5 STAR
How Does the MDS Impact It?

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Background
- December 18, 2008 Five Star Quality Rating System was added to the Nursing Home Compare website
  - Onsite inspections
  - Quality Measures
  - Staffing Levels

Onsite Inspections
- NH's were compared to each other
- Higher star rating if they improve relative to other NH's

Quality Measures
- Fixed numeric thresholds as boundaries between star categories
- Providers can increase their star rating regardless of where other nursing home's improve

Staffing Levels
- Two Measures
  - RN's per resident day
  - Total staffing hours for RN's, LPN's and CNA's per resident day

July 19, 2012
New Additions
New Information

- Quality Measures based on MDS
- Detailed Enforcement History
- Detailed Inspection Reports (Form CMS 2567)
- Ownership information
- Information on Physical Therapist Staffing Hours

Nursing Home Compare “3.0” Five Star Quality Rating System

Expanded and Strengthened

February 20, 2015 Improvements

- Star for QM calculation now includes the antipsychotic medication measures for those who do not have Schizophrenia, Huntington’s or Tourette’s
  - Short Stay resident started med after admission
  - Long stay resident continues med without diagnosis

February 20, 2015 Improvements

- Raise Performance Expectations
  - Raised the threshold for nursing homes to achieve a high rating on all measures

Star Impact

- Homes may see a decline in their QM rating
  - Addition of the antipsychotic data
  - Rebasing of the QM star boundary lines

February 20, 2015 Improvements

- Adjust Staffing Algorithms
  - Must earn 4 Stars on either the individual RN only or the staffing caregivers to receive overall 4 stars on the Overall staffing rating
  - Can have no less than a 3 star rating on any of those dimensions
February 20, 2015

Improvements

- Expand Targeted Surveys
  - Assess adequacy and accuracy of information on the MDS

Quality Measures

- Based on 11 out of 18 of the QM's
  - Long stay measures = 8
  - Short stay measures = 3

Quality Measures

- NOT included for Short Stay
  - Percent of residents who were assessed and appropriately given the Seasonal Influenza Vaccine
  - Percent of residents who were assessed and appropriately given the Pneumococcal Vaccine

- NOT included for Long Stay
  - Percent of residents who were assessed and appropriately given the Seasonal Influenza Vaccine
  - Percent of residents who were assessed and appropriately given the Pneumococcal Vaccine
  - Percent of low risk residents who lose control of their bowels or bladder
  - Percent of residents who lose too much weight
  - Percent of residents who depressive symptoms

Effects on Facility QM Sample

- Dashes reduce 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 Measures-Intent for public reporting

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

- Assist facilities to more effectively focus on quality improvement to ensure that systems are in place for consistent quality care for residents.
  - MDS Quality Improvement Evaluation System (QIES)
**Intent of QM Reports**

- Quality measures reports are designed as “feedback” reports to facilities
  - Quality improvement efforts
  - Guide survey
- These reports are NOT publicly accessible
- Available to facilities via the “secured intranet”

**QMs (continued)**

- QMs are process and outcome
  - Processes are goal directed interrelated series of actions, events, or steps (care delivery)
    - I.e., Catheters, Restraints, help with ADLs increased
  - Outcomes are what happens as a result of care delivery
    - I.e., falls, urinary tract infection

**QMs (continued)**

- QMs are incidence and prevalence
  - Incidence is the development of a condition over time (new case)
    - I.e., new or worsened pressure ulcer, need for help with ADL’s 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

**Target Period:**
- Target Period: span of time that defines the QM reporting period (quarter)

**Stay**
- The period of time between a resident’s entry & either a discharge or 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, or anticipated and did not return in 30 days.
  - Death or end of the target period
**Stay vs. Episode**
- An episode can have multiple stays
- Key is admission as opposed to reentry
- Episodes always 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

**Stays**
- **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
- **Long Stay:** an episode that has a total of cumulative days in facility that is more than 100 days at the end of the target period

**Sample Selection**
- 2 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**
- Scans all assessments within the current episode that have target dates no more than 275 days prior to the target assessment.
  - Short stay residents which it indicates one or more new or worsening Stage II-IV pressure ulcers
  - Long stay residents with one or more look back scan assessments that indicate one or more falls that resulted in major injury

**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 Appendix A Section 2)
   - A detailed approach that is 13 steps long

CASPER Reports VS. Nursing Home Compare

- Why are the results different?
  - Measures included
  - Timing
  - Reporting Periods
  - Averaging across quarters
  - Risk Adjustment

Short Stay

% of residents with PU that are new or worsened (SS)

- Numerator: Look back scan indicates one more new or worsened Stage II-IV PU (275 days)
- Denominator: All residents with one or more assessments that are eligible for a scan unless the data is incomplete

% of residents with PU that are new or worsened (SS)

- Covariates (Extra math):
  - Bed mobility requires limited or more assistance
  - Bowel Incontinence at least occasionally
  - Have Diabetes or peripheral vascular disease on initial assessment
  - Indicator of Low Body Mass index, based on height and weight on the initial assessment

What can we do??

- Ensure thorough skin assessments are done on admission and are thorough
- Review with licensed staff the importance of the skin assessment and subsequent documentation
- Remember once the initial skin assessment is completed anything that is found will be shown in this measure or if anything is worse.
  - Worse is not about size but about the staging. For example Stage 1 to Stage 2
### % of Residents who self report moderate to severe pain (SS)

- **Numerator**: target assessment meets either or both
  1. Daily pain with at least one episode of moderate to severe
     - Almost constant or frequent pain AND
     - At least one episode of moderate to severe pain
  2. Resident reports very severe /horrible pain of any frequency
- **Denominator**: All except incomplete interviews or incomplete data

### What do we do???

- Ensure you have the pain medication available upon admission
- Is the pain med routine or prn.
- Discuss alternatives with resident, nap after lunch, hot packs, music etc.
- **Problem:**
  - It is what the resident says it is, no matter what the chart has
  - Accurate or not pain is subjective and there is no objective way to view it

### % of SS Residents who Newly received an Antipsychotic Med

- **Numerator**: One or more assessments in look back scan not including initial assessment indicates that antipsychotic med received.
- **Denominator**: All SS residents without exclusions or the target assessment is not the same as the initial assessment

### % of SS Residents who Newly received an Antipsychotic Med

- **Exclusions**
  - Information is “dashed”
  - Any of the conditions on any assessment in the look back scan
    - Schizophrenia
    - Tourette’s Syndrome
    - Huntington’s Disease
  - On an antipsychotic upon admission or antipsychotic use is unknown

### What can we do?????

- **Short Stay**
  - Do we have the appropriate diagnosis
  - Compare diagnosis list with medication list
  - Be sure we have an accurate picture/list of meds prior to admission
  - What have we tried before we go to the drug
  - **DOCUMENTATION**

### Long Stay Measures
### What can we do??

- Minimize the usage of dashes even if it is a discharge assessment.
- Will decrease the size of the swimming pool.

### Residents whose need for help with ADL’s has increased

- **Numerator:**
  - Late loss ADL’s only: Bed mobility, transfer, eating and toileting. Comparing target assessment to prior assessment.
    - An individual ADL changed 2 levels.
    - Two ADL’s each changed 1 level.
  - All residents with selected target and prior assessment except those with exclusions.

- **Denominator:**
  - All residents with selected target and prior assessment except those with exclusions.

### Exclusions

- All 4 late loss ADL items are dependent.
- 3 late loss ADL’s were total dependent and the 4th was extensive.
- Resident is comatose.
- Prognosis of life expectancy is less than 6 months.
- Hospice care is marked.
- ADL items are dashed away.

### What do we do??

- Is the information accurate?
- Do the staff who complete the documentation know what they are doing?
- Do you have complete documentation?

### ADL’s

- **Dependent in Bed Mobility, Transfers and Locomotion on the unit**
  - To code dependent on the MDS every single data entry must be dependent.
  - All 3 ADL’s must be dependent.
    - Bed mobility: how resident moves to and from lying position, turns side to side, and positions body while in bed or alternate sleep furniture.
    - Transfers: how resident moves between surface, including to or from: bed, chair, wheelchair, standing position (excludes to/from bath/toilets).
    - Locomotion on unit: how resident moves between locations in his/her room and adjacent corridor on same floor. If in wheel chair, self sufficiency once in chair.

### High Risk Residents with Pressure Ulcers

- **Numerator:** Meet both.
  - Is considered high risk as defined.
  - Has a Stage II to IV.
- **Denominator:** High risk if meet one or more of the following.
  - Impaired bed mobility or transfers either or both Extensive, dependent, happened only 1-2 times or the activity didn’t occur.
- **Exclusions**
  - Admission assessment, or PPS 5 day or readmission return assessment.
  - Items are “dashed”.
What do we do??

- Thorough assessment of skin and or wounds
- Accurate assessment of the wounds
- Thorough documentation
- Accurate documentation of ADL’s specifically bed mobility and transfers

Residents who have/had a catheter inserted & left in their bladder

- Numerator:
  - Target assessment indicates the use of indwelling catheter
- Denominator:
  - Everybody except with exclusions
- Exclusions:
  - Target assessment is admission, PPS 5 day or readmission/return assessment
  - Indwelling catheter status dashed away
  - Neurogenic bladder or item is dashed
  - Obstructive uropathy or item is dashed

Residents who have/had a catheter inserted & left in their bladder

- Covariates (extra math)
  - Frequent bowel incontinence of prior assessment (Frequent or always)
  - Pressure ulcers at stages II, III, IV on prior assessment
  - All covariates are missing if no prior assessment is available

What do we do??

- Do you have documentation in the record whether it is a restraint or not
- Documentation must be done either way to support the coding of the MDS
- What alternatives have you used
- Is it care planned?
- Do we have physician orders if it is a restraint with medical reasons

Residents who were physically restrained

- Numerator:
  - Daily physical restraints
    - Trunk restraint used in bed or in chair
    - Limb restraint used in bed or in chair
    - Chair prevents rising
- Denominator
  - Everybody except if excluded
- Exclusions:
  - Any item of the items were dashed
### Residents with a Urinary Tract Infection

**Numerator:**
- Selected target assessment indicates a UTI in Section I

**Denominator:**
- Everybody except those with exclusions

**Exclusions**
- Target assessment is admission, PPS 5 day or readmission/return assessment
  - Item is "dashed" in Section I

### What do we do???

- Is the MDS coding accurate?
- How do the residents stay hydrated
- Are we offering thorough peri-care being done correctly
- Do we have documentation for all points necessary to code UTI
  - Diagnosis
  - Symptoms
  - Positive lab
  - Physician documentation

### Residents who Self Report Moderate to Severe Pain

**Numerator**
- Target assessment meets either or both:
  - Reports almost constant or frequent moderate to severe pain in the last 5 days. Both of the following must occur
    - Almost constant or frequent pain AND
    - At least one episode of moderate to severe pain
  - Resident reports very severe horrible pain of any frequency

**Denominator**
- Everybody unless has exclusions

### What do we do???

- Is the pain med routine or prn.
- Discuss alternatives with resident, nap after lunch, hot packs, music etc.
- Take credit for alternatives

**Problem:**
- It is what the resident says it is, no matter what the chart has
- Accurate or not pain is subjective and there is no objective way to view it
Residents experiencing one or more falls with major injury

- **Numerator:**
  - Look back scan indicates one or more falls with major injury (275 days)
- **Denominator:**
  - All long stay residents unless has exclusions
- **Exclusions:**
  - Excluded if one of the following is true for ALL look back scan assessments
    - Falls not assessed
    - Fall occurred but number of falls with major injury not assessed

Fall Definition

- Unintentional change in position coming to rest on the ground, floor or onto the next lower surface (e.g., onto a bed, chair, or bedside mat).
- The fall may be witnessed, reported by the resident or an observer or identified when a resident is found on the floor or ground. Falls include any fall, no matter whether it occurred at home, while out in the community, in an acute hospital or a nursing home.
- Falls are not a result of an overwhelming external force (e.g., a resident pushes another resident).
- An intercepted fall occurs when the resident would have fallen if he or she had not caught himself/herself or had not been intercepted by another person - this is still considered a fall.

Falls Definitions

- Injury (except major): includes skin tears, abrasions, lacerations, superficial bruises, hematomas and sprains; or all fall related injury that causes the resident to complain of pain
- Major injury: Includes bone fractures, joint dislocations, closed head injuries with altered consciousness, subdural hematoma

Definition: Fracture related to a Fall

- Any documented bone fracture (in a problem list from a medical record, an x-ray report, or by history of the resident or caregiver) that occurred as a direct result of a fall or was recognized and later attributed to the fall. Do not include fractures caused by trauma related to car crashes or pedestrian versus car accidents or impact of another person or object against the resident.

What can we do???

- Review your current fall program
  - Does your staff really know the resident??
  - Ask yourself with EVERY fall, what was the resident trying to do. Look at basic needs
    - Bathroom
    - Food
    - Tired
    - Lonely
    - Bored

What can we do????

- Raise staff awareness of meeting those basic needs
- How noisy is your units/floors. Alarms, over head paging, staff talking music, TV etc
- Who are they?? What did that resident do before they became a resident??
- Pharmacy reviews to ensure medications are not part of the problem
- All activities should not be just “groups”
  - Self directed based on their assessments
Residents who received an antipsychotic medication

- **Numerator:**
  - Target assessment showed antipsychotic medication was received
- **Denominator:**
  - All residents except those exclusions
- **Exclusions**
  - Items on MDS were dashed away
  - Have related conditions
    - Schizophrenia
    - Tourette's Syndrome
    - Huntington's Disease

Antipsychotic

- Record the number of days an antipsychotic medication was received by the resident at any time during the 7 day look back period (or since admission/entry, or reentry if less than 7 days).
- Code medication's therapeutic category and or pharmacological classification, not how it is used

What can we do???

- **Long Stay**
  - Be sure we have the correct diagnosis within the body of section I
  - Have we done or tried a dose reduction??
  - Are we documenting the behaviors that caused the medication to be started.
  - Get rid of prn's
  - Consistent staffing
  - Care plans that reflect what causes the behavior, what calms them down with specific ideas.
  - Do you know your residents.

Data

<table>
<thead>
<tr>
<th>Short Stay Residents</th>
<th>Collection start</th>
<th>Through</th>
</tr>
</thead>
<tbody>
<tr>
<td>Percent of residents who self report moderate to severe pain</td>
<td>10/1/13</td>
<td>9/30/14</td>
</tr>
<tr>
<td>Percent of residents assessed and screened, appropriately, the seasonal flu vaccine</td>
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<td>Percent of residents assessed and screened, appropriately, the pneumococcal vaccine</td>
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</table>
### Now What

- Changes made now will not have immediate affect but we must start now
  - Improve the care via the QM's won't change the Star now but possibly improve the next survey
  - Are you coding the MDS correctly based on the Manual Definition
  - Are you survey ready everyday or only during your survey "window"

### Resources