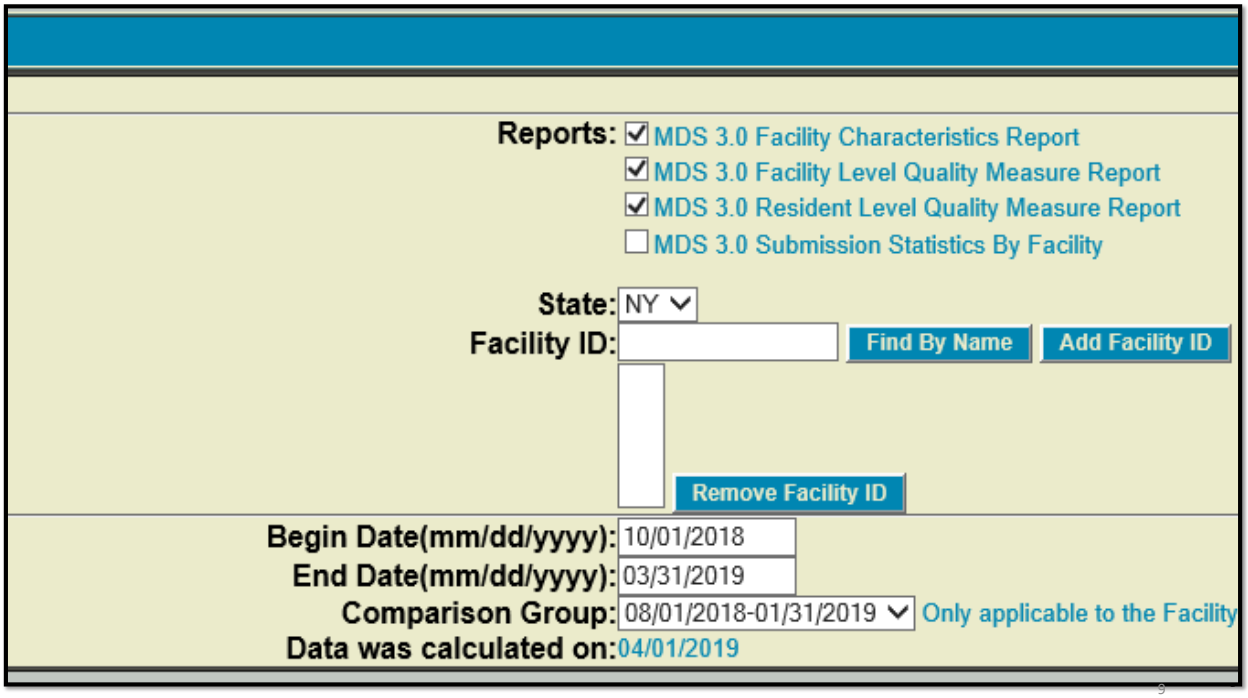

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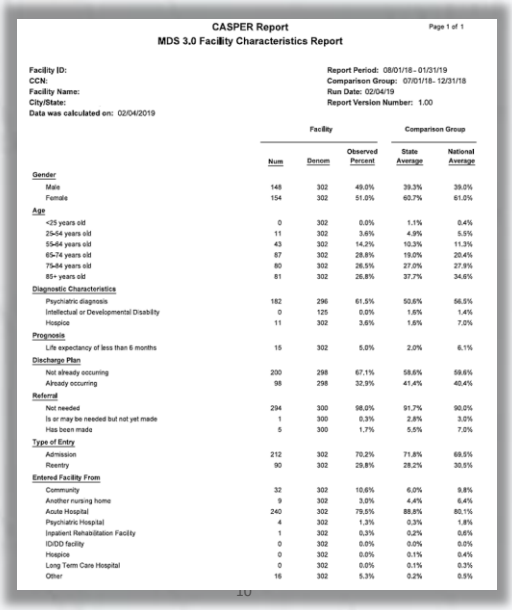
Facility Characteristics Report



CASPER Report
MDS 3.0 Facility Characteristics Report

Page 1 of 1

Facility ID:
CCN:
Facility Name:
City/State:
Data was calculated on: 02/04/2019

Report Period: 08/01/18 - 01/31/19
Comparison Group: 07/01/18 - 12/31/18
Run Date: 02/04/19
Report Version Number: 1.00

	Facility			Comparison Group	
	Num	Denom	Observed Percent	State Average	National Average
Gender					
Male	148	302	49.0%	39.3%	39.0%
Female	154	302	51.0%	60.7%	61.0%
Age					
<25 years old	0	302	0.0%	1.1%	0.4%
25-64 years old	11	302	3.6%	4.9%	5.5%
55-64 years old	43	302	14.2%	10.3%	11.3%
65-74 years old	87	302	28.8%	19.0%	20.4%
75-84 years old	80	302	26.5%	27.0%	27.9%
85+ years old	81	302	26.8%	37.7%	34.6%
Diagnostic Characteristics					
Psychiatric diagnosis	182	296	61.5%	50.6%	56.5%
Intellectual or Developmental Disability	0	125	0.0%	1.6%	1.4%
Hospice	11	302	3.6%	1.6%	7.0%
Prognosis					
Life expectancy of less than 6 months	15	302	5.0%	2.0%	6.1%
Discharge Plan					
Not already occuring	200	298	67.1%	58.6%	59.6%
Already occuring	98	298	32.9%	41.4%	40.4%
Referral					
Not needed	294	300	98.0%	91.7%	90.0%
Is or may be needed but not yet made	1	300	0.3%	2.8%	3.0%
Has been made	5	300	1.7%	5.5%	7.0%
Type of Entry					
Admission	212	302	70.2%	71.8%	69.5%
Reentry	90	302	29.8%	28.2%	30.5%
Entered Facility From					
Community	32	302	10.6%	6.0%	9.8%
Another nursing home	9	302	3.0%	4.4%	6.4%
Acute Hospital	240	302	79.5%	88.8%	80.1%
Psychiatric Hospital	4	302	1.3%	0.3%	1.8%
Inpatient Rehabilitation Facility	1	302	0.3%	0.2%	0.6%
ID/DD facility	0	302	0.0%	0.0%	0.0%
Hospice	0	302	0.0%	0.1%	0.4%
Long Term Care Hospital	0	302	0.0%	0.1%	0.3%
Other	16	302	5.3%	0.2%	0.5%

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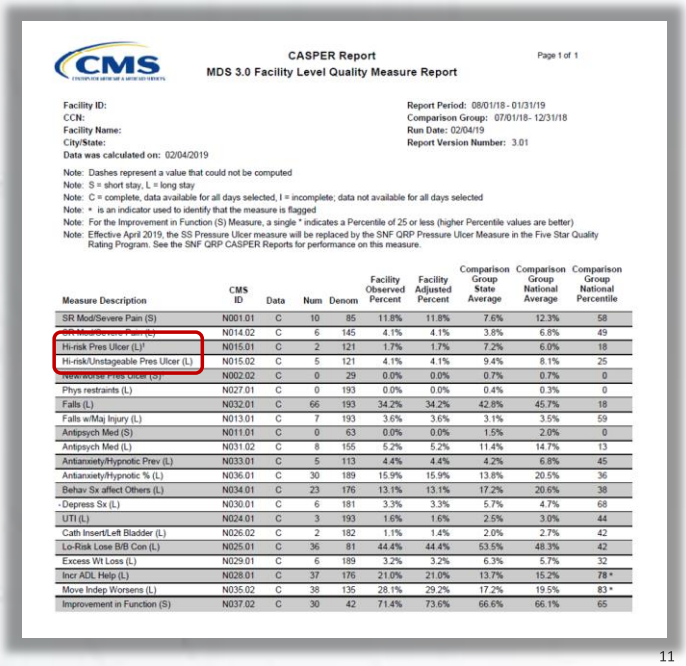
Facility Level QM Report



CASPER Report
MDS 3.0 Facility Level Quality Measure Report

Page 1 of 1

Facility ID:
CCN:
Facility Name:
City/State:
Data was calculated on: 02/04/2019

Report Period: 08/01/18 - 01/31/19
Comparison Group: 07/01/18- 12/31/18
Run Date: 02/04/19
Report Version Number: 3.01

Note: Dashes represent a value that could not be computed
Note: S = short stay, L = long stay
Note: C = complete, data available for all days selected, I = incomplete; data not available for all days selected
Note: * is an indicator used to identify that the measure is flagged
Note: For the Improvement in Function (S) Measure, a single * indicates a Percentile of 25 or less (higher Percentile values are better)
Note: Effective April 2019, the SS Pressure Ulcer measure will be replaced by the SNF QRP Pressure Ulcer Measure in the Five Star Quality Rating Program. See the SNF QRP CASPER Reports for performance on this measure.

Measure Description	CMS ID	Data	Num	Denom	Facility Observed Percent	Facility Adjusted Percent	Comparison Group State Average	Comparison Group National Average	Comparison Group National Percentile
SR Mod/Severe Pain (S)	N001.01	C	10	85	11.8%	11.8%	7.6%	12.3%	58
SR Mod/Severe Pain (L)	N014.02	C	6	145	4.1%	4.1%	3.8%	6.8%	49
Hi-risk Pres Ulcer (L)[1]	N015.01	C	2	121	1.7%	1.7%	7.2%	6.0%	18
Hi-risk/Unstageable Pres Ulcer (L)	N015.02	C	5	121	4.1%	4.1%	9.4%	8.1%	25
New/worse Pres Ulcer (S)[1]	N002.02	C	0	29	0.0%	0.0%	0.7%	0.7%	0
Phys restraints (L)	N027.01	C	0	193	0.0%	0.0%	0.4%	0.3%	0
Falls (L)	N032.01	C	66	193	34.2%	34.2%	42.8%	45.7%	18
Falls w/Maj Injury (L)	N013.01	C	7	193	3.6%	3.6%	3.1%	3.5%	59
Antipsych Med (S)	N011.01	C	0	63	0.0%	0.0%	1.5%	2.0%	0
Antipsych Med (L)	N031.02	C	8	155	5.2%	5.2%	11.4%	14.7%	13
Antianxiety/Hypnotic Prev (L)	N033.01	C	5	113	4.4%	4.4%	4.2%	6.8%	45
Antianxiety/Hypnotic % (L)	N036.01	C	30	189	15.9%	15.9%	13.8%	20.5%	36
Behav Sx affect Others (L)	N034.01	C	23	176	13.1%	13.1%	17.2%	20.6%	38
- Depress Sx (L)	N030.01	C	6	181	3.3%	3.3%	5.7%	4.7%	68
UTI (L)	N024.01	C	3	193	1.6%	1.6%	2.5%	3.0%	44
Cath Insert/Left Bladder (L)	N026.02	C	2	182	1.1%	1.4%	2.0%	2.7%	42
Lo-Risk Lose B/B Con (L)	N025.01	C	36	81	44.4%	44.4%	53.5%	48.3%	42
Excess Wt Loss (L)	N029.01	C	6	189	3.2%	3.2%	6.3%	5.7%	32
Incr ADL Help (L)	N028.01	C	37	176	21.0%	21.0%	13.7%	15.2%	78 *
Move Indep Worsens (L)	N035.02	C	38	135	28.1%	29.2%	17.2%	19.5%	83 *
Improvement in Function (S)	N037.02	C	30	42	71.4%	73.6%	66.6%	66.1%	65

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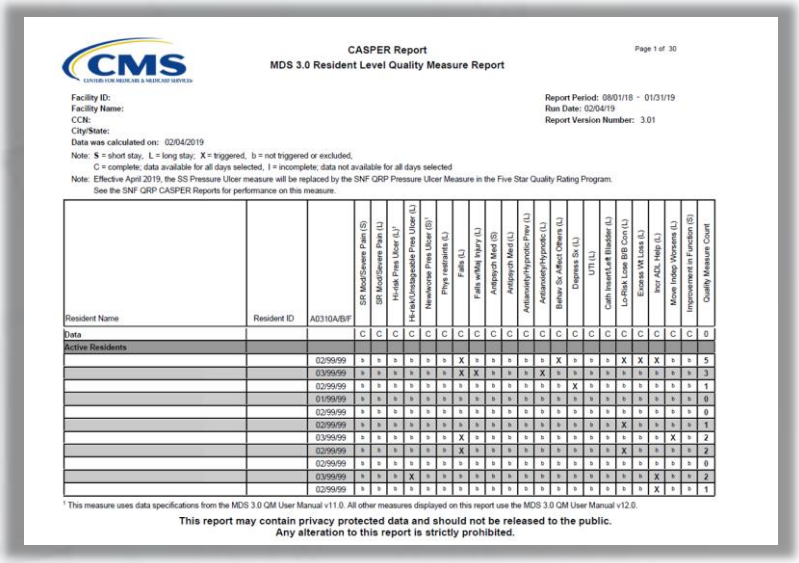
Resident Level QM Report



CASPER Report
MDS 3.0 Resident Level Quality Measure Report

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Facility ID:
Facility Name:
CCN:
City/State:
Data was calculated on: 02/04/2019

Report Period: 08/01/18 - 01/31/19
Run Date: 02/04/19
Report Version Number: 3.01

Note: S = short stay, L = long stay, X = triggered, b = not triggered or excluded,
C = complete; data available for all days selected, I = incomplete; data not available for all days selected
Note: Effective April 2019, the SS Pressure Ulcer measure will be replaced by the SNF QRP Pressure Ulcer Measure in the Five Star Quality Rating Program.
See the SNF QRP CASPER Reports for performance on this measure.

Resident Name	Resident ID	A0310A/B/F	SR Mod/Severe Pain (S)	SR Mod/Severe Pain (L)	Hi-risk Pres Ulcer (L)[1]	Hi-risk/Unstageable Pres Ulcer (L)	New/worse Pres Ulcer (S)[1]	Phys restraints (L)	Falls (L)	Falls w/Maj Injury (L)	Antipsych Med (S)	Antipsych Med (L)	Antianxiety/Hypnotic Prev (L)	Antianxiety/Hypnotic (L)	Behav Sx Affect Others (L)	Depress Sx (L)	UTI (L)	Cath Insert/Left Bladder (L)	Lo-Risk Lose B/B Con (L)	Excess Wt Loss (L)	Incr ADL Help (L)	Move Indep Worsens (L)	Improvement in Function (S)	Quality Measure Count
Data			C	C	C	C	C	C	C	C	C	C	C	C	C	C	C	C	C	C	C	C	C	0
Active Residents																								
		02/99/99	b	b	b	b	b	b	X	b	b	b	b	b	X	b	b	b	X	X	X	b	b	5
		03/99/99	b	b	b	b	b	b	X	X	b	b	b	b	X	b	b	b	b	b	b	b	b	3
		02/99/99	b	b	b	b	b	b	b	b	b	b	b	b	b	b	X	b	b	b	b	b	b	1
		01/99/99	b	b	b	b	b	b	b	b	b	b	b	b	b	b	b	b	b	b	b	b	b	0
		02/99/99	b	b	b	b	b	b	b	b	b	b	b	b	b	b	b	b	b	b	b	b	b	0
		02/99/99	b	b	b	b	b	b	b	b	b	b	b	b	b	b	b	b	X	b	b	b	b	1
		03/99/99	b	b	b	b	b	b	X	b	b	b	b	b	b	b	b	b	b	b	b	X	b	2
		02/99/99	b	b	b	b	b	b	X	b	b	b	b	b	b	b	b	b	X	b	b	b	b	2
		02/99/99	b	b	b	b	b	b	b	b	b	b	b	b	b	b	b	b	b	b	b	b	b	0
		03/99/99	b	b	b	X	b	b	b	b	b	b	b	b	b	b	b	b	b	X	b	b	b	2
		02/99/99	b	b	b	b	b	b	b	b	b	b	b	b	b	b	b	b	b	X	b	b	b	1

[1] This measure uses data specifications from the MDS 3.0 QM User Manual v11.0. All other measures displayed on this report use the MDS 3.0 QM User Manual v12.0.

This report may contain privacy protected data and should not be released to the public.
Any alteration to this report is strictly prohibited.

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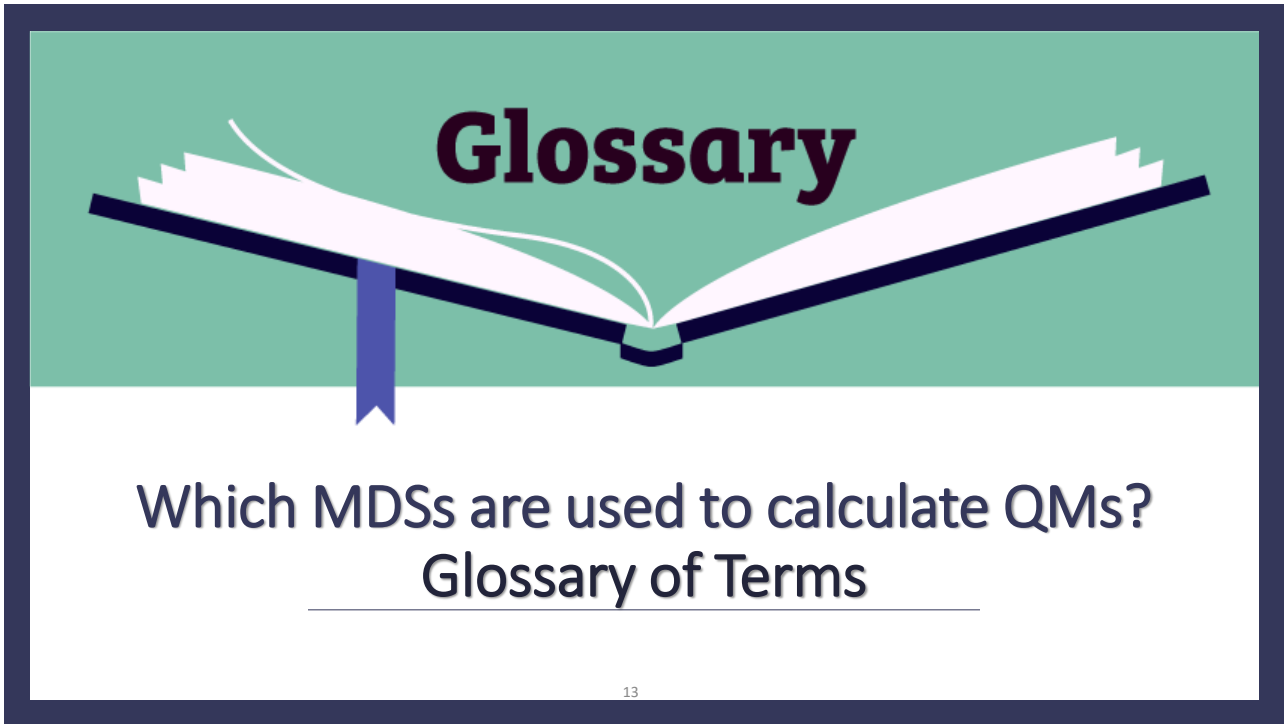

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Definitions

- **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.

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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.

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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.

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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.

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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

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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).

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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.

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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*

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Definitions

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)

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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 ≤ 100 CDIF
  - A PPS assessment may trigger a Long Stay measure if ≥ 100 CDIF (5 Day Assessments are excluded)

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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)

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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

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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

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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

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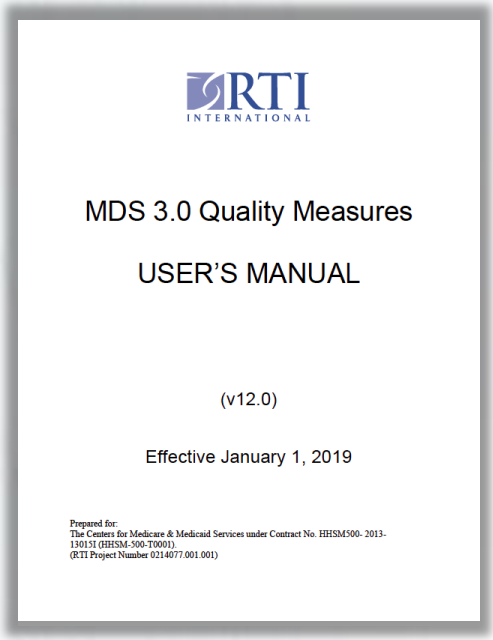
MDS 3.0 Quality Measures User's Manual (v12.0 01-1-2019)


RTI INTERNATIONAL

MDS 3.0 Quality Measures

USER'S MANUAL

(v12.0)

Effective January 1, 2019

Prepared for:
The Centers for Medicare & Medicaid Services under Contract No. HHSM500- 2013-130151 (HHSM-500-T0001).
(RTI Project Number 0214077.001.001)

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Table 2-1
MDS 3.0 Measure: Percent of Residents Who Self-Report Moderate to Severe Pain (Short Stay)[1]
(NQF #0676) (CMS ID: N001.01)

Measure Description
This measure captures the percent of short stay residents, with at least one episode of moderate/severe pain or horrible/excruciating pain of any frequency, in the last 5 days.

Measure Specifications
Numerator
Short-stay residents with a selected target assessment where the target assessment meets ***either or both*** of the following two conditions:
1. Condition #1: resident reports daily pain with at least one episode of moderate/severe pain. ***Both*** of the following conditions must be met:
1.1. Almost constant or frequent pain (J0400 = [1,2]) ***and***
1.2. At least one episode of moderate to severe pain (J0600A = [05, 06, 07, 08, 09] ***or*** J0600B = [2, 3]).
2. Condition #2: resident reports very severe/horrible pain of any frequency (J0600A = [10] ***or*** J0600B = [4]).
Denominator
All short-stay residents with a selected target assessment, except those with exclusions.
Exclusions
If the resident is not included in the numerator (the resident did not meet the pain symptom conditions for the numerator) ***and any*** of the following conditions are true:
1. The pain assessment interview was not completed (J0200= [0, - , ^]).
2. The pain presence item was not completed (J0300 = [9, - , ^]).
3. For residents with pain or hurting at any time in the last 5 days (J0300 = [1]), ***any*** of the following are true:
3.1. The pain frequency item was not completed (J0400 = [9, - , ^]).
3.2. Neither of the pain intensity items was completed (J0600A = [99, - , ^] and J0600B= [9, - ,, ^]).
4. The numeric pain intensity item indicates no pain (J0600A = [00]).
Covariates

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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

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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

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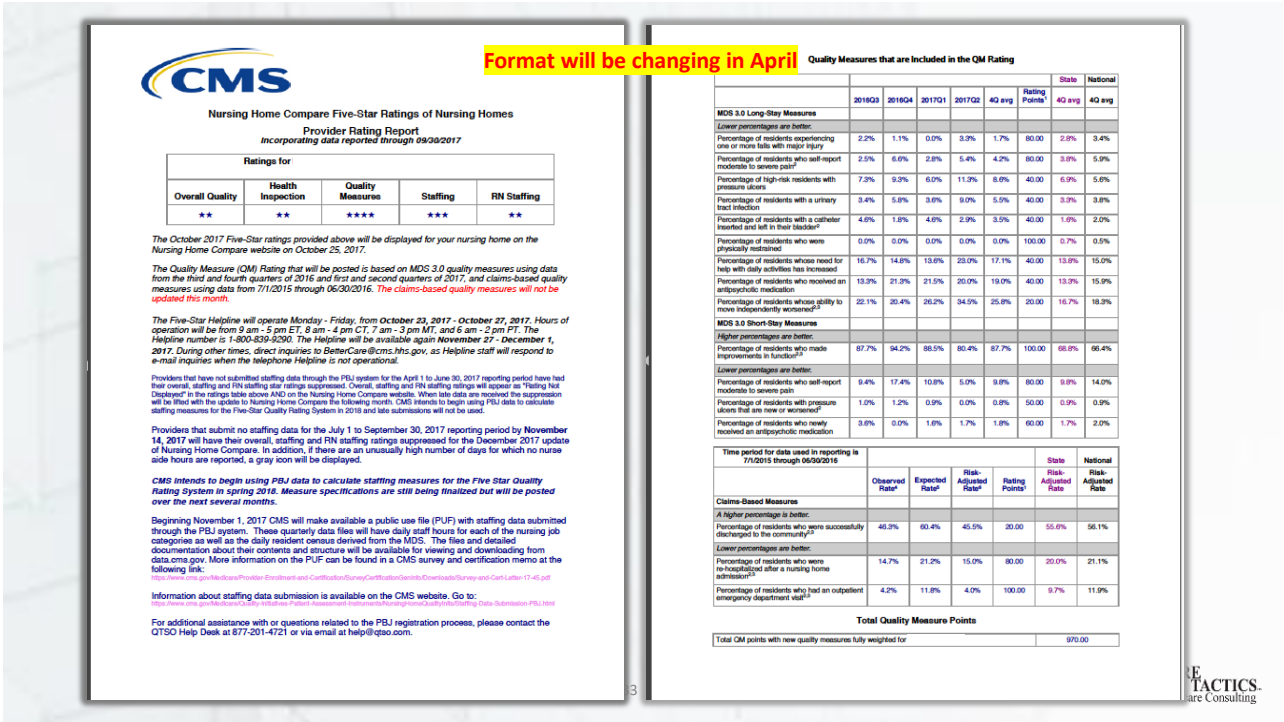

CMS

Nursing Home Compare Five-Star Ratings of Nursing Homes

Provider Rating Report

Incorporating data reported through 09/30/2017

Ratings for				
Overall Quality	Health Inspection	Quality Measures	Staffing	RN Staffing
★★	★★	★★★★	★★★	★★

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

The Quality Measure (QM) Rating that will be posted is based on MDS 3.0 quality measures using data from the third and fourth quarters of 2016 and first and second quarters of 2017, and claims-based quality measures using data from 7/1/2015 through 06/30/2016. The claims-based quality measures will not be updated this month.

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CMS intends to begin using PBJ data to calculate staffing measures for the Five Star Quality Rating System in spring 2018. Measure specifications are still being finalized but will be posted over the next several months.

Beginning November 1, 2017 CMS will make available a public use file (PUF) with staffing data submitted through the PBJ system. These quarterly data files will have daily staff hours for each of the nursing job categories as well as the daily resident census derived from the MDS. The files and detailed documentation about their contents and structure will be available for viewing and downloading from data.cms.gov. More information on the PUF can be found in a CMS survey and certification memo at the following link:
https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/SurveyCertificationGenInfo/Downloads/Survey-and-Cert-Letter-17-45.pdf

Information about staffing data submission is available on the CMS website. Go to:
https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/NursingHomeQualityInits/Staffing-Data-Submission-PBJ.html

For additional assistance with or questions related to the PBJ registration process, please contact the QTSO Help Desk at 877-201-4721 or via email at help@qtso.com.

3

Format will be changing in April

Quality Measures that are Included in the QM Rating

	2016Q3	2016Q4	2017Q1	2017Q2	4Q avg	Rating Points[1]	State 4Q avg	National 4Q avg
MDS 3.0 Long-Stay Measures								
Lower percentages are better.								
Percentage of residents experiencing one or more falls with major injury	2.2%	1.1%	0.0%	3.3%	1.7%	80.00	2.8%	3.4%
Percentage of residents who self-report moderate to severe pain[2]	2.5%	6.6%	2.8%	5.4%	4.2%	80.00	3.8%	5.9%
Percentage of high-risk residents with pressure ulcers	7.3%	9.3%	6.0%	11.3%	8.6%	40.00	6.9%	5.6%
Percentage of residents with a urinary tract infection	3.4%	5.8%	3.6%	9.0%	5.5%	40.00	3.3%	3.8%
Percentage of residents with a catheter inserted and left in their bladder[2]	4.6%	1.8%	4.6%	2.9%	3.5%	40.00	1.6%	2.0%
Percentage of residents who were physically restrained	0.0%	0.0%	0.0%	0.0%	0.0%	100.00	0.7%	0.5%
Percentage of residents whose need for help with daily activities has increased	16.7%	14.8%	13.6%	23.0%	17.1%	40.00	13.8%	15.0%
Percentage of residents who received an antipsychotic medication	13.3%	21.3%	21.5%	20.0%	19.0%	40.00	13.3%	15.9%
Percentage of residents whose ability to move independently worsened[2,3]	22.1%	20.4%	26.2%	34.5%	25.8%	20.00	16.7%	18.3%
MDS 3.0 Short-Stay Measures								
Higher percentages are better.								
Percentage of residents who made improvements in function[2,3]	87.7%	94.2%	88.5%	80.4%	87.7%	100.00	68.8%	66.4%
Lower percentages are better.								
Percentage of residents who self-report moderate to severe pain	9.4%	17.4%	10.8%	5.0%	9.8%	80.00	9.8%	14.0%
Percentage of residents with pressure ulcers that are new or worsened[2]	1.0%	1.2%	0.9%	0.0%	0.8%	50.00	0.9%	0.9%
Percentage of residents who newly received an antipsychotic medication	3.6%	0.0%	1.6%	1.7%	1.8%	60.00	1.7%	2.0%

Time period for data used in reporting is 7/1/2015 through 06/30/2016	Observed Rate[4]	Expected Rate[5]	Risk-Adjusted Rate[6]	Rating Points[1]	State Risk-Adjusted Rate	National Risk-Adjusted Rate
Claims-Based Measures						
A higher percentage is better.						
Percentage of residents who were successfully discharged to the community[2,3]	46.3%	60.4%	45.5%	20.00	55.6%	56.1%
Lower percentages are better.						
Percentage of residents who were re-hospitalized after a nursing home admission[2,3]	14.7%	21.2%	15.0%	80.00	20.0%	21.1%
Percentage of residents who had an outpatient emergency department visit[2,3]	4.2%	11.8%	4.0%	100.00	9.7%	11.9%

Total Quality Measure Points

Total QM points with new quality measures fully weighted for	970.00

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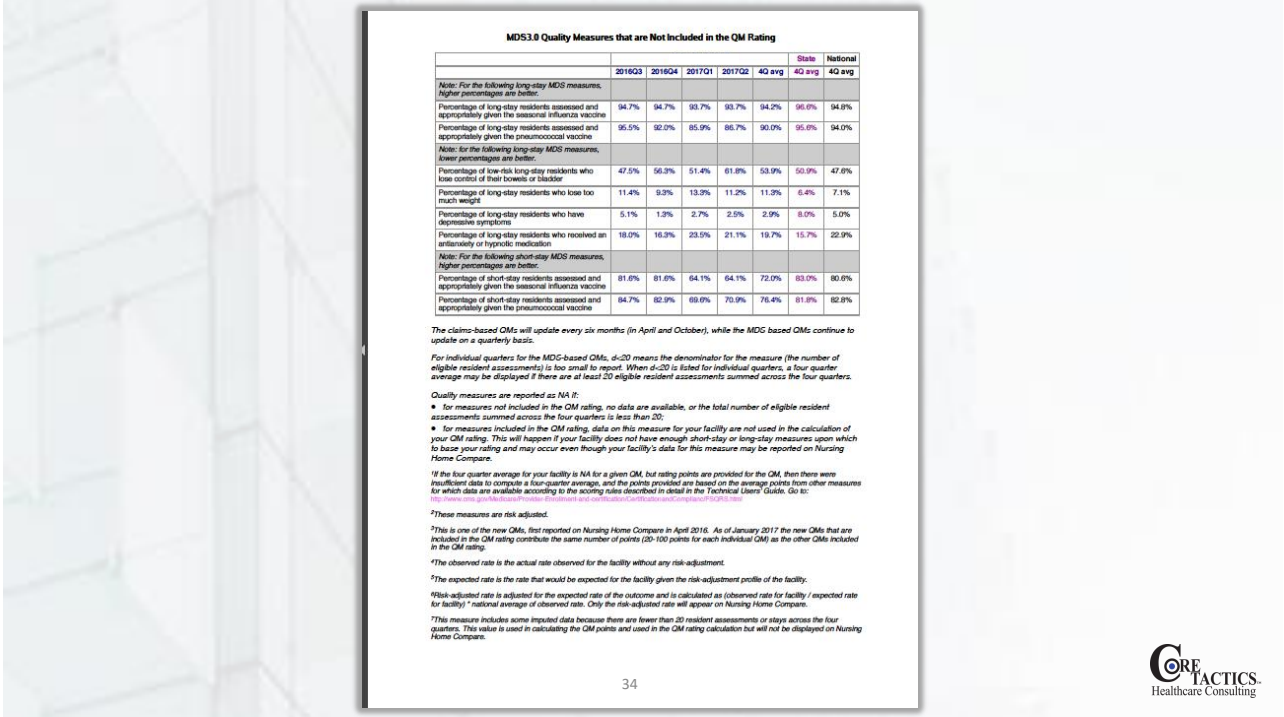

MDS3.0 Quality Measures that are Not Included in the QM Rating

	2016Q3	2016Q4	2017Q1	2017Q2	4Q avg	State 4Q avg	National 4Q avg
Note: For the following long-stay MDS measures, higher percentages are better.							
Percentage of long-stay residents assessed and appropriately given the seasonal influenza vaccine	94.7%	94.7%	93.7%	93.7%	94.2%	96.6%	94.8%
Percentage of long-stay residents assessed and appropriately given the pneumococcal vaccine	95.5%	92.0%	85.9%	86.7%	90.0%	95.6%	94.0%
Note: for the following long-stay MDS measures, lower percentages are better.							
Percentage of low-risk long-stay residents who lose control of their bowels or bladder	47.5%	56.3%	51.4%	61.8%	53.9%	50.9%	47.6%
Percentage of long-stay residents who lose too much weight	11.4%	9.3%	13.3%	11.2%	11.3%	6.4%	7.1%
Percentage of long-stay residents who have depressive symptoms	5.1%	1.3%	2.7%	2.5%	2.9%	8.0%	5.0%
Percentage of long-stay residents who received an antianxiety or hypnotic medication	18.0%	16.3%	23.5%	21.1%	19.7%	15.7%	22.9%
Note: For the following short-stay MDS measures, higher percentages are better.							
Percentage of short-stay residents assessed and appropriately given the seasonal influenza vaccine	81.6%	81.6%	64.1%	64.1%	72.0%	83.0%	80.6%
Percentage of short-stay residents assessed and appropriately given the pneumococcal vaccine	84.7%	82.9%	69.6%	70.9%	76.4%	81.8%	82.8%

The claims-based QMs will update every six months (in April and October), while the MDS based QMs continue to update on a quarterly basis.

For individual quarters for the MDS-based QMs, d<20 means the denominator for the measure (the number of eligible resident assessments) is too small to report. When d<20 is listed for individual quarters, a four quarter average may be displayed if there are at least 20 eligible resident assessments summed across the four quarters.

Quality measures are reported as NA if:

- *for measures not included in the QM rating, no data are available, or the total number of eligible resident assessments summed across the four quarters is less than 20;*
- *for measures included in the QM rating, data on this measure for your facility are not used in the calculation of your QM rating. This will happen if your facility does not have enough short-stay or long-stay measures upon which to base your rating and may occur even though your facility's data for this measure may be reported on Nursing Home Compare.*

[1]If the four quarter average for your facility is NA for a given QM, but rating points are provided for the QM, then there were insufficient data to compute a four-quarter average, and the points provided are based on the average points from other measures for which data are available according to the scoring rules described in detail in the Technical Users' Guide. Go to:
http://www.cms.gov/MedicareProvider-Enrollment-and-Certification/CertificationandComplianc/FSQRS.html

[2]These measures are risk adjusted.

[3]This is one of the new QMs, first reported on Nursing Home Compare in April 2016. As of January 2017 the new QMs that are included in the QM rating contribute the same number of points (20-100 points for each individual QM) as the other QMs included in the QM rating.

[4]The observed rate is the actual rate observed for the facility without any risk-adjustment.

[5]The expected rate is the rate that would be expected for the facility given the risk-adjustment profile of the facility.

*[6]Risk-adjusted rate is adjusted for the expected rate of the outcome and is calculated as (observed rate for facility / expected rate for facility) * national average of observed rate. Only the risk-adjusted rate will appear on Nursing Home Compare.*

[7]This measure includes some imputed data because there are fewer than 20 resident assessments or stays across the four quarters. This value is used in calculating the QM points and used in the QM rating calculation but will not be displayed on Nursing Home Compare.

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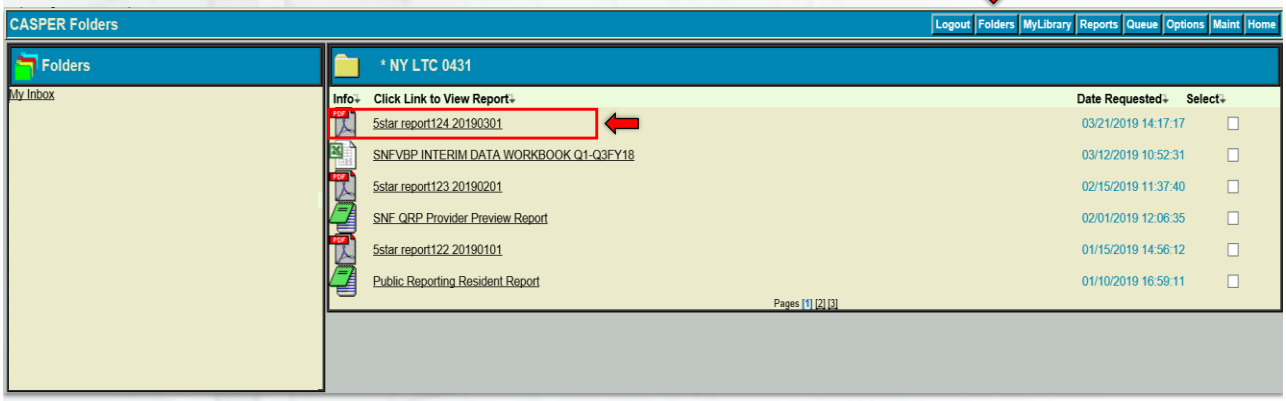
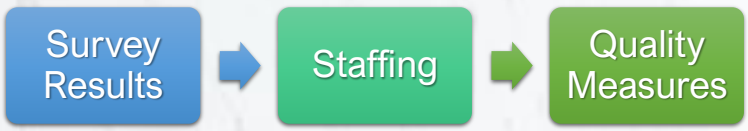
Pulling your Provider Rating Report from QIES



35

1. Survey



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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)

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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

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Table 1
Survey Deficiency Score: Weights for Different Types of Deficiencies

Severity	Scope		
	Isolated	Pattern	Widespread
Immediate jeopardy to resident health or safety	J 50 points (75 points)	K 100 points (125 points)	L 150 points (175 points)
Actual harm that is not immediate jeopardy	G 20 points	H 35 points (40 points)	I 45 points (50 points)
No actual harm with potential for more than minimal harm that is not immediate jeopardy	D 4 points	E 8 points	F 16 points (20 points)
No actual harm with potential for minimal harm	A 0 point	B 0 points	C 0 points

Note: Figures in parentheses indicate points for deficiencies that are for substandard quality of care.
Shaded cells denote deficiency scope/severity levels that constitute substandard quality of care if the requirement which is not met is one that falls under the following federal regulations:42 CFR 483.13 resident behavior and nursing home practices; 42 CFR 483.15 quality of life; 42 CFR 483.25 quality of care.
Source: Centers for Medicare & Medicaid Services

★ ★★ ★★★ ★★★★ ★★★★★

≥40.000 **≤40.000 - >23.200** **≤23.200 – >12.800** **≤12.000 – >3.200** **≤3.2.00**

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

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2. Quality Measures

Survey Results → Staffing → Quality Measures

★★★★★

40

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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 Indepent. 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*

Updated Quarterly (Jan, Apr, Jul & Oct)

*Claims Based Measures

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

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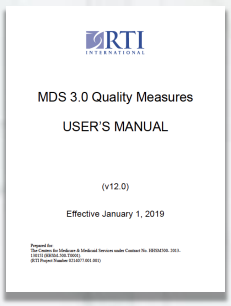

RTI INTERNATIONAL

MDS 3.0 Quality Measures

USER'S MANUAL

(v12.0)

Effective January 1, 2019

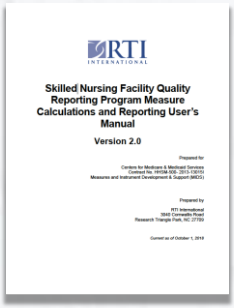
www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/NursingHomeQualityInits/Downloads/MDS-30-QM-USERS-MANUAL-v120.pdf


Abt

Nursing Home Compare Claims-Based Quality Measure Technical Specifications

Final

www.cms.gov/medicare/provider-enrollment-and-certification/certificationandcomplianc/fsgrs.html


RTI INTERNATIONAL

Skilled Nursing Facility Quality Reporting Program Measure Calculations and Reporting User's Manual

Version 2.0

www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/NursingHomeQualityInits/Skilled-Nursing-Facility-Quality-Reporting-Program/SNF-Quality-Reporting-Program-Measures-and-Technical-Information.html

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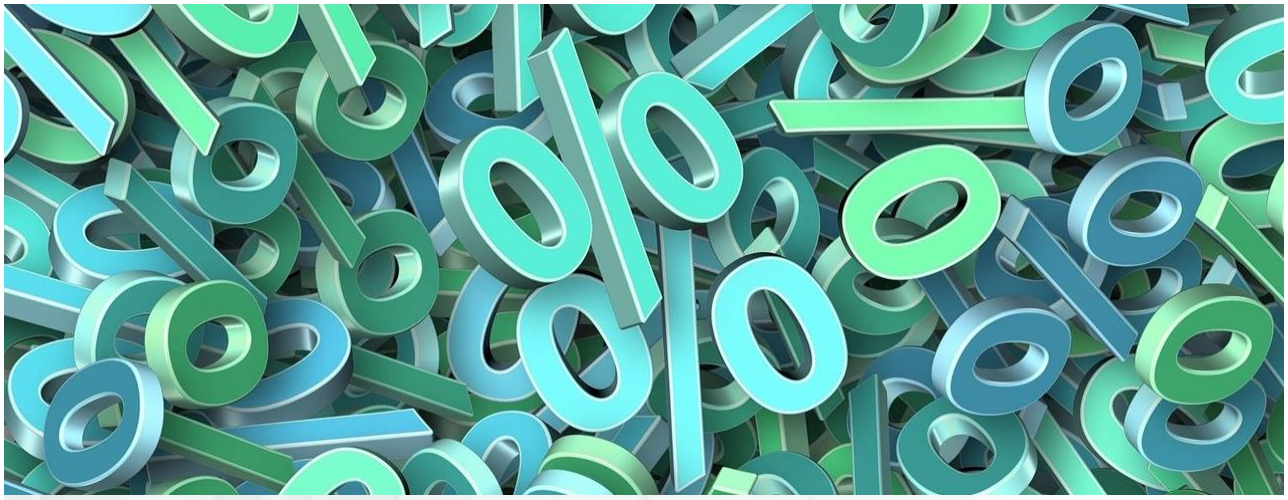

Rehospitalizations
(Claims Based)

43

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.

44

44

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:

- 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

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Short-Stay Rehospitalizations (continued)

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:

- 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).

$$\frac{Observed\ Rate}{Expected\ Rate} \times National\ Rate = Risk\ Standardized\ Rate$$

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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.

47

47

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

48

48

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)

$$\frac{Observed\ Rate}{Expected\ Rate} \times National\ Rate = Risk\ Standardized\ Rate$$

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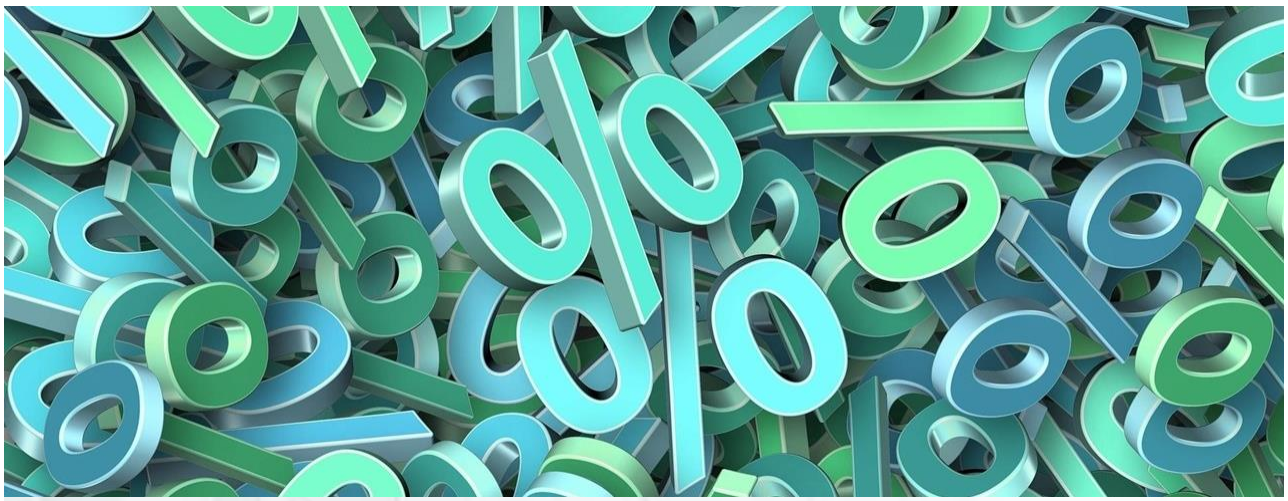

Outpatient ED Visits

(Claims Based)

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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

51

51

Short-Stay ED Visits (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:

- 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

52

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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.

$$\frac{\textit{Observed Rate}}{\textit{Expected Rate}} \times \textit{National Rate} = \textit{Risk Standardized Rate}$$

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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.

54

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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

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Long-Stay Rehospitalizations (continued)

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

$$\frac{\textit{Observed Rate}}{\textit{Expected Rate}} \times \textit{National Rate} = \textit{Risk Standardized Rate}$$

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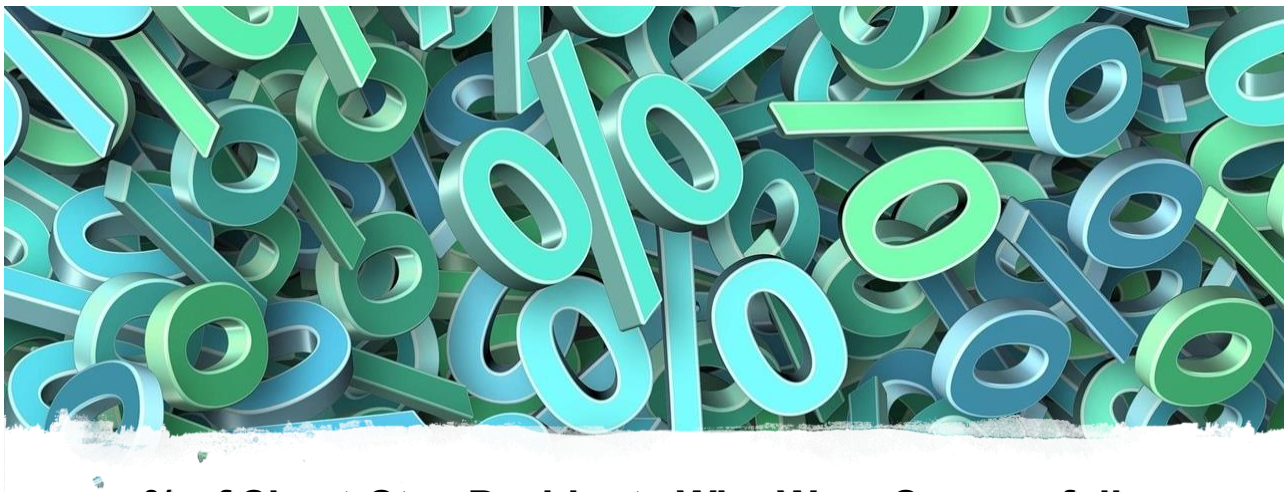
Improvement Strategies

- 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

57

57



% of Short-Stay Residents Who Were Successfully Discharged to the Community

(Claims Based)

58

58

% 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.

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% of Short-Stay Residents Who Were Successfully Discharged to the Community

Numerator:

- The number of nursing home ***episodes*** where the resident was discharge 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.

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% 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

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

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Improvement Strategies

Strategies:

- Role of Rehab Team
- Community partnerships/relationships
- Engage families and caregivers
- Discharge teaching
- Post discharge follow-up

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Format will be changing in April

CMS

Nursing Home Compare Five-Star Ratings of Nursing Homes

Provider Rating Report

Incorporating data reported through 09/30/2017

Ratings for

Overall Quality	Health Inspection	Quality Measures	Staffing	RN Staffing
★★	★★	★★★★	★★★	★★

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

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Providers 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 suppressed for the December 2017 update of Nursing Home Compare. In addition, if there are an unusually high number of days for which no nurse aide hours are reported, a gray icon will be displayed.

CMS intends to begin using PBJ data to calculate staffing measures for the Five Star Quality Rating System in spring 2018. Measure specifications are still being finalized but will be posted over the next several months.

Beginning November 1, 2017 CMS will make available a public use file (PUF) with staffing data submitted through the PBJ system. These quarterly data files will have daily staff hours for each of the nursing job categories as well as the daily resident census derived from the MDS. The files and detailed documentation about their contents and structure will be available for viewing and downloading from data.cms.gov. More information on the PUF can be found in a CMS survey and certification memo at the following link:
https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/SurveyCertificationGenInfo/Downloads/Survey-and-Cert-Letter-17-45.pdf

Information about staffing data submission is available on the CMS website. Go to:
https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/NursingHomeQualityInits/Staffing-Data-Submission-PBJ.html

For additional assistance with or questions related to the PBJ registration process, please contact the QTSO Help Desk at 877-201-4721 or via email at help@qtso.com.

3

Quality Measures that are Included in the QM Rating

	2016Q3	2016Q4	2017Q1	2017Q2	4Q avg	Rating Points[1]	State 4Q avg	National 4Q avg
MDS 3.0 Long-Stay Measures								
Lower percentages are better.								
Percentage of residents experiencing one or more falls with major injury	2.2%	1.1%	0.0%	3.3%	1.7%	80.00	2.8%	3.4%
Percentage of residents who self-report moderate to severe pain[2]	2.5%	6.6%	2.8%	5.4%	4.2%	80.00	3.8%	5.9%
Percentage of high-risk residents with pressure ulcers	7.3%	9.3%	6.0%	11.3%	8.6%	40.00	6.9%	5.6%
Percentage of residents with a urinary tract infection	3.4%	5.8%	3.6%	9.0%	5.5%	40.00	3.3%	3.8%
Percentage of residents with a catheter inserted and left in their bladder[2]	4.6%	1.8%	4.6%	2.9%	3.5%	40.00	1.6%	2.0%
Percentage of residents who were physically restrained	0.0%	0.0%	0.0%	0.0%	0.0%	100.00	0.7%	0.5%
Percentage of residents whose need for help with daily activities has increased	16.7%	14.8%	13.6%	23.0%	17.1%	40.00	13.8%	15.0%
Percentage of residents who received an antipsychotic medication	13.3%	21.3%	21.5%	20.0%	19.0%	40.00	13.3%	15.9%
Percentage of residents whose ability to move independently worsened[2,3]	22.1%	20.4%	26.2%	34.5%	25.8%	20.00	16.7%	18.3%
MDS 3.0 Short-Stay Measures								
Higher percentages are better.								
Percentage of residents who made improvements in function[2,3]	87.7%	94.2%	88.5%	80.4%	87.7%	100.00	68.8%	66.4%
Lower percentages are better.								
Percentage of residents who self-report moderate to severe pain	9.4%	17.4%	10.8%	5.0%	9.8%	80.00	9.8%	14.0%
Percentage of residents with pressure ulcers that are new or worsened[2]	1.0%	1.2%	0.9%	0.0%	0.8%	50.00	0.9%	0.9%
Percentage of residents who newly received an antipsychotic medication	3.6%	0.0%	1.6%	1.7%	1.8%	60.00	1.7%	2.0%

Time period for data used in reporting is 7/1/2015 through 06/30/2016	Observed Rate[4]	Expected Rate[5]	Risk-Adjusted Rate[6]	Rating Points[1]	State Risk-Adjusted Rate	National Risk-Adjusted Rate
Claims-Based Measures						
A higher percentage is better.						
Percentage of residents who were successfully discharged to the community[2,3]	46.3%	60.4%	45.5%	20.00	55.6%	56.1%
Lower percentages are better.						
Percentage of residents who were re-hospitalized after a nursing home admission[2,3]	14.7%	21.2%	15.0%	80.00	20.0%	21.1%
Percentage of residents who had an outpatient emergency department visit[2,3]	4.2%	11.8%	4.0%	100.00	9.7%	11.9%

Total Quality Measure Points

Total QM points with new quality measures fully weighted for	970.00

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MDS3.0 Quality Measures that are Not Included in the QM Rating

	2016Q3	2016Q4	2017Q1	2017Q2	4Q avg	State 4Q avg	National 4Q avg
Note: For the following long-stay MDS measures, higher percentages are better.							
Percentage of long-stay residents assessed and appropriately given the seasonal influenza vaccine	94.7%	94.7%	93.7%	93.7%	94.2%	96.6%	94.8%
Percentage of long-stay residents assessed and appropriately given the pneumococcal vaccine	95.5%	92.0%	85.9%	86.7%	90.0%	95.6%	94.0%
Note: for the following long-stay MDS measures, lower percentages are better.							
Percentage of low-risk long-stay residents who lose control of their bowels or bladder	47.5%	56.3%	51.4%	61.8%	53.9%	50.9%	47.6%
Percentage of long-stay residents who lose too much weight	11.4%	9.3%	13.3%	11.2%	11.3%	6.4%	7.1%
Percentage of long-stay residents who have depressive symptoms	5.1%	1.3%	2.7%	2.5%	2.9%	8.0%	5.0%
Percentage of long-stay residents who received an antianxiety or hypnotic medication	18.0%	16.3%	23.5%	21.1%	19.7%	15.7%	22.9%
Note: For the following short-stay MDS measures, higher percentages are better.							
Percentage of short-stay residents assessed and appropriately given the seasonal influenza vaccine	81.6%	81.6%	64.1%	64.1%	72.0%	83.0%	80.6%
Percentage of short-stay residents assessed and appropriately given the pneumococcal vaccine	84.7%	82.9%	69.6%	70.9%	76.4%	81.8%	82.8%

The claims-based QMs will update every six months (in April and October), while the MDS based QMs continue to update on a quarterly basis.

For individual quarters for the MDS-based QMs, d<20 means the denominator for the measure (the number of eligible resident assessments) is too small to report. When d<20 is listed for individual quarters, a four quarter average may be displayed if there are at least 20 eligible resident assessments summed across the four quarters.

Quality measures are reported as NA if:

- *for measures not included in the QM rating, no data are available, or the total number of eligible resident assessments summed across the four quarters is less than 20;*
- *for measures included in the QM rating, data on this measure for your facility are not used in the calculation of your QM rating. This will happen if your facility does not have enough short-stay or long-stay measures upon which to base your rating and may occur even though your facility's data for this measure may be reported on Nursing Home Compare.*

[1]If the four quarter average for your facility is NA for a given QM, but rating points are provided for the QM, then there were insufficient data to compute a four-quarter average, and the points provided are based on the average points from other measures for which data are available according to the scoring rules described in detail in the Technical Users' Guide. Go to:
http://www.cms.gov/MedicareProvider-Enrollment-and-Certification/CertificationandComplianc/FSQRS.html

[2]These measures are risk adjusted.

[3]This is one of the new QMs, first reported on Nursing Home Compare in April 2016. As of January 2017 the new QMs that are included in the QM rating contribute the same number of points (20-100 points for each individual QM) as the other QMs included in the QM rating.

[4]The observed rate is the actual rate observed for the facility without any risk-adjustment.

[5]The expected rate is the rate that would be expected for the facility given the risk-adjustment profile of the facility.

*[6]Risk-adjusted rate is adjusted for the expected rate of the outcome and is calculated as (observed rate for facility / expected rate for facility) * national average of observed rate. Only the risk-adjusted rate will appear on Nursing Home Compare.*

[7]This measure includes some imputed data because there are fewer than 20 resident assessments or stays across the four quarters. This value is used in calculating the QM points and used in the QM rating calculation but will not be displayed on Nursing Home Compare.

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QM Score Table

QM thresholds update every 6 months. The QM thresholds will increase by 50% oft he 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.

Table 6
Point Ranges for the QM Ratings (as of April 2019)

QM Rating	Long-Stay QM Rating Thresholds	Short-Stay QM Rating Thresholds	Overall QM Rating Thresholds
★	175 – 524	167 – 541	342 - 1066
★★	525 – 619	542 – 638	1067 – 1258
★★★	620 – 704	639 – 714	1259 – 1419
★★★★	705 – 799	715 – 805	1420 – 1605
★★★★★	800 - 1250	806 – 1250	1606 - 2500

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

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3. STAFFING

Survey Results → Staffing → Quality Measures

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Staffing

3 Calculations

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

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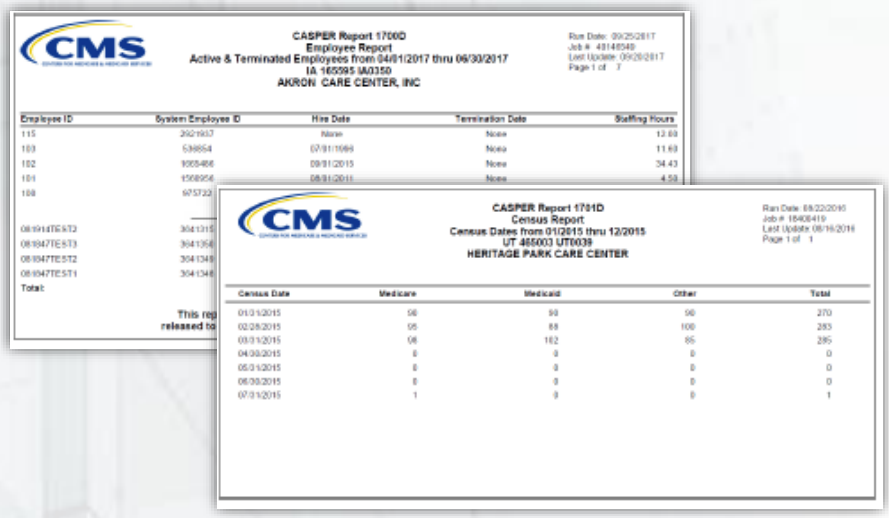
CASPER Employee & Census Report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CASPER Report 1700D
Employee Report
Active & Terminated Employees from 04/01/2017 thru 06/30/2017
IA 165595 IA0350
AKRON CARE CENTER, INC

Employee ID	System Employee ID	Hire Date	Termination Date	Staffing Hours
115	2921937	None	None	12.69
103	538854	07/01/1999	None	11.69
102	1065486	09/01/2015	None	34.43
101	1508956	08/01/2011	None	4.58
108	975722			
08191ATEST3	3041315			
08194ATEST3	3041356			
08194ATEST2	3041348			
08194ATEST1	3041346			
Total:				

This rep
released to

CMS

CASPER Report 1701D
Census Report
Census Dates from 01/2015 thru 12/2015
UT 465003 UT0039
HERITAGE PARK CARE CENTER

Census Date	Medicare	Medicaid	Other	Total
01/31/2015	98	99	99	270
02/28/2015	95	88	100	283
03/31/2015	98	102	85	285
04/30/2015	0	0	0	0
05/31/2015	0	0	0	0
06/30/2015	0	0	0	0
07/31/2015	1	0	0	1

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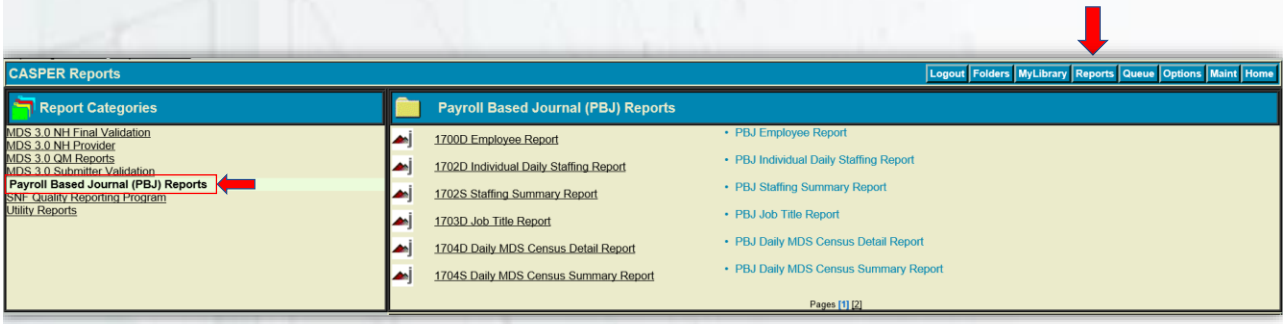
Pulling Staffing Reports from QIES



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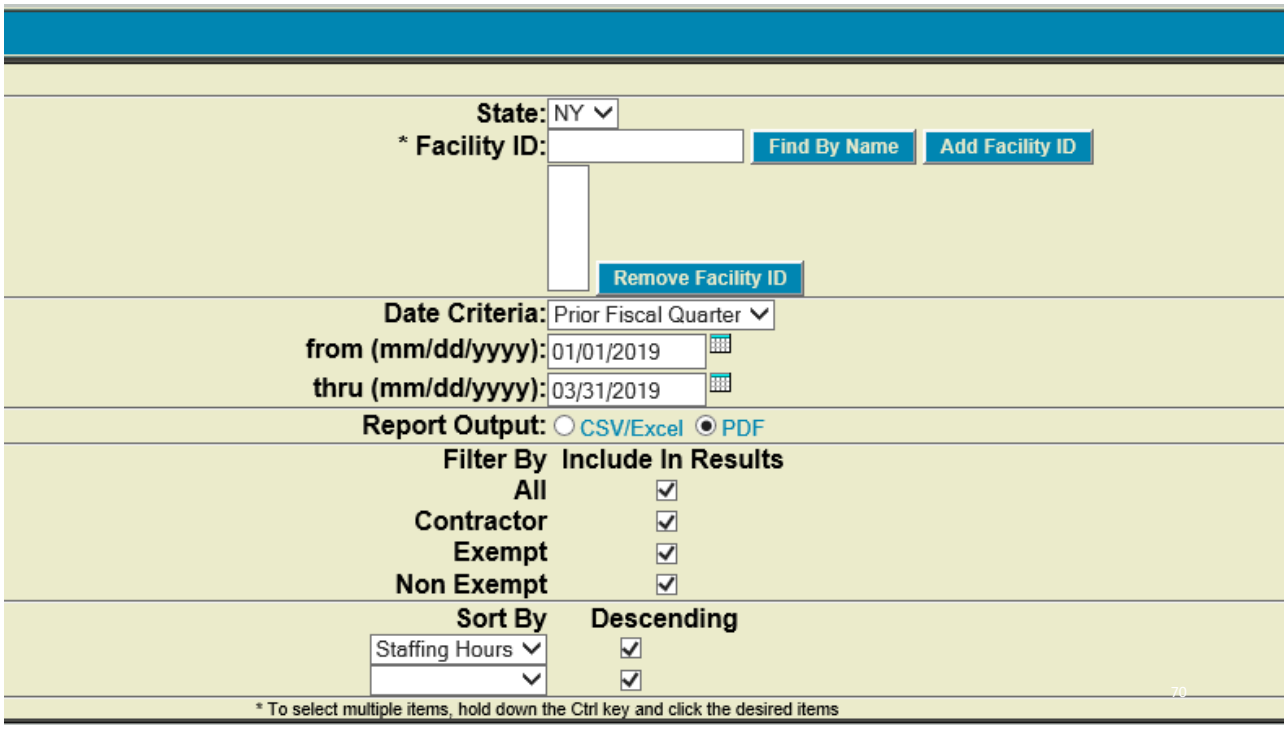

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Actual Staffing Hours PPD

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)

Position	Hours Worked	# of Days	Census	HRD
RN	4,500	90	100	.5
LPN	7,500	90	100	.833
Nurse Aide	17,400	90	100	1.933
Total	29,400	90	100	3.266

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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

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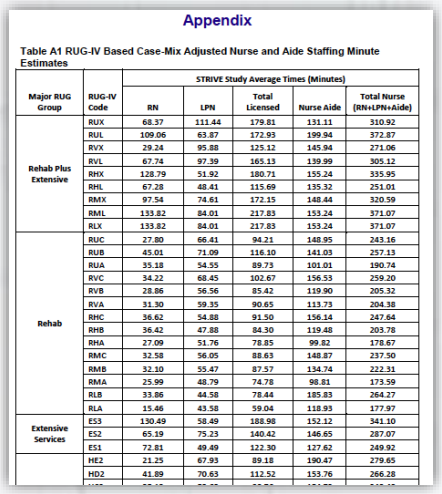
STRIVE Estimates

Five-Star Quality Rating System: Technical Users' Guide



Appendix

Table A1 RUG-IV Based Case-Mix Adjusted Nurse and Aide Staffing Minute Estimates

Major RUG Group	RUG-IV Code	STRIVE Study Average Times (Minutes)				
		RN	LPN	Total Licensed	Nurse Aide	Total Nurse (RN+LPN+Aide)
Rehab Plus Extensive	RUX	68.37	111.44	179.81	131.11	310.92
	RUL	109.06	63.87	172.93	199.94	372.87
	RVX	29.24	95.88	125.12	145.94	271.06
	RVL	67.74	97.39	165.13	139.99	305.12
	RHX	128.79	51.92	180.71	155.24	335.95
	RHL	67.28	48.41	115.69	135.32	251.01
	RMX	97.54	74.61	172.15	148.44	320.59
	RML	133.82	84.01	217.83	153.24	371.07
	RLX	133.82	84.01	217.83	153.24	371.07
Rehab	RUC	27.80	66.41	94.21	148.95	243.16
	RUB	45.01	71.09	116.10	141.03	257.13
	RUA	35.18	54.55	89.73	101.01	190.74
	RVC	34.22	68.45	102.67	156.53	259.20
	RVB	28.86	56.56	85.42	119.90	205.32
	RVA	31.30	59.35	90.65	113.73	204.38
	RHC	36.62	54.88	91.50	156.14	247.64
	RHB	36.42	47.88	84.30	119.48	203.78
	RHA	27.09	51.76	78.85	99.82	178.67
	RMC	32.58	56.05	88.63	148.87	237.50
	RMB	32.10	55.47	87.57	134.74	222.31
	RMA	25.99	48.79	74.78	98.81	173.59
	RLB	33.86	44.58	78.44	185.83	264.27
	RLA	15.46	43.58	59.04	118.93	177.97
Extensive Services	ES3	130.49	58.49	188.98	152.12	341.10
	ES2	65.19	75.23	140.42	146.65	287.07
	ES1	72.81	49.49	122.30	127.62	249.92
	HE2	21.25	67.93	89.18	190.47	279.65
	HD2	41.89	70.63	112.52	153.76	266.28

CMS Five Star Users Manual:
https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/CertificationandComplianc/Downloads/Five-Star-Users-Guide-April-2019.pdf

Adjusted Staffing Hours PPD

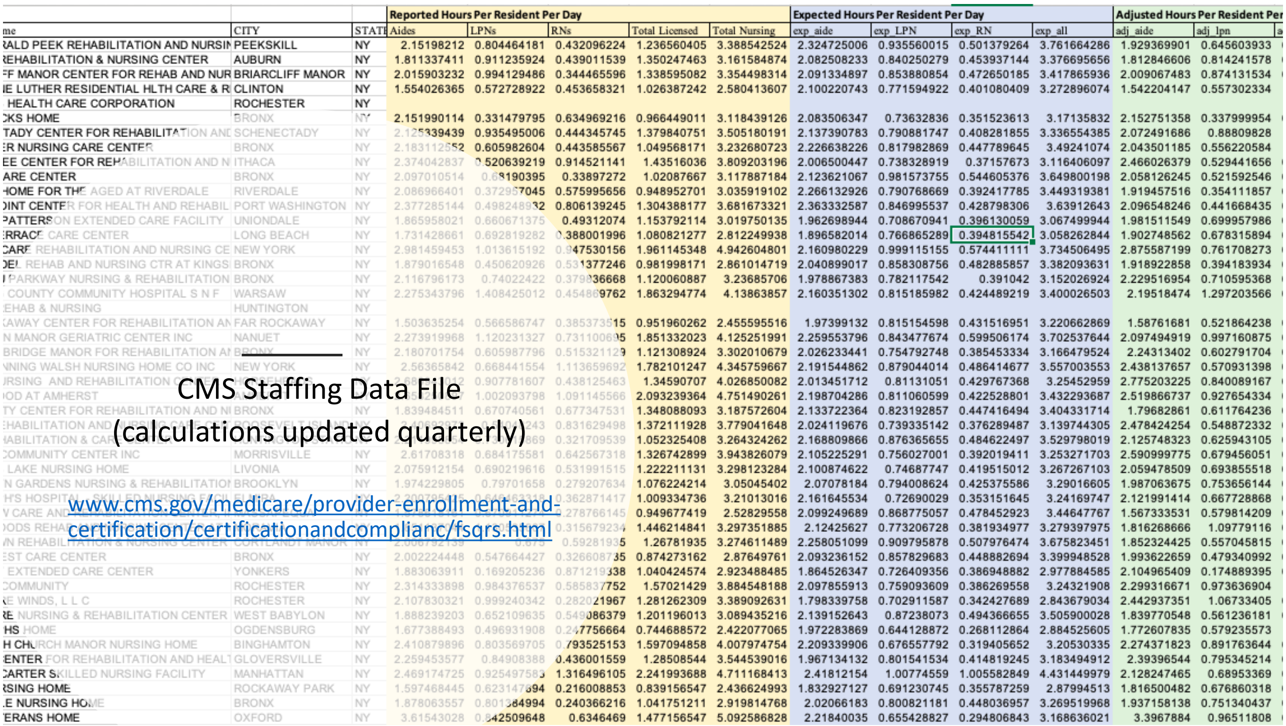
Case Mix Adjusted based on RUG Categories

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

Table 3
National Average Hours per Resident Day Used To Calculate Adjusted Staffing (as of April 2018)

Type of staff	National average expected hours per resident per day
Total nursing staff (Aides + LPNs + RNs)	3.2285
Registered nurses	0.3804

- National Hours Average (updated quarterly)
https://data.medicare.gov/data/nursing-home-compare



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Five Star Staffing Calculation uses the Adjusted Staffing

Staffing Points and Rating (updated April 2019)						
		Total nurse staffing rating and hours (RN, LPN, and nurse aide)				
		1	2	3	4	5
		< 3.107	3.107 – 3.573	3.574 – 4.037	4.038 – 4.403	≥ 4.404
RN rating and hours 1	< 0.316	★	★	★★	★★	★★★
2	0.316 – 0.500	★★	★★	★★	★★★	★★★
3	0.501 – 0.723	★★	★★★	★★★	★★★★	★★★★
4	0.724 – 1.041	★★★	★★★	★★★★	★★★★	★★★★
5	≥ 1.042	★★★	★★★★	★★★★	★★★★★	★★★★★

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

Position	Hours Worked	# of Days	Census	HRD
RN	4,500	90	100	.5
LPN	7,500	90	100	.833
Nurse Aide	17,400	90	100	1.933
Total	29,400	90	100	3.266

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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

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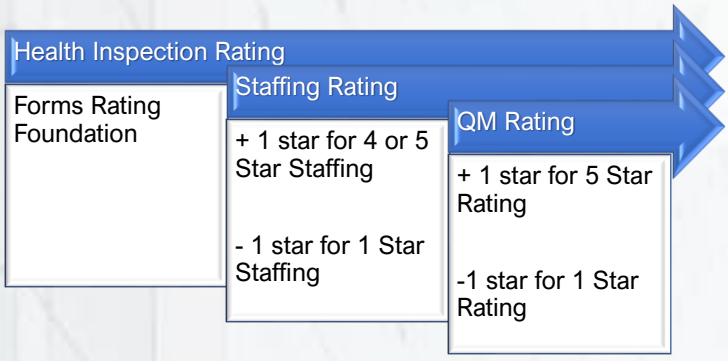
Rating Calculation



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.

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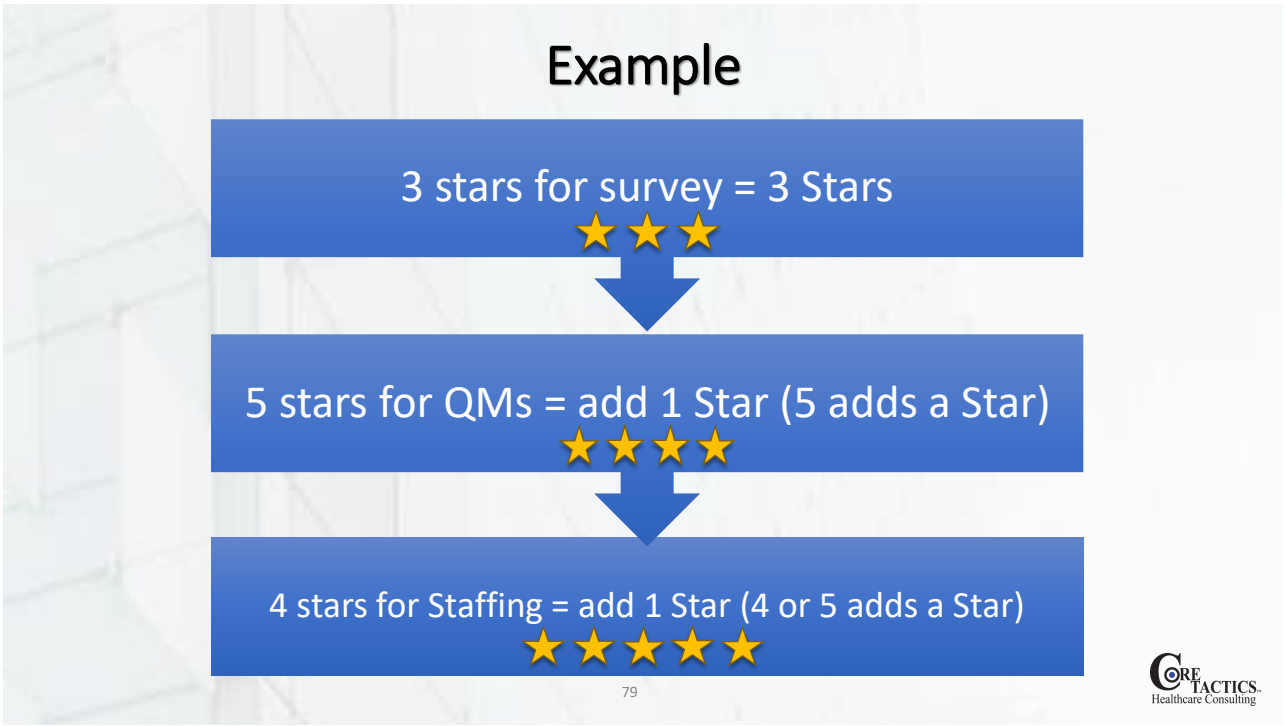
Example
3 stars for survey = 3 Stars
5 stars for QMs = add 1 Star (5 adds a Star)
4 stars for Staffing = add 1 Star (4 or 5 adds a Star)
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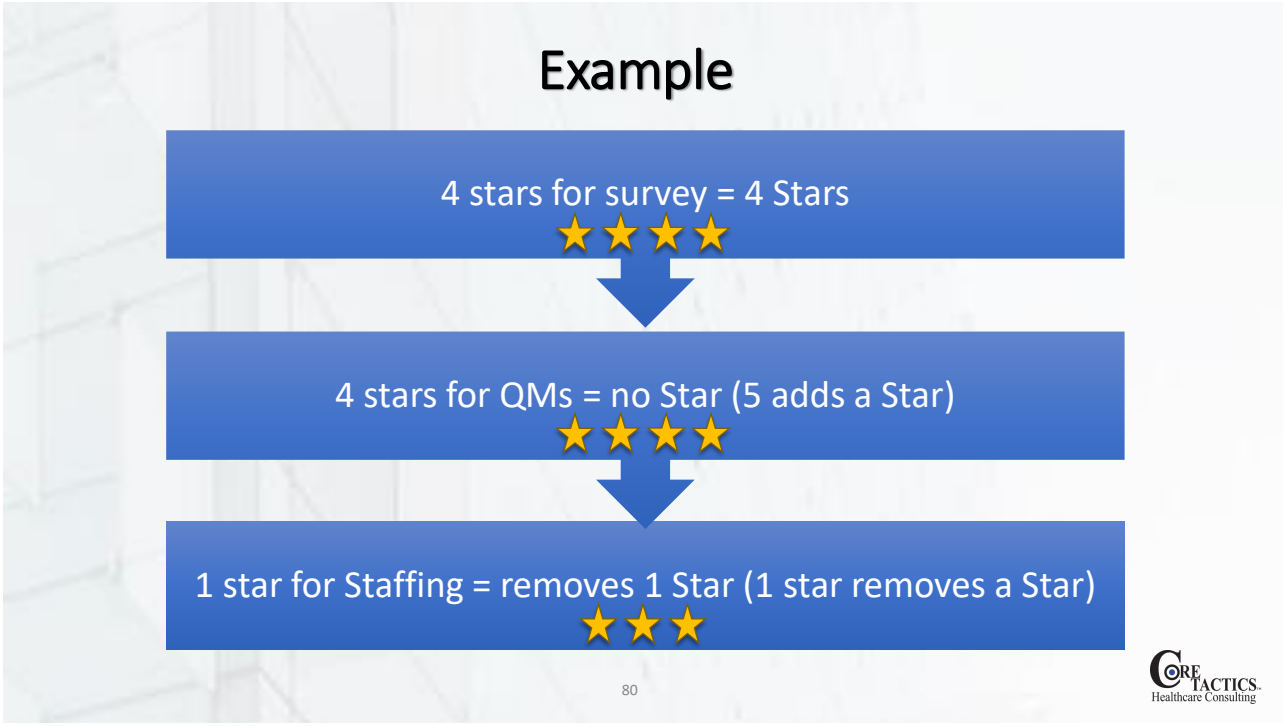
Example
4 stars for survey = 4 Stars
4 stars for QMs = no Star (5 adds a Star)
1 star for Staffing = removes 1 Star (1 star removes a Star)
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MDS Accuracy

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!

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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

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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

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Opportunities are found in Data!

Are there system changes needed?

- Policies & Procedures
- Staff communication
- Staff education
- Equipment
- Environment

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PROFITS
SALES
"What if we don't change at all ...
and something magical just happens?"

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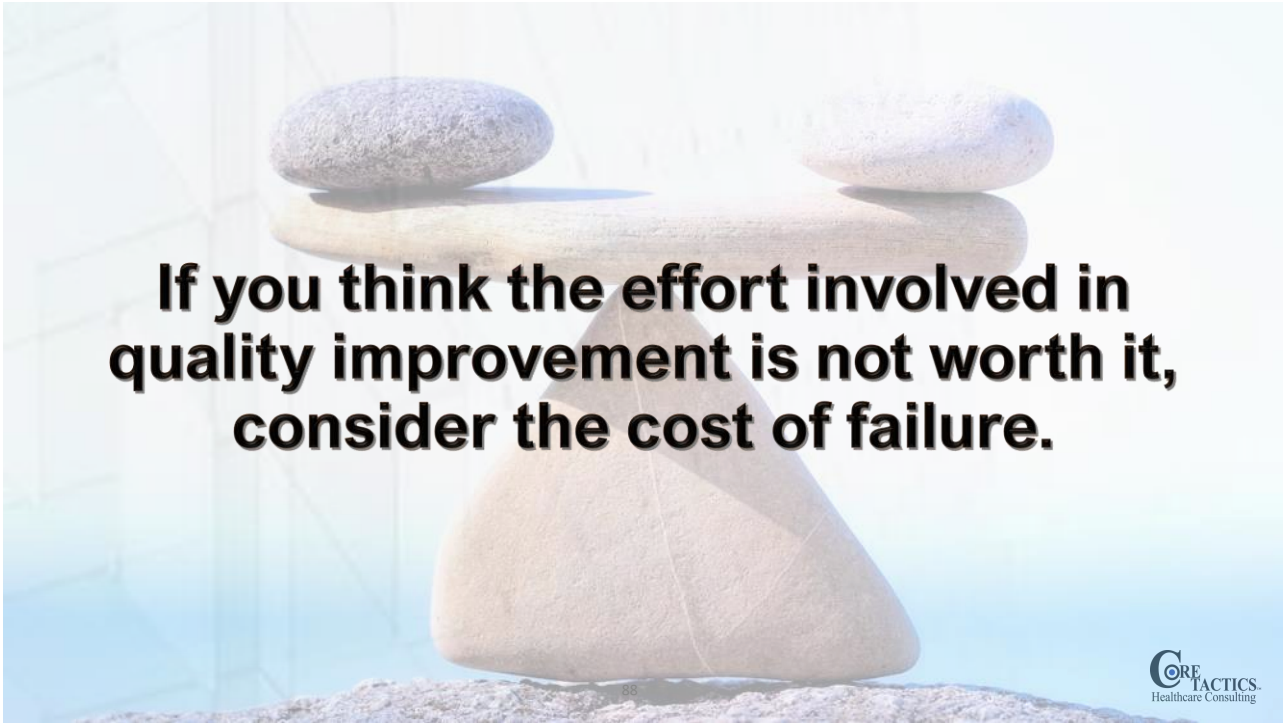
If you think the effort involved in quality improvement is not worth it, consider the cost of failure.

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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.

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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

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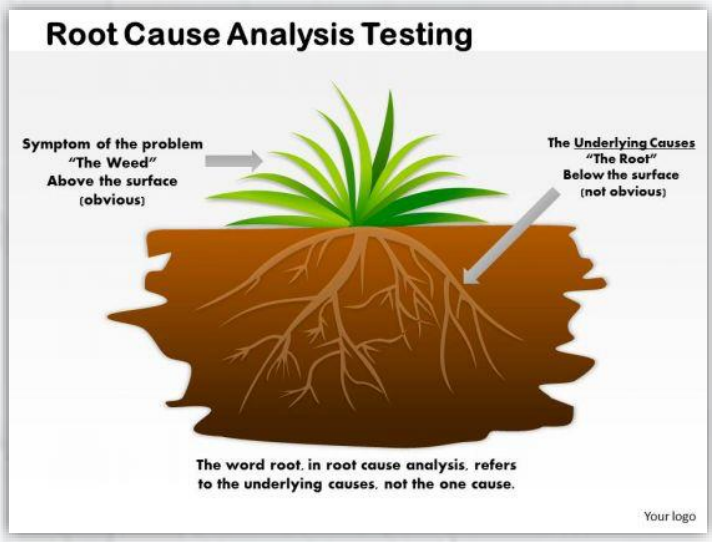
Root Cause Analysis Testing



The solution to the problem generally lies closest to the problem.

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

Opportunity → Root Cause 5 Why's → Corrective Actions → Monitoring

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

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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 <u>she rolled out of bed</u>, 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.

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QAPI Element 5 Analysis & Action

Systematic Analysis & Systemic Action

- **Root Cause Analysis**

  Examples:
  - Five Whys
  - Flowcharting
  - Fishbone Diagram

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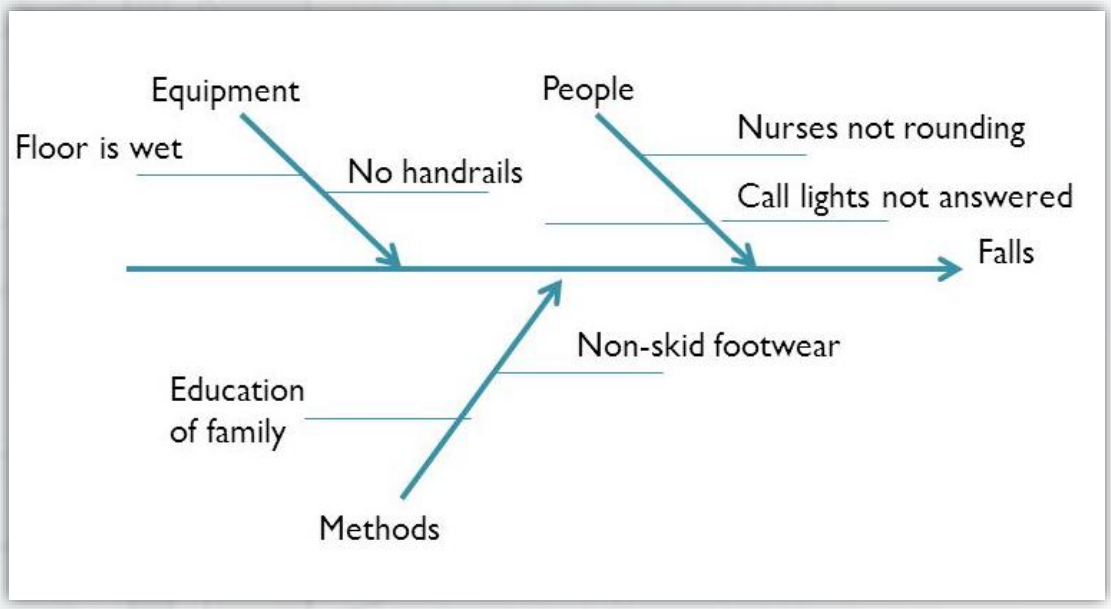

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RCA Scenario

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 then 50% for several weeks."
Why is he eating less?	**CNA**: "He has a sore in his mouth and he won't wear his dentures."

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PDCA: Just like a Care Plan

Performance Improvement Plan (PIP) Team Report

Facility: Date:

- Include dates when Intervention was implemented; when review of interventions occurred and when standardized solution was implemented or the PDCA cycle was continued.

Plan		Do	Check	Act
Problem/Concern/ Opportunity	Objective Goal	Interventions	Review of Interventions	Continue PDCA Cycle or standardized solution (policy updated)

Sustained Improvement

Privileged Document for Internal QA/QI Purposes Only

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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

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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

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Encourage Opportunities to be Reported

Quality Improvement Opportunity Request
[FACILITY NAME]

Opportunity Identified by: _____ **Date:** _____

Reason for Review: ❑ Quality / Satisfaction Issue ❑ Performance Concern ❑ Environmental
❑ Other (Specify)_____

IDENTIFIED OPPORTUNITY:

RECOMMENDATIONS:

This form is for use by any stakeholder who identifies an opportunity for improvement.
Please forward to the facility Administrator

To Be Completed by Facility Staff

Administrator Comments:

PIP Team Requested ❑ Yes ❑ No Signature_____ Date_____

Manager Comments:

PIP Team Requested ❑ Yes ❑ No Signature_____ Date_____

Facility QAPI Committee Findings:

PIP Team Approved ❑ Yes ❑ No Team Chairperson: _____

QAPI Committee Initials: _____

Privileged Document for Internal QA/QI Purposes Only

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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?

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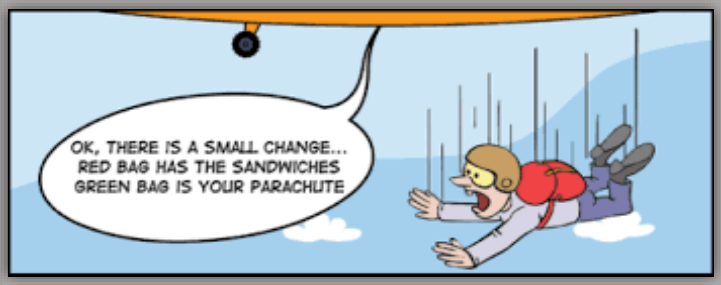
Communication is KEY!



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Thank You for Joining us Today!

Any Questions?

Sarah Ragone, MSPT, RAC-CT, QCP

VP of Reimbursement & Education

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