Quality Assurance and Performance Improvement

Speaker

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Disclosures

- I have no financial relationships to disclose
- I have no conflicts of interests to disclose
- I will not promote any commercial products or services

- All Planning Committee members, content reviewers, authors, and presenters have been evaluated for conflicts of interest, and there are not any to disclose.

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Objectives

- Participants will be able to identify basic QAPI concepts
  - The participants will review the F-tags pertaining to QAPI
  - The 5-elements of QAPI will be discussed
- Define elements of QAPI
  - Examine the 5-elements and HOW they function in a real-life setting
  - QAPI requires information coming IN and work directed going OUT
  - PIPs and how to make them tangible

Objectives

- Systematic evaluation
  - Without using benchmarks (external data) and goals (internal data) and evaluation outcome, it is difficult to be successful
  - How to evaluate
  - Why it's best to start "low and slow"

Tools and Guidance - Free

- Quality Assurance & Performance Improvement. (2019). https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/QAPI/NHQAPI.html
- Root Cause Analysis Kit for Long-term Care. (2014). https://www.stratishealth.org/providers/rca-toolkit/

Basic QAPI Concepts

- F-tags pertaining to QAPI
- The 5-elements of QAPI

F 865 - Definition

- Must develop, implement, and maintain an effective, comprehensive, data-driven QAPI program that focuses on indicators of the outcomes of care and quality of life.
- Maintain documentation and demonstrate evidence of its ongoing QAPI program - systems and reports demonstrating systematic identification, reporting, investigation, analysis, and prevention of **adverse events**; and documentation demonstrating the development, implementation, and evaluation of corrective actions or performance improvement activities

F 865 - Definition

- Present its QAPI plan to the State Survey Agency
- Present documentation and evidence of its ongoing QAPI program's implementation and the facility's compliance with requirements to a State Survey Agency, Federal surveyor or CMS upon request – THIS IS HOW YOU ACHIEVE PAST NONCOMPLIANCE

F 868 QAA

- Committee consisting at a minimum of:
  - The director of nursing services;
  - The Medical Director or his/her designee;
  - 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; and
  - The infection preventionist.

F 868 QAA Committee

- Reports to the facility's governing body, or designated person(s) functioning as a governing body regarding its activities, including implementation of the QAPI program required under paragraphs (a) through (e) of this section. The committee must:
- Meet at least quarterly and as needed to coordinate and evaluate activities under the QAPI program, such as identifying issues with respect to which quality assessment and assurance activities, including performance improvement projects required under the QAPI program, are necessary.

QAA Disclosure of Information

(1) 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.

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QAA Disclosure of Information

(2) Demonstration of compliance may require State or Federal surveyor access to:

(i) Systems and reports demonstrating systematic identification, reporting, investigation, analysis, and prevention of adverse events;

(ii) Documentation demonstrating the development, implementation, and evaluation of corrective actions or performance improvement activities; And

(iii) **Other documentation considered necessary by a State or Federal surveyor in assessing compliance**.

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QAA Sanctions

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

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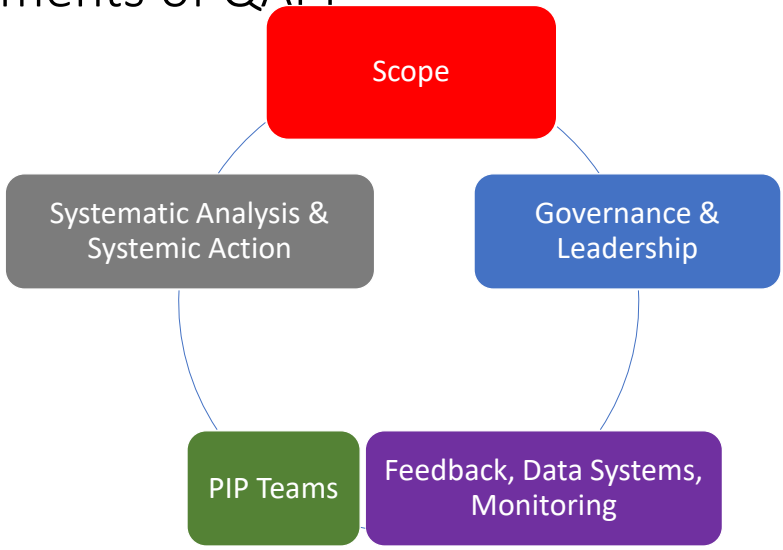
5 Elements of QAPI



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Examine the 5 Elements

- HOW they function in a real-life setting
- QAPI requires information coming IN and work directed going OUT
- PIPs and how to make them tangible

QAPI Scope

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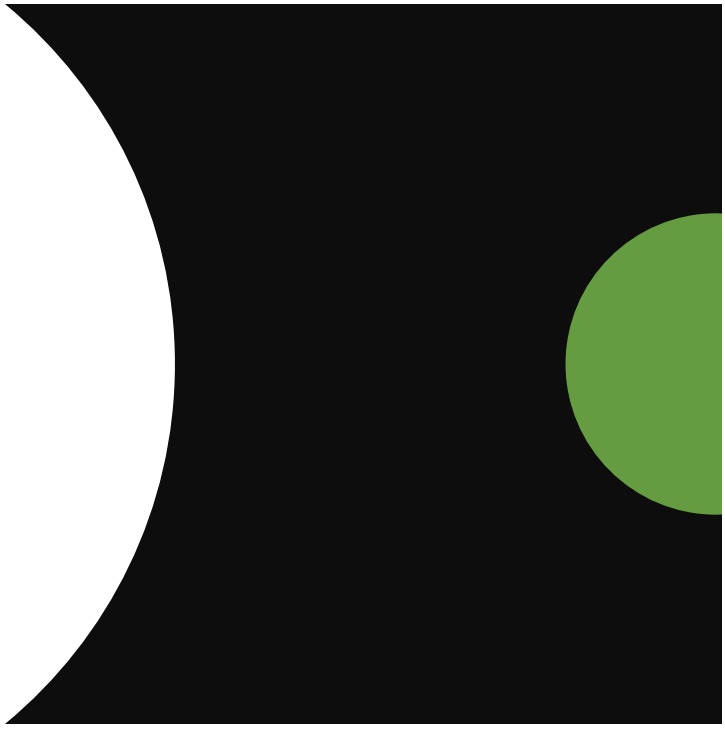

F865 – Program Design and Scope

- Address all systems of care and management practices;
- Include clinical care, quality of life, and resident choice;
- Utilize the best available evidence to define and measure indicators of quality and facility goals that reflect processes of care and facility operations that have been shown to be predictive of desired outcomes for residents of a SNF or NF.
- Reflect the complexities, unique care, and services that the facility provides.

Define the Scope of QAPI

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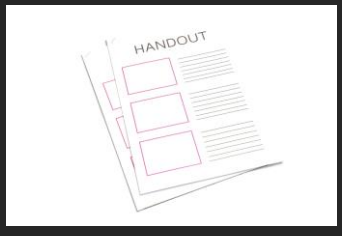

Connect directly to **FACILITY ASSESSMENT**

Once identified, determine how each will use QAPI to assess, monitor and improve performance on an ongoing basis.

High risk, high volume	"Sentinel events"	Monitoring: thresholds

High Risk, High Volume, Problem Prone Adverse Events – separate handouts

- Significant risk to the health or safety of residents, e.g., tracheostomy care; pressure injury prevention; administration of high-risk medications such as warfarin, insulin, and opioids.
- Performed frequently or affecting a large population, thus increasing the scope of the problem, e.g., transcription of orders; medication administration; laboratory testing.
- Historically had repeated problems, e.g., call bell response times; staff turnover; lost laundry
- Adverse event -an untoward, undesirable, and usually unanticipated event that causes death or serious injury, or the risk thereof, which includes **near misses.**

Governance and Leadership

QAPI – Governance and Leadership Responsibilities

- Addresses identified priorities.
- Sustained during transitions in leadership and staffing;
- Adequately resourced, including ensuring staff time, equipment, and technical training as needed;
- identifies and prioritizes problems and opportunities that reflect organizational process, functions, and services provided to residents based on performance indicator data, and resident and staff input, and other information.
- Corrective actions address gaps in systems, and are evaluated for effectiveness; and
- Clear expectations are set around safety, quality, rights, choice, and respect.

QAPI Adequately Resourced

- Designate one or more persons to be accountable for QAPI leadership and for coordination.
- Indicate the plan for developing leadership and facility-wide training on QAPI.
- Describe the plan to provide caregivers time, equipment, and technical training as needed for QAPI.
- Indicate how you will determine if resources are adequate for QAPI. **FACILITY ASSESSMENT**
- Describe how your caregivers will become and remain proficient with process improvement tools and techniques. How will you assess their level of proficiency?

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QAPI Leadership (Steering Committee)

- Small group of individuals who will provide the backbone or structure for QAPI (Mentors & Oversight)
- Describe how this group of people will work together, communicate, and coordinate QAPI activities. This could include but is not limited to:
  - Establishing a format and frequency for meetings
  - Establishing a method for communication between meetings
  - Establishing a designated way to document and track plans and discussions addressing QAPI.
- Describe how the QAPI activities will be reported to the governing body; i.e., Board of Directors, owner.

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Performance Objectives for Job Descriptions & Reviews Worksheet

- All job positions in the organization should be oriented to support quality assurance and performance improvement (QAPI) efforts

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Feedback, Data Systems and Monitoring

Data Management

Sources: Connect to Facility Assessment

Process

Analyze: How findings will be reviewed against benchmarks and/or targets established by the facility

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Communication

- Process to communicate the above information. What types of reports will be used, e.g. . dashboard or dashboards for individual performance improvement projects
- Identify who will receive this information (i.e., executive leadership, QAPI leadership, resident/family council, and a center's caregivers), in what format, and how frequently information will be disseminated

Data: Quality and Quantity

- Meaningful information must come in to get meaningful results
- Data is everywhere. If not using, meaningless. Stop gathering it.
- Taking the time to define the data that you need is key.

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Develop a Strategy for Collecting and Using Data

- Areas to consider
  - Clinical care areas
  - Medications,
  - Complaints from residents and families
  - Hospitalizations and other service use
  - Resident satisfaction
  - Caregiver satisfaction

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Develop a Strategy for Collecting and Using Data

- More Areas to consider
  - Resident and caregiver experiences living and working in the setting
  - State survey results and deficiencies
  - Results from MDS resident assessments
  - Business and administrative processes

Develop a Strategy for Collecting and Using Data

- Systems approach
  - Setting targets for performance in the areas you are monitoring. A target is a goal, usually stated as a percentage
  - Identifying benchmarks

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Develop a Strategy for Collecting and Using Data

- Systems approach
  - Developing a plan for the data you collect.
    - Determine who reviews certain data, and how often. Collecting information is not helpful unless it is actually used .
    - Be purposeful about who should review certain data, and how often—and about the next steps in interpreting the information.

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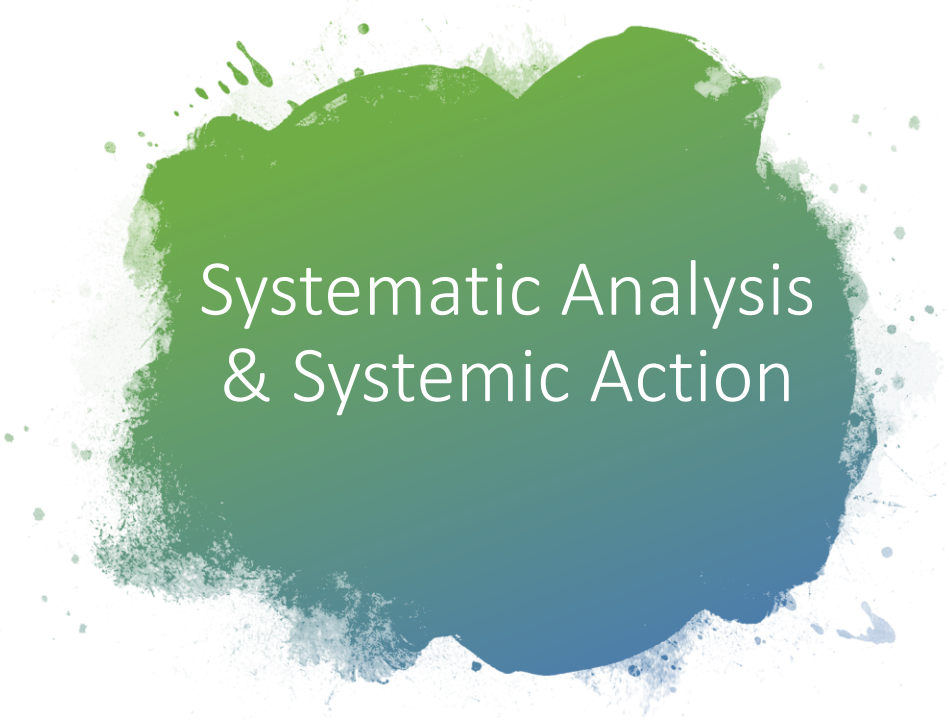
Identify Gaps and Opportunities

- Areas to consider when reviewing your data:
  - MDS data for problem **patterns**.
  - Visit Nursing Home Compare .
  - Recent state survey issues that remain unresolved.
  - **Trends** in complaints.
  - Resident and family satisfaction for **trends**.
  - **Patterns** of caregiver turnover or absences.
  - **Patterns** of ER and/or hospital use.

Exercise

- You have just been cited for three (3) residents that developed unstageable pressure ulcers on their heels within one week of admission. What data do you need before you start root cause analysis? Resident and facility date …


Systematic Analysis
& Systemic Action
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Same scenario – Next Step

- You have just been cited for three (3) residents that developed unstageable pressure ulcers on their heels within one week of admission. Work at your table. Develop the PIP.
- Charter the PIT (Performance Improvement Team) – who needed to be on it and why
- Determine what information you need for PIP.
- Determine a timeline and communicate it to the Steering Committee.
- Identify and request any needed supplies or equipment.
- Select or create measurement tools as needed;
- Develop first in series of PDSA Cycles for this PIP

Root Cause Analysis

- Select a method for RCA: Process you will use to ensure you are getting at the underlying causes of issues, rather than applying quick fixes that address symptoms only.
- Worksheets
  - *FMEA*
  - *RCA*
  - *Flowcharting*
  - *Five Why's*
  - *Fishbone Diagram*

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Exercise Part 2

- Let's try the Five Why's for These Pressure Injuries based on initial data
- All three residents were on the same hall with new employees who stated they did not know to float the residents' heels. Why?
- Type an answer in the chat box and we will go from there …

Systemic Action

- How you will monitor to ensure that interventions or actions are implemented and effective in making and sustaining improvements?

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Generate List of Recommended Actions To Correct

1. Clearly link to root causes
2. Addresses all root causes – not just one
3. Reduce likelihood of recurrence
4. Clear and concise
5. Prioritized
6. SMART: Specific, Measurable, Achievable, Realistic, Timed

Types of Actions

1. Standardize Equipment
2. Redundancy
3. Force functions
4. Change physical plant
5. Update improving software / systems
6. Use cognitive aids – checklists, labels
7. Simplify
8. Educate
9. Develop policies

Impact of Actions

Strong	Intermediate	Weak
• Physical Plant Changes • System fixes that are facility-wide	• Cognitive aids • Worksheets	• Relies on Policy and Procedure • And individual's compliance with the same

Take Systemic Action

- Weak: Depend on staff to remember their training or what is written in the policy. (Enhance or enforce existing processes.)
- Examples of weak actions:
  - Double checks
  - Warnings/labels
  - New policies/procedures/memoranda
  - Training/education
  - Additional study

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Take Systemic Action

- Intermediate: Provide tools to help staff to remember or to promote clear communication. (Modify existing processes.)
- Examples of intermediate actions:
  - Decrease workload
  - Software enhancements/modifications
  - Eliminate/reduce distraction
  - Checklists/cognitive aids/triggers/prompts

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Take Systemic Action

- More examples of intermediate actions:
  - Eliminate look alike and sound alike
  - Read back
  - Enhanced documentation/communication
  - Build in redundancy

Take Systemic Action

- Strong: Do not depend on staff to remember to do the right thing. Provides strong controls. (Change or re-design the process.)

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Take Systemic Action

- Detect and warn so there is an opportunity to correct before the error reaches the patient.
- Involve hard stops which won't allow the process to continue unless something is corrected or gives the chance to intervene to prevent significant harm.

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Take Systemic Action

- Examples of strong actions:
  - Physical changes: grab bars, non slip strips on tubs/showers.
  - Electronic medical records – cannot continue charting unless all fields filled in.
  - Simplifying: unit dose.
  - Same equipment every neighborhood

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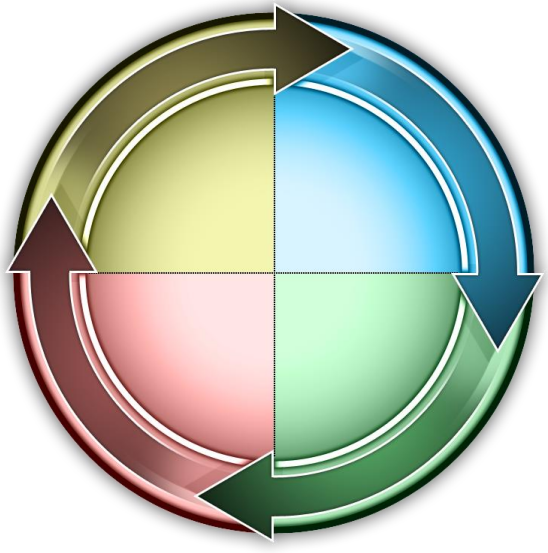
Conduct and Document PIPs

- Use a problem-solving model like PDSA (Plan-Do-Study-Act).
- Report results to the Steering Committee.



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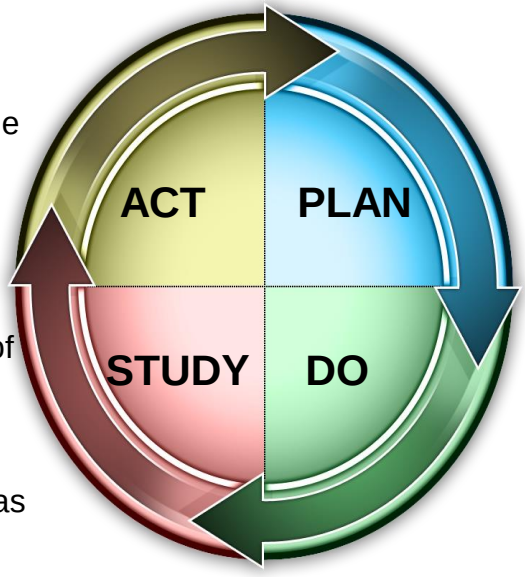
PDSA Cycle

- Change to be made
- Next cycle



- Objective
- Questions / Predictions
- Plan to carry out (who, what, when, where, how)

- Compare analysis of data
- Compare data to prediction
- Summarize what was learned

Slide 51

- Carry out plan
- Document Problems and observations
- Begin analysis

Slide 51

Systematic Evaluation

Using benchmarks (external data) and goals (internal data) and evaluation outcome to be successful
How to evaluate
Why it's best to start "low and slow"

Process

- QAPI – not individual PIPs. Not single PDSA Cycles. Often POCs are single PDSA cycles
- Purpose of Evaluation: Outline the audiences for QAPI communications and the frequency and format of these communications
- *Hint: QAPI Self-Assessment Tool at least annually*
  DO THIS NOW … MEASURE
  CHANGE

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Benchmarks and Goals

- Every PIP has a goal – internal measurement of success
- Systems have benchmarks – external measurements that you strive to be better than … e.g. Quality Measures, National Rate of turnover, etc.

Guidelines for Performance Improvement Projects

Overall Plan for PIPs

Indicate	Indicate how potential topics for PIPs will be identified.
Describe	Describe criteria for prioritizing and selecting PIPs areas FACILITY ASSESSMENT
Define	Define how and when PIP charters will be developed.
Establish	Describe the process for reporting the results of PIPs. Identify who will receive this information, in what format, and how frequently information will be disseminated.

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Documenting PIPs

- Highlights,
- Progress, and
- Lessons learned.
- Project documentation templates should be used consistently and filed electronically in a standardized fashion for future reference

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Starting Point

- SLOW DOWN! Systemic change can take 12 – 36 months.
- "Low hanging fruit" – where can you achieve an internal goal most quickly? Let's go back to the pressure injury issue. You found these root causes:
  1. Braden not being done on admission
  2. CNAs not trained to float heels in last 24 months
  3. Turnover in CNAs is 65%
  4. Orientation does not include pressure relieving methods
  5. The pressure injury prevention program is dated 2002

Which one(s) can you address in 40 days and sustain compliance?

And The Onion Peels Back …

- Start with the one you chose … create a PDSA cycle and finish …
- Use the Fish Bone to dig deeper and identify more root causes.
- Then pick the next priority. Do the root cause analysis of this using the 5 Why's.
- Create a PDSA cycle or two and address it
- Each PDSA Cycle has an internal goal or checkpoint.
- Continue to monitor these to assure compliance. (QA) Modify if needed.
- Repeat until all issues addressed. It may be a year or two to reach your benchmark (PI)


Q&A

Resources

- Quality Assurance & Performance Improvement. (2019). https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/QAPI/NHQAPI.html
- QAPI Tools. http://www.ihi.org/resources/Pages/Tools/default.aspx
- QAPI. https://www.ahcancal.org/Survey-Regulatory-Legal/Pages/QAPI.aspx
- Root Cause Analysis Kit for Long-term Care. (2014). https://www.stratishealth.org/providers/rca-toolkit/