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The Alliance Training Center

BROAD RIVER REHAB

Quality Measurement

Applying and Understanding of the Basics

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ACCREDITED PROVIDER
AMERICAN NURSES CREDENTIALING CENTER

APPROVAL STATEMENT DISCLOSURE

- This nursing continuing professional development activity was approved by Broad River Rehab, an accredited approver by the American Nurses Credentialing Center's Commission on Accreditation.
- This course has been approved for 1.5 contact hours.

CONFLICT OF INTEREST DISCLOSURE

- Broad River Rehab is not charging for this educational offering and has no financial or other conflicts of interest regarding this program.

SUCCESSFUL COMPLETION REQUIREMENTS

- **Live, in-person**
  - In order to obtain nursing contact hours, you must attend the entire activity, participate in case study analysis, and complete the evaluation.
- **Live, virtual**
  - In order to obtain nursing contact hours, you must participate in the entire program, participate in audience polling and/or Q&A and complete the evaluation.
- **Web-Based/On-Demand**
  - In order to obtain nursing contact hours, you must view the entire program, and complete the evaluation.

DISCLOSURE OF THE EXPIRATION DATE FOR AWARDING CONTACT HOURS FOR ENDURING PROGRAMS

- Contact hours for this program will not be awarded after October 1, 2022

Quality Measurement

Applying and Understanding of the Basics

Agenda

Agenda

- A history of Quality Measurement (The Road to Value)
- Technically speaking…
- Specifics: Improvement in Function
- How does this apply to my residents?
- An interdisciplinary approach
- Q&A

Quality Measurement: a history lesson

- Quality Indicators… Anyone… Anyone?
- Current LTC Quality Reporting
  - CASPER QM Reports
  - Quality Measures
  - Care Compare
  - 5-Star Rating
  - Skilled Nursing Facility Value Based Purchasing (SNF VBP)
  - Skilled Nursing Facility Quality Reporting Program (SNF QRP)
  - Meaningful Measures
- List of Current Publicly Reported Quality Measures (See handout)

Quality Measurement: a history lesson

- **CMS National Quality Strategy:** The Centers for Medicare & Medicaid Services (CMS) will set and raise the bar for:
  - A resilient, high-value health care system that promotes quality outcomes, safety, equity, and accessibility for all individuals, especially for people in historically underserved and under-resourced communities.
  - The CMS National Quality Strategy takes a person-centered approach to quality and safety and seeks to improve the overall care journey as individuals move across the continuum of care, from home or community-based settings to hospitals and post-acute care.
  - This initiative will depend on the focus of every person and entity working to optimize a person-centered approach to care that improves safety and quality.

National Quality Strategy Priorities

- CMS National Quality Strategy consists of eight focused and interrelated goals:
  - Embed Quality into the Care Journey
  - Advance Health Equity
  - Promote Safety to Achieve Zero Preventable Harm
  - Foster Engagement to Improve Quality and Build Trust
  - Strengthen Resiliency in the Health Care System
  - Embrace the Digital Age
  - Incentivize Innovation and Technology Adoption to Drive Care Improvements
  - **Increase Quality Measurement Alignment to Promote Seamless and Coordinated Care**

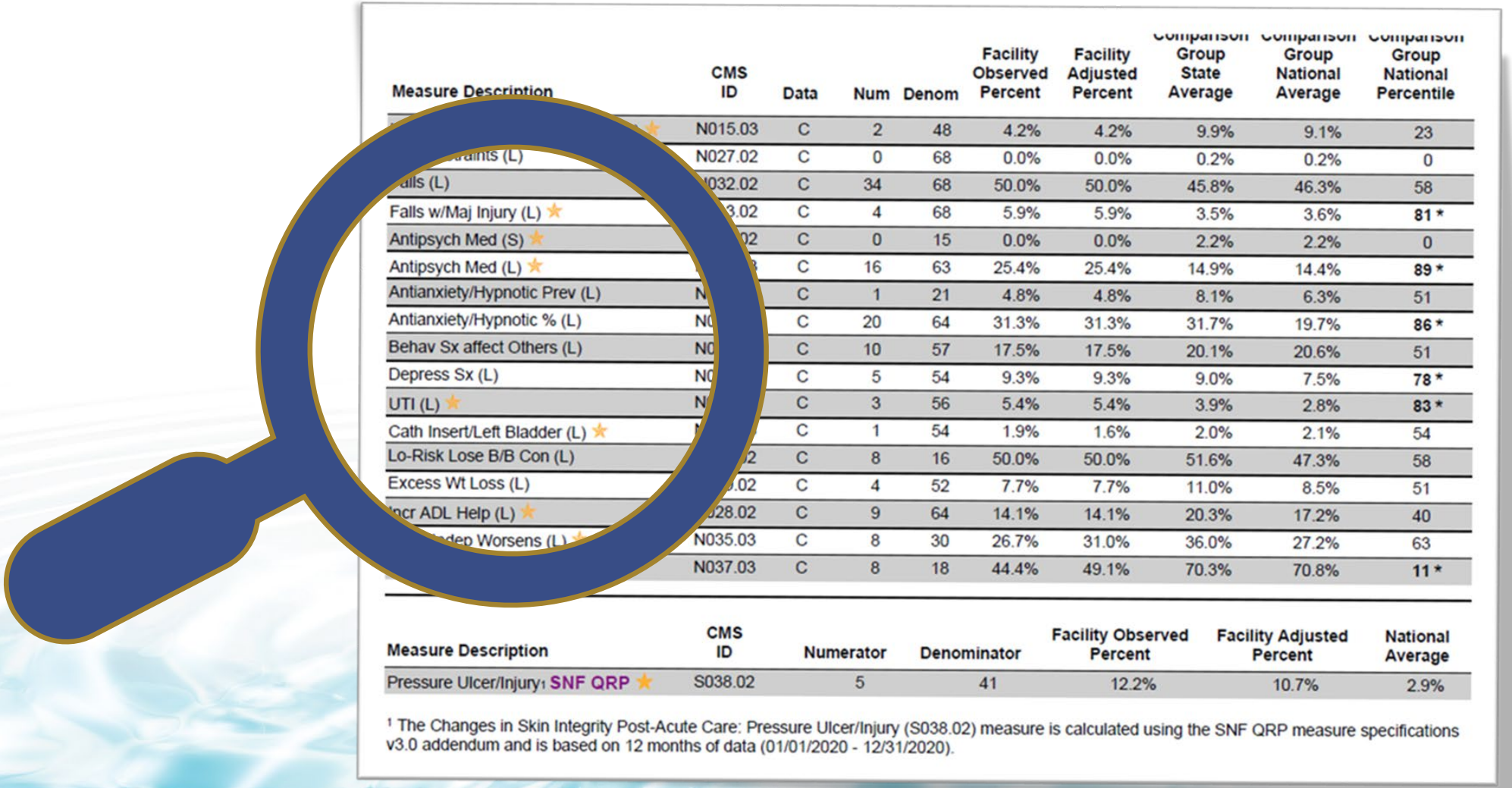
Meaningful measures 2.0

- **Meaningful Measures 2.0 supports five interrelated goals. Click the title of each goal for more details.**
  - Empower consumers to make good health care choices through patient-directed quality measures and public transparency.
  - Leverage quality measures to promote health equity and close gaps in care.
  - **Use the Meaningful Measures Initiative to streamline quality measurement.**
  - Leverage measures to drive outcome improvement through public reporting and payment programs.
  - Improve quality measure efficiency by transitioning to digital measures and using advanced data analytics.

Quality Measurement Future

- CMS has finalized the adoption of one new measure for the SNF QRP beginning with the FY 2024 SNF QRP: the **Influenza Vaccination Coverage among Healthcare Personnel (HCP) (NQF #0431) measure.**
- CMS finalized a revision to the compliance date for the collection of the **Transfer of Health (TOH) Information to the Provider-PAC measure, the TOH Information to the Patient-PAC measure**, and the **six categories of standardized patient assessment data elements** on the **MDS v1.18.11** from October 1st of the year that is at least 2 full fiscal years after the end of the COVID-19 PHE to October 1, 2023.
- CMS has finalized the adoption of two new quality measures for the SNF VBP Program beginning with the FY 2026 program year:
  - (1) Skilled Nursing Facility (SNF) Healthcare Associated Infections (HAI) Requiring Hospitalization (SNF HAI) measure (Patient Safety Domain – Meaningful Measures 2.0 Framework);
  - (2) Total Nursing Hours per Resident Day Staffing (Total Nurse Staffing) measure (Person Centered Care Domain – Meaningful Measures 2.0 Framework).

Focus: CASPER and QM Manual v. 15.0



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
[illegible] ★	N015.03	C	2	48	4.2%	4.2%	9.9%	9.1%	23
[illegible]raints (L)	N027.02	C	0	68	0.0%	0.0%	0.2%	0.2%	0
[illegible]alls (L)	[illegible]032.02	C	34	68	50.0%	50.0%	45.8%	46.3%	58
Falls w/Maj Injury (L) ★	[illegible]3.02	C	4	68	5.9%	5.9%	3.5%	3.6%	**81 ***
Antipsych Med (S) ★	[illegible]02	C	0	15	0.0%	0.0%	2.2%	2.2%	0
Antipsych Med (L) ★	[illegible]	C	16	63	25.4%	25.4%	14.9%	14.4%	**89 ***
Antianxiety/Hypnotic Prev (L)	N[illegible]	C	1	21	4.8%	4.8%	8.1%	6.3%	51
Antianxiety/Hypnotic % (L)	N[illegible]	C	20	64	31.3%	31.3%	31.7%	19.7%	**86 ***
Behav Sx affect Others (L)	N[illegible]	C	10	57	17.5%	17.5%	20.1%	20.6%	51
Depress Sx (L)	N[illegible]	C	5	54	9.3%	9.3%	9.0%	7.5%	**78 ***
UTI (L) ★	N[illegible]	C	3	56	5.4%	5.4%	3.9%	2.8%	**83 ***
Cath Insert/Left Bladder (L) ★	[illegible]	C	1	54	1.9%	1.6%	2.0%	2.1%	54
Lo-Risk Lose B/B Con (L)	[illegible]2	C	8	16	50.0%	50.0%	51.6%	47.3%	58
Excess Wt Loss (L)	[illegible].02	C	4	52	7.7%	7.7%	11.0%	8.5%	51
[illegible]ncr ADL Help (L) ★	[illegible]028.02	C	9	64	14.1%	14.1%	20.3%	17.2%	40
[illegible]dep Worsens (L) ★	N035.03	C	8	30	26.7%	31.0%	36.0%	27.2%	63
[illegible]	N037.03	C	8	18	44.4%	49.1%	70.3%	70.8%	**11 ***

Measure Description	CMS ID	Numerator	Denominator	Facility Observed Percent	Facility Adjusted Percent	National Average
Pressure Ulcer/Injury[1] SNF QRP ★	S038.02	5	41	12.2%	10.7%	2.9%

[1] The Changes in Skin Integrity Post-Acute Care: Pressure Ulcer/Injury (S038.02) measure is calculated using the SNF QRP measure specifications v3.0 addendum and is based on 12 months of data (01/01/2020 - 12/31/2020).

Quality Measures Data

- Originates in the MDS database for appropriate cases during the reporting period
- Specific data that is the focus of the measure must be coded on the MDS – only source
- The data for the measure must follow MDS rules for coding and be reproduceable
- Many measures have data exclusions which block the assessment data from the QM calculation

Emphasis on Data Accuracy and Timelines of Assessment Validation

- Frequently QM data is not truly representative of the events or conditions being measured if the coding on the MDS is not accurate
- Reporting of changes in functional status during a stay can be missed if ADL – or functional scores are not properly assessed and documented in the medical record
- Assessments that are transmitted but not validated can influence the amount of data reporting

Importance of Data Accuracy and Data Formulation Processes

- If Quality Measures are not accurate for the facility population, significant negative outcomes can happen – data accuracy problems distort the data
- Data formulation policies that produce consistent data with reproducibility is the best situation
- The IDT must understand the MDS 3.0 database that creates the Quality Measure statistics and the influence of the exclusions
- Periodic audits of QM data from the Reports to the MDS to the medical record can confirm data accuracy and signal the need for internal policy review

Quality Measure Definitions

- **Target period:** The span of time that defines the QM reporting period (e.g., a calendar quarter).
- **Influenza Season:** Influenza season is July 1 of the current year to June 30 of the following year (e.g., July 1, 2019, through June 30, 2020, for the 2019 – 2020 influenza season).
- **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, thus defined, may include interrupted stays lasting 3 calendar days or less. 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

Quality Measure Definitions

- **Interrupted Stay:** During a stay, the resident had an interruption in their stay and resumed the same stay within three consecutive calendar days. Interrupted stays apply only to Medicare-covered stays and pertain to both short- and long-stay resident episodes.
- **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 within 30 days of discharge, or
  - A death in facility tracking record (A0310F = [12]), or
  - The end of the target period.

Quality Measure 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.
- **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.

Quality Measure 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), and/or one or more stays with interruptions lasting 3 calendar days or less, 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. The following rules are used when computing CDIF:
  - When counting the number of days until the end of the episode, counting stops with:
    - (a) the last record in the target period if that record is a discharge assessment (A0310F = [10, 11]),
    - (b) the last record in the target period if that record is a death in facility (A0310F = [12]), or
    - (c) the end of the target period is reached, whichever is earlier.

Quality Measure Definitions

- **Cumulative days in facility (cont.):**
  - When counting the duration of each stay within an episode, include the day of entry (A1600) but not the day of discharge (A2000) unless the entry and discharge occurred on the same day in which case the number of days in the stay is equal to 1.
    - For example: if a resident is admitted on Monday and discharged the following day (Tuesday), the duration of that episode would be 1 day.
  - While death in facility records (A0310F = [12]) end CDIF counting, these records are not used as target records because they contain only tracking information and do not include clinical information necessary for QM calculation

Quality Measure Definitions

- **Cumulative days in facility (cont.):**
  - **Special rules for influenza vaccination measures.** Influenza vaccination measures are calculated only once per 12-month influenza season, which begins July 1 of a given year and ends on June 30 of the subsequent year. For these measures, the target period begins on October 1 and ends on March 31. This means that the end-of-episode date will be March 31 for an episode that is ongoing at the end of the influenza season and that March 31 should be used as the end date when computing CDIF and for classifying stays as long or short for the influenza vaccination measures.
    - Note, the target period (i.e., October 1 – March 31) is different than the selection period, which begins October 1 and ends June 30 of the following year. The selection period for the influenza vaccination measures is discussed more in Sections 3 and 4 below

Quality Measure Definitions

- **Short stay:** An episode with CDIF less than or equal to 100 days as of the end of the target period. Short stays may include one or more interruptions, indicated by Interrupted Stay (A0310G1 = [1]).
- **Long stay:** An episode with CDIF greater than or equal to 101 days as of the end of the target period. Long stays may include one or more interruptions, indicated by Interrupted Stay (A0310G1 = [1]).
- **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 (ARD, A2300).

Quality Measure Sample Selection

- Two resident samples are selected for computing the QMs: a short-stay sample and a long-stay sample. These samples are selected using the following steps:

1. Select all residents whose latest episode either ends during the target period or is ongoing at the end of the target period. This latest episode is selected for QM calculation.
2. For each episode that is selected, compute the cumulative days in the facility (CDIF).
3. If the CDIF is less than or equal to 100 days, the resident is included in the short-stay sample.
4. If the CDIF is greater than or equal to 101 days, the resident is included in the long-stay sample.

Note that all residents who are selected in Step 1 above will be placed in either the short- or long-stay sample and that the two samples are mutually exclusive. If a resident has multiple episodes within the target period, only the latest episode is used.

Quality Measure Record Definitions

Within each sample, **certain key records are identified** which are used for calculating individual measures.

- Short Stay Records

ASSESSMENT SELECTED	PROPERTY	SELECTION SPECIFICATIONS
Target assessment	Selection period	Most recent 6 months (the short stay target period).
	Qualifying RFAs[2]	A0310A = [01, 02, 03, 04, 05, 06] *or* A0310B = [01] *or* A0310F = [10, 11]
	Selection logic	Latest assessment that meets the following criteria: (a) it is contained within the resident's selected episode, (b) it has a qualifying RFA, and (c) its target date is no more than 120 days[3] before the end of the episode.
	Rationale	Records with a qualifying RFA contain all of the items needed to define the QMs. The target assessment need not have a target date within the target period, but it must occur within 120 days before the end of the resident's selected episode (either the target date of a discharge assessment or death in facility record that is the last record in the target period or the end of the target period if the episode is ongoing). 120 days allows 93 days between quarterly assessments plus an additional 27 days to allow for late assessments. The target assessment represents the resident's status at the end of the episode.

Quality Measure Record Definitions

Within each sample, **certain key records are identified** which are used for calculating individual measures.

- Short Stay Records

Initial assessment	Selection period	First assessment following the admission entry record at the beginning of the resident's selected episode.
	Qualifying RFAs	A0310A = [01] *or* A0310B = [01] *or* A0310F = [10, 11]
	Selection logic	Earliest assessment that meets the following criteria: (a) it is contained within the resident's selected episode, (b) it has a qualifying RFA, (c) it has the earliest target date that is greater than or equal to the admission entry date starting the episode, and (d) its target date is no more than 130 days prior to the target date of the target record. The initial assessment cannot be the same as the target assessment. If the same assessment qualifies as both the initial and target assessments, it is used as the target assessment and the initial assessment is considered to be missing.
	Rationale	Records with a qualifying RFA contain all of the items needed to define the QMs. The initial assessment need not have a target date within the target period. The initial assessment represents the resident's status as soon as possible after the admission that marks the beginning of the episode. If the initial assessment is more than 130 days prior to the target assessment, it is not used and the initial record is considered to be missing. This prevents the use of an initial assessment for a short stay in which a large portion of the resident's episode was spent outside the facility. 130 days allows for as many as 30 days of a 100-day stay to occur outside of the facility.

Quality Measure Record Definitions

Within each sample, **certain key records are identified** which are used for calculating individual measures.

- Short Stay Records

ASSESSMENT SELECTED	PROPERTY	SELECTION SPECIFICATIONS
Look-back Scan	Selection period	Scan all qualifying RFAs within the current episode.
	Qualifying RFAs	A0310A = [01, 02, 03, 04, 05, 06] *or* A0310B = [01] *or* A0310F = [10, 11]
	Selection logic	Include the target assessment and qualifying earlier assessments in the scan. Include an earlier assessment in the scan if it meets all of the following conditions: (a) it is contained within the resident's episode, (b) it has a qualifying RFA, and (c) its target date is on or before the target date for the target assessment. The target assessment and qualifying earlier assessments are scanned to determine whether certain events or conditions occurred during the look-back period. These events and conditions are specified in the definitions of measures that utilize the look-back scan.
	Rationale	Some measures utilize MDS items that record events or conditions that occurred since the prior assessment was performed. The purpose of the look-back scan is to determine whether such events or conditions occurred during the look-back period. All qualifying RFAs with target dates within the episode are examined to determine whether the event or condition of interest occurred at any time during the episode.

Quality Measure Record Definitions

Within each sample, **certain key records are identified** which are used for calculating individual measures.

- Short Stay Records

Influenza vaccination assessment	Selection period[4]	All assessments with target dates on or after October 1 of the most recently completed influenza season (i.e., the target date must be on or between October 1 of the current year and June 30 of the following year).
	Qualifying RFAs	A0310A = [01, 02, 03, 04, 05, 06] *or* A0310B = [01] *or* A0310F = [10, 11]
	Selection logic	Select the record with the latest target date that meets all of the following conditions: a) It has a qualifying RFA, *and* b) Target date is on or after October 1 of the most recently completed influenza season (i.e., the target date must fall on or between October 1 and June 30), *and* c) A1600 (entry date) is on or before March 31 of the most recently completed influenza season.
	Rationale	The selection logic defined above is intended to identify the latest assessment that reports the influenza vaccine status for a resident who was in the facility for at least one day from October 1 through March 31.

Quality Measure Record Definitions

Within each sample, **certain key records are identified** which are used for calculating individual measures.

- Long Stay Records

ASSESSMENT SELECTED	PROPERTY	SELECTION SPECIFICATIONS
Target assessment	Selection period	Most recent 3 months (the long stay target period).
	Qualifying RFAs	A0310A = [01, 02, 03, 04, 05, 06] *or* A0310B = [01] *or* A0310F = [10, 11]
	Selection logic	Latest assessment that meets the following criteria: (a) it is contained within the resident's selected episode, (b) it has a qualifying RFA, and (c) its target date is no more than 120 before the end of the episode.
	Rationale	Records with a qualifying RFA contain all of the items needed to define the QMs. The target assessment need not have a target date within the target period, but it must occur within 120 days of the end of the resident's episode (either the last discharge in the target period or the end of the target period if the episode is ongoing). 120 days allows 93 days between quarterly assessments plus an additional 27 days to allow for late assessments. The target assessment represents the resident's status at the end of the episode.

Quality Measure Record Definitions

Within each sample, **certain key records are identified** which are used for calculating individual measures.

- Long Stay Records

Prior assessment	Selection period	Latest assessment that is 46 to 165 days before the target assessment.
	Qualifying RFAs	A0310A = [01, 02, 03, 04, 05, 06] *or* A0310B = [01] *or* A0310F = [10, 11]
	Selection logic	Latest assessment that meets the following criteria: (a) it is contained within the resident's episode, (b) it has a qualifying RFA, and (c) its target date is contained in the window that is 46 days to 165 days preceding the target date of the target assessment. If no qualifying assessment exists, the prior assessment is considered missing.
	Rationale	Records with a qualifying RFA contain all of the items needed to define the QMs. The prior assessment need not have a target date within the target period, but it must occur within the defined window. The window covers 120 days, which allows 93 days between quarterly assessments plus an additional 27 days to allow for late assessments. Requiring a 45-day gap between the prior assessment and the target assessment insures that the gap between the prior and target assessment will not be small (gaps of 45 days or less are excluded).

Quality Measure Record Definitions

Within each sample, **certain key records are identified** which are used for calculating individual measures.

- Long Stay Records

ASSESSMENT SELECTED	PROPERTY	SELECTION SPECIFICATIONS
Look-back Scan	Selection period	Scan all qualifying RFAs within the current episode that have target dates no more than 275 days prior to the target assessment.
	Qualifying RFAs	A0310A = [01, 02, 03, 04, 05, 06] *or* A0310B = [01] *or* A0310F = [10, 11]
	Selection logic	Include the target assessment and all qualifying earlier assessments in the scan. Include an earlier assessment in the scan, if it meets all of the following conditions: (a) it is contained within the resident's episode, (b) it has a qualifying RFA, (c) its target date is on or before the target date for the target assessment, and (d) its target date is no more than 275 days prior to the target date of the target assessment. The target assessment and qualifying earlier assessments are scanned to determine whether certain events or conditions occurred during the look-back period. These events and conditions are specified in the definitions of measures that utilize the look-back scan.
	Rationale	Some measures utilize MDS items that record events or conditions that occurred since the prior assessment was performed. The purpose of the look-back scan is to determine whether such events or conditions occurred during the look-back period. These measures trigger if the event or condition of interest occurred any time during a one year period. A 275-day time period is used to include up to three quarterly OBRA assessments. The earliest of these assessments would have a look-back period of up to 93 days, which would cover a total of about one year. All qualifying RFAs with target dates in this time period are examined to determine whether the event or condition of interest occurred at any time during the time interval.

Quality Measure Record Definitions

Within each sample, **certain key records are identified** which are used for calculating individual measures.

- Long Stay Records

ASSESSMENT SELECTED	PROPERTY	SELECTION SPECIFICATIONS
Influenza vaccination assessment	Selection period[5]	All assessments with target dates on or after October 1 of the most recently completed influenza season (i.e., the target date must be on or between October 1 of the current year and June 30 of the following year).
	Qualifying RFAs	A0310A = [01, 02, 03, 04, 05, 06] *or* A0310B = [01] *or* A0310F = [10, 11]
	Selection logic	Select the record with the latest target date that meets all of the following conditions: a) It has a qualifying RFA, *and* b) Target date is on or after October 1 of the most recently completed influenza season (i.e., the target date must fall on or between October 1 and June 30), *and* c) A1600 (entry date) is on or before March 31 of the most recently completed influenza season.
	Rationale	The selection logic defined above is intended to identify the latest assessment that reports the influenza vaccine status for a resident who was in the facility for at least one day from October 1 through March 31.

Quality Measure Record Definitions

A Note on Risk Adjustment

- Risk adjustment refines raw QM scores to better reflect the prevalence of problems that facilities should be able to address.
- Two complementary approaches to risk adjustment are applied to the QMs.
  - 1. One approach involves **exclusion** of residents whose outcomes are not under nursing facility control (e.g., outcome is evidenced on admission to the facility) or the outcome may be unavoidable (e.g., the resident has end-stage disease or is comatose). All of the QMs, except the vaccination QMs, are shaped by one or more exclusions. For each QM, the prevalence of the outcome across all residents in a nursing facility, after exclusions, is the facility-level observed QM score.
  - 2. A second approach involves adjusting QM scores directly, using logistic regression. This method of adjustment employs resident-level **covariates** that are found to increase the risks of an outcome.

Table 2-24
Percent of Residents Who Have/Had a Catheter Inserted and Left in Their Bladder (LS)[26]
(CMS ID: N026.03) (NQF #0686)

Measure Description

This measure reports the percentage of residents who have had an indwelling catheter in the last 7 days.

Measure Specifications

Numerator

Long-stay residents with a selected target assessment that indicates the use of indwelling catheters (H0100A = [1]).

Denominator

All long-stay residents with a selected target assessment, except those with exclusions.

Exclusions

1. Target assessment is an admission assessment (A0310A = [01]) *or* a PPS 5-Day assessment (A0310B = [01]).
2. Target assessment indicates that indwelling catheter status is missing (H0100A = [-]).
3. Target assessment indicates neurogenic bladder (I1550 = [1]) *or* neurogenic bladder status is missing (I1550 = [-]).
4. Target assessment indicates obstructive uropathy (I1650 = [1]) *or* obstructive uropathy status is missing (I1650 = [-]).

Covariates

1. Frequent bowel incontinence on prior assessment (H0400 = [2, 3]).
   1.1. Covariate = [1] if (H0400 = [2, 3]).
   1.2. Covariate = [0] if (H0400 = [0, 1, 9, -]).
2. Pressure ulcers at stages II, III, or IV on prior assessment:
   2.1. Covariate = [1] if *any* of the following are true:
      2.1.1. (M0300B1 = [1, 2, 3, 4, 5, 6, 7, 8, 9]), *or*
      2.1.2. (M0300C1 = [1, 2, 3, 4, 5, 6, 7, 8, 9]), *or*
      2.1.3. (M0300D1 = [1, 2, 3, 4, 5, 6, 7, 8, 9]).
   2.2. Covariate = [0] if the following is true:

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[26] This measure is used in the Five-Star Quality Rating System.

Table 2-11
Percent of Residents Who Made Improvements in Function (SS)[21]
(CMS ID: N037.03) (NQF: None)

Measure Description

This measure reports the percentage of short-stay residents who were discharged from the nursing home that gained more independence in transfer, locomotion, and walking during their episodes of care.

Measure Specifications

NOTE:

1. A "valid preceding PPS 5-Day assessment or OBRA Admission assessment" refers to the date of the earliest assessment if a resident has both a PPS 5-Day assessment (A0310B = [01]) and an OBRA Admission assessment (A0310A = [01]).
2. A "valid discharge assessment" refers to a discharge assessment with a date closest to the valid preceding PPS 5-Day assessment or OBRA Admission assessment where a return is not anticipated (A0310F = [10]).
3. The PPS 5-Day assessment or OBRA Admission assessment should be used to calculate the tercile cutoffs. If resident has both a PPS 5-Day assessment and an OBRA Admission assessment, calculate covariate using the assessment with the earlier date. Terciles are recalculated in each quarter.

Numerator

Short-stay residents who:

1. Have a change in performance score that is negative ([valid discharge assessment] - [valid preceding PPS 5-Day assessment or OBRA Admission assessment] < [0]).

Performance is calculated as the sum of G0110B1 (transfer: self- performance), G0110E1 (locomotion on unit: self-performance), and G0110D1 (walk in corridor: self-performance), with 7's (activity occurred only once or twice) and 8's (activity did not occur) recoded to 4's (total dependence).

Denominator

Short-stay residents who meet all of the following conditions, except those with exclusions:

1. Have a valid discharge assessment (A0310F = [10]), *and*
2. Have a valid preceding PPS 5-Day assessment (A0310B = [01]) **or** OBRA Admission assessment (A0310A = [01]).

---

[21] This measure is used in the Five-Star Quality Rating System.

Measure Specifications Continued

Exclusions

1. Residents satisfying any of the following conditions:
   1.1. Comatose (B0100 = [1]) on the PPS 5-Day assessment or OBRA Admission assessment, whichever was used in the QM.
   1.2. Life expectancy of less than 6 months (J1400 = [1]) on the PPS 5-Day assessment or OBRA Admission assessment, whichever was used in the QM.
   1.3. Hospice (O0100K2 = [1]) on the PPS 5-Day assessment or OBRA Admission assessment, whichever was used in the QM.
   1.4. Information on Transfer: self-performance, walk in corridor: self-performance, or locomotion on unit: self-performance is missing on any of the assessments used to calculate the QM (G0110B1, G0110D1, or G0110E1 = [-]) (i.e., valid discharge assessment, and PPS 5-Day assessment or OBRA Admission assessment, whichever was used in the QM).
   1.5. Residents with no impairment (sum of G0110B1, G0110D1 and G0110E1 = [0]) on the PPS 5-Day assessment or OBRA Admission assessment, whichever was used in the QM.
   1.6. Residents with an unplanned discharge on any assessment during the care episode (A0310G = [2])

Covariates

All covariates used throughout this measure are calculated using the valid preceding PPS 5-Day assessment or OBRA Admission assessment described in the NOTE at the top of the measure specifications.

1. Age on the PPS 5-Day assessment (A0310B = [01]) **or** OBRA Admission assessment (A0310A = [01]) as calculated by subtracting date of birth (A0900) from the date of assessment (A2300)

   If (MONTH(A2300) > MONTH(A0900)) ***or*** (MONTH(A2300) = MONTH(A0900) ***and***
   DAY(A2300) >= DAY(A0900)) ***then*** Age = YEAR(A2300)-YEAR(A0900) ***else*** Age = YEAR(A2300)-YEAR(A0900)-1

   1.1 Covariate Age Category ≤ 54 = 1 if Age ≤ 54 ***and*** Covariate Age Category ≤ 54 = 0 if Age >54)

   1.2 Covariate Age Category 54 to 84 = 1 if Age >54 ***and*** ≤ 84 and Covariate Age Category 54 to 84 = 0 if Age ≤ 54 or Age > 84) (reference)

   1.3 Covariate Age Category >84 = 1 if Age >84 ***and*** Covariate Age Category >84 = 0 if Age ≤ 84)

2. Gender

   2.1 Covariate = 1 if (A0800 = [2]) (Female)

   2.2 Covariate = 0 if (A0800 = [1]) (Male)

3. Severe cognitive impairment

   3.1 Covariate = 1 if (C1000 = [3] ***and*** C0700 = [1]) ***or*** BIMS summary score (C0500) ≤ [7]

   3.2 Covariate = 0 if (C1000 = [0, 1, 2, ^, -] ***or*** C0700 = [0, ^, -]) ***and*** (C0500 = [>7, ^, -, 99])

   If Covariate has not been set to 1 or 0 based on logic in 3.1 and 3.2, then Covariate = [0].

4. Long Form ADL (LFADL) Scale (G0110A1 + G0110B1 + G0110E1 + G0110G1 + G0110H1 + G0110I1 + G0110J1). If any (G0110A1, G0110B1, G0110E1, G0110G1, G0110H1, G0110I1, G0110J1) = [7, 8], recode the item to equal [4].

Covariates Continued

4.1 Covariate = 0 if LFADL = (middle tercile[22] or highest tercile) *or* if any (G0110A1, G0110B1, G0110E1, G0110G1, G0110H1, G0110I1, G0110J1) = [-]

Covariate = 1 if LFADL = lowest tercile

4.2 Covariate =0 if (lowest tercile *or* highest tercile)

Covariate = 1 if LFADL = middle tercile (reference)

4.3 Covariate =0 if (lowest tercile *or* middle tercile)

Covariate = 1 if LFADL = highest tercile

5. Heart failure

5.1 Covariate = 1 if (I0600 = [1])

Covariate = 0 if (I0600 = [0, -])

6. CVA, TIA, or Stroke

6.1 Covariate = 1 if (I4500 = [1])

Covariate = 0 if (I4500 = [0, -])

7. Hip Fracture

7.1 Covariate = 1 if (I3900 = [1])

Covariate = 0 if (I3900 = [0, -])

8. Other Fracture

8.1 Covariate = 1 if (I4000 = [1])

Covariate = 0 if (I4000 = [0, -])

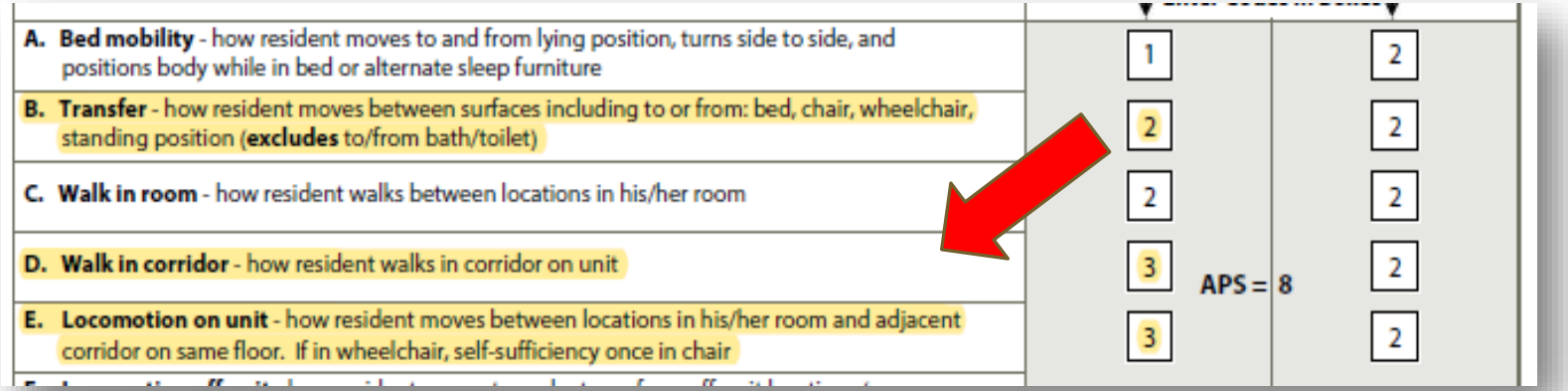
Quality Measure Example

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
Excess Wt Loss (L)	N029.02	C	7	43	16.3%	16.3%	10.9%	8.3%	89 *
Incr ADL Help (L)	N028.02	C	11	57	19.3%	19.3%	21.0%	17.5%	61
Move Indep Worsens (L)	N035.03	C	8	26	30.8%	34.2%	38.5%	27.9%	69
Improvement in Function (S)	N037.03	C	13	21	61.9%	66.3%	69.8%	70.3%	34

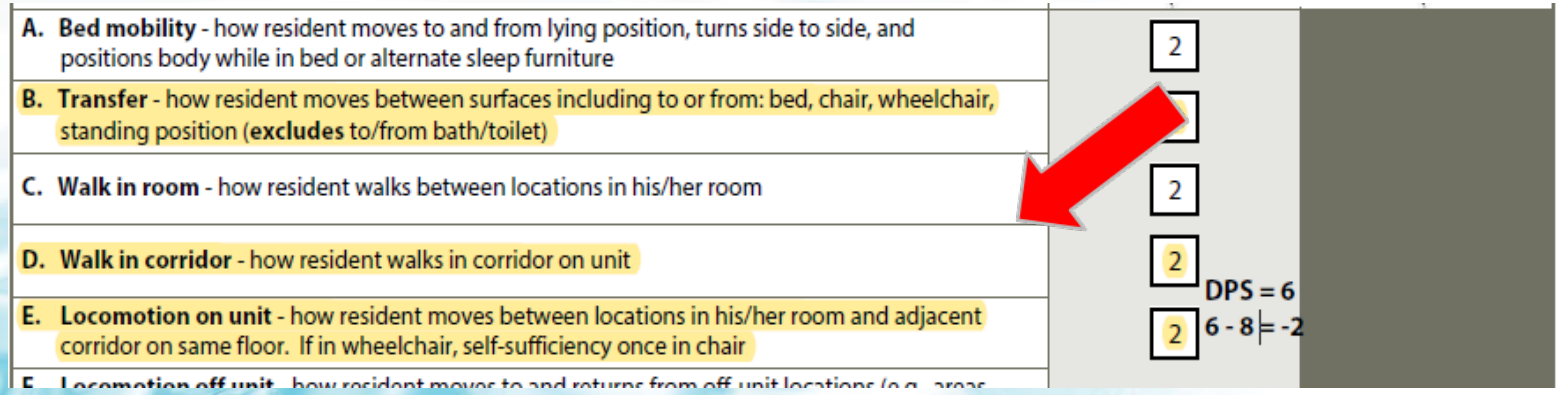
Resident Name	Resident ID	A0310A/B/F	Hi-risk/Unstageable Pres Ulcer (L)	Phys restraints (L)	Falls (L)	Falls w/Maj Injury (L)	Antipsych Med (S)	Antipsych Med (L)	Antianxiety/Hypnotic Prev (L)	Antianxiety/Hypnotic (L)	Behav Sx Affect Others (L)	Depress Sx (L)	UTI (L)	Cath Insert/Left Bladder (L)	Lo-Risk 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	0
Discharged Residents																				
Jane Doe	XXXXXXX	99/99/10	b	b	b	b	b	b	b	b	b	b	b	b	b	b	b	b	X	1
John Smith	XXXXXXX	99/99/10	b	b	b	b	b	b	b	b	b	b	b	b	b	b	b	b	b	0
Bill Jones	XXXXXXX	99/99/10	b	b	b	b	b	b	b	b	b	b	b	b	b	b	b	b	X	1

Quality Measure Example

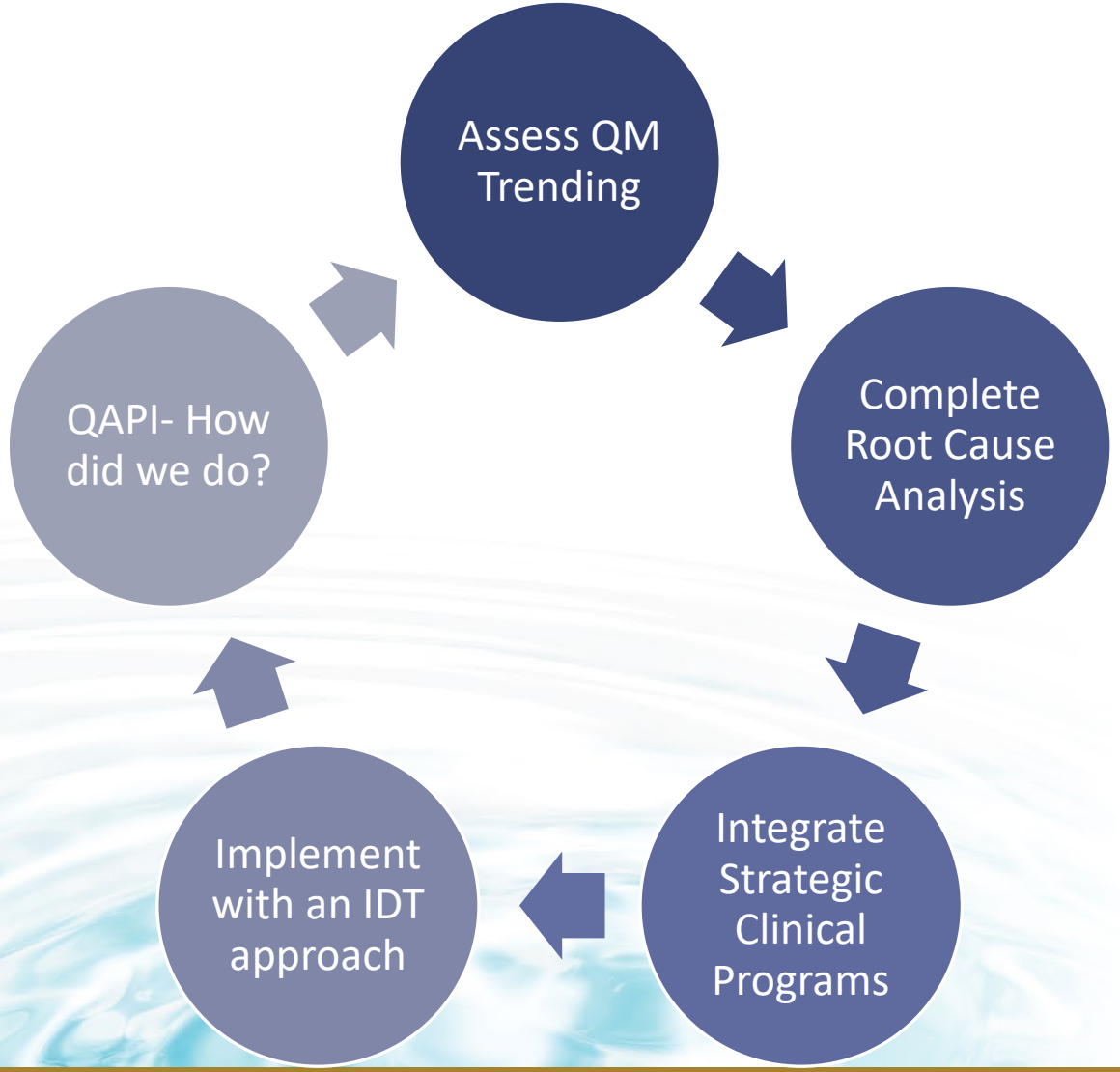
- **Admission**



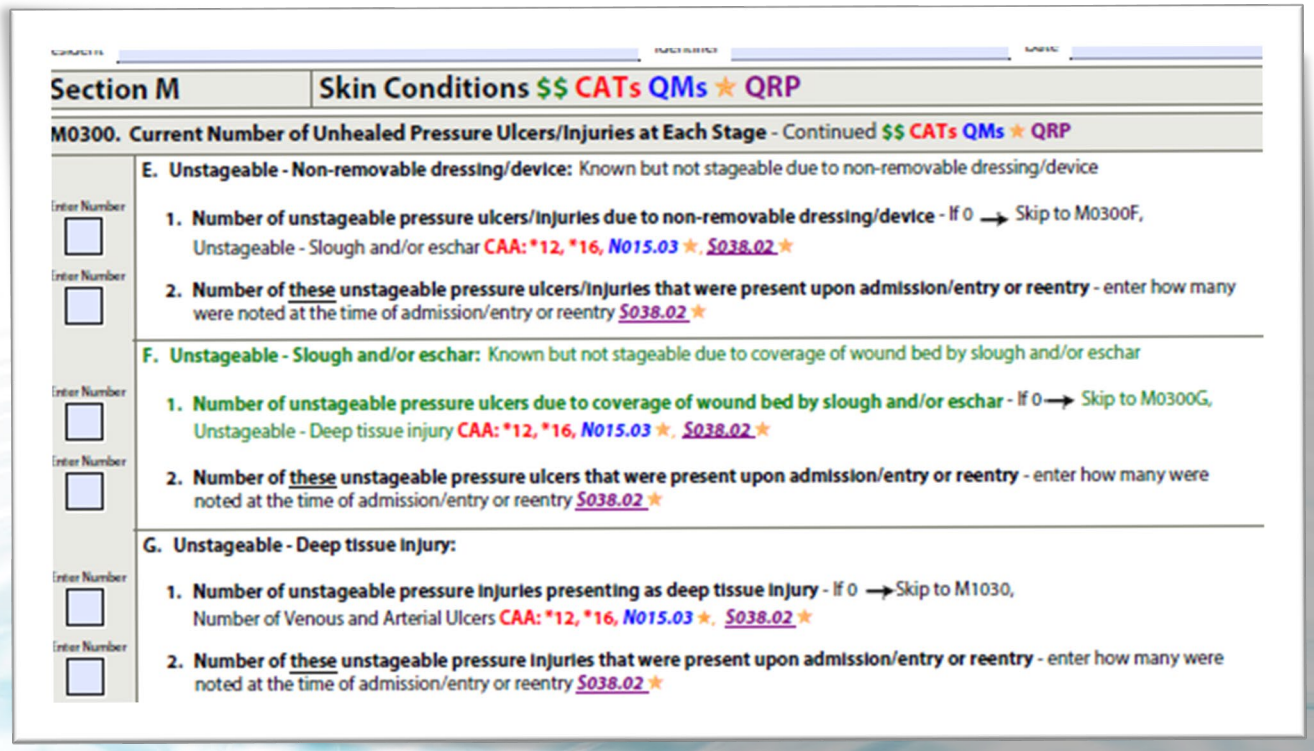
- **Discharge**



Interdisciplinary Roll in Quality Measurement



Quality Measure Management



Section M | **Skin Conditions $$ CATs QMs ★ QRP**

M0300. Current Number of Unhealed Pressure Ulcers/Injuries at Each Stage - Continued $$ CATs QMs ★ QRP

E. Unstageable - Non-removable dressing/device: Known but not stageable due to non-removable dressing/device

Enter Number

1. **Number of unstageable pressure ulcers/injuries due to non-removable dressing/device** - If 0 → Skip to M0300F,
   Unstageable - Slough and/or eschar **CAA: *12, *16, *N015.03** ★, *S038.02* ★

Enter Number

2. **Number of these unstageable pressure ulcers/injuries that were present upon admission/entry or reentry** - enter how many were noted at the time of admission/entry or reentry *S038.02* ★

F. Unstageable - Slough and/or eschar: Known but not stageable due to coverage of wound bed by slough and/or eschar

Enter Number

1. **Number of unstageable pressure ulcers due to coverage of wound bed by slough and/or eschar** - If 0 → Skip to M0300G,
   Unstageable - Deep tissue injury **CAA: *12, *16, *N015.03** ★, *S038.02* ★

Enter Number

2. **Number of these unstageable pressure ulcers that were present upon admission/entry or reentry** - enter how many were noted at the time of admission/entry or reentry *S038.02* ★

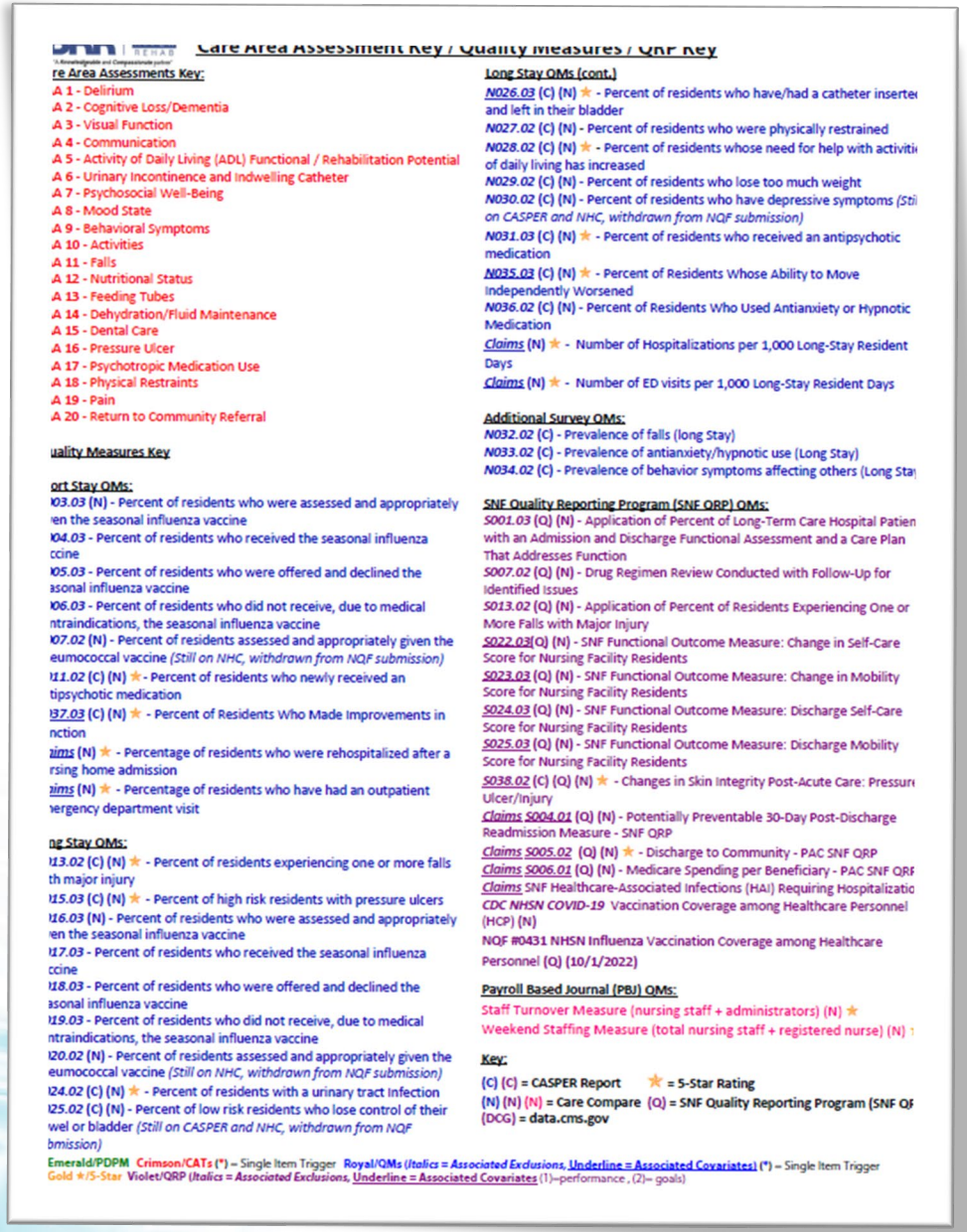
G. Unstageable - Deep tissue injury:

Enter Number

1. **Number of unstageable pressure injuries presenting as deep tissue injury** - If 0 → Skip to M1030,
   Number of Venous and Arterial Ulcers **CAA: *12, *16, *N015.03** ★, *S038.02* ★

Enter Number

2. **Number of these unstageable pressure injuries that were present upon admission/entry or reentry** - enter how many were noted at the time of admission/entry or reentry *S038.02* ★



Care Area Assessment Key / Quality Measures / QRP Key

re Area Assessments Key:

A 1 - Delirium
A 2 - Cognitive Loss/Dementia
A 3 - Visual Function
A 4 - Communication
A 5 - Activity of Daily Living (ADL) Functional / Rehabilitation Potential
A 6 - Urinary Incontinence and Indwelling Catheter
A 7 - Psychosocial Well-Being
A 8 - Mood State
A 9 - Behavioral Symptoms
A 10 - Activities
A 11 - Falls
A 12 - Nutritional Status
A 13 - Feeding Tubes
A 14 - Dehydration/Fluid Maintenance
A 15 - Dental Care
A 16 - Pressure Ulcer
A 17 - Psychotropic Medication Use
A 18 - Physical Restraints
A 19 - Pain
A 20 - Return to Community Referral

uality Measures Key

ort Stay QMs:

03.03 (N) - Percent of residents who were assessed and appropriately en the seasonal influenza vaccine
04.03 - Percent of residents who received the seasonal influenza ccine
05.03 - Percent of residents who were offered and declined the asonal influenza vaccine
06.03 - Percent of residents who did not receive, due to medical ntraindications, the seasonal influenza vaccine
07.02 (N) - Percent of residents assessed and appropriately given the eumococcal vaccine *(Still on NHC, withdrawn from NQF submission)*
11.02 (C) (N) ★ - Percent of residents who newly received an tipsychotic medication
37.03 (C) (N) ★ - Percent of Residents Who Made Improvements in nction
ims (N) ★ - Percentage of residents who were rehospitalized after a rsing home admission
ims (N) ★ - Percentage of residents who have had an outpatient ergency department visit

ng Stay QMs:

13.02 (C) (N) ★ - Percent of residents experiencing one or more falls th major injury
15.03 (C) (N) ★ - Percent of high risk residents with pressure ulcers
16.03 (N) - Percent of residents who were assessed and appropriately en the seasonal influenza vaccine
17.03 - Percent of residents who received the seasonal influenza ccine
18.03 - Percent of residents who were offered and declined the asonal influenza vaccine
19.03 - Percent of residents who did not receive, due to medical ntraindications, the seasonal influenza vaccine
20.02 (N) - Percent of residents assessed and appropriately given the eumococcal vaccine *(Still on NHC, withdrawn from NQF submission)*
24.02 (C) (N) ★ - Percent of residents with a urinary tract infection
25.02 (C) (N) - Percent of low risk residents who lose control of their wel or bladder *(Still on CASPER and NHC, withdrawn from NQF bmission)*

Long Stay QMs (cont.)

N026.03 (C) (N) ★ - Percent of residents who have/had a catheter inserte and left in their bladder
N027.02 (C) (N) - Percent of residents who were physically restrained
N028.02 (C) (N) ★ - Percent of residents whose need for help with activiti of daily living has increased
N029.02 (C) (N) - Percent of residents who lose too much weight
N030.02 (C) (N) - Percent of residents who have depressive symptoms *(Sti on CASPER and NHC, withdrawn from NQF submission)*
N031.03 (C) (N) ★ - Percent of residents who received an antipsychotic medication
N035.03 (C) (N) ★ - Percent of Residents Whose Ability to Move Independently Worsened
N036.02 (C) (N) - Percent of Residents Who Used Antianxiety or Hypnotic Medication
Claims (N) ★ - Number of Hospitalizations per 1,000 Long-Stay Resident Days
Claims (N) ★ - Number of ED visits per 1,000 Long-Stay Resident Days

Additional Survey QMs:

N032.02 (C) - Prevalence of falls (long Stay)
N033.02 (C) - Prevalence of antianxiety/hypnotic use (Long Stay)
N034.02 (C) - Prevalence of behavior symptoms affecting others (Long Sta

SNF Quality Reporting Program (SNF QRP) QMs:

S001.03 (Q) (N) - Application of Percent of Long-Term Care Hospital Patien with an Admission and Discharge Functional Assessment and a Care Plan That Addresses Function
S007.02 (Q) (N) - Drug Regimen Review Conducted with Follow-Up for Identified Issues
S013.02 (Q) (N) - Application of Percent of Residents Experiencing One or More Falls with Major Injury
S022.03(Q) (N) - SNF Functional Outcome Measure: Change in Self-Care Score for Nursing Facility Residents
S023.03 (Q) (N) - SNF Functional Outcome Measure: Change in Mobility Score for Nursing Facility Residents
S024.03 (Q) (N) - SNF Functional Outcome Measure: Discharge Self-Care Score for Nursing Facility Residents
S025.03 (Q) (N) - SNF Functional Outcome Measure: Discharge Mobility Score for Nursing Facility Residents
S038.02 (C) (Q) (N) ★ - Changes in Skin Integrity Post-Acute Care: Pressur Ulcer/Injury
Claims S004.01 (Q) (N) - Potentially Preventable 30-Day Post-Discharge Readmission Measure - SNF QRP
Claims S005.02 (Q) (N) ★ - Discharge to Community - PAC SNF QRP
Claims S006.01 (Q) (N) - Medicare Spending per Beneficiary - PAC SNF QRF
Claims SNF Healthcare-Associated Infections (HAI) Requiring Hospitalizatio
CDC NHSN COVID-19 Vaccination Coverage among Healthcare Personnel (HCP) (N)
NQF #0431 NHSN Influenza Vaccination Coverage among Healthcare Personnel (Q) (10/1/2022)

Payroll Based Journal (PBJ) QMs:

Staff Turnover Measure (nursing staff + administrators) (N) ★
Weekend Staffing Measure (total nursing staff + registered nurse) (N)

Key:

(C) (C) = CASPER Report ★ = 5-Star Rating
(N) (N) (N) = Care Compare (Q) = SNF Quality Reporting Program (SNF QF
(DCG) = data.cms.gov

Emerald/PDPM Crimson/CATs (*) = Single Item Trigger Royal/QMs (*Italics = Associated Exclusions*, Underline = Associated Covariates) (*) = Single Item Trigger
Gold ★/5-Star Violet/QRP (*Italics = Associated Exclusions*, Underline = Associated Covariates (1)=performance , (2)= goals)

Quality Measure Management

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
Hi-risk/Unstageable Pres Ulcer (L) ★	N015.03	C	2	48	4.2%	4.2%	9.9%	9.1%	23
Phys restraints (L)	N027.02	C	0	68	0.0%	0.0%	0.2%	0.2%	0
Falls (L)	N032.02	C	34	68	50.0%	50.0%	45.8%	46.3%	58
Falls w/Maj Injury (L) ★	N013.02	C	4	68	5.9%	5.9%	3.5%	3.6%	**81 ***
Antipsych Med (S) ★	N011.02	C	0	15	0.0%	0.0%	2.2%	2.2%	0
Antipsych Med (L) ★	N031.03	C	16	63	25.4%	25.4%	14.9%	14.4%	**89 ***
Antianxiety/Hypnotic Prev (L)	N033.02	C	1	21	4.8%	4.8%	8.1%	6.3%	51
Antianxiety/Hypnotic % (L)	N036.02	C	20	64	31.3%	31.3%	31.7%	19.7%	**86 ***
Behav Sx affect Others (L)	N034.02	C	10	57	17.5%	17.5%	20.1%	20.6%	51
Depress Sx (L)	N030.02	C	5	54	9.3%	9.3%	9.0%	7.5%	**78 ***
UTI (L) ★	N024.02	C	3	56	5.4%	5.4%	3.9%	2.8%	**83 ***
Cath Insert/Left Bladder (L) ★	N026.03	C	1	54	1.9%	1.6%	2.0%	2.1%	54
Lo-Risk Lose B/B Con (L)	N025.02	C	8	16	50.0%	50.0%	51.6%	47.3%	58
Excess Wt Loss (L)	N029.02	C	4	52	7.7%	7.7%	11.0%	8.5%	51
Incr ADL Help (L) ★	N028.02	C	9	64	14.1%	14.1%	20.3%	17.2%	40
Move Indep Worsens (L) ★	N035.03	C	8	30	26.7%	31.0%	36.0%	27.2%	63
Improvement in Function (S) ★	N037.03	C	8	18	44.4%	49.1%	70.3%	70.8%	**11 ***

Measure Description	CMS ID	Numerator	Denominator	Facility Observed Percent	Facility Adjusted Percent	National Average
Pressure Ulcer/Injury[1] SNF QRP ★	S038.02	5	41	12.2%	10.7%	2.9%

[1] The Changes in Skin Integrity Post-Acute Care: Pressure Ulcer/Injury (S038.02) measure is calculated using the SNF QRP measure specifications v3.0 addendum and is based on 12 months of data (01/01/2020 - 12/31/2020).

Quality Measure Management

Assess QM Trending

(Resident Level)

Figure 11-7. MDS 3.0 Resident Level Quality Measure Report*

CASPER Report

MDS 3.0 Resident Level Quality Measure Report

Facility ID:
Facility Name:
CCN:
City/State:

Report Period: 04/01/2021 - 09/30/2021
Report Run Date: 10/07/2021
Data Calculation Date: 10/04/2021
Report Version Number: 3.03

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

Resident Name	Resident ID	A0310A/B/F	Hi-risk/Unstageable Pres Ulcer (L)	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	0
Active Residents																				
	48207520	04/99/99	b	b	b	b	b	b	b	b	b	b	b	b	b	b	b	b	b	0
	48207523	05/99/99	b	b	b	b	b	b	b	b	b	b	b	b	b	b	b	b	b	0
	48207526	02/99/99	b	b	b	b	b	b	b	b	b	b	b	b	b	b	b	b	b	0
	48207529	06/99/99	b	b	b	b	b	X	X	X	b	X	b	b	b	X	b	b	b	5
	48207532	99/01/99	b	b	b	b	b	X	X	X	b	X	b	b	b	b	b	b	b	4
	48207535	01/99/99	b	b	b	b	b	X	X	X	b	X	b	b	b	b	b	b	b	4
	48207538	03/99/99	b	b	b	b	b	X	X	X	b	X	b	b	b	X	b	b	b	5
	48207541	04/99/99	b	b	b	b	b	X	X	X	b	X	b	b	b	X	b	b	b	5
	48207544	05/99/99	b	b	b	b	b	X	X	X	b	X	b	b	b	X	b	b	b	5
	48207547	02/99/99	b	b	b	b	b	X	X	X	b	X	b	b	b	X	b	b	b	5
	48207550	06/99/99	b	b	b	b	b	X	X	X	b	X	b	b	b	X	b	b	b	5
	48207553	99/01/99	b	b	b	b	b	X	X	X	b	X	b	b	b	b	b	b	b	4
	48207556	01/99/99	b	b	b	b	b	b	b	b	b	b	b	b	b	b	b	b	b	0
	48207559	03/99/99	b	b	b	b	b	b	b	b	b	b	b	b	b	b	b	b	b	0

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

* Fictitious, sample data are depicted.

Quality Measure Management

Complete Root Cause Analysis

5 WHYS?

High-Risk/Unstageable Pressure Ulcers (L)	• Physical Restraints (L)	• Falls (L)	• Falls with Major Injury (L)	• Residents Who Newly Received an Antipsychotic Medication (S)	• Residents Who Received an Antipsychotic Medication (L)
• Prevalence of Antianxiety/Hypnotic Medication Use (L)	• Antianxiety/Hypnotic Medication Use % (L)	• Behavior Symptoms Affecting Others (L)	• Depressive Symptoms (L)	• Urinary Tract Infection (L)	• Catheter Inserted and Left in Bladder (L)*
• Low-Risk Residents Who Lose Bowel/Bladder Control (L)	• Excessive Weight Loss (L)	• Need for Help with ADLs Has Increased (L)	• Percent of Residents Whose Ability to Move Independently Worsened (L)*	• Percent of Residents Who Made Improvements in Function (S)*	• Changes in Skin Integrity Post-Acute Care Pressure Ulcer/Injury* (SNF

Integrate Strategic Clinical Programs

Quality Measure Management

- Excessive Weight Loss (L)

- Root Cause Analysis Reveals that Weight Loss is caused by:
  - Limited community dining, poor positioning during meals, and reduced sensory environment

- Strategic Clinical Programs could include:
  - Walk to Dine; Integrating More Natural Setting in the Dining Environment; Improved Lighting and Contrast
  - Learn from CMS- Integrate Critical Element Pathways in Program Development

Integrate Strategic Clinical Programs

Quality Measure Management

- Falls with Major Injury (L)

- Root Cause Analysis Reveals that Fall with Major Injury is caused by:
  - Reduced opportunity for out of bed movement; physical barriers in room environment, ineffective toileting program

- Strategic Clinical Programs could include:
  - Walk to Dine; Planned out of bed activities, Toileting Program
  - Learn from CMS- Integrate Critical Element Pathways in Program Development

Implement with an IDT approach

Quality Measure Management

- Consider Implementation of Interprofessional Practice and Education as Defined by the World Health Organization

- Interprofessional Education & Interprofessional Collaborative Practice
  - IPP occurs when multiple service providers from different professional backgrounds provide comprehensive healthcare or educational services by working with individuals and their families, caregivers, and communities- to deliver the highest quality of care across settings.

Quality Measure Management

QAPI- How did we do?

QAPI **Quality Assurance & Performance Improvement** **(CMS)**

Effective QAPI programs are critical to improving the quality of life, and quality of care and services delivered in nursing homes.

5 Elements

- Design and Scope
- Governance and Leadership
- Feedback, Data Systems and Monitoring
- Performance Improvement Projects (PIPs)
- Systematic Analysis and Systemic Action

QAPI- How did we do?

Case Study

Quality Measure Management

- **The Issue:** During the monthly QAPI meeting at Whistling Pines, staff discovered a trend of unexplained weight loss among several residents over the last two months. During the discussion, a representative from dining services noted that there had been an increase in the amount of food left on plates, as well as an increase in the amount of supplements being ordered. Although other issues and opportunities for improvement were identified at the meeting, the QAPI Steering Committee decided to launch a Performance Improvement Project (PIP) on the weight loss trend because unexplained weight loss posed a high-risk problem for residents.

QAPI- How did we do?

Case Study

Quality Measure Management

- **What Whistling Pines did:** The QAPI Steering Committee chartered a PIP team composed of a certified nursing assistant (CNA), charge nurse, social worker, dietary worker, registered dietitian, and a nurse practitioner. The team studied the issue, and then performed a root cause analysis (RCA) to help direct a plan of action. The RCA revealed several underlying factors, which included:
  - No process existed for identifying and addressing risks for weight loss such as dental condition, diagnosis, or use of appetite suppressing medications;
  - No system existed to ensure resident preferences are honored;
  - Staff lacked an understanding of how to document food intake percentages; and
  - Residents reported the food was not appetizing.

QAPI- How did we do?

Case Study

Quality Measure Management

- **What Whistling Pines did:** Based on the identified underlying causes, the PIP team recommended the following interventions:
  - Development of a protocol for identifying residents at risk for weight loss to be done on admission and with each care plan. This protocol included a review of medications (appetite suppressants), new diagnoses, and resident assessments, including dental issues;
  - Development of standing orders for residents identified as “at risk” for weight loss. These would include bi-weekly weights, referral to attending physician and dietitian for assessment, and documentation of meal percentages;
  - Development of a new program for CNAs to be “Food Plan Leads” for at risk residents. The program would include identification of food preferences and accurate documentation of meals - laminated badge cards with pictures of meal percentages were distributed to all CNAs; and
  - Revision of the menu to focus on favorite foods, adding finger foods and increasing choices outside of mealtimes. The interventions were implemented in one area of the building that was home to 25 residents.

Quality Measure Management

QAPI- How did we do?

RESULTS

- The PIP team collected data from dietary (food wasted and supplement use), CNAs (observation of resident satisfaction and meal percentages), residents (satisfaction surveys), and weights. After 3 months, they found that 5 residents gained weight,15 remained stable, and 5 lost weight, but the weight loss was not unexpected and consistent with their clinical condition.
- Food costs did not increase, and supplement costs decreased by 12%.
- Whistling Pines decided to adopt and expand the changes to other areas of the facility. They received no deficiencies in the areas of nutrition on their annual survey. Using QAPI allowed them to identify and correct developing issues before they escalated to larger problems

QUESTIONS?

Find Out More

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