QAPI

A Team Approach

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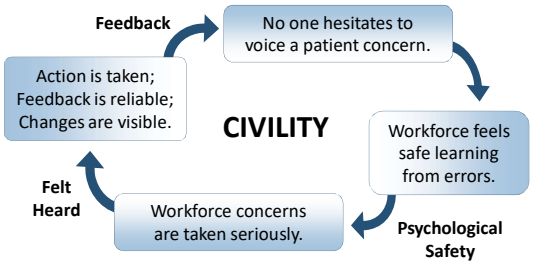
Idaho Health Care Association Annual Convention and Tradeshow
Boise Centre, Idaho
Wednesday, July 18, 2018 ★ 8:30 am – 10:00 am

QAPI

Quality Assurance Performance Improvement

We have a Systematic Approach to Developing and Deploying Action Plans through Cycles of Evaluation and Improvement using PDSA and QAPI

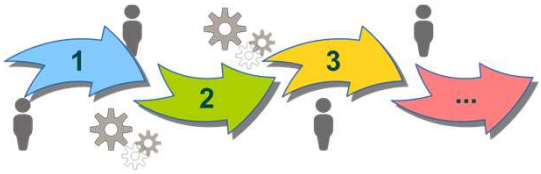
Creating a Culture of Safety



Reference: Sociotechnologix

"If you can't describe what you are doing as a process, you don't know what you are doing."

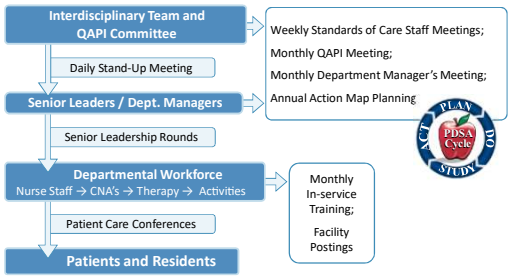
-W. Edwards Deming



QAPI Tools and Techniques

- First step in planning a QAPI initiative is to analyze your processes and understand the problems.
- A process is a series of connected steps or actions to achieve an outcome. It has start point and end point.
- Processes interact with systems as a whole.
- To improve a process, you must refine and optimize the steps in that process making it more efficient.

QAPI Team Members



What if ... we adapt to change?

"Review and Approve" to "Debate and Decide"

"What if we don't change at all ...
and something magical just happens?"

Example of an Effective Meeting

Performance Improvement (PI) Committee Pre-Meeting Checklist

This checklist may be used as an example of how to prepare for your next PI meeting.

Meeting Organizer Checklist:

(Begin several weeks prior to the published meeting date)

- ☐ Review last meeting minutes.
- ☐ List items that require follow-up from the last meeting.
- ☐ Obtain data reports from QIOM, Business Warehouse, Complaints, Resident Council, and Morning Stand up to compile a list of potential agenda items has been distributed to the PI Committee Members. Look for trends and prioritize the information.
- ☐ Review any survey issues and plans of correction. List all items that should be validated through the PI process for state survey.
- ☐ Review any SMART issues that were identified. Refer to the SMART Resource Guide for interviews, audits and observations that need to be completed.
- ☐ Contact all workgroup leaders and review their status and need to report at the PI meeting.
- ☐ Create the agenda.
- ☐ Notify all departments, and presenters of the date, time, and location of the meeting.
- ☐ Publish the agenda.
- ☐ Conduct the meeting. (Assign roles and responsibilities such as recorder, timekeeper, and facilitator.)
- ☐ At the conclusion of every meeting determine and record the date and time of the next meeting.
- ☐ Evaluate the PI meeting for improvements on the process.
- ☐ Review and publish the meeting minutes no later than 1 week post meeting.

Workgroup Leader Checklist:

(With individual assignments or workgroup participant)

- ☐ Review Workgroup's status on projects/activities.
- ☐ Prepare a report on the current activities.

Meeting Member Checklist

- ☐ Review data reports in the member's area of responsibility.
- ☐ Review the meeting minutes.
- ☐ Review the current agenda.
- ☐ Schedule the next meeting on your calendar.
- ☐ Followup on assignments/responsibilities.
- ☐ Notify meeting organizer for potential agenda topics.

Performance Improvement Meeting Attendance and Agenda

Center: Mountain Valley Care

Date: 7/1/2018 **Time:** 7:30

Attendance (Signatures of Attendees)

Executive Director:		Rehabilitation:	
Physician:		Staff Development:	
Director of Nursing Services:		Environmental Services:	
Social Services:		Business Office:	
Nutrition Services:		Licensed Nurse:	
Activities:		Certified Nursing Assistant:	

Agenda Items

Agenda Topics	Time Allotment	Responsible Person
2018 Action Map / Goals	**1 Minutes**	**ED** – Updated second, discussion/review
1) QI QIM – Catheter/SR Pain (L) (S)	**1 Minute**	**ED (See attached clinical MOR)**
2) Falls	**4 Minutes**	**ED/DNS (PI sheets updated)**
3) "A" ADL's	**2 Minutes**	**CMC/MDS/SDC (Review CMCA Audit)**
4) Infection Control	**1 Minute**	**SDC – (Employee Flu Shot Campaign)**
5) Maintenance Audit	**1 Minute**	**ED/Maintenance (round form completed)**
6) Employee Satisfaction	**2 Minutes**	**ED (PI Began see retention minutes)**
7) Therapy/LN Communication	**1 Minute**	**DPT/DNS – PCC Communication**
8) Daily Monitoring Tool	**1 Minute**	**ED/DNS**
9) New Admit Audit	**1 Minute**	**DNS/MR**
10) PreSurvey/CQR	**5 Minutes**	**DNS/DM/ED (follow up 9/18/14)**
Review Current Survey Pl's		**COMPLETED**
F242 Self Determination – Choice	**Completed 12/13**	**PI 100% twice week for 3 weeks**
F309 Care Services Highest	**Completed 12/13**	**PI 100% twice week for 3 weeks**
F431 Storage of Pharmacy	**Completed 12/13**	**PI 100% twice week for 3 weeks**
F441 Infection Control ABAQIS	**Completed 12/13 1 Minutes**	**PI 100% twice week for 3 weeks Reports reviewed (PI with pre-survey)**
Fire Life Safety	**0 Minutes**	Citation Free

Signature/Title: _____ **Date:** _____

‡The Director of Nursing Services and a designated physician are required to attend the PI Meeting with at least 3 other members of the center's staff 42 C.F.R. 483.75(o)

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Performance Measurement System

Group Techniques

Technique	When to Use
Multi-Voting	A group decision-making technique designed to select the most important of popular topics from a list with limited discussion and difficulty.
Structured Discussion	A group decision-making technique designed to gain group consensus on a list of ideas or topics.
High Volume, High Risk, Problem Prone, High Cost	A technique used to prioritize issues so that those issues with the largest impact are addressed first and resources are utilized appropriately.

Key Process for Determining Objectives

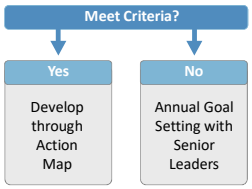
Step 1) **Categorize Objective into Domains**

1) High Volumes?

2) High Risk?

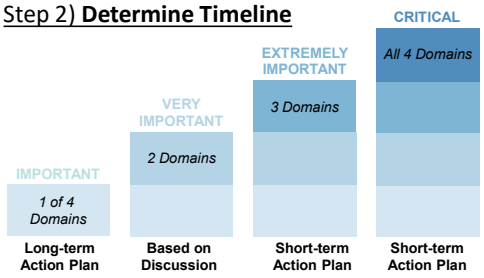
3) Problem Prone?

4) High Cost?



Key Process for Determining Objectives

Step 2) **Determine Timeline**



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QAPI Immediate Action Plan

The Immediate Action Plan is a quick and simple form to address a potential or known problem (such as an isolated issue or concern identified as requiring immediate attention) for which the solution is straightforward. The documentation of this Immediate Action Plan will be reviewed by the QAPI Committee to determine if a Performance Improvement Project should be initiated.

Action Plan Title:

Date: Name of Action Taker, Title:

List the opportunity for improvement (Issue or concern):

Goal/Objective:

What are the implications of not taking action? Please select one and explain.

- High Risk - actual harm has occurred
- Medium Risk - potential for no more than minimal harm
- Low Risk - no potential for actual harm

What are the steps to identify how the area of concern can be addressed?

Step 1

Step 2

Identify individuals such as residents, family, and/or staff who are affected by the issue or concern. *(Prioritize highest-risk individuals for immediate focus.)*

Notes on Action Taken:

☐ Check this box if Action Taker is Department Supervisor

Date turned in to appropriate Department Supervisor, if above box is not checked:

Date turned in to QAPI Committee or QAPI Coordinator:

Area Reserved for QAPI Committee Notes:

Date Reviewed:

providigm

"If you cannot measure it,
you cannot improve it."

-Lord Kelvin

Determining Data

Data Drives Improvement

- Data doesn't provide Effective Basis for Actions or Setting Priorities
- Effective Actions depend on an understanding of Relationships, derived from Data Analysis

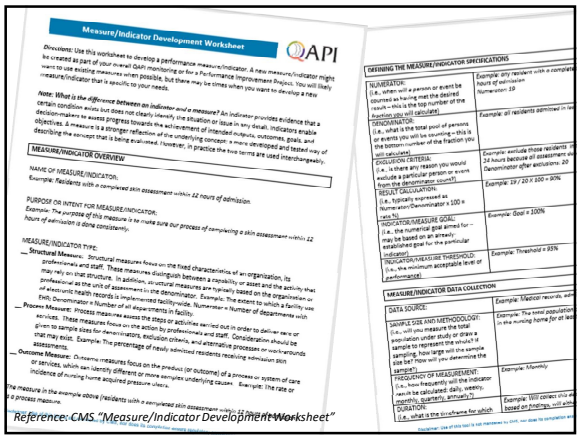
Determining Data

Data Collection and Integrity

- Actionable Data
  - Quality, Availability
- Comparable Data
  - Competitors, Other Providers, Best Practices
- Segmented Data
  - Health Care Services
  - Patient and Stakeholder Groups
  - Workforce Groups
- Repeatable Data
  - Daily, Weekly, Monthly, Annually

MEASURE/INDICATOR DATA COLLECTION	
DATA SOURCE:	***Medical records, admission skin assessment form***
SAMPLE SIZE AND METHODOLOGY: (i.e., will you measure the total population under study or draw a sample to represent the whole? If sampling, how large will the sample size be? How will you determine the sample?)	***The total population admitted in the last month who were in the nursing home for at least 24 hours will be reviewed.***
FREQUENCY OF MEASUREMENT: (i.e., how frequently will the Indicator result be calculated: daily, weekly, monthly, quarterly, annually?)	***Monthly***
DURATION: (i.e., what is the timeframe for which the data will be collected: number of cases/events in the past weeks, months, quarters? This will depend on how frequently cases/events occur.)	***Will collect data for three consecutive months; then based on findings, will develop corrective action and continue monitoring, or consider decreasing frequency of monitoring.***

Reference: CMS "Measure/Indicator Development Worksheet"



Measure/Indicator Development Worksheet

QAPI

Directions: Use this worksheet to develop a performance measure/indicator. A new measure/indicator might be created as part of your overall QAPI monitoring or for a Performance Improvement Project. You will likely want to use existing measures when possible, but there may be times when you want to develop a new measure/indicator that is specific to your needs.

Note: What is the difference between an indicator and a measure? An indicator provides evidence that a certain condition exists but does not clearly identify the situation or issue in any detail. Indicators enable decision-makers to assess progress towards the achievement of intended outputs, outcomes, goals, and objectives. A measure is a stronger reflection of the underlying concept: a more developed and tested way of describing the concept that is being evaluated. However, in practice the two terms are used interchangeably.

MEASURE/INDICATOR OVERVIEW

NAME OF MEASURE/INDICATOR:
Example: *Residents with a completed skin assessment within 12 hours of admission.*

PURPOSE OR INTENT FOR MEASURE/INDICATOR:
Example: *The purpose of this measure is to make sure our process of completing a skin assessment within 12 hours of admission is done consistently.*

MEASURE/INDICATOR TYPE:
__ Structural Measure: Structural measures focus on the fixed characteristics of an organization, its professionals and staff. These measures distinguish between a capability or asset and the activity that may rely on that structure. In addition, structural measures are typically based on the organization or professional as the unit of assessment in the denominator. Example: The extent to which a facility use of electronic health records is implemented facility-wide. Numerator = Number of departments with EHR; Denominator = Number of all departments in facility.
__ Process Measure: Process measures assess the steps or activities carried out in order to deliver care or services. These measures focus on the action by professionals and staff. Consideration should be given to sample sizes for denominators, exclusion criteria, and alternative processes or workarounds that may exist. Example: The percentage of newly admitted residents receiving admission skin assessments.
__ Outcome Measure: Outcome measures focus on the product (or outcome) of a process or system of care or services, which can identify different or more services underlying causes. Example: The rate or incidence of nursing home acquired pressure ulcers.

The measure in the example above (residents with a completed skin assessment within 12 hours) is a process measure.

DEFINING THE MEASURE/INDICATOR SPECIFICATIONS

NUMERATOR: (i.e., when will a person or event be counted as having met the desired result – this is the top number of the fraction you will calculate)	Example: *any residents with a complete hours of admission* Numerator: *19*
DENOMINATOR: (i.e., what is the total pool of persons or events you will be counting – this is the bottom number of the fraction you will calculate)	Example: *all residents admitted in*
EXCLUSION CRITERIA: (i.e. - is there any reason you would exclude a particular person or event from the denominator count?)	Example: *exclude those residents 24 hours because of assessment* Denominator after exclusions: *20*
RESULT CALCULATION: (i.e., typically expressed as Numerator/Denominator x 100 = rate %)	Example: *19 / 20 X 100 = 90%*
INDICATOR/MEASURE GOAL: (i.e., the numerical goal aimed for – may be based on an already established goal for the particular indicator)	Example: *Goal = 100%*
INDICATOR/MEASURE THRESHOLD: (i.e., the minimum acceptable level of performance)	Example: *Threshold = 95%*

MEASURE/INDICATOR DATA COLLECTION

DATA SOURCE:	Example: *Medical records, adm*
SAMPLE SIZE AND METHODOLOGY: (i.e., will you measure the total population under study or draw a sample to represent the whole? If sampling, how large will the sample size be? How will you determine the sample?)	Example: *The total population in the nursing home for at least*
FREQUENCY OF MEASUREMENT: (i.e., how frequently will the indicator result be calculated: daily, weekly, monthly, quarterly, annually?)	Example: *Monthly.*
DURATION: (i.e., what is the timeframe for which	Example: *Will collect data* based on findings, will

Disclaimer: Use of this tool is not required by CMS, nor does its completion ensure

Reference: CMS "Measure/Indicator Development Worksheet"

Measures / Indicators

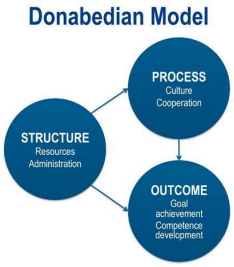
- An **indicator** provides evidence that a certain condition exists but not clearly identify the situation or issue in any detail
- A **measure** is a stronger reflection of the underlying concept
- In practice the two terms are used interchangeably

Reference: CMS "Measure/Indicator Development Worksheet"

Quality Measure/Indicator Types

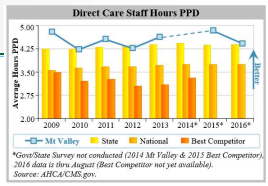
Measures used to assess and compare the quality of health care organizations are classified as:

- ★ Structural Measure
- ★ Process Measure
- ★ Outcome Measure



Reference: CMS "Measure/Indicator Development Worksheet"

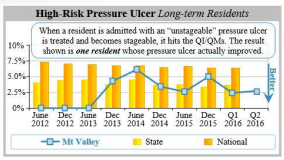
Structural Measures



- ★ Focus on the fixed characteristics of an organization, its professionals and staff
- ★ Distinguish between a capability or asset and the activity that may rely on that structure
- ★ Gives a sense of a health care provider's capacity, systems, and processes
- ★ Example: the ratio of providers to patients

Reference: CMS "Measure/Indicator Development Worksheet"

Process Measures

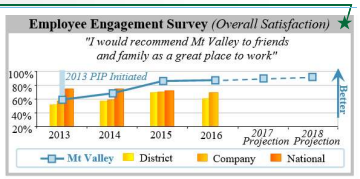


- ★ Access the steps carried out in order to deliver care/services
- ★ Focus on the action by staff
- ★ Considerations should be given to sample sizes for denominators, exclusion criteria, and alternative processes that may exist
- ★ The majority of health care quality measures used for public reporting are process measures

Reference: CMS "Measure/Indicator Development Worksheet"

Outcome Measures

- Focus on the outcome of a process of care or services
- Example: readmission, patient experience, etc. are the quality and cost targets health care organizations are trying to improve
- Can identify more complex underlying causes



Reference: CMS "Measure/Indicator Development Worksheet"

Tools to Understand Data and Analyze Process

Tool	When to Use
Pareto Chart 	To see which causes or problems occur most frequently. To observe the Pareto Effect when 20% of the causes contribute to 80% of the overall problem.
Trend or Run Chart 	To give a visual representation of data over a period of time.

Tools to Understand Data and Analyze Process

Tool	When to Use
Bar Chart 	A chart that uses either horizontal or vertical bars to show comparisons among categories.
Pie Chart 	A form of an area chart. An easy way to visualize percentage breakdowns of a total. They are useful for analyzing polls, statistics, managing money and data.

Guidance for Performing RCA with PIPs

Performing RCA can be an early step in a PIP

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.

Reference: CMS

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

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 personal knowledge of the processes and systems involved in the event to be investigated.
3. Describe what happened	Collect and organize the facts surrounding the event to understand what happened.
4. Identify the contributing factors	The situations, circumstances or conditions that increased the likelihood of the event are identified.
5. Identify the root causes	A thorough analysis of contributing factors leads to identification of the underlying process and system issues (root causes) of the event.
6. Design and implement changes to eliminate the root causes	The team determines how best to change processes and systems to reduce the likelihood of another similar event.
7. Measure the success of changes	Like all improvement projects, the success of improvement actions is evaluated.

Steps two through six should be completed as quickly as possible. For facilities accredited by the Joint Commission, these steps must be completed within 45 days of occurrence of the event.

What is Systems Thinking?

According to CMS:

"….a perspective that considers how things **influence one another as a whole** rather than individual elements, or static 'snapshots'"

Reference: AADNS

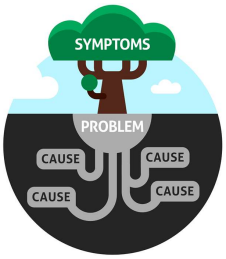
Systems-Thinking Focus

- Identify all components of a system
- Determine effectiveness of each component
- Understand how all components work together
- Be sure the system does what is intended
- Identify any unwanted consequences, even if system works well for its intended purpose

Reference: AADNS

Value of Root-Cause Analysis

- Leads to digging deeper and deeper, looking for reasons behind the reasons
  - Usually leads to more than one root cause
- Once the root causes are identified, they can be targeted by system-level action
  - In essence, the problem can be rooted out



Reference: AADNS

Value of Root-Cause Analysis

- Symptom of the problem
  - The weed
  - Above the surface
  - Obvious
- The underlying cause
  - The root
  - Below the surface
  - Not obvious

Creating an Event Timeline

- Contributing Factors
  - Situations, circumstances, or conditions that collectively increased the likelihood of an incident
  - By itself, a single contributing factor may not have caused the incident, but when two or more occur at the same time, probability of an incident increases
  - Contributing factors are not root causes; further analysis is required

Reference: AADNS

Five Whys Tool for Root Cause Analysis

- The Strategy: Look at any problem and drill down by asking: "Why?" or "What caused this problem?"
  - Keep asking/answering until arrive at answer revealing incident would have been prevented if the identified causes and contributing factors had not been present
- Simple problem-solving technique
- Gets to the root of a problem quickly
- Understanding the contributing factors or causes can help develop actions that sustain corrections

Reference: CMS "Five Whys Tool for Root Cause Analysis"

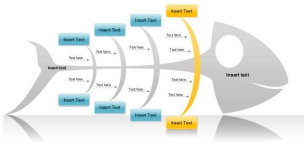
Five Whys Everyday Example

Problem Statement	Once sentence description of event or problem. *Your car gets a flat tire on the way to work.*
Why?	*Why did you get a flat tire?*
Why?	*Why were there nails on the garage floor?*
Why?	*Why was the box of the nails wet?*
Root Cause(s)	*1) You ran over nails in your garage*
If you stopped here and "solved" the problem by sweeping up the nails, you would have missed the root cause of the problem!	*2) The box of nails on the shelf was wet; the box fell apart and the nails fell from the box onto the floor*
	3) There was a leak in the roof and it rained hard last night.
	To validate root cause, ask the following: If you removed this root cause, would this even or problem have been prevented?

Reference: CMS "Five Whys Tool for Root Cause Analysis"

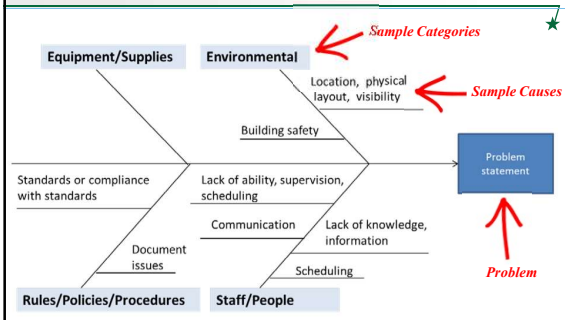
The Fishbone Tool

- A visual way to look at cause and effect
- Helps in brainstorming to identify possible causes of a problem
- Helps in sorting ideas into useful categories
- Offers a more structured approach



Reference: CMS "How to Use the Fishbone Tool for Root Cause Analysis "

Fishbone Diagram Example



Reference: CMS "How to Use the Fishbone Tool for Root Cause Analysis "

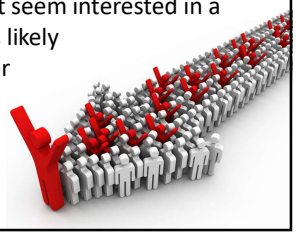
Designing Effective Change

- Actions taken should
  - Target elimination of root causes
  - Offer long-term solutions to the problem
  - Be achievable
  - Be objective
  - Be measurable

Reference: AADNS

Achieving Change Success

- Employees seem to set their priorities based on what they know or perceive their boss's priorities to be.
- If the top boss doesn't seem interested in a particular project, it is likely that many of his or her employees won't either.



Reference: AADNS

Employee Resistance to Change

- Leaders should try to identify reasons and concerns, attempt to address them directly in positive manner
- If strong resistance continues and becomes destructive to the effort, disciplinary action might be called for

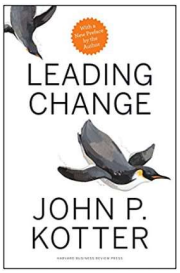
Reference: AADNS

Sustaining the Change

- The team's work is not complete just because the team has successfully ushered in the desired changes.
- Now comes the maintenance work – keeping the changes up and running.

Reference: AADNS

Sustaining the Change



In the final analysis, change sticks only when it becomes "the way we do things around here," when it seeps into the very bloodstream of the work unit or corporate body.

Until new behaviors are rooted in social norms and shared values, they are always subject to degradation as soon as the pressures associated with a change effort are removed.

Reference: AADNS

Resources

- The CMS worksheets are available to everyone
  - Simply google CMS and the name of the worksheet/form
  - OR go to: https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/QAPI/qapitools.html and click "Click here for A Process Tool Framework"
- The "QAPI Immediate Action Plan" is an interactive form available to Abaqis Providigm members
- The American Association of Directors of Nursing Services (AADNS) offers a course to become a QAPI Certified Professional (QCP) at www.aadns-ltc.org
- "Leading Change," John P. Kotter

Thank You

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SILVER AHCA National Quality Award Winner!