Shoot For the Stars With QAPI
Webinar Transcript

Krista Davis: Good afternoon everyone and welcome to today's webinar: Shoot for the Stars with QAPI, which is the third and final program in Quality Insights summer webinar series on topics you've indicated are important to you. My name is Krista Davis and I'm the communication specialist at Quality Insights and your host for today's presentation.

Krista Davis: We'll get started in just a few moments, but first, a few housekeeping items. All participants enter today's webinar in a listen-only mode. Should you have a question or a comment during today's call, we ask that you please type it into either the chat or the Q&A box to the right of your screen. This program is being recorded. The recording and slides you see today will soon be available on the Archived Events page of Quality Insights' website, www.qualityinsights-QIN.org. At the end of today's program, you'll be asked to complete a short evaluation. This evaluation will help tell us how we did and how to shape future programing. We thank you for your help with this. At this time, I would like to turn the program over to the Nursing Home Quality Care Collaborative Network Task Lead from Louisiana, Julie Kueker. Julie?

Julie Kueker: Thank you, Krista, and thank you everyone for attending the last in our summer series, as Krista had mentioned. These are the hot topics that you have indicated to us were very important to your work. Nothing could be hotter, I bet you, than that topic of PDPM that starts October 1st. I know all of you are having your MDS coders get ready and practicing and learning the new way to code for ICD10, but there very well may be a piece that we're missing that we're going to talk about today that can also help you get ready for PDPM. I'm talking about using this topic, using the focus that's going to be implemented for this payment-driven payment model. Using that focus to drive what we're doing for quality right now, having performance improvement projects to really bark and get things going, so we're really ready when this kicks off for October.

Julie Kueker: The objectives for today, we are going to review the elements of PDPM and we're going to go into detail the five components. Now, we're going to lightly describe the mechanism of PDPM because I have no doubt for all the audience that are listening you have attended education, more than likely, webinars. The mechanisms of PDPM is almost its own webinar, almost several webinars, maybe an all day session. We're going to lightly touch on the mechanism of PDPM as it relates to your quality life. Which leads us to kind of going into the QAPI model for improvement. I know it's old hat for many of you on the call. We may have some new DONs, some new folks that are now in that quality department. Plus, QAPI as you know, is fully implemented November of this year. It is worth a re-look to lightly go through with components to make sure everything is ready for that QAPI final implementation, phase three, for the final rule. At the end of the webinar, we're going to talk about performance improvement projects, how you can take some of the topics that we're going to

talk about and get ready for PDPM, learning how to start a performance improvement project and how to make it successful.

Julie Kueker: What we're going to talk about today is the marriage of PDPM and QAPI. We're going to talk about how the reason behind how did PDPM even get going? Well, there was a problem with the way we're currently doing things which is the RUG payments. This is based almost entirely on the amount of therapy a resident receives. It didn't take into account any other unique characteristics of that resident. It didn't take any of that into the payment for that RUG system. PDPM actually improves that payment accuracy by focusing on that resident rather than the volume of the services that are provided.

Julie Kueker: When we look at PDPM through the lens of quality, there's some things that I'll want you to really focus on as we're going through some of these topics as we're looking at some of the things that PDPM focuses on, things you can be doing to get ready. For example, therapy preparedness. How well is your therapy department responding to the goals of your residents and the unique characteristics? Most of you are aware how important coding will be for PDPM. Are we coding accurately? Do we even know how that mechanism would look like? What's an effective care plan that matches the goals and outcomes that can be reflected appropriately for good PDPM? Admission and discharge process, we're going to go a little deeper into this in just a minute. When it comes to admitting that resident from the hospital, it is vital that you get that correct and good information coming from the hospital so that you know how to correctly code that ICD10, that primary diagnosis for that resident. Always bear in mind that your primary ICD10, if they're coming from the hospital, may or may not be the primary diagnosis from the hospital. Always bear that in mind. These are some topics that we're going to be looking at to marry PDPM and QAPI.

Julie Kueker: For today's webinar, we're going to look at PDPM. Then we are going to see what are the components of QAPI. Then apply both of those for a performance improvement project so we can have a successful project for a smooth transition. Part one of today's webinar. We're going to be looking at PDPM. That payment-driven payment model, it is knocking at the door. It is almost here. It takes effect on October 1, 2019. That is your start date. Now this payment-driven payment model is a marked improvement in CMS's eyes over that RUG model. It improvements payment accuracy and appropriateness. For your MDS coders, they are going to enjoy a less administrative burden on some of these PTS assessments. It also is going to improve SNF payments to currently underserved beneficiaries without increasing Medicare payment.

Julie Kueker: Now, be aware, it is a hard transition. 11:59 on September 30, 2019 RUG ends. It's a light switch on and off. Payment-driven payment model starts at midnight on October 1. At that point, every skilled Part A resident at midnight October 1 must have that PDPM health insurance perspective payment system code to be able to bill for services. Now to help you, CMS has created their own patient-driven payment model web page. I encourage you to bookmark this. Go back

frequently because one of the documents in there that you can download, you'll see it close to the bottom where it says PDPM frequently asked questions. When you submit your questions to CMS, not only do they answer them to you, it's quite possible that they find them worthy for SAQ document. It's well done, it's common questions, it answers them succinctly. Just because you downloaded it a few months ago doesn't mean it's the same document. As they get new questions and they're worthy for the document, this document is frequently uploaded. You'll want to mark this page, bookmark this on your internet. Frequent this page as you're getting ready for PDPM, especially downloading that frequently asked questions document. It will be to your benefit.

Julie Kueker: Let's talk a little bit about RUG versus PDPM. RUG was that single payment. PDPM kind of ties everything together. RUG reduced everything about a resident to that single, typically volume-driven, therapy minutes, case-mix group. Somebody could have the same amount of therapy minutes, yet look vastly different on their chart. Whereas PDPM focuses on what made those differences between those residents. It focuses on the unique, individualized needs, characteristics, and goals. Taking into account those PT and the OT speech language path nursing and non-therapy ancillary.

Julie Kueker: RUG, the way it currently works, is almost entirely on therapy, based on that volume of services provided. The nursing case-mix index here does not currently reflect specific variations to that non therapy ancillary utilization. It just is what it was. It was driven mainly by the therapy group. Because of that, because it focused really in that one area, it didn't do as good a job as CMS would have liked of really describing the need and paying upon the needs of those residents.

Julie Kueker: Here are just a few of the differences between RUG and PDPM. Therapy is tracked by minutes for RUG. There is minimum therapy minutes required for each RUG level. Group and concurrent therapy were financially discouraged. Rates remain constant as long as services remain constant. Whereas PDPM, it allows you to really focus on the residents' needs. There is no specific therapy minutes required; however, only 25% of those therapy minutes can without being flagged, belong to the group and concurrent combined. Therapy for group and concurrent therapy is only 25% of the total of therapy minutes provided. 75% of the therapy should be one-to-one as required by PDPM. When you use these calculators, these PDPM calculators, it will help you get to that score to make sure you're within guidelines of these therapy minutes. Group and concurrent therapy are financially beneficial. You are allowed to have them up to your limit. Rates decline after day 21 for those PT and OT section in day three for that non therapy ancillary section.

Julie Kueker: Let's talk a bit about the PT and OT components of Rug versus PDPM. For RUG, the number of PT, OT, and the speech language path therapy treatment minutes are combined. They were all three combined for a total number of treatment minutes. Then the number of minutes was used to classify into that RUG rating.

Whereas PDPM, the resident characteristics are used to predict that therapy cost. PT and OT do have two classifications that are involved in this, which is the clinical category and the functional status.

Julie Kueker: Now, as I stated earlier, that PPS assessment does change. Here is your schedule from the CMS webpage that explains that you need that five day scheduled PPS assessment. You are allowed to do that interim payment assessment and then that PPS discharge assessment. Now this is different from your [inaudible 00:13:06] requirement. This does away with that day 14, day 30, and day 60 PPS that you had to do before. It lessens it to just a five day PPS and that discharge PPS. That does allow for your MDS coder that's going to free her up to help you prepare for this transition. She's going to be able to really help you as a team member as you're starting some of these performance improvement projects to really utilize her to get ready.

Julie Kueker: The effect of PDPM is that each individual resident, their unique needs, are implemented into PDPM and it improves that payment accuracy and encourages you to have a more goal specific, care specific, resident driven care plan. You can see that the examples that I have here below, you have two different patients, A and B. One really has non [MTA 00:14:14] needs, one really has SLP needs. Whereas patient B does not. Their needs are entirely different. To lump them in to just being able to have a reimbursement just totally based on their therapy minutes doesn't really reflect what was going on with this particular resident here.

Julie Kueker: Now, PDPM components have five case-mix adjusted components. Now, under RUG, PT, OT, and SLP, they were combined for a total of therapy minutes. Under PDPM, resident characteristics are now used to predict therapy costs. These components, these two classifications include clinical category and functional status, well they're used to combine. Based upon data driven stakeholder, these resident, vetted resident characteristics. This is what was built into the PDPM model that creates that payment model. PDPM also includes a variable per diem adjustment that adjusts the per diem rate over the course of the stay, which was unlike RUG. If all care remained the same, the rate remained the same.

Julie Kueker: Now for PDPM, the clinical categories, there are 10 of them. The SNF patients are classified into these clinical categories based on that primary diagnosis for the SNF stay. Now, that primary diagnosis, this is your new item on MDS and it's item I0020B. This is your new item where it states what is the primary diagnosis. This is where you put that ICD10 code in. This really drives the rest of the model. As you're looking at these clinical categories and you're thinking about your home and perhaps some of your specialties that you may or may have, is anything that you think would be a great performance improvement project? Is there something here, maybe acute infections and you're working on sepsis? Is there something that also plays into PDPM that you want to make sure you have clear and perfect capabilities for designing a great care plan and really getting to these great goals? Is there something here that is drawing you to a performance

improvement project? Keep that in mind and I'll show you how to start one of those here in just a little bit.

Julie Kueker: I also want to draw your attention to that based on the primary diagnosis for the SNF stay. That primary diagnosis needs to be as accurate as you can possibly get it, which means you need all the information you can get your hands on. If they're coming from the hospital, you need emergency department notes, you need MD notes, you need that discharge summary as soon as possible, you need the medication reconciliation sheet, you need all of this information so you can put in that primary diagnosis that fits the resident for the rest of this journey. Remember, just because what the ICD10 primary code was for the hospital may or may not be your primary diagnosis. You need to really get your hands on all this great information. PDPM will fit them into these 10 categories. Kind of keep those in mind as we're going along our journey here today.

Julie Kueker: Now, once you have those clinical categories, you'll see them there on the left. Those are those 10. From that, they will fall into four PT or OT clinical categories. As you can imagine, there's joint replacement, there is acute neurologic. There is those categories that's coming out that will be in for PT or OT. There's also a nice lump there of medical management. As you're looking at this and you're thinking for what would be a good performance improvement project, or even if it's not a great that you don't need a formal performance improvement project, you still might want that great review team to review how are we medically managing these cardiovascular or acute infections to make sure you like what you see. At this point you also really need to be engaging with your medical director. He will be helpful and important to you so that you both are on the same of what this primary diagnosis is and is that perfect driver for PDPM.

Julie Kueker: For PT and OT functional score, this information is coming straight from section GG on the MDS. Now, whoever has done coding or whoever does the coding in your facility, you'll notice that these numbers look very familiar. GG0130A1, well that's the section, that's the question coming straight from the MDS. It's that section on self-care. For A, it's asking about the eating. It's asking about the section B. It's oral hygiene. Of the functional items, two are bed mobility, three are transfer. One is eating, one is toileting. One is oral hygiene, and two are walking.

Julie Kueker: RUG used items from G and GG. Whereas PDPM uses all items from GG. This is to advance CMS' goal to standardize patient assessments across care settings. As you're going through this list, think about what might be a great project for your facility. Toilet transfer, for example, or toileting hygiene. I know several of you I have worked with have done that toileting retraining program that has been a great performance improvement project. Mobility, so be thinking about what would work for your facility. What is the best for your needs? These are the GG items for PT and OT.

Julie Kueker: Now keeping those in mind as I go to the nursing slide, you'll notice those kind of look familiar. They kind of look like what was in the PT and OT. You are right. These GG items should look familiar to you. From how you code is where you get your functional score. That does play into how PDPM is calculated. Remember under section G, increasing score means increasing dependence. In section GG, increasing score means increasing independence. I try to put everything together in one slide. The next couple of slides I did my best to put it together. At a glance, we can see how PDPM works.

Julie Kueker: It starts with that component rate. It uses the group case mix score, the component adjustment factor. Then from there, it calculates out to your per diem payment. Now, PT is adjusted based on the function score, so is OT. Your speech path is adjusted based on four different items, which is cognitive level, you're going to do your [inaudible 00:22:00] test. SLP-related comorbidities, they have an acute neurological condition. Or do they have a presence of swallowing disorder or a mechanically altered diet? Now, for nursing, it's adjusted on your function score, do they have depression? What is the restorative surfaces that are required? Then there is that non therapy ancillary adjusted on that comorbidity count. That typically involves your drug therapy.

Julie Kueker: This slide comes right from that CMS webpage that I was telling you about. This is how CMS puts it all together. This is what is used to calculate your rate, that per diem rate that you are going to get for PDPM. Now, there is a lot of free calculators out there. There's a lot of ways to help you educate so you can really understand how to put this together. Simply put on this one slide you can see that there's only three that have that variable per diem adjustment factor, which is PT, OT, and NTA, that non-therapy ancillary. Nursing can be adjusted if you do have that patient with AIDS. Since they're more complex and they require more services, you are going to get an adjustment in that rate. You'll notice all of them do use that case mix index in the calculation of their rate.

Julie Kueker: Now, CMS does have a draft version of this calculator. You can go out there and you can, you would almost use this as a teaching tool. I would, with your MDS coordinators or with your project improvement team so everybody understands how this works. I know it seems complex. It really is pretty simple of plugging in all the pieces to get to that final score. Now, there are several websites that have free PDPM calculators. Maybe your electronic health record, those services have developed a PDPM calculator. However you get to it, whether you download it from the web address that I do have on this slide, I would encourage you to use some kind of calculator tool, not just with the MDS coder but with the team in entirety so that they have an understanding of how this is going to work and what their piece to the puzzle is going to be.

Julie Kueker: Here are some key takeaways for PDPM. As we're focusing on quality so that payment is a per diem rate equal to the sum of the component rates, it is resident characteristic based. It is unique to that resident. There's no more multiple PPS assessments. There's new, concurrent, and group therapy guidelines, and interim payment assessment is now optional once PDPM takes

effect on October 1 of this year. I can't stress enough how correct coding of ICD10, especially that primary diagnosis, is key here. Engage with your medical director now. You might even look at what some of the primary diagnosis you would label. Work with your medical director, make sure everybody's on the same page and has agreement for how this works.

Julie Kueker: Your checklist for PDPM includes all MDS coders and nurses. They need that good training on accurate ICD10 coding and MDS documentation. Download the resources on the CMS PDPM website. There is a free webinar that CMS did that's also on the site that is very well done. Download the slides and listen to the recording. See if you can use that as an educational tool for your team. While I said review the FAQ document, I'll add there go on and download that from time to time, maybe once a month to see if new questions have been added. If you have a question, odds are it's the same question providers have across the country.

Julie Kueker: Right now I want you to practice the new PDPM methodology with the free CMS calculator or if you already have one with your EHR or you have found a free one that you like that's at our, your corporation or facility has paid for one. Whatever that PDPM calculator that you're choosing to use, practice it and use that as a teaching instrument for your entire team so they understand their piece to the puzzle. Review their therapy care plans and scrutinize your admission and discharge policy. If those of you that joined us with our readmission collaborative from January to May, you know that we emphasize over and over that you need to have that quality team with your hospitals.

Julie Kueker: You need to be leading from time to time with those good stakeholders so you understand their needs and they understand your needs. Now is the time to include PDPM in that quality team. Or, if you don't already have one, form one so that they understand you need that great information from them out of the gate. What could be accomplished to get you that discharge summary? That medication reconciliation sheet? What would be involved to get that to you as quickly as possible? You need to form a quality review team with your hospital and other vested stakeholders. Start with QAPI.

Julie Kueker: Now I know a lot of you on the call, QAPI is old hat. I understand that. However, we may have some new folks on the call and, plus, by the final rule, phase three, final implementation of QAPI is this November. I thought it would be worth just a quick look, dust off that policy off the shelf and let's review it a little bit to make sure you still like, it's still relevant, it still meets best practices. Now that QAPI policy in your facility also involves your committee and performance improvement projects. All of that is under the umbrella of QAPI.

Julie Kueker: Now QAPI was meant by CMS to be proactive. It was to advance on the old quality assurance where an error or a problem or a near miss occurred. Then we evaluate it, we look at it, we put solutions in place to hopefully that never happens again. The performance improvement side of things says, "Why do we have to wait until something has happened?" Maybe we can make a change

before anything has happened, something that we realize is high risk or problem prone. Medications, for example. Is there something that we can do to look at things proactively to ensure problems don't occur in the future? For example, I have one nursing home that decided to work on their system processes.

Julie Kueker: What I mean by that is is there something that you put into place to, rather, when you're the first day on the job, the system is in place to help you avoid making an error. What they decided to do is when they did their performance improvement project for pressure ulcers, they realized that turning the course of the busy day, the CNA, turning schedules were a little hard to implement. They made everybody, all the CNAs, everybody, a turning angel. Every two hours, gentile chimes came overhead. No one else knew what it meant but the CNA's new that this was their reminder they were a turning angel. Two hours was up and they knew that they needed to turn those residents who had those skin conditions that required them to do so. That's an example of a system change. Day number one, two, three as a CNA in your facility, I hear those chimes, I know what I'm supposed to do. That's a system change. For us, as your QIO, we can help you develop some of these system changes for your facility as you're on your path to improvement.

Julie Kueker: Now, I've shown this slide in so many webinars but it is really worth repeating, especially if I have some new folks on the webinar. This is a great document. This is a document worth downloading. It discusses quality in great terms. It's perfect for new staff and to help them bring them on the journey of quality. I wanted to make sure to include that web address so you can get to that great QAPI at a glance document. In it, it outlines the elements of what is in your QAPI plan. It needs to have the design and scope, the governance, feedback, data systems and monitoring. Performance improvement projects, we'll dive more into that in just a moment, and systematic analysis and systemic action. All of these are found, and there's even an example document for your QAPI plan that has an outline and a structure.

Julie Kueker: Even though you had to have this in place a couple of years ago for the final rule, I do know that, but it's always worth looking at to make sure is it working the way it is intended? Is there something about our QAPI plan that we could improve? I would encourage you to take this document and compare it to what you currently have to see if there's anything that might need to be tweaking to make that plan just a little bit better.

Julie Kueker: Let's go through just steps that you're going to find in that QAPI document including leadership. Make sure that they're fully engaged. If you have a mission and vision statement, make sure that's reflected. You have a deliberate approach to teamwork and this also includes, this word comes from the final rule as well, that multi-disciplinary team. What we mean by that is as you tackle each project, who is at great fit for that multi-disciplinary team? If you're working on nutrition, would it be the dietary and some of your dietary aids, and your CNAs. Think untraditional and really expand these performance

improvement project team members beyond the typical DON and ADON because you'll get some great input if you do.

Julie Kueker: Now, in this QAPI at a glance document, you'll find a self-assessment. We encourage you to do that for those that participated fully with that on this eleventh statement of work journey with us, the QIO. That should seem very familiar to you because a couple of times throughout our journey here in this learning action that were collaborative, we did ask you to take that self-assessment and use that document on your improvement journey. Step four, identify your organizations guiding principles. While it says develop, at this stage of the game you just need to be reviewing your QAPI plan, make sure it reflects your facility well, make sure it's working all the pieces and parts the way that you would like, and conduct a QAPI awareness campaign. Now this will be ongoing. You may educate your staff yearly or bi yearly. As you know with your new admits, you'll get new family in. They will also need to be aware that you are doing quality activities in your facility. It's a way to infuse that resident and family voice. We have some resources in that regard to help you. Just reach out to us.

Julie Kueker: Develop a strategy for collecting and using data. Now we did a whole webinar on data. Our second webinar in this summer series had to with quality measures. I know it seems a bit scary when we get to this part. Especially when we might suggest to you that you need to do some self-collecting of data, some internal data tracking. We can assist you. We can try to make this as easy as possible. There is data from a variety of sources that you might be able to use for your performance improvement project. It's real important that you do so. You have to know where you begin. You have to know the journey. Are we improving the right way? Then we're using data to set our goals so we know when we finally get there.

Julie Kueker: Identify your gaps and your opportunities. What I mean by that is the first idea maybe out of the gate, say for pressure [alters 00:35:13] for example, we think, "Okay, well the CNA's are not on the turning schedule as they should be." We do implement a systematic plan and it's working. The CNAs are great team members with us on this change. Is or was there other gaps or opportunities for this performance improvement project that could really make it kick it in to high gear and ensure that all our gains are sustained? When you're doing these performance improvement projects, don't necessarily get laser focus on that one or two pieces that you're going to improve. Make sure to look at this project in totality. What are the other gaps? What are other opportunities for improvement? Give them their due.

Julie Kueker: Prioritize these opportunities and charter those performance improvement projects. What we mean by that is are there any that's of a higher risk or put your residents at a higher risk? If so, you might put those to the head of the line to institute. The last three steps for that QAPI plan is you do need to have some performance improvement projects. Now, at the end of our talk, I will show you how we, the QIO, would recommend that you document your performance

improvement project. That's there for your consideration. If you would choose to use those, you're welcome to. We have free resources for you. Some of those do include tools for that root cause analysis to allow you to take that systemic action. I'm also going to add the word sustainability here.

Julie Kueker: Before we leave QAPI, this is the last piece of information I want to make sure for phase three that you understand. Then you need to have an infection control and prevention officer be part of this QAA committee. That was from final, phase three of the final rule that takes at the end of November of this year. Also, I want to point out that you have to have at least five staff members and for the one for your medical director in his or, designee, that cannot be duplicated with another one of the mandated roles. For example, the DON cannot also fill the role for the medical director designee. That needs to be somebody separate.

Julie Kueker: That takes us through our journey of QAPI. We understand how performance improvement projects, that they are important. We're going to marry them with our PDPM. If I were a typical nursing home and I was going through the categories that we listed, I might want to focus on MDS. I might think that would be a very good project to start. As you were looking through the categories, maybe is therapy goals and objective, are they effective? The discharge and admission policies, do you need a joint stakeholder team with your hospital? Do you need to compare with best practices? What areas can the team identify to improve? They may come from section GG on the MDS, mobility, self-care, and ADLS. That's the one we're going to choose for our example here today.

Julie Kueker: Also remember that quality measures that impact PDPM, five star, and value based purchasing are also great one for performance improvement project, readmissions, pressure ulcers, falls, UTI and sepsis, and pain. We have example documents and resources in these categories so make sure to reach out to your QIO to get some of these resources for your team. For that performance improvement project, don't forget to partner with your hospital stakeholders. Form that joint performance improvement team. You need, as well as they're going to need from you, timely transfer of information. From that hospital you need discharge summaries, accurate medication reconciliation documents, those full ED records with the MD notes. What are imaging reports? Did they have an MRI or CT scan that you need the results of? Don't forget about the specialty MD records from that hospital stay. Those are going to be important to you because all of that information is going to play in to what you determine to be the primary diagnosis for admissions that ICD can code which is that huge starting place for PDPM.

Julie Kueker: To start the performance improvement project, we're going to choose the project. For today, for this webinar, we're going to choose ADL. Be proactive in your choice and not just the voice of the administrator or DON. Get that team together. What do they see as the great need in where performance, those opportunities might be for that good performance improvement project. Is

there data to support the need for change? Will it improve the residents' families and staff lives? Also, at this point, is there a way to infuse that resident and family voice? Team members need to be multidisciplinary. Leadership needs to truly be involved and support the project. When you design that project, make sure it has a clear timeline. You have a scope or goals of where you want to be. You're going to charter or start this team. What tools do you need? You may reach out to the QIO and get our input. What plan of action do we want to take to improve and reach our goal, and then have sustainability?

Julie Kueker: Now, for me, if I were doing a performance improvement project, I might start myself either with these tabs. I would have an overview of the need of the project. What are some national guidelines and resources? Is it a toileting retraining program? Are we working on sepsis or preventing falls? Are we wanting to improve our activities of daily living? I would look out for national guidelines. I would reach out to the QIO and I would have that be in my first tab for the binder, that overview. I, then, would have a root cause analysis. I know some think that this is just busy work but there's some really good reasons why you need to do it.

Julie Kueker: With your starting a project and you have your multidisciplinary team all in the same room, and you go around the room and you ask everybody their input, "Why do you think the rates are high?" Whatever the question may be. You capture that. You put it on this one document and you decide as a group this is the one area of focus you're pretty sure is the cause of the problem. You start working in that area. Hard work occurs and you know change has occurred there but, yet, your rate isn't moving. Well, it could be there's other pieces to this puzzle. Rather than starting all the way at the beginning, you're going to pull out this root cause analysis document. You're going to say to the team, "What else did we think it was? What else do we think deserves our focus in this improvement journey so that we can get rates that we're proud of?"

Julie Kueker: You're also goal setting with a timeline because if you do not do that, then you will get there someday and someday never comes because there's fires to put out, there's the family who's upset in your office. There was two admits that happened over the weekend and you didn't get a darn bit of paperwork from the hospital. We always have fires to put out so if we don't hold our own self to this goal setting with the timeline, then despite our best efforts, this performance improvement project could take much longer than intended.

Julie Kueker: We want to have improvement data to show these action steps for improvement, to justify that all of the changes that were made, they did what they were supposed to do and are improvement rates are approaching our goal. We need to have an action plan and sustainability. We'll go through some of the resources that the QIO has for you that you can just implement easily, the goal setting and the root cause analysis. We have a great document for that action plan for improvement.

Julie Kueker: To get started, we really are going to have to understand the data. We need to understand the topic to which we chose. We chose ADLs for this particular webinar. First out of the gate if I were running this committee, I would pull from my facility level, quality measure report, that CASPER report. I'm going to run that. It is going to tell me my rate. It's going to show me where I currently am. From that, we can decide if that indeed is our project and what we want our goal to be. Now, when you pull this document, there are a few of these quality measures that are risk adjusted. If you've ever really studied this document, you'll see that there's a facility observed percent and a facility adjusted percent. Use that facility adjusted percent. That's what eventually makes it out to nursing home compare. That's the one that is risk adjusted.

Julie Kueker: For the example that I have here, I know the fonts pretty small. You'll notice on that long stay, sever, moderate to severe pain, you'll notice that the observed percent is 18 and a half, and the facility adjusted percent is 17.7. There's risk adjustment to just a few of these behind the scenes. That's the one that you'll want to pay attention to. Let's not leave this slide before we talk about that very last column called the comparison group national percentile. If any of those values out there are bolded and starred, and in the example the fictitious sample data that I have here, you'll notice there's a lot of them out there. The pain long stay is high, physical strength is high. There's all kind of opportunities for improvement there. Make sure that those are all given their due for improvement. Make sure is it something that's high risk problem prone? Make sure is there something running off the rails that we need to pay attention to.

Julie Kueker: Now after you run this and we're going to focusing on our ADLs. In this particular example, there's 11 in the numerator. Well, this report does not tell me who those 11 are. I'm going to have to run a second report. That is going to be your resident level quality measure report. I call that the resident roster mix. From here, it will give you your active residents and your discharge residents. For this particular quality measure, we'll pay attention to our active residents, and you'll look on the very last column where it says need by has increased for ADL help, anyone with that X in it, well that's going to give me my resident name. That tells me who my 11 are. From that point I will look at that to see if the care plan could be adjusted. What was going on that perhaps an intervention could be best utilized for the improvement for this resident?

Julie Kueker: I also want to point out before we move off of this slide, the very last column has quality measure counts. If you have a resident where this is high, four, five, six, you might want to highlight that resident and look and make sure that you like what you see, the care is awesome for this particular resident and that there is not an opportunity for improvement. If they're triggering, say for falls or UTIs and behavior affecting others, and they're on an antipsychotic and you can kind of see a pattern once you see that they're triggering for a whole lot of items, that might be warrant for a chart review for you to really make sure, is this care plan need to be adjusted for that particular resident?

Julie Kueker: Now, since we've chosen ADLs, it is really important for us to understand how this quality measure works. I've given you the web address at the very bottom where you can download the technical manual. It has all of your public reported quality measures in this document. I know it looks busy. I know it looks like it would be hard to understand. Once you really look at it, and in parenthesis you'll see something that looks very familiar for anybody who has done MDS coding. For example, residents meet the definition of decreased need of help, or late loss ADLs, bed mobility. I know the font is small but that section there is GO11OA. That's a question right out of the MDS. Depending on how you are answering that question, depends on if this person is in the numerator of this quality measure. That's great information to have. In this project if that was our CASPER and we had 11 residents that was in the ADL quality measure, and I know who they are and I've pulled their chart, I can go right to the MDS and I can figure out why they came in that numerator based on the questions that you see here on this sheet. If I'm answering A1, am I answering zero? How am I answering for that particular question that placed them into the numerator?

Julie Kueker: Now, as with some of the quality measures, this one in particular does have exclusions. This is where accuracy and coding plays a very vital role when it comes to how the data that you're putting in to MDS makes it out into a quality measure, into your five star and value based purchasing and so forth. These are some of the exclusions for this particular quality measure. Now we've decided to get started with our project. We have chosen our team members. For us on this example, we made sure to include front line staff. It just makes sense. They're the ones that are closest to the residents. They are the ones that see them on a daily level. They would be more in tune with these changes and perhaps have a handle as to why. We're going to honor the spirit of the final rule in that we need to infuse resident and family voice in to this performance improvement project. Perhaps there's going to be new tools or new changes. We're going to ask them to be part of that pilot study. We're going to ask them to review, we've created a new pamphlet on quality. We're going to ask them to look at and give us their feedback. Maybe they'll attend a meeting or two where it's appropriate to be part of that quality journey.

Julie Kueker: For our example, we want to make sure residents and family are part of that journey. We're going to include therapy members because that is going to be very important for understanding how we can accomplish our goals and how we can best serve our residents. The pharmacists because we need to know how medication safety plays into this. Other key clinical staff, and I put leadership at the bottom on purpose because most performance improvement projects that knock it out of the park, that do well, those are the ones that are more in the backseat. Not in the front seat. We are empowering our LPNs, and our CNAs, and our therapists. We're empowering them to be part of this journey. If they are and they help to decide the solutions, then those solutions are more easily spread.

Julie Kueker: You're going to gather your baseline data on this initial project because, as we stated, you have to know where you are to know where you're going. For this

particular quality measure for ADLs it is, we're lucky. We can use CASPER reports in that facility level quality indicator report. It responds pretty well to the quarter worth of data. It responds pretty well to improvement. Now some of your quality measures do not. Falls with major injury, for example. That CASPER reports are not going to do a very good job of showing improvement because it looks, look, that period is almost a years' worth of time. You have to know how this quality measure operates. What's the look that period? Is it appropriate to use CASPER and to use that to track improvement? We're going to need our resident rosters therapy mix reports. We're going to need our therapy reports and we're probably going to need to do some chart review just so we get a handle on what these goals are. I know that QAA committee only needs to meet once a quarter, but for these performance improvement projects, consider meeting monthly. I even would say try a sub-committee approach as well.

Julie Kueker: As always, we're going to do the plan, do, study, act. I know that is a common improvement slide that gets thrown at you. It's got some really good reasons as to why. If we are doing improvement and we come across this new tool, maybe a new assessment tool for cognitive impairment. We thought, "Hey, we're going to give this a whirl." If you throw it out there to the entire facility and you mandate everybody to use it for a month and then we're going to come back and see if we like it, it was a spectacular failure. Then the next time that you have another great idea, they're going to think, "Oh, my. This is another... This is just going to be another waste of our time." Plan, do, study, act takes that into account. It does a small sample. We're going to try this just on 10 folks. We're going to see if this assessment is really what we think it is. Is it going to make us streamline? Is it going to make it better? If we find out at just the 10 level that it's a spectacular failure, we have lost a very little time. We had empowered team members who are willing to give it a try, but the facility as a whole were not part of this pilot. We are moving along efficiently in our improvement journey by adopting this plan, do, study, act.

Julie Kueker: Now the root cause, it keeps asking why until you have identified the real causes to the problem. As I stated before, it is an essential piece. It's not just busy work. It allows you to really look at all the different parts. The missing parts and are there any particular holes in the system? All the details to the problem. I would recommend that you do this at one of your team meetings. All staff members have equal input and they're empowered. They really, truly feel part of the team.

Julie Kueker: On the next couple of slides are some examples of what we have to offer. They're free of charge, of course. We can help you utilize them as your QIO. This one is the 5 Why's document. It's pretty simple. You keep asking why until you get to the root causes. This is one of my favorites that may look like it's complicated. It's actually very easy to use where you keep asking why and you just put them in to the particular parts of this exercise whether it's equipment or policies. You can bring this document back out from time to time and see if you have addressed all of the pieces to the puzzle.

Julie Kueker: Root cause analysis question to consider for our project would include do we have a complete picture? Are we capturing the residents' capabilities? What are their therapy goals? These are great questions that we're going to tackle in our quality improvement meeting. Then we're going to set a goal. We do have this example document that's free to download. It comes right out of the QAPI document. It allows you to set your goals and set a timeline. During those meetings of questions for the teams to consider about assessments, is the staff educated? Are we coding correctly, is section GG coding correctly. Have we involved our resident and their family? Great questions. The team to consider as we're planning this project and we're meeting. We're going to ask these questions as we do our journey.

Julie Kueker: Now, the last piece that we're going to do for our performance improvement project is I want to take credit for everything that I have done. What are my action steps to improvement? Well, this particular document is on Word on purpose. While it's that one page you see on your screen, you just keep adding boxes. I have nursing homes that have used this document for their performance improvement projects that lasted for several months. They're on their third or fourth page. You're going to give yourself credit for all your action steps to improve.

Julie Kueker: Now we have completed that journey where we understand the topics of PDPM that play into QAPI. To get ready, we're going to do a performance improvement project so we can be successful by the time we get to October 1. Krista, I know I haven't left a lot of time for questions but have any been submitted?

Krista Davis: Hi, Julie. Yes, we do have a few questions in the Q&A box. As Julie said, we only have a few minutes left but if you do have a question, we invite you to type it in now. If we don't have time to actually read your question now, we'll address it via email at a later date. Julie, the first question that we have is: please define or clarify, "Medical management." Also, if a resident cannot physically or cognitively participate in therapy, can they be skilled for medical management disease processes only without receiving any therapy?

Julie Kueker: Well, when you go through your PDPM calculator, what is the free one from CMS? Or it's the one who hooked into your EHR. That's a very complex and great question. It really is going to depend upon how you are plugging in that PDPM, those pieces, on whether they're going to fall into the medical management or how those goals and those therapies of how they're going to plug into that. A lot of those questions are going to be answered. If you play around with that CMS, PDPM calculator, a lot of those questions are going to be answered for you.

Krista Davis: Thank you. We have no further questions. Although I will say for those that are asking for copies of the slide, if you did not receive them earlier when I sent them out around lunch time, please be aware, again, that we will be posting copies of the slide and this recording to our website on the archived event page

probably within the next three or four business days. Julie, at that, I will turn it back over to you for closing remarks.

Julie Kueker: Thank you very much, Krista. Thank you everyone for participating with us on this eleventh statement of work, learning, action, network, collaborative journey. In the next few months we are going to start with our 12th statement of work and we're very excited about that. Make sure to always pay attention to that inbox. As soon as everything kicks off with CMS, you will be invited to be part of the next collaborative in this free journey where you'd get free technical assistance. In the meantime, reach out to us for any of your questions or needs and we'll be happy to help. Thank you to everyone.

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