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Quality Innovation Network - Quality Improvement Organizations
CENTERS FOR MEDICARE & MEDICAID SERVICES
iQUALITY IMPROVEMENT & INNOVATION GROUP

QAPI Overview

Building Blocks of Quality Assurance & Performance Improvement Process

Penny Imes, RN, BSN
Quality Improvement Specialist

Objectives

1. Review the five core elements of QAPI along with the associated F-tags
2. Understand the key role data has in QAPI success
3. Analyze team responsible for QAPI plans and projects
4. Examine key features of a QAPI plan

What is QAPI? – Quality Assurance

Quality Assurance

- The organized structure, processes, and procedures are designed to ensure that care practices are consistently applied.

What is QAPI? – Quality Assurance

Quality Assurance

- Example: Our facility wants to improve pressure ulcer rates through new purchases of better beds and education. We want to ensure that we maintain low rates, so we track the MDS quality indicators monthly AND develop an indicator of all “in house” pressure ulcers. Nurses track this data every month and report to the QAPI committee, which we want to keep below 3%. As long as it is below 3%, we do not do anything—we know the system is working.

What is QAPI? – Performance Improvement

Performance Improvement

- An ongoing interdisciplinary process designed to improve service delivery and resident outcomes.

What is QAPI? – Performance Improvement

Performance Improvement

- Example: Our facility has a high rate of use of antipsychotics. We convene a group to review the records of all those on antipsychotics, with a focus on those with the diagnosis of dementia. During this process, we are going to track all new antipsychotic prescriptions as well as reductions—our goal is to reduce new prescriptions and increase reduction trials. Our interventions will focus on education and on mentoring to select nonpharmacologic options to improve our performance.

QA+PI

	Quality Assurance (QA)	Performance improvement (PI)
Motivation	Measuring compliance with standards	Continually improving processes to meet standards
Means	Inspection	Prevention
Attitude	Required, reactive	Chosen, proactive
Focus	Outliers, “bad outcomes”	Processes or systems
Responsibility	Few	All

Five Elements

Design and Scope

Ongoing and comprehensive, involving full range of departments. Aims are safety and high quality. Written plan.

Governance and Leadership

Administration ensures a culture that encourages input. QAPI is a priority and all staff is accountable.

Feedback, Data Systems and Monitoring

Facility puts systems in place to monitor care and services, drawing data from multiple sources (staff, residents, families).

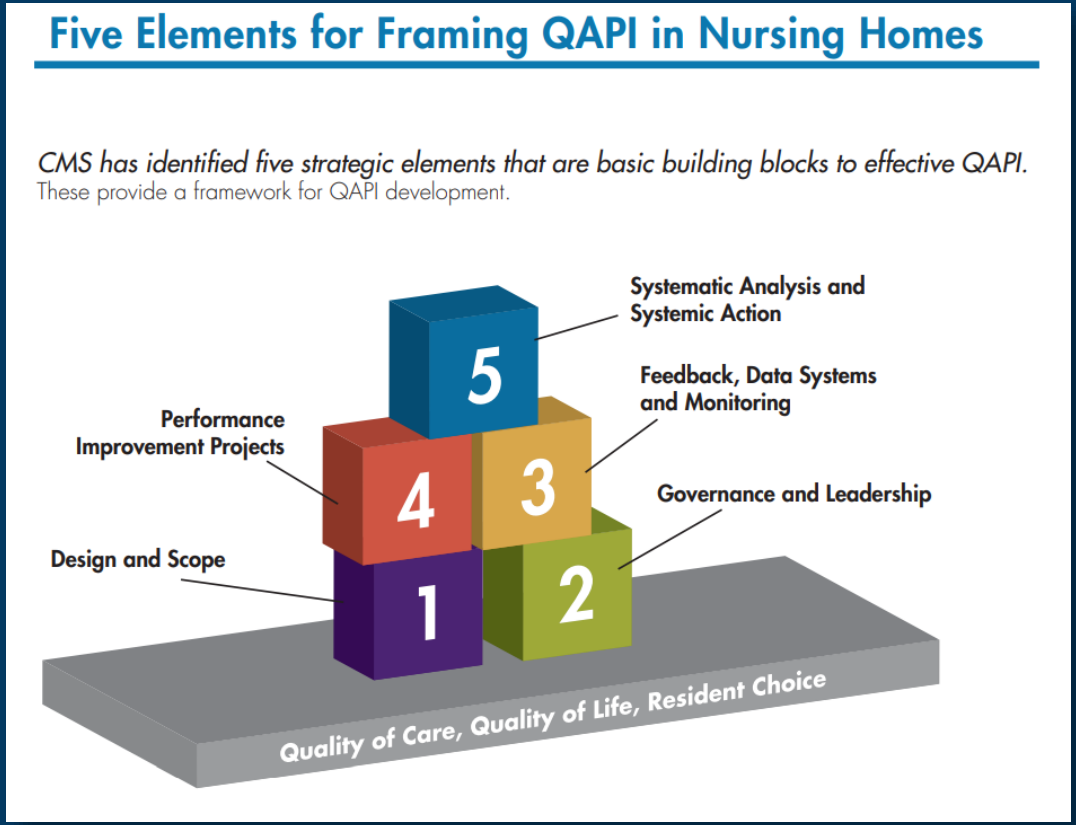
PIPs

A concentrated effort on a particular problem in one area of the facility or facilitywide. PIPs examine and improve care or services. Areas needing attention vary.

Systemic Analysis and Action

Facility uses systemic approach to determine when analysis is needed. Utilize root cause analysis. Continued learning and improvement.

How the 5 Elements Work



https://www.cms.gov/medicare/provider-enrollment-and-certification/qapi/downloads/qapiataglance.pdf

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F-Tags

F-Tag	CFR	Brief Description
F865	§483.75(a) Quality Assurance and performance improvement (QAPI) program.	Each long term care facility must develop, implements, and maintain an effective, comprehensive, data-driven QAPI program that focuses on indicators of the outcomes of care and quality of life.
F866	§483.75(c) Program feedback, data systems, and monitoring.	A facility must establish and implement written policies and procedures for feedback, data collection systems, and monitoring, including adverse event monitoring.
F867	§483.75(d) Program systematic analysis and systemic action	The facility must take actions aimed at performance improvement and, after implementing those actions, measure its success, and track performance to ensure that improvements are realized and sustained.
F868	§483.75(g) Quality assessment and assurance	The facility must maintain a QAA committee consisting at a minimum of: the director of nursing, the medical director (or designee), at least other members of facility staff (one must be NHA, owner, or board member), and the infection preventionist.
F944	§483.95(d) Quality assurance and performance improvement	A facility must include as part of QAPI program mandatory training that outlines and informs staff of the elements and goals of the facility's QAPI program as described in §483.75.

Governance & Leadership

- Foster a culture where QAPI is a priority.
- Ensure adequate resources to conduct QAPI efforts and education – staff, residents, families.
- Develop policies to sustain QAPI despite changes in personnel and turnover.
- Create atmosphere where staff is comfortable identifying and reporting quality problems.
- Empower staff to be part of the QAPI team.

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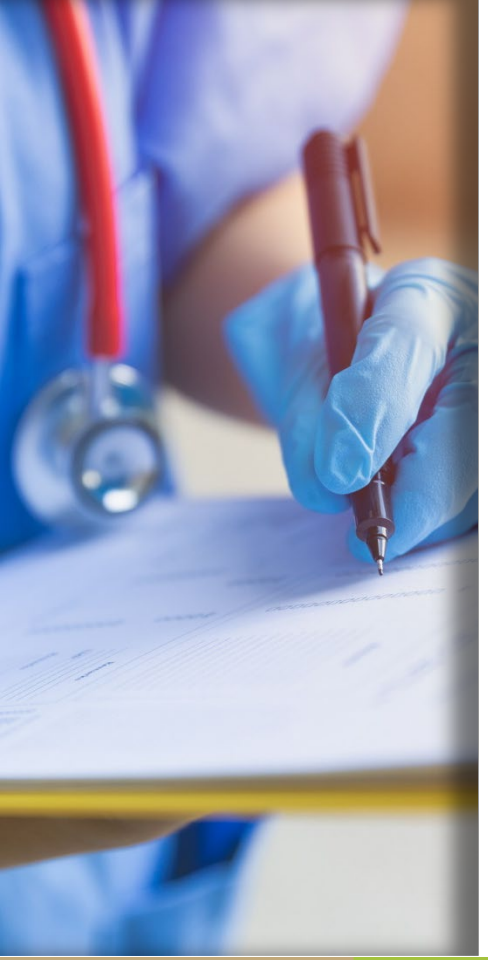


Feedback, Data, Monitoring

- Use data from multiple sources to identify what you need to monitor (CASPER reports, QMs)
- Make data meaningful – use it to drive decisions, prioritize what you will work to improve, and identify gaps and opportunities
- Set goals, benchmarks, and thresholds
- Collect the data that enables tracking and monitoring measures and adverse events

Performance Improvement Projects

- What are we trying to accomplish? (Concentrated effort on a particular problem)
- How will we know it is an improvement? (Use data to clarify the issue and show improvement)
- What change can we implement for improvement?
- Teamwork is core component of PIPs – those involved in the process

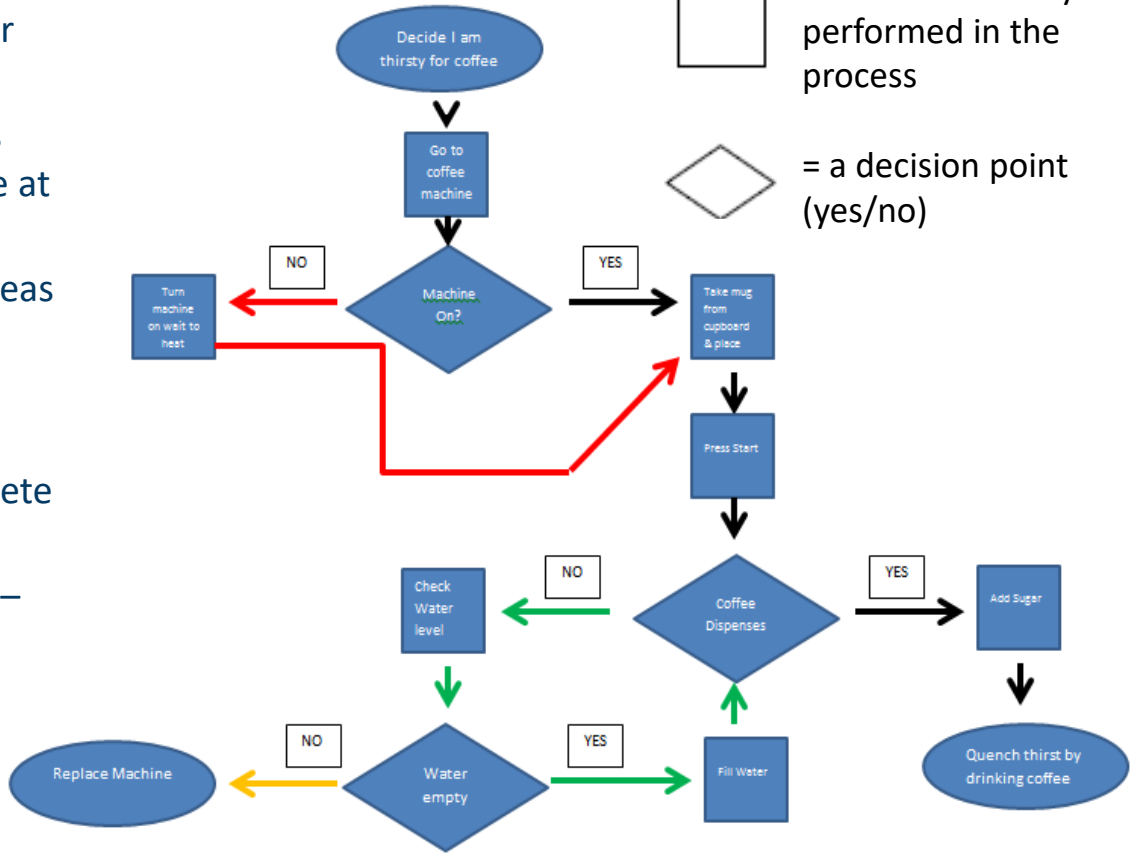
Flow Charting/Process Mapping

- At least two flow charts completed for any process: real and ideal
- Must use direct observation to assess actual process; may need to complete at multiple times
- Compare real with ideal to identify areas for potential improvement
- May lead to areas where systems overlap; this will help identify unintended changes when you complete intervention to correct the issue
- Can be used to standardize a process – don't forget to revise when process is changed
- Sticky notes and flip charts may be easier to use than computer models

= beginning and end of a process

= a task or activity performed in the process

= a decision point (yes/no)



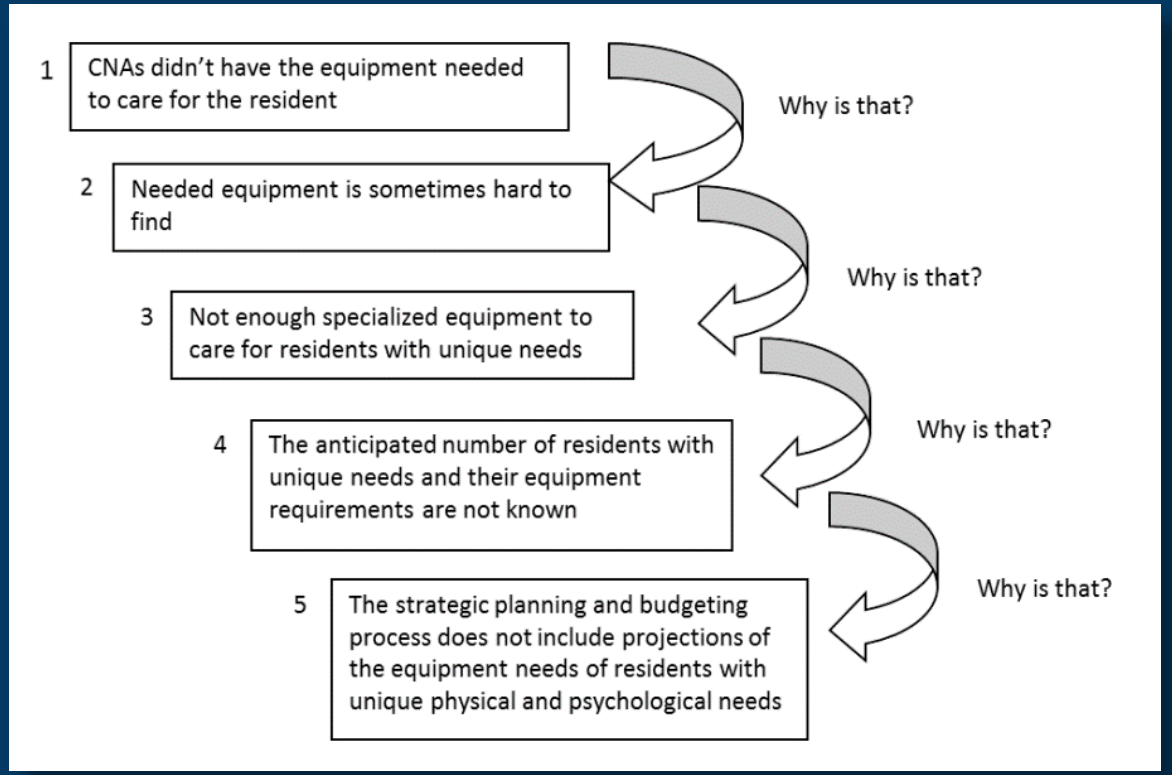
Root Cause Analysis (RCA) in 3 Steps

1. Determine what happened.
2. Determine why it happened.
3. Figure out what preventive measures can be implemented.

RCA in Action

- A resident is placed in the Hoyer Lift from wheelchair to be transferred back to bed.
- The lift begins to sink toward the floor due to the resident's weight exceeding limits of lift capacity.
- The CNA attempts to swing the resident over to the bed to avoid the resident falling to the floor.
- The Hoyer Lift tips, the resident falls to the floor and the Hoyer Lift falls on top of him.

5 Whys and a Collapsed Hoyer Lift



https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/QAPI/downloads/GuidanceforRCA.pdf

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Plan, Do, Study, Act

Plan

What change are you testing?
Who will be involved?
What data needs collected?
What do you predict will happen? Why?
How long will the change take?
What resources are needed?

Do

Carry out a test on a small scale.
Document observations. Collect data.

Study

Determine if the change resulted in the expected outcome.
Are these implementation lessons?
Any surprises? Successes? Failures?
Compare results to predictions.

Act

Based on what you learned: Adopt, adapt, or abandon.

Designing a QAPI Plan

Identify a Problem

UTIs? Facility acquired pressure ulcers? Opioids? Antipsychotics? Falls?

Determine Team

Medical director, DON, NHA, activities, dietary, pharmacist, frontline staff.

Decide PIP Goals

Answer the 3 questions

Root Cause Analysis

5 Whys

PDSA Cycle

Plan, Do, Study, Act, and repeat (if needed)

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QAPI in Action

Real Life Example

Quality is not an act. It is a habit. – Aristotle

Urinary Tract Infections

Can we move the needle?

Your facility has had an increase in the number of urinary tract infections in the last 4 months. The facility urinary tract infection rate is now more than twice the national average compared to 4 months ago when the rate was at the national average. The infection preventionist approaches the DON about the increase.

The Steps

1. Identify a problem
2. Decide on a team
3. Determine PIP goal (ask the 3 questions)
4. Root cause analysis
5. Plan, Do, Study, Act

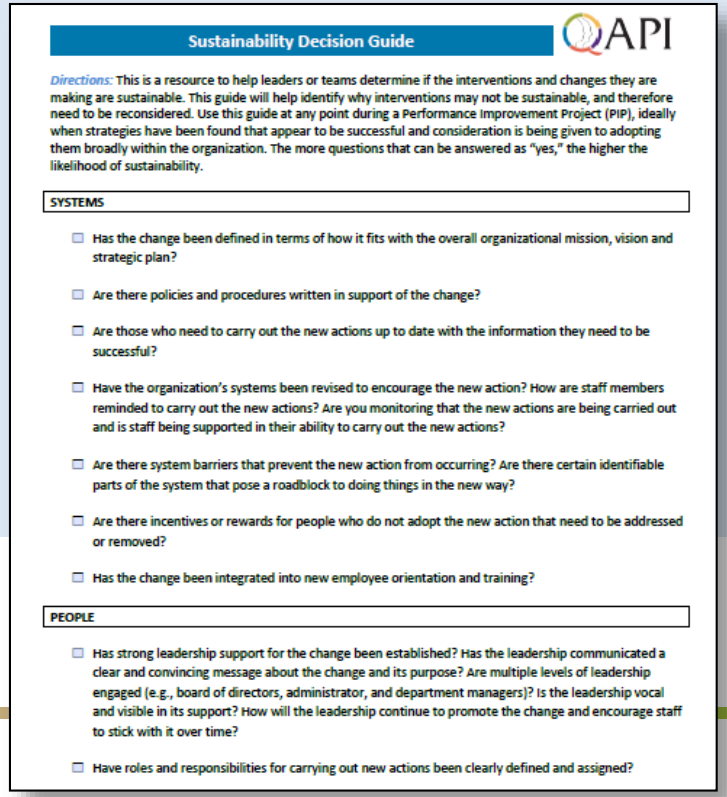
Creating a QAPI Plan

- The infection preventionist prints out a list of all UTIs in the last 6 months and speaks to the MD. They determine that there has been an substantial increase over the last 4 months.
- The IP and MD meet with the DON and NHA about the UTI rates. UTIs are broken down by date and unit. Most UTIs are found to be on 1 unit – PIP team includes staff from that unit.
- PIP goals:
  1. **Aim:** We are trying to reduce the number of UTIs.
  2. **How will we know:** We will have less UTIs diagnosed as well as less UA C&S ordered. We will also have less antibiotics used.
  3. **Change we can implement:** We can utilize an algorithm for UTI diagnosis and treatment.

Creating a QAPI Plan

- Root cause analysis: Why is a UA C&S ordered? Why are there more UTIs on a particular unit? Why is one provider ordering more UAs? Why are certain resident being diagnosed with multiple UTIs?
- PDSA: Implement an algorithm for UTI diagnosis and treatment (start small). Track results of implementation on UTI rates. Study results and adopt, adapt, or abandon. Repeat as needed.

Sustainability Guide



Sustainability Decision Guide

QAPI

Directions: This is a resource to help leaders or teams determine if the interventions and changes they are making are sustainable. This guide will help identify why interventions may not be sustainable, and therefore need to be reconsidered. Use this guide at any point during a Performance Improvement Project (PIP), ideally when strategies have been found that appear to be successful and consideration is being given to adopting them broadly within the organization. The more questions that can be answered as "yes," the higher the likelihood of sustainability.

SYSTEMS

- ☐ Has the change been defined in terms of how it fits with the overall organizational mission, vision and strategic plan?
- ☐ Are there policies and procedures written in support of the change?
- ☐ Are those who need to carry out the new actions up to date with the information they need to be successful?
- ☐ Have the organization's systems been revised to encourage the new action? How are staff members reminded to carry out the new actions? Are you monitoring that the new actions are being carried out and is staff being supported in their ability to carry out the new actions?
- ☐ Are there system barriers that prevent the new action from occurring? Are there certain identifiable parts of the system that pose a roadblock to doing things in the new way?
- ☐ Are there incentives or rewards for people who do not adopt the new action that need to be addressed or removed?
- ☐ Has the change been integrated into new employee orientation and training?

PEOPLE

- ☐ Has strong leadership support for the change been established? Has the leadership communicated a clear and convincing message about the change and its purpose? Are multiple levels of leadership engaged (e.g., board of directors, administrator, and department managers)? Is the leadership vocal and visible in its support? How will the leadership continue to promote the change and encourage staff to stick with it over time?
- ☐ Have roles and responsibilities for carrying out new actions been clearly defined and assigned?
- ☐ Are the people responsible for carrying out the change equipped to manage it? Do staff members have the appropriate skills and knowledge to successfully undertake any new actions required? Have training needs been addressed? Is additional or differently trained staff required?
- ☐ Are there champions for the change who are actively modeling the desired actions? Are there informal or natural leaders among the staff who could be encouraged to act as role models? Are there members of your staff exhibiting clear resistance to the change that should be addressed?

ENVIRONMENT

- ☐ Is the organization ready to take on this change? What issues in the workplace culture should be addressed before the change can be expected to become permanent? Is the reason given for the change in line with the values and attitudes of the staff?
- ☐ Has adequate funding (if applicable) been budgeted to support the change?
- ☐ Have resources (equipment, materials, staff time, information) been made available? What additional resources would help to encourage the new actions to take place?
- ☐ Are there things that can be done to the physical environment that make it unavoidable to do things in the new way (e.g., automation of processes; removal of certain objects necessary to do things the previous way)?

MEASUREMENT

- ☐ Has ongoing periodic measurement and review been scheduled to ensure the new action has been adopted and is performed consistently?
- ☐ Are indicators/measures chosen that tie directly to the new action? Can the indicator/measure distinguish the performance of different work groups (e.g., by unit, department, shift)? Are some work units carrying out the change more successfully than others? Can lessons for success be learned from certain work units and shared with others?
- ☐ Can certain indicators/measures be reviewed more frequently (even daily) by staff to show incremental changes, which can serve as a reminder for the new action and provide encouragement and reinforcement?
- ☐ Does measurement point to any changes in procedure that should be made to help facilitate the change?

https://www.cms.gov/medicare/provider-enrollment-and-certification/qapi/downloads/sustaindecisgdedebedits.pdf

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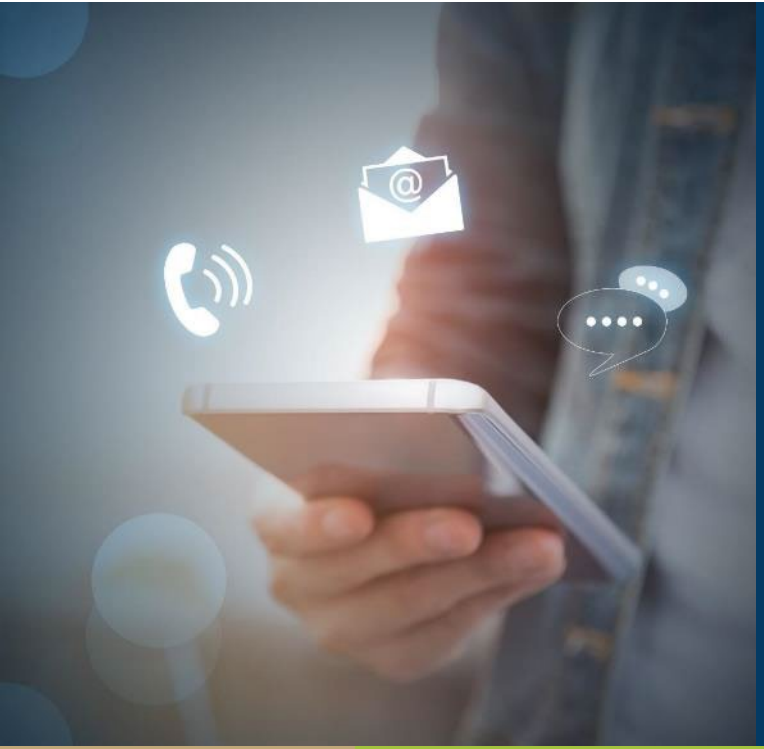
Resources

- https://www.cms.gov/medicare/provider-enrollment-and-certification/qapi/downloads/processtoolframework.pdf
- https://www.cms.gov/medicare/provider-enrollment-and-certification/qapi/qapitools
- https://www.cms.gov/medicare/provider-enrollment-and-certification/qapi/downloads/qapiataglance.pdf

Contact



Penza “Penny” Imes

Quality Improvement Specialist, Quality Insights

EMAIL ADDRESS

pimes@qualityinsights.org

ONLINE

qualityinsights.org/qin

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