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Watch for a Quality Indicator Survey coming near you

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This year will see the expansion of a federal demonstration program that could lead to greater consistency and, hopefully, improvement in the state survey process. Initiated in 2005, principally in the state of Florida, the Quality Indicator Survey (QIS) program being conducted by the Centers for Medicare & Medicaid Services (CMS) is slated to spread into as many as six more states in 2008: California, Connecticut, Louisiana, Kansas, Ohio and, this month, Minnesota. What does it do?

Primarily, it uses resident information from the MDS 2.0 (table) in a system that classifies residents into homogeneous groups for equitable prospective payment and to monitor the quality of both the process *and* outcomes of care. Reports can be used by providers for assistance in self-monitoring their facility care quality. Using these Quality Indicators (QIs) and applying them to random samples of resident and new admission information, surveyors are expected to come up with consistent and useful findings for genuine quality improvement. In practice so far the demonstration has found the number of deficiencies cited increasing somewhat, but overall scope and severity declining.

Assessments Used for QI Reports

MDS 2.0 Section	QI Reports		
A8a.—Primary reason for assessment	Facility	Facility Quality Indicator Profile	Resident Level Summary
1. Admission assessment	X	Excluded	X
2. Annual assessment	X	X	X
3. Significant change in X	X	X	status assessment
4. Significant correction X	X	X	of prior assessment
5. Quarterly review assessment	X	X	X
6. Discharged-return not anticipated	Excluded	Excluded	Excluded
7. Discharged-return anticipated	Excluded	Excluded	Excluded
8. Discharged prior to completing initial assessment	Excluded	Excluded	Excluded
9. Reentry	Excluded	Excluded	Excluded
10. Significant correction of prior quarterly assessment	X	X	X
0. NONE OF ABOVE	Excluded	Excluded	Excluded

The 24 QIs are based on the MDS 2.0 and cover the following domains: Accidents, Nutrition, Eating, Behavior/Emotional Patterns, Physical Functioning, Clinical Management, Psychotropic Drug Use, Cognitive Patterns, Quality of Life, Elimination/Incontinence, Skin Care, and Infection Control. Here, in plain language, is what these mean, based on a QI analysis from the Center for Health Systems Research and Analysis, University of Wisconsin–Madison:

QI 1 Incidence of new fractures

Residents who have a hip fracture or other fracture that is new since the last assessment. This QI is not risk-adjusted, and the denominator is all residents who did not have a fracture on the previous assessment.

QI 2 Prevalence of falls

Residents who have been coded with a fall within the time frame of the most recent assessment (past 30 days). Again, this QI is not risk-adjusted and the denominator is all residents.

QI 3 Prevalence of behavioral symptoms affecting others

A display of behaviors affecting others on the most recent assessment. Behavioral symptoms are defined as verbal abuse, physical abuse, or socially inappropriate/disruptive behavior. The behavior has had to occur at least once in the assessment period (7 days). This QI is risk-adjusted. Residents are considered more likely (are at HIGH RISK) to exhibit behavioral symptoms if they are cognitively impaired or have diagnoses of manic depression or psychotic disorders on the most recent assessment or on the most recent full assessment. Residents who do not have any of these conditions are described as LOW RISK.

QI 4 Prevalence of symptoms of depression

This is a complex definition. Residents are considered to have this QI if they have a sad mood and have two or more symptoms of functional depression. There are five symptoms, and some involve more than one item. Symptoms occurring within the most recent assessment period are: (1) negative statements exhibited up to five days or more per week; (2) agitation or withdrawal exhibited up to five days or more per week, or resists care at least 1-3 days in the last seven days, or withdrawal from activities or reduced social activity exhibited up to five days or more per week; (3) waking with an unpleasant mood up to five days or more per week, or not being awake most of the day and not comatose; (4) being suicidal or having recurrent thoughts of death up to five days or more per week; and (5) weight loss. This QI is not risk-adjusted and the denominator is all residents on the most recent assessment.

QI 5 Prevalence of depression with no antidepressant therapy

Residents with symptoms of depression and receiving no antidepressant therapy on the most recent assessment. Symptoms of depression are defined using the same criteria described above. This QI is not risk-adjusted and the denominator is all residents.

QI 6 Use of nine or more medications

Residents who were receiving nine or more different medications on the most recent assessment. This QI is not risk-adjusted and the denominator is all residents on the most recent assessment.

QI 7 Incidence of cognitive impairment

This QI identifies those residents who were *not* cognitively impaired on the previous assessment, but who *are* cognitively impaired on their most recent assessment. Cognitive impairment is defined as having impaired decision-making abilities *and* short-term memory problems. The denominator is only those residents who were not cognitively impaired on the previous assessment. This QI is not risk-adjusted.

QI 8 Prevalence of bladder or bowel incontinence

Residents who were determined to be incontinent or frequently incontinent on the most recent assessment. The denominator for this QI does *not* count those people who were comatose or had indwelling catheters or ostomies on the most recent assessment.

This QI is risk-adjusted. That is, residents are considered more likely to be incontinent if they have severe cognitive impairment or are totally dependent in activities of daily living (ADLs) having to do with mobility (bed mobility, transfer, and locomotion). These residents are at HIGH RISK for incontinence. Residents who do not have these conditions and are not excluded from the QI are considered LOW RISK.

QI 9 Prevalence of occasional or frequent bladder or bowel incontinence without a toileting plan...

...as found on the most recent assessment. In this case, the denominator would be those residents who are coded with frequent or occasional incontinence on the current assessment. This QI is not risk-adjusted.

QI 10 Prevalence of indwelling catheters

Residents noted to have an indwelling catheter on their most recent assessment. The denominator is all residents.

QI 11 Prevalence of fecal impaction

This QI is considered to be a *sentinel health event*, meaning that even if one person has this QI, it is of sufficient concern to require a review. This QI is not risk-adjusted and the denominator is all residents.

QI 12 Prevalence of urinary tract infections

Residents identified on the most recent assessment as having had a urinary tract infection. This QI is not risk-adjusted and the denominator is all residents.

QI 13 Prevalence of weight loss

Residents noted with a weight loss (5% or more in the last 30 days or 10% or more in the last 6 months) on the most recent assessment. This QI is not risk-adjusted and the denominator is all residents.

QI 14 Prevalence of tube feeding

Residents noted with a feeding tube on the most recent assessment. This QI is not risk-adjusted and the denominator is all residents.

QI 15 Prevalence of dehydration

Residents who have been coded with condition of dehydration (MDS check box) or with a diagnosis of dehydration (MDS ICD-9 CM 276.5). This QI is not risk-adjusted and the denominator is all residents, but is considered a *sentinel health event*.

QI 16 Prevalence of bedfast residents

Residents determined to be bedfast on the most recent assessment. This QI is not risk-adjusted and the denominator is all residents. (The definition of bedfast is very specific and is found in the RAI Manual.)

QI 17 Incidence of decline in late-loss ADLs

A decline in ADL functioning (self-performed) over two assessment periods: the most recent and the assessment immediately prior. Late-loss ADLs are those considered the "last" to decline or deteriorate (e.g., bed mobility, transferring, eating, and toileting). "Decline" means that over the assessment periods, there has been a one-level decline in at least two of these ADLs or a two-level decline in one of them. The denominator does not include residents who already were determined to be totally dependent or comatose on the previous assessment. This QI is not risk-adjusted.

QI 18 Incidence of decline in ROM

Residents who have had an increase in functional limitation in their range of motion (ROM) between the previous and most recent assessment. This QI includes only residents with the previous and most recent assessments on file, with the exclusion of residents with maximal loss of ROM on the previous assessment.

QI 19 Prevalence of antipsychotic use in the

absence of psychotic or related conditions

The denominator for this QI excludes those residents who have psychotic disorders, Tourette syndrome, or Huntington's disease on the most recent assessment or on the most recent full assessment, or those with hallucinations on the most recent assessment. This QI is risk-adjusted. Residents who exhibit both cognitive impairment and behavior problems on the most recent assessment are considered at HIGH RISK to receive antipsychotic medication(s). All others (except those excluded) are considered at LOW RISK.

QI 20 Prevalence of any antianxiety/hypnotic use

The denominator for this QI excludes those residents with one or more psychotic disorders, Tourette syndrome, or Huntington's disease on the most recent assessment or the most recent full assessment, or those with hallucinations on the most recent assessment. This QI is not risk-adjusted.

QI 21 Prevalence of hypnotic use more than twice in the last week

This QI is not risk-adjusted and the denominator is all residents on the most recent assessment.

QI 22 Prevalence of daily physical restraints

Residents who were restrained (trunk, limb, or chair) on a daily basis on the most recent assessment. This QI is not risk-adjusted and the denominator is all residents on the most recent assessment.

QI 23 Prevalence of little or no activity

The denominator includes all residents except those who are comatose. This QI is not risk-adjusted.

QI 24 Prevalence of stage 1-4 pressure ulcers

Residents who have been assessed with a pressure ulcer(s) stage 1-4 on the most recent assessment—either in the coding area for pressure ulcers or with an ICD-9 code. The denominator is all residents on the most recent assessment. This QI is risk-adjusted. Residents are considered HIGH RISK for the development of pressure ulcers if they have any one or more of the following conditions: impaired for bed mobility or transfer, are comatose, or have malnutrition or an end-stage disease on the most recent assessment. All other residents are considered to be LOW RISK. Residents at low risk that flag should be reviewed, however, since this would be considered a *sentinel health event*.

Getting the Information

Exactly to what extent the states named above will become involved with QIS monitoring is still indeterminate, based on state and federal budgeting factors. However, if you find that you reside in a QIS demonstration state, there are several easy ways to access the reports on your facility. Using the information management system you use to connect to your state's system for MDS data submission, connect to the state's MDS system and view the home page. This link will guide you to the proper page on the MDS system to request Quality Indicator (QI) reports for your facility.

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