Objective

• Describe five elements for framing Quality Assurance/Performance Improvement (QAPI) in the nursing home (NH)
• Discuss action steps to implement QAPI in the nursing home
QAPI

- Background – mandated by Affordable Care Act
- Context – regulatory process rooted in quality improvement
Revisiting CMS Regulations
*(Hamilton’s Abridged Version)*

### BASICS
*(Old Testament)*

<table>
<thead>
<tr>
<th>Do This</th>
<th>Learn</th>
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<tbody>
<tr>
<td>Don’t Do That</td>
<td>Become Even Better Internal Governance Internal Quality Champions</td>
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### Special Opportunities in LTC

- Everyone Makes a Difference…
  - Democratizing Improvement
    - Staff
    - Residents, Resident Councils, Families
  - Active involvement of residents, staff
  - Tools that everyone can use
    - Value of feedback
    - Never worry alone
    - PDSA (Plan Do Study Act): Providing the tools that everyone can use
- Culture Change + QAPI: Mutually Reinforcing

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*Thomas Hamilton*
*Director, Survey & Certification*
Timelines and Implementation

• Final rule may be issued in December, 2013
• NHs must have a QAPI program in place (with written plan) a year after final rule
• CMS has developed tools AND resources that are available to all NHs to increase likelihood of successful rollout
• [http://go.cms.gov/Nhqapi](http://go.cms.gov/Nhqapi). Visitors to the site may also email any questions to: Nhqapi@cms.hhs.gov.
  ■ Phase 1 rollout June 2013 S&C: 13.37-NH
  ■ Phase 2 rollout fall 2013-additional process tools
  ■ Phase 3 rollout spring 2014- Training materials for providers
QAPI Self-Assessment Tool

Directions: Use this tool as you begin work on QAPI and then for annual or semiannual evaluation of your organization’s progress with QAPI. This tool should be completed with input from the entire QAPI team and organizational leadership. This is meant to be an honest reflection of your progress with QAPI. The results of this assessment will direct you to areas you need to work on in order to establish QAPI in your organization. You may find it helpful to add notes under each item as to why you rated yourself a certain way.

Date of Review:_________________
Next review scheduled for:_________________

Rate how closely each statement fits your organization

<table>
<thead>
<tr>
<th>Not started</th>
<th>Just starting</th>
<th>On our way</th>
<th>Almost there</th>
<th>Doing great</th>
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</thead>
<tbody>
<tr>
<td>Notes:</td>
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Disclaimer: Use of this tool is not mandated by CMS for regulatory compliance nor does its completion assure regulatory compliance.
Performance Improvement is Continuous

A philosophy that no matter how good we are, there is always room for improvement

<table>
<thead>
<tr>
<th>Quality Assurance</th>
<th>Performance Improvement</th>
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<tbody>
<tr>
<td>Reactive</td>
<td>Proactive</td>
</tr>
<tr>
<td>Episode or event-based</td>
<td>Aggregate data and patterns</td>
</tr>
<tr>
<td>Prevent recurrence</td>
<td>Optimize process</td>
</tr>
<tr>
<td>Sometimes anecdotal</td>
<td>Always measurable</td>
</tr>
<tr>
<td>Retrospective</td>
<td>Concurrent</td>
</tr>
<tr>
<td>Audit-based monitoring</td>
<td>Continuous monitoring</td>
</tr>
<tr>
<td>Sometimes punitive</td>
<td>Positive change</td>
</tr>
</tbody>
</table>
QAPI

- QAPI is the systematic approach to corporate compliance
- Proactive effort to use data to understand and improve your own problems (internal governance)
- “Taking a step beyond quality assessment and assurance (QAA)... performance improvement is the key ingredient, catapulting the QAA movement from its inadequate assessment of compliance to a movement deep rooted in quality improvement.”

- Dr. Rosalie Kane, University of Minnesota

Five Elements of QAPI

- Design & Scope
- Governance and Leadership
- Feedback, Data Systems and Monitoring
- Performance Improvement Projects (PIPs)
- Systematic Analysis and Systemic Action
1. Design & Scope:  
**NH Written QAPI Plan Principles**

- Ongoing and comprehensive
- Full range of services offered by the facility
- Address clinical care, quality of life, resident choice and care transitions
- Safety and high quality with all clinical interventions
- Autonomy and choice in daily life for residents
- Best available evidence to define and measure goals

2. Governance and Leadership Responsibilities

**Responsible for:**
- Setting priorities for the QAPI program
- Building on the principles identified in the design and scope
- Setting expectations around safety, quality, rights, choice and respect
- Ensuring that staff is held accountable

*In an atmosphere free of fear of retaliation for reporting quality concerns*
3. Feedback, Data Systems and Monitoring

This element includes:

• Using performance indicators to monitor a wide range of care processes and outcomes
• Reviewing findings against benchmarks and/or targets the facility has established for performance
• Tracking, investigating and monitoring adverse events that must be investigated every time they occur
• Implementing action plans to prevent recurrences

“In God we trust, all others must bring data.”
W. Edwards Deming

“Measurement is only a handmaiden to improvement… but improvement cannot happen without it.”
- Don Berwick
Sources of Data

- Proprietary
  - abaqis—Medline
  - My InnerView
  - PointRight
  - Long Term Care Trend Tracker
  - Corporate Systems
- Family and resident council
- Staff feedback
- Staff and resident satisfaction surveys

Sources of Data

- MDS data- 672, 802 reports
- Oscar reports
- Quality measures based on MDS data
  - Casper
  - Nursing Home Compare
    http://www.medicare.gov/NursingHomeCompare/
- Industry trends, community relationships
4. Performance Improvement Projects (PIPs)

• To examine and improve care or services in identified areas
• Typically a concentrated effort on a particular problem in one area of the facility or facility wide
• Involves gathering information systematically to clarify issues or problems, and intervening for improvements
• Selected in areas important and meaningful for the specific type and scope of services unique to each facility

Performance Improvement Teams

• Type of members depend on purpose of the team
• Generally each team should be composed of interdisciplinary members
• It is important to include residents and families
• It is important to include the caregivers closest to the resident—floor nurses and CNAs
• Leadership must support the team through action and resources
Team defines goal

• Written goal/aim (make it attainable)
  Your goal should be SMART
  S pecific
  M easurable
  A ttainable
  R elevant
  T ime-bound

• What are we hoping to accomplish?
  (how much? by when?)

• Facilitator/team leader

5. Systematic Analysis and Systemic Action ~ Facility Specific

Facility Expectation:
• To develop policies and procedures and demonstrate proficiency in the use of root cause analysis (RCA)

Systemic Actions:
• Look comprehensively across all involved systems to prevent future events and promote sustained improvement
• Focus on continual learning and continuous improvement
Risk Factors

• Pressure Ulcer
  ■ Weight loss
  ■ Terminal prognosis
  ■ Multiple co-morbidities

• Falls
  ■ Poor impulse control
  ■ Memory loss, poor safety awareness

Root causes

• No individualized plan to mitigate risks
  ■ Turn more frequently
  ■ Manage pain to more easily move resident

• Do we communicate about “at risk” residents every shift?

• Do we have a plan for high risk times for this resident?

• Do we have enough “eyes”?
• Do we have enough activities?

“WHY?”
“How are we delivering care?”

Use Root Cause Analysis for Proactive Improvement

Resident level root cause analysis

• One resident may be a clue that there is a systems problem that will affect more residents
• Consider “near misses”
• Consider family comments
• Consider staff feedback

Facility level systems problems must always be considered while you are analyzing the data
Levels of Causes

- Caregivers rotate... don't know residents
- No one owns the care plan as a whole document
- Poor communication with hospital & family on admission
- Using alarms instead of individualized Care plans
- No system for sharing knowledge between disciplines
- No diagnosis for Anti-psychotic med
- Delay in getting new admits reviewed at behavior mtg.
- Admitted on Antipsychotic, not addressed timely
- 50% of residents have alarms
- Knowledge not available to all disciplines
- Individualized interventions not used consistently
- Noise level causes agitation
- 24% antipsychotic use

Deeper levels

Surface Level

Problem

Symptoms

Survey citation

Quality concern

Corporate concern

Brainstorming Questions

- What would solve the problem?
- What strategy could resolve the root cause?
- What solutions have already been thought of?
- What approaches have not been thought of?
- What different methods might work?
- What “off-the-wall” (unusual) ideas might help?
Compliance- Non-Compliance RCA

• Don’t know
  ■ Never knew
  ■ Forgot
  ■ Tasks implied - Not done due to inexperience

• Can’t comply
  ■ Scarce resources
  ■ Don’t know how
  ■ Impossibility

• Won’t comply
  ■ No reward/no penalty
  ■ Disagree or think is impractical

QAA → PI

• QAA Committee (Steering Committee) identifies need for Performance Improvement Project
  ■ Looks at data
  ■ Prioritizes

• Charters a performance improvement team
  ■ Team does root cause analysis
  ■ Initiates interventions by plan-do-study-act (PDSA)
Why Test?

- Possible Objectives of PDSA Cycles for Testing
  - Increase your belief that the change will result in improvement
  - Opportunity for learning from “failures” without impacting performance
  - Document how much improvement can be expected from the change
  - Learn how to adapt the change to conditions in the local environment
  - Evaluate costs and side-effects of the change
  - Minimize resistance upon implementation

Repeated Use of the Cycles

Changes That Result in Improvement

Hunches, Theories, Ideas

DATA

APSD

APSD

APSD

APSD
Successful Cycles to Test and Adapt Changes

- Plan multiple cycles to test and adapt change
- Think a couple of cycles ahead
- Scale down size of test (# of products, locations)
- Test with volunteers
- Do not try to get buy-in or consensus for the test
- Be innovative to make testing feasible
- Collect useful data during each test
- Eventually, test over a wide range of conditions

The Carriage House of Bay City

- Family owned facility, Continuum of Care
- 151 dual certified beds
- 61 percent long-term, 39 percent short term

Presented by: Marea Trotter
The Carriage House of Bay City

AIM Statement

• The Carriage House antipsychotic team will reduce the off-label use of antipsychotic medications in residents with dementia to less than 10 percent by December 31, 2013
### Team members

#### Behavior Management
- Social workers
- DON
- ADON
- Psychiatrist
- Pharmacist
- Supervisory nurses (2)
- CNAs
- Resident/family

#### Antipsychotic Team
- Social services
- Activities
- Supervisory nurses
- CNAs
- DON/ADON
- Resident/family

### Root Cause Analysis

- Non-pharmacologic interventions are not fully integrated into daily care
  - Why? Need for increased staff training
  - Why? Need more ideas and resources
Plan

- Increase non-pharmacologic interventions
  - Gather additional data to create individualized care plans
  - Increase variety of non-pharmacologic interventions

Do

- Review behavior logs weekly
  - Time of day, location, antecedents, nature of behavior
  - Review interventions
    - Outcome of intervention
- Social services will interview family and residents
  - History/etiology of behaviors
  - Routines, hobbies, personal preferences
- Prior to gradual dose reduction
  - Use above data to create an individualized care plan
Study

• Review the individualized care plan for efficacy bi-weekly
  ■ Decrease/increase in behaviors?
  ■ Adjust as needed
  ■ Dramatic response to intervention will be reported to Social services immediately
  ■ Feedback from staff, family and resident
• Summarize monthly in Behavior Management meeting with Psychiatrist and Pharmacist

Act

• Antipsychotic team will continue to create individualized care plans
• Adjust care plans as necessary
• Track efficacy of non-pharmacological interventions
  ■ Feedback from families and staff
• Spread successful interventions facility wide
• Regularly schedule in-services of staff
  ■ Highlight successes, report on efficacy of interventions
  ■ Review evidence-based research on dementia care
Rapid-Cycle PDSA for One Intervention

• Plan
  ■ Increase non-pharmacological interventions

• Do
  ■ Three 10 day trials of guided imagery
    ◆ Antipsychotic team: Review behavioral log data before and after
    ◆ Activity staff performs 45 minutes of guided imagery at various times throughout the day with high risk residents
    ◆ West wing (first trial 2:30-3:15 p.m.)
    ◆ East North (second trial –various times throughout the day)
    ◆ East North (third trial– 10-10:45 a.m.)

Rapid-Cycle PDSA for One Intervention

• Study
  ■ Anti-psychotic team met to review data—decrease in reported behaviors noted.
    ◆ Results inconclusive—unable to definitively correlate decrease in reported behaviors to imagery
      ♦ Too many variables—habituation to behaviors, educational background of residents and staff etc.
  ■ Anecdotally staff report residents are calmer, more compliant with care, and appear to enjoy guided imagery
  ■ Staff report they feel less stressed, enjoy the guided imagery and are less apprehensive while caring for residents with advanced dementia
  ■ Activity staff report guided imagery stimulates conversation and reminiscing
Rapid-cycle PDSA for one Intervention

• Act
  ■ Continue with guided imagery on East North
  ■ Select high-risk residents on Manor
    ▶ Implement guided imagery with small groups at various times of day to identify beneficial time

Lake Orion Nursing and Rehabilitation Center

• McLaren Healthcare System
• Non-profit
• 120 Beds
• Short term rehab and long term care

Presented by Lynn Schlaud, LBSW
Lake Orion Nursing and Rehab
AIM Statement

- The Lake Orion team will reduce the off-label use of antipsychotic medications in residents with dementia by 15 percent relative improvement or to less than 10 percent by December 31, 2013.

Lake Orion Nursing and Rehabilitation

Antipsychotic Use Long Stay

- Q4 2011, Q1&2 2012
- Q1 2013
- Q2 2013
- Goal
Team Members

- Social services
- Staff development director
- Activities director
- DON
- Consultant pharmacist
- Physician assistant
- Psychiatrist
- Medical director

- Nurse managers
- CNA from memory care
- Family/resident

Root Cause Analysis

- Residents admitted to the facility with currently prescribed antipsychotic medication or with long history of use of antipsychotic
- Residents, families and nursing staff not aware of potential adverse effects of the medication
Plan

• Involve staff, families, residents, physician, psychiatric services and pharmacist in the ‘gradual dose reduction’ process
• Educate staff using the ‘hand-in-hand’ tool

Do

• Meet with physician and psychiatric services to educate about CMS initiative ‘Partnership for Dementia Care’
• Change system for medication management
  ■ All psychoactive medication managed by psychiatric services
  ■ New admissions reviewed by PIP team next morning for psychoactive meds and referral to psychiatric services
  ■ In emergency PCP can prescribe but with time limit (only until psychiatric services can evaluate)
  ■ GDR very slowly with small titrations
  ■ Monitor GDR with behavior monitoring sheet every shift x seven days
**Do**

- PIP team meets weekly to discuss individual residents (behavior log) and individualized interventions
- Staff educated on valuing the relationship with a resident versus the task
- Begin ‘hand-in-hand’ education for staff to integrate person centered approach
- Nurses and psychiatrist communicate with families on the plan for GDR
- Educate all families about antipsychotics and GDR via newsletter
- Educate all residents at resident council

**Study**

- Steady success in reducing the number of residents taking antipsychotics by GDR
- Staff is reflecting better acceptance of appropriate use of antipsychotics
- Staff is integrating an individualized, person-centered approach and using more non-pharmacological interventions
Act

• Continue the process of review and education
• Continue to focus on more communication with families

Lessons learned

• Initially needed to have a “buck stops here” person in charge. (No orders for antipsychotics unless first okayed by DON)
• Continual education of families is necessary. It is especially difficult to do GDR when resident has been on the medication for a long time.
• Value relationships over tasks
• Slow down and listen to the residents
• Stay positive
Questions?
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