# QAPI Affinity Group Session II

## Data Sources, Data Collection, Prioritizing Improvement

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Quality Improvement Organizations
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Quality Insights

# Determine Where Your Information Comes From

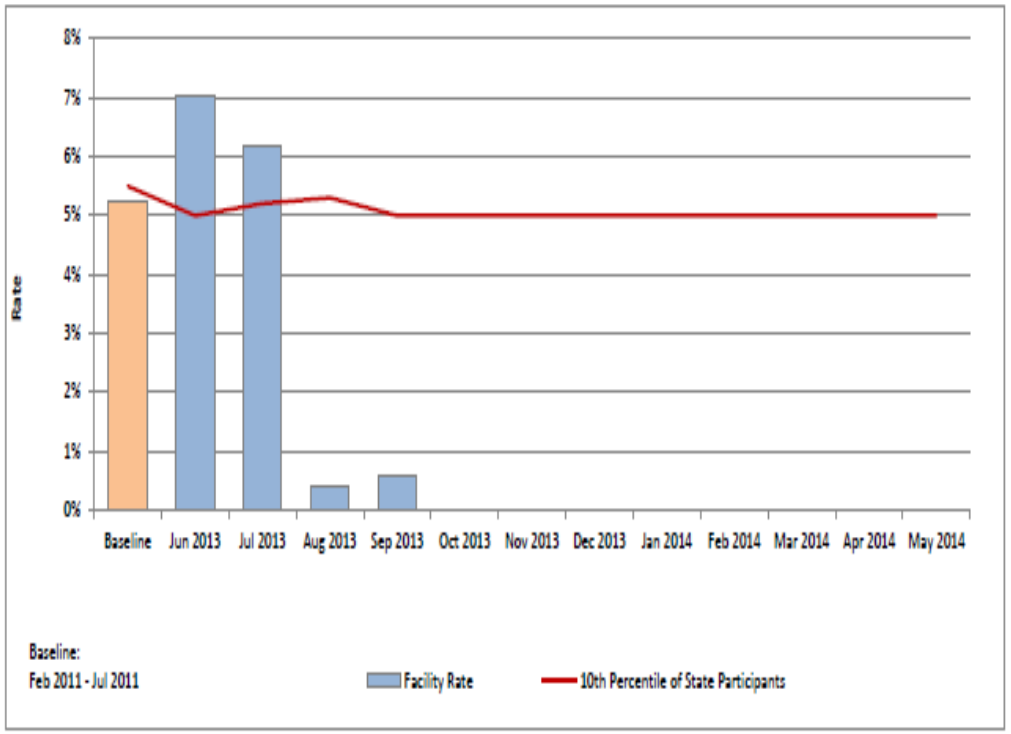
- Data is the backbone of a strong QAPI program.
- Data comes from an almost limitless number of sources. The key is knowing what data is valuable to you in a given situation and understanding how to use the data to set , reach and maintain your goals.

# Determine Where Your Information Comes From, cont.

- Internal Sources
  - Resident/Family Council
  - Resident Concern Logs
  - Employee Feedback/Exit Interview
  - Resident/Employee Incident Reports
  - Satisfaction Surveys
  - Facility Tools (rounding sheets, audits, IC reports, wound reports)
- External Sources
  - Annual and Complaint Survey results
  - CASPER Reports
  - Nursing Home Compare
  - Quality Insights Reports
  - Adjacent Provider Feedback (Hospitals, Physicians, Transportation, Pharmacy, lab)

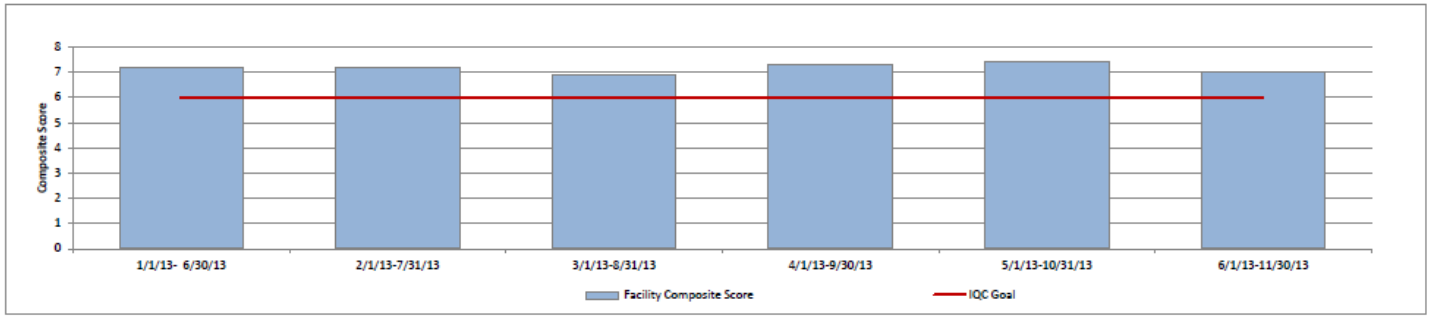
# Reports Contained on My Quality Insights Learning Platform

## Antipsych Med (L)




| Month | Numerator | Denominator | Rate | 10th Percentile of State Participants | Facility Percentile | State Average | National Average |
|---|---|---|---|---|---|---|---|
| Baseline | 60 | 1,147 | 5.23% | 5.50% | 9 | 19.20% | 19.20% |
| Jun 2013 | 20 | 284 | 7.04% | 5.00% | 15 | 18.90% | 18.90% |
| Jul 2013 | 20 | 323 | 6.19% | 5.20% | 12 | 19.60% | 19.60% |
| Aug 2013 | 1 | 254 | 0.39% | 5.30% | 16 | 20.00% | 20.00% |
| Sep 2013 | 1 | 179 | 0.56% | 5.00% | 20 | 18.90% | 18.90% |
| Oct 2013 | 0 | 141 | 0.00% | 5.00% | 18 | 19.60% | 19.60% |
| Nov 2013 | 0 | 133 | 0.00% | 5.00% | 12 | 20.00% | 20.00% |
| Dec 2013 | 0 | 125 | 0.00% | 5.00% | 10 | 18.90% | 18.90% |
| Jan 2014 | 0 | 131 | 0.00% | 5.00% | 15 | 19.60% | 19.60% |
| Feb 2014 | 0 | 120 | 0.00% | 5.00% | 14 | 20.00% | 20.00% |
| Mar 2014 | 0 | 124 | 0.00% | 5.00% | 12 | 18.90% | 18.90% |
| Apr 2014 | 0 | 122 | 0.00% | 5.00% | 10 | 19.60% | 19.60% |
| May 2014 | 0 | 107 | 0.00% | 5.00% | 16 | 20.00% | 20.00% |
| Q1 2014 | 0 | 375 | 0.00% | 5.00% | 19 | 25.30% | 25.30% |

# Reports Contained on My Quality Insights Learning Platform




| Measure | 1/1/13- 6/30/13 | | 2/1/13-7/31/13 | | 3/1/13-8/31/13 | | 4/1/13-9/30/13 | | 5/1/13-10/31/13 | | 6/1/13-11/30/13 | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | Denom | Rate | Denom | Rate | Denom | Rate | Denom | Rate | Denom | Rate | Denom | Rate |
| Antipsych Med (L) | 86 | 10.47% | 86 | 11.63% | 89 | 10.11% | 89 | 10.11% | 89 | 8.99% | 90 | 8.89% |
| Catheter Inserted and Left in Bladder (L) | 82 | 4.88% | 83 | 6.02% | 86 | 4.65% | 85 | 4.71% | 84 | 4.76% | 86 | 4.65% |
| Depressive Symptoms (L) | 82 | 2.44% | 83 | 4.82% | 87 | 4.60% | 87 | 3.45% | 86 | 4.65% | 88 | 2.27% |
| Excessive Weight Loss (L) | 85 | 17.65% | 85 | 15.29% | 89 | 15.73% | 89 | 16.85% | 89 | 13.48% | 90 | 12.22% |
| Falls with Major Injury (L) | 86 | 2.33% | 86 | 3.49% | 89 | 4.49% | 89 | 4.49% | 89 | 5.62% | 90 | 5.56% |
| High-Risk Residents with Pressure Ulcers (L) | 71 | 7.04% | 67 | 10.45% | 71 | 8.45% | 72 | 9.72% | 70 | 10.00% | 66 | 13.64% |
| Low-Risk Residents Who Lose Bowel/Bladder Control (L) | 25 | 32.00% | 22 | 31.82% | 23 | 26.09% | 20 | 30.00% | 18 | 27.78% | 20 | 35.00% |
| Need for Help with ADLs Has Increased (L) | 14 | 21.43% | 19 | 26.32% | 20 | 30.00% | 16 | 25.00% | 13 | 15.38% | 16 | 12.50% |
| Physical Restraints (L) | 86 | 1.16% | 86 | 1.16% | 89 | 1.12% | 89 | 1.12% | 89 | 1.12% | 90 | 1.11% |
| Self-Reported (SR) Moderate/Severe Pain (L) | 20 | 10.00% | 23 | 8.70% | 18 | 5.56% | 18 | 11.11% | 20 | 10.00% | 26 | 7.69% |
| Urinary Tract Infection (L) | 85 | 15.29% | 85 | 9.41% | 88 | 10.23% | 87 | 13.79% | 88 | 11.36% | 90 | 7.78% |
| Flu Inverse | 86 | 0.00% | 86 | 0.00% | 87 | 0.00% | 86 | 0.00% | 86 | 8.14% | 88 | 7.95% |
| PNE Inverse | 86 | 0.00% | 86 | 0.00% | 89 | 0.00% | 89 | 0.00% | 89 | 0.00% | 90 | 0.00% |
| Total | 894 | 7.16% | 897 | 7.25% | 925 | 6.92% | 916 | 7.31% | 910 | 7.36% | 930 | 6.99% |
| Composite Score | 7.2 | | 7.2 | | 6.9 | | 7.3 | | 7.4 | | 7 | |
| IQC Goal | 6.0 | | 6.0 | | 6.0 | | 6.0 | | 6.0 | | 6.0 | |

# Nursing Home Compare, Five Star Rating and Casper Reports

## Short Stay Quality Measures

| Measure | CASPER | Nursing Home Compare | Five Star Rating |
|---|---|---|---|
| Percent Who Self-Report Moderate to Severe Pain (Short Stay) | ✓ | ✓ | ✓ |
| Percent With Pressure Ulcers That Are New or Worsened (Short Stay) | ✓ | ✓ | ✓ |
| Percent Who Were Assessed and Appropriately Given the Seasonal Influenza Vaccine (Short Stay) | | ✓ | |
| Percent Assessed and Appropriately Given the Pneumococcal Vaccine (Short Stay) | | ✓ | |
| Percent of Who Newly Received an Antipsychotic Medication (Short Stay) | ✓ | ✓ | ✓ |
| Percent Who Improved Performance on Transfer, Locomotion, and Walking in the Corridor (Short Stay) | | ✓ | ✓ |
| Percent Who Were Re-hospitalized After A Nursing Home Admission (SS) | | ✓ | ✓ (CLAIMS-BASED) |
| Percent Who Has Had an Outpatient Emergency Department Visit (SS) | | ✓ | ✓ (CLAIMS-BASED) |
| Percent Who Were Successfully D/Cd to the Community (SS) | | ✓ | ✓ (CLAIMS-BASED) |

# Long Stay Quality Measures

| Measure | CASPER | Nursing Home Compare | Five Star Rating |
|---|---|---|---|
| Percent Experiencing One or More Falls with Major Injury (LS) | ✓ | ✓ | ✓ |
| Percent Who Have Had a Fall (Long Stay) | ✓ | | |
| Percent Who Self-Report Moderate to Severe Pain (LS) | ✓ | ✓ | ✓ |
| Percent of High-Risk With Pressure Ulcers (LS) | ✓ | ✓ | ✓ |
| Percent Assessed & Appropriately Given Seasonal Influenza (LS) | | ✓ | |
| Percent Assessed and Appropriately Given the Pneumococcal Vaccine (Long Stay) | | ✓ | |
| Percent With a Urinary Tract Infection (Long Stay) | ✓ | ✓ | ✓ |
| Percent Who Have/Had a Catheter Inserted and Left in Their Bladder (Long Stay) | ✓ | ✓ | ✓ |
| Percent Who Were Physically Restrained (Long Stay) | ✓ | ✓ | ✓ |
| Percent Whose Need for Help with Activities of Daily Living Has Increased (Long Stay) | ✓ | ✓ | ✓ |
| Percent Who Lose Too Much Weight (Long Stay) | ✓ | ✓ | |
| Percent Who Received an Antipsychotic Medication (Long-Stay) | ✓ | ✓ | ✓ |
| Percent Who Used Antianxiety or Hypnotic Medication (Long Stay) | | ✓ | |
| Percent Who Received an AA/Hyp Without Evidence of Psychotic condition (Long Stay) Titled Prevalence | ✓ | | |
| Percent Who Declined in Independence in Locomotion (Long Stay) | | ✓ | ✓ |
| Percent Who Have Had Behaviors Affecting Others (Long Stay) | ✓ | | |
| Percent Who Have Had Depressive Symptoms (Long Stay) | ✓ | ✓ | |
| Percent of Low Risk Who Lose Control of Their Bowel or Bladder (Long Stay) | ✓ | ✓ | |

# DATA in the Final Rule

- A facility must include, as part of its QAPI program, mandatory training that outlines and informs staff of the elements and goals of the facility's QAPI program (F490).
- A facility must establish and implement written policies and procedures for feedback, data collections systems, and monitoring, including adverse event monitoring. The policies and procedures must include, at a minimum, the following:
  - Systems to obtain and use feedback and input from direct care staff, other staff, residents and resident representatives, including how information will be used to identify high risk, high volume or problem prone areas and opportunities for improvement
  - Systems to identify, collect and use data and information from all departments and how such information will be used to develop and monitor performance indicators
  - Develop, monitor and evaluate performance indicators, including the methodology and frequency for development, monitoring and evaluation
  - Monitor adverse events, including the methods used to systematically identify, report, track, investigate, analyze and use data relating to adverse events to develop activities to prevent adverse events

# Data Collection

- You'll want to develop a plan for the data you collect.
- Determine who reviews certain data, and how often.
- Collecting information is not helpful unless it is actually used.
- Be purposeful about who should review certain data – and how often – and about the next steps in interpreting the information.
  - Data gathering should be well defined so it is reproducible

# Data Collection, cont.

- This data will require systematic organization and interpretation in order to achieve meaningful reporting and action. Otherwise, it would only be a collection of unrelated, diverse data and may not be useful.

Resource: Measure/ Indicator Collection and Monitoring Plan ⇒

| What Measure are we using? | When are we measuring this ?(frequency) | How do we measure this (where do we get our data)? | Who is responsible for tracking this measure? | What is our performance goal or aim? | How will data findings be tracked and displayed? |
|---|---|---|---|---|---|
| | | | | | |

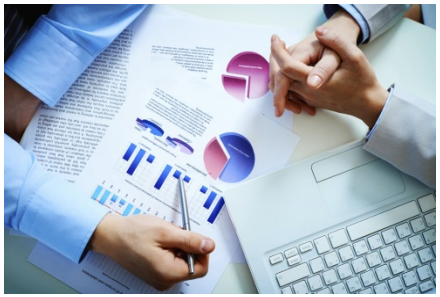
# Preparing Data For Use

- Data has been systematically gathered. This data will require systematic organization and interpretation in order to achieve meaningful reporting and action. Otherwise, it would only be a collection of unrelated, diverse data and may not be useful.
- Determining a benchmark, a target and threshold for each data set will allow you to identify gaps in performance using a predetermined framework.
  - Set targets for performance in the areas you are monitoring. A target is a goal, usually stated as a percentage. May set both short term and long term goals.
  - Identifying benchmarks for performance is an essential component of using data effectively with QAPI. A benchmark is a standard of comparison. May use state, national or internal benchmarks. Once a benchmark is achieved, consider resetting to foster continued improvement.
  - Set threshold.  In this case, a threshold is the point below which you deem unacceptable.

# Preparing Data For Use EXAMPLE

- Data gathered: Falls with injury on the dementia unit
  - Benchmark: 1 fall (internal benchmark based on best month of past 12 months)
  - Threshold: 6 falls ( based on internal data of most falls in a month of past 12)
  - Target: 3 falls/month (short term) 1 fall (long term)

# Prioritizing Data



- Systems are in place to know what data to gather, who is gathering it, where your data falls in relation to benchmarks and thresholds and what your target is for each data point.
- You are now ready to prioritize areas for improvement. From the final rule F 520 : *The QAPI program identifies and prioritizes problems and opportunities that reflect organizational process, functions, and services provided to residents based on performance indicator data, and resident and staff input, and other information.*
- Must have a system to evaluate and prioritize

# Prioritizing Data, cont.

- Factors such as high-risk, high-volume, or problem-prone areas that affect health outcomes, quality of care, and quality of life should be considered
- Not all problems will require a Performance Improvement Project
- Some problems will require an immediate solution followed by a PIP to address systems
- Consider choosing something you believe will be easy to address for your first PIP

# Prioritization Worksheet for Performance Improvement Projects

*Directions:* This tool will assist in choosing which potential areas for improvement are the highest priority based on the needs of the residents and the organization. Follow this systematic assessment process below to identify potential areas for PIPs. This process will consider such factors as high-risk, high-volume, or problem-prone areas that affect health outcomes and quality of care. This tool is intended to be completed and used by the QAPI team that determines which areas to select for PIPs. Begin by listing potential areas for improvement in the left-hand column. Then score each area in the following columns based on a rating system of 1 to 5 as defined below:

| 1 = very low | 2 = low | 3 = medium | 4 = high | 5 = very high |
|---|---|---|---|---|

Rating is subjective and is meant to be a guide and to stimulate discussion. Finally, add the scores across the row and tally in the final column. Potential improvement areas with a higher score indicate a higher priority.

| **POTENTIAL AREAS FOR IMPROVEMENT**Consider areas identified through: Dashboard(s) Feedback from staff, families, residents, other Incidents, near misses, unsafe conditions Survey deficiencies | **PREVALENCE** The frequency at which this issue arises in our organization. | **RISK** The level to which this issue poses a risk to the well-being of our residents. | **COST** The cost incurred by our organization each time this issue occurs. | **RELEVANCE** The extent to which addressing this issue would affect resident quality of life and/or quality of care. | **RESPONSIVENESS** The likelihood an initiative on this issue would address a need expressed by residents, family and/or staff. | **FEASIBILITY** The ability of our organization to implement a PIP on this issue, given current resources. | **CONTINUITY** The level to which an initiative on this issue would support our organizational goals and priorities. | **TOTAL SCORE TALLY** |
|---|---|---|---|---|---|---|---|---|
| | | | | | | | | |
| | | | | | | | | |

# Summary of concepts covered

- Data as the backbone of the QAPI process
- Valuable reports: MQI, Casper, Nursing Home Compare
- Data in the Final Rule
- Preparing Data for Use
- Prioritizing Data

# What is Next?

- Chartering a Performance Improvement Project
- What is a Charter
- Project Overview
- Project Time Table
- Creating a Performance Improvement Team
- Barriers to Effective PIPs
- Brainstorming

Items to consider for next week: What are your commonly used data sources, are they clearly defined? Do you have a method to prioritize data? Do you routinely monitor the results of gathered data?

# Discussion

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