ACCELERATING QAPI USING PROCESS TOOLS

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Welcome

QAPI is a systematic, comprehensive, data-driven, approach to improving the quality of life, care, and services in nursing homes.

Involve members at all levels of the organization to:

- Identify opportunities for improvement.
- Address gaps in systems or processes.
- Develop and implement an improvement or corrective plan.
- Continuously monitor effectiveness of interventions.

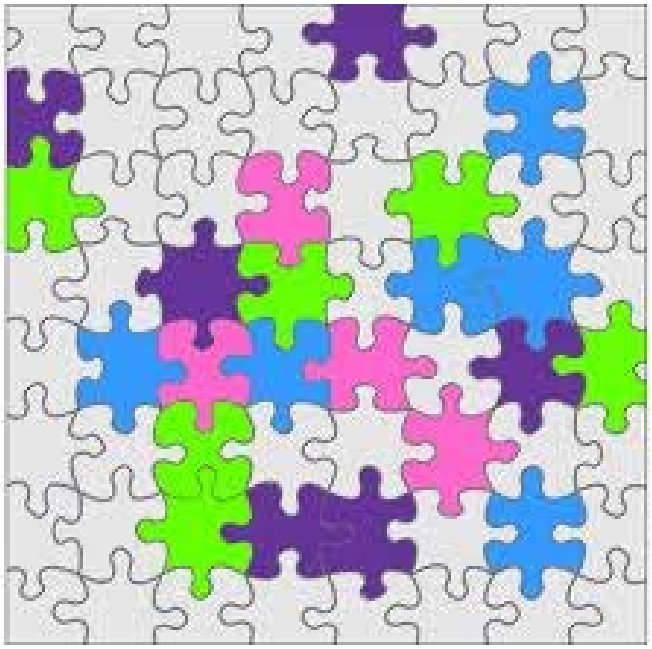
Please have a copy of the QAPI Self Assessment and the Guide for Developing a QAPI Plan for reference.

Objectives

- Explain why now is the time to accelerate Quality Assurance and Performance Improvement (QAPI) in nursing homes.
- Discuss examples of QAPI self assessment ratings.
- Discuss QAPI plan examples.

Now is the Time

- Nursing homes have pieces in place through QAA.
- QAPI builds out the puzzle:
  - Element 1, Design and Scope, creates the border.
  - Other QAPI elements fill in the details.

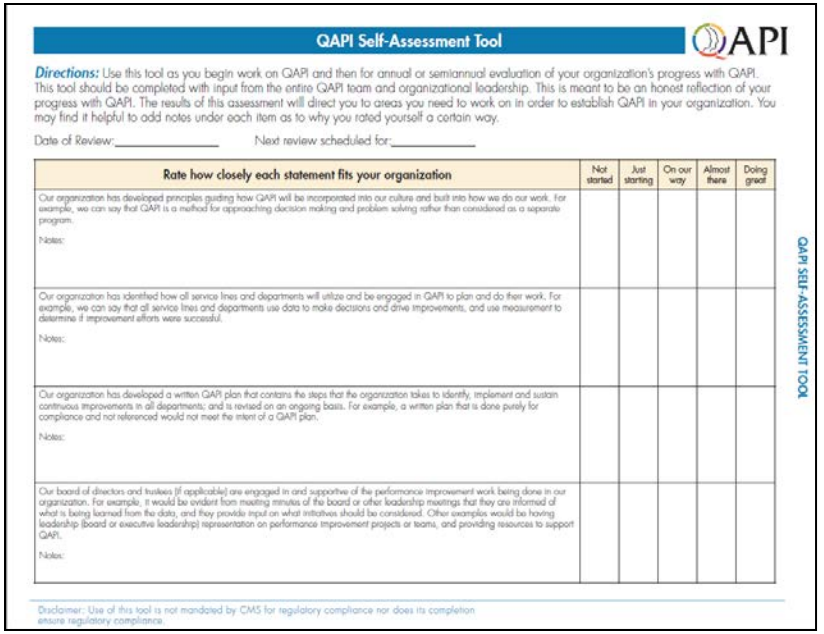


Foundational QAPI Tools

- QAPI Self-Assessment
- Guide for Developing a QAPI Plan

QAPI Self-Assessment

- Identifies gaps in the “puzzle.”
- Evaluates which components are in place.
- Completed by leaders.



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.

Self-Assessment Question: Focus

When addressing performance improvement opportunities, our organization focuses on making changes to systems and processes rather than focusing on addressing individual behaviors. For example, we avoid assuming that education or training of an individual is the problem, instead, we focus on what was going on at the time that allowed a problem to occur and look for opportunities to change the process in order to minimize the chance of the problem recurring.

What would “doing great” look like?

Self-Assessment Question: Culture

Our organization has established a culture in which caregivers are held accountable for their performance, but not punished for errors and do not fear retaliation for reporting quality concerns. For example, we have a process in place to distinguish between unintentional errors and intentional reckless behavior and only the latter is addressed through disciplinary action.

What would “doing great” look like?

Self-Assessment Question: Approach to QAPI

Leadership can clearly describe, to someone unfamiliar with the organization, our approach to QAPI and give accurate and up-to-date examples of how the facility is using QAPI to improve quality and safety of resident care. For example, the administrator can clearly describe the current performance improvement initiatives, or projects, and how the work is guided by caregivers involved in the topic as well as input from residents and families.

What would “doing great” look like?

Self-Assessment Question: Data

Our organization has identified all of our sources of data and information relevant to our organization to use for QAPI. This includes data that reflects measures of clinical care; input from caregivers, residents, families, and stakeholders, and other data that reflects the services provided by our organization. For example, we have listed all available measures, indicators or sources of data and carefully selected those that are relevant to our organization that we will use for decision making. Likewise, we have excluded measures that are not currently relevant and that we are not actively using in our decision making process.

What would “doing great” look like?

Self-Assessment Question: Goals & Thresholds

For the relevant sources of data we identify, our organization sets targets or goals for desired performance, as well as thresholds for minimum performance. For example, our goal for resident ratings for recommending our facility to family and friends is 100% and our threshold is 85% (meaning we will revise the strategy we are using to reach our goal if we fall below this level).

What would “doing great” look like?

Self-Assessment Question: Prioritization

From our identified opportunities for improvement, we have a systematic and objective way to prioritize the opportunities in order to determine what we will work on. This process takes into consideration input from multiple disciplines, residents and families. This process identifies problems that pose a high risk to residents or caregivers, is frequent in nature, or otherwise impact the safety and quality of life of the residents.

What would “doing great” look like?

Self-Assessment Question: Chartering

When a performance improvement opportunity is identified as a priority, we have a process in place to charter a project. This charter describes the scope and objectives of the project so the team working on it has a clear understanding of what they are being asked to accomplish.

What would “doing great” look like?

Self-Assessment Question: Documentation

For our Performance Improvement Projects, we have a process in place for documenting what we have done, including highlights, progress, and lessons learned. For example, we have project documentation templates that are consistently used and filed electronically in a standardized fashion for future reference.

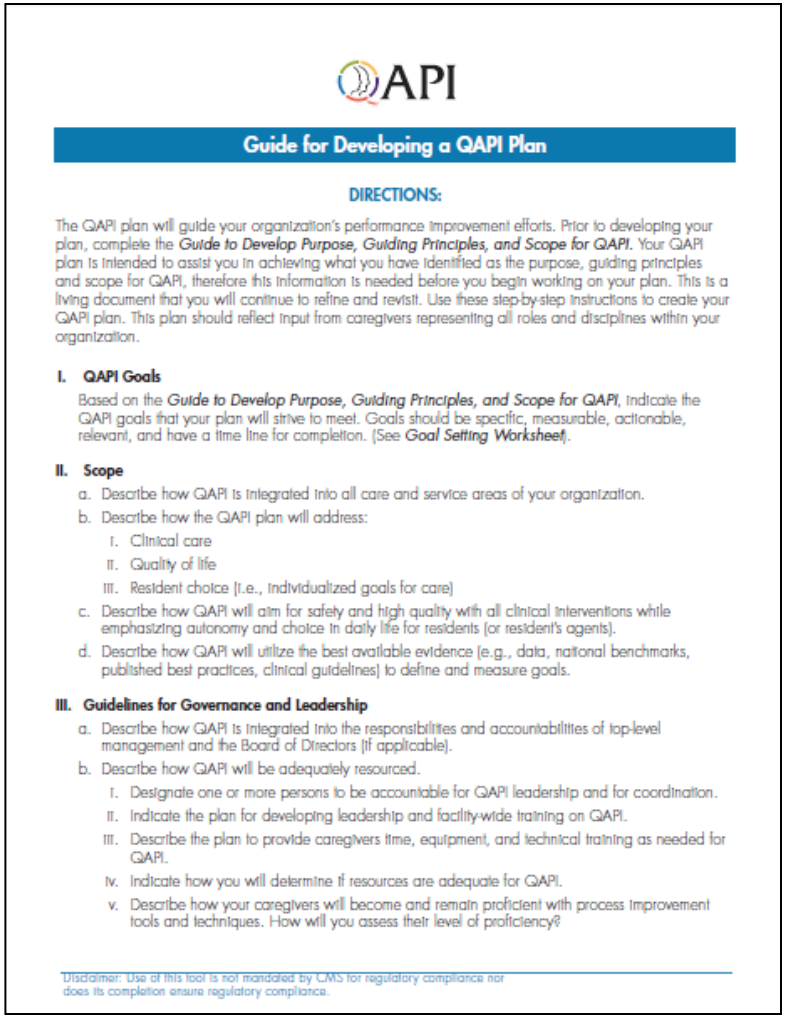
What would “doing great” look like?

Action Plan

- What might you do in the next two weeks, one month and six months to support your nursing homes in using the self assessment tool?

Guide for Developing a QAPI Plan

- The QAPI plan:
  - Steers the quality efforts
  - A “living, breathing” document
  - Reflects input from people representing all roles and disciplines in the organization
  - Something you turn to frequently for guidance
  - Unique to your organization



QAPI

Guide for Developing a QAPI Plan

DIRECTIONS:

The QAPI plan will guide your organization's performance improvement efforts. Prior to developing your plan, complete the ***Guide to Develop Purpose, Guiding Principles, and Scope for QAPI.*** Your QAPI plan is intended to assist you in achieving what you have identified as the purpose, guiding principles and scope for QAPI, therefore this information is needed before you begin working on your plan. This is a living document that you will continue to refine and revisit. Use these step-by-step instructions to create your QAPI plan. This plan should reflect input from caregivers representing all roles and disciplines within your organization.

I. QAPI Goals

Based on the ***Guide to Develop Purpose, Guiding Principles, and Scope for QAPI***, indicate the QAPI goals that your plan will strive to meet. Goals should be specific, measurable, actionable, relevant, and have a time line for completion. (See ***Goal Setting Worksheet***).

II. Scope

a. Describe how QAPI is integrated into all care and service areas of your organization.
b. Describe how the QAPI plan will address:
   i. Clinical care
   ii. Quality of life
   iii. Resident choice (i.e., individualized goals for care)
c. Describe how QAPI will aim for safety and high quality with all clinical interventions while emphasizing autonomy and choice in daily life for residents (or resident's agents).
d. Describe how QAPI will utilize the best available evidence (e.g., data, national benchmarks, published best practices, clinical guidelines) to define and measure goals.

III. Guidelines for Governance and Leadership

a. Describe how QAPI is integrated into the responsibilities and accountabilities of top-level management and the Board of Directors (if applicable).
b. Describe how QAPI will be adequately resourced.
   i. Designate one or more persons to be accountable for QAPI leadership and for coordination.
   ii. Indicate the plan for developing leadership and facility-wide training on QAPI.
   iii. Describe the plan to provide caregivers time, equipment, and technical training as needed for QAPI.
   iv. Indicate how you will determine if resources are adequate for QAPI.
   v. 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 Plan Sections

I. QAPI Goals
II. Scope
III. Guidelines for Governance and Leadership
IV. Feedback, Data Systems, and Monitoring
V. Guidelines for Performance Improvement Project (PIP) Teams
VI. Systematic Analysis and Systemic Action
VII. Communications
VIII. Evaluation
IX. Establishment of Plan

QAPI Plan Discussion

- Review examples – these are not meant to represent gold standards
- Discuss strengths and weaknesses of examples
- Goal: identify potential best practices

Scope

- II.a. Our center's full range of services included in our QAPI program are post acute care, long term care, and outpatient therapies. Our center's departments include: (*departments listed*)- nursing, dietary, housekeeping, laundry, maintenance, HIM, activities and staff education will have a representative on the QAPI committee. Therapy, music therapy, human resources, resource development, business office and therapy departments will be asked for input or sit on a performance improvement project sub- committee as requested.

Scope

II.b

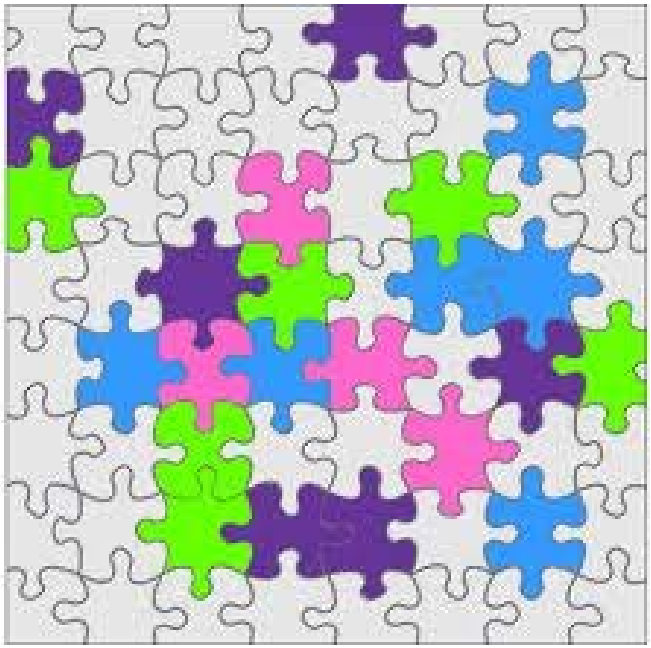
- **Clinical Care** – monitor existing QI/QM results, internal monitors for falls, medication errors, pressure ulcers, incident reports, infection reports. The QOC Team meets monthly with Medical Director and others to address “care concerns.”
- **Quality of Life** - monitor existing data available through QOL survey, resident/family satisfaction surveys, resident/family concerns brought up at Household/Community Council meetings, concerns from care conferences and individual rounding with residents and family members. The QOL Team meets monthly to address “life concerns.”
- **Resident Choice** – Individualized goals for care are addressed at care conferences, through the formal survey processes, and with rounding.

Scope

II.c. We will use the performance prioritization sheet to identify areas of improvement and rank them by factors such as prevalence, risk, cost, relevance, responsiveness, feasibility, and continuity. From this we will determine our PIPs. Our focus will also be on how we can create innovative best practices while making sure resident's autonomy is maintained.

II.d. Review of State/National and past facility measures will be used to benchmark for improvement in all areas. These benchmarks will be reviewed at least monthly, and reported to the QAPI Committee on a quarterly basis.

Discussion



Guidelines for Governance and Leadership

III.a. The community advisory board and administration will be responsible and accountable for developing, leading, and closely monitoring a QAPI program.

- Input will be obtained from facility staff on a monthly basis through the QAPI Council. Department heads are responsible for talking to their employees before reporting in to QAPI. Residents and families have input through resident and family council and our satisfaction surveys.
- The input given will be acted upon and bring QAPI to life in the facility. Concerns will be brought up when a certain department or task is not hitting benchmark. The concern will be discussed and an action plan developed. If necessary it will go on the Performance Improvement Project Prioritization sheet.

Guidelines for Governance and Leadership

III.b. The administrator ensures that the quality program is adequately resourced.

i. A Quality Management Coordinator is responsible for QAPI processes.

ii. The Quality Management Coordinator ensures that consistent, appropriate and just-in-time training is provided to facility employees. Quality topics are covered at general orientation and with on-going training.

iii. Allocation of resources for quality activities such as time, equipment, and technical training are provided as needed by the Administrator in conjunction with the Quality Council.

iv. A determination of adequacy of resources will be determined by on-going monitoring of quality improvement team progress and the annual completion of our Quality evaluation tool.

v. Caregivers will become and remain proficient with QI tools and techniques through on-going training and on-going use in day-to-day operations. The caregivers level of proficiency is assessed by the Quality Council through on-going monitoring of quality data.

Guidelines for Governance and Leadership

III.b.v. Small group education sessions on QAPI will be provided to all caregivers working in the building. The use of visual aide tools describing process improvement will be utilized as reminders to keep staff members focused on performance improvement techniques. Paycheck stuffers will contain "Bits of QAPI" designed to provide ongoing information on the commitment to incorporate QAPI in the fabric of our culture and daily operations. QAPI will also become part of orientation for new staff members joining our team. Quarterly QAPI focus meetings will be implemented to ensure that staff members' level of proficiency will remain current. Also, as part of annual evaluations, staff members will be expected to answer questions regarding performance improvement and how QAPI is used in operations of the facility.

Guidelines for Governance and Leadership

III.c. QAPI Leadership

i. The QAPI Council will provide the backbone and structure for QAPI. This group includes all of the Executive Leadership team (list titles of team members including administrator, DON, medical director), plus xx staff members, physician, contracted pharmacist, etc).

ii. This group of people will work together to communicate and coordinate QAPI activities. Currently QAPI Council meets once a month. We also have a bi-weekly QAPI meeting to discuss QAPI, what our next steps are, and how things are going throughout the building. This is where we come up with ideas to communicate new tools to staff.

- Existing ongoing committees (e.g., mobility/falls) report their data and activities to the QAPI council.

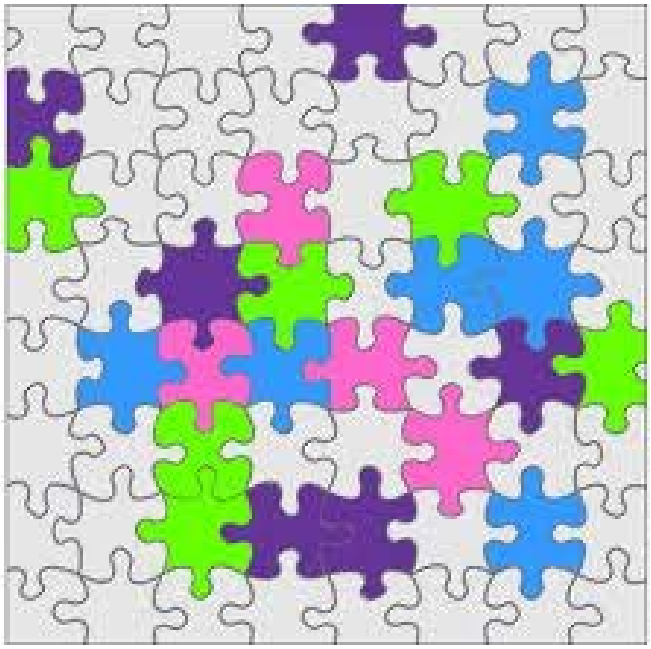
iii. QAPI activities will be reported to the governing body at every Board meeting which is held every other month.

Guidelines for Governance and Leadership

III.c. **The QAPI Steering Committee:**

- Steering Committee membership is interdisciplinary with at least 2 non-licensed staff members, and one resident council member.
- The QAPI Committee meets monthly and maintains minutes of all activity.
- The committee maintains a QAPI manual that houses meeting minutes, project charters, PIP's, PSDA reviews, data, data analysis and sample performance improvement support tools. Note this QAPI manual is different from the QAPI plan.
- Communication about the QAPI activities is shared via staff meetings, trainings, a bi - monthly article in the Center News Letter. The administrator also includes QAPI issues in bi-weekly reports to the DOO and the facility ownership.
- The QAPI Steering Committee will complete an annual self assessment / review of the QAPI program.

Discussion



Feedback, Data Systems, and Monitoring

- IV.b. The following data will be monitored through QAPI:
  - Input from caregivers, residents, families, and others; Adverse events; Performance indicators; Survey findings; Complaints
- IV.c. Process for collecting the above information:
  - Gather input from caregivers, residents, families, and others (Surveys, Council Meetings, written evals, PCP input)
  - Adverse events (incident reports, 24 hour report)
  - Performance indicators (Monthly QM, 5 Start Rating, Advancing Excellence)
  - Survey findings (2567)
  - Complaints. (input at PCP, surveys, Council Meetings, written comments)

Feedback, Data Systems, and Monitoring

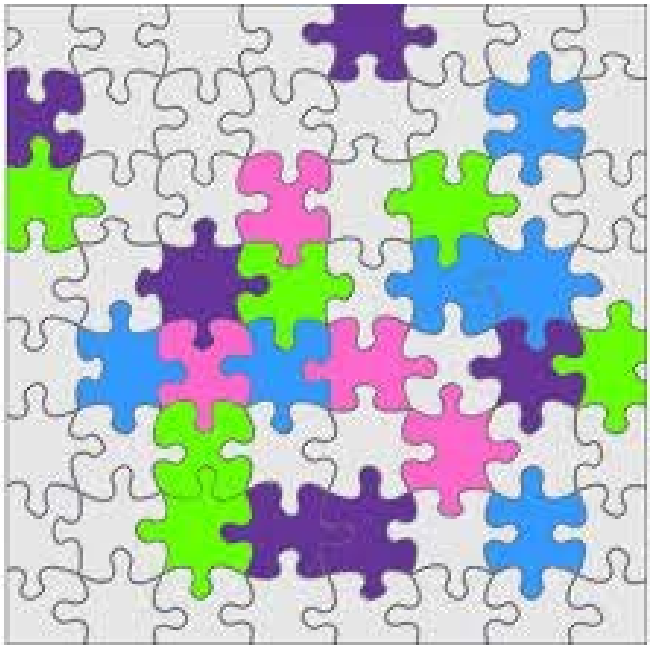
IV.d. Process for analyzing the above information, including how findings will be reviewed against benchmarks and/or targets established by the facility.

- Current scores will be analyzed against bench marks that have been set – quarterly
- Daily IDT will review adverse events/complaints – daily
  - We have a mechanism for communicating patterns, trends identified during IDT meetings to the broader QAPI committee.
- Consultant reports will be compared to goals - monthly
- QAPI teams will analyze data PRN

Feedback, Data Systems, and Monitoring

- IV.e-f. Describe the process to communicate the above information.
  - Dashboard – corporate maintains info
  - Monthly reports / graphs – Dept managers and/or QAPI Lead Person
  - Logs – QAPI Lead
  - Minutes of all meetings – person in charge

Discussion



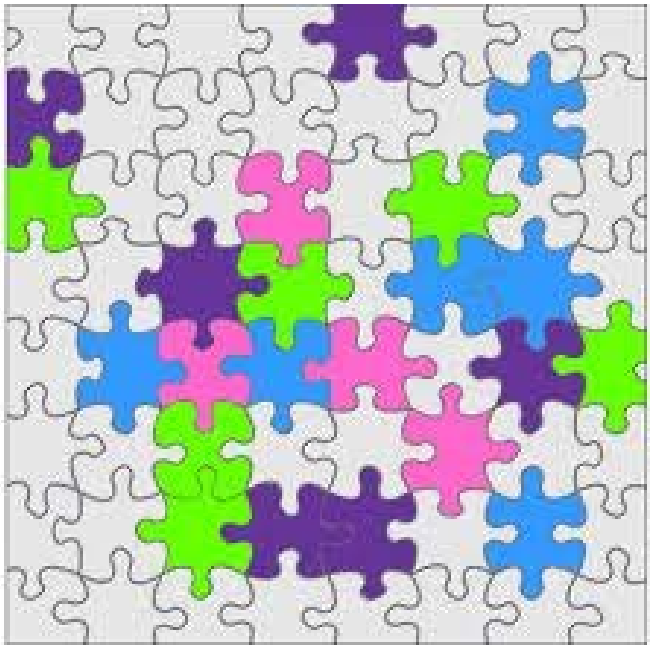
Guidelines for Performance Improvement Project (PIP) Teams

- V.a.i. Potential topics for PIPs will be indentified through a prioritization process in the QAPI Committee.
- ii. Criteria for prioritizing and selecting PIP's will be based on prevalence, risk, cost, relevance, responsiveness, feasibility, and continuity.
- iii. PIP's will involve gathering information to clarify issues or problems, design and implement interventions, assess results, and sustain improvements utilizing the PDSA Cycle.
- iv. PIP project charters will be developed based on a prioritizing process with a minimum of one project chartered at a time, more than one may be chartered based on the project, available resources and QAPI Committee recommendation.
- v. Results will be reported to resident, families, staff and others verbally or in writing at least one time during the performance improvement plan more often as appropriate.

Guidelines for Performance Improvement Project (PIP) Teams

- V.b. How PIP teams will be designated. The QAPI committee along with the project lead will be responsible for assembling the PIP team
- c. The QAPI Committee will select a qualified staff member to lead the project. PIP team will be interdisciplinary with representation of each of the job roles affected by the project and resident representation will be included as appropriate.
- d. PIPs will be reported by the project lead to the monthly QAPI Committee meeting verbally and documented in the meeting minutes.

Discussion



Systematic Analysis and Systemic Action

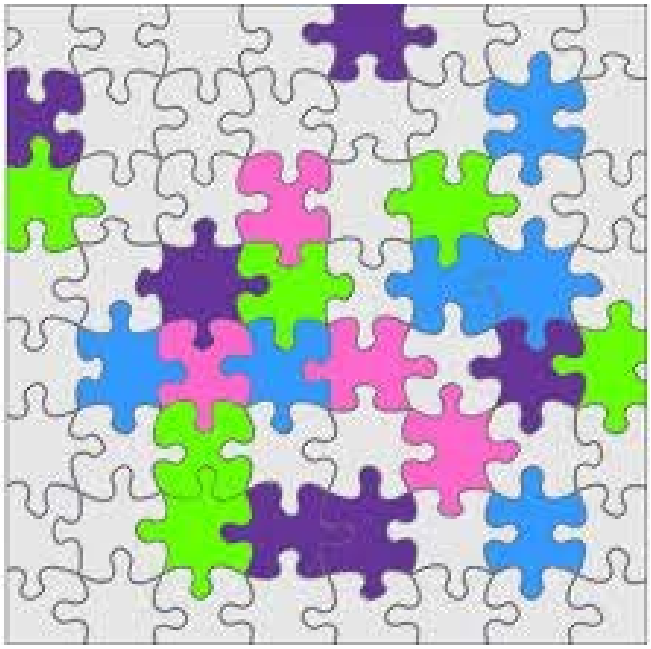
VI. Each PIP will be conducted systematically, utilizing a structured format.

- Development of a flow chart, describing the current process we use, identifying any areas of breakdown or weakness in the current process
- Make a plan describing what areas of the process we are going to change (where breakdowns were observed), utilizing the Project Plan and Monitoring Tool. (PLAN). Depending on the problem, this section can be expanded. We will use structured RCA and/or FMEA depending on the issue/opportunity.
- Implement changes to these areas in the process (DO)
- Monitor the process according to pre-determined time frames, observing if the changes in the process resulted in the desired outcome. (STUDY)

Systematic Analysis and Systemic Action

- If the changes to the process have not resulted in the goal of the PIP, make further changes and monitor the process again. (ACT)
- Once the PIP goals have been met, the PIP will placed on a permanent tracking log, to assure the PIP doesn’t get “forgotten”.

Discussion



Communications

- VII. Communications from the quality committee and its subcommittees and their actions will be communicated based on the audience.
  - For Staff we plan to communicate via staff newsletters, monthly department meetings, email updates, and memos.
  - For residents we plan to communicate via resident council, neighborhood meetings, newsletters and letters.
  - For families we plan to communicated via newsletters, neighborhood meetings and memos.

Evaluation

- VIII. The QAPI program will be evaluated annually by the Steering Committee with input from other staff and stakeholders.
  - The key elements of the program will be reviewed to assure that they are occurring, that the program is efficient, it is accessible to community members and that the results are communicated to the appropriate audience.
  - performance indicators that are monitored will be reviewed - are they still relevant, do we need to monitor them as frequently, or more frequently? Are our goals, thresholds still relevant, achievable, etc.
  - Ongoing training needs will be identified and addressed.
  - Staff will participate in a brief survey about our QAPI program as well as identifying any issues in their individual performance assessment.

Evaluation

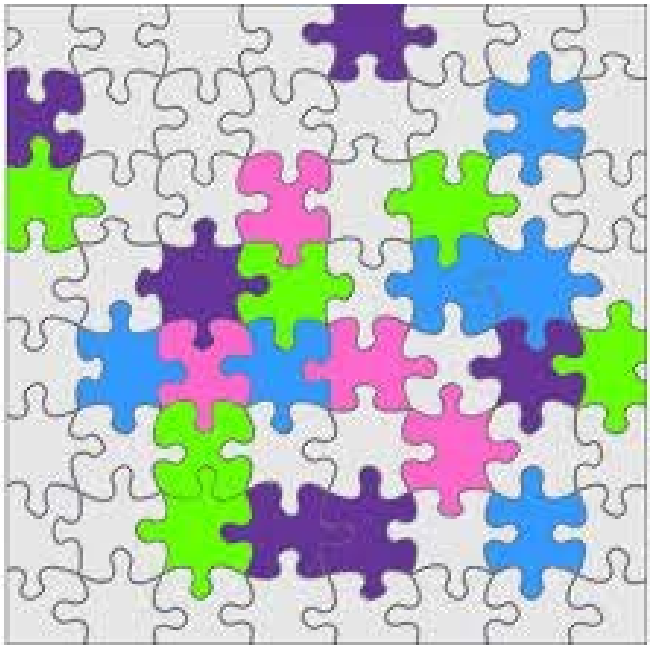
- VIII. This evaluation should include an assessment of the leadership provided by the Quality Council, which could include self-evaluation as well as feedback from project teams under the guidance of the committee and/or other stakeholders. A report will be compiled summarizing activities that take place under the QAPI Program and their current status, including care delivery processes modified and evidence of improvement goal attainment. QAPI council will review this bi-annually.

Establishment of the Plan

- IX. Review date (one year past start date)
- Revisions to this plan are identified below

Date of Revision	Revision	Explanation of reason for the change	Date approved by Quality Council

Discussion



Action Plan

- What might you do in the next two weeks, one month and six months to support your nursing homes in developing useful QAPI plans?

More Resources and Tools Coming

- QAPI learning sessions for leaders, direct care staff, and residents/families
- Tools:
  - Making data meaningful
  - Understanding processes and systems
  - Implementing PIPs
  - Enhancing QAPI communications

Spread the Word and the Work

Conclusion

QAPI

- Helps nursing homes achieve higher quality.
- Is fulfilling for direct care staff, who are active partners in performance improvement.
- Results in better care and quality of life for residents.

QIO Discussion

- Share your number 1 insight from this discussion.
- What do you think are the keys to developing a QAPI plan that is useful to the facility?
- What are you going to do to support nursing homes in using the self assessment tool and the guide to develop a QAPI plan?

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Sharing Knowledge. Improving Health Care.
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