Crash Course on QAPI

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NURSE'S COUNCIL WEBINAR

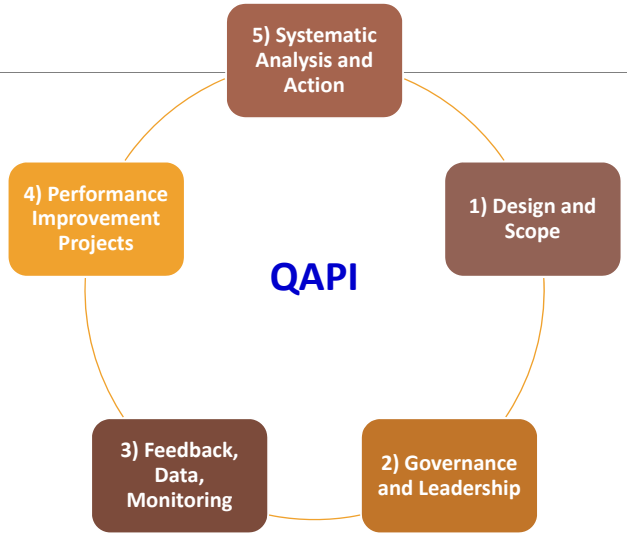
CRASH COURSE on QAPI

- Key Concepts
- Key Elements
- Survey Ready for QAPI

Key Concepts – §483.75 QAPI

- **Effective** and comprehensive system - **Data** driven
- **Focused** on indicators of outcomes of care and quality of life
- **Address all systems** of care and management practices
- **Evidenced-based** processes for clinical care, quality of life, resident choice
- Feedback from **Direct Care Staff, residents** and their representatives
- Addresses **high risk, high volume, problem-prone** and opportunities for improvement (incl adverse events)

5 Core Components

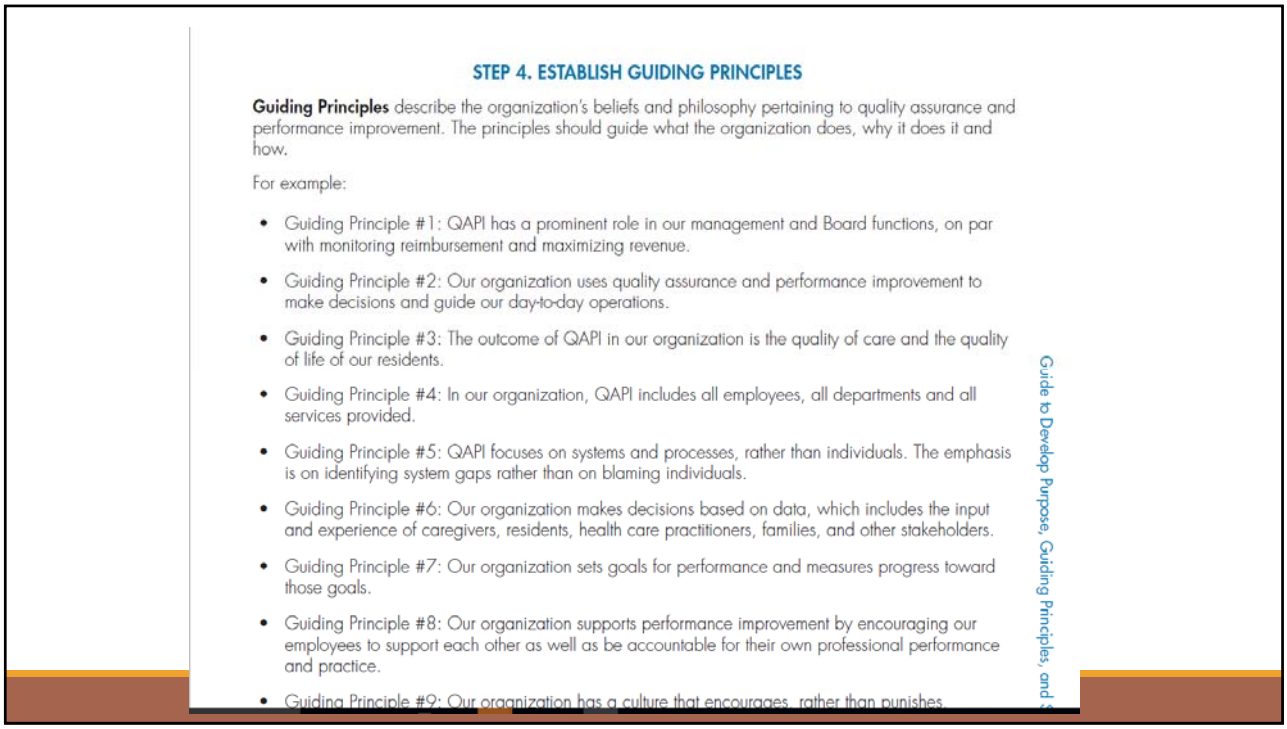


QAPI Elements

ELEMENT	
#1. **Design and Scope**	**Principles incorporated into culture**
	Written QAPI plan
#2. Governance/Leadership	**Look at systems instead of punishing individuals**
	Allocate resources for staff involvement
	Trained staff
#3. Feedback, Data, Monitoring	**Collect, analyze, display data**
	Prioritizing PI opportunities
#4. PIP	**Formal structure and documentation for PIP Teams**
	All service lines involved
#5. Systematic Analysis/Action	**Root Cause Analysis with staff input**
	System and process breakdowns are addressed

1. Scope

QAPI
Mission, vision, and core values, creates the **foundation for organizational QAPI** performance.
Standardized process; information focuses on **key performance indicators.**
Aims for safe (highly reliable) care with focus on patient choice.
Information **flows up and down the organization** in an organized format.
The **guiding principles** of the organization **guide the priorities** for performance improvement projects.



STEP 4. ESTABLISH GUIDING PRINCIPLES

Guiding Principles describe the organization's beliefs and philosophy pertaining to quality assurance and performance improvement. The principles should guide what the organization does, why it does it and how.

For example:

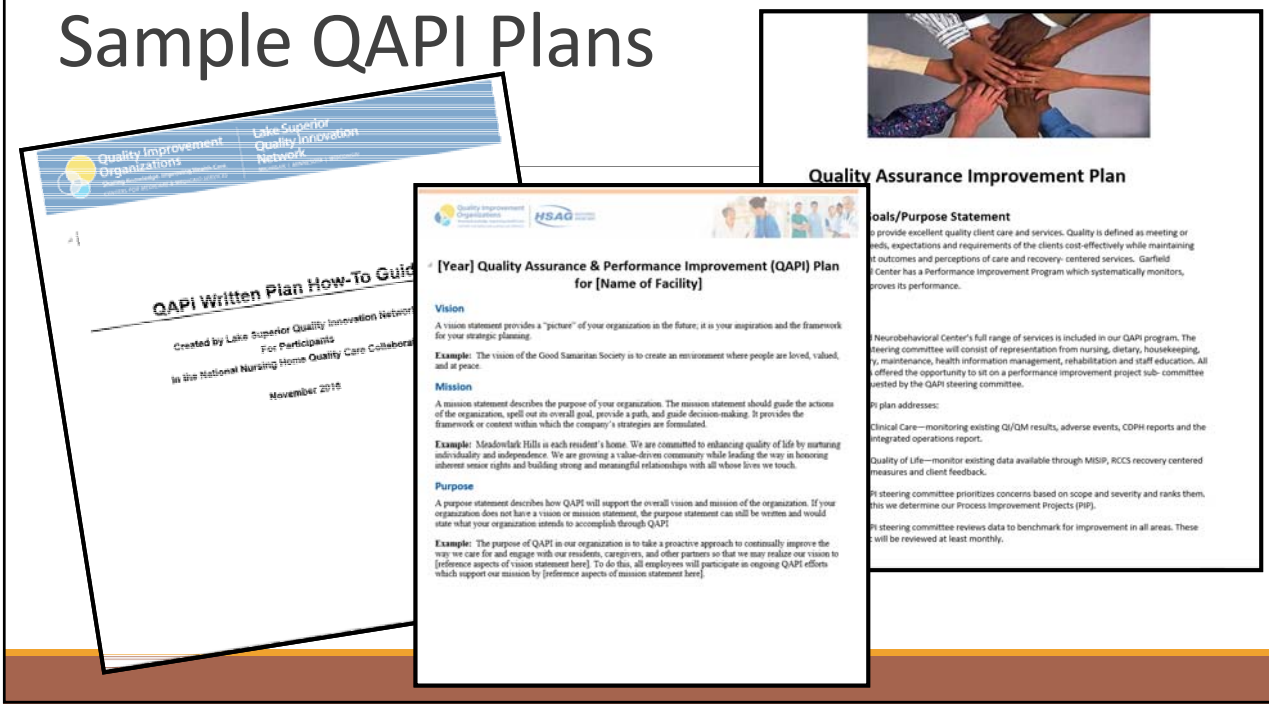
- Guiding Principle #1: QAPI has a prominent role in our management and Board functions, on par with monitoring reimbursement and maximizing revenue.
- Guiding Principle #2: Our organization uses quality assurance and performance improvement to make decisions and guide our day-to-day operations.
- Guiding Principle #3: The outcome of QAPI in our organization is the quality of care and the quality of life of our residents.
- Guiding Principle #4: In our organization, QAPI includes all employees, all departments and all services provided.
- Guiding Principle #5: QAPI focuses on systems and processes, rather than individuals. The emphasis is on identifying system gaps rather than on blaming individuals.
- Guiding Principle #6: Our organization makes decisions based on data, which includes the input and experience of caregivers, residents, health care practitioners, families, and other stakeholders.
- Guiding Principle #7: Our organization sets goals for performance and measures progress toward those goals.
- Guiding Principle #8: Our organization supports performance improvement by encouraging our employees to support each other as well as be accountable for their own professional performance and practice.
- Guiding Principle #9: Our organization has a culture that encourages, rather than punishes

Guide to Develop Purpose, Guiding Principles, and

Your QAPI Program must be ongoing and comprehensive

- Includes all services and departments
- Address the system of care and management practices
- Always include clinical care, quality of life, and resident choice
- Be based on best available evidence to define measure goals
- **Be described by a written program that demonstrates adherence to the five elements**

Sample QAPI Plans



2. Governance and Leadership

QAPI
Executive team lead QAPI with **input from stakeholders including partners, patients, families**.
Ensures QAPI is **adequately resourced** with established leadership administrator, etc. and designates one or more persons to support the program.
Establish policies to **sustain the QAPI program despite changes in personnel and turnover.** **(change of ownership)**
Set priorities for improvement, establishes reporting/communications expectations and documentation process.
Standards committee(s) **ensures that the organization is aware of needed changes** in standards and/or regulations.
Ensures staff are held accountable, however; creates an atmosphere in which staff are not punished for errors and **understand that quality problems are elevated until corrected.**

§483.75(f) – QAPI (continued)

F. Governing Body/Executive Leadership is responsible for ensuring QAPI is:

- Ongoing and process implemented addresses identified priorities
- Adequately resourced (staff time/training)
- Sustained during transition in leadership/staffing
- Corrective actions address gaps in systems
- Corrective actions are effective
- Clear expectations are set around safety, quality, rights, choice and respect.

- November 28, 2019

3. Feedback, Data Systems, and Monitoring

QAPI
Your QAPI program must monitor care and services using data from multiple sources. **The data are analyzed against standards of performance and annual targets established for each metric.**
Have a tracking system to monitor adverse events
Include feedback systems that actively incorporate input from partners, patients, families, and others as appropriate.
Investigate events, develop and implement action plans, track and analyze data to determine if the action plan is working
Additional data collection includes in-depth review of **unscheduled data** sources such as annual and complaint surveys, committed to caring hotline calls, grievances.

If systems don't exist, they may need to be developed. If systems impede quality, they must be changed.

COMMUNICATE WITH RESIDENTS AND FAMILIES

- Make sure all residents and families know that their views are sought, valued, and considered in facility decision-making and process improvements by announcing and discussing QAPI in resident and family councils and other venues.
- Ask residents and family members to tell you about their quality concerns. Many facilities today are using some type of customer-satisfaction survey—results should be used to identify opportunities for improvement that will proactively have an impact on all residents and their families.
- Try to view concerns through residents' eyes. For example, getting back to a resident in 10 minutes may seem responsive, but may feel like an eternity to the resident. How would that feel to a resident waiting an answer to a call light or for help to the bathroom?
- Consider including QAPI information in routine communications to families.

Family and resident complaints are often underused, and yet they are a valuable way of identifying more general problems.

§483.75(c) – QAPI (continued)

- C. (Continued)
- Facility maintenance of effective systems to identify, collect, and use data from all departments, including but not limited to the facility assessment required at §483.75(e).
- Facility adverse event monitoring, including the methods to systematically track, investigate, analyze and use data to prevent adverse events.
- *November 28, 2019*

4. Performance Improvement Projects (PIPs)
The center/office/agency **conducts Performance Improvement Projects (PIPs)** to examine and improve outcomes that are identified as needing attention and/or to implement new/revised programs.
Performance improvement **charter**—defines scope, objectives & participants, delineates roles & responsibilities—serves as a reference for the future of the project.
During a PIP a center/office/agency will try out some changes and then see whether or not they made a difference in the area they were trying to improve. **(PDSA)**
A PIP **involves gathering information systematically** to clarify issues or problems, designing interventions for improvements and/or new or revised program implementation.

§483.75(d) – QAPI (continued)

D. Performance improvement actions

- Implement, measure/track improvements
- Maintain (sustain) improvements
- Policies must address systematic approach:
  - Determine underlying causes of larger systems processes (root cause analysis)

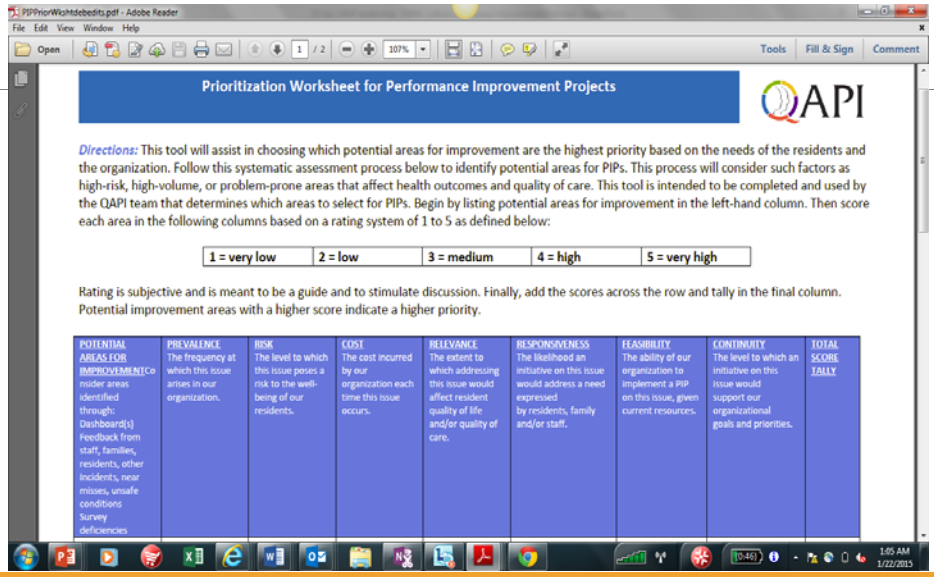
- *November 28, 2019*

§483.75(e) – QAPI (continued)

E. Facility must set priorities for Performance Improvement that:

- Focus on high-risk, high-volume, or problem-prone areas
- Implement preventive actions that include feedback/learning in facilities
  - Must conduct distinct Performance Improvement Projects (at least one)
  - *November 28, 2019*

Prioritization Worksheet for Selecting PIPs



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Prioritization Worksheet for Performance Improvement Projects

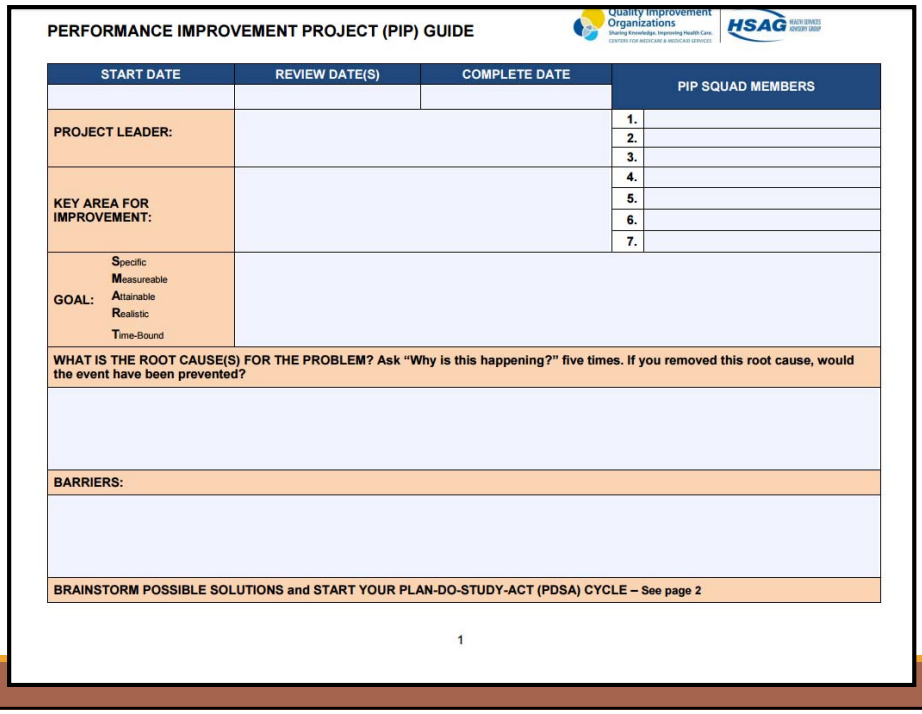
QAPI

Directions: This tool will assist in choosing which potential areas for improvement are the highest priority based on the needs of the residents and the organization. Follow this systematic assessment process below to identify potential areas for PIPs. This process will consider such factors as high-risk, high-volume, or problem-prone areas that affect health outcomes and quality of care. This tool is intended to be completed and used by the QAPI team that determines which areas to select for PIPs. Begin by listing potential areas for improvement in the left-hand column. Then score each area in the following columns based on a rating system of 1 to 5 as defined below:

1 = very low	2 = low	3 = medium	4 = high	5 = very high

Rating is subjective and is meant to be a guide and to stimulate discussion. Finally, add the scores across the row and tally in the final column. Potential improvement areas with a higher score indicate a higher priority.

POTENTIAL AREAS FOR IMPROVEMENTConsider areas identified through: Dashboard(s) Feedback from staff, families, residents, other Incidents, near misses, unsafe conditions Survey deficiencies	PREVALENCE The frequency at which this issue arises in our organization.	RISK The level to which this issue poses a risk to the well-being of our residents.	COST The cost incurred by our organization each time this issue occurs.	RELEVANCE The extent to which addressing this issue would affect resident quality of life and/or quality of care.	RESPONSIVENESS The likelihood an initiative on this issue would address a need expressed by residents, family and/or staff.	FEASIBILITY The ability of our organization to implement a PIP on this issue, given current resources.	CONTINUITY The level to which an initiative on this issue would support our organizational goals and priorities.	TOTAL SCORE TALLY



PERFORMANCE IMPROVEMENT PROJECT (PIP) GUIDE

Quality Improvement Organizations — Sharing Knowledge. Improving Health Care. CENTERS FOR MEDICARE & MEDICAID SERVICES | HSAG HEALTH SERVICES ADVISORY GROUP

START DATE	REVIEW DATE(S)	COMPLETE DATE	PIP SQUAD MEMBERS

PROJECT LEADER:		1.	
		2.	
		3.	
KEY AREA FOR IMPROVEMENT:		4.	
		5.	
		6.	
		7.	
GOAL: **S**pecific **M**easureable **A**ttainable **R**ealistic **T**ime-Bound			

WHAT IS THE ROOT CAUSE(S) FOR THE PROBLEM? Ask "Why is this happening?" five times. If you removed this root cause, would the event have been prevented?

BARRIERS:

BRAINSTORM POSSIBLE SOLUTIONS and START YOUR PLAN-DO-STUDY-ACT (PDSA) CYCLE – See page 2

1

5. Systematic Analysis and Systemic Action

Systematic approach determine when in-depth analysis is needed for **identifying contributing causal factors** that underlie variations in performance.

Systemic Actions look comprehensively across all involved systems to **prevent future events and promote sustained improvement.**

Goal is to do early and ongoing review to **proactively identify** incremental change in expected outcomes.

Unexpected/unanticipated process failures or outcomes are evaluated to determine the "root cause" (RCA).

Asking "WHY" and documenting causes on the diagram, is helpful to understand the underlying: gaps in systems or processes; and identify processes/systems that need improvement.

§483.75(b) - QAPI

B. Comprehensive & ongoing process that addresses
- Systems of care & management practices
- Full range of clinical care, quality of life and resident choice
- Unique care, complexities and services facility provides
- Defines and measures indicators of quality and facility goals reflecting processes of care & facility operations—predictive of desired outcomes.

- *November 28, 2019*

§483.75(c) - QAPI

C. Program feedback, data system and monitoring, including adverse events requires written policies used to:
- Gather feedback from stakeholders
- Use in identifying problems
  - High-risk
  - High volume
  - Problem-prone activities
  - Opportunities for Improvement

Guidance for Performing Root Cause Analysis (RCA) with Performance Improvement Projects (PIPs)

QAPI

Overview: RCA is a structured facilitated team process to identify root causes of an event that resulted in an undesired outcome and develop corrective actions. The RCA process provides you with a way to identify breakdowns in processes and systems that contributed to the event and how to prevent future events. The purpose of an RCA is to find out what happened, why it happened, and determine what changes need to be made. It can be an early step in a PIP, helping to identify what needs to be changed to improve performance. Once you have identified what changes need to be made, the steps you will follow are those you would use in any type of PIP. Note there are a number of tools you can use to perform RCA, described below.

Directions: Use this guide to walk through a Root Cause Analysis (RCA) to investigate events in your facility (e.g., adverse event, incident, near miss, complaint). Facilities accredited by the Joint Commission or in states with regulations governing completion of RCAs should refer to those requirements to be sure all necessary steps are followed.

Below is a quick overview of the steps a PIP team might use to conduct RCA.

Steps	Explanation
1. Identify the event to be investigated and gather preliminary information	Events and issues can come from many sources (e.g., incident report, risk management referral, resident or family complaint, health department citation). The facility should have a process for selecting events that will undergo an RCA.
2. Charter and select team facilitator and team members	Leadership should provide a project charter to launch the team. The facilitator is appointed by leadership. Team members are people with

SURVEY TIME!

- ✓ Ready Now
- ✓ Ready in November

Tool: QAPI Detailed Checklist (Phase 1)

483.75: Quality Assurance and Performance Improvement (QAPI)

AHCA NCAL RequirED

Purpose & Intent of 483.75: To develop, implement, and maintain an effective comprehensive, data-driven QAPI program that focuses on systems of care, outcomes of care, and quality of life.

QAPI requirements will be enforced over three phases (I- Nov 2016, II- Nov 2017, and III- Nov 2019). Most of the requirements for the QAPI program will be implemented in Phase 3. This checklist highlights the QAPI requirements that **must** be implemented in **Phase 1** (Nov 28, 2016).

Phase 1 – Checklist

Regulation	Necessary Actions
(g) Quality assessment and assurance. (1) A facility must maintain a quality assessment and assurance (QAA) committee consisting at a minimum of: (i) The director of nursing services; (ii) The Medical Director or his or her designee; (iii) At least **three** other members of the facility's staff, at least one of who must be the administrator, owner, a board member or other individual in a leadership role; (iv) Infection Control and Prevention Officer (AKA Infection Preventionist) – Phase 3	Form a QAA Committee for your center with at least the following **five** staff members: ☐ Director of nursing services (DON) ☐ Medical Director ☐ _____ (Leadership Representative) ☐ _____ ☐ _____ ☐ Infection Preventionist (Phase 3) *Note: Centers may add additional members based on needs and priorities of the center.*
(h) Disclosure of information. A State or the Secretary may not require disclosure of the records of such committee except in so far as such disclosure is related to the compliance of such committee with the requirements of this section. *Note: Awaiting CMS guidance on how they will reconcile "requirements of this section" that are in Phase 2 and 3 but say they need to be disclosed in Phase 1.*	☐ Inform the QAA committee that documents may be requested to evaluate regulatory compliance.* ☐ Staff will need to know the distinction between QAPI and QAA materials. ☐ Information likely needed to show compliance with QAPI section: o Systems or reports on how you identify, report, investigate, analyze, and prevent adverse events. o Documentation on how you develop, implement, and evaluate corrective actions or performance improvement activities.
(i) Sanctions. Good faith attempts by the committee to identify and correct quality	*Note: Centers do not need to share all details and information from their QAA committee but do need to show information on

483.75 Quality Assurance and Performance Improvement

- Phase 1 - Participation in QAA Committee and maintain existing QAA requirements
- Make sure P&P for Infection Prevention addressed by QAA
- Phase 2 – QAPI Plan – as required by Affordable Care Act
- Phase 3 – Full Implementation of QAPI and integration of Infection Preventionist

§483.75(g) – QAPI (continued)

G. Quality Assessment & Assurance Committee

- Lists required members of QAA Committee
- Meet at least quarterly and as needed **
- Develop/implement actions to correct identified quality deficiencies
- Regularly review and analyze data
  - Act on data to make improvements

CURRENT REGULATIONS REGARDING QAA REMAIN IN PLACE!

§483.75(h) – QAPI (continued)

H. Disclosure of Information

- Requires disclosure of information to ensure the QAA/QAPI process is in compliance with requirements of this section.
- May require surveyor access to:
  - Systems and reports demonstrating identification, reporting, investigation, analysis, and prevention of adverse events;
  - Development, implementation, and evaluation of corrective actions or performance improvement activities; and
  - Other documentation considered necessary by a State or Federal surveyor in assessing compliance.

§483.75(i) – QAPI (continued)

I. Sanctions

- Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions.

Documenting the QAPI Meeting

- Use sign-in sheet template to keep in QAPI.
- QAPI report on a dashboard that can be projected or can be printed for review.
- Utilize QAPI Standard Meeting Agenda and run through in order
  - Assign a responsible party for review/discussion of each metric

Quality Assessment/QAPI Committee Meeting Attendance Sheet

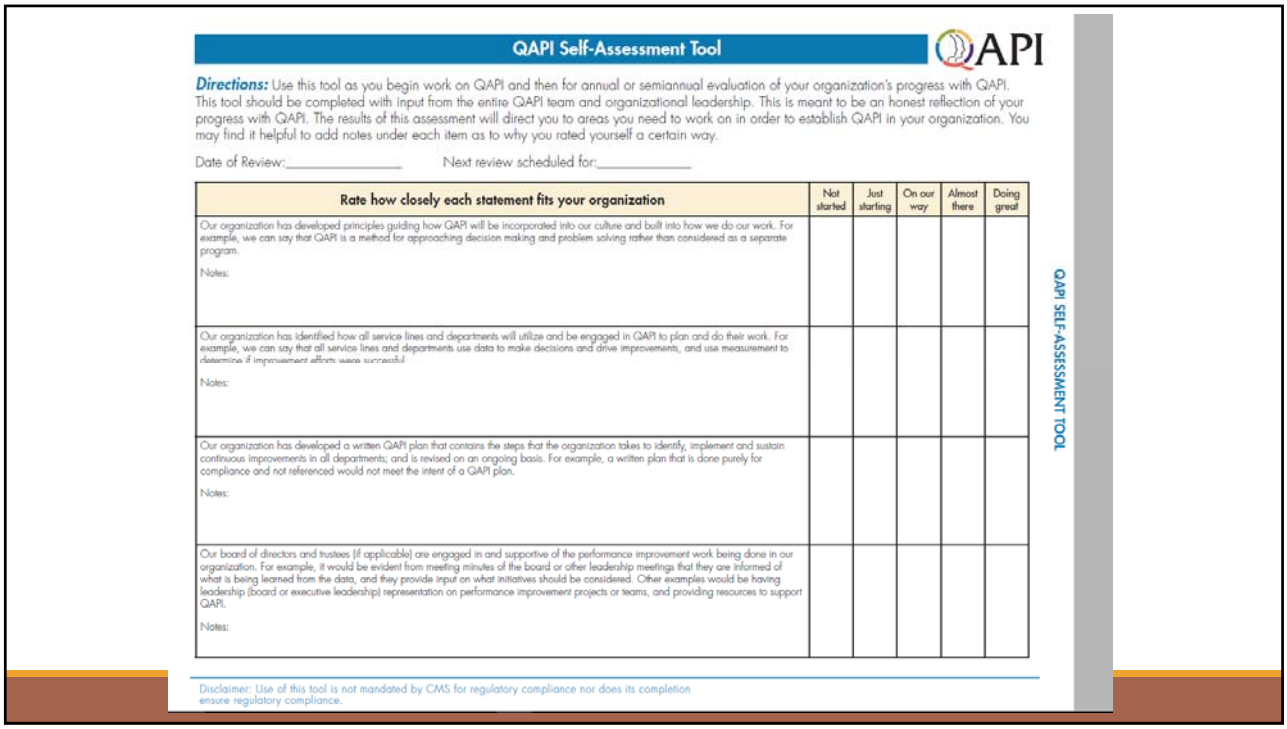
Date of Meeting:		
Attendees:	List Name of Person Attending:	Signature:
Administrator		
Director of Health Services (Dir. of Nursing)		
Medical Director		
Infection Control Preventionist		
Other Attendees:		
Activities		
Admissions		
Business Office		
Clinical Competency Coordinator		
Case Mix Directors		
Dietary Services		
Dietician		
Environmental Services		
Human Resources		
Maintenance		
Medical Records		
QAPI Coordinator		
Pharmacy		
Restorative		
Respiratory		
Safety Committee Coordinator		

QAPI Meeting Minutes Tool

- Discuss areas of existing performance improvement plan (PIP)
- Document items QAPI Meeting Minutes
- Status of Metric item to prioritizing
- Review and prioritize items needing PI focus
- Select 3 – 5 focus areas a quarter
- Assign PIP for each area

QAPI Meeting Minutes Tool (continued)

AGENDA ITEM	System Champion	Status of Metric	Discussion if Goal is not met	Action Needed	PIP Team Lead
1. Review previous minutes and Document Progress on Performance Improvement Plans since last meeting					
	All				
2. Service	System Champion	Status of Metric	Discussion if Goal is not met	Action Needed	PIP Team Lead
a. Customer Satisfaction - NPS/Survey Results					
b. Abaqis Family Interview Results					
c. Grievances (800 calls/Complaint Log)					
d. Resident Council					
e. Care Ambassador Program					
3. Quality	System Champion	Status of Metric	Discussion if Goal is not met	Action Needed	PIP Team Lead
a. Care Transitions					
b. Rehospitalization Rate					
c. CMS Overall 5 Star Rating					
A. CMS Five Star Staffing Rating					
B. CMS Five Star Quality Measure Rating					
d. Quality Measures (Short Stay/Long Stay)					



QAPI Self-Assessment Tool

QAPI

Directions: Use this tool as you begin work on QAPI and then for annual or semiannual evaluation of your organization's progress with QAPI. This tool should be completed with input from the entire QAPI team and organizational leadership. This is meant to be an honest reflection of your progress with QAPI. The results of this assessment will direct you to areas you need to work on in order to establish QAPI in your organization. You may find it helpful to add notes under each item as to why you rated yourself a certain way.

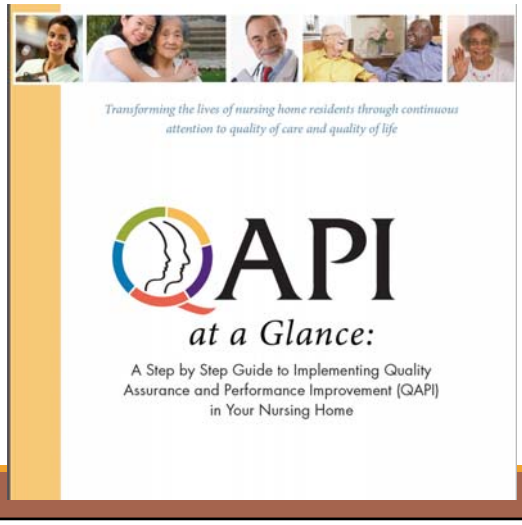
Date of Review:_____ Next review scheduled for:_____

Rate how closely each statement fits your organization	Not started	Just starting	On our way	Almost there	Doing great
Our organization has developed principles guiding how QAPI will be incorporated into our culture and built into how we do our work. For example, we can say that QAPI is a method for approaching decision making and problem solving rather than considered as a separate program. Notes:					
Our organization has identified how all service lines and departments will utilize and be engaged in QAPI to plan and do their work. For example, we can say that all service lines and departments use data to make decisions and drive improvements, and use measurement to determine if improvement efforts were successful. Notes:					
Our organization has developed a written QAPI plan that contains the steps that the organization takes to identify, implement and sustain continuous improvements in all departments; and is revised on an ongoing basis. For example, a written plan that is done purely for compliance and not referenced would not meet the intent of a QAPI plan. Notes:					
Our board of directors and trustees (if applicable) are engaged in and supportive of the performance improvement work being done in our organization. For example, it would be evident from meeting minutes of the board or other leadership meetings that they are informed of what is being learned from the data, and they provide input on what initiatives should be considered. Other examples would be having leadership (board or executive leadership) representation on performance improvement projects or teams, and providing resources to support QAPI. Notes:					

QAPI SELF-ASSESSMENT TOOL

Disclaimer: Use of this tool is not mandated by CMS for regulatory compliance nor does its completion ensure regulatory compliance.

RESOURCES



https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/QAPI/qapitools.html

https://educate.ahcancal.org/required

https://www.hsag.com/en/medicare-providers/nursing-home/quality-assurance-performance-improvement-qapi/

AHCA/NCAL – The Quality Initiative

The Quality Initiative | AN OVERVIEW

The American Health Care Association (AHCA) has broadened its Quality Initiative® to further improve the quality of care in America's skilled nursing care centers. The expansion of the Initiative will challenge members to apply the Baldrige Excellence Framework to meet measurable targets in eight critical areas by March 2018. These areas are aligned with the Centers for Medicare & Medicaid Services (CMS)' Quality Assurance/Performance Improvement (QAPI) program and federal mandates, such as Five-Star and the Improving Medicare Post-Acute Care Transformation (IMPACT) Act.

IMPROVE ORGANIZATIONAL SUCCESS BY:

INCREASING Staff Stability

The Issue

Those who work most closely with residents and patients are at the core of providing quality care. The more consistent the staff is, the more they understand and are able to effectively respond to each person's needs – reinforcing our commitment to delivering person-centered care. Additionally, dwindling government resources make it all the more critical for centers to reduce the excess costs generated by frequent turnover.

Target

Decrease turnover rates among nursing staff (RN, LPN/LVN, CNA/LNA) by 15% or achieve/ maintain at or less than 40% by March 2018.

Measurement

AHCA will measure progress using staffing data members submit to LTC Trend Tracker℠ starting in May. LTC Trend TrackerSM will allow members to upload, track and benchmark their turnover and retention information. By the end of 2016, the Centers for Medicare & Medicaid Services (CMS) also plans to implement a nationwide system of electronic reporting on turnover and retention in the Five-Star Quality Rating System that will provide a national data source for all nursing centers.

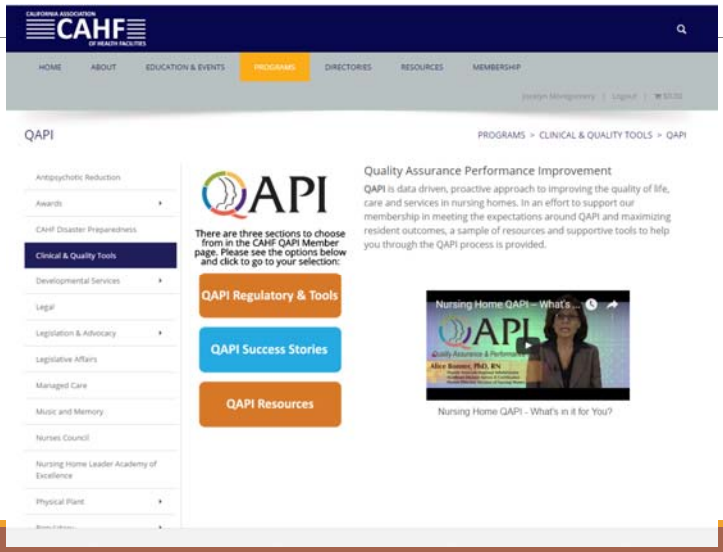
ADOPTING Customer Satisfaction Questionaire & Measure

LINK TO OVERVIEW

https://www.ahcancal.org/quality_improvement/qualityinitiative/Pages/default.aspx

Visit CAHF Member Website Clinical/Quality Page

http://www.cahf.org/Programs/Clinical-Quality-Tools/QAPI



QAPI Five Elements	Goals	Tools
Element 1 – Design and Scope	Learn the basics of QAPI • Review QAPI five elements • Understand how QAPI coordinates with QAA	QAPI Five Elements QAPI at a Glance QAPI News Brief - Volume 1
	Assess QAPI in your organization	QAPI Self-Assessment Tool
	Create a structure and plan to support QAPI	Guide to Developing Purpose, Guiding Principles and Scope for QAPI Guide for Developing a QAPI Plan
Element 2 – Governance and Leadership	Understand the QAPI business case	CMS Video: Nursing Home QAPI – What's in it for you?
	Promote a fair and open culture where staff are comfortable identifying quality problems and opportunities • Know your current culture • Assess your individual skills, practice, attitude • Create a learning organization that drives and reinforces a process for organizational change • Distinguish between human error, at risk, and reckless behavior, and respond differently/ appropriately to each	QAPI at a Glance QAPI News Brief - Volume 1

Thank You

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