Disclosure of Commercial Interests

List the Name of Your Employer:
-Executive Director
-The Alliance Training Center
-Providing Solutions in Health Care

If consultant for organizations, only list the names of the companies for which you consult.

- MedPass
- eHealth Data Solutions
- Domtar
- Encore Rehab

DATA ACCURACY – A KEY FACTOR FOR SUCCESSFUL OPERATIONS

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Objectives

- Identify for the NH Administrators the structure and requirements for the MDS 3.0 assessment process.
- Review the HIPPA issues and the privacy Act statement requirements
- Discuss the impact of the definitions and structure in the RAI manual on the overall compliance of the facility.
- Describe the most recent changes to the sections for the MDS assessments and new assessment documents
- Identify the implications for nursing home administrators related to payment and regulatory changes.

Data Issues Primary Topic in 2017

- Many changes to data base content.
- New integration of data from various sources and data feeds.
- Federal agencies utilizing more analytics.
- Regulatory oversight of primary data base content and process. New Survey
- Increased data impact on Q.M.
- 5 – Star rankings are public information.
- Nursing Home Compare – Expanded QM

View from 40,000 Feet!

- What does your facility data base say?
- How many data bases do you create?
- How is the data base content changing in 2017?
- What new data is being utilized?

What does your facility data base say?

- Do you look at your data base specifics?
- Is the data base accurate?
- Provides CMS & other agencies a picture of elders and facility services.
- Who is responsible for accuracy and compliance with federal rules?
- Could your MDS data base content increase risk of audits or oversight?

How many Data Bases Do you Create?

- MDS Data Base – Facility & Elder Specific (claims)
- Quality Measures Data Base – 3 QM data bases
- PPS Data Base – PEPPER Reports
- Case Mix Data Base – State Specific
- Billing Data Base – Claims Analytics
- Data tracking elders between service providers – Elder Specific data base – Cost per episode of Care

Creating an Accurate Facility Data Base

- Know the rules-
  - *Federal regulations*
  - *Policy issues*
  - *Manuals that direct data base content.*
  - *Agencies involved*

Delegation of responsibility for data base content.
Training and support documents
Policy and procedure development related to compliance.

Monitoring Data

- Know content & Use Payment VS. Non-Payment items Q.M. triggers
- Audits – tracking data
- Audits – accuracy of data
- Data base integration
- Changes in data base content – October 2017

Begin with an Honest Review

- Do not be afraid to do an audit or evaluation.
- Know the rules and resource materials
- Look at training and performance in MDS office and Billing Department
- Know where data reports from CMS are available - CASPER

Data Issues 2017

- Outcome data on MDS in October 2016 "Section GG" for P.P.S. Assessments.
- New Quality Measures impacting 5 Star Ratings since 2016
  - *New data used for independent movement and functional improvements.*

Renewed audit focus on Therapy RUG and ADL scores.

Use of claims data with MDS data for re-hospitilizations and Emergency Department visits.

- *Public reporting of PBJ data – November 1, 2017*

Risk Issues

- CMS is looking for functional outcomes of therapy cases after October 2016.
- 5 – Star Quality Measures – new data – new liability – July 2016
- Regulatory outcomes for MDS Accuracy Survey. New Survey Protocol
- MDS Office staff without current RAI Manual and CMS policy updates.
- Coding accuracy of payment related items – therapy and ADL's. Very significant risk here!

FOCUS OF GOVERNMENTAL AGENCIES

- COMPLIANCE – LINK POLICIES AND PROCESSES TO THE COVERAGE GUIDELINES
- REGULATORY STRUCTURE OF FEDERAL AND STATE PROGRAMS – MEDICARE AND MEDICAID
- NEW SURVEY PROTOCOL ON MDS ACCURACY – FITS INTO THE CURRENT CMS FOCUS AND NEW REGULATIONS.
- PAYMENT – WHAT ARE YOU BEING PAID FOR AND THE INTEGRITY OF YOUR SUBSTANIATING DATA AS WELL AS THE BILLING PROCESS?
- NEW ANALYTICS – CMS & GAO REPORTS
- ALL DATA MUST BE SUPPORTED BY THE MEDICAL RECORD.

– *PROVIDERS CAN NOT ELIMINATE ALL RISK BUT NEGATIVE OUTCOMES CAN BE MINIMAL OR ELIMINATED WITH PROACTIVE APPROACHES, TRAINING AND POLICY DEVELOPMENT. THE INDUSTRY IS <u>NOT READY</u> FOR THIS ORGANIZED OVERSIGHT AND MORE AUDITS OF THE DATA BASE AND RELATED DOCUMENTS.*

HIPAA Compliance

- Big Issue
- RAI Manual Chapter 1 page 1-15
- Section 1.8 – Protecting Privacy of the MDS Data
- "The Privacy Act requires by regulation that all individuals whose data are collected and maintained in a federal database must receive notice." RAI manual October 2017 1-15
- "Residents or their Representative must be supplied with a copy of the noticed." RAI Manual October 2016 Page 1-16
- Put updated Privacy Act Statement in Admission packet.

Are You Ready for the Looming MDS 3.0 Changes?

NEW ITEMS FOR THE MDS 3.0 October 2017

- The MDS data set will change in October 2017 with the addition of new items in Section N and Section P
- The new MDS will be version 1.15.0 and will begin use October 1, 2017
- Section N will add 5 new items
- Section P will have a new title and add 7 new items

Section N – New Items

- Item N0410H – Opioid – will be coded with other medications received in the last 7 days
- Item N0450 Antipsychotic Medication Review – item title
- Item N0450A – Did the resident receive antipsychotic medications since admission/entry or reentry or the prior OBRA assessment, whichever is more recent?
  - *Four options for answers*
  - *No*
  - *Yes routine*
  - *Yes PRN*
  - *Yes routine and PRN*

- Item N0450B – Has gradual dose reduction (GDR) been attempted?
- Options No – Yes
- If Yes then go to item N0450C
- Item N0450C – Date of last attempted GDR
- Item N0450D – Physician documented GDR as clinically contraindicated – options yes or no
- Item N0450E – Date physician documented GDR as clinically contraindicated.

Section P – New Items

- Section P - P200 has a new title – Restraints and Alarms
- New item Alarms – Instructions: An alarm is any physical or electronic device that monitors resident movement and alerts the staff when movement is detected
- Item P200A – Bed alarm
- Item P200B - Chair alarm
- Item P200C – Floor mat alarm
- Item P200D – Motion sensor alarm
- Item P200E – Wander /elopement alarm
- Item P200F – Other alarm

- The corresponding definitions for the various types of alarms listed on the assessment and are in the RAI Manual P-9 to P-10.
- The entire team must focus on alarm use and proper documentation as well as evaluation of the utility of the alarm and alternatives.
- Alarms that are also restraints need to be coded in both sections.
- The content of the MDS 3.0 will change as of that date as well.

RAI Manual Update is much larger than the New Items

- Changes to Chapter 1, 2, 4 and6
- Chapter 3 Changes in Sections A, G, GG, H, I, J, L, M, N, O, P and Q
- The largest changes in Section GG and M.
- Many coding Tips and new criteria in definitions
- RAI Manual replacement pages – large
- Because of page# changes
- Track changes document very helpful for all content changes

■Check with your software vendor about systems update and check that new items are present

RAI Manual Chapter 2 Changes

- All RAI Documents will now be specified by CMS not the states.
- States can still add optional Section S items
- Clinical records related to the MDS process includes
  - *All MDs records*
  - *CAA summary*
  - *Quality Assessments*
  - *Identification Information*
  - *Entry and Discharge tracking*
  - *Correction Requests*
  - *Signed Attestations*

RAI Manual
Chapter 2 Changes cont'd

- "Comprehensive care Plan must be prepared by an interdisciplinary team that includes but is not limited to the attending physician, a registered nurse with responsibility for the resident, a nurse aide with responsibility for the resident, a member of food and nutrition staff or professionals in disciplines as determined by the resident's needs or as requested by the resident."
- Use of the word "Major" to describe improvement or decline related to significant change
- Added items to list of declines
- Definition of significant error
- Requirements for baseline Care Plan after each regular assessment

Operational Issues

- MDS Manager needs to adapt or change the MDS policy and procedure document to reflect the changes
- Baseline Care Plan development must meet new regulatory guidelines
- Communication of Changes with the IDT
- Review all regulatory tags related to Care Planning and confirm compliance.

Section G Functional Status

- Clarification of coding when using a mechanical lift
- New ADL Self performance algorithm page G-8
- Clarification of Rule of 3 page G-24 – Use of Supervision code
- Coding instructions when using lifts and transfers for toileting
- Operational Issues:
  - *Education with caregivers*
  - *Changing forms and formats*
  - *Orientation issues*

Section GG Functional Abilities and Goals

- Steps for Assessment reprint of already released Section GG rules
- Clarification of onset of therapy during first three days of stay
- Admission and Discharge performance coding page GG-5 and GG-19 & GG-21
- Discharge assessment collects data from the day of discharge and the two days prior
- Definition of "effort" page GG-5 and GG-21
- Discharge Goals – at least 1 goal
- Definition of a "Helper" Page GG -19

Section GG Functional Abilities and Goals cont'd

- Item GG0130 – Self Care – Coding of Goals and use of dashes page GG-6 & GG-7
- Documentation of GG data in the Medicaid record – Important!
- Admission coding should reflect persons baseline admission functional status page GG-19
- Discharge Goals Coding tips – page GG-14 – include consideration of discharge planning goals – anticipated length of stay & treatments and resident motivation – Utilization Review
- Use of the wheelchair – page GG-34 page GG-38 & GG-39 additional guidance "Use of wheelchair for self mobilization: rather than wheelchair for all uses – just transportation."

Operational Issues:

- Communication with MDS and therapy
- Accuracy on Section GG is very important for overall compliance
- Identification of Discharge goals, length of stay and resident motivation
- Implement data collection tools for GG substantiation on Admission and Discharge

Section H Bladder and Bowel

- Self Catheterizations coded as intermittent (H01000)

Section I Active Diagnosis

- Use of the Z code – new ICD-10 coding guidance web site
- New criteria for U.T.I. coding
- Diagnosis of U.T.I.
- Use of Evidence – based criteria McGeer, NHSN or Loeb
- Reference to Infection Prevention and Control Program regulation. Page I-9
- Review all criteria and select which one the facility will use – Establish policy for U.T.I. determination page I-8 & I-9

Operational Issues

- Complete change in U.T.I. criteria
- MDS manager needs to establish a policy for U.T.I. documentation to be used after October 1, 2017
- Medical director and attending physicians must have information about criteria
- Increase team focus on Quality Measure statistics

Section J Health Conditions

- Addition to falls definition page J-27 "Challenging resident's balance during supervised therapeutic interventions"

Section L Oral/Dental Status

- New definition of edentulous page L-1
- Coding of partial tooth loss page L-3
- Handling of dentures page L-3

Section M Skin Condition

- Significant changes – 2016 Manual was 52 pages 2017 manual is 54 pages
- Coding of Mucosal ulcers
- Coding ulcers for residents with diabetes page M-5 & M-6
- Unstageable on admission page M-7
- Definition – Stage 3 Pressure Ulcer
- New word for obesity – Adiposity
- MASDs are not coded as pressure ulcers

Section M Skin Condition cont'd

- Example for worsened pressure ulcers page M-14, M-27, M-28
- Coding open lesions – exemptions page M-36

Operational Issues:

- Clinical staff needs to understand the proper definition of pressure ulcers
- Specific guidance for worsening pressure ulcers needs to be understood by clinical & caregiving staff
- Documentation in the medical record must match coding on the MDS

Section N Medications

- New item Opioid – N0410 page N-7
- Therapeutic Categories – page N-7 and N-8
- New web reference for psychoactive medications
  - *http://www.psychiatry.org/psychiatrists/practice/dsm*
- N0450 – Antipsychotic Medication Review page N-11 to N -13
- Coding tips & documentation page N-13

Section O Special Treatments, Procedures, and Programs

- 2007 Guideline for Isolation Precautions
- Clarification of vaccine administration page O-13
- Respiratory Therapy Coding and definition
- Expansion of who can write orders dependent on State laws page O-45

Operational Issues

- Use the CDC guidelines for coding 00100-M
- Focus on Respiratory Therapy – documentation and qualifications of professionals
- Policy development for signing orders - Important

Section P Restraints and Alarms

- Regulatory references updated for restraint use page P-1 and P-7
- Alarms – new section P-200
- Have manufactures instructions for all alarms
- Definitions
- Steps for assessment page P-9
- Coding types page P-9 & P-10

Section Q Participation in Assessment and Goal Setting

- Updates are focused on resident empowerment – see Intent statement page Q-1
- Discharge planning team must be aware of changes
- The residents overall expectations are central to coding item Q0300. New coding tips related to civil rights page Q-5
- Expansion of LCA – Local contact agency page Q-10
- Item Q0500 is documented on page Q-15 – Steps for the assessment – changes to steps 2-3-4-5. New content clarifies the purpose of the assessment.
- Definition – designated local contact agency updated with case example page Q-21

Chapter 4

- Many regulatory references
- Discussion of care plan development and odds to the content of the care plan page 4-10 bullet point 7 "reflects the resident's/resident representative's input, goals and desired outcomes."
- Overall care plan should be oriented towards: (3 new bullet points and additions to #13 & #14. Eliminates #6 and #15 from previous manual) Chapter 4 page 4-10 & 4-11
- CAA tips and clarifications items 6 & 7 are new page 4-12
- Suggest all members of the IDT read and discuss Chapter 4 to make sure Care Planning process is compliant with new updates

Appendix A

- Definition of Respiratory Therapists, Respiratory Nurse Appendix A page A-19
- Very important- changes nebulizer treatments

Impact of Definitions and Structure of RAI Manual as they impact Compliance & Impact

- MDS data base becoming the basis for outcome determination
- C.M.S. uses definitions in key decisions about payment and outcome
- Key issues to determine outcomes
  - *BIMS*
  - *Mood Score*
  - *A.D.L. Score*
  - *Diagnosis*
  - *Measurable items - (i.e. test for balance)*

So What about R.C.S. - I

- New Part A Medicare payment system
- Total change in Criteria
- Focus on Cognitive Performance & Mood
- ADL Score
- Primary Diagnosis – combined with ADL Score
- Limited Diagnosis categories
- PT/OT Separate from ST

PART A MEDICARE

- What document tells you the federal rules and coverage guidelines for Part A Medicare?
- Who needs to have the specific guidelines for admission, coverage of services, documentation, and certification?
- MEDICARE BENEFIT POLICY MANUAL – CHAPTER 8 is the reference – the only reference – Who has copies and knows content?
- All claims denials and audit denials need to be justified from this document – have been for many years.
- WHO HAS THIS DOCUMENT IN YOUR CORPORATE COMPLIANCE OFFICE AND ON SITE IN THE FACILITIES WHERE ADMISSION AND COVERAGE DECISIONS ARE MADE?
- YOU MUST DOCUMENT THAT ADMISSIONS & SERVICES ARE COVERED

- USE THE MEDICARE BENEFIT POLICY MANUAL (CHAPTER 8)FOR ORIENTATION, INSERVICES, DOCUMENTAITON GUIDELINES AND COVERAGE DECISIONS.
- DOCUMENT THE SECTIONS OF CHAPTER 8 IN YOUR DOCUMENTATION NOTES AND UTILIZATION MINUTES TO CONFIRM COVERAGE.

COMPLIANCE AUDITS – ESSENTIAL

- ARE YOU ACTIVE WITH AUDITS :
  - *ADMISSION CRITERIA – DOCUMENTATION IN THE CHART – WHY WAS THIS PERSON ADMITTED UNDER Part A?*
  - *Admission primary diagnosis – very important – MDS & Billing – MUST MATCH!*
  - *Certification documents – signed and dated on time – original documents must be available if outside audit is done. No cert no payment.*
  - *Treatment records, orders and documentation of interventions for skilled nursing or skilled therapy – specific documentation – resident specific plans & interventions are required.*
  - *Outcomes and documentation of changes in coverage.*
  - *This is the facility responsibility – not the therapy contractor – The facility owns the record.*
  - *Document the audits and outcomes as well as actions to improve compliance.*
  - *When a contractor changes - where are the records?*

WHO IS RESPONSIBLE FOR: (Be Specific)

- *THE MDS CODING AND ACCURACY IN THE FACILITIES?*
- *TRAINING?*
- *AUDITS?*
- *DATA BASE ACCURACY FOR INTERNAL AND EXTERNAL REVIEW?*
- *INTERNAL ANALYTICS – YOU LOOK AT YOUR DATA!*

WHERE TO BEGIN ?????????

- AN HONEST ASSESSMENT OF THE CURRENT DATA COLLECTION PROCESS IS ESSENTIAL
- INCLUDES CURRENT MANUALS AND REGULATORY MATERIALS
- A WRITTEN REPRESENTATION OF THE FLOW OF THE DATA – WHO FILLS OUT THE SECTIONS OF THE DATA SET .
- THE ASSESSMENT PROCESS IS THE RESPONSIBILITY OF THE ADMINISTRATOR OF THE FACILITY – " THE FACILITY MUST....."
- THE ADMINISTRATOR WILL BE ASKED QUESTIONS DURING THE SURVEY – THEY NEED TO BE READY AND AWARE OF THE PROCESS IN THE FACILITY.
- WHAT ARE THE REQUIREMENTS IN THE PROCESS?
- WHO IS THE R.N. ASSESSMENT COORDINATOR? – THIS IS REQUIRED FOR EACH FACILITY.

- THE LAST MANUAL UPDATE IS OCTOBER 2017 – RELEASED AUGUST 31, 2017
- MDS DATA MUST BE LOGICAL. RESIDENT GETTING INSULIN BUT DOES NOT HAVE A DIABETES DIAGNOSIS ON THE MDS.
- THIS IS A VERY DETAILED TECHNICAL DOCUMENT – USE OF ANALYTICS IS VERY HELPFUL AND CAN BE SAVE MANY PROBLEMS WITH DATA ERRORS.
- MDS IS THE FOUNDATION FOR PAYMENT – MEDICARE, MEDICAID IN CASE MIX STATES, INSURANCE
- MDS CREATES THE QUALITY MEASURES – 5 STAR AND SURVEY ACTIVITY – BE CAREFUL
- CREATES THE CARE PLAN FOR THE RESIDENT
- CREATES THE DEMOGRAPHICS FOR FEDERAL REPORTS ABOUT THE FACILITY, PEPPER AND CASPER REPORTS AND INTERNAL CMS DATA ABOUT YOUR FACILITY.

Facility Assessment - Administration Basis in Law

- Governing Law – Section 1919 [42 U.S.C. 1396r] – **(d) (1)(A)**
  - *IN GENERAL.—A nursing facility must be administered in a manner that enables it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident (consistent with requirements established under subsection (f)(5)).*

Administration

Facility Assessment – Here is the Question!

- Can an operator show residents attain or maintain the highest practicable physical, mental, and psychosocial well-being each and everyday ?
  - *What is needed to demonstrate needs are met?*
- Can an operator demonstrate their nursing facility uses its resources effectively and efficiently?

***Person-centered care*.**

- *For purposes of this subpart, person-centered care means*
  - *focus on the resident as the locus of control*
  - *support the resident in making their own choices*
  - *support the resident as having control over their daily lives.*
  - *§483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility.*

From the Federal Register

- *We require facilities to conduct, document, and annually review a facility-wide assessment to determine what resources are necessary to care for its residents competently during both day-to-day operations and emergencies. Facilities are required to* ***address in the facility assessment the facility's resident population (that is, number of residents, overall types of care and staff competencies required by the residents, and cultural aspects)****, resources (for example, equipment, and overall personnel), and a facility-based and community-based risk assessment.*
- *https://www.federalregister.gov/documents/2016/10/04/2016-23503/medicare-and-medicaid-programs-reform-of-requirements-for-long-term-care-facilities#h-30*

What do we now?

- Establish Administrative leadership
- Plan with your team
- Training and education will all interdisciplinary team members
- Document competency of Clinical and Care giving staff
- Have all members of DIT read Chapter 4 of the RAI Manual
- Focus on CAA documentation
- Review details in update of Section Q and reflect contact with the resident in the medical record to prove compliance

Link to CMS Website

https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/NursingHomeQualityInits/MDS30RAIManual.html

ANALYTICS

- ARE VERY HELPFUL
- CAN LOOK AT ALL SEGMENTS OF THE DATA
- ADDITIONAL RISK MANAGEMENT DATA CAN TRACK FALLS, SKIN AND OTHER CLINICAL AND OUTCOME RISK AREAS
- REHOSPITALIZATIONS CAN BE TRACKED AND EVALUATED
- MDS AND BILLING DOCUMENTS CAN BE SCRUBBED PRIOR TO TRANSMISSION TO ELIMINATE ERRORS
- ANALYSIS OF ALL ASPECTS OF THE CARE PROCESS CAN ASSIST STAFF TO EVALUATE OUTCOMES AN PATTERNS OF CARE

Quality Measures October 2017

- Very confusing because of different data base measures.
- 24 Measures on Nursing Home Compare
  - *9 Short Stay – 15 Long Stay*
- Casper – 17 Quality Measures
  - *3 Short Stay – 14 Long Stay*
- CMS list of Quality Measures – 18 Measures
  - *5 Short Stay – 13 Long Stay*

New Survey Protocols related to Data Formulation & Accuracy

- Resident Assessment Critical Element Pathway
- Specialized Rehabilitative or Restorative Services Critical Element Pathway
- Urinary Catheter or urinary Tract Infection Critical Element Pathway

What is 5-Star Quality Rating?

What do the stars mean?

Rating system as an easy way for ***residents, patients and families to understand***:

- assessment of nursing home performance, and
- making meaningful distinctions between high and low performing nursing homes.

Why do Stars matter?

- Statement of Reputation to and for our Community, Stakeholders and the Public
- Be an "Approved SNF" for ACOs and Bundled Payments
  - *An approved SNF can participate with a Next Generation ACO*
    - has an overall rating of three or more stars under the CMS 5-Star Nursing Home Quality Rating System
- Stars are evaluated to set interest rates for mortgage and capital.
  - *Lower Stars*
    - questionable eligibility for financing
    - If eligible – higher interest rates and costs
  - *Higher Stars = more preferred for lending, lower costs, better rates*
- Insurance Companies use SNF Stars to set rates
- Liability Attorneys use 5-Star to support allegations of poor care

Overall Nursing Home Star Rating Methodology

- Overall nursing home rating is assigned in five steps:
  - ***Step 1:*** *Start with the health inspection star rating*
  - ***Step 2:***
    - Add one star to the Step 1 result <u>if</u> staffing rating is 4 or 5 stars <u>and</u> greater than the Survey Star rating;
    - Subtract one star if staffing rating is 1-star.

Overall Nursing Home Star Rating Methodology

- ***Step 3:***
  - Add one star to Step 2 result if the quality measure rating is 5-Star;
  - Subtract one star if quality measure rating is 1-Star.
- ***Step 4: If the Health Inspection rating is 1-Star, then:***
  - The Overall Rating cannot be upgraded by more than one star based on the staffing and quality measure ratings
  - Note – 1 Star Survey = Max 2 Overall Stars

Overall Nursing Home Star Rating Methodology

- ***Step 5: If the nursing home is a Special Focus Facility (SFF) that has not graduated, the maximum overall quality rating is 3-star***
  - 12 months after SFF graduation a facility's stars may go above 3

- The Overall Rating cannot be more than five stars or less than one star

With a 5-Star Health Survey the Math stops unless

- Overall Stars is 5 unless:

1 star subtracted for "1" star Quality Measure rating

OR

1 star subtracted for "1" star Total Staff rating

Note: CMS did not remove an Overall Star where the Quality Measures are not available

Question for today's participants –

What is the key lesson on this slide?

Three approaches to attain 5

Approach 1 to improve Stars – Better Survey

- Mastery of the CMS Survey and Certification rules and processes

Approach 2 to improve Stars – 5-Star Quality

- Deliver MDS Assessment, Care Plans and Care to attend to and produce 5-Star Quality and gain the Bonus Star

Approach 3 to improve Staff capability and sufficiency

- Work to have a minimum of 3-Star or "Average" Staffing – Note that a 3-Star Survey plus 4 Star Staffing yields a bonus 4 Overall Star Status.

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Approach # 1

Mastery of CMS Survey &Certification Process and Requirements

- Means nursing center managers and staff bring
  - *action, work and creativity and energy so that the services promised by entitlements (Medicare and Medicaid) are delivered as a result of the policies and practices of the nursing center.*
- Means Comprehensive knowledge or skill in a particular subject or activity
  - *The action of mastering a subject or skill*
    - Oxford English Dictionary
- **Definition of MASTERY**
- ***1a*** **:** the authority of a master ***b*** **:** the upper hand in a contest or competition **:** SUPERIORITY, ASCENDANCY
- ***2a*** **:** possession or display of great skill or technique ***b*** **:** skill or knowledge that makes one master of a subject
  - *Merriam Webster Dictionary*

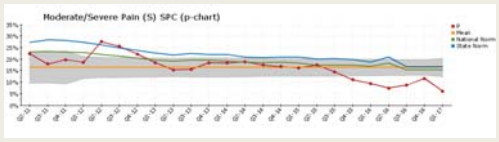
ROP Central Survey & Certification Themes Challenging the SNF and NF

1) Overarching Theme = Person Centered Care
   - *Strategies – new ways improving*
     - Resident Rights
     - QAPI
     - Facility Assessment
     - Compliance & Ethics
     - Infection Control and Prevention
2) Are we maintaining, achieving what your SNF/NF said we're going to do? (M&M Provider Agreement)
3) Pro-action – Right Care …
   - *Reduce our SNF Deficiency risk level?*

Questions to lead to steps to improve Quality Stars

- MDS Process – Does the Care Plan match the MDS?
  - *Examples:*
    - 30 Day look back for UTI
    - Use of Catheters?
    - Pain
- Are the Claim QM Covariates appropriately captured?
  - *This is the "one" chance to assure accurate consideration in the Medicare "administrative claims"*
- Is our QAPI process driven by data or preference?
- Is the Care Plan process reviewing individual resident progress on each of the Quality Measures over at least the past 15 months?
- Have we applied lean statistical process control thinking or "six sigma" to measure and monitor our quality?

Can we improve our QMs to 5-Star? System-wide example: Pain



- Challenge: Address Short Stay Pain results and apply QAPI
- Solution: Pain Committee reviewed and implemented xyz
- Change or "SHIFT" from special cause poor to special cause good means the QAPI PIP was successful and is sustained!

Are there any stumbling blocks?

Biggest ongoing challenge?

Getting the front line staff to realize the benefits of the tools, reinforcing that Unit managers must spend the time to:

- Dive into the resident history
- Make the most of the analytics tools
- Getting past the numbers and seeing the residents

Competitive advantage – 5 Star Quality

- Preferred Provider status
- Using data to earn a seat at the table
- Using data to KEEP it

5 Things I Need to Do:

1.
2.
3.
4.
5.