Operator: Welcome to Building a Solid Foundation for QAPI Using Your Quality Measures Conference Call. My name is Paulette, and I will be your operator for today’s call. At this time, all participants are in a listen-only mode. Later, we will conduct a question-and-answer session. Please note that this conference is being recorded.

I will now turn the call over to Lori Hintz. Ms. Hintz, you may begin.

Lori Hintz: Thank you, Paulette. Well welcome, everyone, to the South Dakota Nursing Home Quality Care Collaborative Learning and Action Kickoff Webinar. On behalf of the South Dakota Foundation for Medical Care, which is South Dakota's Quality Improvement Organization or you most commonly know it as your QIO, Holly Beving and myself, Lori Hintz, are happy to be involved in the Centers for Medicaid & Medicare Services' National Collaborative. While you can expect to have access to national long-term care experts and some of the nation's best practices and resources, you can also expect to learn from some best practices that are happening in our own great State of South Dakota in long-term care. Throughout the next 18 months, the collaborative is designed to help provide the foundation for any nursing home to be focused on data-driven quality resident-centered care. The major focus areas will be Quality Assurance Performance Improvement and how to be prepared for the soon-to-be mandate that every nursing home will have a written QAPI Plan and that nursing homes across America make QAPI a part of the way they do their work.
The other main focus of this collaborative is to work toward reducing unnecessary antipsychotics or if you already have low antipsychotic grades in your facility, you can work towards sustaining that rate and then of course work to improve resident dementia care. There will be additional opportunities for facilities to work on other areas of focus that they feel is specific to their own facility. When you did the sign-up, we asked what are other areas of focus you might want to work on, and we figured facilities would pick just one other area. Well we were surprised. The majority of the 78 facilities that picked, they picked two to three to even five areas of places to work on. We think that's great and we definitely took it as enthusiasm for this collaborative.

So as we move along in this process, you may want to rethink and narrow down your focus areas, but, you know what, no need to make a hard decision on that right now. I did want to mention though that falls were overwhelmingly selected as an additional focus that facilities wanted to work on, followed by preventing unnecessary re-hospitalizations. So we'll take a look at those numbers and get back to you on that.

Because this collaborative is new, it's a work in progress, much like QAPI is. Holly and I want to lead you to the information and resources you want, not necessarily what WE want. We promise to be flexible and attentive to your needs while still working on the national initiative. We promise to try and coordinate events to be mindful of your time. We do not intend to make extra work that you wouldn't be doing anyway and somehow help to make sense of all these initiatives and align the work together, such as advancing excellence and the national partnership to improve dementia care. We will have little assignments or maybe you could just call them friendly reminders to help keep you on track with your projects. Yes, we will collect a little data from you here and there just to see how you are doing and to spur you on, but we can discuss more collaborative issues later.

Now, I am so pleased to welcome Pat Boyer as our featured speaker. The title of her presentation is

*Building a Solid Foundation for QAPI Using Your Quality Measures.* The answers to where to start with
Quality Assurance Performance Improvement may well indeed come from reports and data that you already have. Pat brings a wealth of knowledge and experience in the health industry. She is the president of Boyer & Associates and has more than 30 years of professional health industry experience. Her areas of expertise include long-term care and sub acute operations, state and federal compliance programs, and performance improvement process development. She has worked for a national nursing home company where her roles included director of nursing services, administrator, quality improvement specialist, and director of regulatory compliance. In these roles, Pat used the resident assessment instrument to improve survey outcomes and facility processes. She has extensive experience in evaluating facility processes, documentation systems, and developing performance improvement plans to improve efficiency and effectiveness of facility systems. She has conducted numerous workshops and she has been in South Dakota as well with workshops. She's talked on national, state, and local levels.

So with that, I'll hand over the presentation to Pat.

Pat Boyer: Thanks, Lori. I appreciate the introduction. Well welcome, everyone. I hope that you're ready for a packed full of information workshop here this morning. I want to spend a little bit of time giving you some background information as we start the - - our hour together talking, but let me first off start with what our focus is for today.

We are going to talk about the quality measures, and I still consider those quality measures fairly new because it is something that went into effect that were published in 2012 and really we didn't really have them finalized and published and ready to use till about midyear, so we're going to talk about those, especially because I go into a lot of facilities where I don't see the quality measures being utilized and so we want to talk about how you can utilize them. But we do want to talk about the new methodology of the quality measures because one of the things we could depend on in the past with the MDS 2.0 measures was that if a resident left the facility, those numbers were no longer included in your picture; and I want you to understand that your quality - - your residents will stay on your quality measures for a longer period
of time, but we also need to know what - - how the methodology goes to really determine who's going to be included in your quality measure, so we'll spend a little time on that. We're going to then shift over how to use them, and I think that's probably the most important part of our presentation today is how can you use your quality measures on a day-to-day basis because, as Lori said, we really don't want to create more work for you, we want you to learn how to use what you have in place now to really be more effective and so we'll end our hour together talking about how you can integrate those quality measures into your QA program as you have it today and into developing your QAPI program, your Quality Assurance Performance Improvement program.

So let's do a little bit of background first. QAPI really is a result of the Affordable Care Act. You may hear it referred to as Obamacare. It's kind of the act that put all of that into place, but it is the Affordable Care Act and it's really what nursing facilities are going to be accountable for and held accountable for, and one of them is a QAPI program, that you establish a QAPI program and that you use established standards related to quality assurance and performance improvement and at some point you will have to submit a plan to meet the standards. Now as far QAPI is concerned right now, we don't have those standards yet because CMS, the Centers for Medicare and Medicaid, has not yet published them, but they are doing some pilots and they're expecting to have some information out to you fairly soon.

So let's talk a little bit about definition because over time we talk about QA a lot and so we have quality assessment, which is an evaluation of a process. We have quality assurance, which is an organizational structure where you use those processes, and then we have quality improvement or we can call it process or performance improvement, which is that ongoing interdisciplinary process that helps you to improve your services and your residents' outcome. So really when we talk about QAPI, Quality Assurance Performance Improvement, we're really kind of just talking about putting those pieces together. So we're not just saying we identify that we may have a risk here, we're saying, "What are the actions that we're going to take to really improve or minimize that risk?"
So why is it important to you? Well it's important, number one, because it is the right thing to do. Obviously you're in this industry because you want to provide good care to your residents, so process improvement really does that, helped us to provide and maintain that good quality of care. This... QAPI also helps to define and make that a stronger process and it helps to make us a little bit more accountable for quality, which I know that we all focus on that, but you know that CMS constantly wants to be making sure that we're providing better quality to our residents.

So let's talk about who uses that information. Hold just a minute, I got to turn something off here real quick, if I can figure out how to do that. My printer just set off just right at the wrong moment, so I apologize for that. State surveyors use your quality measures and when we look at the quality measures a little bit later, we will see that they will use any percentile ranking above the 75th percentile. We've always known that. That has not changed, but they will look at that data. They will also... CMS also uses your quality measures because it is electronic data. It's calculated electronically to really look at any trends. So as they - - as CMS defines what your QIOs are going to do or what focus they're going to have in the industry, they're going to be looking at any trends we have maybe in weight loss, in falls, many of you mentioned falls that you wanted to see some training on, and pressure ulcers and things of that sort. So it's something that they are monitoring on an ongoing basis.

Your five star rating system also uses some of your quality measures. They actually use nine of those measures to tell your consumer how you're doing and how you're rating, and your consumer uses that information through Nursing Home Compare. I have to tell you that I recently was looking for nursing home placement for my stepfather and you've got to know the first place I went was Nursing Home Compare and even though I looked at their survey data and I looked at their staffing, the most important data to me was their quality measures because I wanted to know because he was going to be limited in his mobility how they were doing with pressure ulcer prevention, how they were doing ADL function, and so forth and that was a really a good gauge for me to determine whether I had the right placement for him or not, and many more consumers are doing that on an ongoing basis. And then in addition as we're
talking about today, you're going to use that information in building your quality assurance and your Q-A-P-I process, your QAPI process.

So quality measures, as you know, are derived from your MDS and so when you submit your MDS, it uses that information to determine whether your measures are short-term - short stay, or long stay measures. So again, we already talked about it being used by your consumer, but there were originally 18 measures that were endorsed by the National Quality Forum. A few of those measures did not go into place, mostly because it was going to require additional data and you probably in the future will see some data about resident satisfaction, consumer satisfaction and those were really some of the pieces that were removed.

Now you may feel that this new process and this new methodology is sort of like a rat race and it really feels that way. It's really a much more complex data usage and frequency of usage than it was in the past, so we're going to step through some of these definitions here because in order for you to know how to evaluate your quality measures, you need to understand some of the specifics, so we're going to go through some definitions. Now let me tell you that in your handout, if you downloaded your handouts from the website, then you have a list of these definitions in a little bit more detail than you're going to see on the slides today; and I may not have the time to really go through all of them in detail, so please do refer to that handout after our session today so that you can keep those in mind and keep on top of what information is being utilized.

So the first term is a target period, and that is the span of time that defines the quality measure reporting period and, as an example, it might be a calendar quarter that might be utilized. A stay in your facility is considered a set of contiguous days in the facility and so it is that period of time between when the resident enters your facility and is either discharged or is at the end of the target period, whichever comes first. So the target period, for instance, is the end of the quarter, then it will be those residents who were discharged or are still in your building at the end of a quarter. An episode is a period of time that can span
one or more stays, and I think this is important to know because you need to remember that a stay, a resident may not just be this one stay in the facility at the information, but it may be over a period of time. So it's one or more stays. It begins with admission and ends with a discharge or the end of that target period begin and so the start of any episode is an admission entry record. And so we're going to correlate this directly to your MDS process; and the end of an episode is the discharge with return not anticipated or a discharge with a return anticipated and the resident does not return within 30 days, a death in facility tracking record, or the end of a period. That all of those are definitions of episode.

Okay, why do not I want to move here? There we go. Okay, an admission into your facility is driven by an admission entry record and so that is you're A-0-310-F equals a one or a 17 - - and a 1700 equals one and when any of the one of the following occur: The resident has never been in your facility before or they were previously discharged with return not anticipated or they had been in your facility previously or discharged with return anticipated, but they returned - - did not return within 30 days of discharge to your facility, so that would be considered an admission. A reentry is all of the following: The resident was discharged return anticipated and they returned to your facility within 30 days of discharge. So once again, that discharge information is really important now for your quality measures as well as other information in your facility.

This is probably one of the most important terms for you to get your hands around, and that is cumulative days in the facility. The cumulative days in a facility is the total number of days within an episode during which the resident was in the facility. Now remember episode could be multiple stays. The sum of the number of days in each stay included in the episode and if an episode does have more than one stay separated by periods out of your facility, such as in the hospital, then they will only count those days that they were actually in the facility towards the cumulative days in the facility. The reason this date is - - this term is so important is that it really determines whether a resident is on the short stay measure or a long stay measure. So cumulative days, they count the number of days until the end of an episode, the counting stops with the last record being a discharge assessment, the last record being a death in the
facility, or the end of the target period. The days in the facility, cumulative days does include the day of entry, but not the day of discharge. We're pretty used to that methodology. And then when death in facility ends the cumulative days, the record is not used as a target record as they do not include clinical information in the discharge assessment to really calculate the quality measures.

So now we get to why those terms were really important, and that is because we have to know who's going to fit into that short stay and who's going to fit into the long stay. Quite different from the previous quality measures, if you remember previously those of you who were here during the MDS 2.0 quality measures, a short stay was someone who only had -- who had a five-day and a 14-day assessment, so it really based on Medicare PPS, and then anyone that was over 30 days was considered to be a long stay. Now that's very, very different. A short stay is an episode, and remember an episode can be multiple stays, and episode with cumulative days in the facility less than or equal to 100 days as of the end of the target period. So that short stay measure, that person could become a long stay later on. But if they've been in equal to or less than 100 days, excuse me, then they're considered to be part of a short stay measure. Long stay measures are episodes with cumulative days in the facility greater than or equal to 101 days as of the end of the target period. And then the target date is that event date for an MDS record, so it could be the entry record, a discharge or death, or all other -- for all other records, the target date is equal to the ARD date or the A2300 date.

I don't want to get too caught up in these, but I do want to make sure that you understand the definitions. There will be two resident samples again, short stay sample and a long stay sample, and the selection process is that those select all residents whose latest episode either ends during the target period or is ongoing at the end and the latest episode is actually selected for the quality measure calculation. They will compute those cumulative days in the facility and that will make the difference as to whether that resident becomes a short stay or a long stay resident, and those samples are mutually exclusive so the resident cannot be in both, they will be in one or the other. So for each of those, there are very specific target assessments, very specific in the short stay the initial assessment is used or defines the initial
assessment and in the - - and also defines the look back scan. For the short/long stay measures, there's also definitions of what is used as a prior assessment. You'll see a terminology that is called Reason For Assessment, or RFA. Now I'm not going to take the time today to go through these key records, but I did give you that handout in your handouts that were on the website for the short stay record definitions and the long stay record definitions, so I encourage you after this workshop to really spend some time and go through those and understand exactly which assessments are going to be utilized for each of those samples. The look back scan that I just mentioned is your episode and stay determination logic which really kind of starts from the most recent assessment and works backwards and it determines what episode to utilize and it determines which resident fits in short stay or long stay, and there are some - - there is some information for what happens if you have missing assessments as well, so you'll want to look at that.

Now this slide is extremely important to you. If you have not already done so, you need to download the Quality Measure Manual from the CMS website, and this is your website where you can do that. It's a PDF file. It's not really too enormous. It's... And it's there because it has all the detailed information for you. I am only giving you a few samples today of the quality measures. We're going to look at one short stay and one long stay and one surveyor quality measure, but all the information on every one of the other quality measures are included in the manual. One of the things that I want you to put on your to-do list as you go away from this workshop is each department that has a quality measure that's included in their area of expertise. So for instance, you're going to want dietary to look at significant weight loss as well as nursing. You want to pull those quality measures, make sure that your team members, your interdisciplinary team, reads each of those quality measures so they understand which elements of your MDS are utilized for the numerator and which are utilized for the denominator, and we're going to talk about that in just a moment, and also what are your exclusions because what we found historically is that sometimes facilities will have high percentile rankings simply because they didn't code the exclusions correctly, and we'll talk about that in a couple of (inaudible). As an example, one of the exclusions is your J1400, which is the resident is anticipated to live less than six months, so it's that terminal status
which can exclude somebody from, for instance, a significant weight loss. So you want to know what the numerators are, what residents are going to be looked at, what are all the residents that are going to be included in that measure, what are the exclusions, and then in addition to that there are some risk adjustment factors that we need to take a look at. So after... The risk adjustment is after the exclusions have been applied and after resident level covariance are looked at, and these are really some information of probability the resident will evidence an outcome. There are only three quality measures that really use those resident level covariance and that is the percent of residents with pressure ulcers that are new and worsened in the short stay, the percent of residents who self-report moderate to severe pain in the long stay, and under the long stay the percent of residents who have or had a catheter inserted and left in the bladder. So those are three that you're really going to want to pay attention to what are those other factors, those covariance that are going to be looked at to determine whether somebody is high risk or low risk or included in the adjustment factor, and we'll see some of those covariance coming up in our examples here.

So in your pack or in your - - first off, your short stay measures, I've listed those short stay measures on your slide for you. Those are the only short stay measures. You'll notice that with the exception of your self-reported moderate to severe pain and your new worsened pressure ulcers, the others are really all to do with vaccines. You're influenza vaccine, your pneumonia vaccine, so those are your short measures much more limited than what we had before, and we'll take a look at one of those in a moment.

In fact, why don't you turn to your next handout that was on the website that is called Percent of Residents with Pressure Ulcers that are New or Worsened Short Stay? It should have a page number 10 on the bottom, which is not 10 pages in this presentation but 10 - - page 10 in the manual. And if you look at this, you'll see on the left-hand side that there is a description of the measure and it says, "This measure captures the percentage of short stay residents with new or worsening Stage 2 through 4 pressure ulcers. In the next column, it will tell you the specifications of that measure, so it will tell you the numerator. Short stay residents for which a look back scan indicates one or more new or worsening
Stage 2 to 4 pressure ulcers where an assessment in the look back scan and you'll see the MDS data elements there, section M of the MDS, and it's only looking at Stage 2, Stage 3, or Stage 4 new or worsening pressure ulcers, so it's not the number, it's the new or worsening. So that's your numerator. Your denominator is all residents with one or more assessments that are eligible for the look back scan except those with exclusions, so in other words the number of residents who have pressure ulcers divided by all the residents who have not been excluded who are involved in this look back scan. Your exclusions here are residents -- are excluded. None of the assessments that are included in the look back scan has a usable response, so there hasn't been a coding in those areas and then, number two, if all residents -- if all assessments that are eligible in the look back scan are discarded and no useable assessments remain, then the resident is excluded from the numerator and denominator. So that is just a matter of our coding and what we need it to code on the MDS because if you said that there weren't any pressure ulcers, then we would have no response in those areas. Then in the third column is your covariance, and so this will again tell you where people might fit into whether they're going to be -- they're going to be actually utilized or not, so you can see there's a number of covariance for pressure ulcers. One is dead mobility, another is bowel incontinence, another is diabetes or peripheral vascular disease, another is a low body mass. That's really calculated from the weight and the height on the MDS, and then number five says, "All covariance are missing if no initial assessment is available." So it will kind or rank that person based on those covariance to determine whether they will be utilized in that quality measure or not. So that's your short stay measure that I wanted to… And all of the rest of these also have the same type of data, maybe not as detailed as the pressure ulcer one, but they have still the description, the measurement specifications, and covariance if they have any. Your short stay measures, you can see, there's quite a few more of those. Again, we have the influenza and pneumonia, but we have quite a listing on the right-hand side of the slide of the quality measures.

The one that I picked for you as an example that you have a handout for is the percent of residents experiencing one or more calls with major injury long stay. So again, our description is this measure reports the percent of long stay residents who have experienced one or more falls with major injury
reported in the target period. The numerator, well our long stay residents in the middle column, long stay residents with one or more look back scan assessments that indicate one or more falls that resulted in major injury, that is section J of your MDS, J19C, would equal a one or a two. Your denominator is all long stay residents with one or more look back scan assessments except those with exclusions and your exclusions in this area are your residents excluded if one of the following is true for all of the look back scan assessments, so every assessment that's in that look back scan period. The occurrence of a fall was not assessed or the assessment indicates that a fall occurred and the number of falls with major injury was not assessed, so in other words we didn't have all of the data filled in on all of the MDSs, which would be a rare occurrence. And in this case, you could see (or should be a rare occurrence, I should say) there are no covariance, so no risk adjustment factors for that stay.

Now we also in this system have what are called Surveyor Quality Measures and some of these quality measures you may not see all of these come up in your quality measures and some you do and some you don't, so we'll take a look at that when we look at your report. But the quality - - the Surveyor Quality Measures are there because when they finally put everything together for the quality measures, the surveyors felt that there was some significant data that was absent or missing from the quality measures and so they requested that these be put back in place. These are not measures that are seen by the public, so beware of that, but they are still being tracked by your surveyors. So in the first column, the description I'm using prevalence of fall long stay. Now the one we just looked at was fall with major injury, now it's just falls, so prevalence of falls. This measure reports the percentage of long stay residents who have had a fall during their episode of care. The numerator are long stay residents with one or more look back assessments that indicate the occurrence of a fall, J1800 equals one, and then the denominator is all long stay residents with one or more look back scans except those with exclusions, and again the exclusion here is where there were blanks or dashes. So those are three examples of your quality measures. Again, the manual that I showed you the website for is where you're going to find all the rest of them.
So now that we got through that, I really want to spend some time talking about how you need to use this data because that's what we're here for today. But I felt like if any had not been through that methodology yet, you really have to understand the methodology of how people get onto the quality measures in order to really understand how to positively affect your outcomes in your quality measures.

So first off, your quality measures are used in the traditional survey process. They're flagged at the 75th percentile ranking. At the entrance tour, the surveyor is focused on the quality measures and they focus on residents. They come in say, "Okay, you've got a high percentile ranking in pressure ulcers, so now we're going to look as we tour your facility to see if we see any residents that we think are poorly positioned, don't have positioning devices, don't have anti or reducing pressure devices and so forth and see if we think during that entrance tour that there's still a problem." Then during phase one of the traditional survey process, they will look at those focus care areas plus any resident trigger areas that come off of your Residents-Specific Report in your quality measures. And again, we're going to kind of step through that report a little bit later.

In phase two of your process, they will only look at any of the focused areas identified in phase one as areas of concern. So what they do is they kind of have that broad look at your facility as they come into your facility, kind of anticipating where you might have problems in phase one or the beginning portion of your survey. They're going to look at all the areas that a particular resident really flagged in to see if there's any other areas they need to look at and also those areas they were concerned about. And then when they get into phase two, very simply just looking at the areas that at that point in time they have determined is a problem area or they want more information to see if it's a problem area. So the surveyors definitely are one group that use your quality measures.

Now your five star rating, I talked about this earlier, it is a subset of nine of your most - - of your quality measures, and the five star rating uses the three most recent quarters. So one of the things to realize is that your five star rating quality measure percentages will not match your quality measure report that you
pull off of your computer because you're looking at a different span of time. And also where you get percentile rankings on your quality measures, your consumers just see percentages, so it's using the same quality measures which means the same numerator and denominator information that we talked about a few moments ago, but it's just putting it together differently. So that says to you that your quality measures you pull off your CSPR report is very important to you, but so is this five star rating because that's what your consumer's seeing. So not only should you be pulling them off your computer on a monthly basis, but I would suggest that you also look at your five star rating and what those percentages. And on your five star rating, if you haven't looked at Nursing Home Compare lately, it has changed some, but it will give you a comparison of national and state numbers in the five star rating. As we'll talk about a little bit later in the QM reports that you're going to pull off your CSPR report, that now only compares you to national numbers, and so you want to look at this five star rating and make sure that your team that's going to talk to your consumer knows where you are on some of those. If you are above the state or national numbers, then you want really do some research in that and you want to find out what you are and look at those particular residents that are driving that, but in addition you want to have something to say back to your consumer if they say, "Hey, I've seen that your pressure ulcer numbers are high, so how can I feel comfortable putting my loved one in your facility?" You need to be prepared as a facility on how you're going to respond to those types of questions. Very, very important for your consumers and for your census and so forth.

Now there's other ways that you can use your quality measures and one of them is restorative nursing. We're going to talk a little bit more about that. We'll talk about care planning, your Part E census and then some of your other targeted critical pathways or investigative protocols that you have that you can utilize if your triggering those quality measures.

So let's talk about restorative first. The resident has recently fallen and is listed under that 2M that you have that they have fallen. What might be some appropriate restorative nursing programs that you might consider as part of their plan of care? Maybe it's a walking program, maybe it's an exercise program. It's
really what can you do that might help to improve that resident. Maybe they need a splinter or brace. Maybe it's bed mobility. Maybe they need some therapy, but first restorative might be your first avenue that you want to take a look at it. Care planning, it's the percentage of residents - increased residents whose locomotion in and out of the room worsen, then you might want to look at things such as: How can we care plan that person and what are the interventions that we may need to use, such as maybe they're at risk for injury and what are the interventions. Maybe it is that we want to put a restorative nursing program in or maybe we want them to be evaluated by therapy. So those - triggering those quality measures can lead you to these areas.

What are the quality measures that your resident might benefit from Medicare Part B for the restorative? Well there's a quite list here. I mean when you go into your Medicare meetings, and I hope that you're not only including your Part A residents in your Medicare meeting, but you're also including your Part B residents, here are some of the things that you might look at: You might look at their Quality Measure Report, see for instance how many residents have lost weight. Well if residents have lost weight, then is there a need for speech therapy to evaluate them. Are they having difficulty swallowing or what about adaptive equipment? Do they have a need for adaptive equipment that they can - that can help them to eat more independently? What are the factors? What can we evaluate? I always say that your best source of Part B residents in your facility is your dining room because physical therapy can look at positioning needs, occupational therapy can look at adaptive equipment, and speech therapy can look at any swallowing issues, and there's so much that they can really gather in assessing your residents just being in your diner, but obviously there are other types of residents as well that could benefit from therapy services or if therapy is not appropriate and they don't meet the criteria for skilled care, then at least maybe restorative nursing.

So again, if somebody has falls with major injury, those numbers are up, or prevalence of falls, then we're going to want to look at making sure that your screening your residents on a quarterly basis, that therapy is screening residents after each fall to see if there's any new interventions and then we're doing those
therapy evaluations as is appropriate for the residents in your facility, so we're looking at positioning; we're looking at that rehab potential, and we're looking at adaptive equipment.

So a quote for you, those who say it can't be done should get out of the way of those who are doing it. So I want to shift over now to talk about your QAPI program and how you can actually integrate these quality measures into that program and make that a more functional program. We go into a lot of facilities across the country and we - - because we're in an internal or we an external consultant, we're not the state, we're not the Medicare police (inaudible), we can ask to look or we do look at many facilities quality assurance programs; and I will tell you that many, many times as we look at these quality assurance programs, what we're seeing is we're identifying that we have a problem, but rarely do I see - - or maybe I shouldn't say rarely, but sometimes I don't see what we're doing about the tracking. So we can track infections; we can track falls, but what are going to do about it and how are we going to take that to the next step? Well you know we've all had programs in place for a very long period of time in different ways and different names and so we just have one more name here because we've had process improvement. We've had quality improvement. We've had continuous quality improvement and now we have QAPI, Quality Assurance Performance Improvement. And so sometimes we just get so tired of process, but the reality is: I think it works the best when it becomes functional for you and it helps you truly improve the quality of care that you're doing in your facility.

So I've got to go to my favorite slide and those of you who know me or have heard me speak before know that I rarely do a workshop without this slide incorporated into it, and this is the nursing process. I was speaking one time in Texas a couple years ago and one of the state Medicaid nurses was talking and she said, "This is Nursing 101." It truly is what we should know from day one of how to care for residents. So the (inaudible) nurse out there think of it as a system process. It's the care process. I don't care what you call it, but it's how we care for our residents in our facility and it's how things have to function and the problem that we have in today's environment is we've gotten so focused on tasks that we don't always
remember this process, so it's a good place for us to start about integrating the quality measures in your facility process.

So we're going to start in the upper right-hand side with identify. Our responsibility as a resident comes into your facility is to assess that resident and to identify what their current clinical condition is and what their risk factors are and we do that by doing what we call Foundational Assessments - your nutrition risk assessment, your Braden or your Norton, your falls risk assessment, your social history. All of those foundational tools, we look to see what is the resident's current clinical condition or what's the risk factors and then we utilize that information of their current condition and their risk factors to complete our MDS, the minimum data set. Even though we focus so much of your time on the MDS as a reimbursement tool, it really is there to drive patient care.

So next we go to the evaluation step, the bottom right-hand side, and in the evaluation, we actually utilize that information from those risk assessments, from the MDS to really determine what triggers we had for the resident, what care area triggers we had, or CATs, and to work through the care area assessment process to look at (inaudible) factors, to look at other factors that may impact the resident's response in your facility and then we use that care area assessment process to develop an individualized plan of care for the resident. That's our process. That plan of care must come from the foundational assessments and the MDS that we completed for that resident, that flows right into that process.

Then let's go to the left-hand side, the bottom left-hand side. We then implement that plan for the resident at their bedside. We follow clinical standards of practice; and when I say that, I'm talking about whether it's the AMDA guidelines, the American Medical Director Association, the Iowa Foundation of Care, the American Geriatric Nursing Association, the National Pressure Ulcer Advisory Panel. Whatever you as a facility choose to use, it's your clinical standards of practice and we must implement the needs of the care plan of our residents using those clinical standards and we must get that information to our care staff that's actually at the bedside. And it may not just be the CNAs, but that's probably a main player in that so
that they know from that assessment we did and into building that care plan, what are we actually going
to do for the resident.

And then our final step, in the upper left-hand corner, is that we monitor and modify that plan, so we do
that on a quarterly basis. We do it on an annual basis. Those are OGRA* requirements, and then we do it
whenever there's a change in our resident's condition, and that condition change may be ongoing
throughout every cycle because if we identify a new problem, then we begin again to identify it, to
evaluate it, to implement the plan, and to monitor it and so that care plan should be fluid and it should be
changing whenever a change occurs in the - - with the resident. So that's our process. That's our Nursing
101. It's our basic process. And by the way, you have a copy of that in your handout as well so you can
hang that up on your bulletin boards so that you never forget it. Very important that we think of it as a
process, not just what is our piece that we need to do.

If you're an MDS nurse, that has to be all integrated together and it has to all work together with all of
those pieces and whoever is there on the unit, the nurse manager, the charge nurse, the LPNs, the CNAs
needs to understands that process as well. So on your to-do list, you might want to add doing some
education to your staff because this is a process that we don't see always working as well as it should
work in the facilities, but it's the basis of what we're doing and it's important to us with these QNs as well.

So let's move to your reports. Now I understand from Lori and Holly that they did ask you to have your
own Quality Measure Report in front of you for this presentation today. Now in case you don't have that
handy, I had put a copy of a sample one, two-pages of the report. The first page I put in was the part with
your percentile ranking, so your summary report, and the second one was the sample of the (inaudible)
Level Report. So if you don't have your own in front of you, then you may want to look at the one that was
handed out to you.
Okay, so let's talk a little about the QM profile characteristic report and what are the areas that are included here and what do we need to look at. So it does list all the quality measures and the facility percentage in each. So if you look for instance, some of this is difficult to see if you downloaded mine because some of it shaded, so let's go down to falls. Falls is probably one of the easier ones to see. So if you see falls, you notice that there's not a measure ID next to it, that's because falls are a surveyor measure, not a - - not one that was in the listing that I talked about earlier. It will tell you here how many residents are on - - are in the numerator, how many are in the denominator. Now that should be meaningful to you because you know you can go back and look at that quality measure chart from your manual and know exactly who's included, what type of - - what residents would be included in the numerator, what would be - - who would be included in the denominator. Then it will give you your facility observed percent. So in this case, in the example one I have 41 percent. You'll have to look at what you have. If there's an adjustment because of the covarious [sic], it will give you an adjusted - - a different adjusted percent. In this case, there's no difference on my example here. Then it will give you a comparison group state average. So even though there's a difference in the methodology, it will give you a different - - it will still give you your state average, so you can compare. In this case, where I'm using the example of falls, of 41 percent in my sample one I gave you and 48.8 percent in state average. So I'd say, "Oh, that's pretty good. I'm lower than the state average." Then I look and I see that the national average is 44.3 percent. So I'm still lower than the national average, so I'm feeling pretty good about that. So now I want to go over to the comparison group national percentile, and understand what a percentile is. A percentile is where you rank amongst all others. And if you look at the top of that column, it says "comparison group national percentile." In the previous quality measures, it was you were compared to state comparison group or all of the facilities in your state. To even the playing field, CMS changed that so now you are compared to everyone else, all other facilities in the entire nation. In this case, your percentile ranking is 36. So that means that 64 percent of the facilities in the country do a worse job than you do and only 35 percent do better than you. So the lower the number, the better the number in that case, in that quality measure. So you need to understand what the quality measure is telling you in order to get your percentile ranking.
If you're looking at my example page or if you're looking at your own, look for any that have stars after them or an asterisk after them. The asterisk are any percentile rankings that are above - - at or above the 75th percentile. Now you remember in the old report, those of you around, they weren't flagged till the 90th percentile, but we learned that the state uses 75th, so at least now they're obvious and they're putting the asterisk if it's above the 75th. So if somebody… And in the example I have in front of me, the example I posted on the website, if I'm looking at behavior symptoms affecting others, it says that I'm an 82nd percentile, so that means that 18 percent of the facilities do worse than me and 81 percent of them do better than me. That would be a concern for me and so I want to go back then and I want to look at what is involved in my numerators and denominators, which residents actually flagged or had those flags on their resident report and then I want to do some investigation.

So let's go to the Resident-Specific Report, which is my second handout, or if you have your own to where your residents are listed on the left-hand side, you will notice a change, and this is not as easy to read as it used to be because now they have all these Bs in here, and B means blank. Because of HIPAA, they cannot leave blanks, so they put Bs in there to take - - to stand for blank and then you have to find your Xs, and I wish they had kind of faded out the Bs so it wouldn't be so busy. But anyway, for each resident, you want to find your Xs to identify what actual measures that person triggered and you want to go and you want to do some investigation of those residents too because one of the things that you want to make sure that you look at is: Is your MDS accurate? Because errors in your MDS will really cause errors on your QMs because accuracy of MDS data is critically important. However, I don't want you to stop there. I want you to also beyond the resident, I want you to look at your system and I want you to go back to that nursing process and think about it. Did we properly assess the resident? Let's say it's falls. Falls is a good easy example. Did we…Are we properly assessing our residents when they come into the facility or they have a fall to determine what their current clinical status is and what their risk factors are? Did we build an appropriate care plan for that resident that had a problem? Did we make sure that plan was implemented at the bedside and did we periodically monitor and modify it?
So let me give you a real quick example of that. Had a resident in a facility that I was doing MOC* survey in and they had an accident where they dropped hot liquid on themselves. Well I couldn't find any evidence that there was anything wrong with what they did when the resident first came in. They really had no indication that that was a risk for the resident. But once the resident dropped the hot liquids on their lap and burned themselves, then they knew that they had a problem, so they needed to identify that and they needed to make sure that they had identified this was a risk for the resident. Then they needed to build a care plan, and they did a really good job on that. They implemented a care plan for that resident to try to keep hot liquids a little further away from the resident so the staff was assisting them, but all their hot liquids had to have a cap on it or a cover on it and so I went to look… And by the way, the care plan in the chart said that and also the care plan in the resident room that the - - behind the door that the CNAs used said that they had to have lids on hot liquids. All of that looked really great. But when I went to observe the dining room and observe meal service, I didn't see a cap - - a lid on the hot fluids and what we found out when we investigated was that the one place that they didn't get that information was the dietary card and they had a new activity person who had just started the week before didn't know the resident and because it wasn't written on the card didn't know to do that and had delivered that resident's tray to their table. So again, that implementation, you got to think about all the aspects of that and do some critical thinking about where will I find this information or where could this affect the resident and so they - - that was a breakdown and then they needed to monitor and modify that on a routine basis. So that's how your surveyors assess those areas as well is to see if you hit those four areas, so you want to make sure you remember that this is an official database, that errors in your MDS can affect it. It helps you to track your clinical outcomes and you do need to review the content of your MDS coding related to the quality measures as well to verify the accuracy of them.

So first review of the Quality Measure Report to assure accuracy, use the QM results with Nursing Home Compare to evaluate your outcomes and then your facility CQI QA or as we’re talking about QAPI
program should include routine monitoring of your RAI, your scheduling, your MDS coding, timeliness, completion, and all of those factors as well and your quality measures are a big part of that process.

So let's talk about 10 steps that you can do to integrate this into your quality assurance program, or your QAPI program. So number one, review your quality measures, and I suggest that you identify a champion for each one. So who is going to be responsible for that quality measure? And then I want you to develop a quality assurance monitoring report. Now you will notice that that is one handout that is not in your packet and I did fail to - - we missed that one and so let me see if I can just show it to you real quick. I brought it up on my computer and I'm going to send this to Lori after our program and I'm going to - - so it'll be available to you. So what you do on this Quality Assurance Monitoring Report is you determine who's going to monitor it; who's going to be the champion; how are you going to monitor; what is the standard, so what is your clinical standard of practice? It could be your F-tag from your federal survey. It could be a clinical standard. How are you going to... What are using as your base for this process? What is your frequency of evaluation? What is your method? It could be observation. It could be chart review. And then what are you going to monitor? So this is a blank form that you can utilize to do that and I now that your QIO may have some other ideas on how you can do that, but if this works for you, you are welcome to use the Boyer form for that. So just an idea for you. But again, the importance of this is that you do identify a champion for each one. I think I went backwards. And then you develop a monitoring report, somehow you're going to monitor it. Complete the report per the frequency of the calendar. Do you need to look at every month or do you need to look at it every other month? If you're above the percentile, if you're within the percentile ranking or you have a low percentile, maybe quarterly is enough. But if you're exceeding that 75th percentile, then probably monthly is much more appropriate for that quality measure.

You complete your report; you analyze that data, and then you make those changes in your system or your process according to where your - - where you are not up to par, where you are not meeting your goals. You implement those changes in your system. Evaluate what impact those system changes have
on your process. You trend that data week-to-week, month-to-month. How was your quality measure last month? How is it this month? One of the things that you're going to find with QAPI is it's very much based on data, and data is what they're going to want to see you really looking at and trending and tracking and evaluating. So again, with your quality measures, you can do that very easily by looking week-to-week, month-to-month. Then monitor your quality measures again at regular intervals and then demonstrate flexibility to QM data to change systems, processes, structures in the dynamic data-driven environment. And I want to read that specifically to you because that is critically important. You have got to be open to change. I had to learn that the hard way one time that you can't expect changes and outcomes if you don't make changes in how you're doing things. If you continue doing things the same way you've been doing them, then your results are going to be the same. So you got to be open and your team has to be open to doing things differently, and I think that's the fun of an interdisciplinary process is that you are able to really be able to look at flexibility and look at new ways of doing things.

So here is some keys for you to remember: Remember MDS coding accuracy. If your MDS are not accurate, you are not going to have good outcomes in your quality measures because you're going to be triggering things that kind of spinning your wheels and investigating things you don't need to. You need to submit your MDSs timely and in proper sequence because that could make a difference because remember now it's driven by your look back scan and your cumulative days in the facility, so you need to be doing the process correctly. You need to know your outliers. Know where you're triggering. What are your areas that you need to be concerned about and make sure you are pulling those quality measures off your CSPR system at least on a monthly basis. And then be prepared for your savvy consumer. I don't think that nursing facility that I called to look for placement for my stepfather knew that they were talking to a savvy consumer, but they found it out very quickly. And the first time that I had to call a nursing home and I talked to them about quality measures, I talked to a social worker who was in charge of admissions and I went through the quality measures that were on Nursing Home Compare and the social worker said, "How do you know that?" Well your staff has to understand what your consumer is seeing today and she was kind of not prepared. She was like" Uh, um, you're going to have to talk to the DON or the
administrator about that. I don't have... I don't know about that." So you have to know what your consumers are seeing and know how you're going to respond to those.

Some uses again, trending and benchmarking, visually graphing your performance, making sure you're setting your facility goal. Those of you who are part of a large corporation, your corporation may be setting a goal for you or you as an internal team might be setting your goal, and so compare yourself to that goal. It may not be 75th percentile. If you're not 90 right now, maybe it's unrealistic to think you're going to be a 75 or below that next month, but how can you get to from 95 to 90? So set some goals.

Know the exclusions for each of those QMs. Now as I said, Section J and coding hospice affect some of your quality measures, so you're going to want to know how - - when that can be coded. And one of the things I always tell people is: In order to code J1400 or your hospice, you have to have a physician statement certifying your resident who has less than six months to leave. Well if the resident on hospice, they have that, but you need to get that in your medical record so that you can code it on your MDS because you don't want residents included that don't need to be included because that's kind of like a false positive for you. Review your admission and your charting documentation. Make sure you know who - - what - - who's included in the numerator, who's included in the denominator, and how you can collect information for those exclusions.

Just some ideas for how you can use that information. Use your numerator for residents who trigger daily or weekly review. Ask staff what can be done to prevent those triggers. Identify them as special focus. Use them as teaching points for your staff and focus charting or special focus on those residents so that you can get those outcomes to change a little bit. Talk with families. Ask for input from them on what needs to occur. Talk with your peers, your state association, your QIO. That's what your QIO is there for is to help you to improve your outcomes. Talk with your staff, root cause analysis and I'm going to briefly go over the QAPI requirements in just a moment, and you'll see root cause analysis. It's one of those we need to drill down to actually caused the problem, otherwise you're putting a band-aid on it and you want to not a put a band-aid, but you want to actually solve the problem. And then set up some criteria to give
some rewards to your staff whether it's financial or just feel good rewards that we've lowered our QM down to the 75th percentile, now we're having a pizza party. Whatever's going to work for you. So remember in the race for quality, there is no finish line.

But to finish our workshop today, we need to talk just briefly again about the elements of QAPI. Now we started out by saying that CMS is not yet published what they - - their expectations are, but there is some information that you can get a hold of that will help you as you're building up your program. One of those pieces of information I put in your packet, it's called the Five Elements of QAPI, and what it says is that you need to design your program. It needs to look at governance and leadership, feedback, data systems monitoring. There's a terminology of Performance Improvement Projects, or PIPs, and then systematic analysis and systematic action.

So really what does that mean? You need to build a program that involves all your departments. It address safety, quality of care, quality of life, resident choice transitions. It's based on best available. That's your standards of practice. This is your QAPI plan. You then need to make sure that your board of directors or your executive leadership buys into it. That there's administration sees value in the programs. You have resources and the programs are sustainable. You need to have feedback from multiple sources, including residents and staff, and that's why I mentioned that if you have a few QM problem, maybe you need to talk to your residents or their families and say, "What could we be doing better?" Might be a source of some good information. You want to look at benchmarking and targeting. So if you're using your QMs and you're using your national percentiles, comparing yourself to state and national, that'll be part of that. And then you need to look at any adverse events. So if you do have a fall with major injury for instance, you need to look at your investigation process. Make sure that all your pieces in place. You need to prioritize your topics. These are the PIPs. Number of PIPs depends on your facility program. It needs to be part of the team effort and it needs to follow the PDCA cycle and that really - - and then for systematic analysis, root cause analysis, systems thinking, and system changing. So I put the PDCA in your packet so that just a visual so that you could see what that's about, but probably one of the biggest
and I also put a description in your packet of each of the PDCA cycle so you can take a look at that and read through that, but it really says you're going to establish objectives. You're going to implement the plan. You're going to study the results of the plan and then you're going to take corrective action. So hopefully that'll be helpful to you as you start planning through. So again, with QAPI, you're provided data through monitoring a potential problem is identified, next steps are to evaluate if it's a true problem, so looking at that root cause analysis. Interpreting data, developing interventions, monitoring, and reevaluating and so it's all part of an overall program within your facility to proactively monitor your processes of care in order to ensure the highest quality of care and quality of life for your residents.

And then here's your QIO phone number and all for you to get more assistance, more feedback, and be ready for that's going to happen in your facility.

So I think with that, boy, I'm right on target here, we're going to open up for any questions, Paulette.

**Operator:** Thank you. We will now begin the question-and-answer session. If you have a question, please press star then one on your touchtone phone. If you wish to be removed from the queue, please press the pound sign or the hash key. If you are using a speakerphone, you may need to pick up the handset first before pressing the numbers. Once again, if you have a question, please press star then one on your touchtone phone. Standing by for questions.

And our first question comes from Chad Stroschion. Please go ahead, Chad. Chad, your line is now open.

**Chad Stroschion:** I'm sorry. I have no question.

**Operator:** Our next question comes from Vicki Barfuss. Please go ahead.
Vicki Barfuss: We have a question on the report period and the comparison group and how come the times are different?

Pat Boyer: On the actual report?

Vicki Barfuss: Yep.

Pat Boyer: Okay, let me pull my copy here. I put all my stuff together, so I got to find where I put it. Sorry about that. Okay, got it, finally. So on the actual report, you're saying, "Why is the comparison group and the reporting period different?" Oh because you're talking about in the upper right-hand side, so your report period is the period of time that this report is measuring for you, but the comparison group I believe will be every six months; and I can double check that for you, but I'm pretty sure it's going to be six-month period of time. I think in the previous MDS 2.0, it was a three-month period of time. It's just the way CMS is running it.

Lori Hintz: Pat, this is Lori, and that's the way I understood it too. It was for six months, the previous six months in the comparison report.

Pat Boyer: Correct. But I believe that you can run the report (Lori, tell me if I'm correct in this.) for whatever period of time you want to run it for.

Lori Hintz: You can, but I think the comparison report still stays at six months.

Pat Boyer: That's my understanding as well. Thank you.

Female Speaker: (Inaudible)…
Vicki Barfuss: Wouldn't it make sense to compare the same time in time?

Female Speaker: (Inaudible)…

Vicki Barfuss: …to have accuracy?

Pat Boyer: Well it could if you want to... But you may want to compare your assessments up to this particular date. So for instance, if I ran this report the beginning of September, I don't want to run just through June. I want my Resident-Specific Report to be through August, so I can still look at my flag for my Resident-Specific Report. So I think that's the importance is that you want to run your reports for a period of time every time you run it and you're going to run it monthly; and just don't run it for one month, run it for at least a quarter, but you want to still - - your comparison group just isn't going to change as frequently as that. Does that make sense? I mean I think for your percentile, it might be nice to have apples-to-apples. But for your resident-specific measure, you need all residents that have triggered that and that may be some newer admitted residents, so you want those as well so you can investigate them.

Vicki Barfuss: Okay.

Pat Boyer: Paulette, do we have any more questions?

Operator: Once again, if you do have an audio question, please press star/one on your touchtone phone, and we're showing no further audio questions at this time.

Pat Boyer: So, Lori, I think I'll turn it over to you and you have some closing statements that you wanted to make.
Lori Hintz: Sure. First of all, just thank you so much, Pat, for this presentation. I learned a lot. You helped clarify some questions I had and I hope that our participants felt it was beneficial too.

To the collaborative participants, you can expect an email from me within the next week, and I just wanted to give you time to think about this presentation and how this information will be beneficial in your work. We’re going to try to utilize survey monkey online as a way to get feedback from you, and I guess as I listened to this, I wrote down some - - I think I've got some little friendly reminders to write down to you. For instance, have you downloaded the QMS manual from CMS as Pat suggests? Have you involved department heads to know this or department people to look at the particular sections that are important for them? I think that - - we should do what Pat says. And then she had those ten steps, to champion - - identify a champion for quality measure that kind of that's their deal, so I think I'm going to put that down as little reminders too. How many of you looked at your QMs? Well you've done that. If you ran your QMs for this webinar, you did that. Do you do this regularly? Have you looked at your five star rating? Anyway, I think I've got some ideas for us as just gentle reminders to carry on with this work.

As far as collaborative news, if you hear of anyone not receiving my emails, let me know. Things to pertinent to this collaborative will be sent via email, not the statewide nursing home list serve because not everybody on that list serve is in this collaborative. The next collaborative-specific event is going to be held on February 26th - - February 26th and this is a national call. It's rolling out this collaborative. They're going to introduce change package on QAPI and they've got some resources in the wings. They're in draft form yet, but I've been told that they're going to be released here by that February 26th and that's going to actually give us some steps what to do for the QAPI plan. But we don't need to just wait for that, there's things just looking at your QMs and what you want to focus on. We can't just do one thing at a time. I think we all multitask and this is no different. Now not necessarily just for the collaborative, but there are some other events I'll be sending out that you might be interested in. I know you can’t do everything and I can't make them all either, but Thursday, January 31st, there's a webinar sponsored by the Foundation here. It's called Enhancing Patient Empowerment Through the Use of Teach Back. It's a way to educate
patients and to see if they're understanding what you're saying. I think it's geared a lot to help prevent those unnecessary re-hospitalizations. I'll send the flyer on that to everybody. And then of course on the same day, there's this national call from CMS on the Partnership To Improve Dementia Care, which I would think most people would be somewhat interested in that. And then on...Oh, I wanted to let - - just a heads up on February 19th, the Foundation, South Dakota Foundation for Medical Care, is going to host an office hours call. Sue Johnson* has just received some training on Interact and just want to have an information kind of call if anybody is interested. Interact, it's a training that many nursing homes and other healthcare facilities are using regarding communication and I'll send out the flyer on that as well.

So with that, does anybody have any questions for me?

**Operator:** Once again, if you do have a question, please press star then one on your touchtone phone.

*And we do have a follow-up question from Vicki Barfuss. Please go ahead.*

Lori Hintz: Hi, Vicki.

Vicki Barfuss: Hi. One of my... My question is: How are we determining the numerator and the denominator? I'm fuzzy on that.

Pat Boyer: I can answer that Lori.

Lori Hintz: Okay.

Pat Boyer: You need to go to that manual and pull the manual for each of those specific quality measures and the middle column of each chart will tell you exactly the data elements from the MDS that are included in the numerator and the denominator and so it's totally based on what you're coding on the
MDS and so each one is a little bit different, but all of that information is in a standard place in the middle column in the Quality Measure Manual.

**Vicki Barfuss:** Fabulous. Thank you.

**Operator:** And we're showing no further questions.

**Lori Hintz:** Okay. Well I just want to thank everybody for joining in and welcome to the collaborative. I think in the months to come we'll learn a lot and hopefully, well you know, who will benefit will be our residents. So thanks, everybody. Have a great day and a good weekend.

**Operator:** Thank you, ladies and gentlemen. This concludes today's conference. Thank you for participating. You may now disconnect.