QAPI: Quality Assurance Performance Improvement
“NOT ALL CHANGE IS IMPROVEMENT, BUT ALL IMPROVEMENT IS CHANGE”

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• WHAT IS QAPI?

− Mandated as part of the Affordable Care Act through the federal government (section 6102(c))
− “The merger of two complementary approaches to quality management, Quality Assurance (QA) and Performance Improvement (PI)…” (CMS training materials)
− Accountability for quality of individualized resident care and cost management
− Expectation for quality throughout all departments and across the facility
− Comprehensive approach to ensuring high quality care
• WHAT IS QAPI?
  – Shift in the culture of providing health care
  – Engagement of the culture of the organization
  – Creation of an infrastructure that builds care systems based on a systematic, comprehensive and data driven approach
  – A continuous and proactive study of systems and processes with the intent to prevent or at least decrease the likelihood of concerns
  – An opportunity to identify areas of concern and new approaches to address underlying causes that are systemic
• **GETTING STARTED WITH QAPI**
  
  - Regulatory guidance
    - CMS has not published the QAPI regulation and does not have a timeline
    - CMS does have a webpage available with QAPI resources
    - Surveyors are learning QAPI but will not use QAPI principles in surveys until the official rules have been publicized by CMS
    - Providers will be expected to have QAPI plans implemented within one year of when the final regulation is issued
    - OIG publication of adverse events report has resulted in increased focus on QAPI to address adverse events
**GETTING STARTED WITH QAPI**

Some tips from CMS

1. Know the facts about QAPI
   - Review the language in the Affordable care Act Section 6102
   - Review the CMS “QAPI At a Glance” guidance provided at the website and other materials provided but not mandated
   - Assess your facility to know what you are currently doing and the effectiveness
   - Assess your teams/staff to determine readiness for QAPI and the change in culture that comes with it
• GETTING STARTED WITH QAPI

2. Address QAPI with Board members, facility leadership, team members and staff
   • Provide education to assist with understanding and buy in
   • Review the current models used for problem resolution and their effectiveness – be prepared to answer tough questions to explain the need to change

3. Get ideas from others
   • Discuss with other similar facilities who are implementing
   • If you are a multi-facility organization: learn from each other and take the best ideas for development and implementation
   • Attend training webinars and seminars for additional ideas
GETTING STARTED WITH QAPI

4. Consider what you will do to restructure current processes
   • Who will lead the program?
   • What will you salvage from the current QA program?
   • What new processes will you incorporate into QAPI?
   • How will you reform the QA/QI committee into the QAA or QAPI team?
5. Think about the facility culture and performance improvement
   • Does your staff work well in teams?
   • Have previous improvement efforts been successful and why or why not?
   • How well do you use data to drive improvement efforts?
   • Is everyone comfortable at identifying areas that need improvement?
GETTING STARTED WITH QAPI

- Provide education in small bites and assure understanding before proceeding
- Educate both internal and external customers
- Communicate the plan frequently and use terminology to increase staff comfort and confidence
- Remind all team members of the expectation to raise quality concerns that need to be addressed
- Remember the focus is on systems and how everything is a part of a bigger system
- Include residents and families in communication and QAPI education and implementation
Why Is It Important?

- QAPI environment balances safety and accountability with fairness and openness.
- QAPI process assists with providing the tools that we need to solve quality problems in our work areas.
- Working through the QAPI process increases our competencies to achieve the quality goals that we have to impact quality of care and quality of life for our residents.
- Everyone in the facility becomes an active partner in performance improvement.
Benefits From Using QAPI

- Taking time to put a personal face on Quality Issues
  - Assures that residents, families and all team members have opportunity to meet and discuss quality concerns throughout the process
  - Assures that leadership works side by side with staff and residents/families to determine needs and work on performance improvement that is sustainable
  - Brings the QAPI teams into every part of the facility
  - Increases awareness of what the quality issues really are in our facilities and helps to develop an awareness of other needs and concerns
5 ELEMENTS FOR FRAMING QAPI

- Identified by CMS – these are the building blocks and strategic framework to effective and sustained QAPI
  - Your individual plan should address all 5 elements
  - 5 elements are closely related
    1. Design and Scope
    2. Governance and Leadership
    3. Feedback, Data Systems and Monitoring
    4. Performance Improvement Projects
    5. Systematic Analysis and Systemic Action
1. **Design and Scope**

- Comprehensive and on-going
- Includes all departments all functions
- Addresses all systems that impact care and management practices i.e. safety, resident choice, transfers, etc.
- Uses evidenced based practices
- Aims for high quality that is sustainable
- Includes resident choices and their concerns
- Culminates in a written QAPI plan
2. Governance and Leadership

- Systemic and systematic approach to collect data from all stakeholders: team members, residents, resident families, vendors, external agents, etc.
- Board of Directors ultimate leaders of process but facility leadership manages operations; “culture of QAPI”
- Must have one or more persons designated as accountable for QAPI at each facility
- Balance of accountability and encouragement to identify and report quality concerns
“Culture of QAPI”

• Team members should feel comfortable in coming forward with useful information in the interest of system safety

• Should not result in a system where no one is held accountable for behaviors or for violating policy

• Team members respect the opportunity as one to result in improvement
3. Feedback and Data Monitoring Systems

- Includes multiple sources of data such as residents, team members from all departments, families, surveys, grievances, etc.
- Must be able to turn data into information through review, discussion, evaluation and analysis
- Information must be actionable
- Compares findings against a wide variety of benchmarks and targets that are performance indicators for facility
Making Data Meaningful

• You are unable to know if you are doing what is meaningful if you don’t have a baseline

• Data alone is not meaningful it must be evaluated and analyzed and presented as information to have meaning

• Audits are the start of the process – conversion of the data to information following a process and comparing it brings meaning and usefulness to the data
Making Data Meaningful

• Benchmarks: a standard against which other things can be judged
  - Nursing Home Compare and Advancing Excellence

• Targets: an internal goal of performance level that organization is trying to achieve

• Thresholds: a measure that must be achieved to mitigate risk; performance cannot go below
4. **Performance Improvement Projects (PIP)**

- Completed to examine and improve care and service as the end result outcome
- Should be prioritized by the team
- Start at items needing attention or at high risk
- Number of PIPs varies per facility and the team decisions
- Generally is a concentrated effort on one project or in one area of the facility but can be multiple teams working in multiple areas
- PIPs are selected in areas that are important and meaningful to someone: residents, families, facility, department, team, etc.
Performance Improvement Project (PIP)

• Include a sponsor from facility leadership/management to provide resources
• Designate a team leader for each PIP to manage the project
• Assure the PIP team has representation from all departments that are involved in and impacted by the situation being addressed
• Provide PIP autonomy within guidelines and set expectation for report
Performance Improvement Projects (PIP)

• Planned change is tested and implemented under the guidance of the team
• Implementation occurs after test is completed
• Monitoring results in knowing if goals were accomplished with the change and there was actually performance improvement
• Uses the PDSA Cycle:
  – Plan, Do, Study, Act
• PDSA Cycle
  – **PLAN** – establish goals
  – Plan to do an observation
  – Plan for collection of data
  – Plan to transfer data into information
  – Make educated predictions about what will happen and why
  – Develop plans to test the performance improvement or change
PDSA Cycle

- **DO** – Let’s Try It
  - Carry out the plan
  - Try out the plan on a small scale first
  - Monitor what you are trying
  - Document all problems and unexpected findings
  - Get feedback from others involved
  - Analyze your observations and findings
• PDSA Cycle
  – STUDY – Did It Work?
  – Finalize analysis of the collected data
  – Transfer the data into information
  – Compare what you found out to what you thought would happen when you made the educated predictions
  – Summarize what you learned from doing
• **PDSA Cycle**
  • **ACT** – What’s Next?
  • What changes need to be made from what we thought originally?
  • Make the changes based on what we learned from our observations and data collections and analysis
  • Make the modifications
  • Plan for the next phase which is implementation
  • Implement the performance improvement throughout the facility and the system
5. **Systematic Analysis and Systemic Action**

- Use a systematic approach to fully understand the problem, its causes and implications for a change
- Structured approach to determine how identified problems are caused or exacerbated – looks at organization, delivery, systems and process, etc.
- When changes or PIPs are implemented, there is a need for policies and procedures
- Systemic actions mean that we looked across all systems that are involved in the area we are working on to prevent future events
- Focus is on continual learning and improvement
**Root Cause Analysis**

- Is a structured facilitated process that results in identification of “root” causes that resulted in events with undesired outcomes
- Guides the team to make decisions based on data and information rather than “hunches” or what has been heard
- Provides a systematic method to identify breakdowns in systems and processes that may have contributed to the event
- Addresses the need to develop a plan that will assist in preventing future events
- RCA is a process that determines what happened, why it happened and what can we do to prevent it from happening again
Root Cause Analysis

There are a variety of methods to display the discussion through the RCA process but generally looking at one of the following as a root cause:

- Manpower/People
- Environment
- Material
- Equipment
- Methods/Processes
Root Cause Analysis

- Should document a timeline of the event and a list of contributing factors which are not the causes
- Can use a flowchart or 5 whys to diagram the RCA process
- Does not include judgments about the event or the persons involved
- Should not include bias based on being able to look back on the event but worked through in its entirety
12 ACTION STEPS TO EFFECTIVE QAPI

- CMS has offered 12 implementation steps
- All steps need to be addressed but not necessarily sequentially
- 12 steps provide significant opportunity for all team members to become involved in the process at some point or all points
- Teamwork is a core component of QAPI but is listed as only one of the 12 steps – but needs to be in pace for any of the steps to be effective
- Many of the steps are included in the 5 elements of QAPI but are broken out further
12 ACTION STEPS TO EFFECTIVE QAPI

- Leadership Responsibility and Accountability
- Develop a Deliberate Approach to Teamwork
- Identify Your Organization’s Guiding Principles
- Develop Your QAPI Plan
- Conduct a QAPI Awareness Campaign
- Develop a Strategy for Collecting and Using QAPI Data
- Identify Your Gaps and Opportunities
- Prioritize Quality Opportunities and Charter PIPs
- Plan, Conduct and Document PIPs
- Getting to the “Root” of the Problem
- Take Systemic Action
• How Will We Know When a Change is An Improvement?
  – Three ways that we can measure
    • **Outcome measures**: feedback from our customers – residents, families, team members, external surveys, vendors, etc.
    • **Process measures**: the parts of the system that we worked with are performing as planned (changes in weight loss statistics, equipment is working, etc.)
    • **Balancing measures**: looking at the system from different ways to see how the performance improvements we implemented impact other parts of the system
Sustainability of Changes

- Effective interventions target the elimination of root causes and offer long term solutions to the issues
- Effective changes are achievable, objective and measurable
- Weak actions rely on team members remembering
- Intermediate actions have some requirement for team members to remember with tools
- Strong actions provides strong controls
Develop Dashboards

- System to track key performance indicators (KPI) in an easy to understand manner
- Assists in monitoring for key decision making
- Can be spread sheets, graphs or text documents depending on the audience and what is easiest to review
- Data results should be reported over multiple time periods to show trends and should include benchmarks, targets and thresholds
- Revise dashboards as data changes
• **QAPI THOUGHTS**
  – Consider each step implemented as a learning process
  – Be prepared for negative outcomes and negative information
  – Getting the whole team involved is not easy or always fun
  – Remember that data is only one step, transform data to information and then use it to make a difference
  – Consider which projects you will start with
    • A few quick successes shows the team that the process **CAN** work and **DOES** work
    • Overwhelming projects turn into paper compliance
QAPI

• **QAPI THOUGHTS**
  – Define the scope of each project clearly so it is not overwhelming, especially while we are all learning
  – Select your QAPI initial project teams for best results
    • Negative about change so they can show results
    • Results oriented so you have quick successes
  – Don’t eliminate what you are doing until you have evaluated it
    • You may just want to add to what is already effective
  – Communicate projects and outcomes to all teams in the facility and to the Board of Directors
• QAPI THOUGHTS
  – Quality improvement should not be an extra thing to do
  – Hard wire quality improvement into what you do every day
  – Monitor areas of concern in your facilities
  – Monitor available reports for comparisons
  – Know and understand what you should be seeing as far as quality of care delivery and quality of resident life
  – Compare what you should be seeing to what you are seeing and consider the opportunities
  – Discuss quality improvement at every meeting
  – Don’t miss opportunities!
Celebrate the successes and what you are doing well!
Websites for additional assistance:
http://go.cms.gov/Nhqapi
http://www.nhqualitycampaign.org/
www.interact2.net
“Life is 10 percent what happens to you and 90 percent how you react to it”
QUESTIONS???
THANK YOU!