New Nursing Home Quality Composite Score, Quality Improvement and QAPI

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TMF Health Quality Institute
Objectives

- Define the National Nursing Home Quality Care Collaborative (NNHQCC) Quality Composite Measure Score (CS)
- Identify the relationship between the CS, the Minimum Data Set (MDS) and the Quality Measures (QMs)
- Understand how to use the Composite Score for Quality Improvement (QI)
- Jumpstart Element 3 of QAPI
About the TMF QIN-QIO

TMF Health Quality Institute has partnered with the Arkansas Foundation for Medical Care, Primaris in Missouri and the Quality Improvement Professional Organization, Inc. in Puerto Rico to form the TMF Quality Innovation Network Quality Improvement Organization (TMF QIN-QIO), under contract with the Centers for Medicare & Medicaid Services (CMS). The TMF QIN-QIO works with providers across all care settings to provide quality improvement services in the states of Arkansas, Missouri, Oklahoma and Texas, and the territory of Puerto Rico.
QIN-QIO Key Roles

- Champion local-level, results-oriented change
- Facilitate learning and action networks (LAN)
- Teach and advise as technical experts
- Provide integrated communications across provider types and health care segments
11 SOW QIN-QIO Map

Link to: Interactive QIN-QIO Map

*Virgin Islands award has not yet been determined
Goals for this Five-Year Project Ending 2019

- Achieve a score of **six or less** on the National Nursing Home Quality Composite Measure Score
- Increase mobility of long-stay residents*
- Decrease antipsychotic medication use
- Decrease healthcare-associated infections and other healthcare-acquired conditions
- Decrease potentially avoidable hospitalizations
QMs and the New Nursing Home Quality Composite Score
Disclaimer

- I am not a MDS expert
- Always use the:
  - Resident Assessment Instrument User’s Manual (RAI)
  - MDS 3.0 QM User’s Manual
  - Quality Measure Identification Number (QMID) by CMS Reporting Module
  - Five-Star Quality Rating System Technical Users’ Guide
Resources

- Five-Star Quality Rating System Technical Users’ Guide:
  http://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/CertificationandComplianc/FSQRS.html

- MDS 3.0 RAI Manual:

- QM & QMID Manuals:

***Subject to change in location and manual content***
Texas MDS Program Staff

MDS Automation and QIES Coordinator

For assistance with MDS reporting schedule, data file submission, Texas-specific requirements, validation reports, data correction, QIES access, CASPER Reports, QM Reports and data requests:

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Texas MDS Program Staff

MDS Clinical Coordinator
For assistance with the MDS RAI Manual, specific MDS sections or items, RUGs, CAAs, RAPs, care plans and Swing Bed MDS:

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Phone: 210-619-8010
Fax: 210-871-6484 (shared fax – call first)
Data = a Person
How are QMs used?

QMs developed by the National Quality Forum (NQF) and/or CMS:

- Texas Quality Reporting System uses 18 QMs
- CMS CASPER uses 17 QMs
  
  *Two are not NQF-endorsed*
- CMS Nursing Home Compare uses 18 QMs
- Five-Star Quality Rating System uses 11 QMs
- NNHQCC Quality Composite Measure Score uses 13 QMs
- Survey process
Other ways the QMs and the MDS are used?

- Research
- Funding
  - RUGs
  - Accountable care organizations
  - Preferred provider status
- What else?
Five-Star Quality Rating System

- **Long-Stay Residents:**
  - Percent of residents whose need for help with activities of daily living has increased
  - Percent of high risk residents with pressure ulcers (sores)
  - Percent of residents who have/had a catheter inserted and left in their bladder
  - Percent of residents who were physically restrained
  - Percent of residents with a urinary tract infection
  - Percent of residents who self-report moderate to severe pain
  - Percent of residents experiencing one or more falls with major injury
  - **Percent of residents who received an antipsychotic medication**

- **Short-stay residents:**
  - Percent of residents with pressure ulcers (sores) that are new or worsened
  - Percent of residents who self-report moderate to severe pain
  - **Percent of residents who newly received an antipsychotic medication**
NNHQCC Quality Composite Measure Score

The composite score is comprised of 13 long-stay QMs:
1. Percent of residents who self-report moderate to severe pain
2. Percent of high-risk residents with pressure ulcer
3. Percent of residents physically restrained
4. Percent of residents with one or more falls with major injury
5. Percent of residents who received antipsychotic medications
6. Percent of residents who have depressive symptoms
7. Percent of residents with a UTI
8. Percent of residents with catheter inserted or left in bladder
9. Percent of low-risk residents with loss of bowels or bladder
10. Percent of residents who lose too much weight
11. Percent of residents whose need for help with ADL has increased
12. Percent of residents assessed and appropriately given flu vaccine*
13. Percent of residents assessed and appropriately given pneumococcal vaccine*
How is the Composite Measure Score used?

- NNHQCC measures progress of the facilities in the aggregate and at the state level
- CMS measures progress in the QIN-QIO project work
- TMF quality improvement consultants help guide facilities in QI project selection
By YOU!

- Identify what might be a problem
- Prioritize improvement opportunities
- Search for correlations in the QMs
- Benchmark
Benefits of the Composite Score

- It paints a more complete picture of the facility
- Uses only long-stay measures, which usually account for the largest portion of the nursing home population
- Participating facilities have new comparison groups
Benefits of the Composite Score

These QMs were selected as they represent connected processes as well as being influenced by larger systems within the nursing home.
‘Opportunity Model’ Concept

Each QM numerator (residents who triggered) is a potential “missed opportunity” to deliver good care.

For example:

Who wants to be in pain?

No one – therefore not managing someone’s pain is our missed opportunity to deliver great care.
Calculating the Composite Score

• Sum the 13 measure numerators to obtain the composite numerator
• Sum the 13 measure denominators to obtain the composite denominator
• Divide the composite numerator by the composite denominator
• Multiply by 100
<table>
<thead>
<tr>
<th>Quality Measure</th>
<th>Numerator</th>
<th>Denominator</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Percent of residents who self-report moderate to severe pain</td>
<td>2</td>
<td>70</td>
</tr>
<tr>
<td>2. Percent of high-risk residents with a pressure ulcer</td>
<td>6</td>
<td>50</td>
</tr>
<tr>
<td>3. Percent of residents physically restrained</td>
<td>0</td>
<td>71</td>
</tr>
<tr>
<td>4. Percent of residents with one or more falls with major injury</td>
<td>5</td>
<td>71</td>
</tr>
<tr>
<td>5. Percent of residents who received antipsychotic medications</td>
<td>21</td>
<td>70</td>
</tr>
<tr>
<td>6. Percent of residents who have depressive symptoms</td>
<td>15</td>
<td>66</td>
</tr>
<tr>
<td>7. Percent of residents with a UTI</td>
<td>3</td>
<td>52</td>
</tr>
<tr>
<td>8. Percent of residents with catheter inserted or left in bladder</td>
<td>3</td>
<td>68</td>
</tr>
<tr>
<td>9. Percent of low-risk residents who lose control of their bowels or bladder</td>
<td>10</td>
<td>29</td>
</tr>
<tr>
<td>10. Percent of residents who lose too much weight</td>
<td>10</td>
<td>70</td>
</tr>
<tr>
<td>11. Percent of residents whose need for help with ADL has increased</td>
<td>12</td>
<td>56</td>
</tr>
<tr>
<td>12. Percent of residents assessed and appropriately given flu vaccine*</td>
<td>68</td>
<td>69</td>
</tr>
<tr>
<td>13. Percent of residents assessed and appropriately given Pneumococcal vaccine*</td>
<td>70</td>
<td>71</td>
</tr>
<tr>
<td><strong>reverse flu</strong></td>
<td>1</td>
<td>69</td>
</tr>
<tr>
<td><strong>reverse Pneumonia</strong></td>
<td>1</td>
<td>71</td>
</tr>
<tr>
<td>Totals for 1 – 11 plus using the reverse for flu/pneumonia</td>
<td>89</td>
<td>813</td>
</tr>
<tr>
<td>numerator/denominator</td>
<td></td>
<td>0.109471095</td>
</tr>
<tr>
<td>numerator/denominator x 100</td>
<td></td>
<td>10.9%</td>
</tr>
<tr>
<td><strong>composite score:</strong></td>
<td></td>
<td><strong>10.9%</strong></td>
</tr>
<tr>
<td>Quality Measure</td>
<td>Numerator</td>
<td>Denominator</td>
</tr>
<tr>
<td>--------------------------------------------------------------------------------</td>
<td>-----------</td>
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</tr>
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<td></td>
<td>10.9%</td>
</tr>
<tr>
<td>composite score:</td>
<td></td>
<td>10.9%</td>
</tr>
</tbody>
</table>
Calculating the Composite Score

**Numerator** (missed opportunities/residents that triggered)  

\[ \frac{\text{Numerator}}{\text{Denominator}} \times 100 = \text{CS}\% \]

**Denominator** (total opportunities/residents who could trigger)

*Reverse Flu and Pneumonia Numerators!*
Flu and Pneumonia Vaccinations

- Are not on the QM facility report
- Are not reported to the facility
- Require the facility to track individually
- And, you have to “flip” the numerator to find the missed opportunities
## Facility Report

### CASPER Report

**MDS 3.0 Facility Quality Measure Report**

<table>
<thead>
<tr>
<th>Facility ID:</th>
<th>XXXX</th>
</tr>
</thead>
<tbody>
<tr>
<td>CCN:</td>
<td>XXXXXX</td>
</tr>
<tr>
<td>Facility Name:</td>
<td>XXXXXXXXXXXXXXXXXXXXX XXXXXXXXXXXXX</td>
</tr>
<tr>
<td>City/State:</td>
<td>XXXXXX</td>
</tr>
<tr>
<td>Data was calculated on:</td>
<td>08/08/2012</td>
</tr>
</tbody>
</table>

Note: Dashes represent a value that could not be computed
Note: S = short stay, L = long stay
Note: * is an indicator used to identify that the measure is flagged

<table>
<thead>
<tr>
<th>Measure ID</th>
<th>Num</th>
<th>Denom</th>
<th>Facility Observed Percent</th>
<th>Facility Adjusted Percent</th>
<th>Comparison Group State Average</th>
<th>Comparison Group National Average</th>
<th>Comparison Group National Percentile</th>
</tr>
</thead>
<tbody>
<tr>
<td>Self-Reported (SR) Moderate/Severe Pain (S)</td>
<td>0676</td>
<td>12</td>
<td>21</td>
<td>57.1%</td>
<td>22.1%</td>
<td>22.3%</td>
<td>96 *</td>
</tr>
<tr>
<td>Self-Reported (SR) Moderate/Severe Pain (L)</td>
<td>0677</td>
<td>18</td>
<td>65</td>
<td>27.7%</td>
<td>13.3%</td>
<td>11.8%</td>
<td>93 *</td>
</tr>
</tbody>
</table>

High-Risk Residents with Pressure Ulcers | 0679 | 4 | 44 | 9.1% | 9.1% | 8.3% | 7.5% | 68 |
<table>
<thead>
<tr>
<th>Long Stay Quality Measures</th>
<th>Performance</th>
<th>State</th>
<th>State Average</th>
<th>Regional Average</th>
<th>National Average</th>
</tr>
</thead>
<tbody>
<tr>
<td>Falls w/ major injury</td>
<td>1.8</td>
<td>1.9</td>
<td>1.8</td>
<td>1.7</td>
<td>0.0</td>
</tr>
<tr>
<td>Pain</td>
<td>0.0</td>
<td>0.0</td>
<td>0.0</td>
<td>0.0</td>
<td>0.0</td>
</tr>
<tr>
<td>High Risk Pressure ulcers</td>
<td>8.3</td>
<td>8.6</td>
<td>5.7</td>
<td>8.1</td>
<td>3.0</td>
</tr>
<tr>
<td>Flu vaccine</td>
<td>98.3</td>
<td>98.1</td>
<td>98.2</td>
<td>98.3</td>
<td>100.0</td>
</tr>
<tr>
<td>Pneum vaccine</td>
<td>100.0</td>
<td>100.0</td>
<td>100.0</td>
<td>100.0</td>
<td>100.0</td>
</tr>
<tr>
<td>UTI</td>
<td>3.6</td>
<td>3.8</td>
<td>5.7</td>
<td>1.8</td>
<td>3.6</td>
</tr>
<tr>
<td>Incontinence</td>
<td>55.6</td>
<td>65.0</td>
<td>60.0</td>
<td>60.0</td>
<td>61.9</td>
</tr>
<tr>
<td>Catheter</td>
<td>0.0</td>
<td>0.0</td>
<td>2.0</td>
<td>1.9</td>
<td>1.9</td>
</tr>
<tr>
<td>Physical restraints</td>
<td>7.0</td>
<td>5.6</td>
<td>7.1</td>
<td>6.9</td>
<td>8.8</td>
</tr>
<tr>
<td>Decline in ADLs</td>
<td>22.2</td>
<td>27.3</td>
<td>22.2</td>
<td>19.6</td>
<td>16.5</td>
</tr>
<tr>
<td>Weight loss</td>
<td>7.3</td>
<td>5.7</td>
<td>3.8</td>
<td>5.5</td>
<td>1.8</td>
</tr>
<tr>
<td>Depression</td>
<td>2.1</td>
<td>0.0</td>
<td>0.0</td>
<td>2.1</td>
<td>0.0</td>
</tr>
<tr>
<td>Antipsychotic meds</td>
<td>42.3</td>
<td>37.5</td>
<td>34.0</td>
<td>34.6</td>
<td>40.0</td>
</tr>
</tbody>
</table>

* The Regional Average refers to the average rate of all nursing homes in the QIN Region.

Legend:
- **Below 25th Percentile**
- **Between 25th and 50th Percentile**
- **Between 50th and 75th Percentile**
- **Above 75th Percentile**

The Lower the rate of each quality measure the better except flu and pneum vaccine which should be the higher the better.
<table>
<thead>
<tr>
<th>Long Stay Quality Measures</th>
<th>Performance</th>
<th>State</th>
<th>Regional Average*</th>
<th>National Average*</th>
</tr>
</thead>
<tbody>
<tr>
<td>Falls w/ major injury</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pain</td>
<td></td>
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<tr>
<td>High Risk Pressure Ulcers</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Flu vaccine</td>
<td></td>
<td></td>
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<tr>
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<td>Weight loss</td>
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<tr>
<td>Depression</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Antipsychotic meds</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Composite Score</td>
<td>9.28</td>
<td>9.29</td>
<td>8.56</td>
<td>8.62</td>
</tr>
</tbody>
</table>

*The Regional Average refers to the average rate of all nursing homes in the QIN Region.

The Lower the rate of each quality measure the better except flu and pneum vaccine which should be the higher the better.

Legend:
- Below 25th Percentile
- Between 25th and 50th Percentile
- Between 50th and 75th Percentile
- Above 75th Percentile
Composite Score Facility Report

The Composite Score

Rolling 6-month Time Period
(label indicates the last month of the time period)


Goal: less than 6
Composite Score QM Run Charts

- Falls w/ major injury
- Pain
- High risk Pressure Ulcers
- Flu Vaccine
- Pneu Vaccine
- UTI
- Incontinence
- Catheter
- Physical Restraint
- Decline in ADLs
- Weight Loss
- Depression
Individual Run Charts

Antipsychotic Meds

- Blue line: Your facility
- Brown dots: State
- Green line: National

Data from January 13 to January 14.
Percent Contribution to Overall Composite Score by Each Quality Measure
(5/1/2014 - 10/1/2014)

- Depression: 31.00%
- Antipsychotic Medications: 16.00%
- Weight Loss: 13.00%
- Decline in Activities of Daily Living: 13.00%
- Incontinence: 9.00%
- High Risk Pressure Ulcers: 6.00%
- Falls with major injury: 4.00%
- Urinary Tract Infection: 2.00%
- Pain: 2.00%
- Catheters: 2.00%
- Pneumonia Vaccine: 1.00%
- Flu Vaccine: 1.00%
- Physical Restraint: 0.00%
# MDS 3.0 Measure: Percent of Long-Stay Residents Who Received An Antipsychotic Medication

<table>
<thead>
<tr>
<th>MEASURE DESCRIPTION</th>
<th>MEASURE SPECIFICATIONS</th>
<th>COVARIATES</th>
</tr>
</thead>
<tbody>
<tr>
<td>CMS: N031.02</td>
<td><strong>Numerator</strong></td>
<td>Not applicable.</td>
</tr>
</tbody>
</table>
| NQF: none           | Long-stay residents with a selected target assessment where the following condition is true: antipsychotic medications received. This condition is defined as follows:  
  - For assessments with target dates on or before 03/31/2012: N0400A = [1].  
  - For assessments with target dates on or after 04/01/2012: N0410A=[1,2,3,4,5,6,7]. |
|                     | **Denominator**        |            |
|                     | All long-stay residents with a selected target assessment, except those with exclusions. |
|                     | **Exclusions**         |            |
|                     | 1. The resident did not qualify for the numerator and any of the following is true:  
  1.1. For assessments with target dates on or before 03/31/2012: N0400A = [-].  
  1.2. For assessments with target dates on or after 04/01/2012: N0410A=[-]. |
|                     | 2. *Any* of the following related conditions are present on the target assessment (unless otherwise indicated):  
  2.1. Schizophrenia (I6000 = [1]).  
  2.2. Tourette's Syndrome (I5350 = [1]).  
  2.3. Tourette's Syndrome (I5350 = [1]) on the prior assessment if this item is not active on the target assessment and if a prior assessment is available.  
  2.4. Huntington's Disease (I5250 = [1]). |

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*This measure has not been submitted to NQF for approval. The measure will appear on Nursing Home Compare beginning in Summer, 2012 and will appear in the CASPER reports at a later time. When it appears on CASPER, it will replace the surveyor measure: Prevalence of Psychoactive Medication Use, in the Absence of Psychotic or Related Conditions (Long Stay).*
QAPI Element 3

Feedback, Data Systems and Monitoring
Element 3: Feedback, Data Systems and Monitoring

- Use systems to monitor care and services, drawing data from multiple sources.
- Use feedback systems to actively incorporate input from staff, residents, families and others as appropriate.
- Use performance indicators to monitor a wide range of care processes and outcomes, and review findings against benchmarks and/or targets that the facility has established for performance.
- Use tracking, investigating and monitoring of adverse events that must be investigated every time they occur, and implement action plans to prevent recurrences.
Adverse Events

What are your adverse events?

- 60 percent of nursing home adverse events, including pressure ulcers, medication errors, falls and infections, are deemed preventable.

*Only reviewed Medicare residents.

**Modified Version of the NCC MERP Index for Categorizing Errors Used in the OIG Study of Adverse Events in SNFs**

<table>
<thead>
<tr>
<th>Level</th>
<th>Description</th>
<th>Category</th>
</tr>
</thead>
<tbody>
<tr>
<td>E</td>
<td>Harm occurred that caused temporary harm that required intervention.</td>
<td>Temporary Harm Event</td>
</tr>
<tr>
<td>F</td>
<td>Harm occurred that prolonged the SNF stay and led to a transfer to a different SNF or other post-acute facility and/or hospitalization (i.e., admission to a hospital observation unit, an emergency department, or inpatient care).</td>
<td>Adverse Event</td>
</tr>
<tr>
<td>G</td>
<td>Harm occurred that contributed to or resulted in permanent resident harm.</td>
<td></td>
</tr>
<tr>
<td>H</td>
<td>Harm occurred that required intervention to sustain the resident’s life.</td>
<td></td>
</tr>
<tr>
<td>I</td>
<td>Harm occurred that may have contributed to or resulted in resident death.</td>
<td></td>
</tr>
</tbody>
</table>
OIG SNF Trigger Tool Items

- Diagnostic radiology or imaging studies
- Rising serum creatinine
- Antibiotics started in SNF
- Postoperative/post-procedure complication
- In (SNF) stroke or transient ischemic attack
- Epinephrine use
OIG SNF Trigger Tool Items

- Increasing pain medication needs
- Significant Change in Status Assessment in MDS
- New onset diarrhea
- New onset of incontinence
- Family complaint
- Call to physician or family members
OIG Report Recommendations

- “AHRQ and CMS should raise awareness of adverse events in post-acute care and seek to reduce harm to nursing home residents through methods used to promote hospital safety”

- “CMS should include potential events and information about resident harm in its quality guidance to nursing homes”
OIG Report Recommendations

- “AHRQ and CMS should encourage nursing homes to report adverse events to Patient Safety Organizations”

- “CMS should instruct nursing home surveyors to review facility practices for identifying and reducing adverse events”
Jump-Starting Element 3

So much data...

...So little time
Jump-Starting Element 3

- What is most important to you?
- What is costing you (and the resident) the most:
  - Time
  - Talent
  - Dollars
  - Pain and suffering
Jump-Starting Element 3

What do you do that is:

- High volume
- Problem prone
- High cost
- High risk
- Low volume
Jump-Starting Element 3

Don’t forget non-clinical issues:

- Turnover
- Paying bills
- Emergency prep/drills
- Maintenance work requests
- Vendors
Develop a Strategy for Collecting and Using QAPI Data

- Set performance targets and identify performance benchmarks
  - performance targets = goals
  - performance benchmarks = industry bests
Develop a Strategy for Collecting and Using QAPI Data

- Set performance targets and identify performance benchmarks
- Identify what performance metrics will be monitored (your organization's activities and performance)
- Identify who and how data will be collected, analyzed and used
Develop a Strategy for Collecting and Using QAPI Data

- Develop a process for organizing and interpreting data
  - Graphs
  - Charts
  - Sharing with teams
  - Transparency
Potential QAPI Data Sources

- QMs and Composite Score
- New mobility measure
- 24-hour report
- Interact 3.0 Tools (SBAR Communication Form, Stop and Watch)
- AHCA LTC Trend Tracker
- Survey history and prep reports
Potential QAPI Data Sources

- Readmission reports
- Staff error and near-miss reports
- Non-clinical reports
  - Turnover
  - Satisfaction surveys
  - Visitor and vendor reports
  - Family/resident complaints/comments
QAPI Data Measure Specifications

- Define the population measured
- *Who’s* in the numerator
- Who’s in the denominator
- Who’s excluded
- Timeframe for data collection
- What is the source data (e.g. MDS)
- *Use the QM manual as an example*
Element 3

Use tracking, investigating and monitoring of adverse events that must be investigated every time they occur, and action plans are implemented to prevent recurrences.
Think Deep and Wide

- Not just for this one resident
- Not just for this adverse event
- What warning signs did we miss/catch
- What can we learn
- How do we push the learning forward
Where to Start?
Identify Gaps and QI Opportunities

- Conduct gap analyses to identify areas for improvement
- Gap analysis is a strategic planning tool to help you understand:
  - where you are
  - where you want to be, and
  - how you’re going to get there
Identify Gaps and QI Opportunities

- Determine who will review data and how often
- Identify how the data will be used to improve the organization
- Select areas in need of improvement to monitor based on established threshold compared to organization performance
Data Considerations

- Integrity: Veterans Affairs medical appointment wait-time targets and ill-structured incentives
- Measurement is useless unless you find ways to improve
- Data can help you make better decisions and take smarter actions
- Users need data in a format that they can use
What’s Your Vision?

- What data do you need to help you achieve that vision?
- Your mission?
Questions?
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