

Nursing Facility Quality Incentive Payment Program

Division of Aging Services (DoAS) and
Division of Medical Assistance and Health
Services (DMAHS)

October 2019



Agenda

- AWQP Initiative Background
- FY20 Nursing Facility Rate Setting and Appropriations
- Nursing Facility Quality Incentive Payment Program (NF QIPP)
- NF QIPP Mandatory Requirements
- Quality Performance Measures
- NF & SCNF Considerations
- Facility Rate Performance Add-Ons
- Quality Performance Standards Reporting
- Question and Answer

AWQP Initiative Background and Status

The AWQP Initiative was developed in collaboration with the MLTSS Steering Committee Quality Workgroup which includes representatives from nursing facility providers, MCOs, and other long-term care stakeholders and advocates. The selection of these initial quality measures was a collaborative process over the course of several meetings in 2016. In January 2018, the AWQP Initiative was launched.

In 2019, under the Governor Murphy administration, the AWQP initiative was placed on hold and opportunities to provide rate incentives based on the collected quality metrics were identified. As a result, the quality measure outcomes were utilized to provide rate enhancements to both nursing facilities and special care nursing facilities.

FY20 Appropriations Act Funding Sources

Funding for the increase in the FY20 Nursing Facility rates came from two sources:

1. An increase in the annual Provider Assessment on nursing homes consistent with N.J.S.A. 26:2H-96, which when matched with federal funds adds a total of \$60 million to rates; and,
2. A Legislative Add in the FY20 Appropriations Act (P.L.2019, c. 150 as amended by P.L.2019, c.151 and P.L.2019,c.152) which increased funding to nursing facilities in the amount of \$30 million combined State and Federal Appropriations.

FY20 Appropriations Act Allocation

- Increased to the Minimum Case Mix Rate to \$188.35 for facilities whose rates were below that amount;
- Increased to the Provider Assessment Distribution of \$4.10 per day (from \$9.57 per day to \$13.67 per day) for those facilities qualifying to receive the Provider Assessment Distribution;
- Increased to the Case Mix Rate of \$3.01 per day for all facilities to distribute the Legislative Add included in the Appropriations Act; and
- Increased to the facility's rate if the facility received average performance scores for four select metrics (as published by the Centers for Medicare and Medicaid Services) that met or exceeded the national average for the period Q2 2017 thru Q1 2018. For each measure met, an additional \$0.60 was added to the facility's rate. An additional \$0.60 per day for facilities who achieved 75% or greater on the CoreQ Long-Stay experience survey.

FY20 Appropriations Act Performance Add-Ons

Fiscal Year 2020 Appropriations Act included significant changes to the per diem reimbursement rates provided to facilities. The facility rate performance add-ons were based on the following CMS quality metrics that met the national average as calculated by DHS:

- Antipsychotic Medication Use
- Incidence of Pressure Ulcers
- Use of Physical Restraints
- Falls with Major Injury
- CoreQ Q2 2018 with a benchmark of 75% or greater
 - CoreQ Q2 2018 consisted of survey data submitted between January – May 2018
 - SCNFs and their respective NFs were grandfathered into CoreQ for participation for FY 2020 only

NURSING FACILITY QUALITY INCENTIVE PAYMENT PROGRAM: FISCAL YEAR 2021



Nursing Facility Quality Incentive Payment Program (NF QIPP)

- Primary goal is to improve quality for individuals receiving care in a Medicaid certified Nursing Facility (NF) or Special Care Nursing Facility (SCNF) based on the components and metrics established under the AWQP initiative
- Leverages performance add-ons in state set Medicaid NF rate payments
 - Dependent on budget appropriations
- Focuses on long-stay Medicaid residents
- Inclusion of SCNFs
- Continued exclusion of low volume Medicaid facilities due to low Medicaid census
- Focuses on a fiscal year cycle

Mandatory Requirements for NF QIPP Consideration: Quality Incentive Survey

1. Mandatory participation in the DHS Quality Incentive Survey (QIS)

- DHS mailed the QIS links via (Survey Monkey platform) via US Postal Service mail
- The QIS collects two key elements:
 - a. Hospital Utilization Tracking Tool
 - b. CoreQ Vendor Intent

***Note: The surveys were sent out the week of October 7th and have a due date of 11/1/19. Surveys will be deactivated as of **11/16/19 at 12am** and no longer available.**

Mandatory Requirements for NF QIPP Consideration: Hospital Utilization Tracking (HUT) Tool

Hospital Utilization Tracking is identifying if a facility uses software that is specifically created for hospital utilization tracking of a facility's entire population. The software must have the ability to collect data, apply specific population inclusion/exclusion, and generate reports.

- HUT Tool response must be “Yes” **and** identify the software name
 - HUT Tool capability is utilized to establish eligibility for NF QIPP consideration only. There is no incentive payment for this quality measure
 - Homegrown tools, Excel spreadsheets, tracking systems not created for the purpose of hospital utilization tracking are not acceptable

Hospital Utilization Tracking Tool

The hospital utilization tracking tool question asks each facility to attest to its use of a specific validated type of tool that allows a facility to track, trend, and implement interventions based on all facility residents' hospital inpatient utilization. Internal Excel spreadsheets or other non-validated software tool is not sufficient.

Please answer the following question:

Do you track and trend hospital inpatient utilization with the use of a validated software system specific to hospital utilization tracking? YES NO

*If yes, what tool do you use?

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Other

If other, list the name of the tool below or respond N/A. (Response invalid if not specified.)

*must specify software name

Mandatory Requirements for NF QIPP Consideration: CoreQ Minimum Survey Sample Size

2. Mandatory participation in calculating a CoreQ Long-Stay Minimum Survey Sample Size

All Facilities Must Submit the Calculation Grid Regardless of CoreQ Vendor

- Exception: Stand-alone SCNFs (see slide 27)

CoreQ is a short, reliable, and validated questionnaire to calculate a set of quality measures for long-stay residents of facilities.

- A long-stay resident is defined as a resident whose cumulative days in the facility is equal to or greater than 100 days.
- There are two groups included in each survey sample
 - Long-stay residents
 - Families of long-stay residents

Mandatory Requirements for NF QIPP Consideration: CoreQ Minimum Survey Sample Size (cont'd)

Following completion of the QIS indicating CoreQ vendor intent, the facility is responsible for identifying the long-stay census, applying the CoreQ exclusions, and identifying a minimum sample size.

- This information is recorded on the DHS “CoreQ Long-Stay Survey Sample Size Calculation Grid”

Mandatory Requirements for NF QIPP Consideration: CoreQ Minimum Survey Sample Size (cont'd)

- The Grid and Instructions including information on the CoreQ exclusions is available at <https://www.state.nj.us/humanservices/doas/resources/>
- The CoreQ Long-Stay Survey Sample Size Calculation Grid is submitted to DoAS at NFIquiry@dhs.state.nj.us
- The due date for the calculation grid is 11/1/19

***NOTE: No CoreQ Long-Stay Survey Sample Size Calculation Grids will be accepted after 11/15/19.**

Mandatory Requirements for NF QIPP Consideration: CoreQ Minimum Survey Sample Size (cont'd)

A facility must participate in establishing if they can meet a minimum sample size

- Facilities unable to meet the minimum sample size will not be eligible for the performance rate add-on for CoreQ
 - There is no appeal process for inability to meet sample size
- Facilities able to meet the sample size must complete the survey process and receive a CoreQ Survey Composite Score equal to or greater than 75% to receive a performance add-on for this measure

Mandatory Requirements for NF QIPP Consideration: CoreQ Eligible and CoreQ Demographic Submission

Following the submission of the CoreQ Long-Stay Survey Sample Size Calculation Grid, DoAS will provide guidance on next steps:

1. DoAS will advise the facility they meet the minimum sample size and provide the CoreQ Long-Stay Demographics for Residents and Families template for completion
 - a. Facilities are responsible for documenting the resident and family demographics and submitting the template to the applicable CoreQ vendor
 - i. **Note:** Submissions to the DHS Vendor, Dr. Nick Castle, are required no later than November 8, 2019.

***NOTE: No submissions will be accepted by Dr. Castle after 11/15/19**

Mandatory Requirements for NF QIPP Consideration: CoreQ Ineligible

2. DoAS will advise the facility that they do not meet the minimum sample size
 - a. Facilities that are unable to meet the minimum sample size are ineligible to participate in the CoreQ survey process for the NF QIPP process. ***NOTE: This does not preclude a facility from conducting satisfaction surveys**
 - b. These facilities are eligible for performance add-on considerations, however, they will not receive payment for the CoreQ performance measure.

NF QIPP Ineligibility

A facility with either of the following **do not qualify** for participation in NF QIPP performance rate add-ons for any quality metrics

a. HUT = “No” or “No Response”

- “No” is defined as a facility who has indicated no use of a HUT as defined by NJ
- “No Response” is defined as a facility who did not respond to the QIS by the due date of 11/15/19

b. CoreQ = “No Response”

- “No Response ” is defined as a facility who did not respond to the QIS by the due date of 11/15/19

Quality Metrics Utilized for NF QIPP

The quality metrics for NF QIPP performance add-ons include:

- 5 Minimum Data Set (MDS) measures collected quarterly by CMS and calculated once annually by DHS
- 1 CoreQ Survey Composite Score: Long-stay resident and family experience survey collected by a CoreQ vendor

Calculation of Quality Metric Averages

The quality metric average will be calculated using one annual average score per metric

- Average of **4 quarters of data** for one annual average per metric **as calculated by DHS**
 - Annual quarters will have a lag dependent on fiscal year cycle.
 - **Note:** CMS posts one annual score for Influenza

Fiscal Year 2020 CMS Quarters	Fiscal Year 2021 CMS Quarters
Q2 2017	TBD
Q3 2017	TBD
Q4 2017	TBD
Q1 2018	TBD

QUALITY PERFORMANCE MEASURES



**NF QIPP
Quality
Performance
Measurement
Domains**

**CoreQ: Long-Stay
Resident/Family
Experience Survey**



Clinical

**Physical Restraints
Antipsychotic Medication
Falls with Major Injury
Pressure Ulcers
Influenza**



Minimum Data Set (MDS)

The NF QIPP uses five Minimum Data Set (MDS) measures that are collected by CMS under its Medicare Nursing Home Compare program.

These five core MDS measures are a part of the federally mandated process for clinical assessment of all residents in Medicare and Medicaid certified nursing homes collected by CMS.

DHS utilizes standard quarters (see Slide 20) that are both finalized (no further revisions by CMS) and publically available.

Quality Performance Measures

<u>QPS</u>	<u>Measures</u>	<u>Data Source</u>
QPS 1	Is the percentage of long-stay residents who are physically restrained at or below the national average as calculated by DHS?	MDS
QPS 2*	Is the percentage of long-stay residents receiving antipsychotic medication at or below the national average as calculated by DHS?	
QPS 3*	Is the percentage of long-stay residents experiencing one or more falls with major injury at or below the national average as calculated by DHS?	
QPS 4*	Is the percentage of long-stay, high risk residents with a pressure ulcer at or below the national average as calculated by DHS?	
QPS 5*	Is the percentage of long-stay residents who are given, appropriately, the influenza vaccination during the most recent influenza season at or above the national average? (calculated annually during influenza season)	
QPS 6**	Is the long-stay resident/family CoreQ Composite score at or above the DHS established benchmark.	CoreQ Composite Score

*To meet each of these standards, facilities must be at or above/below the National Average benchmark for 4 data quarters for which an average is calculated by DHS.

** Collected annually by CoreQ vendor or by DHS vendor.

Quality Performance Measure Criteria

<ul style="list-style-type: none"> ▪ Physical Restraints ▪ Falls with Major Injury ▪ Antipsychotic Medication ▪ Pressure Ulcers 	<p>To meet each of these four metrics, facilities must be at or below the National Average for the 4 quarters of data for which an average is calculated by DHS.</p>
<ul style="list-style-type: none"> ▪ Influenza Vaccination 	<p>To meet these metric, facilities must be at or above the National Average for the CMS reporting year. *Not applicable for FY20 only.</p>
<ul style="list-style-type: none"> ▪ CoreQ Long-Stay Survey: A standardized and validated survey tool to capture the resident and family experience of care. 	<p>To meet this metric, facilities must be at or above the State established annual benchmark of 75% for the annual survey cycle established by DHS. Facilities unable to meet the minimum sample size will result in “No Score.” Facilities must participate in establishing a sample size.</p> <p>Note: Establishment of a sample size is a mandatory requirement for consideration of NF QIPP. A score is not required for NF QIPP consideration; however, no performance add-on is available for CoreQ if “No Score” is obtained.</p>

NOTE: Performance measures are subject to change as the program matures.

NF/SCNF CONSIDERATIONS



NF/SCNF Inclusion

- All NF and SCNF facilities are included in the NF QIPP
- NFs that have a SCNF Unit(s):
 - CMS combines the MDS data of both the NF and SCNF. It is considered as one measure score for the entire score for the entire facility.
 - However, the performance add-on rates will be applied to each entity.
- If a SCNF is able to meet the CoreQ requirements, they must follow all CoreQ processes.
- Stand-alone SCNFs (previously identified) will generally be unable to meet the CoreQ minimum survey sample size requirements.
 - Stand-alone SCNFs must complete the mandatory requirement of step 1 in order to be considered for the CMS measures as outlined in the mailed letter.

Long-Stay Low Volume

Facilities with low volume long-stay census as determined by CMS do not have a sufficient amount of CMS data to be calculated for the long-stay quality metrics. The facilities impacted by this may vary each fiscal year.

- These facilities are primarily short-term facilities serving Medicare recipients.
- Due to lack of CMS data, performance add-ons cannot be considered for these facilities in which no CMS data is available for all quarters used in the NF QIPP.
- If a facility is reporting at least one quarter, this data will be calculated.

***NOTE: Low volume has nothing to do with the number of beds a facility has, it has to do with the data.**

Too Small To Report/Fail To Report

CMS designations of “too small to report” or the facility “failed to submit data” will be processed as follows:

- Those “too small to report” will have their averages calculated using the available data for the quarters in consideration.
 - For example, if a facility only has 2 of 4 quarters reportable, then the average will be based on those two quarters of data.
- Those who “fail to report” for **any** of the 4 quarters, no average will be calculated and there will be no consideration for a performance add-on for this metric.

FACILITY RATE PERFORMANCE ADD-ONS



Facility Rate Performance Add-Ons

- Additional rates above the established facility FFS rate will be applied to facilities that:
 - Meet the mandatory requirements for consideration and
 - Meet specific benchmarks
- Performance add-ons will be applied to each individual measure in which the facility meets the established benchmark
- Rates will be applied for one full fiscal year
- Rates will be passed through to the MCOs through capitation

NF QIPP Reporting Periods and Annual Rate Setting

- NF Rates and applicable incentives are dependent upon budget appropriations.
- All data collection and reporting will be on an annual basis.
- Performance add-ons must be established in advance of each fiscal year period.
 - Performance add-on amounts are determined by availability of budget funds.
- Rate letters are sent to each facility in July and will outline all rate components.

QUALITY PERFORMANCE STANDARDS (QPS) REPORTING



Quality Performance Standards Data Reporting

DHS collects and posts the Quality Performance Standards (QPS) data annually along with the rate worksheet in July. Data is posted on the Division of Aging Services webpage under “Resources for Providers.”

The QPS data will enable providers to review their performance as calculated by DHS.

NOTE: July is the start of the new fiscal year.

Benchmarks

Facility Name	Provider Number	QPS # 1: Physically Restrained 409 (National Avg: 0.40% ↓)						QPS # 2: Falls with Major Injury 410 (National Avg: 3.37% ↓)						QPS # 3: Antipsychotic Medication 419 (National Avg: 15.48% ↓)						QPS # 4: Pressure Ulcer 453 (National Avg: 5.57% ↓)						QPS # 5: 'Influenza 454 (National Avg: 95.05% ↑)		QPS # 6: CoreQ (Benchmark 75% ↑)		Hospital Utilization Tracking Tool
		2017 Q2	2017 Q3	2017 Q4	2018 Q1	Average	Meets National	2017 Q2	2017 Q3	2017 Q4	2018 Q1	Average	Meets National	2017 Q2	2017 Q3	2017 Q4	2018 Q1	Average	Meets National	2017 Q2	2017 Q3	2017 Q4	2018 Q1	Average	Meets National	Seasonal 2017	Q2 2018	Meets Average		
APRIL VIEW NURSING CENTER	315999	0.00%	0.00%	0.00%	0.00%	0.00%	Y	3.70%	0.00%	0.00%	0.00%	0.93%	Y	0.00%	0.00%	0.00%	0.00%	0.00%	Y	*	*	*	*	NA	NA	100.00%	83.50%	Y	Y	
MAY MANOR REHAB & CARE	315123	0.00%	0.76%	0.00%	0.00%	0.19%	Y	3.05%	3.82%	2.96%	1.54%	2.84%	Y	6.92%	10.08%	6.87%	6.35%	7.56%	Y	5.49%	4.55%	5.88%	3.85%	4.94%	Y	98.67%	NR	NR		
JULY NURSING HOME	315000	0.00%	0.00%	0.00%	0.00%	0.00%	Y	---	---	---	---	NA	NA	15.22%	11.63%	9.30%	6.67%	10.70%	Y	2.99%	3.95%	4.17%	4.17%	3.82%	Y	94.86%	NS	N	None	

- The national average is established by CMS.
- To meet the metrics, facilities must be at or above/below the national average as calculated by DHS.
- CoreQ Composite Score must be at or above the state benchmark as established by DHS which is 75%.

Provider Identification Number

Facility Name	Provider Number	QPS # 1: Physically Restrained 409 (National Avg: 0.40% ↓)						QPS # 2: Falls with Major Injury 410 (National Avg: 3.37% ↓)						QPS # 3: Antipsychotic Medication 419 (National Avg: 15.48% ↓)						QPS # 4: Pressure Ulcer 453 (National Avg: 5.57% ↓)						QPS # 5: 'Influenza 454 (National Avg: 95.05% ↑)		QPS # 6: CoreQ (Benchmark 75% ↑)		Hospital Utilization Tracking Tool
		2017 Q2	2017 Q3	2017 Q4	2018 Q1	Average	Meets National	2017 Q2	2017 Q3	2017 Q4	2018 Q1	Average	Meets National	2017 Q2	2017 Q3	2017 Q4	2018 Q1	Average	Meets National	2017 Q2	2017 Q3	2017 Q4	2018 Q1	Average	Meets National	Seasonal 2017	Q2 2018	Meets Average		
APRIL VIEW NURSING CENTER	315999	0.00%	0.00%	0.00%	0.00%	0.00%	Y	3.70%	0.00%	0.00%	0.00%	0.93%	Y	0.00%	0.00%	0.00%	0.00%	0.00%	Y	*	*	*	*	NA	NA	100.00%	83.50%	Y	Y	
MAY MANOR REHAB & CARE	315123	0.00%	0.76%	0.00%	0.00%	0.19%	Y	3.05%	3.82%	2.96%	1.54%	2.84%	Y	6.92%	10.08%	6.87%	6.35%	7.56%	Y	5.49%	4.55%	5.88%	3.85%	4.94%	Y	98.67%	NR	NR		
JULY NURSING HOME	315000	0.00%	0.00%	0.00%	0.00%	0.00%	Y	---	---	---	---	NA	NA	15.22%	11.63%	9.30%	6.67%	10.70%	Y	2.99%	3.95%	4.17%	4.17%	3.82%	Y	94.86%	NS	N	None	

- To identify each facility, DHS uses the CMS provider identification number. It is a six digit number starting with 315. This allows continuation of data despite facility name changes.
- Change in ownership, in most cases, retains the same CMS provider identification numbers. The data reported under the CMS provider number continues regardless of change in ownership.
- If a change in ownership is approved by NJ DOH, the new facility owner is responsible for notifying DHS via email.
- All correspondence must be sent to NFINquiry@dhs.state.nj.us and must reference the CMS provider identification number.

Symbols on the QPS Report

Facility Name	Provider Number	QPS # 1: Physically Restrained 409 (National Avg: 0.40% ↓)						QPS # 2: Falls with Major Injury 410 (National Avg: 3.37% ↓)						QPS # 3: Antipsychotic Medication 419 (National Avg: 15.48% ↓)						QPS # 4: Pressure Ulcer 453 (National Avg: 5.57% ↓)						QPS # 5: 'Influenza 454 (National Avg: 95.06% ↑)		QPS # 6: CoreQ (Benchmark 75% ↑)		Hospital Utilization Tracking Tool
		2017 Q2	2017 Q3	2017 Q4	2018 Q1	Average	Meets National	2017 Q2	2017 Q3	2017 Q4	2018 Q1	Average	Meets National	2017 Q2	2017 Q3	2017 Q4	2018 Q1	Average	Meets National	2017 Q2	2017 Q3	2017 Q4	2018 Q1	Average	Meets National	Seasonal 2017	Q2 2018	Meets Average		
APRIL VIEW NURSING CENTER	315999	0.00%	0.00%	0.00%	0.00%	0.00%	Y	3.70%	0.00%	0.00%	0.00%	0.93%	Y	0.00%	0.00%	0.00%	0.00%	0.00%	Y	*	*	*	*	NA	NA	100.00%	83.50%	Y	Y	
MAY MANOR REHAB & CARE	315123	0.00%	0.76%	0.00%	0.00%	0.19%	Y	3.05%	3.82%	2.96%	1.54%	2.84%	Y	6.92%	10.08%	6.87%	6.35%	7.56%	Y	5.49%	4.55%	5.88%	3.85%	4.94%	Y	98.67%	NR	NR		
JULY NURSING HOME	315000	0.00%	0.00%	0.00%	0.00%	0.00%	Y	---	---	---	---	NA	NA	15.22%	11.63%	9.30%	6.67%	10.70%	Y	2.99%	3.95%	4.17%	4.17%	3.82%	Y	94.86%	NS	N	None	

Symbols	Description	Impact on QPS
Down/Up Arrow Symbol (↓/↑)	The down arrow (↓) indicates the data result must be at or below the national average to meet the measure. The up arrow (↑) indicates the data result must be at or above the national average or state benchmark for CoreQ to meet the measure.	Depending on the national or state benchmark, facilities may or may not meet the standard for the measure.
Asterisk Symbol (*)	Indicates CMS had a footnote of “The number of residents is too small to report. Call the facility to discuss this quality measure.”	A data period with asterisks is not included in the DHS average calculation. (See N/A Symbol)
Three Dashes Symbol (---)	Indicates CMS had a footnote of “The data for this measure is missing. Call the facility to discuss this quality measure.”	Any data period with dashes due to the facility’s failure to report will result in the facility being ineligible for performance add-on for the applicable measure for the fiscal year. There will be no calculation of average. (See N/A Symbol)
Not Applicable (N/A) in Average & Meets National Average Columns Only	Indicates the facility did not meet the average of the four quarters of data for one annual average per metric as calculated by DHS.	Facilities did not meet the national average for the measure.

Symbols on the QPS Report (cont'd)

Facility Name	Provider Number	QPS # 1: Physically Restrained 409 (National Avg: 0.40% ↓)						QPS # 2: Falls with Major Injury 410 (National Avg: 3.37% ↓)						QPS # 3: Antipsychotic Medication 419 (National Avg: 15.48% ↓)						QPS # 4: Pressure Ulcer 453 (National Avg: 5.57% ↓)						QPS # 5: Influenza 454 (National Avg: 95.05% ↑)		QPS # 6: CoreQ (Benchmark 75% ↑)		Hospital Utilization Tracking Tool
		2017 Q2	2017 Q3	2017 Q4	2018 Q1	Average	Meets National	2017 Q2	2017 Q3	2017 Q4	2018 Q1	Average	Meets National	2017 Q2	2017 Q3	2017 Q4	2018 Q1	Average	Meets National	2017 Q2	2017 Q3	2017 Q4	2018 Q1	Average	Meets National	Seasonal 2017	Q2 2018	Meets Average		
APRIL VIEW NURSING CENTER	315999	0.00%	0.00%	0.00%	0.00%	0.00%	Y	3.70%	0.00%	0.00%	0.00%	0.93%	Y	0.00%	0.00%	0.00%	0.00%	0.00%	Y	*	*	*	*	NA	NA	100.00%	83.50%	Y	Y	
MAY MANOR REHAB & CARE	315123	0.00%	0.76%	0.00%	0.00%	0.19%	Y	3.05%	3.82%	2.96%	1.54%	2.84%	Y	6.92%	10.08%	6.87%	6.35%	7.56%	Y	5.49%	4.55%	5.88%	3.85%	4.94%	Y	98.67%	NR	NR		
JULY NURSING HOME	315000	0.00%	0.00%	0.00%	0.00%	0.00%	Y	---	---	---	---	NA	NA	15.22%	11.63%	9.30%	6.67%	10.70%	Y	2.99%	3.95%	4.17%	4.17%	3.82%	Y	94.86%	NS	N	None	

<u>Symbols</u>	<u>Definition</u>	<u>Impact on QPS</u>
None *for HUT only	Indicates the facility reports no use of a validated Hospital Utilization Tracking software system	None results in the facility being ineligible for performance add-on for all measures for the fiscal year due to not meeting the NF QIPP mandatory requirement.
No Response (NR) *for CoreQ and HUT only	Indicates one of the following: a. The facility CoreQ vendor did not provide data to the DHS CoreQ vendor. b. The facility did not establish a minimum survey sample size. c. The facility did not respond to the QIS	A data period with NR results in the facility being ineligible for performance add-on for all measures for the fiscal year due to not meeting the NF QIPP mandatory requirement(s).
No Score (NS) *for CoreQ only	Indicates the facility did not have a sufficient minimum survey sample size or sufficient number/rate of CoreQ survey responses.	A data period with NS results in the facility being ineligible for performance add-on for CoreQ for the fiscal year.

COREQ LONG-STAY SURVEYS



CoreQ Questions

For the resident, the three questions are as follows:

1. In recommending this facility to your friends and family, how would you rate it overall?
2. Overall, how would you rate the staff?
3. How would you rate the care you receive?

For the family, the three questions are as follows:

1. In recommending this facility to your friends and family, how would you rate it overall?
2. Overall, how would you rate the staff?
3. How would you rate the care your family member receives?

The response scale is as follows with one being the lowest and five being the highest:

- One (1) – Poor
- Two (2) – Average
- Three (3) – Good
- Four (4) – Very Good
- Five (5) – Excellent

CoreQ Survey Valid Sample Criteria

A CoreQ score is calculated based on the results of the questionnaires that meet the valid sample criteria. A valid sample is:

- 1) A minimum of 30 residents and 30 families eligible to be surveyed each cycle;
- 2) A minimum of 20 returned and useable surveys within each survey group (e.g., the numerator must be > 20 residents and >20 families = 40 returned and useable surveys)
- 3) A minimum response rate of 30% or greater. The response rate is calculated by counting all the valid responses divided by the number of people who were given the survey to complete

CoreQ Survey Results

CoreQ Results can be one of the following:

1. No Response
2. No Score
3. Composite Score
 - a. 75% or greater
 - b. Less than 75%

Minimum Survey Sample Size for CoreQ

- Facilities are required to report annually through the Quality Incentive Survey process. **The facility is responsible to determine the group of eligible long-stay residents and families and report to DHS via the CoreQ Long-Stay Survey Sample Size Calculation Grid.** DHS will advise the facility if the minimum sample size is met and submitted within the designated timeframes*
 - If the minimum sample size is not met, the facility will receive a “No Score.” This meets one of the 2 minimum requirements to be considered for NF QIPP performance add-ons, however, the facility will be ineligible for a CoreQ performance add-on.
 - If the minimum sample size is met, the facility is responsible to submit resident and family member contact information to the CoreQ vendor on the DHS designated form within the specified timeframe.
 - Surveys will be sent to resident and family from the CoreQ vendor.

***NOTE: No CoreQ Long-Stay Survey Sample Size Calculation Grids will be accepted after 11/15/19.**

CoreQ Long-Stay Survey Sample Size Calculation Grid

NJ DHS CoreQ Long-Stay Survey Sample Size Calculation Grid

Facility Name: _____

CMS Provider #: _____ **Year:** 2019 (FY21)

Insert more rows after # 48 if needed. Do not provide member specific information. Refer to "Instructions for Completing the CoreQ Long-Stay Survey Sample Size Calculation Grid" document for guidance. Return form to NFinquiry@dhs.state.nj.us no later than 11/1/19.

	Column A	Column B	Column C	Column D	Column E	Column F	Column G	Column H	Column I
	LTC Resident with Stay ≥ 100 Days	Resident BIMS Score ≤ 7	Resident on Hospice (Y/N)	Resident has Legal Guardian (Y/N)	Resident Appropriate for CoreQ Survey (Y/N)		Family Member Initials	Family Members Living in Another Country (Y/N)	Family Appropriate for CoreQ Survey (Y/N)
Example:	1234 or ABC	9	N	N	Y		JKL	N	Y
1									
48									
Totals:	Total # of LTC Residents with Stay ≥ 100 Days:	Total # of Residents with BIMS Score ≤ 7:	Total # of Residents on Hospice:	Total # of Residents Who Has a Legal Guardian:	Total # of Residents Appropriate for CoreQ Survey:		Total # of Family Members:	Total # of Family Members Living in Another Country:	Total # of Family Members Appropriate for CoreQ Survey:
Totals:									

October 17, 2019

Column A is all LTC residents regardless of the payer source and at the time of reporting. Actual BIMS Scores are needed in Column B. Column B is where the BIMS Score will be recorded (00 through 15 or 99). Residents with a BIMS Score of 7 or less will be coded "N" in the eligible for survey column (Column E). Facilities would still look to apply the exclusions for the family of this resident (hospice, guardian, or lives out of country). Additionally, residents with a BIMS Score of 99 will also be excluded. At the end of the calculation grid, provide the totals. If you are using a calculation grid and the BIMS Score does not say equal to or less than 7 or October 17, 2019, you are using the incorrect grid. Incorrect grids will not be accepted.

***NOTE: No CoreQ Long-Stay Survey Sample Size Calculation Grids will be accepted after 11/15/19.**

CoreQ Demographic Submission

- **Facilities Using the DHS CoreQ Vendor:** The facility is responsible to submit resident and family member contact information to Dr. Castle on the designated form (after receiving the notification of eligibility from DHS, if applicable) within the specified timeframe. Surveys will be sent to residents and families from Dr. Castle via the U.S. Postal Service. The resident and family member will return the survey directly to Dr. Castle.
- **Facilities Currently Collecting CoreQ Information Through a Contracted Vendor:** The facility is responsible to submit resident and family member contact information to their vendor. These vendors are responsible to initiate the CoreQ surveys and submit survey response data to Dr. Castle to be calculated. It is the facility responsibility to ensure the vendor is complying with the requirements.

***NOTE: No CoreQ Long-Stay Demographics for Facilities Templates will be accepted by Dr. Castle after 11/15/19.**

CoreQ Demographic Submission

CoreQ Long-Stay Demographics for Residents

Facility Name:		CMS Provider #:	
Address:			
Date of Submission:			
Include all eligible Residents as calculated on the CoreQ Long-Stay Survey Sample Size Calculation Grid. (Add another page if necessary.) Send to Dr. Castle at castlen@coreq.biz no later than 11/8/19. Submissions after 11/15/19 will not be accepted.			
Name of Residents:			
1			
2			

CoreQ Long-Stay Demographics for Families

Facility Name:		CMS Provider #:	
Address:		Date of Submission:	
Include all eligible Families as calculated on the CoreQ Long-Stay Survey Sample Size Calculation Grid. (Add another page if necessary.) Send to Dr. Castle at castlen@coreq.biz no later than 11/8/19. Submissions after 11/15/19 will not be accepted.			
Name of Long-Stay Families:		Addresses:	
Ex:	Jane A. Doe	12 Springfield Lane, Springview, NJ 11111	
1			
2			

Facilities will only receive the demographics template from DHS if applicable.

***NOTE: No CoreQ Long-Stay Demographics for Facilities Templates will be accepted by Dr. Castle after 11/15/19.**

CoreQ Exclusions

Excluded from the survey are the following long-stay residents or family members of long-stay residents:

Long-stay Resident Exclusions	Family Members of Long-Stay Residents Exclusions
<ul style="list-style-type: none"> Residents who have lived in the facility for less than 100 days will be identified from the MDS. This is recorded in the MDS Section A1600 and/or A1900. 	<ul style="list-style-type: none"> Families of residents who have lived in the facility for less than 100 days will be identified from the MDS. This is recorded in the MDS Section A1600 and/or A1900.
<ul style="list-style-type: none"> Residents receiving hospice: This is recorded in the MDS as Hospice (O0100K2 = 2). 	<ul style="list-style-type: none"> Families of residents receiving hospice: This is recorded in the MDS as Hospice (O0100K2 = 2).
<ul style="list-style-type: none"> Residents with court appointed legal guardians for all decisions will be identified from the facility health information system. 	<ul style="list-style-type: none"> Families of residents who are court appointed legal guardians for all decisions will be identified from the facility health information system.
<ul style="list-style-type: none"> Residents who have poor cognition: Provider will determine if the resident is able to be interviewed (choices are yes (1) or no (0)). Then, the Brief Interview for Mental Status (BIMS) will be given. Residents with BIMS scores of equal to or less than 7 are excluded. (MDS Section C0200-C0500 used). 	<ul style="list-style-type: none"> Family members who reside in another country.

CoreQ Administration Requirements

Facilities With NF Contracted CoreQ Vendors

Requirements include the ability to:

- Calculate and submit to DHS the CoreQ Long-Stay Survey Sample Size Calculation Grid
- Submit long-stay resident and family data to contracted CoreQ vendor
- Use a vendor contracted to collect CoreQ information from long-stay residents and families of long-stay residents annually
- Use a vendor able to provide the number of long-stay residents and families of long-stay residents given CoreQ surveys annually
- Use a vendor able to provide Dr. Castle with CoreQ data annually by established due date

Facilities using the DHS CoreQ Vendor (Dr. Castle)

Requirements include the ability to:

- Calculate and submit to DHS the CoreQ Long-Stay Survey Sample Size Calculation Grid
- Submit long-stay resident and family data to Dr. Castle by 11/15/19
- DHS vendor will collect CoreQ information from long-stay residents and families of long-stay residents annually.
- DHS vendor will collect CoreQ data on behalf of NFs as well as from CoreQ vendors contracted with NFs annually
- DHS vendor will calculate CoreQ composite scores annually by established due date and report to DHS.

CoreQ Administration

- The CoreQ surveys are initiated annually.
- Facilities must respond annually to the Quality Incentive Survey via Survey Monkey.
- Facilities and vendors must comply with the timeframes for submission of resident data.
- All information is confidential and will only be used for the survey. Individual surveys completed by the resident or family member will not be shared with the facility.
- Dr. Castle will provide DHS with the data results annually.
- Dr. Castle will not provide CoreQ composite scores to the facilities under the DHS contract for NF QIPP.

FY21 CoreQ Timeline for Collection, Transmission, and Reporting for Facilities using DHS CoreQ Vendor

The vendor will collect and report out as per the timeline:

Timeframe	Due Date	Survey Collection	Transmission by Facility	Dr. Castle Reporting to DHS
November 2019	11/1/19 *No data will be accepted after 11/15/19	Quality Incentive Survey (QIS)	Survey Monkey	December 2019
November 2019	11/1/19 *No data will be accepted after 11/15/19	DHS CoreQ Long-Stay Survey Sample Size Calculation Grid	To DHS via NFinquiry@dhs.state.nj.us	N/A
November 2019	11/8/19 *No data will be accepted after 11/15/19	CoreQ-Long-Stay Demographics for Facilities	To DHS CoreQ Vendor via castlen@coreq.biz	December 2019
November 2019 – February 2020	2/14/20 *No surveys will be accepted after 2/14/20	CoreQ Surveys Initiated and Responses Received	N/A	February 2020

FY21 CoreQ Timeline for Collection, Transmission, and Reporting for Facilities using **NF Contracted CoreQ Vendor**

The NF and NF contracted CoreQ vendor will collect and report out as per the timeline:

Timeframe	Due Date	Survey Collection	Transmission by NF	Dr. Castle Reporting to DHS
November 2019	11/1/19 *No data will be accepted after 11/15/19	Quality Incentive Survey (QIS)	Survey Monkey	December 2019
November 2019	11/1/19 *No data will be accepted after 11/15/19 Note: Be sure to include the survey initiation date on the grid for each population and do not remove any columns	DHS CoreQ Long-Stay Survey Sample Size Calculation Grid	To DHS via NFINquiry@dhs.state.nj.us	N/A
November 2019	Determined by NF	CoreQ Long-Stay Demographics for Facilities	To NF Contracted CoreQ Vendor	N/A
July 1, 2019 – February 2020		CoreQ Surveys Initiated and Responses Received	N/A	N/A
February 2020	2/14/20 *No CoreQ survey results will be accepted after 2/14/20	CoreQ data Submitted to DHS CoreQ Vendor	To DHS Contracted CoreQ Vendor via castlen@coreq.biz	February 2020

Question and Answer



Helpful Links

Nursing Facility Quality Improvement Payment Program:

<https://www.state.nj.us/humanservices/doas/resources/>

Fiscal Year 2020 Rate Setting and Quality Metrics Report:

<https://www.state.nj.us/humanservices/doas/resources/>

CMS Nursing Home Long-Stay Quality Measures Website: <https://data.medicare.gov>

CoreQ: <http://www.coreq.org/>

Quality Improvement Organizations (QIOs) Resource Information

- 1. The National Nursing Home Quality Improvement Campaign** (<https://www.nhqualitycampaign.org/default.aspx>)
The National Nursing Home Quality Improvement (NNHQI) Campaign exists to provide long term care providers, consumers and their advocates, and quality improvement professionals with free, easy access to evidence-based and model-practice resources to support continuous quality improvement. The Campaign promotes focus on individuals' preferences, staff empowerment, and involving all staff, consumers and leadership in creating a culture of continuous quality improvement.
- 2. Agency for Healthcare Research and Quality** (<https://www.ahrq.gov>)
The Agency for Healthcare Research and Quality (AHRQ) is the lead Federal agency charged with improving the safety and quality of America's health care system. AHRQ develops the knowledge, tools, and data needed to improve the health care system and help Americans, health care professionals, and policymakers make facility informed health decisions.
- 3. New Jersey Hospital Association Institute for Quality and Patient Safety** (<http://www.niha.com>)
Utilizing IHI's Breakthrough Series methodology, a learning collaborative has been established for each hospital acquired condition (HAC). Learning sessions, conference calls, and ongoing communication are vital elements that add to the robust nature and success of each collaborative. By continuing the work plans of previous collaboratives and capitalizing on successes achieved, enhancing their scope of activities, and expediting the feedback cycles for more rapid implementation of changes, well-tested and measured best practices will boast improved quality and safe patient care.

Improving organizational and system efficiencies is a necessary foundation to any quality improvement effort. By integrating system improvements and reengineering with quality improvement initiatives, care processes and clinical outcomes will be improved. Incremental changes are necessary but not sufficient to address care quality issues. New Jersey's integrated approach is the only way that quality improvement efforts can lead to sustainable changes.
- 4. Health Care Association of New Jersey** (<https://www.hcanj.org>)
The Health Care Association of New Jersey (HCANJ) is a non-profit trade association representing long term care providers who believe that the individuals they serve are entitled to a supportive environment in which professional and compassionate care is delivered. This belief compels HCANJ and its members to advocate for individuals who, because of social needs, disability, trauma, or illness, require services provided in a long term care setting, while also advocating for the long term care provider community.

Contact Information

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