National Alliance for Care at Home

REVISED OCTOBER 2022

Measures of Excellence (MOE)

User Guide and FAQs

This resource was originally produced by National Hospice and Palliative Care Organization (NHPCO). NHPCO has now joined together with the National Association for Home Care (NAHC) to form a new national organization representing providers of home care, home health, hospice, palliative care, and other health care services mainly delivered in the home – the National Alliance for Care at Home (the Alliance).

Introduction

The **Measures of Excellence** (MOE) is a quarterly data collection tool and dashboard that tracks operational and clinical data which can be used to inform high quality care. The quarterly MOE Dashboard allows organizations to compare themselves to other organizations for benchmarking. Participants will be able to identify performance improvement opportunities and track their performance improvement efforts through the quarterly dashboard. Access to the MOE data collection tool is open to all hospice providers. The MOE dashboard is provided as a benefit to NHPCO members and is available for purchase to non-members. For more information, please contact moe@nhpco.org.

NOTE: The MOE replaces the National Data Submission, which was an annual data collection tool and report.

Benefits of Participation

The Measures of Excellence (MOE) represents a comprehensive compilation of often hard to find and timely data points on hospice clinical and operations data. This is instrumental in providing industry insights, supporting advocacy efforts, and providing useful benchmarking data to hospice providers that aids in developing a quality driven organizational culture, refining strategic goals, setting operational targets and staffing levels, and improving quality of care delivery. This data includes information on:

- Who provides care
- Who receives care
- Where care is provided
- The range and quality of hospice services
- Staffing levels
- Demographic, cost, and payer data
- Utilization of emergency room and hospital
- Clinical safety data (infections, medication errors, falls)

The MOE offers quarterly data submission and a real-time quarterly dashboard allowing participants to:

- Compare their data with other organizations
- Filter comparison by ownership type, tax status, size, geography, and state
- Set benchmarks
- Identify performance improvement opportunities
- Track and trend data for performance improvement projects
- Demonstrate value to internal and external stakeholders

Data Protection

According to AHRQ (2018), "Patient Safety Organizations (PSOs) conduct activities to improve the safety and quality of patient care. PSOs create a legally secure environment (conferring privilege and confidentiality) where clinicians and health care organizations can voluntarily report, aggregate, and analyze data, with the goal of reducing the risks and hazards associated with patient care."[1]

NHPCO has contracted with a Patient Safety Organization, the Center for Patient Safety (CPS), to support and monitor the data collection, storage, and reporting of our members' clinical safety data. You can participate with confidence that your aggregate data remains anonymous and is protected from any misuse. The CPS PSO also offers educational opportunities and supports our members efforts to prevent future adverse events.

1 Patient Safety Organizations Program. Content last reviewed July 2018. Agency for Healthcare Research and Quality, Rockville, MD. www.ahrq.gov/cpi/about/ otherwebsites/pso.ahrq.gov/index.html

Completing the MOE Survey Tool

Step One: Review the "Center for Patient Safety" Memorandum of Understanding (MOU)

The CPS requires all MOE participants review a Memorandum of Understanding to acknowledge the NHPCO member's relationship with the CPS PSO.

Step Two: Data Collection

Organizations should download the MOE pdf and/or the MOE csv spreadsheet to review the data collection required to participate in the MOE data submission and dashboard.

- Meet internally with your team to determine internal roles and responsibilities to integrate data collection into your workflows.
- Identify the primary individual responsible for data submission. This individual should oversee the organization's efforts to collect data required for quarterly MOE data submission.

NOTE: the person in the organization responsible for MOE data submission must have access to the organization's DART ID*

- Determine your process for data collection.
- Assign data collection roles and responsibilities to applicable staff.
  - Payer mix: Finance Department
  - Patient volume and demographics: Clinical supervisor and IT/EMR
  - Staffing/Volunteers: Volunteer coordinator
  - Staffing/Bereavement: Bereavement coordinator
  - Staffing/Productivity: Human resources
  - Clinical/Patient Level Safety: Clinical supervisor
- Determine frequency of collection: monthly or quarterly.
- Determine collection method. Some suggested options are using the MOE pdf or MOE csv spreadsheet or using the MOE data collection tool (you can update as needed throughout the quarter)
- Meet with your IT vendor to share the MOE pdf to determine opportunities to pull data from your Electronic Medical Record (EMR) to enhance efficiencies in data collection.

Step Three: Data Entry

Organizations may access the MOE Data Submission Portal via the NHPCO website MOE Survey. Quality Connections participants may also access the MOE Survey via their Quality Connections portal.

As organizations enter data in the MOE Survey portal, it will automatically save. It is not necessary to complete the entire survey at one time. If an organization enters partial data, the system will autogenerate a survey retake link to the associated email account (Question A9: Email Address of Person Completing Survey).

NOTE: When returning to complete a survey, it is important to access the MOE survey tool via the survey retake link that has been emailed to the address entered in Question A9. Attempting to access a partially completed survey directly via the website or QC portal will result in initiation of a new survey, and previously entered data will not be accessible.

Organizations who are unable to locate the survey retake link should contact moe@nhpco.org.

The first page of the MOE submission asks the participant to choose which quarter data submission is for:

- Current Quarter
- Previous Quarter

The first page also requires the participant to submit their organization's DART ID. The DART ID is the NHPCO identification number assigned to your hospice. It is the same ID you used to enter the DART system. Enter N/A if you are not a NHPCO Member.

NOTE: Using your DART ID grants you access to the full MOE dashboard, including the ability to compare your results to others. There is a maximum of four separate inpatient facility entries for the inpatient facility section.

Advancing the document occurs by clicking on the arrow in the right lower corner of each screen. You can go back to the previous page by clicking on the arrow in the lower left corner of the screen but data on the current screen will not be saved. Definitions are available below, as well as within the MOE online data collection tool.

Step Four: Data Submission

Data submission deadlines for each quarter are updated and posted at www.nhpco.org/moe. However, organizations may request access to enter data in older quarters by emailing moe@nhpco.org.

If you are part of a larger organization, we do ask data to be submitted by each DART ID. This will allow the most accurate comparisons of data. (Under the Program Demographic section, there is an opportunity to choose your affiliation with your parent organization.)

Your submission is not complete until you hit the arrow in the lower right corner of the screen at the end of the MOE. Once you submit, you will receive an email with a retake link in case you need to update data before the quarterly submission deadline.

MOE Content Areas

Profile Demographics

HOSPICE PROFILE AND CONTACT INFORMATION
PROGRAM DEMOGRAPHICS

NOTE: The program demographics and annual application credits will carry over from quarter to quarter. You will have the ability to review and update the information, but you will not have to re-enter this information every quarter. Other fields are updated quarterly.

Operational Excellence

ANNUAL APPLICATION CREDITS FOR QC PAYER MIX
PATIENT VOLUME PATIENT DEMOGRAPHICS

Staffing (Clinical)

VOLUNTEER
SERVICES BEREAVEMENT
SERVICES PRODUCTIVITY

Clinical

EMERGENCY ROOM VISITS and **HOSPITALIZATIONS**

Patient Level Safety Data Set

PATIENT LEVEL SAFETY DATA SET
PATIENT INFECTIONS MEDICATION ERRORS
PATIENT FALLS

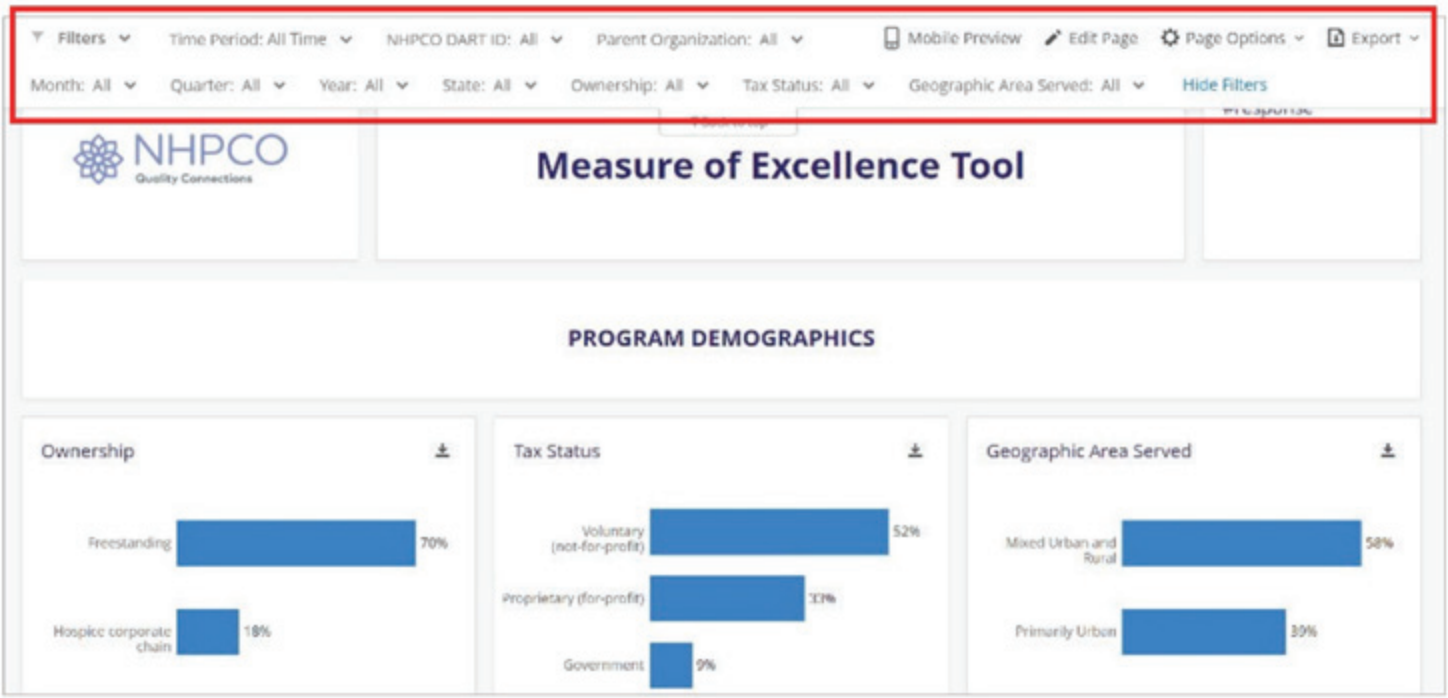
Inpatient and Residential Facilities

INPATIENT AND RESIDENTIAL FACILITIES

NOTE: If you have more than one inpatient facility, you will enter data separately for each one. The option will appear based on the number you enter under how many facilities you operate.

Accessing the MOE Dashboard

The MOE Tool Dashboard is informed by the completion of the MOE data submission. The top of the dashboard has a variety of filters the organization can use to compare their results to others. These filters include state, ownership, tax status, and geographic area served. You can also choose to look at data by year, quarter, or month. A parent organization can look at all their subsidiaries.



Timing: You should access the quarterly MOE Dashboard after the quarterly submission deadline to have the most accurate comparison data.

Display: The left side of the screen will display your organization's results. The right side of the screen will provide the comparison of all respondents based on the filter you have used.

Pages: At the top in the center, you can navigate to other pages of the dashboard: Staffing (Clinical) and Patient Level Safety Data Set.

Downloading and emailing the Dashboard: In the top right corner of the dashboard screen, you have the option of downloading the dashboard or emailing the dashboard to others.

The NHPCO Quality team welcomes your questions and suggestions. Please contact moe@nhpco.org with any questions about the survey tool or dashboard.

Safety Data Set - Definitions

1. Objectives for collecting patient level safety data include the following:

- Utilization of data for national benchmarking
- Identification of factors that contribute to patient falls, infections, and medication errors to mitigate risk
- Utilization in individualized care planning
- Utilization in innovative patient safety program development (hospice and national level)

2. Plan for Data Collection

Participants will submit/upload data into NHPCO's Quality Connections portal on a calendar quarterly basis. Data should be entered by month within two (2) weeks after the quarter ends. Data analysis reports will be available to participants for benchmarking quarterly and at the end of the calendar year in a final report.

Note: Only participants who submit data will have access to data outcomes and analysis from NHPCO.

3. Calculation methodology

- An incidence rate is typically used to measure the frequency of occurrence of new cases of infection within a defined population during a specified time frame.
- There is no specific infection/falls/medications error incidence rate calculation for hospice care. The Centers for Disease Control and Prevention utilize the "per 1000 patient days" calculation in their resources which is a standard practice utilized among hospice providers. This methodology represents the number of patient days for the population at risk. This is calculated by taking the number of what is being measured divided by the number of patient days, multiplied by 1,000.[2]
- Total incidence rate calculation

  Example: Determine healthcare associated infection incidence rates by dividing the number of cases by total patient days and multiply by 1000.

4. Location of care definitions

- **Home setting (Private residence):** Patient resides in a private dwelling which could be a house, apartment, etc.
- **Inpatient hospital:** An institution primarily engaged in providing, by or under the supervision of physicians, inpatient diagnostic and therapeutic services or rehabilitation services. This location includes Critical Access Hospitals (CAHs) and psychiatric hospitals.[3]
- **Hospice inpatient unit:** This is a hospice owned Medicare certified facility or state licensed hospice residence.
- **Skilled nursing facility:** An institution or a distinct part of an institution such as a skilled nursing home or rehabilitation center, which has a transfer agreement in effect with one or more participating hospitals and which: A. Is primarily engaged in providing skilled nursing care and related services for residents who require medical or nursing care; or rehabilitation services for the rehabilitation of injured, disabled, or sick persons, and B. Meets the requirements for participation in §1819 of the Social Security Act and in regulations in 42 CFR part 483, subpart B.[4]
- **Nursing facility:** An institution (or a distinct part of an institution) which is primarily engaged in providing skilled nursing care and related services for residents who require medical or nursing care, rehabilitation services for the rehabilitation of injured, disabled, or sick persons, or on a regular basis, health-related care and services to individuals who because of their mental or physical condition require care and services (above the level of room and board) which can be made available to them only through institutional facilities, and is not primarily for the care and treatment of mental diseases; has in effect a transfer agreement (meeting the requirements of §1861(1)) with one or more hospitals having agreements in effect under §1866.
- **Assisted living facility:** Assisted living is part of a continuum of long-term care services that provides a combination of housing, personal care services, and health care designed to respond to individuals who need assistance with normal daily activities in a way that promotes maximum independence. Assisted living services can be provided in freestanding communities, near or integrated with skilled nursing homes or hospitals, as components of continuing care retirement communities, or at independent housing complexes.[5]
- **Other congregate living facility:** a facility with in which multiple individuals share living space (i.e., personal care home, group home, etc.)[6]

2 The Centers for Disease Management and Control. (2020, Apr 24). NHSN Reports. Retrieved from: www.cdc.gov/nhsn/datastat/index.html?CDC_AA_ refVal=https%3A%2F%2Fwww.cdc.gov%2Fnhsn%2Fdatastat.html

3 The Centers for Medicare and Medicaid Services. (2020, Oct 21). Hospitals. Retrieved from www.cms.gov/Medicare/Provider-Enrollment-and-Certification/CertificationandComplianc/Hospitals#:~:text=A%20hospital%20is%20an%20institution,are%20certified%20under%20separate%20standards.

4 The Centers for Medicare and Medicaid Services. (2000). Skilled nursing facility manual. Retrieved from: www.cms.gov/Regulations-and-Guidance/Guidance/ Transmittals/downloads/R367SNF.pdf

5 The Centers for Medicare and Medicaid Services. (2007). State Operations Manual Appendix PP - Guidance to Surveyors for Long Term Care Facilities. Retrieved from: www.cms.gov/Regulations-and-Guidance/Legislation/CFCsAndCoPs/Downloads/som107ap_pp_guidelines_ltcfpdf

6 American Health Association. (2020). What is assisted living? Retrieved from: www.ahcancal.org/Assisted-Living/Consumer-Resources/Pages/default.aspx

Patient Infection Data Targets for Benchmarking

1. Patient infections

- **Infection:** A disease caused by microorganisms which include bacteria, viruses, fungus, and prions.[7]
- **Healthcare associated infection (HAI):** An infection that develops in a patient who is cared for in any setting in which healthcare is delivered (i.e., acute care hospital, chronic care facility, ambulatory clinic, dialysis center) and is related to receiving health care (i.e., was not incubating or present at the time healthcare was provided).[8]
- **Multi drug resistant organisms (MDROs):** Bacteria (excluding M. tuberculosis) that are resistant to one or more classes of antimicrobial agents and usually are resistant to all but one or two commercially available antimicrobial agents (i.e., MRSA, VRE, extended spectrum beta-lactamase [ESBL]-producing or intrinsically resistant gram-negative bacilli).[9]
- **Coronavirus Disease 2019 (COVID-19):** COVID-19 is caused by a new coronavirus. Coronaviruses are a large family of viruses that are common in people and many different species of animals, including camels, cattle, cats, and bats. Rarely, animal coronaviruses can infect people and then spread between people such as with MERS-CoV, SARS-CoV, and now with this new virus, named SARS-CoV-2.[10]

  Probable COVID-19 case
  - Meets clinical criteria AND epidemiologic evidence with no confirmatory laboratory testing performed for COVID-19.
  - Meets presumptive laboratory evidence AND either clinical criteria OR epidemiologic evidence.
  - Meets vital records criteria with no confirmatory laboratory testing performed for COVID-19.[11]

  Confirmed COVID-19 case
  - Meets confirmatory laboratory evidence.[12]

- Total number of patient days: A count of the number of patients in a patient care location during a defined time period. This count can be determined electronically or manually by a daily count or, depending on the location type, weekly sampling.[13]

  Example: Any patient with a day of service in a targeted month is counted as a patient day. If Patient A was on service for 2 of the 30 days in this month his total patient days are 2. Patient B was on service last month and this month you only count 30 days for Patient B this month.

- **Numerator:** Number of patients described in each data target.
- **Denominator:** Total number of patient days
- **Exclusions:** Patients 18 years and younger; patients not enrolled in hospice.

7 Tabers Medical Dictionary. (2000-2020). Retrieved from: www.tabers.com/tabersonline/view/Tabers-Dictionary/770294/all/infection
8 APIC. (2008). HICPAC Surveillance definitions for home health care and home hospice infections. Retrieved from: www.apic.org/Resource_/TinyMceFileManager/ Practice_Guidance/HH-Surv-Def.pdf
9 The Centers for Disease Management and Control. (2006). Management of multidrug-resistant organisms in healthcare settings/Glossary. Retrieved from: www. cdc.gov/infectioncontrol/guidelines/mdro/glossary.html#M
10 The Centers for Disease Management and Control. (2020). Coronavirus Disease (COVID-19). Retrieved from: www.cdc.gov/coronavirus/2019-ncov/cases-updates/ summary.html
11 The Centers for Disease Management and Control. (2020, Apr 5). Coronavirus Disease 2019 (COVID-19); 2020 Interim Case Definition, Approved April 5, 2020. Retrieved from: wwwn.cdc.gov/nndss/conditions/coronavirus-disease-2019-covid-19/case-definition/2020/
12 The Centers for Disease Management and Control. (2020, Apr 5). Coronavirus Disease 2019 (COVID-19); 2020 Interim Case Definition, Approved April 5, 2020. Retrieved from: wwwn.cdc.gov/nndss/conditions/coronavirus-disease-2019-covid-19/case-definition/2020/
13 The Centers for Disease Management and Control. (2020, Jan) National Healthcare Safety Network (NHSN) Patient Safety Component Manual. Retrieved from: www.cdc.gov/nhsn/pdfs/pscmanual/pcsmanual_current.pdf

Patient Falls Data Targets for Benchmarking

2. Patient falls

- **Fall:** An unplanned descent to the floor (or extension of the floor) with or without injury. All types of falls are included, whether they result from physiological reasons or environmental reasons.[14]
- **Fall-related injuries categories:**

  None indicates that the patient did not sustain an injury secondary to the fall.

  Minor indicates those injuries requiring a simple intervention.

  Moderate indicates injuries requiring sutures or splints.

  Major injuries are those that require surgery, casting, further examination (i.e., for a neurological injury).

  Deaths refers to those that result from injuries sustained from the fall.[15]
- **Sentinel event:** A sentinel event is an unexpected occurrence involving death or serious physical or psychological injury, or the risk thereof. Serious injury specifically includes loss of limb or function. The phrase "or the risk thereof" includes any process variation for which a recurrence would carry a significant chance of a serious adverse outcome. Such events are called "sentinel" because they signal the need for immediate investigation and response. The terms "sentinel event" and "error" are not synonymous; not all sentinel events occur because of an error, and not all errors result in sentinel events.[16]
- **Total number of patient days:** A count of the number of patients in a patient care location during a defined time period. This count can be determined electronically or manually by a daily count or, depending on the location type, weekly sampling.[17]

  Example: Any patient with a day of service in a targeted month is counted as a patient day. If Patient A was on service for 2 of the 30 days in this month his total patient days are 2. Patient B was on service last month and this month you only count 30 days for Patient B this month.
- **Numerator:** Number of patients described in each data target.
- **Denominator:** Total number of patient days
- **Exclusions:** Patients 18 years and younger; patients not enrolled in hospice.

Patient Medication Errors Data Targets for Benchmarking

3. Patient medication errors

- **Medication Error:** Defined by the National Coordinating Council for Medication Error Reporting and Preventions (NCC MERP), "A medication error is any preventable event that may cause or lead to inappropriate medication use or patient harm while the medication is in the control of the health care professional, patient, or consumer. Such events may be related to professional practice, health care products, procedures, and systems, including prescribing, order communication, product labeling, packaging, and nomenclature, compounding,

14 Montalvo, I., (September 30, 2007) "The National Database of Nursing Quality Indicators (NDNQI®)" OJIN: *The Online Journal of Issues in Nursing*. Vol. 12 No. 3, Manuscript 2. DOI: 10.3912/OJIN.Vol12No03Man02

15 Montalvo, I., (September 30, 2007) "The National Database of Nursing Quality Indicators (NDNQI®)" OJIN: *The Online Journal of Issues in Nursing*. Vol. 12 No. 3, Manuscript 2. DOI: 10.3912/OJIN.Vol12No03Man02

16 Joint Commission. (2013). Sentinel Events (SE). Retrieved from: www.jointcommission.org/-/media/deprecated-unorganized/imported-assets/tjc/system-fold- ers/topics-library/camh_2012_update2_24_sepdf.pdf?db=web&hash=FD320B7BAF3E08EC28B44AA51CB21ABE

17 The Centers for Disease Management and Control. (2020, Jan) National Healthcare Safety Network (NHSN) Patient Safety Component Manual. Retrieved from: www.cdc.gov/nhsn/pdfs/pscmanual/pcsmanual_current.pdf

dispensing, distribution, administration, education, monitoring, and use."[18] This definition is utilized by the Centers for Medicare and Medicaid Services.

Errors Definitions:

Harm: Impairment of the physical, emotional, or psychological function or structure of the body and/or pain resulting therefrom.

Monitoring: To observe or record relevant physiological or psychological signs.

Intervention: May include change in therapy or active medical/surgical treatment.

Intervention Necessary to Sustain Life: Includes cardiovascular and respiratory support (e.g., CPR, defibrillation, intubation, etc.)[19]

- **Sentinel event:** A sentinel event is an unexpected occurrence involving death or serious physical or psychological injury, or the risk thereof. Serious injury specifically includes loss of limb or function. The phrase "or the risk thereof" includes any process variation for which a recurrence would carry a significant chance of a serious adverse outcome. Such events are called "sentinel" because they signal the need for immediate investigation and response. The terms "sentinel event" and "error" are not synonymous; not all sentinel events occur because of an error, and not all errors result in sentinel events.[20]

- **Medication Error Type definitions:**

Prescription writing error: the prescription content contains an error.

Medication dispensing error: an error occurred during the dispensing (filling) of the medication prescription.

Medication delivery error: an error occurred when the medication was physically delivered to the patient.

Near miss errors: any event or situation that didn't produce patient injury, but only because of chance[21]

- **NCC MERP Index for Categorizing Medication Errors Definition of harm:**

Adverse Reaction(s) with a result of sentinel event: See Joint Commission definition of Sentinel event.

- **Total number of patient days:** A count of the number of patients in a patient care location during a defined time period. This count can be determined electronically or manually by a daily count or, depending on the location type, weekly sampling.[22]

Example: Any patient with a day of service in a targeted month is counted as a patient day. If Patient A was on service for 2 of the 30 days in this month his total patient days are 2. Patient B was on service last month and this month you only count 30 days for Patient B this month.

- **Numerator:** Number of patients described in each data target.

- **Denominator:** Total number of patient days

- **Exclusions:** Patients 18 years and younger; patients not enrolled in hospice.

18 National Coordinating Council for Medication Error Reporting and Prevention. (2020). About medication errors. Retrieved from: www.nccmerp.org/about-medica- tion-errors

19 National Coordinating Council for Medication Error Reporting and Prevention. (2001). NCC MERP index for categorizing medication errors. Retrieved from: www.nccmerp.org/sites/default/files/indexColor2001-06-12.pdf

20 Joint Commission. (2013). Sentinel Events (SE). Retrieved from: www.jointcommission.org/-/media/deprecated-unorganized/imported-assets/tjc/system-fold- ers/topics-library/camh_2012_update2_24_sepdf.pdf?db=web&hash=FD320B7BAF3E08EC28B44AA51CB21ABE

21 Institute for Safe Medication Practices. IMSP survey helps define near miss and close call. 2009. Acute Care ISMP Medication Safety Alert! www.ismp.org/ newsletters/acutecare/articles/20090924.asp.

22 The Centers for Disease Management and Control. (2020, Jan) National Healthcare Safety Network (NHSN) Patient Safety Component Manual. Retrieved from: www.cdc.gov/nhsn/pdfs/pscmanual/pcsmanual_current.pdf

Frequently Asked Questions

1. I missed the quarterly deadline for data submission. Is there any way to go back and submit older data?

a. You can always enter previous quarter data by choosing Previous Quarter on page one of the MOE tool. Email moe@nhpco.org with requests to have earlier quarters made available for data submission.

2. What is the easiest way to access the MOE Survey Tool?

a. You can access the survey directly from the NHPCO website at NHPCO Measures of Excellence (MOE) or, for Quality Connections participants, via your Quality Connections portal.

3. I wasn't able to complete my submission in one sitting, but when I accessed the survey to continue, my data was wiped out and I had to reenter everything. What happened?

a. Please ensure that you are using the Survey Retake Link to access the tool to complete data submission. If you attempt to access your survey via the original link, the webpage, or your QC portal, you will automatically be directed to a blank survey to begin again.

b. The Survey Retake Link is automatically sent to the email address of the individual completing the MOE survey data submission as indicated in Question A9. If you are unable to locate the link, email moe@nhpco.org.

4. When viewing my Dashboard, I'm unable to tell which quarters I'm viewing. How do I set the time ranges I'd like to view?

a. The filter settings on the top right display area in the MOE dashboard allow viewing data based on Time period, DARTID, Month, Year, State, Ownership type, Tax status, Geographic area served and Quarters. Use these filters to adjust the data you'd like to view.

5. My organization is not an NHPCO member, are we able to utilize the MOE survey?

a. Yes! Any organization may submit data to the MOE. Non-members may purchase dashboard access for a fee. Please contact moe@nhpco.org for more information.

6. Where can I find more information about Measures of Excellence?

a. Please visit the NHPCO Measures of Excellence webpage for instructions, survey tool access, and an MOE walkthrough video.

Measures of Excellence Dashboard

Update Dec. 2023

New Page: Rates–Falls, Medication Errors &Infections

The Rates – Falls, Medication Errors & Infections page of the Measures of Excellence (MOE) dashboard presents patient safety data from three metrics – Falls, Medication Errors and Patient Infections. Each metric is presented in two tables.

The first table reports accumulated data from 2021 (the first year of the MOE) to the current date

Filters | Year: All | Quarter: All | State: All | Ownership: All | Accreditation: All | Medicare Certified: All | Memberships: All | Tax Status: All

All viewers are currently seeing the new version of this dashboard. Switch back or Leave feedback.

Patient Fall Rate - All Years (2021-Current)

Total Days of Care	21,190,362
Sum (Patient falls by care location)	103,128
Patient Fall Rate	0.005
Fall Rate Per 1000 Days	4.9

The second table reports the data broken down by each year of the MOE. Subsequent years will be added as data is accumulated

Filters | Year: All | Quarter: All | State: All | Ownership: All | Accreditation: All | Medicare Certified: All | Memberships: All | Tax Status: All

Back to top

Patient Fall Rate By Year

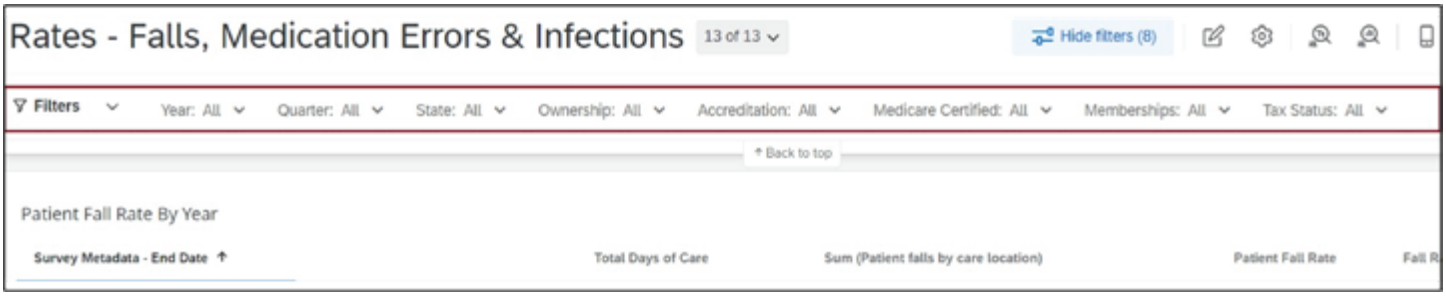
Survey Metadata - End Date	Total Days of Care	Sum (Patient falls by care location)	Patient Fall Rate	Fall Rate Per 1000 Days
2021	8,035,545	37,307	0.005	4.6
2022	7,793,422	36,977	0.005	4.7
2023	5,342,062	28,844	0.005	5.4

The tables provide a standard rate by dividing the number of incidents/errors/infections over the total days of care. There is no further calculation in this formula and the data is provided as a baseline.

The second reporting method provides a 'per 1000 patient days' calculation, which is a measure of the frequency of an event. This calculation is recommended by the Agency for Healthcare Research & Quality (A component of the Department of Health & Human Services). It is calculated by first obtaining the standard rate and then multiplying it by 1000. For example, a standard rate of .05 translates to an incident rate of 50 per 1000 patient days.

Filters

In addition, the Measures of Excellence dashboard allows users to filter these rates to benchmark against like organizations



The available filters are:

- Year
- Quarter (MOE submissions are accepted quarterly each year)
- State (Geographic)
- Ownership (Type of ownership)
- Accreditation
- Medicare Certified
- Memberships
- Tax Status

Using this dashboard page should allow users to more quickly access their own rates following prescribed calculations, and compare with other organizations that participate in the MOE based on the user's criteria.

For more information on the methodology or the data points used, please continue to the next section.

Data Methodology:

Table data is taken from the following MOE areas:

Total Days of Care:

Sum of MOE question(s):

- Days of care - Total - Days of Continuous Care
- Days of care - Total - Days of Routine Hospice Care
- Days of care - Total - Days of General Inpatient Care
- Days of care - Total - Days of Respite Care

Patient Falls:

Combines all categories for the different Patient Falls by Location to obtain one data point. The data used for the total falls was taken from the **sum of Patient Falls By Care Location:**

- Patient falls by care location: - Home Setting (Private Residence)
- Patient falls by care location: - Inpatient Hospital
- Patient falls by care location: - Hospice Inpatient Unit (IPU) or residence
- Patient falls by care location: - Skilled Nursing Facility (SNF)
- Patient falls by care location: - Nursing Facility (NF)
- Patient falls by care location: - Assisted Living Facility (ALF)
- Patient falls by care location: - Other Congregate Living Facility

Medication Errors:

The data used for the total Medication Errors was taken from the **Sum of Medication Errors by Care Location:**

- Medication Errors by Care Location - Assisted Living Facility
- Medication Errors by Care Location - Home Setting (Private Residence)
- Medication Errors by Care Location - Hospice Inpatient Unit (IPU) or residence
- Medication Errors by Care Location - Inpatient Hospital
- Medication Errors by Care Location - Nursing Facility (NF)

- Medication Errors by Care Location - Other Congregate Living Facility
- Medication Errors by Care Location - Skilled Nursing Facility (SNF)

Patient Infections:

The data used for the total Infections was taken from the **Sum of Patient Infections By Location of Care**

- Patient Infections By Location of Care - Assisted Living Facility
- Patient Infections By Location of Care - Assisted Home Setting (Private Residence)
- Patient Infections By Location of Care - Assisted Hospice Inpatient Unit (IPU) or residence
- Patient Infections By Location of Care - Assisted Inpatient Hospital
- Patient Infections By Location of Care - Assisted Nursing Facility (NF)
- Patient Infections By Location of Care - Assisted Other Congregate Living Facility
- Patient Infections By Location of Care - Assisted Skilled Nursing Facility (SNF)

The methodology excludes incidents that may have been reported more than once in other categories - for example, reporting the same fall twice as both an Injury and one that resulted in Death. By combining the metrics as summed By Location, each reportable incident/fall/error is counted once.

Formulas

Patient Falls Rate: Total Falls by Location / Total Days of Care

Patient Falls Per 1000 Days: (Total Falls by Location / Total Days of Care) * 1000

Medication Errors Rate: Total Medication Errors by Location / Total Days of Care

Medication Errors Per 1000 Days: (Total Medication Errors by Location / Total Days of Care) * 1000

Patient Infections Rate: Total Patient Infections by Location / Total Days of Care

Patient Infections Per 1000 Days: (Total Patient Infections by Location / Total Days of Care) * 1000

For additional questions please contact us at moe@nhpco.org

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