Quality Assurance and Performance Improvement (QAPI) Program

What's New?

F-866 and F-867

Presenter

Janis A. Franich, RN, MSN

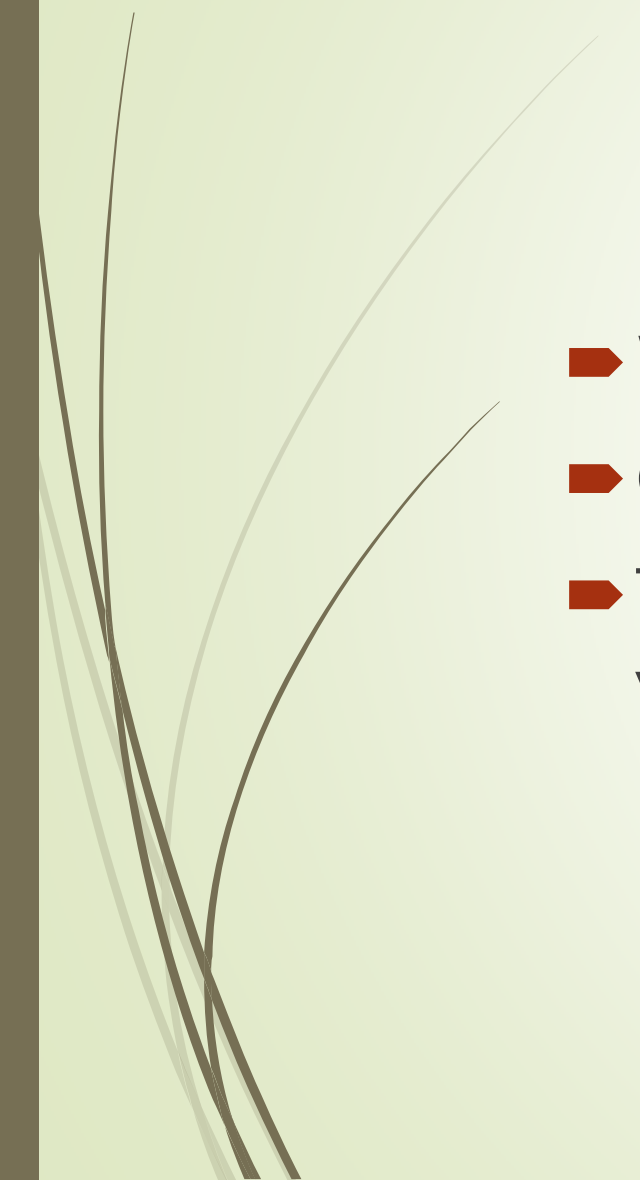**Nurse Consultant, State of Michigan**

Objectives

At the conclusion of this presentation, participants will be able to identify the five **new** elements of compliance with QAA and QAPI.
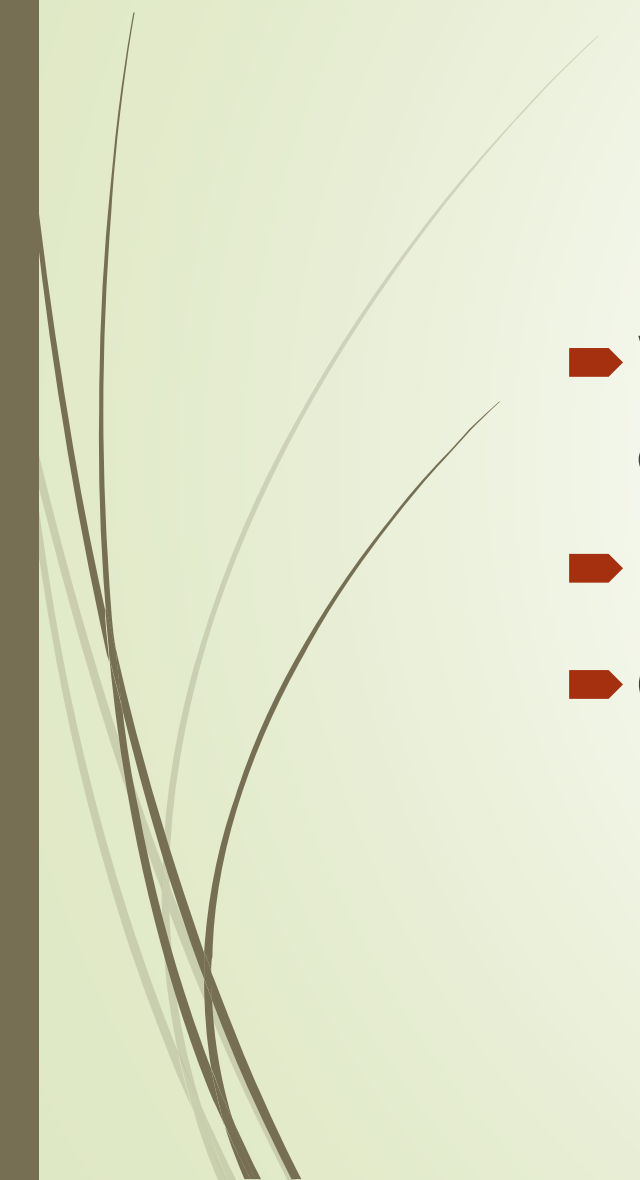
QAPI Program Feedback

- Written policies and procedures for feedback.
- Could be different for each project.
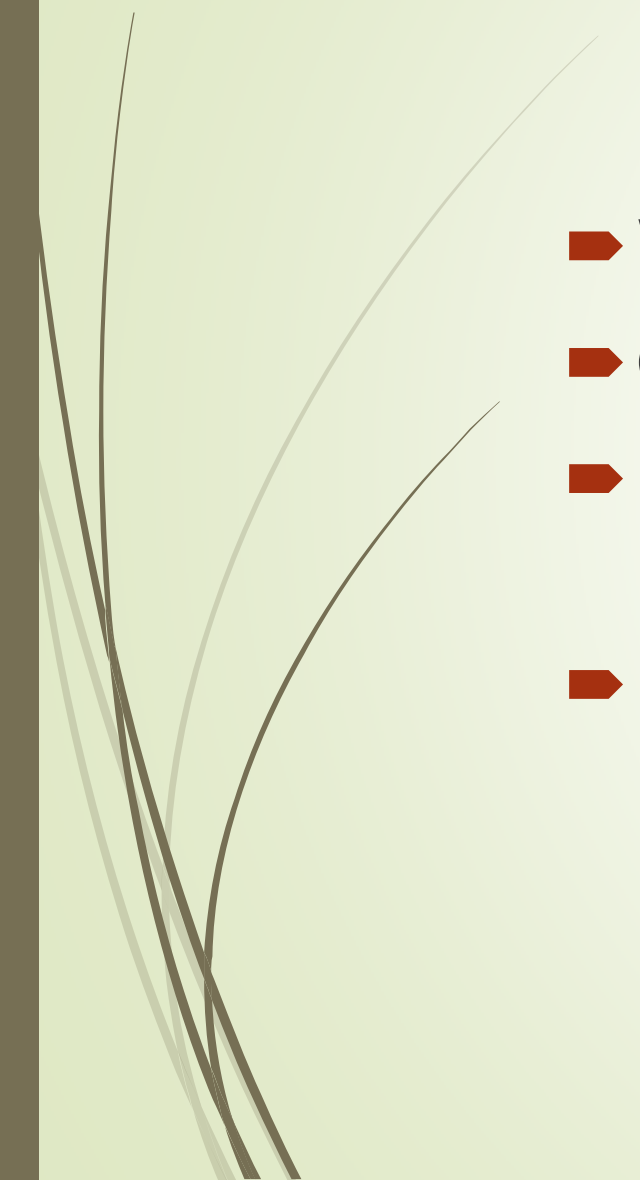- Think about who you want feedback from. How will you determine the stakeholders?

Data Collection Systems

- Written policies and procedures for data collection systems.
- How will you collect information?
- Could be different for each project.

Monitoring

- Written policies and procedures for monitoring.
- Could be different for each project.
- How will you know when improvements are made?
- Establish goals and thresholds for performance measurement.

Adverse Event Monitoring
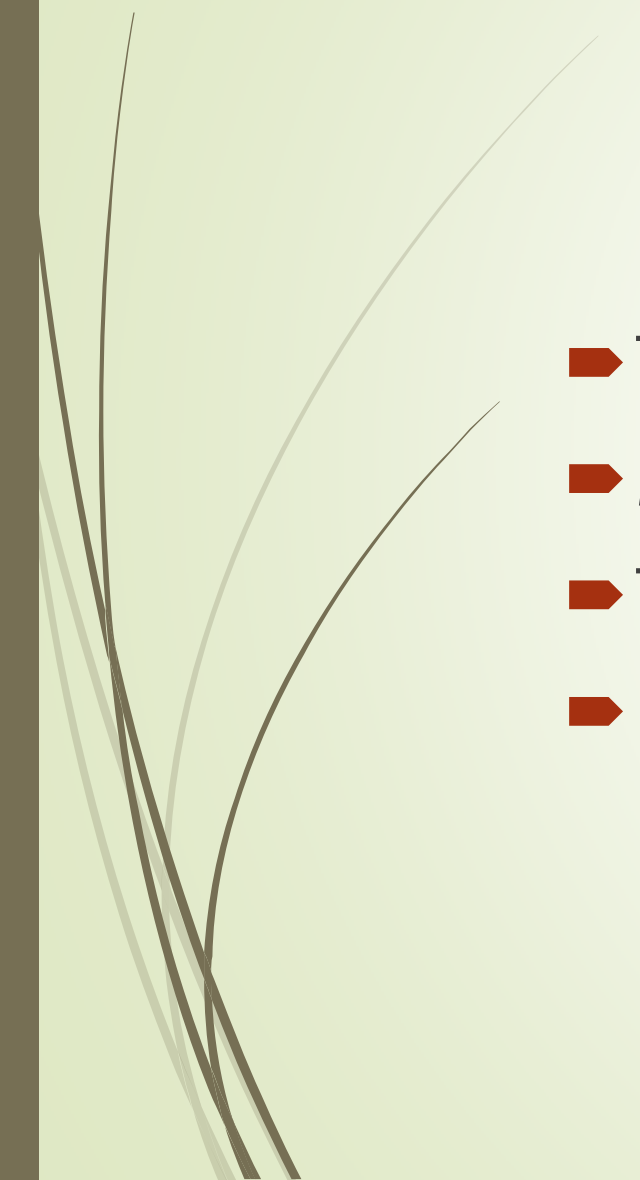
- What is that?

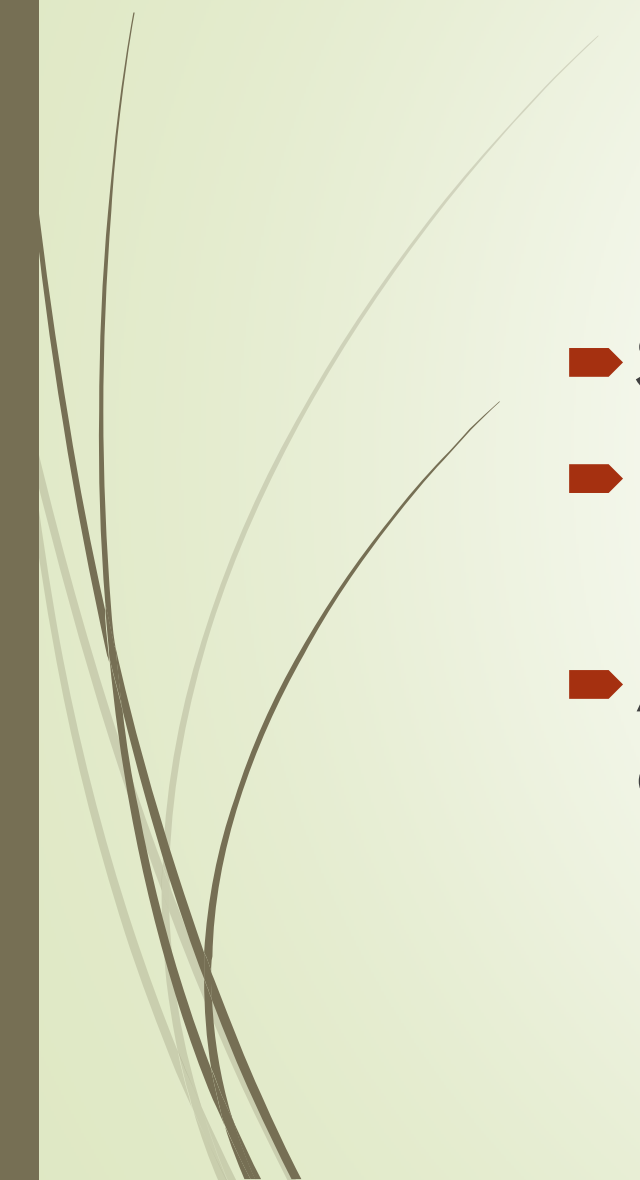- How to know what is an adverse event.

Systematic Analysis and Systemic Action

- Take action.
- Measure success.
- Track performance.
- Ensure sustained improvements.

Program Activities

- Set priorities.

- Focus on high-risk, high volume, or problem-prone areas.

- Affect health outcomes, resident safety, resident autonomy, resident choice, and quality of care.
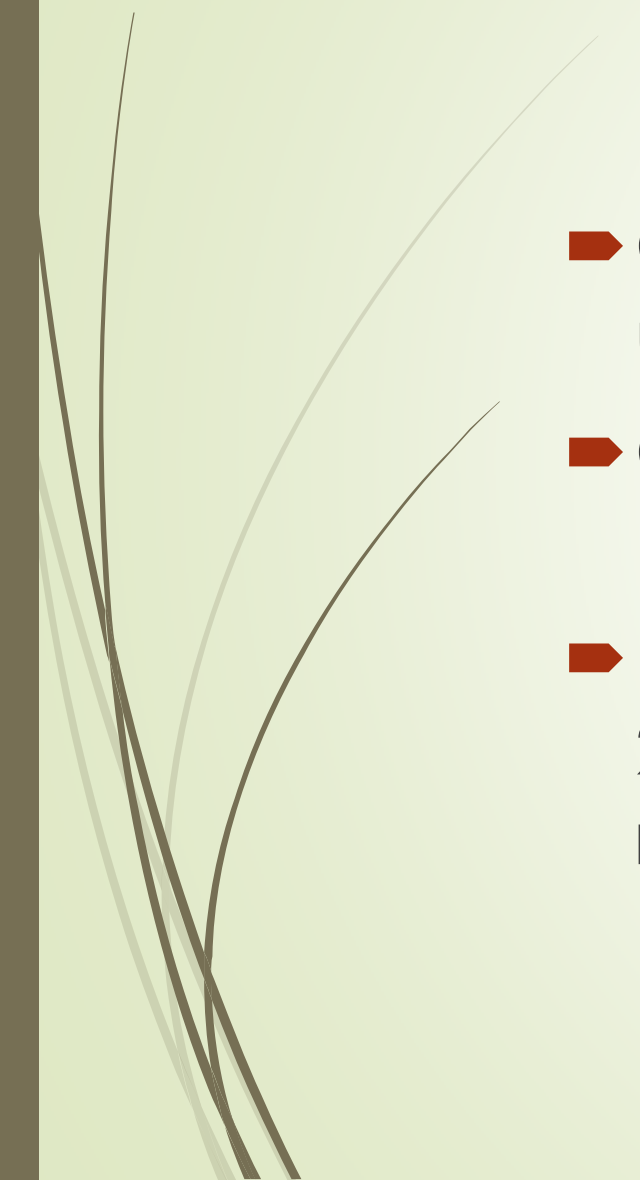
What to Expect During Survey

- QAA/QAPI task done toward the end of the survey.

- Disclose records if needed to determine compliance with QAA/QAPI regulations.

- QAPI information not used to determine new areas of concern or non-compliance.

- May ask about quality problems identified by survey team during the survey.

Implementation Dates

- Comment period on proposed rule was open until September 16, 2019.

- Changes were proposed to be made to the published Phase 3 regulation implementation.

- Implementation scheduled for November 28, 2019 yet may be delayed pending proposed rule determination.

Resources

- "QAPI at a Glance: A Step by Step Guide to Implementing Quality Assurance and Performance Improvement (QAPI) in Your Nursing Home" a CMS publication. http://go.cms.gov/Nhqapi.

- Adler L, Moore J, Federico F. *IHI Skilled Nursing Facility Trigger Tool for Measuring Adverse Events*. Cambridge, MA: Institute for Healthcare Improvement; November 2015. (Available at ihi.org).

- State Operations Manual (SOM), Appendix PP Guidance to Surveyors for Long Term Care Facilities.

- National Archives. Federal Register. The Daily Journal of the United States Government. Retrieved 8-23-2019 from https://www.federalregister.gov/documents/2019/07/18/2019-14946/medicare-and-medicaid-programs-requirements-for-long-term-care-facilities-regulatory-provisions-to.

QAPI

Putting the Quality in the QAPI and PIP Process

Presenters

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Char Murphy, RN
Rehab ADON

*Presenters have no conflicts of interest to disclose

Objectives

1. Describe 2 methods of finding high risk, high volume, problem prone concerns with the facility.

2. Understand the value of using the Plan, Do, Study, Act (PDSA) model with Performance Improvement Projects (PIPs).

3. Understand the importance of involving frontline staff in the PIP process.

QAPI~ Elements

- The program must be ongoing and include a comprehensive review of care and services.

- The program must be governed by a high position in the facility in order to ensure appropriate resources are in place.

- The program must establish baseline data and have systems in place to monitor outcomes.

- The program must include Performance Improvement Projects which address concerns in the facility through an in-depth analysis and team approach.

- The program must have methods to perform root cause analysis to find systemic improvement opportunities and implement systemic actions with a method to follow up on interventions for effectiveness.

Systematic Analysis and Systemic Action

Feedback, Data Systems and Monitoring

Performance Improvement Projects

Governance and Leadership

Design and Scope

Quality of Care, Quality of Life, Resident Choice
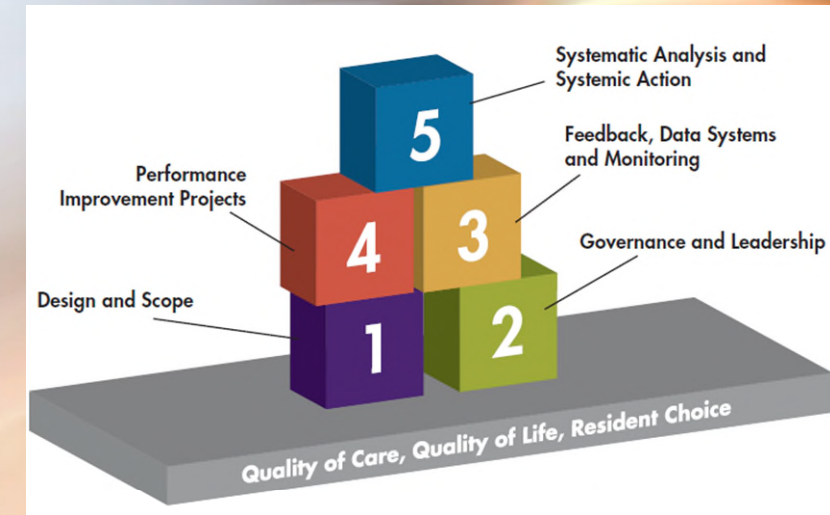
Feedback, Data Systems, and Monitoring

QA: One way to monitor Quality Assurance is through trending information. Our facility has implemented the use of monthly dashboards which aide to establish baselines and thresholds for compliance. Dashboards also provide trending on compliance and corrective actions throughout the entire year, rather than focusing on a single reporting event.

- For Example:

Department	Monitor/Audit Item	Freq	Threshold	Jan	Feb	Mar	April	May	June	July
Quality	Customer Service Surveys Willingness to Recommend	Monthly	90%		93.3%	86.3%	90.9%	78.3%	95.0%	91.0%
	Action/Intervention				None	Reviewed poor surveys, isolated concerns addressed	None	Initial: Reviewed poor surveys. Room and food concerns were trends. Reviewed trends for all concerns with response and actions taken by unit manager.	none	none

As stated in QAPI at a Glance:

"Identifying benchmarks for performance is an essential component of using data effectively with QAPI." (pg 15).

Feedback, Data Systems, and Monitoring

- When an area on the dashboard is out of compliance with the threshold, the auditor/department completes a Corrective Action Plan.

Per CMS guidance,

There are many different methodologies available to facilities for developing corrective action. CMS has not prescribed a particular method that must be used. Corrective action generally involves a written plan that includes:

- A definition of the problem – which, depending on the severity and extent of the problem, may require further study by the committee to determine contributing causes of the problem (Root Cause Analysis);
- Measurable goals or targets;
- Step-by-step interventions to correct the problem and achieve established goals; and
- A description of how the QAA committee will monitor to ensure changes yield the expected results.

Corrective actions may take the form of one or more tests of change, or PDSA cycles until the desired performance goals have been met, or facilities may convene a Performance Improvement Project (PIP).

(American Health Care Association [AHCA], 2017, p. 933-934)

Feedback, Data Systems, and Monitoring

- A critical component of a successful QAPI program is the ability to monitor interventions or corrective actions to ensure you have achieved the desired outcome. The guidance states:

Identifying and correcting problems requires facilities to:
- Collect data from various sources related to high risk, high volume, and problem-prone issues such as medical errors and adverse events;
- Analyze the data collected to identify performance indicators signaling deviation from expected performance;
- Study the issue to determine underlying causes and contributing factors;
- Develop and implement corrective actions; and
- Monitor data related to the issue to determine if they are sustaining corrections, or if revisions are necessary.

(AHCA, 2017, p. 924-925)

So Much To Do…

When corrective action plans do not achieve desired results, a PIP may be necessary.

- How many projects can you think of that you need to do at this time? One, two… hundred?

- Deciding on where to begin with seeking out quality projects can seem overwhelming since many individuals and departments likely have great ideas on projects to start. The key will be to have a solid process in place to track and prioritize project decisions, so that the teams are not inundated with work.

- The point of QAPI is not to do everything at once, but to find high priority issues and do those well.

…So Little Time

QAPI at a Glance provides resources to assist with coordinating performance improvement at facilities.

One such tool is the Prioritization Worksheet. This is useful to track PIP ideas and use a consistent, logical process to decide what must be addressed immediately and what can wait. The QAPI committee should decide collectively on the priority of projects and list rationales for these decisions. This worksheet can be found at:

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

This will help serve as proof that your facility is seeking concerns and improvement opportunities. The expectation is not that you must work on everything all at once, but have a reasonable way to decide what you will work on and why.

To PIP or Not To PIP

- One of the main concepts of QAPI is to have processes in place to identify concerns and then prioritize concerns based on the impact on Residents.

- Key focus areas are ones that are identified as **high risk**, **high volume**, and **problem prone**, as described in F 865:

  > "The **key point** is that the facility must provide satisfactory evidence that it has, through its QAA committee, identified its own high risk, high volume, and problem-prone quality deficiencies, and are making a "good faith attempt" to correct them." (AHCA, 2017, p. 922)

High Risk

High Volume
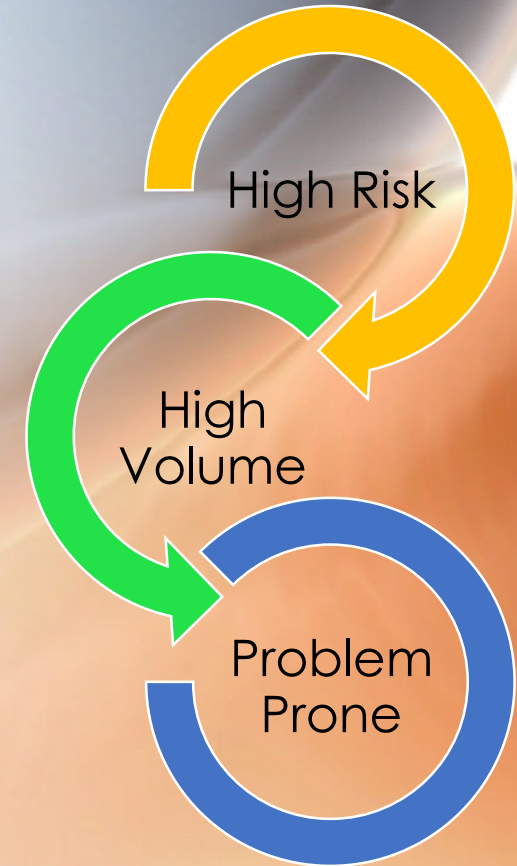
Problem Prone

High Risk, High Volume, Problem Prone

Examples of these could include:

- **<u>High Risk</u>**: care or services which are associated with high risks to residents, such as trach care, pressure ulcer prevention, and high risk meds, such as warfarin or insulin

- **<u>High Volume</u>**: care or services which are provided frequently to residents, such as medication pass, call light concerns, or dining concerns

- **<u>Problem Prone</u>**: care or services which have repeated problems reported, such as falls or food quality

Identifying Concerns
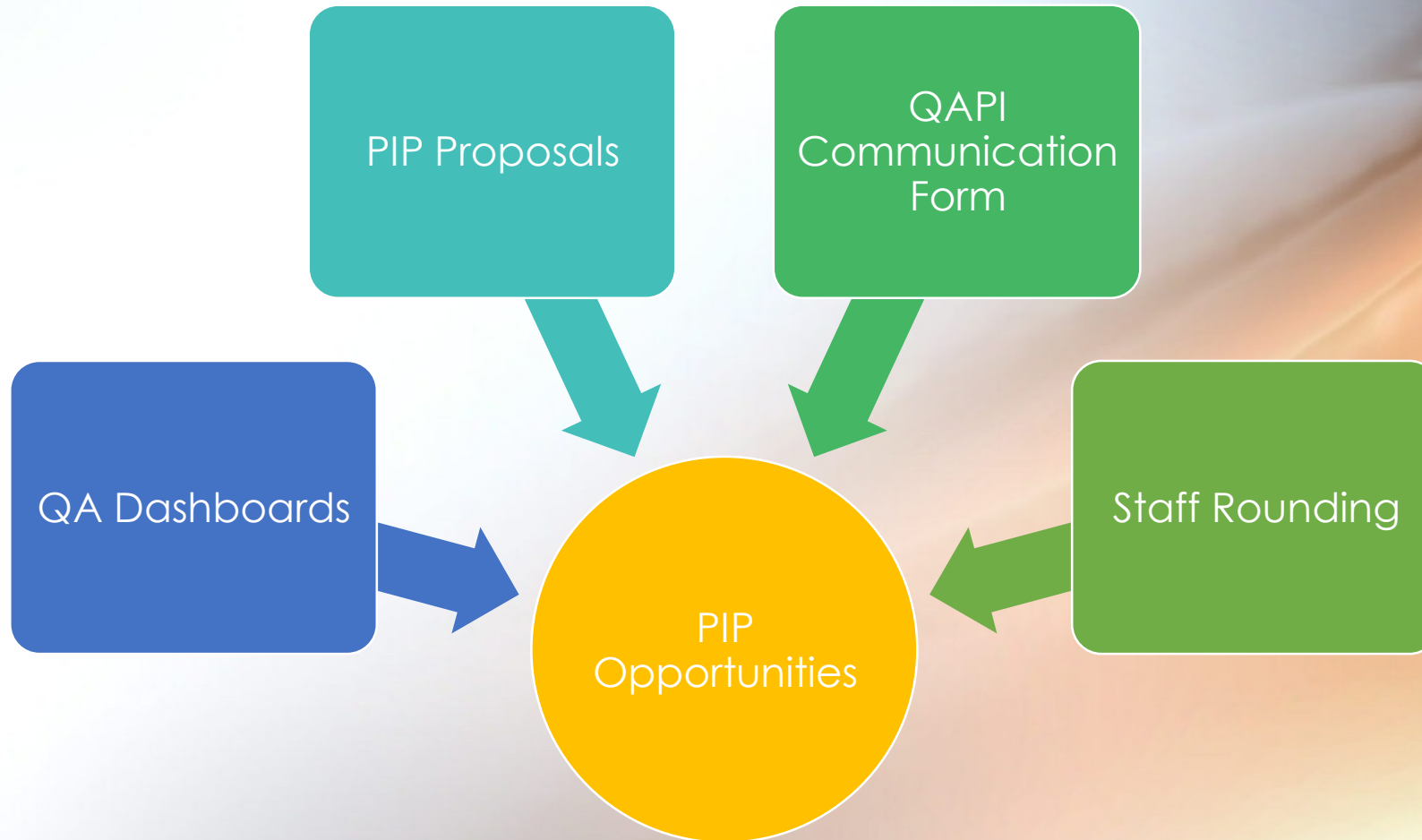
Identifying Concerns

Facilities can identify concerns in various ways. We identify opportunities for PIPs through:

QA Dashboards

- QA meeting dashboards, if an area or audit item is routinely out of compliance and not responding to corrective action plans, a PIP is considered.

PIP Proposals

- PIP Proposal Forms that can be submitted by any staff member. This allows a staff member to submit ideas based on concerns or potential improvement they see directly in their areas. This form goes to the QAPI Committee for review and determination on whether to proceed at this time.

QAPI Communication Form

- QAPI Communication Form that gathers basic information about an observed or perceived concern and focuses if the concern could be considered high risk, high volume, or problem prone. This is returned to the QAPI Committee for review of next steps.

Staff Rounding

- Monthly staff rounding where we ask "do you have any high risk, high volume, or problem prone concerns?" If the answer is Yes the manager assists in completing the QAPI Communication Form.

Performance Improvement

- What changes need to be made to the next cycle?
- If no changes, roll out the improvement

- Set improvement goals
- Predict what will happen
- Plan the cycle (who, where, what and how)
  - Decide what data to gather

- Fully analyse data
- Compare data to predictions
- Examine learning

- Carry out the plan
- Document any problems encountered and observations
- Gather data
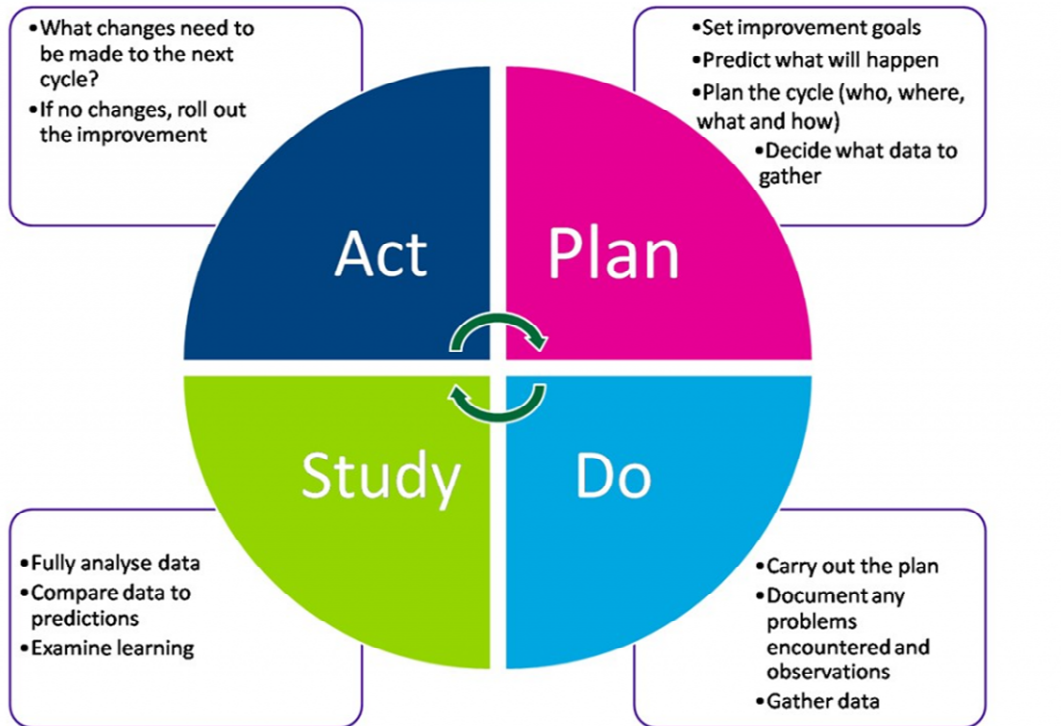
- Once a concern or opportunity is identified and agreed upon to address through the PIP process, the PIP Report Template is used.

- This template provides a layout for the Plan, Do, Study, Act phases of a project.

- Currently we are working on Reducing Hospitalizations on our Short Term Rehab unit.

Reducing Hospitalizations- Proposal

- When the VBP(Value-Based Purchasing) results were released last year, we found we were higher in our hospital readmission rate than we would like for quality patient care. Additionally these results impacted FY19 and many facilities were subject to a decrease in Medicare Reimbursement (us included!) due to performance.

- So we knew we needed to reduce hospitalizations, but how and where to start?

Reducing Hospitalizations- Data

First we had to analyze the data. We assumed things about hospitalizations, such as most hospitalizations happen on the weekend when we have on-call doctors, or most occur within 1-3 days of admission because of hospital errors.

Patient Rehospitalizations

Bar chart: # Patient Rehospitalizations

- 0-5 Days: 8
- 6-10 Days: 16
- 11-15 Days: 13
- 16-20 Days: 2
- 21-30 Days: 3

■ # Patient Rehospitalizations
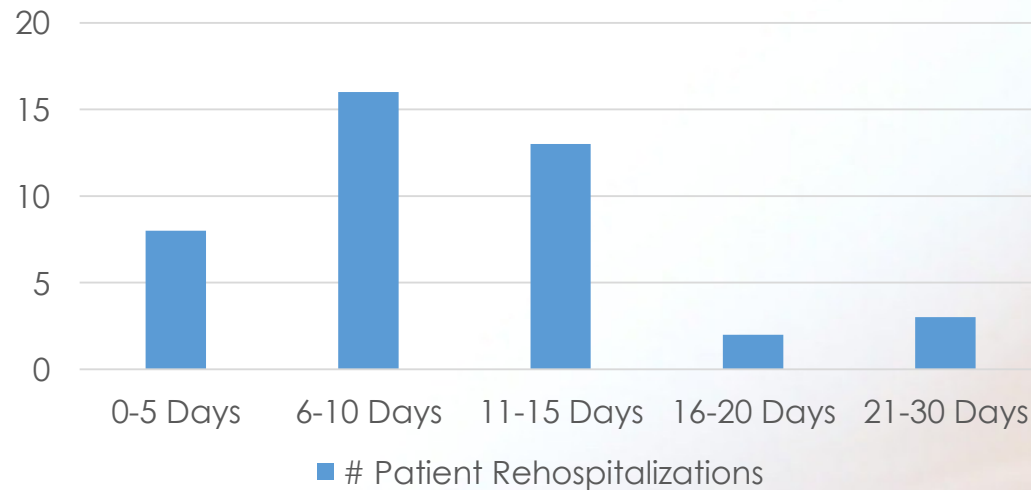
But once we organized the information, we were able to draw the following conclusions:

1- 69.4% of patients readmitted to the hospital from our facility (as opposed to readmitting after they returned home). So our focus was readmissions during the SNF stay.

2- Most hospital readmissions occurred on Wednesdays, between 6-10 days of the patient's stay.

3- The highest readmitting hospital diagnosis was heart failure.

Reducing Hospitalizations- Planning

- Now, armed with accurate data, we were able to start planning. We gathered a team that focused on nursing, dietary, therapy and the medical director.

- We then completed an activity "In a Perfect World…" where a resident's stay was divided into days 1-3, 4-5, 6-10, Greater than 10, and post discharge. Each discipline wrote under every category what they could do to prevent heart failure patients from returning to the hospital in a perfect world (not thinking about cost, staffing or other barriers).

Nursing	Dining Services
PIP Team	
Therapy	Medical Director
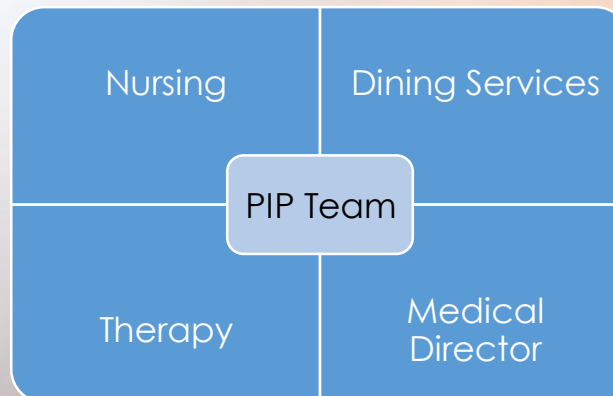
Reducing Hospitalizations- Planning

- The results were amazing! Teams were talking and working out ideas collaboratively. Everyone had contributions from simple ideas to complex process change.

- Next the team met to sort through the ideas based on what we could accomplish with our current resources. Now we had a plan!

- We began to develop our own Heart Failure Pathway, utilizing our individual tools and incorporating resources from the American Association of Heart Failure.

Developing our Heart Failure Pathway

- Based on the numerous ideas from our activity, we developed specific interventions for each department to contribute.
    - Dining Services:
        - Worked to develop low sodium (2 G or less) menus with an "always available" option as well.
        - Registered Dietitian provides the physician with the estimated fluid needs for a patient with heart failure near admission.
        - Patient education from a dietary perspective is completed.

Developing our Heart Failure Pathway

- Nursing Involvement:
    - Implemented a heart failure specific nursing assessment in EMR. The focus of this assessment is to have the nurses comment on trends, not just the current information. For example, nurses must note the current weight, activity tolerance, and lower extremity edema and compare these results to yesterday, 3 days ago, and 5 days ago.
    - We developed and provide a Heart Failure Education Packet, which includes the American Heart Association (AHA) Patient's Self Check Assessment (extracted from the AHA CHF Toolkit). This assessment is used in conjunction with the nurses to daily focused assessment. This helps to first incorporate how the patient is feeling as compared to what the nurses are objectively seeing, and secondly trains patients how to assess themselves and continue this practice post discharge.
    - The interdisciplinary team meets weekly (as needed) with the medical director to review patients who were readmitted to the hospital and collaborate on what could have been done to prevent that occurrence.

Self-Check Plan Tool

Self-Check Plan for HF Management

RISE ABOVE Heart Failure

✓ Excellent – Keep Up the Good Work!

- ☐ No new or worsening shortness of breath
- ☐ Physical activity level is normal for you
- ☐ No new swelling, feet and legs look normal for you
- ☐ Weight check stable Weight: _____
- ☐ No sign of chest pain

GREAT! CONTINUE: Daily Weight Check | Meds as Directed | Low Sodium Eating | Follow-up Visits

⚑ Pay Attention – Use Caution!

- ☐ Dry, hacking cough
- ☐ Worsening shortness of breath with activity
- ☐ Increased swelling of legs, feet, and ankles
- ☐ Sudden weight gain of more than 2-3 lbs In a 24 hour period (or 5 lbs in a week)
- ☐ Discomfort or swelling in the abdomen
- ☐ Trouble Sleeping

CHECK IN! Your symptoms may indicate: A need to contact your doctor or provider | A need for a change in medications

⚠ Medical Alert – Warning!

- ☐ Frequent dry, hacking cough
- ☐ Shortness of breath at rest
- ☐ Increased discomfort or swelling in the lower body
- ☐ Sudden weight gain of more than 2-3 lbs In a 24 hour period (or 5 lbs in a week)
- ☐ New or worsening dizziness, confusion, sadness or depression
- ☐ Loss of appetite
- ☐ Increased trouble sleeping; cannot lie flat

WARNING! You need to be evaluated right away. Call your physician or call **911**

American Heart Association | American Stroke Association. life is why™

www.RiseAboveHF.org

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Developing our Heart Failure Pathway

- Medical Director Involvement:
  - Contributed scheduled lab draws to help establish the patient's baseline and changes.
  - Use of the ZOE monitor for assistance in assessment of fluid status.
  - Communicated to our other practicing physicians the focus on heart failure and our plan.

Developing our Heart Failure Pathway

- Therapy Involvement:
  - Closely monitors the patient's biox and activity tolerance during therapy sessions.
  - Reports this information to the nurse to include in the focused heart failure assessment.

Generating our Heart Failure Pathway

We created a heart failure order set on admission. This includes:

- Reduced Sodium diet and encouraging Heart Healthy menu choices
- Daily weights
- Double layer tubigrips to lower extremities
- Dietitian to follow up with Physician on fluid needs assessed
- Providing a Heart Failure Education Packet
- Encouraging elevating legs above heart
- Notify Physician of weight increases >3lbs in 24 hours or >5lbs in 1 week
- Notify Physician if biox drops below 90%

Putting Our Interventions Into Action- Do

Next we planned out our implementation. Factors considered were:

- Who needs to be educated and what is the time frame?

- What barriers could we anticipate?

- When will we start?

- Where will we start?

- How will we measure our outcomes?

Intervention	Write orders for 'encourage heart healthy menu choices' for all rehab pts with dx chf
How	Nursing write orders at admission
When	Start Nov 1st 2018
Where	Rehab Unit
Who	All pts w/ dx of heart failure
Measure/tracked	Michelle to monitor every admit to ensure orders are in place

Put Your PLAN into ACTION

Putting Our Interventions Into Action- Do

- It was critical to have the frontline staff well educated and involved. Frontline dining services staff were responsible to encourage the lower sodium diet and nurses were key to accurate assessments and patient education.

- During implementation we frequently checked with our frontline staff on what was working, what wasn't, and why. We were able to overcome barriers and resistance with the changes. After a few weeks, the heart failure pathway became second nature for our staff.

- Our nurses feel more confident in managing patients with heart failure and are excited to engage patients in the tools and provide education.
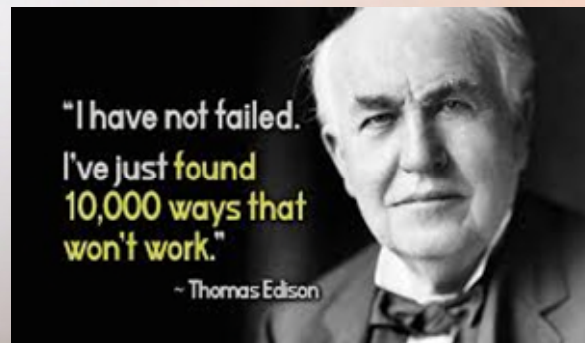
Next Steps- Study

- Currently we are in the study phase- we are monitoring our interventions and trending results.

- ***IMPORTANT-*** It is critical to provide feedback to the team and frontline staff on results, and also to reassure progress may not be observed immediately. Many times staff who are not experienced with project work feel discouraged by the day to day, however when you trend over a period of time improvements can be seen.

- While we are still in the study phase, we have found improvement thus far as well as positive feedback from staff, physicians, and patients, and their families.

- We have decreased our monthly PIP meetings to quarterly, which provides time to collect trends and re-evaluate the interventions implemented.

Final Phase- Act

- Once we have determined we have enough data to confirm an impact from our interventions, we will decide whether to "Act" and formally put these interventions into facility practice or "Adjust", where we will evaluate items not working and what we need to change for improvement.

  - *It is always important in this phase to look closely at what you put in place and if the items are having an impact. Do away with interventions that are just 'bust work'.

Summary

- Key points in QAPI:
  - Monitoring care and services with specific thresholds and implementing corrective action plans for areas out of compliance.
  - Focus on system issues rather than individual situations, seek patterns and trends.
  - Prioritizing projects with a focus on high risk, high volume, and problem-prone areas.
  - Have a consistent, process based method to document your QAPI activities.
  - Remember- QAPI is not about doing everything, but finding those high priority concerns and doing those well.
  - Finally- do not become discouraged when you do not generate the outcomes you desired from PIPs. Continue to work through the cycles of PDSA.

"I have not failed. I've just found 10,000 ways that won't work."
~ Thomas Edison

References

1. CMS QAPI at a Glance.(n.d.). Retrieved from https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/QAPI/Downloads/QAPIAtaGlance.pdf

2. American Health Care Association. (2017). *The Long Term Care Survey* (November 2017 ed.). Hurlock, MD: Author

3. Self Check Plan for Heart Failure. (2015). Retrieved from https://www.heart.org/en/health-topics/heart-failure/heart-failure-tools-resources/heart-failure-guidelines-toolkit

Thank you

- Questions?