Implementation Guidelines for an Effective Quality Assurance and Performance Improvement (QAPI) System

AUDIO CONFERENCE

Date/Time:
Thursday, March 28, 2013, 10 a.m. – noon

Presenter:
Demetria Haffenreffer, RN, MBA, president, Haffenreffer & Associates, Inc.

Packet Contents:
- Handout
- Credit Instructions
- CEU Affidavit
- Evaluation/Credit Form
- Post-Test

Dial-In Instructions:
Conference Phone Number: 866-380-9615
Participant Access Code: 325419#
You may dial the toll-free number no sooner than five minutes prior to the program.
Today’s topics

- Review of implementation steps
- QAPI Plan
  - Identifying and setting measures
  - Root cause analysis
- Establishing and enabling Performance teams
- Designing a QAPI project
Implementation

- Conduct a Self-Assessment of your current QAPI program
- Identify gaps
- Develop a plan based on gaps identified in Self-Assessment
- Develop policies and guiding principles
  - Utilize resources available
- Establish measures
  - Those that will be monitored routinely
- Conduct training
- Identify projects

CMS Five Elements

- Design and Scope
- Governance and Leadership
- Feedback, Data Systems and Monitoring
- Performance Improvement Projects
- Systematic Analysis and Systemic Action
QAPI Plan outline

- Overall goals
- Scope
- Overall responsibilities
- Feedback, Data systems and Monitoring
- Systematic analysis and action
- Projects and project teams
- Communications
- Training
- Evaluation

Core Components of QA Methodology

- Identify the process to improve
- Identify the team
- Clarify what is known about the process and how it currently works
- Identify and verify root cause(s) of the problem(s)
- Determine the solution
- Implement plan
- Check to see if plan worked (evaluate)
- Maintain improvements and / or determine next steps
- Document and communicate
Using QA Methodology

- PDSA
- PDCA
- FOCUS PDSA or PDCA
- FADE (Focus, Analyze, Develop, Execute and Evaluate)
- DMAIC (Define, Measure, Analyze, Improve, Control)
- There are more!
Six Sigma – Key Dimensions

Driven by customer needs

Enabled by quality team.

Led by Senior Mgmt

Methodology

Organization

Tools

Define

Measure

Analyze

Improve

Control

Process variation

Upper/Lower specification limits

Regression

Vendor

Process B

Process A

Customer

Vendor

Process B

Process A

Customer

Model for Improvement

Set Aims: Time specific, and measurable

Establish Measures: Quantitative and well defined

Select Change: Select those that will result in most improvement

Test the Change: Use PDSA to test change first on a small scale – then implement
Steps

- **F** – Find something (process or system) to improve
- **O** – Organize to improve the process
  - Utilize PITS – Process Improvement Teams
- **C** – Clarify current knowledge of the process or system
  - Understand the current process
- **U** – Understand the sources of process variation
  - Where are the variations and the results – and why
- **S** – Select the process improvement

\[ P D S A \]

CQI Problem Solving Methodology

Plan
What are you planning to change?

Act
Revise plan / retest. Spread or expand the test. Implement change.

DO
Pilot your test. What were the results? Document.

Study
What happened? What were the results? What did you learn?
Why Measure?

- Know how processes are performing
- Know if you are achieving results
- Identify areas for improvement
- Determine the effect of a change you made
- Provide data for decision making
- Management oversight
- Meet regulatory requirements
- Provide evidence of quality
Data Collection Steps

- Define
  - Operational definition
- How will it be measured
  - Tools needed?
- Determine when will be collected
- Determine where data will be collected
- Determine who will collect
- Determine if training is needed

How to Plan & Set a Measure

- Start by asking these questions
  - What will you measure & why is it important?
  - What is the overall goal?
  - How will you specifically define it?
    - Definition
      - Numerator & Denominator
    - How are you going to collect the data?
    - How will you display and analyze it?
    - Who will review it and when
Example of a Measure / Goal

- **Definition**
  - “All falls as defined by the RAI that occurred in the past month”
  - “All residents receiving an antipsychotic medication with only the diagnosis of Dementia”
  - “All residents with hospital readmissions who have been admitted within the last thirty days”

- **Overall Measure**
  - “Falls no greater than 25% of average daily census. No major injuries (RAI definition)"
  - “Will decrease current antipsychotic use in residents with dementia by 15% of current rate in 2013 (35%) – to 32%"
  - “Will decrease current avoidable hospital readmission rate by 15% in 2013”

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Example of a Measure / Goal

- **Numerator**
  - “Total number of falls”
  - “Total number of residents receiving antipsychotics with only the diagnosis of Dementia for the year (2012)”
  - “Total number of residents discharged to hospital within thirty days who were admitted within that thirty day period for the year (2012).”

- **Denominator**
  For falls = “Average daily census for the past 30 days X 100”
  For Meds & Hospital readmissions: “Average daily census for the year (2012) X 100”
Example of a Measure / Goal

- **Exclusions**
  “Falls related to resident:resident behaviors”
  “Residents receiving antipsychotics with diagnosis of schizophrenia”
  “Residents who required discharge due to extreme medical conditions.”

- **How / When will data be collected**
  “Data will be collected monthly from incident reports/pharmacy report/census information by the 5th of the next month”

- **Who is responsible**
  “Director of Nursing or other”

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How to Measure

- Prioritize according to services
  - High risk
  - High volume
  - Problem prone
  - Life threatening
  - Contractual requirement
  - Cost/financial
  - Customer satisfaction
  - Ethics and rights
  - Infection control
  - Mission, vision, values, and organizational objectives
  - Outcomes
  - Regulatory
  - Risk management/liability
  - Safety
  - Issue involves more than one of the above impact areas
What to Measure

- Admissions/Discharges
- Care Transitions (Services and information flow across settings of care)
- Ethics and Compliance activities (OIG Guidance)
- Restraint use
- Activity Programs
- Palliative Care and End of Life
- Resident Satisfaction
- Family Satisfaction

What to Measure

- Medical record review, closed and open – Assessment timing and completion
- Medication use and management (including medication errors)
- Pressure Ulcer rates
- Resident Safety Issues
- Sentinel events (such as death or serious injury due to a fall, medication errors, or other facility identified events)
- Resuscitation and its outcomes
What to Measure

- Staffing
- Absenteeism
- Employee satisfaction
- Dietary/food services – weight loss
- Physician visits
- Rehabilitation services
- Utilization management
- Infection control
- Housekeeping
- Environment of care/safety/plant/facilities

What to Measure

- Financial services/business office
- Employee turnover & retention rates
- Staff competencies & training
- Performance improvement teams
- Radiology and other diagnostic services (provided by facility or under agreement)
- Laboratory (including blood and transfusion services) (provided by facility or under agreement)
- Staff views related to career development
- Contract and agreement services (includes dental, pharmacy, others)
- Risk management
What to Measure

- Centers for Medicare and Medicaid Services improvement initiatives
- Aggregate outcome data
- Physician, Discharge Planner, Vendor Satisfaction
- Peer review trends
- Publicly reported data and comparative databases
- Regulatory issues
- Specific processes – such as medication pass and other competencies

How to Measure

- As part of your planning process you have identified your key services & processes
- Start by asking these questions
  - What will you measure
  - Why do you want to measure something?
  - How are you going to collect the data?
  - How will you display and analyze it?
  - Who will review it and when
Types of Data

- **Process**
  - How something is occurring along the way, before the outcome occurs.

- **Outcome**
  - The end result or output of a process.

- **Observable**
  - Observation of a process

- **Count**
  - Events counted and placed into categories

- There are others

Where to get Data

- Quality Indicators/Quality Measures Profile and Resident Level Summary
- Publicly reported quality measures
- The QIS QCLI dictionary has indicators and measures for QIS survey
- OSCAR/CASPER and other CMS databases and reports
- Complaints and survey history
- Facility internal clinical reports such as recent falls, other accidents, skin breakdown, weight loss, reasons for discharges, infection control (e.g., overall infection rates), and medication errors
- Other facility reports such as employee and resident satisfaction surveys, grievances, financial reports, employee retention and turnover reports, and corporate compliance and/or other risk management reports
- Corporate scorecards, dashboards, or other data provisions
- Reports available from outside resources and organizations such as Ombudsmen, Resident Advocates, AHCA, AAHSA, State Quality Programs, State QIOs, Advancing Excellence, and others
- Outside the industry
How to Display what you Measure

- Flow charts
- Run Charts
- Pareto Charts
- Tables
- Graphs

Run Charts
How do you analyze and solve problems / improve systems effectively within your organization?

**Analyze**

<table>
<thead>
<tr>
<th>What is it</th>
<th>Why important</th>
<th>What it includes</th>
<th>How to Implement</th>
</tr>
</thead>
<tbody>
<tr>
<td>● Putting data in a structure that can be used to analyze and determine conclusions. A graphical picture allows one to identify at a glance any patterns, trends, or priorities that emerge</td>
<td>● Processes and systems rarely operate in isolation and must always be considered in relation to other processes and systems that impact them. ● Finding the root cause will increase the likelihood of resolving the problem</td>
<td>● Root cause analysis ● Run charts ● Flow charts ● A QI methodology – see enable ● Data-driven decision making</td>
<td>● Develop policies ● Develop training ● Develop a strategic plan ● Implement QI teams ● Communicate findings</td>
</tr>
</tbody>
</table>
Multi-Causal Theory “Swiss Cheese” diagram (Reason, 1991)

Root Cause Analysis

- Root cause is the most basic reason for an undesirable condition or problem which if eliminated or corrected, would have prevented it from existing or occurring.
- RCA helps you to determine:
  - The series of events that actually happened
  - What parts of your system worked well
  - What parts of your system lined up to allow an error
  - What meaningful steps your system can take to improve safety
  - Prioritization of causes & therefore assists with prioritizing action plans
  - Resident specific and employee specific problems
Root Cause Analysis Key Concepts

- The focus is on safety and prevention: immediate & long-range
- Everyone has a voice and the voices all ask "why?" – five times & more
- All available evidence is used to analyze the situation
- The analysis is used to develop a goal and make an action plan
  - Uses Tools for analysis – such as flowcharts to understand processes and variation from processes; cause and effect diagrams (fish bone) to explore cause and effect variations in a process
- The plan is reassessed (evaluated / re-evaluated) and tweaked until it works
- Quality Improvement is a proactive process, not a reactive event

Root Cause Analysis

5 Whys
Ask "why" something happened at least five times, going deeper with each "why."
It is likely that the last answer will be the actual root cause.
How to Construct a Flow Chart

- Bring people together who perform the process or are affected by it
- Identify the beginning and end points
- Have each person walk through the process
- Determine symbols (optional)
- Ask clarifying questions
  - How is this done? How else is this done? Can you explain this in more detail? Does it always work this way? Is this done any other ways? What do you mean by______? Walk me through this part. Can you give me an example?

Flow Charting Tips

- Stay with the process
- Make sure no steps are missing
- There should be only one arrow out of a process box
- Decision points have yes or no options
- Maintain a clear flow
- Suspend “WHY’s” at this point
- Expect that people are doing things differently
- Reserve judgments
- Clarify and probe
Flow Chart

1. Start
2. Process
3. Process
4. Process
5. Decision
6. Process
7. Decision
8. Process
9. End

Figure 3: RCA/Causal Tree Diagram

- Cognitive decline during staffing not documented in plan
- Staff did not report changes in cognition
- Staff did not report decline in cognition
- Lack of consistent staffing
- Sink drawing
- Sink overflowing
- Maintenance unaware of problem
- Water on floor
- Memory of staff seeking for help not documented in previous FAME investigation
- No systematic intervention protocol for staff to use
- No system in place to report problems
- Management did not establish process
Fish Bone

Causal Tree Diagram
Develop an Action Plan

- Use a team
- What will keep this from happening again?
- Focus on the root causes
- Develop short range and long range goals
- Document the plan
- Implement – start small

Evaluation of the Results

- You have defined your goals earlier on, such as for a resident: Those measures we already discussed
- How successful have we been?
- Do we need a new plan?
  - Develop a PIT?
Tips for Developing Effective Teams

- Develop a team charter
- Teach team members new skills
- Use team building exercises
- Encourage the team to follow the Manager-as-Developer approach
- Consider a team facilitator
- Assign team member roles
- Rotate team assignments
- Establish a specific quality action plan
- Organize meetings
- Deliver quick wins
- Reward and celebrate
QAPI Example

Medication Error Issues

Medication Errors
Medication Errors Action Plan

<table>
<thead>
<tr>
<th>Action Item</th>
<th>Responsible Person(s)</th>
<th>Completion Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Implement competency checks on hire and annually</td>
<td>Staff Education</td>
<td>9/1/12</td>
</tr>
<tr>
<td>- Complete competency checks on all current medication aides</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. Place pictures of residents in all tackle boxes</td>
<td>Resident Coordinator</td>
<td>8/15/12</td>
</tr>
<tr>
<td>3. Add communication specifics related to resident meds and packaging to admission packet.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Enforce medication packaging in 30 days of admission</td>
<td>Executive Director in collaboration with Admission Coordinator</td>
<td>9/1/12</td>
</tr>
<tr>
<td>4. Contact pharmacy for Tallman lettering</td>
<td>Director of Nursing</td>
<td>8/15/12</td>
</tr>
<tr>
<td>- review implementation date</td>
<td></td>
<td></td>
</tr>
<tr>
<td>5. Implement consistent med pass procedure</td>
<td>Director of Nursing</td>
<td>9/1/12</td>
</tr>
</tbody>
</table>

QUESTIONS?
Resources


Resources

CREDIT INSTRUCTIONS

Audio Conference: Implementation Guidelines for an Effective Quality Assurance and Performance Improvement (QAPI) System

Date/Time: Thursday, March 28, 2013, 10 a.m. - noon

Credit Available: 2 hours of Licensed Nursing Home Administrator (NAB) credit for up to four individuals from the same facility (no affiliates).

Instructions for Obtaining Credit:
Please complete and fax the following forms to 518.867.8386 or 518.867.8389 no later than April 11th:

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- Evaluation/Credit Form
- Post-Test

Print the credit forms for each individual seeking credit. On each form, indicate the name of the person that your organization’s registration is under.

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If you have any questions, please contact Linda Smith at 518.867.8385, ext. 154 or lsmith@leadingagency.org
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Organization: ________________________________________________________________

Name of Registrant: __________________________________________________________

This form attests that ____________________________________________________________,

(Full name of person seeking credit)

____________________________________________, was in attendance for the full 2 hours of the

(Title)


Witness: (Print) ________________________________________________________________

(Staff in attendance, other than the person seeking credit)

(Signature) ________________________________________________________________ Date: ______________
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EVALUATION

1. How many other staff from your organization were listening to the audio conference with you? _______________

2. Please check the box that best describes your rating:  
   Excellent  Good  Fair  Poor
   a. Overall rating
   b. Presenter’s knowledge of material/topic
   c. Learning objectives & content material
   d. Usefulness of the knowledge/skill required
   e. Appropriateness of topic content

3. Was participating in this seminar a wise business decision? ☐ Yes ☐ No
   If not, why? __________________________________________________________

4. Is LeadingAge New York/FLTC your first choice for educational opportunities? ☐ Yes ☐ No

5. What new developments in the field do you believe will have an important future impact?
   ______________________________________________________________________
   ______________________________________________________________________

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Name & Title of Person Seeking Credit: ______________________________________________

Organization: ___________________________________________________________________

Address: _______________________________________________________________________

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Telephone: ( ) __________________________ E-Mail: ___________________________________

NYS NH Administrator License No.: ________________________________________________

I am also licensed in other states with license numbers as follows: ____________________________

This program has been reviewed and approved by NAB/NCERS. NCERS strives to approve only quality programs whose content can reasonably contribute to the professional development of long-term care administrators. If you have any confidential comments concerning this program, which you would like to make to NCERS administrators, please direct them to cecomments@nabweb.org.
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Name of Registrant: ____________________________________________________________

Name of Person Seeking Credit: ________________________________________________

PLEASE CIRCLE THE CORRECT ANSWER:

1. For a root cause analysis you should ask why about 7 times.
   a. True
   b. False

2. The FOCUS model should be used to assist the team in developing and implementing a plan for improvement.
   a. True
   b. False

3. Feedback, data systems, and monitoring are an important part of a QAPI plan.
   a. True
   b. False

4. As part of your planning process, you need to identify your key services & processes.
   a. True
   b. False

5. Care transition is not an important area that your organization needs to measure.
   a. True
   b. False

6. “Systematic Analysis” and “Systemic Action” are part of the CMS five elements.
   a. True
   b. False

7. Evaluation is not part of the QAPI plan.
   a. True
   b. False

8. FADE represents Focus, Analyze, Divide, Execute and Evaluate.
   a. True
   b. False

9. Providing data for decision making is an important reason for setting measures.
   a. True
   b. False

10. The survey history is a good place to collect data.
    a. True
    b. False