Quality Assurance Performance Improvement Overview

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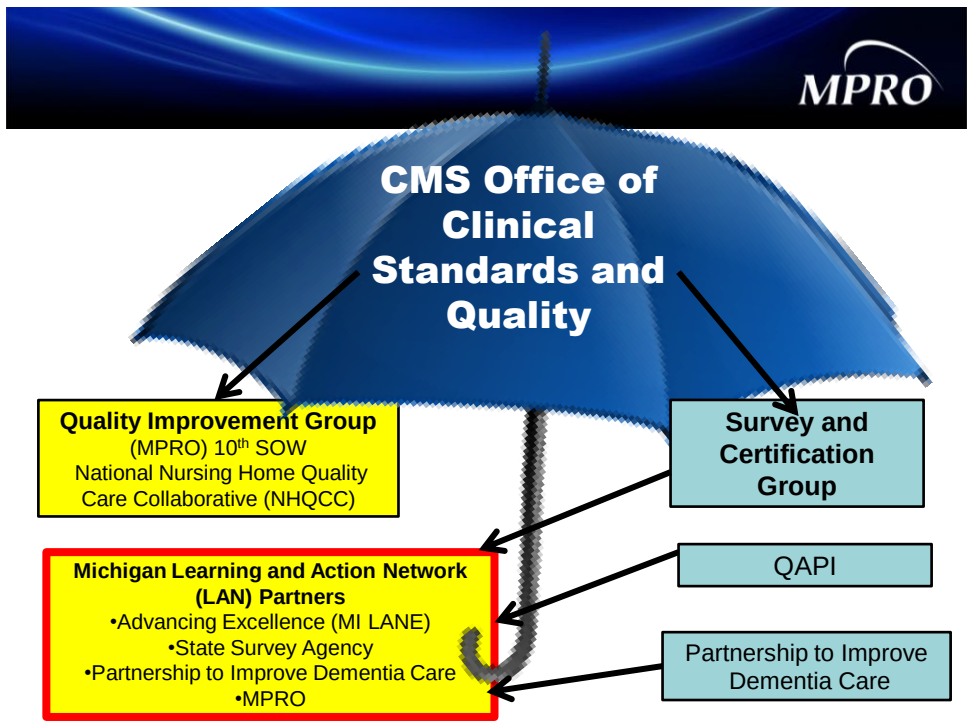
Objectives

- 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)*	**Beyond the Basics** *(New Testament)*
Do This	**Learn**
Don't Do That	**Become Even Better** **Internal Governance** **Internal Quality Champions**

Examples in Nursing Homes:

• Resident Rights (483.10) • Admission, transfer discharge (483.12) • Quality of Life (488.15) • Quality of Care (488.25) • Nursing, Dietary, Physician Services (488.30-40) •Specialized Rehab (488.45) • Pharmacy Services (488.60) • Infection Control (488.65) • Physical Environment (488.70) • Administration (488.75) ***180 Tags***	• QAPI Requirement • Outcomes Expectations ***Thomas Hamilton*** ***Director, Survey & Certification***

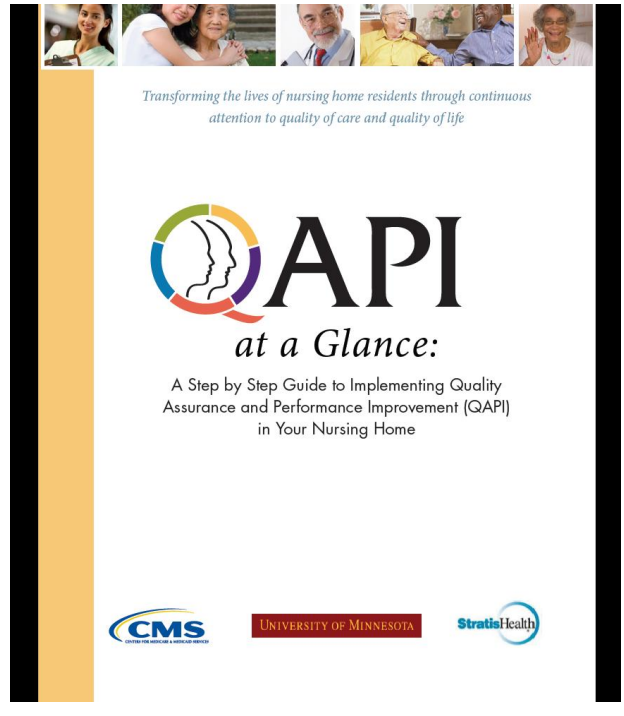
Special Opportunities in LTC

- 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

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. 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	Not started	Just starting	On our way	Almost there	Doing great
Our organization has developed principles guiding how QAPI will be incorporated into our culture and built into how we do our work. For example, we can say that QAPI is a method for approaching decision making and problem solving rather than considered as a separate program. Notes:					
Our organization has identified how all service lines and departments will utilize and be engaged in QAPI to plan and do their work. For example, we can say that all service lines and departments use data to make decisions and drive improvements, and use measurement to determine if improvement efforts were successful. Notes:					
Our organization has developed a written QAPI plan that contains the steps that the organization takes to identify, implement and sustain continuous improvements in all departments; and is revised on an ongoing basis. For example, a written plan that is done purely for compliance and not referenced would not meet the intent of a QAPI plan. Notes:					
Our board of directors and trustees (if applicable) are engaged in and supportive of the performance improvement work being done in our organization. For example, it would be evident from meeting minutes of the board or other leadership meetings that they are informed of what is being learned from the data, and they provide input on what initiatives should be considered. Other examples would be having leadership (board or executive leadership) representation on performance improvement projects or teams, and providing resources to support QAPI. Notes:					

Guide for Developing a QAPI Plan

DIRECTIONS:

The QAPI plan will guide your organization's performance improvement efforts. Prior to developing your plan, complete the ***Guide to Develop Purpose, Guiding Principles, and Scope for QAPI***. Your QAPI plan is intended to assist you in achieving what you have identified as the purpose, guiding principles and scope for QAPI, therefore this information is needed before you begin working on your plan. This is a living document that you will continue to refine and revisit. Use these step-by-step instructions to create your QAPI plan. This plan should reflect input from caregivers representing all roles and disciplines within your organization.

I. QAPI Goals

Based on the ***Guide to Develop Purpose, Guiding Principles, and Scope for QAPI***, indicate the QAPI goals that your plan will strive to meet. Goals should be specific, measurable, actionable, relevant, and have a time line for completion. (See ***Goal Setting Worksheet***).

II. Scope

a. Describe how QAPI is integrated into all care and service areas of your organization.
b. Describe how the QAPI plan will address:
   i. Clinical care
   ii. Quality of life
   iii. Resident choice (i.e., individualized goals for care)
c. Describe how QAPI will aim for safety and high quality with all clinical interventions while emphasizing autonomy and choice in daily life for residents (or resident's agents).
d. Describe how QAPI will utilize the best available evidence (e.g., data, national benchmarks, published best practices, clinical guidelines) to define and measure goals.

III. Guidelines for Governance and Leadership

a. Describe how QAPI is integrated into the responsibilities and accountabilities of top-level management and the Board of Directors (if applicable).
b. Describe how QAPI will be adequately resourced.
   i. Designate one or more persons to be accountable for QAPI leadership and for coordination.
   ii. Indicate the plan for developing leadership and facility-wide training on QAPI.
   iii. Describe the plan to provide caregivers time, equipment, and technical training as needed for QAPI.
   iv. Indicate how you will determine if resources are adequate for QAPI.
   v. Describe how your caregivers will become and remain proficient with process improvement tools and techniques. How will you assess their level of proficiency?

Performance Improvement is Continuous

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

Quality Assurance	Performance Improvement
Reactive	Proactive
Episode or event-based	Aggregate data and patterns
Prevent recurrence	Optimize process
Sometimes anecdotal	Always measurable
Retrospective	Concurrent
Audit-based monitoring	Continuous monitoring
Sometimes punitive	Positive change

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

"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?”

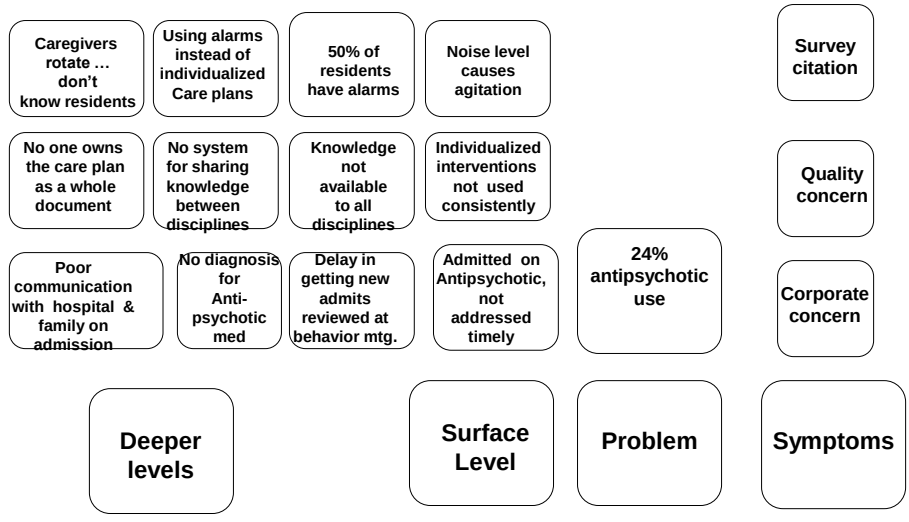
Use Root Cause Analysis for Proactive Improvement

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 feed back

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

Levels of Causes



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)

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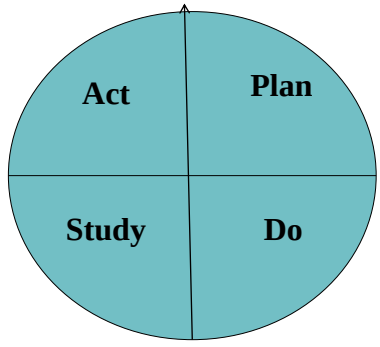
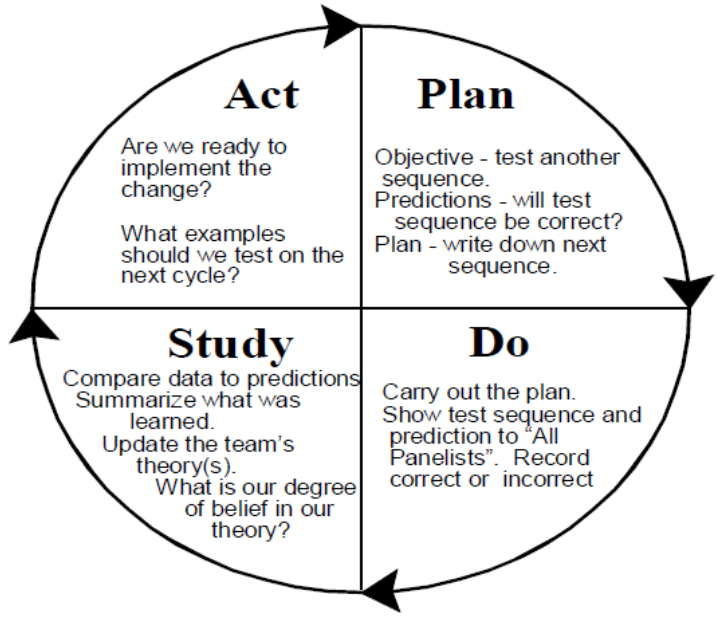
Performance Improvement Roadmap



- State Desired Outcomes
- Describe Current Situation Identify Problems
- Collect and Analyze Data
- Uncover Root Causes
- Generate Solutions
- Plan
- Do, Implement
- Study, Check/Evaluate
- Act

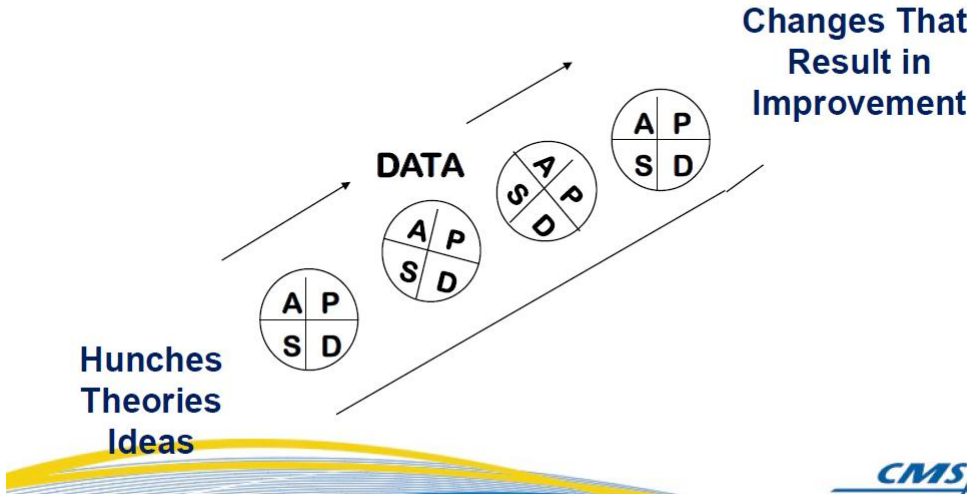
PDSA Cycle for Learning the Sequence



Why Test?

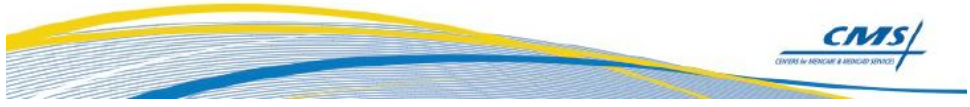
- Possible Objectives of PDSA Cycles for Testing
  - Increase your belief that the change will result in improvement
  - Opportunity for learning from "failures" without impacting performance
  - Document how much improvement can be expected from the change
  - Learn how to adapt the change to conditions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

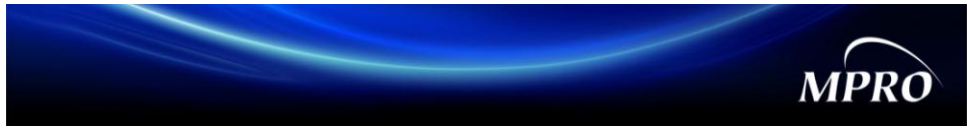
Repeated Use of the Cycles



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

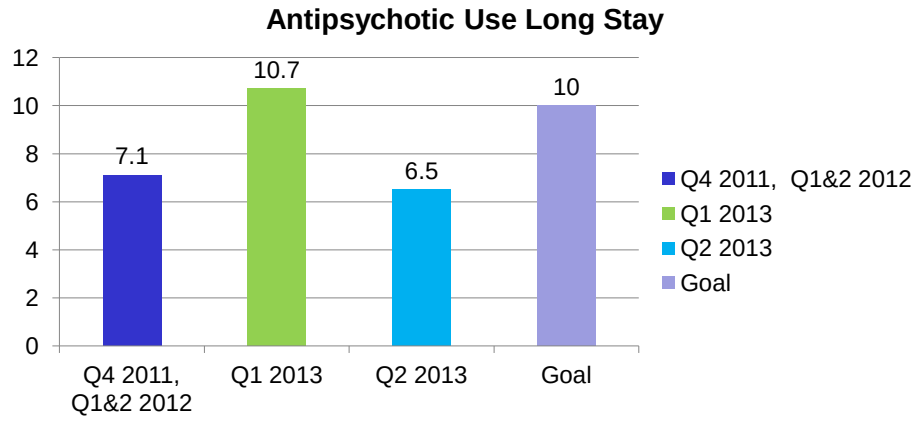
- Family owned facility, Continuum of Care
- 151 dual certified beds
- 61 percent long-term, 39 percent short term

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

The Carriage House of Bay City



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

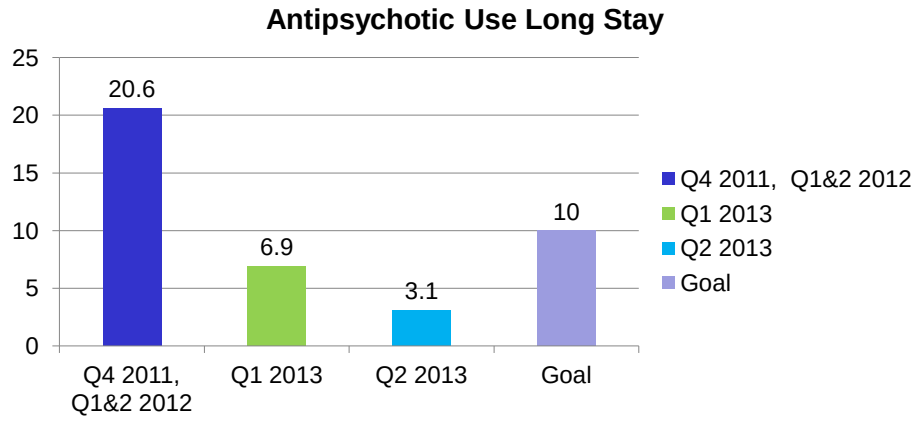
- McLaren Healthcare System
- Non-profit
- 120 Beds
- Short term rehab and long term care

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



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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MPRO's Mission:
Improving quality, safety and efficiency
across the healthcare continuum.

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