Long-Term Care Survey Alert

Survey Strategies: DIG DEEP TO EXPLAIN QUALITY OUTCOMES

Once the government's national nursing home quality initiative goes live in October, facilities will need to explain to consumers and surveyors with confidence what their resident outcomes really say about their care.

But that's no new task for facilities dealing with surveyors, even if the new publicly reported quality measures don't end up being risk adjusted at the facility level (see article 2).

"Most of the existing quality indicators used by surveyors aren't risk adjusted," notes **Kathy Hurst**, principal of **Hurst Consulting Group** in Chino Hills, CA. "And if they are risk adjusted, it doesn't make sense. For example, unless a resident is severely cognitive impaired, they are going to go in the low risk category for bladder incontinence even though the person can't follow a training program. So you have to look at the facility's patient population to put them into context."

Hurst always advises facilities to head off any surveyor concerns with their quality outcomes at the entrance conference. "You can say, 'Let me tell you a little about our facility ... and why some quality indicators are sometimes high.'" For example, the surveyors may say, "Your facility's use of psychotropics is at the 90th percentile,'" Hurst notes. "And the administrator responds, if accurate, 'That's because we admit all these psychiatric patients who require the medication as part of their treatment plan.'"

In some ways, the quality measures will be an improvement over the quality indicators. "The problem with QIs is that facilities are ranked on percentiles which means only one can be at a certain percentile," explains **Cheryl Field**, director of clinical/reimbursement for **LTCQ Inc.** in Bedford, MA.

Sidestep Easy Answers

Facilities must avoid the trap, however, of settling too quickly for surface explanations for scores that fall on the wrong end of the bell curve.

"It's not enough to just explain [a higher or lower than average percentage] away by saying, 'My patients are different,'" cautions **Ruta Kadonoff**, a health policy analyst for the **American Association of Homes and Services for the Aging**. "That's what happens when managed care profiles physicians about aberrant utilization or outcomes. Physicians claim their patients are sicker or different. That may well be true but you really have to ... quantify and document how much of that difference actually contributes to the inflated numbers."

Facilities may, for example, be tempted to explain away a high percentage score on the new pain management quality measure as an artifact of their more sophisticated pain assessment protocols. "To be included in the pain quality measure, a resident has to have moderate pain at least daily" coded on the MDS assessment, Field explains. "Or 'horrible or excruciating pain' of any frequency during the assessment period will include the resident in the percentage score."

Kadonoff says she'd worry about a facility with a low percentage of patients complaining of pain, which may indicate the facility isn't doing a good job of assessment. Even so, "a facility that scores high on the pain indicator may, upon further investigation, realize that it is doing a good job assessing and documenting pain but could still improve its actual treatment approaches or reevaluation to see if the residents' pain has been relieved."

In some cases, the way a facility performs and codes the MDS assessment can contribute to unusually high or low scores on the quality measures or quality indicators (see Long Term Care Survey Alert, Vol. 3, No. 12, p. 1).

For example, the Resident Assessment Instrument doesn't clearly define "moderate" pain, Field notes, so a facility's definition of moderate pain will affect its percentage score on that particular quality measure.

Editor's note: For an in-depth look at the pain quality measure and what it means for your facility's pain management program, see the June issue of Long-Term Care Survey Alert.