QAPI Plan Workshop Session 5: Data Is Not Voodoo

Krista: Good afternoon. Welcome to today's QAPI Plan Workshop webinar, Data is Not Voodoo, presented by Quality Insights Quality Innovation Network.

We'll get started with today's program in just a few moments. But first, a few housekeeping items. This is the fifth of seven sessions that will take place this summer. You will need to register for each session separately. If you have not yet registered for the last two sessions, please contact your local QAPI Quality Insights Project Coordinator, and he or she will help you. Contact information will be included later in the presentation.

All participants entered today's webinar in listen only mode. Should you have a question during today's webinar, we ask that you please type it into either the chat or the Q&A box to the right of your screen. Questions will be addressed at the end.

Today's webinar is being recorded. The recording and the slides you see today will both be posted on My Quality Insights and the Reducing Healthcare Acquired Conditions in Nursing Homes section. Following the conclusion of today's webinar, you'll be asked to complete a short evaluation. We thank you in advance for your completion of the evaluation, as it helps us know how we did and how to shape future programs.

Today's speaker is Quality Insights Reducing Healthcare Acquired Conditions in Nursing Homes Project Coordinator from West Virginia, Pam Meador, to whom I would now like to turn the program over. Pam.

Pam Meador: Make sure I am off mute. Yes I am. Thank you, Krista. I appreciate that. I want to welcome everybody to Session Five: Data is Not Voodoo. I hope everybody had a wonderful fourth of July and you got all your stuff down for the past three weeks. You're ready for your next step, which is gonna be talking about data and how we monitor data, and the feedback and all of that good stuff surrounding data. Data and I have not been friends for very long, but we have become really good friends, and I hope that you develop a relationship with data too, which we're gonna help you with in the next upcoming slides. So, let's get ready and see ... There we go.

First thing we want to do is, is to do a quick review from our session four and something that I wanted to talk about from previous session as well, which is goals. The feedback that I get from you guys on these trainings has been absolutely phenomenal and I appreciate it. There is a whole lot of hard work that goes in to this, and it really makes me feel like this is a complete, worth all the time and energies that we're putting into this, when such wonderful questions and information comes back to us, from you guys.

One of the things that someone brought to my attention was talking about when we were writing the goals. How your facility is going to move forward with writing goals in

your QAPI work that you'll be doing. What I wanted to clarify was in this process, you're writing how your facility or your organization is going to write goals. You're not writing goals when you're writing your QAPI plan. You're writing how you're gonna write goals.

For example, if you're doing a QAPI PIP, project in one unit, however they write that goal for that unit or for that charter team, is the same way that you would write a goal if the board of directors was doing a QAPI project. Basically, you're writing how your facility will write the goals, whether you're gonna use the goal setting worksheet that we shared from CMS or if you're gonna use SMART goals every time a goal is written, or a combination of those. Or if there's some other goal setting way that your facility does it or the hospital that you work with sets goals. That's what you're doing. You're just writing a policy on, not a policy or a procedure, I guess it is, on how your facility is going to write goals in a consistent manner.

I just wanted to make it clear, because it was kind of unclear, that when you're writing your plan, that's exactly what you're doing, is writing directions on how you're gonna do it. How you're gonna write the goals, just like we all of this other stuff. What is the procedure that you're gonna use, within your facility, to do these things, and that includes writing goals. So I hope that clears that up just a little bit.

We also talked about, last time, top level management. What their responsibilities and accountabilities are, including the role details. You should have written information on who will report to top level management, how it's gonna be reporting, who top level management is, and who is on the steering committee. Sometimes that's one in the same. We talked about that last time.

You have written information on the steering committee and how often they're gonna meet, who's gonna be involved in all of that. You've written that. You've written an education plan statement, how you plan to educate the staff and the vendors and the families and the residents and whoever else you can think of, on what QAPI is.

You've written a QAPI priority statement, because it is a commitment and it's not going away. You have to make sure that everybody understands this is going to be priority within your facility. You have written your resource list statement, addressing everything that was associated with your resources, like how much do you have. If it's not enough, how do we get more? Those types of issues.

Then, you should have already written a caregiver proficiency statement. How are we gonna make sure our caregivers are proficient in using QAPI and that they understand it is a foundation for the way we do business, problem solving, making things better, working on a day to day basis, on a systems level, all of that. Those things, and session four, it was a whopper, so hopefully you have nailed that down, you've got that finished. If you haven't, you're still working on it or you're well on your way to getting that leadership section completed.

With that, we will move on into our data portion. Data Systems, monitoring, and feedback. These are the three areas that we're gonna focus on today. What we're gonna

do, we're gonna have to identify the data sources that will help us to analyze our facility's performance. When we do this identification of these data sources, and we're gonna talk about what data is and what it means to your facility in just a few minutes.

One of the first things that we're gonna do is focus on the fact that it is all departments. This is not just clinical information. All departments need to have their input on what data we look at. We're gonna be brainstorming lists and each department needs to be involved in this. When I was writing this, I was thinking about, for example, housekeeping. If you have an issue with washcloths, because we all know, washcloths tend to grow legs and walk right out the building. We don't know where they go. We think they turn into extra socks, but they sometimes grow legs and just walk away. Sometimes we think, maybe it's down the toilet, but that's just from experience, sometimes I think that's where they go.

If we have an issue with linen or laundry or any type of linen like that, that may be a data source that your housekeeping supervisor may want to include in the data source list, their linen counts. When you're brainstorming these lists, when you're doing the brainstorm, one of the rules of brainstorming is there's no bad idea. If someone says a data source that they think their department needs to have included in this data source list, then we need to take it a little bit seriouser, more serious than, if we think about it, and we're like, that's not something that we want to put in this, but is it? Is it an area of improvement? If it is, it definitely needs to be thought about.

All departments need to be included. When you think about that, what other areas, not just departments, might you want to include in your brainstorming sessions? Residents? Families? Volunteers? Who could you think of to include in getting the information that you're looking for? We'll talk a little bit more about that in a minute, but all departments definitely need to be involved.

Data sources will be really identified when your facility gets to using the facility assessment that will be required come phase two of the condition of participation, November 28, 2017. There's more information coming out on that. We're getting some information now about some calls and things that CMS may be doing with this, so as soon as we at the QIO get a little bit more information, you guys will be the first to hear about from us. When the facility assessment is being completed, you're gonna have an even richer source of data sources that you'll be able to pull out of that. You'll be able to look at that and say, "Wow. This is an area we need to look at based on our facility assessment." It'll be a good tool to use as well.

We also want to monitor for risks when it comes to data systems, monitoring and feedbacks, but not just risks. I'm a big proponent of monitoring your successes as well. We always want to make sure everything is perfect, and that we're fixing any problems that we have, but we don't want to forget to celebrate the things that we do very well. We also don't want to forget to take those things that we're doing very well, and even make them better, if that's possible. How can we do that? We'll talk about that.

These data sources that we've identified, we want to be able to use that data that we've collected. How are we gonna do that? We're gonna be looking at our benchmarks,

where we want our goals to be, and our targets, and monitor for the areas using this data. Monitor for the areas that could potentially be issues, quality issues, survey issues, anything that could potentially cause us heartburn down the road. We want to address before it gives us heartburn.

We also want to solicit feedback and input, and from who and how often do we want to do that? This is a two way communication. When you solicit feedback and input, you want to give it to your stakeholders and to the folks that you serve and you want to get it from them. It's a two way street. Sometimes we forget that. Sometimes we forget that we should not only be taking complaints and things like that, but we should also be giving information to our staff, to our residents, to our families, to our vendors, all of those people. We want this feedback.

Sometimes it's not feedback that is very pleasant. We have to think about this and understand that when someone gives us feedback, we need to use that data.

Now, data systems. The first portion of this is data systems. We want to talk a little bit about data to prove that data is not voodoo. We always hear that data is very, very important. We hear that data is the future. We hear that data is linked to our successes. But, really, what is data? And what is data to you? That's a very good question.

So, here we go. Where do we go to when we want to find the meaning of word? We go the dictionary. I even put the little phonics up there, in case you don't know how to say it, because some people say data, some people say data, and lookey there, they're both right. It is a noun. It's facts and statistics collected together for reference or analysis.

I said at the beginning, and the Quality Insights analytic folks can attest to it, data ... I'm really trying to love my data and trying to understand it. I'm telling you folks, trust an old nurse right here. When you start to understand data, it becomes, it's like the light comes on and the clouds open. It's a beautiful day. Once you understand where you're coming from, where the information is coming from and why it's there, and why it is what it is, it really makes things a whole lot simpler.

Okay, so we know what data is. Data is how we express observation in usable forms. If you'll notice on this slide, we have taken the most important term, and we've brought it out, which is usable. If you are collecting data and it means nothing to you, what good is that time spent pulling that data?

When this occurs, there's one of two things that needs to happen. One of the two things is, you need to learn what that data means. You need to learn where it comes from. Why is it the way it is? Why is it important for you to be familiar with it? Or you need to be looking at that data and determining, is this something that I need to continue to be pulling? If it is, then, back to number one. Why did I even question it and why am I not understanding it?

Again, this is something, especially with your quality measures, your five star rating. Those are the data points that if you don't understand, trust me people, you are not

lone ranger. There are many, many folks out there who are expected to work in this industry, and use these numbers, use these CASPER reports. I guess we were expected to come out of the womb knowing how to read these things. That's not the way it is. So, if you don't understand how to read your CASPER report, you don't understand why you're five star is where it is, or you don't understand how come you've been working your tail end off and it's still where it is, you need to reach out to us. We can help you with project coordinators. We can help you to understand where this data is coming from and what it means to you. You are not alone. You are not the only one who's not looked at a CASPER report, if you're a director of nursing, or administrator, no matter what your position is. You are not the only one.

Please, let us help you understand the data. Let us understand, we're trying to be subject matter experts on this area, so we can help you with that. It's one of the things that I love to do is, teach about quality measures. To teach about the five star rating system, even though most of it is fantastic. You've got to understand where these numbers are coming from and you've got to understand where they're going. I think I might be getting ahead of myself. I think that might be on my next slide. Look at me. Okay. No. Maybe it's not.

So, when we're looking at this data systems that you're gonna be using, what data are you going to use? Will the data that you use be the same data that the folks down the street, in the other nursing home or the facility, use? The answer to that is, no. If you, let's take restraints for example. Most facilities, that I work with, are at zero restraints. Is that something that you want to monitor? Well, yeah. You want to make sure that you remain at that level if that's what you're wanting to do. But is it something that you gotta spend a lot of time on? Is it something that you want to make sure that's included in your QAPI data collection list? But is it something that you want to spend a lot of time with, whereas, the facility down the road, still has several restraints. Their priority level for that data system may be a little bit higher than your facility.

Each facility is different. We can't tell you, this is the data you should be monitoring and this is the data you shouldn't be monitoring, because that is up to your team. Now, we can tell you that there are some that most likely everybody will want to monitor, such as your survey reports. Or, such as, the quality measures, such as, the five star ratings. How you do that is completely up to your team.

Let's move on to some action steps related to data. Data information sources, action steps. It always starts, poor ole steering committee has to start all this process going. Pulling the steering committee together and brainstorming your list of data sources is one of the first steps when you're to this section of writing your QAPI plan.

Some ideas associated with, that your team might come up with, is any input from your residents, families, staff, vendors, those type of folks. Getting input from them based on the surveys that you do, based on the complaints that you receive, based on adverse events that occur within your facility. You always want to make sure all of these things are included in your data sources, or it could be included in your brainstorming session, someone coming up with these things.

Your performance indicators. Your survey reports could be a very important data information source, could be, is and most likely is for everybody on this call. And of course, the facility assessment that's going to be coming up soon. Those are all examples of data sources that your facility could come up with. There are tons more. I've just kind of wrote out just some extra ones after I put them on the slide. Things like medication errors, or audits that you complete on a routine basis that's required by your corporate, maybe. There's just so many things. How about case mix, if case mix is an issue within your facility. How is that, is that something that you're wanting to include in the data sources?

You gotta make the list with the steering committee. I want to point out that, remember when we were talking about this being a fluid or living document? When you do your facility assessment, and you find different data sources that you hadn't thought about before, can you add them to that? The answer to that is, absolutely, positively, yes. You can add anything. It is a living document and just because November 28, 2017 comes along and your plan is written, and then in December, surveyors come and you show it to them, then they leave. Then in January, you think about another data source that you're gonna want to start monitoring, that you can't add it, because you've already passed that date. That's not the way this works at all.

You want to make sure though, because your facility is continuously improving. That's what it is. Continuous quality improvement. If you're not updating your list of sources, then that might indicate a problem, that the fact that you're getting stagnant and that you're not improving in areas and you're not finding areas that need to have a little bit more attention given to them. Again, it's a living document. It's not stagnant at all.

Now we move into feedback, input and monitoring. I kind of put those two together because of course, they go together. This includes, how are you gonna use those, take those data sources and analyze the information and communicate the information? That's the feedback and monitoring that we're gonna need to determine how your facility is going to do that. That's what you're writing your plan.

How are we gonna analyze this data? How are we gonna communicate it? You can do this one of two ways. One of them is to write your statements and describe in your QAPI plan how your data will be collected, who's gonna do it, how often it's gonna be done, how it's gonna be communicated. All of those things listed out in your statement of data sources, feedback, input and monitoring. You can write a statement like that if that's what you choose to do.

Or, you can develop a dashboard. A dashboard is also not voodoo. A dashboard is a system to track key performance indicators within an organization. If your facility has a report that you have to go in, probably every month, maybe every quarter, I'm not sure, depending on your facility. You have a report that's on a spreadsheet that you have to go in and fill in all of these numbers, and you have goals and you have all of these things that are from maybe your corporate office, or from your leadership. You're working on a dashboard already. That is a dashboard. A dashboard is designed to be easy to read. It's designed to be quick to understand. It shows both positives and negatives. It also

focuses on short term indicators, which are your milestones and your long term outcomes, which are your goals.

There are so many different levels of dashboards that you can have. The one we're talking about today is the overall QAPI plan dashboard. This is the way we're gonna monitor what we're doing. This is the way, let me go back, this is the way we're gonna list our data sources. This is the way, this is the information, the feedput, I'm wanting to put feedback and input together, so I come up with feedput. So if I say feedput, that's what I mean. Feedback and input and monitoring, that's what this overall dashboard is going to be talking about.

You can have more than one dashboard, and we'll be talking about that in just a second. You did receive a resource. It's a four pager from CMS, and again, I want to remind you, these resources that you get from us or from when you go to the CMS website, the QAPI website, and you get their tools, they are not mandatory, nor do they indicate that it's a absolute compliance with regulations if you fill these out. But, I would think that it would surely help and it would give you an indication of how things are ... A helping hand on getting these things done.

This instructions to developing a dashboard is extremely step by step. If you have learned anything about me, I'm a step by step person. I'm one that has to be baby steps in order to get something done, eating the elephant and all that good stuff. That's how I like things. If that's your kind of thing, this will help you develop a dashboard. It gives you the, the first step is of course reviewing the basics of what a dashboard is, why it's important and what's it look like.

It also, step two, talks about deciding how your dashboard will be used within your facility. Step three is creating your dashboard. If you have a computer literate person within your facility that can do the little Excel spreadsheets or the tables in Word, then you need to go buy them a box of doughnuts or something and let them know that they're gonna be well loved over this process. Not that doughnuts would woo everybody, but I'd almost make you one for a box of doughnuts. We've been doing low carb a little while, so that's what we're doing.

Step four is using your dashboard. Step five is revisiting your dashboard. I'm not gonna sit here and read this entire thing to you because you have it and if this is something that you decide to do, then it's a wonderful resource that can help you develop whatever dashboard you're wanting to develop.

Again, a dashboard is a fluid document in itself and it will forever be changing as your facility changes. Your facility changes. Is your facility the same as it was last year? The answer to that is most likely, no. Your dashboard will change as well.

Remember when I said you would have more than one dashboard? The one we're working on is probably your overall, how we're gonna do QAPI. These are the things that we'll want to be monitoring in our QAPI overall plan. Now, you can have more than dashboard. Once you get to using them, you're gonna realize how, and I'm gonna have

some examples on here. I know examples are everybody's friend, we're gonna have a few examples on here. I wanted to put more but, it just was really difficult to come up with the ones I did. It's hard when you don't have a facility that you're working with, like your own facility to come up with examples. You just kind of sit there and think, that sounds crazy. Nobody will understand that. The ones we did come up with, hopefully will give you an idea of how to do a dashboard.

This one again, is an overall. But you could have a board of director dashboard. This is for overall monitoring of things like the five star, the finances, the staffing, your survey activity. The stuff your board of directors want to see and want to know about. You could have a QAPI board of directors dashboard. You could have a steering committee dashboard that lists all the charter teams that your facility is working on at the current time, with their milestones and their goals. Where they're at now and how the progress that they're making on one spreadsheet, so that it's very easy to see where they're at, where they're going, and where they need to be.

Or there can be unit dashboards, specific unit related issues. Things that, this hall has an issue with this and here's where we're at. Here's our goals. Here's where we are now and here's where we want to be. Once you see the dashboards in the examples, you'll see what I mean.

So having more than one dashboard is a definite possibility. This is an example dashboard. You're probably needing to get a little bit closer to your screen to see it, because I sure did. This is a very high level example of a dashboard. In this, you've got the various columns, areas that this facility wanted to look at and probably, on a very high level basis. You got the column for your data sources. Then you've got the column for data collection frequency. How often will this data be collected?

The benchmarks to analyze this data source. It's got some examples there. Where are we looking at, as far as numbers go, that we want to be on this, in this data source. Who is responsible for this analyzing of the data? I'll tell that one on the next one. Data analyst frequency. That doesn't have to be analyzing. It could be data collection. Who is gonna collect the data? Who is gonna analyze the data? Who is going to, when, how often is the data gonna be collected? It don't have to be those exact titles. It could be whatever you want to include in your dashboard.

Then of course, the next one is data will be communicated with whom. Communicate the data via what source. Is it gonna be emailed, if it can be emailed. Is it going to go out in newsletters? Is it going to go out in staff meetings? Is it going to go out in board of director meeting? How are we gonna communicate this data? How often are we gonna communicate this data? This hits all the required areas, but it's very ... It looks busy, but let me show you the next one, which is a filled out version of this.

This one again, very high level. It's not anything that can meet any one facility, because this facility is focusing on abuse and neglect and mistreatment reports. That's one of their data sources, which might be a data source for every facility in the nation. It's up to the facility, but it tells how often it's gonna be collected, who's gonna collect it. It says leadership team. As a usable document, leadership team is there because if we were to

put something, for example, and please don't kill me social workers, if I were to put social worker in there. We didn't want folks to come back and say, "Well, that thing right there says, social workers should be doing this." That's not it at all.

Whoever you decide is the best person within your facility to collect that data, would be the title that would go there. I would not put names. I would definitely put titles, but it could be as specific as you want it to be or it could be as nonspecific. It can be as general as this one is, leadership team.

Talks about how often, who it's communicated with, etc. You can see how the data sources are listed and then the information about that data is moved across the table. If you determine that, let's say, it says, the second one, CMS quality measures, long stay and short stay, says monthly. Well, okay. That's great from all of the quality measures. But look on down, it has falls. If that is something that you need to pull out and do a little bit more specifically, which you see they have weekly here for falls. They must have an issue that they're wanting to follow with falls.

It's not set in stone. Whatever your facility needs, is what your dashboard should look like. Now, this one being an overall dashboard. Here's a very, very, a much simpler, more specific dashboard. I just put a couple of quality measures on there in order for you to see what we're wanting, what we're trying to teach you about dashboards.

On this one, you've got the quality measure, which is your data source. Then you've got what your baseline goal is. You can put actual numbers in there. It doesn't have to be below national average. You put your actual whatever it is that you want your goal to be. What your baseline rate is, what you are right now when you're first starting, and then you put what your milestone is, and then your rate. What it is, whenever you go and you collect your data. Then your next milestone. Then a place for the data, and so forth and so on.

We did then, for you visual people, lookey how this looks filled out. Where does your eyes go automatically? It goes to that big nasty red square that you just want to stab when you see this, because it means that there's something that we need to focus on. I know we have a dashboard in the Quality Insights, and it's something that shows us, in this bright red blood colored death font, it's not a font, but it's a background. It tells us the areas that `we are not meeting our goals.

This, to me, is such a time saver, because I don't need to even focus, as a board member maybe, I don't even need to focus on the greens, because I know that they're doing ... Although I probably should let them know what a good job they're doing on their catheter, the reduction of their catheters per their goals. I know, that right there, is an area that I need to look at. Then I look over, and I'm like, oh, look. Q2 of 2018, we have met our goal, even though we're not there yet, but we're pretending we are. I can look at that and think, okay, I can move on. They're moving on. They're doing what they need to be doing and there's no issue.

But if there is an issue, we need to address it. We need an easy way to look at this and to see what needs to be addressed in each of the data sources.

All right, now. So, our action items for this time, include writing a list of our data sources, by brainstorming with our steering committee. Writing how the data will be collected, by whom, how often, all of those things we listed in the previous slides. How it's gonna be communicated. Doing our little statement on how we're gonna be doing data, feedback and monitoring. Or develop our statement or plan on using a QAPI dashboard, by listing our data sources that we have come up with and listing our ideal thoughts about those, when it's gonna be collected, how it's gonna be collected, who's gonna be collecting it, who's gonna communicate it, that kind of thing.

Those are the action items for this session. Here is the project coordinator list for your state. Again, reach out to us if we can be of any help at all in understanding data sources and understanding how to use some of this stuff, if you're not sure. Do not hesitate to reach out to us. That is what we're here for.

I would like to, it's now twenty till, and I want to turn it back over to Krista for any questions.

Krista: Thank you very much, Pam. Once again, if you have any questions for Pam, regarding today's presentation, we invite you to now type them into either the chat or the Q&A box on the right side of the screen, and we'll address them as they come.

We do have two questions already in the queue. Pam, the first one was typed in when you were talking around slide eight.

Pam Meador: Okay.

Krista: It was a question about what is VBP?

Pam Meador: Oh, I meant to say that.

Krista: What is VBP report?

Pam Meador: Yeah. I am so bad for saying those abbreviations and then not following up on that. Those are the value based payment reports that eventually ... We don't have, those are in hospitals and right now the value based payment systems. We don't have those yet, but eventually, we're gonna be getting value based reports. Those are things we're gonna be using. I apologize. As a matter of fact, I meant to take that one out because I knew I would forget to talk about that. Thank you very much.

Krista: Okay. Our next question is, will the QAPI program be mandatory in 2017 or 2019?

Pam Meador: Good question. Well, the QAPI plan has to be written by November 28, 2017. That's why we're doing this in this step by step method or process, so that by August, you have your plan written. After November 28, 2017, surveyors come in. Let's say surveyors come in

on December 1, 2017, they're gonna say, "May I please see your QAPI plan?" And you have to present it to them. Now, you don't have to be using efficiently this QAPI plan, per regulations until November 28, 2019. That is a beautiful thing. We have two years in order to learn how to use these things. We have two years in order to take this plan and mold it into what we want and teach all our people how to use it, and understand that it is a foundation of how we're gonna do business from now on.

You have to have the plan written by November 28, 2017. It has to be fully implemented and used and completely user friendly by November 28, 2019.

Krista: Thank you. Our next question is, for QAPI, when looking at QMs on the CASPER, do you use data for the last three months, or rolling six months?

Pam Meador: Very good question. I just had a wonderful training with a facility yesterday. We talked about the time frames for CASPER reports. You can use whatever time frame works best for you. A quarterly or a three month look back can work well, because that corresponds maybe with what your corporate office is asking for, looking at the report. I personally, and this is just personally, I like to look at these reports on a monthly basis. What are we in, July? July 12th, June data is pretty much updated. All MDSs and everything should be in. We're good to go. I pull June 1st through June 30th. Thirty days past September, April, June, okay. The 1st through the 30th and I will look at that, and I will also have pulled May 1st through May 31st. I will look to see what kind of right now changes I'm making, to see how my data is improving on a month to month basis.

You can change those reports to whatever report period you want to look at. A six month look back. Sometimes that's helpful with making sure sustainability has been there. Something that you've been working on, you want to make sure for this past six months, you're still doing well in sustaining where you wanted to be. That's a great idea.

Another thought process is your five star. Some of those are 14 months worth of data. Some of it is a year's worth of data. The short stay and the long stay varies, so you can go into your CASPER reports, change the dates to correspond with whatever the current five star is, and that way you can kind of get an idea of where you were and what residents affected that five star rating, with the ones that are available on CASPER. Those reports are so versatile in being able to change those respective dates. That's a really good question.

Again, that's stuff that we can help you with as project coordinators.

Krista: Thank you. Our next question is, on the action statement on the last page, do we do the first four action items or the dashboard, or do we do both?

Pam Meador: Okay. That's a good question. You can do either or. You can do both if you wanted to. If you want to make a statement, you can. But if you just want to make a dashboard that tells everybody we're gonna be using these data sources, and this dashboard, because it tells you the very same thing. It's gonna tell you the data sources. It's gonna tell you all those things that I've listed. It's gonna tell you how often you're gonna get that data

collected. It's gonna tell you who's gonna be responsible for collecting it. It's gonna tell you all of those things that's required in either one. You can write both if you want, or you can just do one if you want. You just have to have the information in your plan somewhere, somehow. These are just a couple of ideas of how you can do that.

Krista: Thank you. Our next question actually isn't a question, but more of a statement, that perhaps, Pam, you'd like to comment on. It is, we feel we need statisticians for this, that the RNs are not trained to handle all of this data. It's very overwhelming.

Pam Meador: I 100% agree. It is overwhelming. It's something that ... I am so far from a statistician, it is not even, it's kind of scary. Like I said, you can talk to my analytic folks and they'll tell you that statistics, to me, is the devil. But I'm learning. I'm gonna tell ya. It is very overwhelming. I always say, in long term care, everything is a priority. It doesn't matter what it is, we have to be an expert on it. We don't have, in long term care, respiratory therapists to call, although, some facilities do, most facilities do not, when there's lung sounds to be listened to. Or we don't have an IV tech or team to come and start IVs. We don't have a hospitalist to come in and access a potential blood clot. We don't have these things.

We have to be experts on everything. Data is one of the things that's just, unfortunately, not going away. Again, if you feel overwhelmed about it, and you don't understand it, I promise you, we can help you understand this. We can help you understand quality measures, to a lot of people, quality measures are also voodoo, and no one understands. Your staff, they don't understand how come we're a 100 bed facility and we have, and I'm just pulling this out, we have 50 long stay and 50 short stay, why is our denominator 30 on this long stay measure. Shouldn't it be 50? Well, there's a reason that it is. You have to understand that reason before you can make any changes on those quality measures.

Those are things that we can help you with. We can help you understand. We can help you, teach you ways to train your staff, ways that make it a little bit more user friendly. Your five star rating. Lots of people don't understand the various facets that go into making a five star. It's because it is very overwhelming and there's so many changes and things going on in long term care. If you don't already drink, you might think about it, although we don't want you to.

Use us to help you get a little less overwhelmed. Understanding is probably the big key to all of this.

Krista: Thank you. Our next question is, how do we get the CASPER report? The PEPPER report is sent, but not CASPER.

Pam Meador: Nope. CASPER reports you have to go in and get. You have to have access to the, what's called the QIES system. If you ask me what it stands for, I can probably fake it. It's Quality Improvement Evaluation System. I believe that's what it stands for. It's CMS's website, not website, it's CMS's data collection portal, where your MDSs go. You have to have access into that in order to be able to get into your CASPER reports. We can help

you. If you don't know who has access within your facility, then that would probably be one of the first things we need to help you find out. Reach out to your project coordinator. We can help you figure out what you need to do. We can't give you access. That's not our job at all, that's through CMS. But we can send you the link that you need to go to, to get in touch with them and get some CASPER report help.

But as far as learning about CASPER reports, we can do that too.

Krista: Thank you. Before I read the next question, I just wanted to address. I've been asked several times in the Q&A for a copy of the slides, not in the notes format. That's the format with the lines beside them. I've been asked for them with one slide per page so that they can actually read the words on those examples, Pam, that you had on there. I will resave them as full size slides and resend them out to you, all the attendees that attended today. Watch your email. That will go out later on today.

Pam Meador: Okay.

Krista: Back to questions. The next question is, what's the new F tag number for QAPI under the new regulatory groups?

Pam Meador: Oh, that's a good question. Maybe somebody can look that up for me while we're going on to the next question, and type it on in there, because I don't have that in front of me.

Krista: Okay.

Pam Meador: If not, maybe we can go back to it.

Krista: Sure. Our next question is, I'm having difficulty understanding denominators and how to write them. Do you have any training for that or anything to add in regards to denominators?

Pam Meador: Oh. Well, you know, one of the easiest ways that I, and it's very, very elementary the way that I explain a denominator and a numerator. One of the ways I explain it is, if you have a room with 100 people, I use 100 because, again, math is not my friend. You have a room with 100 people, and your quality measure is trying to find out how many men are in this room. We've determined that there is only two choices. There's male and there's female. Those are the two choices, and there's 100 people in this room, and all 100 people will fit into that category. So our denominator is 100. Our numerator then is how many men are in this room. We've counted and determined there's 50 men. So our numerator is 50, and our denominator is 100.

Now, to clarify it a little bit further. Here we still have that same room. 100 people. What we're trying to do with this next quality measure is to determine how many folks in this room is in active diagnosed menopause. In order to be active diagnosed menopause, you have to be female. We already know 50 of those folks are excluded. When you've got an exclusion, they're out of the denominator. You've got then a new denominator, even though you've got a room of 100 people, you've got a denominator

now of 50, because 50 of those people, who are men, we know there are 50 men in there. 50 of those folks are excluded.

So now 50 is our denominator. We go through. We count. There's five women in here who have active diagnosed menopause. Five is our numerator and 50 is our denominator. And yes, ma'am, we do do training on quality measures on how you can understand where to get the denominators for each of the, where they get the denominators for each of the quality measures. We can definitely help you with that.

Krista: Thank you. We did get a response that it's F944.

Pam Meador: Okay. There you go.

Krista: And also Sheila.

Pam Meador: I also see where Sheila. That's in the new ... Oh, my screen went blank. Okay. That's where the final rule has, that's where you can find the information for QAPI and the final rule. Thank you, Sheila. That's absolutely right. They have not ... I don't think they've come out with the new, well, we call it watermelon book, and now I can't think of what else it's called. The new federal regulation interpretative guidelines. There we go. I don't think they have come up with those and released that yet, unless they've done it recently and I've not seen it. There you go.

Hello?

Okay. Krista has lost her audio, so we are finished. I really, really appreciate you guys attending these training sessions. If you need anything else, please don't forget to do your evaluation and let me know how I'm doing. If there's any other questions, email your project coordinator and you guys have a great rest of the day.

Thanks. Bye.

This material was prepared by Quality Insights, the Medicare Quality Innovation Network-Quality Improvement Organization for West Virginia, Pennsylvania, Delaware, New Jersey and Louisiana under contract with the Centers for Medicare & Medicaid Services (CMS), an agency of the U.S. Department of Health and Human Services. The contents presented do not necessarily reflect CMS policy. Publication number QI-C2-071417a