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QAPI: Quality Assurance Performance Improvement - Meeting the Requirements of Participation

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Your presenter today is:

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Objectives for the Session Include:

1. Learners will be able to distinguish between a QAA program and the QAPI process
2. Learners will be able to identify the CMS recommended implementation process for QAPI
3. Learners will be able to correlate the QAPI process implementation to the federal regulatory requirements in the Final Rule Requirements of Participation

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"NOT ALL CHANGE IS IMPROVEMENT,

BUT ALL IMPROVEMENT IS CHANGE"

Donald Berwick, MD
Former CMS Administrator

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- **WHAT IS QAPI?**
  - Mandated as part of the Affordable Care Act (ACA) through the federal government (section 6102(c)) law signed in 2010
  - Coordinated application of two mutually reinforcing aspects of a quality management system: Quality Assurance (QA) and Performance Improvement (PI)
  - An organized method of doing business and achieve optimal quality outcomes
  - Engages the organization as a culture of individualized care
  - An infrastructure that supports the development of strategies to identify concerns and outline plans to amend them

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- **What is Involved in QAPI?**
  - Using data to identify quality problems and to identify opportunities for improvement and setting priorities
  - Incorporating every member of the facility team in some way into the process of a shared QAPI mission
  - Developing Performance Improvement Project (PIP) teams with specific goals
  - Performing Root Cause Analysis to arrive at the reason for concern
  - Implementing systemic change to correct problems
  - Developing a monitoring system to sustain improvement

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CURRENT STATUS

- Quality Assessment and Assurance (QAA) provision currently exists at provision 42 CFR, Part 483.75(o) and specifies:
  - Committee composition
  - Frequency of meetings in nursing facilities
  - Requires facilities to develop and implement appropriate plans of action to correct identified quality deficiencies
- Provision provides “a rule” but not the methods to implement the regulation for QAA

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- **GETTING STARTED WITH QAPI**
  - Regulatory guidance provided in the ACA
  - CMS has published QAPI instructions including the 5 elements and the 12 action steps for implementation
  - CMS has a webpage available with QAPI resources
  - Requirements of Participation (ROPs) in the Final Rule promulgated September 28, 2016 provide obligations for compliance
  - Revisions to the State Operations Manual (SOM) Appendix PP was released by CMS on November 9, 2016 and was effective November 28, 2016 and includes revisions to F520 related to QAPI

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- **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 the terminology so staff become competent and confident
  - Remind everyone that they are expected to raise quality concerns and they will be addressed
  - Remember the focus is on systems and how everything is part of a bigger system
  - Include residents, families, Board members and all team members in communication and QAPI implementation

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Websites for additional assistance:

http://go.cms.gov/Nhqapi

http://www.nhqualitycampaign.org/

http://cms.gov/Medicare/Provider-Enrollment-and-Certification/QAPI/Downloads/QAPIPlan.pdf

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Quality Assurance

- Using standards to measure compliance
- Inspection as means to determine compliance
- Retrospective/reactive
- Not continuous
- Involves a small group
- Focus is “bad individuals”
- Evaluates an item

Performance Improvement

- Continuous
- Focus on processes to meet standards
- Prevention as means to compliance
- Proactive/chosen
- Evaluates processes and systems
- Scope is resident care and service
- All staff are responsible

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- **5 ELEMENTS FOR FRAMING QAPI**
  - Identified by CMS – these are the building blocks and strategic framework to effective and sustained QAPI
    - Your individual facility 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

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1. Design and Scope

- Comprehensive and on-going
- Includes all departments and all services
- Addresses all systems impacting care and management practices, especially clinical care, quality of life and resident choice
- Includes resident choices and their concerns
- Uses evidenced based practices to define and measure
- Aims for high quality that is sustainable
- Must be a written QAPI plan

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2. Governance and Leadership

- Culture of systemic and systematic approach to collect data from all stakeholders: staff, residents, resident families, vendors, external agents, etc.
- Board of Directors and facility leadership develops “culture of QAPI”
- Must have one or more persons designated as accountable for QAPI at each facility and governing body responsible for resources
- Governing body and leadership create atmosphere of accountability and encouragement to identify and report quality concerns

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3. Feedback and Data Monitoring Systems

- Implement systems to monitor care and services using data from multiple sources such as residents, staff from all departments, families, surveys, grievances, etc.
- Must used performance indicators to monitor and compare against benchmarks and facility targets
- Must be able to turn data into information through review, discussion and evaluation
- Information must be actionable

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4. Performance Improvement Projects (PIP)

- Concentrated effort on a specific concern in one area or that impacts the facility or can be multiple team PIPs
- Involves gathering information systematically to clarify and to intervene for improvement
- Should be prioritized by the team
- Start at items needing attention
- Number of PIPs varies per facility and the team decisions
- PIPs are selected in areas that are important and meaningful to someone: residents, families, facility, department, team, etc.

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Root Cause Analysis

- Allows team to get at the "root" of the problem by better understanding where and why the problem exists
- Structured method of analysis for identifying contributing factors and root cause underlying variations in performance
- Guides the team to make decisions based on data
- Multiple charts can be used but generally looking at one of the following as a root cause:
  - Manpower/People
  - Environment
  - Material
  - Equipment
  - Methods/Processes

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- **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

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- **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

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- **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

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- **PDSA Cycle**
  - **ACT** – What's Next?
  - What changes need to be made from 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

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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 look across all systems that are involved in the area we are working on to prevent future events and sustain improvements
- Focus is on continual learning and improvement

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- 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 staff 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 place for any of the steps to be effective
  - Many of the steps are included in the 5 elements of QAPI but are further broken out

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- **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

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- How Will We Know When a Change is An Improvement?
  - Three ways that we can measure
    - Outcome measures: from our customers – residents, families, staff, other departments, 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

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Celebrate the successes and what you are doing well!

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- **Requirements of Participation for §483.75**
  - **Phase 1**: all current requirements in regulation remain the same with some clarification
    - Disclosure of information and sanctions are not new and language is unchanged
    - All requirements for the QAA committee remain the same except for clarification of language and that the ICPO is not required until phase 3
    - Clarify that the members of the QAA committee are only minimum requirements: medical director or designee is required and 1 of 3 members of staff must be the owner, NHA, board member or another leadership position

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- **Requirements of Participation for §483.75**
  - **Phase 2**: Initial QAPI plan must be provided to State Agency Surveyor at annual survey
  - **Phase 3**: Addition of the ICPO to the QAPI committee

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Requirements of Participation for §483.75 and F520

–§483.75: Each LTC facility 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

–§483.75(a)(1): Facility must document and demonstrate evidence of the ongoing QAPI program including documented reports demonstrating:

- systematic identification
- analysis
- implementation and evaluation of performance improvement actions
- investigation
- prevention of concerns

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Requirements of Participation for §483.75 and F520

- §483.75(a)(2): Present facility QAPI plan to State Survey Agency as part of phase 2 required November 28, 2017
- §483.75(a)(3) and (4): Present facility QAPI plan to State or Federal surveyors at each annual recertification survey and upon request during any other type of survey and to CMS upon request demonstrating evidence of the compliance with the requirements in the program implementation

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Requirements of Participation for §483.75 and F520

- §483.75(b): Facilities must design QAPI programs to be on-going, comprehensive and address full range of care and services provided. Must (1) address all systems of care and management practices; (2) include clinical care, quality of life and resident choice; (3) utilize available evidence to define and measure quality and facility goals that reflect processes of care and operations of desired outcomes; (4) reflect the complexities, unique care and services provided

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Requirements of Participation for §483.75 and F520

- §483.75(c)(1)(2)(3)(4): Facility must establish and implement written policies and procedures for feedback, data collection and monitoring and must minimally include:

  (1): Maintain effective systems to obtain and use feedback from multiple sources including how information is used;

  (2): Maintain effective systems to identify, collect and use data to monitor performance indicators;

  (3): Development, monitoring and evaluation of performance indicators and the frequency;

  (4): Adverse event monitoring and activities to prevent

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Requirements of Participation for §483.75 and F520

- §483.75(d)(1)(2): Systematic analysis and systemic action in the QAPI program to include:

  (1): Measure success and track performance to ensure performance improvement is realized and sustained; (2): Develop policies addressing approach to determine underlying causes of problems; how corrective actions will be designed to effect change; how to monitor effectiveness of performance improvement activities

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Requirements of Participation for §483.75 and F520

- §483.75(e)(1)(2)(3): QAPI program activities

(1): Set priorities for performance improvement activities

to focus on high risk, high volume or problem prone areas using incidence, prevalence and severity of concerns;

(2): Performance improvement activities must track

medical errors and resident events and analyze their causes and implement preventive actions;

(3): Must conduct distinct performance improvement

projects

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Requirements of Participation for §483.75 and F520

- §483.75(f)(1)(2)(3)(4)(5)(6): Governing body and/or executive leadership is responsible and accountable for ensuring compliance with QAPI compliance**:**

  (1): Program is defined, implemented and maintained;

  (2): Program sustains with staffing and leadership changes

  (3): Program is adequately resourced;

  (4): Program identifies and prioritizes concerns reflecting organization processes and services;

  (5): Corrective actions address gaps in systems;

  (6): Clear expectations are set

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Requirements of Participation for §483.75 and F520

- §483.75(g)(1)(2): Quality assessment and assurance:

  (1): Facility must maintain QAA committee minimally consisting of DON, medical director or designee, at least 3 other members of which at least 1 must be NHA, board member or other leadership position and the ICPO (by phase 3);

  (2): QAA committee reports to the facility's governing body or designated person functioning as governing body

  - QAA committee must meet at least quarterly and as needed

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Requirements of Participation for §483.75 and F520

- §483.75(h): Disclosure of information:
  - A state or the Secretary may not require disclosure of records of the QAA or QAPI committee except if disclosure is related to committee with the requirements of these requirements
- §483.75(i): Good faith attempts by the QAA/QAPI committee to identify and correct quality deficiencies will not be used as basis for sanctions

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- Quality Improvement
  - Should not be an extra thing to do
  - Hard wire it into what you do every day in your work
  - Monitor areas of concern in your facilities
  - Those who have access should monitor the Quality Measures reports
  - 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 think about opportunities
  - Discuss quality and quality assurance within the facility

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"Life is 10 percent what happens to you and 90 percent how you react to it"

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QUESTIONS???

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