

Section 4

REPORT SPECIFICS

Facility Characteristics Report

This report (see Figure B-1 in Appendix B) can be used to help identify possible areas for further emphasis or review as part of a survey or a facility's quality assurance and improvement processes. This report contains facility demographic information, including percentages for comparison with state and national averages. By comparing the facility percentages with the state and national average percentages, the user can determine whether the facility's demographic characteristics are unusual.

Facilities characteristics may indicate a need to concentrate a review on certain resident groups. Examples are:

- A very old population.
- An unusually high percentage of male residents.
- A higher than average percentage of Medicare residents, indicating an emphasis on rehabilitation or a more acutely ill population.
- A higher than average percentage of psychiatric and mentally retarded residents.
- A higher than average percentage of residents receiving hospice care.
- A higher than average percentages of admission assessments or significant change assessments.

The demographic information contained in this report is similar to the old CHSRA QI reports. Enhancements have been made to the header and body of the report and are as follows:

Header

- Addition of a *City/State* field
- Addition of a federal *Provider Number* field
- Addition of a facility *Internal ID* field that displays next to the facility *Login ID*
- Addition of a *Report Version Number* field

Body

- A new *Facility* column heading. Displayed beneath this heading are three fields: *Num* (numerator), *Denom* (denominator) and *Observed Percent*. The *Number of Residents* field was removed from the old CHSRA QI report and was replaced with *Num* and *Denom* fields. The *Num* indicates the number of residents that had the identified characteristic, the *Denom* field indicates the number of residents in the facility and the *Observed Percent* replaces the *Facility %* field from the CHSRA report. These facility results are for the user-selected *Report Period* given in the report header.
- A new *Comparison Group* column heading. Displayed beneath this heading are the *State Average* and *National Average* fields. The *National Average* field is new for this report. These two fields display the simple average percentage for each characteristic among all facilities in the state or in the nation. These comparison group results are for the user-selected *Comparison Group* period given in the report header.

Facility Quality Measure/Indicator Report

This was previously known as the Facility Quality Indicator Profile report. This report (see Figure B-2 in Appendix B) shows each QI/QM, the facility percentage and how the facility compares with other facilities in the state and the nation. The comparisons with the state are shown using both percentages and a percentile ranking system. This report helps you to identify possible areas for further emphasis in facility quality improvement activities or investigation during the survey process. Because the goal is to highlight potential quality of care problems for the facility, this report only includes residents for whom the target assessment is likely to reflect care in the facility. For example, residents with an admission target assessment are excluded from prevalence measures, since conditions present on admission are not likely to reflect care in the facility. See Appendix A for the details concerning exclusion for each measure.

Enhancements have been made to the header and body of the report and are as follows:

Header

- Addition of a *City/State* field
- Addition of a federal *Provider Number* field
- Addition of an facility *Internal ID* field that displays next to the facility *Login ID*
- Addition of a *Report Version Number* field

Body

- A new *Facility* column heading. Displayed beneath this heading are four fields: *Num* (numerator), *Denom* (denominator), *Observed Percent* and *Adjusted Percent*. The *Observed Percent* field was previously titled the *Facility Percent* and the new *Adjusted Percent* column contains risk-adjusted values for appropriate measures.
- A new *Comparison Group* column heading. Displayed beneath this heading are the *State Average*, *National Average* and *State Percentile* fields.
- A new *Measure ID* numbering system is in place for the measures. *Measure ID* uniquely identifies each measure with a domain number followed by a period and then the QI/QM number within the domain.
- *Domain/Measure Description* replaces the *Domain/Quality Indicator* title.
- The report is divided between the Chronic Care Measures and the Post Acute Care (PAC) Measures (the old reports contained only chronic care measures).

Facility Section

All of the facility results in this column are for the user-selected *Report Period* given in the report header.

The first column is *Num*. This represents the number of residents who triggered the QI/QM. These are the people who "have" the QI/QM. For the purposes of calculating the facility percentage, it is the numerator.

The second column is *Denom*. This is the number of people in the facility who "could have" the QI/QM. For the purposes of calculating facility percentage, it is the denominator. For some measures, the number of cases in the denominator will be equal to the current number of chronic care or post-acute care residents in the facility. For other measures, the denominator will be limited to a specific sub-group of residents who "could have" triggered the QI/QM.

A good example of such a sub-group is the QI/QM 10.1 "Prevalence of antipsychotic use, in the absence of psychotic and related conditions". The only residents who "could have" this QI/QM are those without a psychotic disorder or other related condition. In the case of incidence QI/QMs, the group of residents who could have the QI/QM only includes residents who have a prior assessment and did not have the QI/QM condition in the previous period. This is because incidence QI/QMs measure the development of the condition where it did not exist previously. An example of an incidence QI/QM with a specific sub-group is QI 4.1 "Incidence of Cognitive Impairment". The denominator for this QI/QM only includes those residents who were not cognitively impaired on the prior assessment.

The third column is the *Observed Percent*. This column shows the percentage of residents who could have the QI/QM and actually triggered it. If 60 people could trigger a measure (*Denom* column) and 30 people actually did trigger it (*Num* column), the facility *Observed Percent* column would be 50%.

The fourth column is the *Adjusted Percent*. The *Adjusted Percent* applies a mathematical model that takes other health characteristics of the resident and the national percent for the measure into account and adjusts the observed percent accordingly. This methodology is applied to only a subset of measures; therefore the *Adjusted Percent* is reported only for those measures (e.g., measure 5.2).

Comparison Group Section

The statistics reported in the *Comparison Group* section in the body of the report are based upon QI/QM calculations that are performed for every facility in your state and in the nation. These calculations are performed on a monthly basis. When you request a report, the reporting software offers the most recent comparison period as a default (you may change this and select an earlier comparison group period if you wish). The exact comparison group period that was used to produce the report is indicated in the header of the report next to the *Comparison Group* title.

The first column is the *State Average*. This column shows the average statewide percentage for the QM for comparison with the facility. It represents the simple average of the observed percentages (or the adjusted percentages, for risk-adjusted measures) across all facilities in your state. This column can be very helpful in determining whether a facility is substantially above or below the statewide percentage. Such facilities are called "outliers," meaning their percentages are unusual with respect to the rest of the state.

The second column is the *National Average*. This column is new for the report and shows the average observed or adjusted percentage for the measure for all facilities in the nation. Again, this column allows comparisons with the facility percent.

The third column is the *State Percentile*. This column ranks facilities relative to other facilities in the state on each measure. The higher the ranking, the more likely the measure needs to be reviewed as part of the facility quality improvement process or emphasized on the survey. The values in this column represent the percent of facilities in the state that are at or below the observed (or adjusted) percentage for your facility. For example, if your facility is at the 85th percentile for a measure, it means that 85% of the facilities in the state have an observed (or adjusted) percentage that is at or below your facility's percentage.

Some of the values in the *State Percentile* column may be followed by an asterisk. The asterisk identifies those measures that have crossed an investigative threshold (have been "flagged"). This column identifies those measures where the facility's ranking is high enough that it should be investigated or emphasized on the survey or in any internal quality improvement initiative. It means that this facility's performance on this particular QM is higher than some critical value, and there is a possible concern for the quality of care. It is an area to highlight for investigation or emphasis during offsite survey preparation or to choose for review in the facility quality assurance or quality improvement processes. QI/QMs at or above the 90th percentile in this column will be designated with an asterisk (*). All sentinel health event measures (5.4 Prevalence of Fecal Impaction, 7.3 Prevalence of Dehydration, and 12.2 Prevalence of Stage 1 –4 Pressure Ulcers-Low Risk) with any triggering cases (a numerator larger than zero) will also be designated with an asterisk (*).

Remember that just because a QI/QM has flagged (exceeds a threshold) does not mean that there is an automatic assumption of a problem. It means that the information suggests that there is a concern that should be reviewed to see whether a problem exists and how it is being addressed. Remember also that just because a facility does not flag does not mean that there is no problem with the quality of care in that area. You need to consider all of the information available, and use your best clinical judgment. The QI/QM information is only a tool for surveyors and facility staff to use. It is not the only information to be used for quality assurance and improvement activities or to make assumptions about care. This report is used by the facility to identify areas of potential concern for further quality assurance and improvement review using the following steps:

Step 1 – As concerns for review, choose all QIs/QMs for which the facility is ranked on or above the 90th percentile (or other percentile level the facility may wish to choose). Determine whether any of the QI/QMs above the selected percentile threshold are clinically linked to each other.

Step 2 – Choose all sentinel health event measures (i.e., 4.5 Prevalence of Fecal Impaction, 7.3 Prevalence of Dehydration, or 12.2 Prevalence of Stage 1-4 Pressure Ulcers - Low Risk) with any occurrence. Any occurrence is sufficient to warrant review.

Step 3 – Look at the actual percentages for the facility compared to the comparison group (state and national averages). Are there any percentages that are of particular concern even though the facility does not rank very high? For example, 50% of the residents are involved in little or no activities.

Step 4 – Identify the actual number of residents that flag the QI/QM (that exhibit the condition represented by the QI/QM). This will help in determining the prevalence of the condition in the facility and may also suggest the number of residents that should be considered for inclusion in a review sample.

Quality Indicator/Measure Monthly Trend Report

This new report shows a facility's monthly scores on any single QI/QM Measure (see Figure B-3 in Appendix B). The months that are displayed are based upon a time period selected by the user. For each month, the report displays the facility's score as well as the average score for the facility's state and for the nation. The scores for each month represent QI/QM calculations for the six-month target period ending with that month. The scores are observed QI/QM percentages for most measures but adjusted QI/QM percentages for risk adjusted measures. The data are displayed in both tabular and graphical form, allowing the user to determine whether the facility's scores are increasing or decreasing over time and how those scores compare with state and national averages.

The report title indicates the QI/QM measure being reported. The report header includes the *Report Period* selected by the user. In the graph, the red line shows the facility QI/QM percentage for each month (six-month target period ending with that month). The green and blue lines are the corresponding national and state percentages for each target period. The Y-axis title will indicate whether the *Observed Percent* or *Adjusted Percent* is being reported for this measure.

The same data are also presented in the table below. The *Report Period* columns give the six-month report period for each set of facility, state and national scores. For each report period, the *Facility* columns give the facility numerator count in the *Num* column, the facility denominator count in the *Den* column, and facility observed percentage in the *Obs Pcnt* column. If an adjusted QI/QM were being reported, the facility adjusted percentage would be reported and the column would be labeled *Adj Pcnt* rather than *Obs Pcnt*. Finally, for each report period, the *Comparison Group* columns give the average observed (or adjusted) *State* and *National* percentages for the measure.

Resident Level Quality Measure/Indicator Report: Chronic Care Sample

This report (see Figure B-4 in Appendix B) contains data for those residents who are included in the chronic care sample, because they have an OBRA assessment (admission, quarterly, annual, significant change, or significant correction assessment) in the user-selected *Report Period* given in the report header. Note that it is possible for residents to be included in both the chronic care and post acute care samples if they have qualifying OBRA and post-acute assessments during the target period.

Residents are listed in two groups: active residents and discharged residents (residents whose last MDS record during the target period was a discharge). Residents are listed in alphabetical order within each of these two groups. The report identifies each resident by his or her resident internal ID and name. The primary reason for assessment (AA8a) for the selected OBRA target assessment is also listed. The types of chronic care target assessments that are listed in this report are given in Table 4-1.

Table 4-1. Types of Chronic Care Target Assessments

AA8a Code	Description
01	Admission
02	Annual
03	Significant change in status assessment
04	Significant correction of prior full assessment
05	Quarterly review assessment
10	Significant correction of prior quarterly assessment

Following the identifying information, the report contains columns for each QI/QM. An **X** appears in the QI/QM column when the resident triggers a measure (i.e., is included in the numerator for that measure). The last column in each row displays a count of the number of measures that were triggered for the resident.

Recall that residents with admission target assessments are excluded from the observed (or adjusted) facility percentages for prevalence measures on the previous report (*Facility Quality Measure/Indicator Report*). This exclusion insures that facility percentages do not include residents with conditions present on admission, conditions that do not reflect care in the facility. However, in the present report (*Resident Level Quality Measure/Indicator Report: Chronic Care Sample*), all chronic care residents are listed regardless of whether the target assessment is an admission assessment or not. The triggering status of these residents is listed for all chronic care measures (including prevalence measures). For example, the second resident on the example resident-level report in Figure B-4 in Appendix B is shown as triggering the falls measure, even though this is based on an admission assessment. If there is interest in reviewing falls in the facility, then it is important to know that this resident had a recent fall (even if it occurred outside of the facility)

The Resident Level Quality Measure/Indicator Report can be used in two ways. First, it can be used to identify the residents that trigger a particular QI/QM (by scanning a column of interest and looking for the residents with and **X**. Second, it can be used to identify residents who trigger multiple QI/QM measures. Such residents may merit special consideration or more intensive review.

Enhancements have been made to the header and body of the report and are as follows:

Header

- Addition of a *City/State* field
- Addition of a federal *Provider Number* field
- Addition of a facility *Internal ID* field that displays next to the facility *Login ID*
- Addition of a *Report Version Number* field

Body

- A *Resident Int Id* (resident internal ID) column was added and displays before the *Resident Name* column. This is the ID that is assigned when the assessment record is submitted to the database. It can be used to link data on the resident level report with data on the Resident Listing Report (described below).
- The most recent assessment date and type were removed. This was done to allow all of the QI/QM measures to be shown on a single page. These fields were moved to the Resident Listing Report (described below).
- Domains and individual QI/QM measure column headings were added to accommodate the QMs that were added to the reporting system.

Resident Level Quality /Measure Indicator Report: Post Acute Care Sample

This new report (see Figure B-5 in Appendix B) parallels the chronic care report described above. It contains data for residents who are in the post-acute care sample (who had a 14-day SNF PPS assessment during the target period). In all other respects, it parallels the chronic care report – please refer to the description above for details.

Resident Listing Report: Chronic Care Sample

This report (see Figure B-6 in Appendix B) lists those residents who are included in the chronic care sample, because they have an OBRA admission, quarterly, annual, significant change, or significant correction assessment in the target period (see Table 4-1 above). The residents listed in this report match those in the chronic care Resident Level Quality Measure/Quality Indicator Report. Like that report, the Resident Listing Report divides residents into two groups: active and discharged. Residents are listed alphabetically within each of those groups. The purpose of the Resident Listing Report is to supply supplementary information about the residents in the chronic care sample.

Enhancements have been made to the header and body of the report and are as follows:

Header

- Addition of a *City/State* field
- Addition of a federal *Provider Number* field
- Addition of an facility *Internal ID* field that displays next to the facility *Login ID*
- Addition of a *Report Version Number* field

Body

- The *Resident Id* field was changed to *Resident Int ID (resident internal ID)*
- A *Gender* field was added
- The *SSN* and *Medicare #* columns were removed
- The *Most Recent Assessment* column heading was changed to *Target Assessment*
- The *Previous Assessment* column heading was changed to *Prior Assessment*
- The *AA8b* values are displayed in addition to the *AA8a* values
- The *Date* column heading was change to *A3a* (the assessment reference date)
- All active residents are listed before all discharged residents.

The first column, *Resident Int Id* (resident internal ID) column displays the ID that is assigned when the assessment record is submitted to the state database. It can be used to link data on the Resident Listing Report with data on the Resident Level Quality Measure/Indicator Report (described above).

The *Resident Name* column displays the resident's last name and first name. The *Gender* column displays the resident's gender. The *DOB* column contains the resident's birth date and the *Room No* column displays his or her room number.

Two columns display the information about the selected assessments, one for the *Target Assessment* and one for the *Prior Assessment*. Sub-columns for the target and prior assessments are *A3a* (assessment reference date) and *AA8a/AA8b* (primary and special reason for assessment). The last column displayed on this report is the *Discharge Date*. This field is blank for active residents, and shows the most recent discharge date for residents who were discharged at the end of the target period. Note that discharges occurring before the target assessment reference date are not shown.

Resident Listing Report: Post Acute Care Sample

This new report (see Figure B-7 in Appendix B) parallels the chronic care Resident Listing report described above. It lists the residents who are in the post-acute care sample (who had a 14-day SNF PPS assessment during the target period). In all other respects, it parallels the chronic care report – please refer to the description above for details