

QAPI: NEW PROGRAM OR WHAT WE DO EVERY DAY?

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Learning Objectives

- Identify the five principles of QAPI
- Recognize top down vs bottom up leadership strategies to implement QAPI in your organization
- Apply strategies to more effectively conduct root cause analysis



CMS QAPI Requirements

- The Affordable Care Act of 2010 requires nursing homes to have an acceptable QAPI plan within a year of CMS issuing QAPI regulations
 - Proposed regulations are expected later this year
- QAPI approach is to ensure a systematic, comprehensive, data-driven approach to care
 - QAPI at a glance is available CMS web site:
<http://go.cms.gov/Nhqapi>



What do you think QAPI is?

- a. New program we have to add to all the other stuff we need to do
- b. An additional requirement mandated by the Feds
- c. Impossible to implement without more resources
- d. Another fad that it to shall pass
- e. Another bad acronym from CMS
- f. A bunch of new terms for what we already do
- g. A business management approach

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The Five Elements of QAPI



CMS Survey and Certification letter 13-05
<http://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/SurveyCertificationGenInfo/Downloads/Survey-and-Cert-Letter-13-05.pdf>

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Five Elements of QAPI



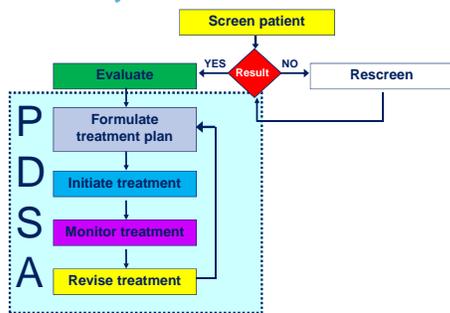
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Five Elements of QAPI

1. **Design and Scope**
 - QAPI program must be ongoing, comprehensive, and deal with the full range of services offered by the facility, and include all departments.
2. **Governance and Leadership**
 - The leadership leads the program, involves staff, residents and families; and assures QAPI is adequately resourced including a champion for QAPI.
3. **Feedback, Data Systems and Monitoring**
 - The facility puts in place systems to monitor care and services, drawing data from multiple sources. Feedback systems incorporate input from staff, residents, and families.
4. **Systematic Analysis and Systemic Action**
 - The facility uses a systematic approach to fully understand a problem, its causes, and implications of a change (e.g. Root Cause Analysis) and to prevent future events.
5. **Performance Improvement Projects (PIPs)**
 - PIPs examine and improve care or services needing attention and involves gathering information systematically to clarify issues or problems, and intervening for improvements.

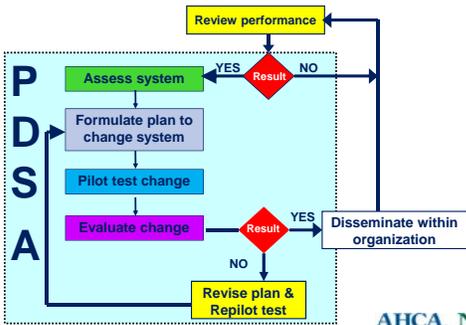
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Clinical System



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Organizational QAPI System



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PDSA Revisited ...



Question #1

#1 What were the biggest challenge encountered by skilled nursing centers in the CMS QAPI pilot?

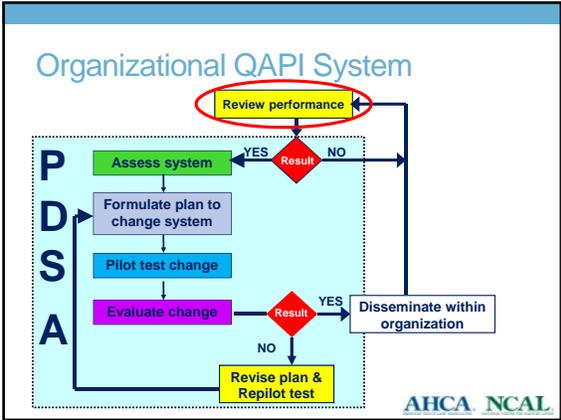
- A. Selecting the right measures to use
- B. Conducting root cause analysis
- C. Adding QAPI to an already busy daily schedule
- D. Forming Performance Improvement (PIP) teams
- E. Focusing on systems (e.g. how things are being done)
- F. Using data to track progress

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From QAPI Demonstration: Biggest Challenges to Implementation

- Lack of systematic thinking
- Failure to do effective root cause analysis
- Challenges with building & empowering effective teams (QAPI terminology is PIPs)

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Priority Setting

- Most organizations can only focus on fixing 3-4 problems at one time
 - Need to prioritize data review for issues that
 - Effect the most people
 - Have higher likelihood of harm
- Can you say the following to the SSA

“we review our performance based on <insert data measures, staff reports and observations> and the QA committee prioritizes the top 5 based on <insert prioritization criteria>; we charter PIPs to focus on these and as they solve the problem; we charter a new PIP for the next most important issue. “

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Proactive Review of Performance

- Testing or Drilling
 - Elopement
 - Individual found without pulse (test DNR and CPR)
 - Loss of power (e.g. EMR, oxygen, elevator)
 - Equipment (e.g. wheelchairs, lifts, etc)
- Observing staff performing common or uncommon procedures
 - Medication pass
 - Follow up to in-service training
 - Wheelchair use
 - Communicating with physician, hospital, family members
- Reviewing documentation (staff review & rate each other)

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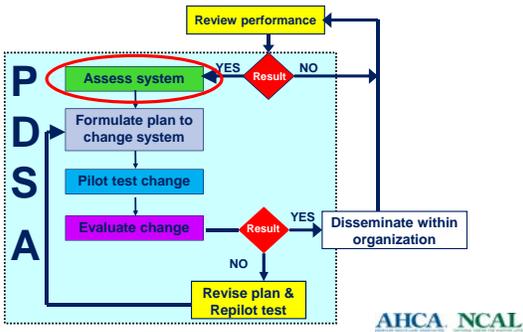
What are Performance Improvement Projects (PIPs)

- A PIP project is a concentrated effort on a particular problem
 - Often PIPs have a written mission/charter which defines scope, objectives & participants, delineates roles & responsibilities—serves as a reference for the future of the project.
 - A PIP team is usually comprised of multidisciplinary staff who are usually directly involved in the issue needing attention.

A typical PIP identifies:

- What the underlying problem is (e.g. conduct root cause analysis to figure out the cause of the problem)
- A PIP team that will work on it, meet, and report back to the QAPI team in the building
- Design and test which interventions you will do to fix the problem
- What measure you will use to know if the changes are successful

Organizational QAPI System



We Often Miss the "Root Cause" Part

- Root cause is often complex, related to the system and due to multiple issues not just "one thing".
 - "Often there is more than one right answer to a problem."
- By asking "who, what, how, when, where" questions, and delving into the root cause by asking "Why 5 Times", you will more often than not identify the underlying issues.

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Evaluate the system

- Look at policies and procedures
 - Are you setting up staff to fail?
- Look at work flow
 - Ask staff why something is not working (why 5 times)
 - Ask them what "frustrates" them about the problem
- Look at availability of equipment
- Look at environment
 - Design, lighting, noise, distance to travel
- Look at staffing type, level and patterns
- Look at staff attitudes and beliefs

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Group example

To be provided

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Rehospitalization Scenario

- Hospital calls the administrator because they are concerned with the facilities high 30 day readmission rate. The administrator asks the QA committee to review their rehospitalizations. They review the medical record of each rehospitalization in past 3 months and can find only one case that could have been prevented. Most readmissions were due to
 - severe medical problems (i.e., CHF, pneumonia, urosepsis, falls with fractures, or CVA)
 - lack of equipment/medication/test results available after admission from the hospital
 - Family request



Quality Improvement Tool

QUALITY IMPROVEMENT TOOL
 For the purpose of analysis, use the following information to complete the tool. The goal is to understand the reasons for the transfer and identify potential areas for improvement. Please complete the tool for each transfer.

Section 1. BACKGROUND INFORMATION

Resident's Last Name: _____ First Name: _____ Age: _____ DOB: _____
 Gender: _____ Race: _____
 Date of (last) admission to nursing home: _____
 Resident hospitalized in the past year? No Yes. If yes, list dates and reason below:

 Reason for admission to transfer: Long-term care Short-term care
 If yes, was it: Voluntary Involuntary Because of a fall Because of a fall Other (please specify): _____

Section 2. TRANSFER INFORMATION

Date of transfer: _____ Time of week: _____ Time of transfer: _____
 Name of receiving facility: _____ Date by which transfer was completed: _____
 What circumstances or signs prompted the transfer? _____

Was the resident admitted to the hospital? Yes No
 If yes - what was the admitting diagnosis: _____
 What happened on the day of the transfer? _____
 Identify the resident's medical condition (ICD-9) at the time of transfer - use ICD-9 for reference:

What was the resident's code status at the time of transfer? Full code DNR Other: _____

The growth process:
 "My initial determination was based on the fact thatif the patient was admitted....I automatically felt it was unavoidable....but I've had a culture change with my thought process..."

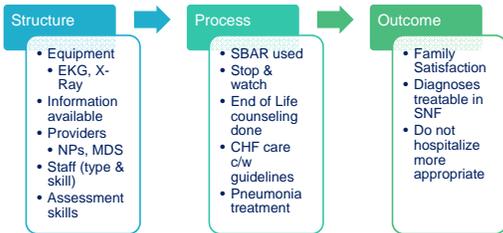


Tips on using QI review tool

- Approach as if every hospitalization was preventable
 - Defensive approach will justify all hospitalizations
- Look back up to 2 weeks prior to hospitalization
 - Interview staff (including non-clinical staff) re signs resident "was different" from normal
 - Use Structure – Process – Outcome framework
 - Use HACTH model to assess reasons for poor outcome



Applying a Framework to Reviewing Your Rehospitalizations



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The HATCh Model



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Technical vs Adaptive Change

- Balance technical vs adaptive changes
 - Technical changes often do not work because the adaptive changes needed to get staff to adopt and utilize the technical change have not been addressed.
 - New form vs workflow redesign to complete the new form

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Successful Implementation Strategies

- Rely on staff to design & test new strategies
- Learn from Peers
 - Participate in learning collaboratives
 - Visit other facilities
- Get at the adaptive change that is needed
 - Ask "what is the problem/issue we are trying to solve?"
 - How will what we/you propose help us solve the problem?
- Avoid "1 and Done" approach to implementation

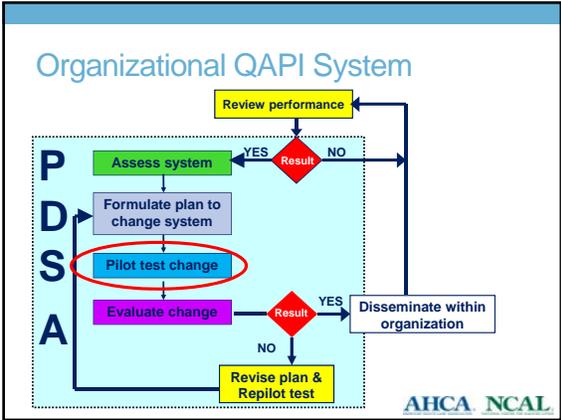
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Question #2

#2 As part of the INTERACT Program, CNAs are to use Stop & Watch form to identify early changes in a resident's condition. Each of the following are examples of technical changes rather than adaptive changes except for

- A. Using a checklist to assure CNAs complete Stop & Watch
- B. Send CNAs to another facility that implemented INTERACT to learn how they use Stop & Watch
- C. Pilot testing INTERACT's STOP & WATCH on one unit
- D. Post how often each CNA completes the stop & watch by name in the staff break room

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- ### Engage & Empower Staff in Creating Change
- Pilot test
 - Let staff design how new programs or processes will be implemented and pilot test their ideas
 - Ask staff to visit other centers to learn how they are implementing new program (e.g. INTERACT)
 - Provide time for staff to work on project
 - Let them make mistakes
 - Respond to feedback & make changes they recommend
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- ### Balancing Top-Down vs. Bottom-Up Leadership
- Top-Down Leadership
 - Set the vision
 - Set the goal
 - Provide resources need to achieve goal
 - Remove barriers to accomplishing the goal
 - Reward success and hard work
 - Bottom-Up Leadership (empower staff)
 - Allow the staff to figure out how to accomplish the goal
 - Support staff in implementing tools
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What Matters Most to Employees?

- Management cares about employees
- Management listens to employees
- Help with stress and burnout
- Workplace is safe
- Supervisor cares about you as a person
- Supervisor shows appreciation

Source: My Interview survey & interviews with employees



Actions Speak Louder than words

- Actions speak louder than words
 - Exercise: list at least two actions you have seen someone in a leadership position in your organization do that sends the “wrong” message during any of the following:
 - Walk rounds
 - Team meeting
 - QA committee
 - Staff memo or email



Pilot Test on a Micro Scale

- Pilot test on 1 unit, 1 staff, 1 resident, 1 day
 - Find staff that are supportive of new program
 - Optimal if they are respected by peers
 - Announce you are pilot testing a new program
 - Promote the 1 unit, “1 staff” doing the pilot
 - Make changes based on staff feedback
 - After a few changes, add additional staff 1 at a time



Use of “Huddles”

- Brief 1-5 minute stand up meetings on the unit to review
 - Patient care issues needing attention
 - Divide up work
 - Make staff aware of specific needs (e.g. who is looking “sick” today)
 - Progress on implementation of new programs
 - What worked?
 - What needs to be changed and tested today?
 - Reminder to try the new practice

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HOW DOES QAPI WORK WITH THE SURVEY PROCESS?

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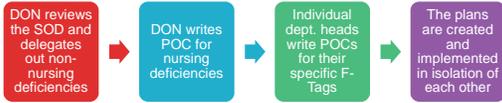
How Does QAPI Work with the Survey Process??

Typical Current Flow of Events

- Survey window approaches & conduct mock survey
- Scramble to correct mock survey findings
- Survey finally happens
- 2567 reveals deficiencies – relief if no IJ or SQC or if they missed issues identified in mock survey
- Scramble to create plan of correction (done by the DON or corporate person)
- Relief when plan is accepted & revisit is successful in correcting the deficiencies
- The cycle starts back when the survey window opens

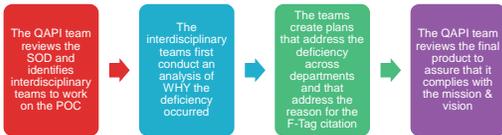
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Creating the Plan of Correction - What We Commonly Do Now



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Adding QAPI to the Process



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How is CMS incorporating QAPI into F Tag guidance and reviews?

Recent Example:
F-309 Dementia Care

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F-309 Dementia Care

- CMS released two new surveyor training videos and new guidance for F309 about care for persons with dementia and use of antipsychotics
 - What are surveyors going to be looking for?
 - How does your QA&A Committee fit in?

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Surveyors Are Being Instructed to...#1

- Focus their investigations using more observations and interviews with staff, residents, families & clinical team, including physician(s), pharmacist, Medical Director
- Looking at:
 - **Communication between shifts**, between nurses and clinicians
 - Whether medications prescribed by a covering practitioner in an urgent situation are **re-evaluated** by the primary care team and discontinued when possible
 - Whether antipsychotics present on admission are being **re-evaluated** – not OK to continue without valid indications
 - Reviewed and revised/updated care plan based on **monitoring for effectiveness**
 - Staff aware of care plan and follow care plan

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Surveyors Are Being Instructed to...#2

- Does staff working with the resident **know** the person; they will ask staff about their knowledge of the resident's:
 - What's in the care plan?
 - What do they like/dislike?
 - What are typical ways of communicating needs, typical responses in different situations?
 - What is resident like on other shifts?
- Observe staff to see if they
 - Follow resident's care plan
 - Demonstrate competency in skills and techniques to care for individuals with dementia

Demonstrate Competency; Deemphasize Documentation



Documentation

- Documentation is necessary, but not sufficient to demonstrate this aspect of compliance
- How will direct care staff respond to surveyor questions?

"I don't know, let me check her care plan..."

OR

"Sure, let me tell you about her... she used to... she likes... she doesn't like... so what we do is..."

Demonstrate Competency; Deemphasize Documentation



What is CMS looking for QA Committee?

- Is it looking at areas SSA found to be non-compliant during the survey?
- Is the QA committee looking at:
 - Tracking antipsychotic use and effectiveness of efforts to lower their use
 - If physicians are following pharmacist's recommendations?
 - Policies and procedures about dementia care
 - Content AND compliance with those policies
 - If care plans are consistent with policies
 - Monitoring if care policies are implemented and care plan followed
 - Do staff receive annual dementia training & know how to apply training

NOT looking for QA committee data, notes or minutes



Documentation Needed

- SSA will interview the staff person responsible for QA committee
- Facilities do NOT have to share QA committee
 - Minutes
 - Notes
 - Data analysis
- Recommend that a facility consult its lawyer before sharing QA committee information with SSA

NOT looking for QA committee data, notes or minutes



Documentation Needed

- You do have to show SSA how you are making changes to address certain issues* for example,
 - How did you address physicians not following pharmacist's recommendations?
 - How are you tracking staff training and ability to apply content of training?

* Note: You do NOT have to use QA committee material but SSA will expect to see in other areas some type of response by the facility to how it is making changes (e.g. personal folders, medical record, etc)



How to avoid a deficiency

- When asked by the SSA can you say:
"Yes the QA committee tracks the following <insert what you track> and as a result we have made the following changes <list changes> that have resulted in a <fill in change in antipsychotic use or changes in practice>"

This answer is likely from a facility that has adopted QAPI



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