CASPER Reports and the Quality Measures 2012

QIPMO
Quality Improvement for Missouri
Sinclair School of Nursing
University of Missouri

CASPER Reports

- Certification And Survey Provider Enhanced Reports
- Password-protected in the CMS-secured site
- Should be reviewed monthly
- MDS 3.0 reports are automatically purged after 60 days
Welcome to the CMS MDS System!

Reminder: The State QIES System may be down for maintenance the third Sunday of each month. If you experience any problems submitting or retrieving reports, please try again on Monday.

Please Note: User IDs should be entered using all uppercase letters.

MDS 2.0 Submissions

Unable to login? Click here to reset your MDS User ID / Password

MDS 3.0 Submissions

You do not need a new MDS personal login ID to access MDS 3.0. Your current MDS personal login ID is to be used to access the MDS 2.0 and MDS 3.0 Submission Systems and CASPER Reports.

QIES User Maintenance Application User's Guide

Select this link to access the Final Validation and Provider reports.

CASPER Reporting Users Manual

Accessibility Policy | Privacy Policy | Help

CASPER Login

Welcome!
Please enter your User ID and Password.
Select Login

User ID
Password

- Failed Login: After 3 consecutive unsuccessful login attempts, your User ID may be locked out of the system. (MDS/HCIA Providers - Please remember your User IDPassword is the same that you used in your submission process.) If locked out, your User ID and Password must be reset. Contact the QFSD Help Desk at 1-800-339-6913, QIES_helpl@fmc.org, or MDS_helpl@fmc.org.
- Notice on use of Internet Explorer 7.0
- QIES Minimum System Requirements (effective 01/01/2009) Although users may be able to get reports without meeting the minimum system requirements outlined below, deviating from these is not recommended. Any other configuration, including all previous system requirements, is not supported by CMS (e.g., using the Netscape browser, Windows 98, etc.).

- CPU: Pentium 3 (600 MHz)
- Memory: 256 MB
- Operating System: Windows 2000 or XP
- Hard Drive: 500 MB free space
- Browser: Internet Explorer v5.5 SP2
Welcome to CASPER

Use the buttons in the toolbar above as follows:
- Layout: End current session and exit the CASPER Application
- Folders: View your folders and the documents in them
- Reports: Select report categories and request reports
- Queue: List the reports that have been requested but not yet completed
- Options: Customize the report format, number of links displayed per page and report display size
- Mail: Perform maintenance such as creating, renaming and/or deleting folders
- Home: Return to this page
Provider Reports

- **MDS 3.0 ACTIVITY**
- MDS 3.0 ADMISSION/REENTRY
- MDS 3.0 ASSESSMENTS WITH ERROR NUMBER XXXX
- MDS 3.0 DISCHARGES
- MDS 3.0 ERROR DETAIL BY FACILITY
- MDS 3.0 ERROR NUMBER SUMMARY BY FACILITY BY VENDOR
- MDS 3.0 ERRORS BY FIELD BY FACILITY
- **MDS 3.0 MISSING ASSESSMENT**
- MDS 3.0 NH ASSESSMENT PRINT
- MDS 3.0 RFA STATISTICS
- **MDS 3.0 ROSTER**
- MDS 3.0 SUBMISSION STATISTICS BY FACILITY
- MDS 3.0 VENDOR LIST
MDS 3.0 Activity

- Review the activity for the prior month
- List will show all MDS's that were submitted in the prior month
- Will show:
  - Resident name
  - Reason for assessment
  - Target date
  - Submission date
  - Medicare RUG

This report may contain privacy protected data and should not be released to the public.
MDS 3.0 Missing Assessment

- No time frame is submitted
- Shows residents who have not had an assessment in at least 138 days
- Also includes residents with no OBRA assessment in the last 60 days of the current episode (only has Entry or PPS assessments)

CASPER Report
(MD) MDS 3.0 Missing OBRA Assessment

<table>
<thead>
<tr>
<th>Resident Identifier</th>
<th>Resident Name</th>
<th>SSN</th>
<th>Date of Birth</th>
<th>Gender</th>
<th>OBRA ADR290</th>
<th>PPS ADR290</th>
<th>Target Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>B8868490</td>
<td>BROOKLYN, BROOKLYN</td>
<td>410124780</td>
<td>01/04/1953</td>
<td>M</td>
<td>1</td>
<td>1</td>
<td>04/09/2012</td>
</tr>
<tr>
<td>S8077480</td>
<td>BROOKLYN, BROOKLYN</td>
<td>121212128</td>
<td>11/37/1957</td>
<td>M</td>
<td>99</td>
<td>99</td>
<td>06/04/2011</td>
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<tr>
<td>95811870</td>
<td>COCCOC, COCCOC</td>
<td>321589463</td>
<td>04/09/1953</td>
<td>M</td>
<td>1</td>
<td>1</td>
<td>11/05/2019</td>
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<tr>
<td>2784975</td>
<td>COCCOC, COCCOC</td>
<td>240944392</td>
<td>10/04/1957</td>
<td>M</td>
<td>1</td>
<td>1</td>
<td>11/05/2019</td>
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<tr>
<td>2542506</td>
<td>COCCOC, COCCOC</td>
<td>462529430</td>
<td>03/17/1952</td>
<td>M</td>
<td>99</td>
<td>3</td>
<td>10/01/2019</td>
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<tr>
<td>5656208</td>
<td>COCCOC, COCCOC</td>
<td>329313140</td>
<td>10/05/1910</td>
<td>F</td>
<td>1</td>
<td>1</td>
<td>11/01/2019</td>
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<tr>
<td>51950950</td>
<td>DOGDOOGDOOG, DOGDOOG</td>
<td>430516333</td>
<td>12/01/1932</td>
<td>M</td>
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<td>1</td>
<td>11/02/2019</td>
</tr>
<tr>
<td>S65444</td>
<td>DOGDOOGDOOG, DOGDOOG</td>
<td>324396333</td>
<td>03/05/1950</td>
<td>F</td>
<td>99</td>
<td>99</td>
<td>10/05/2011</td>
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<td>2243369</td>
<td>DOGDOOGDOOG, DOGDOOG</td>
<td>490243333</td>
<td>10/05/1935</td>
<td>F</td>
<td>99</td>
<td>2</td>
<td>10/04/2013</td>
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<tr>
<td>1536061</td>
<td>DOGDOOGDOOG, DOGDOOG</td>
<td>510396363</td>
<td>07/04/1919</td>
<td>F</td>
<td>2</td>
<td>99</td>
<td>10/05/2019</td>
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<tr>
<td>32401163</td>
<td>DOGDOOGDOOG, DOGDOOG</td>
<td>259294979</td>
<td>11/05/1927</td>
<td>F</td>
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<td>1</td>
<td>12/07/2019</td>
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<tr>
<td>1064529</td>
<td>DOGDOOGDOOG, DOGDOOG</td>
<td>458142989</td>
<td>04/03/1929</td>
<td>F</td>
<td>99</td>
<td>3</td>
<td>10/01/2019</td>
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<tr>
<td>155914</td>
<td>DOGDOOGDOOG, DOGDOOG</td>
<td>419311298</td>
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<tr>
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<td>537117779</td>
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<td>F</td>
<td>1</td>
<td>1</td>
<td>11/05/2019</td>
</tr>
</tbody>
</table>

This report may contain privacy protected data and should not be released to the public.
# MDS 3.0 Roster

- List all residents CMS has recorded based upon MDS submissions
- Review roster at least monthly to ensure all residents have an up-to-date MDS
- Report includes
  - Resident name
  - Reason for assessment
  - Target date
  - Submission date
  - Admission date
  - Admission type

## Report

**CASPER Report (MO) MDS 3.0 Roster**

<table>
<thead>
<tr>
<th>Resident Intern ID</th>
<th>SSN</th>
<th>Resident Name</th>
<th>DOB</th>
<th>Gender</th>
<th>Race/Ethnicity</th>
<th>ADH</th>
<th>Admission Date</th>
<th>Target Date</th>
<th>Submission Date</th>
<th>Admission Date</th>
<th>Diagnosis Type</th>
</tr>
</thead>
<tbody>
<tr>
<td>453900</td>
<td>2012-01-01</td>
<td>AAAA, Bob</td>
<td>05/01/1980</td>
<td>M</td>
<td>White</td>
<td></td>
<td>02/15/2021</td>
<td>03/15/2021</td>
<td>04/20/2021</td>
<td>05/10/2021</td>
<td>Alzheimer's</td>
</tr>
<tr>
<td>345678</td>
<td>1987-02-02</td>
<td>AAAA, Jane</td>
<td>06/10/1990</td>
<td>F</td>
<td>Asian</td>
<td></td>
<td>03/01/2020</td>
<td>04/02/2020</td>
<td>05/03/2020</td>
<td>06/03/2020</td>
<td>Dementia</td>
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<tr>
<td>123456</td>
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<td>AAAA, John</td>
<td>07/15/1985</td>
<td>M</td>
<td>African</td>
<td></td>
<td>04/10/2019</td>
<td>05/10/2019</td>
<td>06/10/2019</td>
<td>07/10/2019</td>
<td>Arthritis</td>
</tr>
</tbody>
</table>

NOTE: All personal protected data in this report has been replaced with fictional information.
Overview of RAI Process

Overview of the Resident Assessment Instrument (RAI) Process

- General Purpose:
  - Provide a standardized method for comprehensive assessment of complex nursing home residents
  - Establish a plan of care that serves as a basis for communication of resident-specific care needs
  - Assist facility staff to view residents in a holistic manner i.e., as a whole person with individual problems, needs, strengths, and preferences
RAI Overview (continued)

- Mandated for all residents in certified beds (Medicare/Medicaid)
- Must be conducted and/or coordinated by an RN who certifies that the PROCESS is complete
- Recommended to be completed as an interdisciplinary process including involvement of the resident, family, physician, and nursing home staff
- Further guidance provided in the RAI Manual April 2012

Resident Assessment Instrument (RAI) Process

- Involves the following process:
  - Completion of the Minimum Data Set (MDS) - initial assessment
  - Completion of the Care Area Assessment (CAA) review-in-depth assessment and problem identification process
  - Development of the plan of care - identifying problems/potential problems, establishing goals and interventions that may affect resident outcomes
Quality Measures

Use of MDS Data for Quality Measures

- Several QMs use data from MDS sections that assess mental status, depression and pain
- Includes data from the discharge assessment under certain circumstances
- Use of ‘dash’ (-) may result in resident being excluded from QM measure calculations
- Affects the accuracy of:
  - Nursing Home Compare
  - 5 STAR Nursing Home Quality Rating System
**Effects on Facility QM Sample**

- Reduces the size of the facility's quality measure resident sample
  - Skews QM data
  - Results in an inaccurate representation of the facility’s actual resident population

**Quality Measure Versions**

- Publicly reported which can be found on Nursing Home Compare
- Internally reported to the facility which can be found at CASPER
Quality Measures

Nursing home QM’s have four intended purposes:
1. Information about the Quality of Care at nursing homes to help the public choose a nursing home
2. Prompt consumers to talk to nursing home staff about the Quality of Care
3. To give data to the nursing home to help them with their Quality Improvement efforts
4. To give data to the State Survey Agency for inspection

Quality Measures - Intent for Public Reporting

- Intended to provide consumers an additional data source to use when selecting a nursing facility: www.medicare.gov

- Assists facilities to more effectively focus on quality improvement to ensure that systems are in place for to care for the residents
  - MDS Quality Improvement Evaluation System (QIES)
Intent of Internal Facility QM Reports

- Quality measures reports are designed as “feedback” tools for facilities:
  - Quality improvement efforts
  - Survey guidance
- These reports are NOT publicly accessible

QMs (continued)

- QMs are process-and-outcome directed:
  - Processes are goal-directed, interrelated series of actions, events, or steps (care delivery)
    - i.e. catheters, restraints, increased dependence for ADLs
  - Outcomes are a result of care delivery practices
    - i.e. falls, urinary tract infections (UTIs)
QMs (continued)

- QMs are also incidence-and-prevalence directed:
  - Incidence is the development of a condition over time (new case)
    - i.e. new or worsened pressure ulcer, need for help with ADLs has increased
  - Prevalence is the presence or absence of a condition at a single point in time
    - i.e. falls, self-report of pain, etc.

3 NEW MDS 3.0 QMs

- Percent of Residents Experiencing One or More Falls with Major Injury (Long Stay)
- The Percentage of Residents on a scheduled Pain Medication Regimen on Admission who Self Report a decrease in Pain Intensity or Frequency (Short Stay)
- The percentage of residents who newly received an antipsychotic medication
4 Retired MDS 2.0 QMs

- PAC Percent of short stay residents with delirium
- CC Percent of residents whose ability to move about in and around their room got worse
- CC Percent of residents who spent more of their time in bed or in a chair during the assessment period
- CC Percent of low-risk residents who have pressure sores

Reasons for QM Retirement

- Delirium: CAM is used to screen for further evaluation but is not appropriate to use for identification or evaluation of improvement
- Mobility Decline: Issues with the scientific acceptability (sensitivity, reliability, validity, and risk adjustment)
### Reasons for QM Retirement

- Bedfast: Item deleted from MDS 3.0
- Low-risk pressure sores: Issues with the scientific acceptability (sensitivity, reliability, validity, and risk adjustment)

### Quality Measure Endorsement and Public Reporting

- National Quality Forum (NQF) endorsement process
- CMS Measures Management (Blue Print) system
- CMS 5 Star reporting
- CMS SNF Value-Based Purchasing
MDS 3.0 QM National Quality Forum Process

- January 2009 – NQF ‘Call for Measures’
- September 2009 – CMS report summarizing new nursing home QMs developed for NQF
- **October 2010 – QM TEP convened (Carol was there!)**
- March 2010 – Two new MDS 3.0 QMs and 15 QMs founded on MDS 2.0 submitted to NQF
- February 2011 – NQF endorses 17 MDS 3.0 QMs (7 TLE)
- Fall 2011 – anticipate NQF expanding 4 vaccination QMs
- February 2012 – testing results due to NQF for 7 TLE QMs

5 MDS 3.0 Quality Measures with NQF Time-Limited Endorsement (TLE)

- Percent of Residents Who Self-Report Moderate to Severe Pain (Short Stay) (NQF #0676)
- Percent of Residents who Self-Report Moderate to Severe Pain (Long Stay) (NQF #0677)
- Percent Residents with Pressure Ulcers that are New or Worsened (Short Stay) (NQF #0678)
- Percent High-Risk Residents with Pressure Ulcers (Long Stay) (NQF #0679)
- Percent Residents Who Have Depressive Symptoms (Long Stay) (NQF #0690)
CMS Measures Management System

- Measures development process
- Guides CMS-contracted measure developers on the development and maintenance of measures
- Maintain measures inventory
- Blueprint Version 8 forms

CMS 5 Star Quality Reporting System

- Based on health inspections, staffing, and quality measures
- Previously based on MDS 2.0 quality measures
  - Long-stay prevalence quality measures
    - ADL change
    - Mobility change
    - High-risk pressure ulcers
    - Long-term catheters
    - Physical restraints
    - Urinary Tract Infections (UTIs)
    - Pain
  - Short-stay prevalence quality measures
    - Delirium
    - Pain
    - Pressure Ulcers
**CMS 5 STAR with MDS 3.0 Data**

<table>
<thead>
<tr>
<th>Short Stay</th>
</tr>
</thead>
<tbody>
<tr>
<td>Self-reported moderate to severe pain</td>
</tr>
<tr>
<td>New/worsened pressure ulcers*</td>
</tr>
<tr>
<td>Seasonal influenza assessed and given appropriately</td>
</tr>
<tr>
<td>Pneumococcal vaccine assessed and given appropriately</td>
</tr>
<tr>
<td>% of residents who newly received an antipsychotic medication* (not in 5 STAR calculation)</td>
</tr>
</tbody>
</table>

*Risk-adjusted Quality Measure using resident-level covariates for public reporting

<table>
<thead>
<tr>
<th>Long Stay</th>
</tr>
</thead>
<tbody>
<tr>
<td>Self-reported moderate to severe pain*</td>
</tr>
<tr>
<td>High-risk residents with pressure ulcers*</td>
</tr>
<tr>
<td>Physical restraints</td>
</tr>
<tr>
<td>Falls with major injury</td>
</tr>
<tr>
<td>Depressive symptoms</td>
</tr>
<tr>
<td>Urinary tract infections</td>
</tr>
<tr>
<td>Catheter inserted and left in bladder*</td>
</tr>
<tr>
<td>Low-risk residents who lose bowel/bladder control</td>
</tr>
<tr>
<td>Excessive weight loss</td>
</tr>
<tr>
<td>Need for help with ADLs has increased</td>
</tr>
<tr>
<td>% of residents who received an antipsychotic medication* (not in the 5 STAR calculation)</td>
</tr>
</tbody>
</table>
5 STAR Quality Rating

- Much Above Average
- Above Average
- Average
- Below Average
- Much Below Average

Calculating the Overall Rating (STAR Rating)

<table>
<thead>
<tr>
<th>Step 1</th>
<th>Step 2</th>
<th>Step 3</th>
<th>Overall Rating</th>
</tr>
</thead>
<tbody>
<tr>
<td>Health Inspection Rating</td>
<td>Staffing Rating</td>
<td>Quality Measures Rating (QMs)</td>
<td></td>
</tr>
<tr>
<td>Start with Health Inspection Rating</td>
<td>Add 1 star for 4 or 5-Star Staffing</td>
<td>Add 1 star for 5-Star QMs</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Subtract 1 star for 1-Star Staffing</td>
<td>Subtract 1 star for 1-Star QMs</td>
<td></td>
</tr>
</tbody>
</table>
On June 22, 2012 CMS announces:

- **Nursing Home Compare:** The Centers for Medicare & Medicaid Services (CMS) will launch a re-designed Nursing Home Compare website on July 19, 2012.

- **New Information:** Website will add new MDS 3.0 quality measures, detailed inspection reports (CMS 2567s), nursing home ownership information, and additional staffing data.
### As of July 2012

#### Nursing home compare website will display
- The Quality Measure (QM) Rating that will be posted on the Nursing Home Compare website is based on the new MDS 3.0 quality measures, using data from the second, third, and fourth quarters of 2011.
- Detailed Inspection Reports (Form CMS-2567).
- Ownership information (information on the legal business names of nursing homes) posted later this year.
- Information on Physical Therapist staffing levels - Physical Therapist hours per resident day will be reported (PT staffing will be displayed as reported on CMS 671).

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### As of July 2012

#### Nursing home compare website will display
- As of April 2012, the calculation of adjusted staffing (used in assigning the staffing ratings has been updated to incorporate case-mix data derived from MDS 3.0 assessments from 2011 as well as new national averages of reported staffing. The rating thresholds have also been revised so that the overall proportion of nursing homes in each rating category in April 2012 was the same as it was in December 2011.

The 5 Star Help line (800-839-9290) will be available from June 19 through August 3, 2012. Provider preview reports will continue to be available on a monthly basis in advance of public posting and will include the dates and hours of helpline availability. BetterCare@cms.hhs.gov is an alternative communication medium to direct inquiries.
As of July 2012

MDS 3.0 Facility and Resident Quality Measure Preview Reports

- The MDS 3.0 Facility and Resident Quality Measure Preview reports are available in your facility’s shared folder. These reports are similar to the MDS 2.0 Facility and Resident Quality Measure Preview reports, but have been updated to contain the new MDS 3.0 Quality Measures.
- The MDS 3.0 Facility Preview report displays the quarterly numerator, denominator and reported percent values for each of the publicly reported MDS 3.0 quality measures. This report will contain quality measure data for the fourth quarter (Q4) of 2011. The preview report allows the provider to see their measure percent values prior to being posted on the Nursing Home Compare website.

As of July 2012

MDS 3.0 Facility and Resident Quality Measure Preview Reports

- The MDS 3.0 Resident Preview report displays the list of residents who triggered one or more of the publicly reported MDS 3.0 Quality Measures. For the Influenza or Pneumococcal vaccination measures, only residents who did not receive the vaccinations are listed. The information from this report is not publicly reported and is for use by the provider only.
The Five Star Preview Reports will be available beginning June 18th. To access these reports:

- Select the CASPER Reporting link located at the top of your MDS State Welcome page.
- Click on the 'Folders' button and access the Five Star Report in your 'st LTC facid' folder, where st is the 2-character postal code of the state in which your facility is located and facid is the state-assigned Facility ID of your facility.

**July, 2012 NH compare website will show:**

1. CMS will post data on **two** measures of **use of anti-psychotic medication use (short-stay incidence and long-stay prevalence).**
2. The QMS rating is based on **nine** QMS derived from MDS 3.0. The QM values for the nursing home that contribute to the QM rating, along with other MDS 3.0 QMs that will be posted on NH compare but that are **not part** of the QM rating are shown on the table.
CMS SNF Value-Based Purchasing

- **RTI Report to Congress** (under Section 3006(f) of the Affordable Care Act) in clearance with CMS
  - Anticipate public posting Winter 2011/12
- **Ongoing 3-State Demonstration (AZ, WI, NY)**
  - QM composite addressing four domains
    - Staffing
    - Appropriate hospitalizations
    - MDS outcome measures
    - Survey deficiencies

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Potential New Quality Measures

- Hospital readmissions
- Catheter-acquired urinary tract infection
## Antipsychotic Usage

- Looking at those meds with the Black Box Warnings: Zyprexa, Abilify, Risperdal, and Seroquel
- Goal is to reduce the national rate by 15% by the end of the year
- Current rate is approximately 20%

## Antipsychotic Usage

**Steps:**
- Change surveyor guidance
- Worksheets to be developed for surveyors
- Training for surveyors
- Training for providers
- LANEs and QIOs to assist disseminating the information
Antipsychotic Usage

- What should be in place:
  - Staff education
  - Engaging MDs and NPs
  - Specific interventions for the resident
  - Documentation
    - Target behaviors
    - Goals
    - Monitoring

Antipsychotic Usage

- CMS will be sharing tools/resources such as
  - Provider Question worksheet
  - Flow diagram for providers
  - Performance Indicator Checklist
Physician Education

- Letter from AMDA has been sent to all AMDA physicians
- Same letter will be sent to all physicians by the MO LANE

QUALITY MEASURES
GENERAL INFORMATION
Surveyor Quality Measures

For Long Stay Residents Only
1. Falls
2. Psychoactive Medication Use in Absence of Psychotic or Related Condition
3. Anti-Anxiety/Hypnotic Medication Use
4. Behavior Symptoms Affecting Others

Prevalence of Falls
For Long Stay Residents Only

<table>
<thead>
<tr>
<th>Numerator</th>
<th>Denominator</th>
</tr>
</thead>
<tbody>
<tr>
<td>Residents with one or more look-back assessments that indicate a fall (J1800=1)</td>
<td>All long stay residents</td>
</tr>
</tbody>
</table>

Exclusions
- All look-back scan assessments not assessed (J1800=dash)
Psychoactive Medication Use in Absence of Psychotic or Related Condition
For Long Stay Residents Only

**Numerator:**
- N0400A=1 (assessments 3/31/12 or before)
- N0410A=1-7 (assessments 4/1/12 or after)

**Denominator:** All long stay residents

**Exclusions**
- Schizophrenia
- Psychotic disorder
- Manic depression
- Tourette’s
- Huntington’s
- Hallucinations
- Delusions

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Anti-anxiety/Hypnotic Medication Use
For Long Stay Residents Only

**Numerator:**
- N0400B=1 (assessments 3/31/12 or before) or
- N0400D=1 (assessments 3/31/12 or before)
- N0410B=1-7 (assessments 4/1/12 or after) or
- N0410D=1-7 (assessments 4/1/12 or after)

**Denominator:** All long stay residents

**Exclusions**
- Schizophrenia
- Psychotic disorder
- Manic depression
- Tourette’s
- Huntington’s
- Hallucinations
- Delusions
Behavior Symptoms Affecting Others  
*For Long Stay Residents Only*

**Numerator:**
- E0200A = 1, 2, 3 or E0200B = 1, 2, 3 or
- E0200C = 1, 2, 3 or E0800 = 1, 2, 3 or E0900 = 1, 2, 3

**Exclusions:**
Target assessment is a discharge, dash at any of the above items.

**Denominator:** All long stay residents

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**CMS-802**

**ROSTER/SAMPLE MATRIX**
Accessing the MDS 3.0 Reports

**CASPER Reports**

- **Report Categories**
  - MDS 3.0 NH Final Validation
  - MDS 3.0 NH Provider
  - MDS 3.0 NH Reports
  - MDS 3.0 QM Reports
  - MDS 3.0 Submitter Validation
  - MDS 3.0 Reports

- **MDS 3.0 QM Reports**
  - MDS 3.0 Facility Quality Measure Report
  - MDS 3.0 Monthly Comparison Report
  - MDS 3.0 QM Package Report
  - MDS 3.0 Resident Level Quality Measure Report
Prefilled for the most recent completed 6 month period prior to the month the data were last calculated

Comparison: Most recent 6 month data ending 3 months prior to the current month

Quality Measure data are calculated weekly for the assessments since the previous week’s data calculation
### NFQ: 10 ST (INCLUDING 6 SUB QMS)

<table>
<thead>
<tr>
<th>NFQ ID</th>
<th>Short Stay Quality Measures (4 QMS + 6 Sub QMS = 10 QMS)</th>
<th>CASPER</th>
<th>NH Compass</th>
<th>Surveyor</th>
<th>5-star QMs from Casper</th>
</tr>
</thead>
<tbody>
<tr>
<td>#0676</td>
<td>Percent of Residents Who Self-Report Moderate to Severe Pain</td>
<td>?</td>
<td>?</td>
<td>*</td>
<td>*</td>
</tr>
<tr>
<td>#0678</td>
<td>Percent of Residents With Pressure Ulcers That Are New or Worsened</td>
<td>?</td>
<td>?</td>
<td>*</td>
<td>*</td>
</tr>
<tr>
<td>#0680</td>
<td>Percent of Residents Who Were Assessed and Appropriately Given the Seasonal Influenza Vaccine</td>
<td>?</td>
<td>?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>#0680A</td>
<td>Percent of Residents Who Received the Seasonal Influenza Vaccine</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>#0680B</td>
<td>Percent of Residents Who Were Offered and Declined the Seasonal Influenza Vaccine</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>#0680C</td>
<td>Percent of Residents Who Did Not Receive, Due to Medical Contraindication, the Seasonal Influenza Vaccine</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>#0682</td>
<td>Percent of Residents Assessed and Appropriately Given the Pneumococcal Vaccine</td>
<td>?</td>
<td>?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>#0682A</td>
<td>Percent of Residents Who Received the Pneumococcal Vaccine</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>#0682B</td>
<td>Percent of Residents Who Were Offered and Declined the Pneumococcal Vaccine</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>#0682C</td>
<td>Percent of Residents Who Did Not Receive, Due to Medical Contraindication, the Pneumococcal Vaccine</td>
<td></td>
<td></td>
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<td></td>
</tr>
</tbody>
</table>

**Percent of resident who NEWLY received an antipsychotic medication** (exclude schizophrenia, Huntington’s disease or Tourette’s syndrome. This DIFFER from CASPER antipsychotic QMs)

### NFQ: 15 LS (INCLUDING 6 SUB QMS)

<table>
<thead>
<tr>
<th>NFQ ID</th>
<th>Long Stay Quality Measures (12 QMS + 6 Sub QMS = 18 QMS)</th>
<th>CASPER</th>
<th>NH Compass</th>
<th>Surveyor</th>
<th>5-star QMs from Casper</th>
</tr>
</thead>
<tbody>
<tr>
<td>#0674</td>
<td>Percent of Residents Experiencing One or More Falls with Major Injury</td>
<td>X</td>
<td>*</td>
<td>*</td>
<td>*</td>
</tr>
<tr>
<td>#0677</td>
<td>Percent of Residents Who Self-Report Moderate to Severe Pain</td>
<td>X</td>
<td>?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>#0679</td>
<td>Percent of High-Risk Residents With Pressure Ulcers</td>
<td>X</td>
<td>?</td>
<td>*</td>
<td>*</td>
</tr>
<tr>
<td>#0681</td>
<td>Percent of Residents Assessed and Appropriately Given the Seasonal Influenza Vaccine</td>
<td>?</td>
<td>?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>#0681A</td>
<td>Percent of Residents Who Received the Seasonal Influenza Vaccine</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>#0681B</td>
<td>Percent of Residents Who Were Offered and Declined the Seasonal Influenza Vaccine</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>#0681C</td>
<td>Percent of Residents Who Did Not Receive, Due to Medical Contraindication, the Seasonal Influenza Vaccine</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>#0683</td>
<td>Percent of Residents Assessed and Appropriately Given the Pneumococcal Vaccine</td>
<td>?</td>
<td>?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>#0683A</td>
<td>Percent of Residents Who Received the Pneumococcal Vaccine</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>#0683B</td>
<td>Percent of Residents Who Were Offered and Declined the Pneumococcal Vaccine</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>#0683C</td>
<td>Percent of Residents Who Did Not Receive, Due to Medical Contraindication, the Pneumococcal Vaccine</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>#0684</td>
<td>Percent of Residents With a Urinary Tract Infection</td>
<td>X</td>
<td>*</td>
<td>*</td>
<td>*</td>
</tr>
<tr>
<td>#0685</td>
<td>Percent of Low Risk Residents Who Lost Control of their Bowel or Bladder</td>
<td>X</td>
<td>?</td>
<td>*</td>
<td>*</td>
</tr>
<tr>
<td>#0686</td>
<td>Percent of Residents Who Have Had a Catheter Inserted and Left in Their Bladder</td>
<td>X</td>
<td>?</td>
<td>*</td>
<td>*</td>
</tr>
<tr>
<td>#0687</td>
<td>Percent of Residents Who Were Physically Restrainted</td>
<td>X</td>
<td>?</td>
<td>*</td>
<td>*</td>
</tr>
<tr>
<td>#0688</td>
<td>Percent of Residents Whose Need for Help with Activities of Daily Living Has Increased</td>
<td>X</td>
<td>?</td>
<td>*</td>
<td>*</td>
</tr>
<tr>
<td>#0689</td>
<td>Percent of Residents Who Lose Too Much Weight</td>
<td>X</td>
<td>?</td>
<td>*</td>
<td>*</td>
</tr>
<tr>
<td>#0690</td>
<td>Percent of Residents Who Have Depressive Symptoms</td>
<td>X</td>
<td>?</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Percent of resident who received an antipsychotic medication** (exclude schizophrenia, Huntington’s disease or Tourette’s syndrome. This DIFFER from CASPER antipsychotic QMs)

**Surveyors (on facility CASPER QM report)**

<table>
<thead>
<tr>
<th>Fail</th>
<th>Psychotropic Medication Use in Absence of Psychotic or Related Condition</th>
<th>Antipsychotic Medication Use</th>
<th>Antidepressant/Hypnotic Medication Use</th>
<th>Behavior Symptoms Affecting Others</th>
</tr>
</thead>
<tbody>
<tr>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
</tbody>
</table>

5-star QMs from Casper: NDS 3.0 QMs for provider that is retrieved from Casper system for 5-star ratings of nursing home since July 18th.
Casper Report
MDS 3.0 Facility Quality Measure Report

<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 (SRR) Moderate/Severe Pain (S)</td>
<td>0676</td>
<td>0</td>
<td>4.453</td>
<td>0.0%</td>
<td>0.0%</td>
<td>23.7%</td>
<td>23.1%</td>
</tr>
<tr>
<td>Self-Reported (SRR) Moderate/Severe Pain (L)</td>
<td>0677</td>
<td>0</td>
<td>1.038</td>
<td>0.0%</td>
<td>0.0%</td>
<td>19.7%</td>
<td>16.0%</td>
</tr>
<tr>
<td>High-Risk Residents with Pressure Ulcers (L)</td>
<td>0679</td>
<td>576.591</td>
<td>64.0%</td>
<td>64.0%</td>
<td>16.4%</td>
<td>10.2%</td>
<td>98</td>
</tr>
<tr>
<td>New/Worsened Pressure Ulcers (S)</td>
<td>0670</td>
<td>567</td>
<td>2.516</td>
<td>22.1%</td>
<td>0.0%</td>
<td>2.1%</td>
<td>2.7%</td>
</tr>
<tr>
<td>Physical Restraints (L)</td>
<td>0664</td>
<td>0</td>
<td>1.560</td>
<td>0.0%</td>
<td>0.0%</td>
<td>0.9%</td>
<td>2.1%</td>
</tr>
<tr>
<td>Falls (L)</td>
<td>0673</td>
<td>0</td>
<td>1.560</td>
<td>0.1%</td>
<td>0.1%</td>
<td>28.3%</td>
<td>35.1%</td>
</tr>
<tr>
<td>Falls with Major Injury (L)</td>
<td>0674</td>
<td>0</td>
<td>1.560</td>
<td>0.0%</td>
<td>0.0%</td>
<td>2.9%</td>
<td>2.9%</td>
</tr>
<tr>
<td>Psychotropic Medication Use in Absence of Psychotic or Related Condition (L)</td>
<td>0665</td>
<td>0</td>
<td>1.567</td>
<td>0.0%</td>
<td>0.0%</td>
<td>1.1%</td>
<td>1.6%</td>
</tr>
<tr>
<td>Ambulatory/Hypnotic Medication Use (L)</td>
<td>0666</td>
<td>0</td>
<td>1.567</td>
<td>0.0%</td>
<td>0.0%</td>
<td>2.0%</td>
<td>1.9%</td>
</tr>
<tr>
<td>Incontinence Symptoms Affecting Others (L)</td>
<td>0667</td>
<td>0</td>
<td>1.566</td>
<td>0.1%</td>
<td>0.1%</td>
<td>15.0%</td>
<td>22.0%</td>
</tr>
<tr>
<td>Depression Symptoms (L)</td>
<td>0668</td>
<td>1.566</td>
<td>1.568</td>
<td>99.5%</td>
<td>99.0%</td>
<td>11.2%</td>
<td>16.2%</td>
</tr>
<tr>
<td>Uremic Tract Infection (L)</td>
<td>0669</td>
<td>0</td>
<td>1.039</td>
<td>0.0%</td>
<td>0.0%</td>
<td>12.7%</td>
<td>10.7%</td>
</tr>
<tr>
<td>Catheter Inserted and Left in Bladder (L)</td>
<td>0670</td>
<td>0</td>
<td>1.039</td>
<td>0.0%</td>
<td>0.0%</td>
<td>12.3%</td>
<td>7.0%</td>
</tr>
<tr>
<td>Low-Vitality Residents Who Lose Bowel/Bladder Control (L)</td>
<td>0671</td>
<td>0</td>
<td>1.039</td>
<td>0.0%</td>
<td>0.0%</td>
<td>51.1%</td>
<td>36.0%</td>
</tr>
<tr>
<td>Excessive Weight Loss (L)</td>
<td>0672</td>
<td>1.039</td>
<td>1.039</td>
<td>99.7%</td>
<td>99.7%</td>
<td>57.9%</td>
<td>10.2%</td>
</tr>
<tr>
<td>Need for Help with ADLs Has Increased (L)</td>
<td>0673</td>
<td>0</td>
<td>9</td>
<td>0.0%</td>
<td>0.0%</td>
<td>22.0%</td>
<td>19.8%</td>
</tr>
</tbody>
</table>

This report may contain privacy protected data and should not be released to the public.
MDS 3.0 Resident Level Quality Measure Report

- Begin and End date are pre-filled for most recent completed 6 month period prior to the month data were last calculated
- QM data are calculated weekly for the assessments submitted since the previous weeks
MDS 3.0 Monthly Comparison Report

- Begin month and end month are pre-filled for the previous full 6 month period
- You may select an alternate end month and the begin month will adjust to show 6 months
### CASPER Reports vs Nursing Home Compare

- **Why are the results different?**
  - Measures included
  - Timing
  - Reporting periods
  - Averaging across quarters
  - Risk adjustment
# CASPER Reports vs Nursing Home Compare

<table>
<thead>
<tr>
<th></th>
<th>Nursing Home Compare</th>
<th>Casper</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Timing</strong></td>
<td>Run once a Quarter</td>
<td>Updated Frequently</td>
</tr>
<tr>
<td><strong>Report Periods</strong></td>
<td>Uses most recent 3 months for LS &amp; most recent 6 months for SS</td>
<td>Customized by User</td>
</tr>
<tr>
<td><strong>Average Across Quarters</strong></td>
<td>Avg. Across several calendar Quarters</td>
<td>For only one single report period</td>
</tr>
<tr>
<td><strong>Risk Adjusted (related to Timing)</strong></td>
<td>Calculations performed at different times based on National Average</td>
<td>Calculations performed at different times based on National Average</td>
</tr>
</tbody>
</table>

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## DATA SPECIFICATIONS FOR INDIVIDUAL QM’S

---
Self-Report Moderate to Severe Pain

(Short Stay)

**Numerator**
Short-stay residents with a selected target assessment where the target assessment meets *either or both* of the following two conditions:

**Condition #1**: resident reports daily pain with at least one episode of moderate/severe pain. *Both* of the following conditions must be met:
- Almost constant or frequent pain (J0400=[1,2]) *and*
- At least one episode of moderate to severe pain (J0600A=[05,06,07,08,09] OR J0600B=[2,3])

**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.

Self-Report Moderate to Severe Pain

(Long Stay)

**Numerator**
Long-stay residents with a selected target assessment where the target assessment meets *either or both* of the following two conditions:

**Condition #1**: resident report almost constant or frequent moderate to severe pain in the last 5 days. *Both* of the following conditions must be met:
- Almost constant or frequent pain (J0400=[1,2]), *and*
- At least one episode of moderate to severe pain: (J0600A=[05,06,07,08,09] OR J0600B=[2,3])

**Condition #2**: resident reports very severe/horrible pain of any frequency (J0600A=[10] OR J0600B=[4]).

**Denominator**
All long-stay residents with a selected target assessment, except those with exclusions.
Percent of High-Risk Residents With Pressure Ulcers (Long Stay)

**Numerator**
All residents with a selected target assessment that meets both of the following conditions:

**Condition #1:** There is a high risk for pressure ulcers, where “high-risk” is defined in the denominator definition below.

**Condition #2:** Stage II-IV pressure ulcers are present, as indicated by any of the following three conditions:

- M0300B1 = [1, 2, 3, 4, 5, 6, 7, 8, 9] or
- M0300C1 = [1, 2, 3, 4, 5, 6, 7, 8, 9] or
- M0300D1 = [1, 2, 3, 4, 5, 6, 7, 8, 9] or
- Any of additional active diagnoses is a Stage II-IV ulcer ICD-9 (I8000 = [707.22, 707.23, 707.24])

**Denominator**
All residents with a selected target assessment who meet the definition of high risk except those with exclusions.

Percent of Residents With Pressure Ulcers That Are New or Worsened (Short Stay)

**Numerator**
Short-stay residents for which a look-back scan indicates one or more new or worsening Stage II-IV pressure ulcers where on any assessment in the look-back scan:

- Stage II (M0800A) > [0] and M0800A < = M0300B1, OR
- Stage III (M0800B) > [0] and M0800B < = M0300C1, OR
- Stage IV (M0800C) > [0] and M0800C < = M0300D1.

**Denominator**
All residents with one or more assessments that are eligible for a look-back scan, except those with exclusions.
Percent of Residents Who Were Physically Restrained (Long Stay)

**Numerator**
Long-stay residents with a selected target assessment that indicates daily physical restraints, where:
- trunk restraint used in bed \((P0100B = [2])\) OR
- limb restraint used in bed \((P0100C = [2])\) OR
- trunk restraint used in chair or out of bed \((P0100E = [2])\) OR
- limb restraint used in chair or out of bed \((P0100F = [2])\) OR
- chair prevents rising used in chair or out of bed \((P0100G) = [2])\)

**Denominator**
All residents with a target assessment, except those with exclusions.

Percent of Residents Experiencing One or More Falls with Major Injury (Long Stay)

**Numerator**
Long-stay residents with one or more look-back scan assessments that indicate one or more falls that resulted in major injury \((J1900C = [1, 2])\).

**Denominator**
All long-stay nursing home residents with a one or more look-back scan assessments except those with exclusions.
Percent of Residents Who Have Depressive Symptoms (Long Stay)

**Numerator**
Long-stay residents with a selected target assessment where the target assessment meets either of the following two conditions:

- **CONDITION A** (The resident mood interview must meet Part 1 and Part 2 below)
  - PART 1: little interest or pleasure in doing things half or more of the days over the last two weeks (D0200A2 = [2, 3]) OR Feeling down, depressed, or hopeless half or more of the days over the last two weeks (D0200B2 = [2, 3])
  - PART 2: The resident interview total severity score indicates the presence of depression (D0300 ≥ [10] and D0300 ≤ [27]).

- **CONDITION B**: (The staff assessment of resident mood must meet Part 1 and Part 2 below)
  - PART 1: Little interest or pleasure in doing things half or more of the days over the last two weeks (D0500A2 = [2, 3]) OR Feeling or appearing down, depressed, or hopeless half or more of the days over the last two weeks (D0500B2 = [2, 3])
  - PART 2: The staff assessment total severity score indicates the presence of depression (D0600 ≥ [10] and D0600 ≤ [30]).

**Denominator**
All long-stay residents with a selected target assessment, except those with exclusions.
Percent of Residents With a Urinary Tract Infection (*Long Stay*)

**Numerator**
Long-stay residents with a selected target assessment that indicates urinary tract infection within the last 30 days (I2300 = √).

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

---

Percent of Residents Who Have/Had a Catheter Inserted and Left in Their Bladder (*Long Stay*)

**Numerator**
Long-stay residents with a selected target assessment that indicates the use of indwelling catheters (H0100A = √).

**Denominator**
All long-stay residents with a selected target assessment, except those with exclusions.
Percent of Low Risk Residents Who Lose Control of Their Bowel or Bladder *(Long Stay)*

**Numerator**
Long-stay residents with a selected target assessment that indicates frequently or always incontinence of the bladder \( (H0300 = [2, 3]) \) or bowel \( (H0400 = [2, 3]) \).

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

---

Percent of Residents Who Lose Too Much Weight *(Long Stay)*

**Numerator**
Long-stay nursing home residents with a selected target assessment which indicates a weight loss of 5% or more in the last month or 10% or more in the last 6 months who were not on a physician prescribed weight-loss regimen \( (K0300 = [2]) \).

**Denominator**
Long-stay nursing home residents with a selected target assessment except those with exclusions.
**Percent of Residents Whose Need for Help with Activities of Daily Living Has Increased (Long Stay)**

**Numerator**
Long-stay residents with selected target and prior assessment assessments that indicate the need for help with late-loss Activities of Daily Living (ADLs) has increased when the selected assessments are compared. The **four late-loss ADL items** are:
1. self-performance bed mobility (G0110A1)
2. self-performance transfer (G0110B1)
3. self-performance eating (G0110H1) and
4. self-performance toileting (G0110I1)

Residents meet the definition of increased need of help with late-loss ADLs if **either of the following** are true:

1. **At least two** of the following are true (note that in the notation below, [t] refers to the target assessment, and [t-1] refers to the prior assessment):
   - Bed mobility: (G0110A1[t] - prior assessment (G0110A1[t-1]) > [0], or
   - Transfer: (G0110B1[t] - prior assessment (G0110B1[t-1]) > [0], or
   - Eating: (G0110H1[t] - prior assessment (G0110H1[t-1]) > [0], or
   - Toileting: (G0110I1[t] - prior assessment (G0110I1[t-1]) > [0],

2. **At least one** of the following is true:
   - Bed mobility: (G0110A1[t] - [Level at prior assessment (G0110A1[t-1])] > [1], or
   - Transfer: (G0110B1[t] - [Level at prior assessment (G0110B1[t-1])] > [1], or
   - Eating: (G0110H1[t] - [Level at prior assessment (G0110H1[t-1])] > [1], or
   - Toileting: (G0110I1[t] - [Level at prior assessment (G0110I1[t-1])] > [1].

**Denominator**
All residents with a selected target and prior assessment except those with exclusions.
Definitions

- **Target Period**: span of time that defines the QM reporting period (quarter)
  - **Stay**: period of time between resident’s entry and either a D/C, death, or end of the target period
  - **Episode**: begins with entry or reentry and ends with a D/C or death
  - **Admission**: never been admitted, D/C return not anticipated, or D/C return anticipated but *did not* return within 30 days
  - **Reentry**: D/C return anticipated and *did return* to facility within 30 days
Definitions

- **Stay**
  - The period of time between a resident’s entry and either a discharge or the end of the target period
  - Starts with admission or reentry
  - Ends with discharge, death, or end of the target period

- **Episode**
  - The period of time spanning one or more stays
  - Starts with admission
  - Ends with discharge return not anticipated; anticipated and did not return within 30 days; death; or end of the target period
Definitions

- **Stay vs. Episode**
  - An episode can have multiple stays
  - Key is *admission* opposed to *reentry*
    - Episodes start with admission
    - Stays start with admission or reentry

- **Cumulative days in facility (CDIF):**
  total number of days within an episode during which the resident was in facility
  - Sum of days resident was in the building during an episode
  - Determines if resident is counted in a short-stay or long-stay measure
Definitions

- **Short-stay:**
  
  An episode that has a total of cumulative days in facility that is less than or equal to 100 days at the end of the target period

Definitions

- **Long-stay:** an episode that has a total of cumulative days in facility that is greater than or equal to 101 days at the end of the target period
Definitions

- **Target Date**
  - Entry: entry date
  - Discharge/death in facility: discharge date or date of death
  - All other records: ARD

Sample Selection

- Two samples are selected
- If multi-episodes, only the last one is used
  - All residents whose latest episode ends during the target period or is ongoing
  - Compute the cumulative days
  - If the CDIF is less than or equal to 100 days, it is a short-stay
  - If the CDIF is greater than or equal to 101 days, it is a long-stay
Look Back Scan

- **Short stay**: All assessments with target dates within the episode is looked at for specific event occurrence of condition occurred. (ex. Falls with major injury)
- **Long Stay**: Same as above except it reviews all MDS’s during a one year period

Risk Adjustment

- Percent of residents with pressure ulcers that are new or worsened (short-stay)
- Percent of residents who self-report moderate to severe pain (long-stay)
- Percent of residents who have/had a catheter inserted and left in their bladder (long-stay)
## Risk Adjustment

### Two steps

1. Exclude residents whose outcomes are not under nursing home control or outcome is unavoidable

2. Logistic regression (See MDS 3.0 Quality Measures Users Manual)

## Steps Used in National QM Calculation

- A detailed approach that is 13 steps long

- See MDS 3.0 Quality Measures Users Manual, Appendix A, Section 2
5 STAR Update

- 5 STAR information can be found at:
  http://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/CertificationandComplianc/FSQRS.html

- July 19 the 5 STAR will be open for public viewing

Application for Consumer Education

- Important to be aware of QM scores and how that is reflective of facility care
- Be aware of how your facility compares to other facilities in the area
- Be prepared to discuss QM results openly with present and potential consumers
  - Problem areas and how you are resolving them
  - Special programs affecting QM scores (i.e. hospice care, wound care)
Application for Survey Prep

- Off-site preparation identifies potential areas of concern
- QMs that flagged/* at the 75th percentile or greater
- QMs that are related to those that flagged
- QMs that are very low in comparison to other QMs

Application for Quality Improvement How to Start

- Consider monthly quality improvement committee meetings with key staff; your medical director/invited physicians will attend at least quarterly
- Use monthly forum to review
  - Quality Indicator reports
  - Event logs (falls, incidents)
  - Infection control reports
  - Complaint logs
## Application for Quality Improvement
### How to Start
- Formalize meeting efforts
- Set specific meeting date and time
- Assure staff attend
- Circulate agenda prior to the meeting, include follow-up from previous minutes
- Record meeting minutes and distribute to committee members
- Be diligent with follow-up; assure resources are available and that progress is being made

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## Application for Quality Improvement
### Using Teams
- **Identify** an initial team to review QM scores - this is often the care plan team or department manager staff
  - Review most current scores
  - Low scores indicate that there are few residents in the facility with that problem
  - High scores indicate a potential care issue that may require further review
Application for Quality Improvement Using Teams

- **Verify accuracy**
  - Review the definition
  - Does the MDS item match the definition
  - Review/discuss resident condition at the time the MDS was completed
  - Does the MDS accurately reflect the resident's condition at the time it was completed

Application for Quality Improvement

- **Use a team to review scores**
  - Add additional staff
  - Are there scores that are related
  - Are there other sources of contributing data
  - Are there customer complaints
  - Is this a high-risk process
  - Is there a high volume process
  - Where is the problem in the process
  - What part of the process does the team want to review first
**Application for Quality Improvement**

- Select the QMs for further review
- Select a small sample for review using the QM resident roster
- Use monitoring tools, review actual care delivery

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**Application for Quality Improvement**

- Consider using only portions of a monitoring plan, observe specific aspects of care
  - Is care optimal based on practice standards
  - If not, is a current standard in place to direct care
  - If so, what needs to be changed - additional education, management intervention
Application for Quality Improvement

- Select the piece of the process to change
- Identify what change needs to occur (team participation is critical)
- Make the change on a “small trial” group
  - Identify desired improvement, then implement
  - Evaluate the change - did it result in improved care and outcomes
    - If yes, make the change on every unit, wing, etc.
    - If no, begin the problem solving process again

Application for Quality Improvement

As problems are identified, be willing to consider that not all solutions will work every time!
Advancing Excellence

- Voluntary Campaign
  - Monitor key indicators
  - Promotion of Excellence
  - Acknowledgement of critical roles of staff in providing care
  - Create a culture of person-centered care

F-Tag 520

- Quality Assessment and Assurance
- Became effective June 1, 2006
- Following slides are taken directly from the Guidance Training Instructor’s Guide provided by CMS
A facility must maintain a quality assessment and assurance committee consisting of:
- The director of nursing services
- A physician designated by the facility
- At least 3 other members of the facility's staff

The quality assessment and assurance committee
- Meets at least quarterly to identify issues with respect to which quality assessment and assurance activities are necessary
- Develops and implements appropriate plans of action to correct identified quality deficiencies
Regulatory Language

- A State or the Secretary may not require disclosure of the records of such committee except in so far as such disclosure is related to the compliance of such committee with the requirements of this section
- Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions

Interpretive Guidelines Overview

- QAA is a management process that is ongoing, multi-level, and facility-wide
- Encompasses all managerial, administrative, clinical, and environmental services, as well as the performance of outside (contracted) providers and suppliers of care and services
## Interpretive Guidelines Overview

- **QAA’s purpose is continuous evaluation of facility systems which includes meeting the following objectives:**
  - Keeping systems functioning satisfactory
  - Preventing deviation from care processes
  - Discerning issues and concerns
  - Correcting inappropriate care processes

## Interpretive Guidelines Overview

- **QAA committees provide points of accountability or ensuring quality of care and quality of life in nursing homes**

- **QAA committees allow nursing homes opportunities to deal with quality deficiencies in a confidential manner**
## Interpretive Guidelines

### QAA Committee Functions

<table>
<thead>
<tr>
<th>Key aspects of QAA requirements</th>
</tr>
</thead>
<tbody>
<tr>
<td>Facility must have a QAA committee</td>
</tr>
<tr>
<td>Committee includes certain staff</td>
</tr>
<tr>
<td>Committee must meet quarterly</td>
</tr>
<tr>
<td>Responsible for identifying quality deficiencies</td>
</tr>
<tr>
<td>Responsible for developing plans of action</td>
</tr>
</tbody>
</table>

### Additional members may include:
- The administrator or assistant administrator
- The medical director
- Other staff with responsibility for direct resident care and services, and/or
- Staff with responsibility for the physical plant
Interpretive Guidelines
QAA Composition

- One key element is communication!
  - Consideration should be given as to how committee information is provided to consultants who may not be members of the committee but whose responsibilities include oversight of departments or services.

Interpretive Guidelines
Frequency of QAA Committee Meetings

- Meetings of the QAA committee are held as often as the facility deems necessary to fulfill committee functions and operate effectively, **but must be held at least quarterly**
- The committee should maintain a record of the dates of all meetings and the names/titles of those attending each meeting.
**Interpretive Guidelines**

Identification of Quality Deficiencies

1. Collect and Analyze Data

   - Practices that cause negative outcomes
   - Enhancing quality of care and quality of life

2. Improve Systems

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**Interpretive Guidelines**

Identification of Quality Deficiencies

- Records of the QAA committee may **not** be reviewed by surveyors
- Reports that surveyors may review include:
  - Open and closed record audits
  - Facility logs and tracking forms
  - Incident forms
  - Consultant reports
  - Other reports as part of the QAA function
### Interpretive Guidelines

#### Development of Action Plans

- Action plans may include:
  - Development/revisions of clinical protocols
  - Revisions of policies and procedures
  - Development of training for staff
  - Plans to purchase or repair equipment/improve physical plant
  - Development of standards for evaluating staff performance

#### Interpretive Guidelines

- The facility implements action plans to address quality deficiencies
- Action plans may be implemented in a variety of ways:
  - Staff training and deployment of changes to procedures
  - Monitoring and feedback mechanisms
  - Processes to revise plans
Investigative Protocol Procedures

- If QAA committee records reveal that the committee is making good faith efforts to identify quality deficiencies and to develop action plans to correct quality deficiencies, this requirement (F520) should not be cited.

Determination of Compliance
Routes to Noncompliance

- Route 1: Absence of a key member
- Route 2: Failure to meet quarterly
- Route 3: Committee does not identify quality deficiencies
- Route 4: Committee does not develop or implement action plans

Noncompliance At F-520
Background

- F-Tag 520 is a rule without details as to means and methods
- QAPI is reinforcing the critical importance of establishing and maintaining accountability to sustain quality of care and quality of life for our residents
Affordable Care Act

- CMS to mobilize best practices and to identify technical assistance needs
- Ensure facilities continuously identify and correct quality deficiencies and sustain performance improvement

QAPI Prototype

- Began 9/2011
- To establish tools and resources using best practice approach
- **Tools and resource material will be coming late summer 2012**
**QAPI Regulation**

- All homes must submit to the Secretary (CMS) a plan for the facility to meet QAPI standards and implement QAPI best practices, including how to coordinate the implementation of a QAPI plan with QAA activities under existing regulations.

**QAPI Questionnaire**

- **June 2012**
  - Distribute a 20-minute questionnaire to a representative sample of 4,200 randomly selected nursing homes.
  - Check your CASPER in-box; Give to information to your ADM.
QAPI Questionnaire

- Example questions
  - Who has received formal training in QI techniques
  - Dedicated person for QI
  - Satisfaction surveys: resident, family, staff
  - Frequency of data review such as: infections, readmissions, QMs, adverse events, staff turnover, survey deficiencies

QAPI Questionnaire

- Example questions
  - Barriers to QI activities: resources, knowledge
  - Turnover of key positions: ADM, DON
  - Culture Change activities
QAPI Questionnaire

- The findings will be used to:
  - Address identified challenges and barriers to implementing effective QAPI programs
  - Shape the direction and content of the QAPI tools and resources

Five Elements of QAPI

- **Element 1: Design and Scope**
  - Ongoing and comprehensive dealing with full range of services and departments
  - Should address: clinical care, quality of life, resident choice, and care transitions
Five Elements of QAPI

- **Element 2:** Governance and Leadership
  - Input from staff, residents, and families
  - Adequate resources to do the job
  - Policies to sustain the program
  - Setting expectations

Five Elements of QAPI

- **Element 3:** Feedback, Data Systems, and Monitoring
  - Systems to monitor care and services drawing data from multiple sources
  - Tracking and investigating and monitoring adverse events
Five Elements of QAPI

■ **Element 4**: Performance Improvement Projects (PIPs)
  - Information gathering
  - Clarify issues or problems and intervening for improvements

Five Elements of QAPI

■ **Element 5**: Systematic Analysis and Systemic Action
  - Thorough and highly organized/structured approach to determine whether and how identified problems may be caused, or exacerbated
  - Develop policies and procedures and demonstrate proficiency in the use of Root Cause analysis
Getting Started

- **Begin with the Basics:**
  - Compliance with F520
- **Interdisciplinary Team members:**
  - Administrator, DON, Medical Director
  - Must always include, involve and engage
  - Certified Nursing Assistant (CNAs)
- **Medical Director Participation**
- **Self identification**
- **QAPI is not designed to displace current regulation**

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Getting Started

- Evaluate current QAA program, be honest!
  - Does it meet current requirement and guidelines?
  - Is it how you manage your facility/organization of just something you do monthly/quarterly
  - How knowledgeable is all staff?
- **Use readiness tool to assess your organization (CMS is developing tool to be used in demonstration)**
Getting Started Readiness

Design and Scope

- Determine key functions and responsibilities of each department
- Establish a mission, vision, core values and tie to program and organizational performance
  - Vision: What the organization aspires to do
  - Mission: What is your purpose
  - Values: What is most important to your organization
- Develop a written plan or policies and procedures to guide the organization
- Determine scope that meets all services/activities of the organization

Getting Started Readiness

Governance and Leadership

- Owner/Board of Directors understands and affirms their role for support and oversight
- Facility leadership understands and is knowledgeable regarding QAPI activities
  - Training is developed and provided to all staff
- Establish formal accountability for QAPI (e.g., administrator, CEO)
- Revise job descriptions to include QAPI responsibilities and accountabilities, including ethical behavior
- Resources are allocated and documentation process for performance improvement projects is established
Getting Started Readiness

- **Feedback, data systems, and monitoring**
  - Establish tool (dashboard/scorecard) which can be populated with key metrics to monitor the program
  - Identify sources of scheduled (e.g., quality indicators/monthly) and unscheduled data (e.g., survey, adverse events, unsafe conditions, customer feedback)
  - QAPI plan specifies collection, monitoring, and review of data

- **Data for Quality Assurance and Performance**

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Getting Started Readiness

- **Performance Improvement Projects**
  - Areas for new PIPs are identified following systematic review of data and other assessment tools
  - Systematically prioritize PIPs based on what has the most significant impact
Getting Started Readiness

- Systematic analysis and systematic action
  - Establish formal process for Root Cause Analysis
  - Share QAPI results with stakeholders
  - Systematic review of policy and procedures to include improvements

Stay tuned for more information as it becomes available!
Resources

- CASPER Reporting User’s Guide For MDS Providers - (Updated 03/2012)
  https://www.qtso.com/mds30.html
- 5 STAR Website
  http://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/CertificationandComplianc/FSQRS.html

Resources

- MDS 3.0 Quality Measures User’s Manual
## Resources

- **Antipsychotic Usage**
  

- **Needs Driven Behaviors**
  

## Resources

- **Pharmacists**
  - [https://www.ascp.com/articles/antipsychotic-medication-use-nursing-facility-residents](https://www.ascp.com/articles/antipsychotic-medication-use-nursing-facility-residents)
QAPI Resources

- *Implementing Change in Long-Term Care*, by Barbara Bowers, et al, is a detailed guide for how to engage nursing home staff at all levels in the change process:
  
  http://www.nhqualitycampaign.org/star_index.asp
  x?controls=resManualForChange

- *The Long-Term Care Improvement Guide*, developed by Planetree in partnership with Picker Institute, was created to propel long-term care communities in their improvement efforts:
  
  http://www.residentcenteredcare.org/

QUESTIONS?