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**Advancing Excellence in America’s Nursing Home Campaign**

Presented by Carol Benner 90 Minute Webinar 05-10-2012

Kristi Wergin:
Hello everyone, this is Kristi Wergin with Stratis Health, the Quality Improvement Organization in Minnesota. I would like to welcome you to this educational session entitled Advancing Excellence in America’s Nursing Home Campaign. This session is being offered to nursing homes in Minnesota, Alaska, Hawaii, Kansas, Montana, Nebraska, New Mexico, Nevada, South Dakota, Utah and Wyoming.

The QIOs in these states work together to provide educational sessions for participating providers, as a national quality improvement effort to improve individual resident care in nursing homes. Due to the high volume on this call, all lines will be muted during the webinar; however, after the presentation we will have a time for questions and answers, so make note of any questions that may come up as you listen to the presentation.

We’re thrilled and it’s a pleasure to bring you the session today and to have Carol Benner as our speaker. Carol joined the Advancing Excellence in America’s Nursing Home Campaign in 2007, after a long career in long-term care and quality improvement. She currently serves as the campaign’s national director. She works with 50 statewide coalitions to bring together more than 54% of all nursing homes in the country to implement quality improvement and make nursing homes better places to live, work, and visit.

Welcome Carol, and thank you for being with us today. I’ll now turn the presentation over to you.

Carol Benner:
Thank you, Kristi, and everyone who’s joining us on this call. It’s amazing how you can pull together folks from all over the nation on a Thursday afternoon to talk about quality improvement. What I want to do this afternoon is talk about three different areas.
First, the science of change and improvement and what QAPI (quality assurance performance improvement) is all about.

Second, the new Federal program that’s rolling out in a year called QAPI, and

Third, I’ll talk about how you can use the campaign to help with your QAPI programs.

As Kristi stated, I’m with the Advancing Excellence in America’s Nursing Home Campaign which is really all about improvement. I want to mention at the outset, that I used to be a state survey agency director and the one thing that really struck me while I had that job was how focused everyone is on survey, and how people literally live from survey to survey in nursing homes.

I was really struck when nursing home administrators were on vacation and they would come back when a survey was going on in their building. That is really sad to me because what we have to do is get away from living survey to survey and start thinking and talking about quality improvement and trying to change the dynamic in the nursing home so that everybody is focused on improvement. Let me say at the outset that that means everybody, including the surveyors and the press. For me it’s all about improvement.

I mentioned QAPI, sometimes it’s called ‘quapi’, CMS prefers that it’s called QAPI which means Quality Assurance Performance Improvement. QAPI is coming and is part of a Federal program that will be rolled out at the end of 2012 or in the beginning of 2013. There are five different elements to a QAPI program.

Design and scope; program or QAPI plan
Governance and leadership
Feedback, data systems and monitoring
Performance improvement projects (what I’m most interested in- sometimes these are called PIPs)
Systematic analysis and systemic actions

Those are the words that CMS uses and hopefully, by the end of this next 90 minutes you’ll be able to explain what those mean a little better. QAPI comes from the Affordable Care Act. It’s actually Section 6102 in the thousand-page Obama Care Bill and it requires CMS to strengthen quality assurance requirements in nursing homes.

Right now everyone is required to do quality assurance, but those regulations have really been in place for over 15 years and they haven’t been updated. What’s new and one thing required in the Affordable Care Act is that CMS must provide technical assistance to nursing homes, in order to meet the new requirement, which is unusual to hear that CMS is going to help you meet the requirement.
The law required implementation by December 31, 2011 and the first thing you’re thinking is oh my goodness, we’re already passed that deadline. CMS is doing something differently than they’ve done in the past. Usually a law will be passed and CMS will write the regulations and then implement those regulations right away. This time around what CMS is doing is trying to figure out what the program should look like and they’re actually doing a demonstration project in four states.

Then, after they figure out how the program should be implemented they’re going to write the regulations. So it’s a total flip-flop of how CMS usually acts. What we do know though, is that after implementation the QAPI plans, every nursing home will have to write a QAPI plan and it will have to be submitted to HHS. When the law says something has to be submitted to HHS, that means it has to be submitted to CMS, which means it will have to then be submitted to the state survey agency. We expect that at least one year later it’s going to be either, at the very end of 2012 or at the beginning of 2013.

So, QAPI is coming and what we can say about it is that CMS is kicking it up a notch and not letting go of quality assurance, and I’ll explain the difference between QA and PI, but they are adding performance improvement which is why we have QAPI.

Why is nursing home QAPI important? It’s the right thing to do. The Affordable Care Act is going to require it and also with the shift to MDS 3.0 and the change in the quality measures, nursing homes are more accountable than ever for quality. So we’re talking about something that’s really transformative in the nursing home and something that hopefully will improve care.

The next slide shows all the things we frequently call ‘flavor of the month’. You’ve all been through this where we talked about QI, PI, quality control or TQM, RN, QANA and you may be thinking that QAPI is just another one of these things, but it really isn’t. This is huge what’s about to happen. It’s transformative and it will be hard work. That’s why we’re out here trying to get the message out to everybody, so that you can begin to prepare in your nursing homes.

The next slide explains the difference between quality assurance and performance improvement. Quality assurance is a reactive process that’s usually based on an organizational mistake, something happened in the nursing home and what I’ve heard, and I’m sure will resonate with you, is that lots of times we’re going to QA that. Somebody falls and breaks a hip, maybe because of an inappropriate transfer, oh we’re going to QA that or we did QA that.

The whole purpose is to look at the episode or incident and try to prevent it from happening it again. Oftentimes, the information that we have about the incident is anecdotal. It’s usually always retrospected, meaning we look back in time to figure
out what happened and we do audits. If somebody fell and broke a hip, we might say okay we’re going to look at all the falls in the last two months.

Then unfortunately, QA is frequently punitive, that instead of really using the incident and what happened as an opportunity for learning, somebody may get fired because of it or it’s looked on as a bad thing and we tend to blame.

Performance improvement on the other hand, is a very different kind of process. It’s proactive in nature, looks at aggregate data and organizational processes, like how we do things. It improves overall performance, so it’s not looking at something that’s happened and trying to fix that one little incident, it’s trying to look at a bigger picture and improve overall performance. It’s almost always measurable. It happens in real time and it’s continuous, you know, you look at something as it occurs in real time and it’s looked at positively, something that we should all be proud of.

An example of quality assurance is a resident who is confined to bed suddenly has a broken leg and nobody knows how. And what we hear in the nursing home is, we’re going to QA that or, somebody in the nursing home gains 10 pounds in two weeks and what we hear is we’re going to QA that, where QA has almost become a verb.

An example of performance improvement, on the other hand, here is an aim statement, where you look at your pressure ulcer rate and say wow, our rate is 13% or its 2% above the national average and then what we say is, let’s improve our performance by 2% in the next 12 months, so this isn’t geared to an individual resident like QA is, its much more geared towards data or as a population and it says we’re going to fix something by X amount in some period of time.

So that’s the difference between QA where an instance occurred and you’re going to look at the incident and figure out how to prevent it from ever happening again, to looking at an overall issue that you want to improve. And it could be that your pressure ulcer rate is 2% below the national average and what you want is to make it even better. Therefore, it’s not based on the negative it’s based on positive.

Here’s an example of performance improvement with consistent assignment and you can use performance improvement across the board with just about anything. Here in this example we would say, our family’s like consistent but wish we could do it better. Right now the residents on two units have no more than 10 CNAs per week working with them and we want to get that down to 8. So here’s a good example of an organizational process that you can fit into performance improvement.

So QAPI techniques are pretty similar to what you have been doing in part of your work, but it’s a little more organized. What you want to do is identify a meaningful area for improvement and a meaningful area needs something that people care about, so you want to look at something the public is interested in, something that really affects the quality of care and life of your residents.
The first thing you want to do, usually I say is to stand on the scales. You want to benchmark and measure your starting point, so right off the bat we’re going to start to look at data. If you go on a diet to lose weight, the first thing you do is figure out where you are. What is that number? What does the scale say? That’s my starting point.

The next thing you do is decide what your target will be or what improvement you want to make. If you step on the scale you see the God-awful number and then its like, I want to lose 20 pounds. Then you figure out what processes will impact change and this is where that thing called ‘the root cause analysis’ comes into play. You have to look at what the issue is and why your rate or benchmark is where it is.

Like with the weight example, I could be overweight for a lot of reasons. It could be first that I just eat too much or it could be because I'm 65 and people tend to put on pounds as they get older. Maybe it’s a medication someone is taking or lack of exercise or certain surgeries they’ve had that tend to cause people to gain weight. You have to figure out what the root cause is and then after that you need to figure out what your intervention will be, choose the intervention that makes sense then you continue to monitor, which is so very important.

Again, if we’re losing weight we do that all the time. You’ve heard people say oh, I lost 2 pounds last week or in Weight Watchers its like 1 ½ pounds, you’re monitoring and if something isn’t working, if you’re not seeing the improvement that you want over a period of time, then its time to look at your intervention and tweak it a little. Try something new.

The next slide then looks at what we call the IHI (Institute for Healthcare Improvement) and it’s very simple. Three questions…

What do you want to change?

How will you know you were successful?

What do you have to do to make the change happen?

When we talk about QAPI, we talk about improvement and the aforementioned three questions. This is the model for improvement and I won’t go through all of it, but when we talk about change and about improvement, a lot of folks think that change is linear. That you go from point A to point B and that that happens in a straight line, but I think all of us know from our real life experiences that change doesn’t happen that way. You usually go up three steps and back two. Or up one and back two or maybe up five and back two. We call it the change of cyclic which is to go up and back and up and back and you’re constantly monitoring and making tweaks, studying what you’re doing to make it better.
So, for the first slide I would encourage you to look at when you have the time to see a picture of that cyclic change where you can see what we call the PDSA cycle, which is a method of improvement where you’re constantly planning your change, doing your intervention, studying or monitoring and then doing the action of tweaking or changing to get the change you want. Here it is again, these aren’t too technical but you should look at them. There is a lot of information about this on the web.

On the next slide called one is an improvement we have an example of a run chart. When you talk about performance improvement we talk about data and if you have data the most frequently used way to display it is by what’s called a run chart where you plot your points over time. That allows you to see if there are any patterns or trends developing.

In the example you can see the points going up and down and so forth, but what you see overall is a trend of going down. There are all kinds of rules that go along with run charts, like how many points you have to have below the average. Again, it’s all helpful to let you know whether you have a real change going on.

So again reference the three questions listed earlier, to answer those questions, what’s really important is that if you can ask in your nursing home 10 different people the questions and they can all come up and give you the same answer. One thing you want to always be mindful of with performance improvement is that you want to compare apples to apples and not apples to oranges.

In the campaign we talked about a model for change, and I think this is an important model, this triangle where at the very bottom in the nursing home we have the organizational workplace practices. Those are structural components, the building blocks and structural components that you need to have in place for a good PI program. You need to have strong leadership and you need this thing called ‘the just of accountable culture’ which means we’re not going to blame everyone for everything that happens.

You need to have good hiring practices, good orientation, competent staff and ways to ensure that you have competent staff. You also need to have stable staff. We promote the use of consistent assignment, staff engagement and performance improvement and the use of evidence-based care practices. Evidence-based care practices we approve that things have been tried and tested and are true.

So, I’m going backwards a little bit to my triangle, the organizational workplace practices and structural components. The middle part of the triangle is where we have care planning, personal incentive care which are related to processes, what you do everyday to deliver care. Here you can see that we use the MBS and data collection, assessment process and the interdisciplinary team, care planning and have good communication among all your staff members. You use critical thinking
and problem solving techniques and then you do the monitoring to make sure again that what you’re doing is working.

Lastly, you hope that if you’ve got the structure and process in place that the good outcomes for quality of care and of life will follow and you would do both. You would do quality assurance, like those incident reviews and then I think even more importantly, you’re doing performance improvement.

So the signs have changed, follow the scientific method and when you have a scientific method you have a hypothesis and measure. I say that a lot and use the word measure often, because that’s where this is taking us. Again, here’s my weight example if we want to lose weight, we stand on the scale, benchmark, set a goal, figure out why we gained weight, choose the best solution, try it and if it doesn’t work then try something else.

Performance improvement is almost always measurable. It doesn’t look at a single person but at a population or unit. The AIMS, a new performance improvement word you’ll hear a lot, are time specific and measurable. You want to decrease something by some amount, some specific amount by some time, so everything is measurable, dependent on change and then we use the PDSA cycle to test small changes. One thing to remember is that not all change is improvement, but all improvement is change.

The other thing that Dr. Berwick, frequently says is “some is not a number and soon is not a time.” So you can’t say we’re going to reduce pressure ulcers, because that really doesn’t mean anything. You’re going to reduce pressure ulcers by how much and by when? When a friend of mine looked at these slides, she said Carol you really should add one in there which is, hope is not a strategy. Sometimes we hope things will happen and that over time there will be a miracle where we’ll see a decrease in size in pressure ulcers and a list of restraints.

Now, there’s a lot of repetition but I think its important because this is fairly new material. Next is an example of an A statement for a hospital…’we will reduce the days between positive mammography and biopsy to five days before the end of FY 12, so we have a population, unit of measure, time expectation and a goal.

Okay, I’m going to talk now a little about the campaign and if we have time I’ll go online and show you how to use the campaign.

This is the mission of the Advancing Excellence campaign. Usually if I was in a room with people I’d say how many of you know about the campaign? How many of you are members? I can’t really do that over the phone. The campaign has a mission which is very similar to the old, it’s not old, what is old is new…Oprah language where we want to help all of the stakeholders of long-term care and that’s you, to achieve the highest practical level of physical, mental and psychosocial well being for residents receiving long-term care services.
The campaign is the largest national coalition of stakeholders working together to help nursing homes. It’s absolutely voluntary and free of charge for nursing homes. As of today we have 54% of all nursing homes in the country, signed up to be part of the campaign. If you’re not part of the campaign you’re now in the minority and hopefully you’ll get signed up.

The campaign is based on the measurement of meaningful goals and again our definition of meaningful is that people care about the goals. We want you to work on things that people care about. The campaign started in 2006 and was meant to be a two-year campaign, but what happened is it was so successful that the campaign actually incorporated in 2010 and became a non-profit entity. What’s happened over the past five/six years is that we have data now that actually show the campaign works and is successful.

We have a board of directors. We call this the national part of the campaign. They set the goals, develops resources to help you and then it provides support to the LANE. The LANEs is my middle block, are called local area networks of excellence, which is a big word for nothing more than a stakeholder coalition or group of people in a state that care about quality. The usual people who are on a LANE include the Quality Improvement Organization the, for and non-profit provider associations in the state, a representative from the state survey agency and the long-term care ombudsman. Those are the five key people that make up a LANE.

What the LANE does is it provides a neutral space for these people to come together and talk about what’s happening in the state and how they can help you improve quality. So the LANEs over the past couple years have focused on nursing home recruitment into the campaign and they’ve done a dynamite job in getting 54% of all nursing homes enrolled. The LANEs also coordinate the statewide actively. In many of your states you may have had educational programs that were sponsored by the LANEs and isn’t it nice to go to an educational program that is co-sponsored by the provider associations, state survey agencies, the QIO and the ombudsman.

So you have everybody singing the same tune and then the LANEs provide support to the nursing homes. Finally, what the nursing home does is it registers for the campaign and the way you register is to go on the website, choose three goals and set targets for those goals. If you don’t have the bench line data then we will show you how to gather the bench line data and then you set your target.

Then, we have a wide variety of resources to help you, which are absolutely free of charge for you.
The next slide shows all the organizations that currently make up the Advancing Excellence board of directors and it is in alphabetical order, but you can look through it to see we have quite a group of people on our board of directors, including CMS. When I say CMS, they are an equal partner and that includes both the QIO side and the survey and certification side.

That’s important too because again what we’re trying to do here is get everybody in the same room at the same time, talking about quality. We’re trying to help nursing homes. So all of these people and some as you know from your individual states, may not get along together all the time, but what they do in a LANE or at the national board of directors is leave their guns outside the door and come in with the whole goal and focus as seeing how we can work together to improve nursing home quality of care.

So funding for the campaign comes from four different areas.

A number of organizations that contribute money.
CMS also supports the Advancing Excellence website and does data analysis for us.
We received a grant from the commonwealth fund for about half a million a year, and
We have in-kind contributions from many organizations.

Overall it costs about $800,000 a year to maintain this campaign and that is purely voluntary and free for you to use.

What does the campaign do? It provides free practical evidence-based QAPI resources to support PI efforts. We also believe in supporting the front lines of nursing home care and encourage the engagement of front line staff. I’ll show you some tools that we have which are specifically for those front line staff. We also believe that you really need to work with the residents to promote open communication and transparency.

So I’ve said it before, based on meaningful issues we’re aligned with national initiatives. I can just imagine some of you are there thinking, oh my goodness is this another quality initiative, AHCA just came out with a quality initiative or our corporation wants us to do this. There are so many things hitting us at once. What we’ve tried to do is make sure that all the goals from Advancing Excellence are aligned with what’s happening on a national level and the third key element that measurement is key.

This next slide talks about registration, choose three goals or more, identify benchmarks, set targets, use the campaign resources, collect and monitor data and then enter data on the website.
Our working hypothesis is that if you have good organizational workplace practices and good care planning practices, the critical outcomes will follow and the staff, residents and families will be happy. I don’t think anybody would argue with that.

So these are the 8 current goals we have for the campaign.

On the left you see staff turnover and consistent assignment. These are the part of those organizational building blocks and what we want is a stable staff. Turnover in this country right now is about 65-70% for CNAs. The average DON stays in a nursing home 18 months and the same for a nursing home administrator. If you don’t have the administrator and the DON staying, how can you expect the CNAs to stay? And if you don’t have CNAs that stay for long periods, how can you expect them to get to know the residents and deliver good quality care? Its very important that we stabilize our staff and that we try to reduce staff turnover.

We also know if you reduce staff turnover the staff are happier as well as the residents. It’s the same way with consistent assignment. The definition of consistent assignment is that the same person takes care of the same resident every time he/she is in the nursing home. If you think about it, over the course of a week, if you are working on three 8-hour shifts, you could have as many as 21 different pairs of hands touching a resident, which would be 21 different people that are bathing, dressing, feeding, waking, putting to bed, turning and repositioning them and doing all those personal things.

If I had that many people touching me over the course of the week I think I’d go nuts. So with consistent assignment we really want to reduce the number of people taking care of the residents. Usually, when we think about scheduling a nursing home, we think about it the opposite way. We think about how many residents are assigned to each staff person and what we really need to think about is how many staff people are assigned to each residents.

What the campaign has done is to come up with a tool to help you collect the data you need to see if you are doing consistent assignment. Lots of time when I go around I ask who is doing consistent assignment and everybody raises their hands and then I ask; how do you know? And they say we do it. I ask what their definition is of consistent assignment. They go well we schedule that way, yet they don’t collect the data to show it.

I’m going to show you a data collection tool that will help you with consistent assignment and what’s really exciting about consistent assignment is that we’re beginning to get some data that shows if you are really doing consistent assignment, you can reduce the number of deficiencies with what you receive and actually the figure that’s been attached to that is down to 41% and you can also reduce staff turnover.
So consistent assignment seems to be the better way to go when it comes to scheduling and somebody calls it ‘dedicated assignment’ which I like, because consistent assignment is really all about getting to know the resident, learning about them, becoming friendly with family to the resident and I think when you call it dedicated assignment really puts the resident in the middle of it all, which is where we should be.

Moving forward, in the next column you’ll find restraints and pressure ulcers. These are like polio and small pox of the old days and they’re the polio and small pox for nursing homes. Although likely eradicated, small pox, it seems like we’ve almost done that with restraints. The national restraint rate used to be about 8 or 10 eight years ago, but is now below 3%. One half of all nursing homes are at zero restraints. Another quarter of nursing homes are below 2%

What keeps us at a national average of under 3% is that we have a few outliers of states and nursing homes that are still above 8 to 12%. So there are few states and nursing homes that really need to get hustling and working on restraints. I believe that if we did that we could eradicate restraints, eliminate them the same way we did small pox and polio.
Pressure ulcers are a little more difficult. That number, although dropping over time is still high. The national average right now using the old MDS quality measures is about 10-11% and again, we have to be careful that we differentiate between in-house acquired and community acquired and the quality measure doesn’t do that, that’s why it’s important that you collect the information in your internal PI programs, so you know whether you are truly responsible for those pressure ulcers.

You have to heal pressure ulcers that come to you, but you also have to prevent them from coming. Right now I think folks are saying that in-house acquired pressure ulcers should be at about 2% or below.

The next column talks about pain. Pain is another goal of the campaign and again we don’t want anybody for any reason to feel pain. Our pain goal looks at two different measures. It looks at chronic pain for residents who are in the nursing home for long stays and it looks at acute pain for residents who are in for rehab. It’s very important that you learn how to measure pain in your residents and that you keep that at a very low level.

Advanced care planning is really a personal centered care approach and our intent when we developed this goal was really to acknowledge the choices and wishes of residents.

Now, in the fourth column resident and staff satisfaction, so our original thinking was that what you do is work on your staff stability, then your clinical goals and then you check with your customers, residents and staff to see how well you did. One of the things the campaign tries to do is to make sure that our goals are aligned with the national initiatives.
So we’re in the process of changing the goals to bring them up to date. This is actually the third time we’ve done that. We did it two years ago and we’re now doing it again.

The new goal we’re working on right now, which we’ll be rolling out gradually over the next six or so months, would be to reduce hospitalization safely, a major initiative of CMS and some other quality organizations.

And also reducing hospitalization safely keeps your residents from getting hospital-acquired complications. It keeps your residents in the nursing homes where they know the staff and it prevents any kind of trauma from being relocated.

A second new goal that we have is to appropriate use of medications and we’ll be focusing on the use of antipsychotic drugs and using non-pharmacological interventions in place of antipsychotic drugs.

I’m not sure what the number is but its huge, the number of antipsychotic drugs that are prescribed for residents who do not have diagnoses of mental illness. It’s like 80%. The GAO just came out with a report on that, so there’s an effort nationally to look at antipsychotic usage in nursing homes and to reduce it. Some of the other thinking that goes with this goal is if you are on an antipsychotic drug for more than six weeks, your risk of stroke, death or other serious complications increases. Therefore, we really want to limit the use of antipsychotics to when there are really no other choices and there are plenty of non-pharmacological interventions.

Now CMS is taking this on and if you go to the website we have a button on the front page that will take you to a list of resources that can help you reduce the antipsychotics in your nursing home.

The third new goal is to look at mobility.

Again, what you see is we moved from these goals to these, we’ve tried to make them a little more dimensional and you can see they are a little more complicated. Mobility includes things like restraints, but also looks at range of motion, the ability of somebody to walk around and to prevent falls. So mobility is much more than just restraints, its looking at how well a person get around.

We have changed staff turnover to staff stability and that again makes it a little stronger. It’s not just about staff turnover its also about attendance, tardiness, retention and other things that go into a stable staff. We’re also keeping consistent assignments, very important.

In the middle you’ll see we have a ninth goal called ‘person centered care’ and decision making, we’re jumping right into there, a lot of folks have started the culture change journey and are trying to move into person centered or person
directed care and we are developing tools that will help you. Again, we’re not reinventing the wheel, but we’re trying to work with the Pioneer Network and other resources that are out there to bring you the best and greatest.

On the far right column we have three clinical goals, pressure ulcers won’t go away and until we get that number down we’ll keep plugging away on it, trying to reduce it. We also have a goal to look at infections and specifically what the campaign is going to do is look at C-difficile infections in nursing homes. You may not have a problem with this but if you do that goal is there to help you. Pain management is left over from before, but it’s significant enough that we’re going to keep it.

Those are the nine new goals and we will be rolling these out over the next six months.

Next you’ll see a picture of the nine new goals we have for the campaign and then across the top these are the major national initiatives. If you are a member of the American Healthcare Association and a member of your state AHCA affiliate, there is an AHCA initiative that is 4% staff stability, consistent assignment, resisting hospitalization and appropriate use of antipsychotics. You can see how that’s right in there with the AE.

Also, the QAPI is looking at the process for all these things. CMS GPR goals, meaning government performance and reduction act and this is something that’s in the President’s budget when he said nix it, but it used to say for years and years that the state survey agencies would reduce restraints in nursing homes. And they have finally reduced restraints but they have kept pressure ulcers, added infections, they’re looking at hospitalizations and medications, the antipsychotic drug initiative is huge.

You can see it cuts across just about everything. Then we have the CMS QIO tenth scope of work. I think by now in this country all the nursing homes know their QIOs and what they’re working on. The first half of their three-year contract they worked with a specific number of nursing homes to reduce restraints and pressure ulcers. This summer they will be switching over to look at hospitalizations, guess what, antipsychotics probably and consistent assignment.

So there into with everything else on this chart as well. The interact II tool is a spot of tools that are free and are on the web. The interact II tools can help you reduce hospitalizations. We will be putting up a link to interact II very shortly to help nursing homes with that.

Next column is the national quality forum or national priority partnerships and this is a group in Washington that decides what the hot issues are for nursing homes, hospitals and other types of healthcare facilities. You can see they’re pretty much in alignment.
What we all know is that to make improvements on all of these, you really need to stabilize your workforce and get the staff stability done, along with consistent assignment. Pay for performance is getting bigger and bigger. A lot of states are actually adopting Advancing Excellence goals and are holding the nursing home accountable for meeting some of those goals. There are some states that require nursing homes to join the campaign and/or to write the goals to work on which differs state to state.

The last column talks about the Pioneer Network and I’d like to think of the Pioneer Network as really our sister organization, which focuses on staff stability, consistent assignment, person centered care and more and more they’re talking about some of these other rules as well.

I hope that I’ve convinced you that we’re not out there trying to come up with busy work that nobody cares about. We have tried to keep our work consistent with what’s going on nationally. The benefits of participating in the campaign focus on meaningful issues, better staff stability, better relationships, satisfaction, saved money, preparation for pay for performance, bringing stakeholders to the table so they talk to each other and complimentary of other initiatives and last but not least, it prepares you for QAPI.

So, this is a picture of the AE website. It’s not too old because it shows 54.1% but I believe we’re at 54.2 or .3 right now, but the website has news which is where we put in things that are happening in the campaign, so its almost like a mini newsletter and I mentioned that we have a button for CMS to put its antipsychotic drug resources which is also on the site and then any time we have new or updated tools we will signal it on the page. We also have a Facebook page where we can keep you up to date on things as they happen.

The rest of the website has to do with participation, if you’re a nursing home and you haven’t yet registered, what we want you to do is click and sign up and I’ll show you what some of the screen shots look like. Over here is a map of the country, where you can click on your state and find out information about your state. Because this is just a slide though I can’t do it and show you, but if you go to the website you can do it yourself.

At the top are the important buttons and the most important one is called resources. For those of you in the campaign, when you registered you signed on with a username and password, so you can login at the top and get to your profile and to some other information as well. So login with your username and password, and if you have forgotten it or there’s been staff turnover in the nursing home, contact your QIO and they’ll help you with it.

How to register…if you’re reregistering you’ll need to contact your LANE computer, follow the steps over the next few screens and then what’s nice now is that we will allow nursing homes to change goals, probably around October. So when you login
or hit the register button, you put in your username and password and if you have forgotten your password you can click before calling the QIO and get help.

Next you’ll see the profile area you should fill out with some basic information, like your six digit Medicare/Medicaid provider number to sign up for the campaign. On the screen on the left and nobody else can see that, this is something that you and only participants can see is a special menu to enter data, set targets, view your progress and update your goals. It’s the bottom half of the profile you fill out.

We do have two options that are important to mention…One allows the LANE to see what goals you’ve selected and that’s important, so they can help your buying educational programs for the state that are geared towards what the folks in the state want.

We ask that you check that one otherwise everything you enter is absolutely confidential. The only thing that is public or available to CMS or surveyors or anybody else is what is currently public right now. If you start putting in your staff turnover data or your consistent assignment data nobody will see it but you. It is absolutely confidential.

What this says here is the only thing you’re sharing with LANE is your goal selections, so you’re not sharing your data you’re only sharing that you chose staff stability to work on.

We have another option for you right here and that is, if you want to participate in pilot projects and this has been wonderful, nursing homes which have checked this box, we’ve contacted them and they’ve become our guinea pigs to test some of our resources. So, when you go to select a goal what we’ve tried to do is walk you through the performance process and when you open up the section, update my goal selection, the goals will pop up and if you roll the cursor over the goal number it opens so you can click to see your data and see a run chart, to show you what your pressure ulcers have done over the last couple years.

Then we have a definition of what the campaign goal is what you have to do to achieve the goal and then if you click it will take you to the resources section of the website to show you what’s available to help you. We tried to make it very easy to navigate.

If I click here I’ll get my run chart and again this will change when we get the new quality measures, but at least you can see and I think we’ll have it so you can see how you were doing before, but then we’ll have to start over with the new quality measures. This will also have the national nine-trend line as well as the state line.

Going back to the home page, I mentioned the resources button is important, when you click on it you’ll get a drop down menu that says show me resources by goals, by implementation guides, newsletters, webinars, videos, etc. You can see that we
have CNA fact sheets as well as consumer fact sheets. If you open up resources by goal, you'll get all the goals and then you would click on one to see the information revealing everything we have on that portion.

We have an implementation guide that's good but is being revised right now. It walks you through the performance improvement process and the questions you would ask if you wanted to work on reducing staff turnover. Then we have a tool for collecting staff turnover. The tools are all easy to use, Excel spreadsheets and look alike, so if you learn how to use this one than you'll know how to use the pressure ulcer ones or the consistent assignment ones.

Then we have a 15-minute video on how to use the tool, as well as a transcript of the video on how to use the tool, so we've tried to make it as easy as possible for you to use these tools, and you'll see they're pretty good. We have a fax sheet for consumer's which is almost like a PR piece you can use in nursing homes. There's a place for you to put your logo on it and you can leave these out on the nursing station or wherever to give to consumers or family and friends that come to visit residents of the nursing homes.

You can explain to them that these are the issues that you're working on. For example, if you're changing to consistent assignment there may be some glitches along the way. I don't know anybody who has smoothly implemented consistent assignment, there are usually a few bumps, but if you tell your families that's what you're doing and that three months from now things will be much better, they'll be happy customers.

So we have these facts sheets for consumers. Another good example of the consumer fact sheet is when I was on the state survey as a director, we had a lot of families that wanted residents restrained. I think many of you came late to that and it was often hard to explain to the families that there are more injuries using restraints and they are also more severe than when you do not use them. These fact sheets address that, so it's a tool you can use when you're talking with your consumers and family members.

We also have fact sheets for the nursing home staff members, which are great. These are ideals of things you can do today to improve the currently eight, soon to be nine goals of things you can do to improve staff turnover. In this case it seems like, be kind to your co-workers. If your co-worker has a problem then offer to take their shift or things you can do today that can make life better for the residents and the staff. These 8 fact sheets for the nursing home staff members, you can fold them up and put them in with paychecks and do all kinds of things with them. It's something that's geared for the CNAs.

There are a couple webinars on the website, as well as some videos and in the staff stability area we also have a staff stability toolkit, which gets into some depth. So
we have tried to keep it simple and we’re even trying to streamline it and make it more simple, as my dad would say.

Next, let me show you an example of a consumer’s fact sheet...why is reducing pressure ulcers important? It explains what a pressure ulcer is and also says in here somewhere that sometimes pressure ulcers are not always avoidable. I frequently say that my older sister was in a nursing home and had serious spinal cancer and she developed a stage four pressure ulcer before her death. What was important was that the nursing home kept her comfortable and clean and pain free. So, we don’t have unreasonable expectations.

The data collection tools are performance improvement tools. We’re trying to move them to the QAPI language, so if something is directly PI we’ll call it performance improvement tools, but once everyone is used to the language all the tools are evidence-based, developed by experts and we have work groups right now for all the nine new goals and they’re working on them. There are Excel spreadsheets that are easy to use and automatically give you calculations and trend graphs and everything is complimentary so that if you’re using a tool it will use the same language that we use in the facts sheets for the consumers and CNAs.

And, the big thing is they’re free. We have six tools currently, one to make staff turnover, one to make consistent assignments, one to measure pressure ulcers and the pressure ulcer tool differentiates between the in-house acquired vs. the community acquired pressure ulcers, restraints, pain and addresses care monitoring.

There’s a 15-minute WebEx for every single tool. So, when you go to use a tool you would download it from the website, view the WebEx and after you complete the data in the tool you would take two numbers and enter the data into the website by logging in and putting it into the website. We’ll do more of the data entry on the website when we roll out the new campaign, but that will allow you to compare it for staff turnover and consistent assignment what other states are doing across the country.

It’s very important that you develop a habit of tracking performance improvement information on a monthly basis. I think we’ve made a real mistake in this country with the quality measures and evaluating nursing homes based on the quality measures. I think everybody, on the call knows that quality measures are four to six months old by the time you get them and they don’t always include the information that you need.

The pressure ulcer quality measure is a good example. It gives you prevalence or a picture of all the pressure ulcers in the nursing, instead of those that are acquired in-house. So, our tools, we have tried to include in our data gathering tools the information that you need for performance improvement and hopefully, folks will download those tools and collect their data on a monthly basis, so if you do have
some resident-specific issues, you can QA them and get them fixed. You can also use the aggregate data for your performance improvement.

Data entry on the website let us track it for you. By putting data in the website, also it shows that you’re participating in the campaign and that’s also very important. We want to show people that nursing homes will do performance improvement on a voluntary basis. Remember, when you put the data in the website nobody is going to see that except for you. It does allow us to collect aggregate data so we can get a picture of what the norms are for certain goals.

For example, we initially said you shouldn’t have more than 8 people taking care of a resident over a four-week period for consistent assignment. What we now know is that that 8 is probably unrealistic and probably unachievable. The number is much more reasonable at 10, so we need the data so we can tell you what the norms are.

Now we go back to the website, the pressure ulcer resources again, implementation guides, the data collection tool, the how-to fill out the tool and the fact sheets. Using the pressure ulcer tool with the one I’m going to explain, you go to the goal, download the tool, have Excel on your computer of course, and make sure you click the X on the right side of your computer to make sure you have the full Excel worksheet open.

Enter data for one month and if you’re going to do it from January 15 to February 14, that’s fine, just make sure you’re going to pick up February 15 and go to March 14 or you’re going to do it from January 1st to January 31st.

The pressure ulcer tool allows you to monitor in-house acquired and also to tell you where your community acquired are coming from by source and stage and it will provide you with brass. Here’s what the tool looks like. It’s an Excel spreadsheet and you’ll recognize it by the letters across the top and the numbers on the side. We have a table of contents down here at the very bottom and that coincides with the table of contents right here, so all of the tools will have a welcome, instructions, data entry, a summary and notes.

If you open to see what that looks like, this is the instruction page and in addition to those WebEx we want you to look at this, I know this is tiny, but this column says business is the census at the end of the month. This is how many pressure ulcers were acquired in-house and then these columns are the number of pressure ulcers that were acquired for various sources, like home health or the hospital. Now, once you put in the numbers here and here and here, these cells will automatically populate, so you will automatically get your range.

So if you have a census of 116 or so, you'll have two that were acquired in-house, it will give you a 2% rate. That’s the way the tool works. Here it is a little bigger, 115 and two in-house and 2% rate. Then the tool will automatically give you the charts of your in-house compared to your community acquired and then gives you a pie
chart of where your pressure ulcers are coming from, which is perfect for you to tell your performance improvement committees.

What’s also nice about this is when QAPI is fully implemented the surveyors may well say show us what you’re doing for PI and this would certainly be acceptable to them. The tool also gives you an area where you can put in resident-specific information and actions that affect you. So this gives you a comprehensive way to do your performance improvement and we have one of these for each of the goals except for satisfaction.

Now for consistent assignment here are the resources, everything looks alike. Here’s the tool, the WebEx’s and fact sheet. Then we have some articles and other information. This is the current goal and we’re going to change this because what we know now is that CNA caregivers over a one-month period of time is unreasonable, so we’ll change it.

Again, as with any performance improvement project or tip, go back to the clipboard that if you measure your consistent assignment and determine that you have 16 people taking care of a resident, don’t be alarmed by that, say okay we’ll see if we can knock that down to 14 and then maybe to 12. Performance improvement is for you and when you want to set goals that are not overly ambitious and you want to set goals that are reasonable and achievable.

The consistent assignment tool is the only nationalized/standardized tool. We are in the process of redoing it. In fact, I think it may be brand new up on the website in this week, but we’re trying to make it easier. It has been a little cumbersome, but the tool will calculate the average number of CNAs per resident and it will tell you the minimum and maximum number as well.

So here’s what the consistent assignment tool looks like. Again, the table of contents, the tabs found on the page and in this case you would have to pre-populate some of the cells. The tool wants you to put in the names of the CNAs and the names of the residents and then it becomes very simple, you just come down here and pull down the menus to check off who’s taking care of who.

We also have common questions and answers and again this is a guide for you to use. A lot of people ask questions like, if we assign two people do we count that as one person or two? If we have students do we count them? Do we count people who come in to help teeth a resident? You can do it however you want, what’s important is when you’re filling out a data collection tool you do it the same way every time you do it.

So if you want to count and say there’s two that’s fine, just do it January, February, March, April and May. If you want to count them as one that’s fine, just do it the same way; otherwise, if you were to count them as two one month and one the next month it will look like you have an improvement and you really don’t. It’s because you measure differently.
We do have some guidelines, which you don’t necessarily have to follow, you can read through them and say hey this doesn’t pertain to us we want to do it a little differently. Next is where you would put in the CNA and resident names and then this is the kind of result you would get.

Then you would enter the data, login to the campaign at the top and go enter my data, go to the goal where it says submit, consistent assignment submit data and it is going to ask you for those summary numbers that the worksheet popped out for you. What this does is it allows us to collect national information that we can aggregate.

Again, we know it’s not going to be all apples vs. apples, but it’s better than what we have right now. Again, develop a habit of tracking data monthly.

Last but not least, I want to make sure that quality improvement, performance improvement is not something extra it’s something that we all do with everything we do in every space of our life and what we need to do is to do it in nursing homes as well. It can make our jobs easier, we’ll get better service, have better turnovers and happier residents. Generally, using performance improvement will simplify and get rid of the crises. It will give you a process to use when something arises and you want to take a deeper look at it.

There’s more to come, especially with new goals. We’ll be putting a preview page up. Visit the AE website often. Right now we have a great video there on consistent assignment. If anybody has any best practices they want to share or make a video for us 3 minutes or less of a best practice we would love that and we’d be happy to highlight it. Just let me know.

The next slides in the presentation simply show in general how, I said earlier that we had data that shows that the campaign works, let’s just have in the first phase of the campaign, 1:17:00, selective restraints and worked on restraints improved at a rate much faster than everybody else. You can see before the campaign, people who were in the campaign but didn’t select a goal, non-campaign participants and campaign participants selecting a goal, all improved at about the same rate.

After the campaign started, these guys started using the tools and they went way down. The same thing happens with pressure ulcers. You can see how the green line pulls away from the other two lines. This just shows that nursing homes that joined the campaign, selected a goal and set a target which is the dark blue line, improved faster than everybody else.

I do believe that’s about it. I’m sorry I took so long I certainly didn’t plan too, but we have a few minutes left for questions.