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MDS Alert

Quality Reporting: Do You Know How The Quality Indicators/Measures Really Work?

Learn the rest of the story about this quality reporting system.

Misinformation about the QIs/QMs can cause you unnecessary concern or, worse, lull the QA team into a false sense that all is well, which surveyors will quickly dispel.

For one, you don't have to worry about triggering a sentinel event (dehydration, low-risk pressure ulcer or fecal impaction) on an OBRA admission assessment.

OBRA admission assessments don't count for the chronic indicators, but some items are used for risk adjustment, says **Steven Littlehale, MS, ARNP**, chief clinical officer for **LTCQ Inc**. in Lexington, MA.

Thus, if the resident comes from the hospital with unresolved dehydration, a low-risk pressure ulcer or fecal impaction, those conditions won't trigger the QI/QM on the OBRA admission assessment.

You do, of course, need to care plan the issue immediately and be prepared to show surveyors that you implemented the plan consistently.

Conditions present at admission will ultimately count for the chronic care QIs/QMs if the resident still has them on the first OBRA non-admission assessment, including a significant change in status assessment done days after the admission assessment, says Littlehale. For example, a Stage 3 pressure ulcer that hasn't resolved by the quarterly assessment will count towards the QI/QM, he says.

Capture Exclusions

Aim to provide services and code the MDS accurately to capture items that will exclude a resident from a QI/QM. For example, a resident will be excluded from the ADL decline QI/QM if he has end-stage disease (J5c = checked) or hospice care (P1ao = checked) on the target assessment or the most recent full assessment, says Littlehale.

The problem: Studies show that J5c -- end-stage disease -- is seldom checked and use of hospice services is quite low. "Therefore many residents known to be actively dying will trigger ADL decline," Littlehale points out.

Solution: "Education and focus on proper coding of J5c resolves this issue," he says.

Postacute Measures Differ From Chronic Care Ones

For the postacute measures (delirium, pain and pressure ulcers), the SNF PPS 14-day MDS is the target assessment.

The good news is that residents admitted with delirium or pain that resolves by the 14-day assessment won't trigger those two QMs.

But a resident will trigger on the postacute pressure ulcer measure if he has a pressure ulcer on the 14-day MDS that wasn't coded on the 5-day MDS -- or a decub that got worse or failed to improve from the 5-day to the 14-day assessment.

Document, code, heal ulcers: You should be able to show surveyors and plaintiff attorneys that you inherited a patient with an existing pressure ulcer from the hospital or other setting. So do a head-to-toe skin assessment on every resident at admission, and document any pre-existing pressure ulcers.

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"Many facilities also take pictures of skin problems at the time of admission," notes **Marilyn Mines, RN, BC**, director of clinical services for **FR&R Healthcare Consulting** in Deerfield, IL.

Also implement appropriate skin care protocols immediately to help pressure ulcers heal before the 14-day assessment -- and code the treatments at M5, Mines adds. If the team thinks a pressure ulcer may be totally healed by the 14-day assessment, it could choose an assessment reference date that would not capture the ulcer on the postacute measure, she says.

Recognize Limits of QIs/QMs

The QIs/QMs will miss some potential quality issues in the facility if you don't augment the information.

Example: A resident has to have a daily physical restraint during the 7-day lookback to trigger on that QI/QM. And mild daily pain -- or moderate pain that's less than daily -- isn't counted in the pain QIs/QMs, Littlehale says.

And "using the triggering of a QI/QM to determine your care plan for pain or 'resident watch list' is going to miss a proportion of residents who need attention."

"The QM/QI report should not be the only tool used for developing care plans," emphasizes Mines.

Keep a running list of all residents with any restraint use or pain. Then revisit the assessment and care planning for those individuals.

Suggestion: A full six-month QI/QM report will give you the most accurate picture of what's going on in your facility, in the view of **Clara Boland, RN, PhD**. She is a nursing professor at **University of Missouri-Columbia** and clinical consultant/ educator for the Quality Improvement Program for Missouri, which works with nursing homes on MDS and quality assurance issues.

Risk management gem: Many facilities spend most of their time "chasing after negative results," said **Rena Shephard, RN, RAC-MT, MHA, FACDONA**, in a talk on MDS compliance at the September **American Association of Nurse Assessment Coordinators** conference in Las Vegas. Instead, do auditing up front to identify and fix problems, including MDS coding and documentation shortfalls, before they become trends, Shephard urged.

Editor's note: Review the QI/QM definitions and technical specifications at http://www.qtso.com/download/mds/qiqm_rpt/Appendix_A_Technical_Specs.pdf.

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