QAPI: Systematic Analysis and Systemic Action via Plan-Do-Study-Act Cycles

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Objectives

• Obtain a high-level overview of QAPI Regulation and what this could look like in reality
• Explore basics of Plan-Do-Study-Act Cycles
• Complete Coin Spinning Game and Discuss
• Learn about the QAPI Element Systematic Analysis and Systemic Action
§ 483.75 Quality Assurance and Performance Improvement

F865, F866, F867
- Phase 3 (November 28, 2019)
- Except for § 483.75(a)(2) (Part of F865) QAPI Plan
  - Phase 2, November 28, 2017 (Part of F865)

QAPI Self-Assessment

Start with QAPI Self-Assessment and then QAPI Plan


QAPI Plan

- Phase 2 Regulation - November 28, 2017
- Must be presented to surveyor team after November 28, 2017
- Don’t reinvent the wheel, but make it your own: QAPI Plan Guide
- Framework for QAPI Program
- Continuously changing document
- Develop with team
- Share with others
QAPI Implementation Self-Assessment

- Parallels with QAPI Regulations

NetFusion

QAPI Implementation Self-Assessment

QAPI Plan Guidance

The QAPI plan must describe the process for identifying and correcting quality deficiencies

**Key Components:**

1. Tracking and measuring performance
2. Establishing goals and thresholds for performance measurement
3. Identifying and prioritizing quality deficiencies
4. Systematically analyzing underlying causes of systemic quality deficiencies
5. Developing and implementing corrective action or performance improvement activities
6. Monitoring or evaluating the effectiveness of corrective action/performance improvement activities, and revising as needed
Critical Element Pathway: QAA and QAPI Plan Review

QAA Review
- The seven-disk routine at the start of the survey offers completion of an interpretation of all requirements. Therefore, classification of errors encountered in the development of the QAA program must be approved by the Quality Assurance and Performance Improvement (QAPI) Committee.

QAPI Plan Review
- Make note of errors identified during the process review, which will be further investigated during the survey (e.g., deficiencies, completion standards, and compliance criteria). These errors will be reviewed during the survey to determine their impact on facility operations and compliance.

Focus on QAPI Plan: Boxes: Same as the Interpretive Guidelines for QAPI Plan

Page 3:
- Boxes: Same as the Interpretive Guidelines for QAPI Plan

Bottom of Page 2:
- Focus on QAPI Plan

Boxes: Same as the Interpretive Guidelines for QAPI Plan
1. Tracking and Measuring Performance

- Internal data collection
  - Infection data
  - Adverse events data
  - Grievances
  - Feedback
- Data generated from electronic health record (EHR)
- CASPER Data
  - Benchmark
- Data provided by pharmacy
- Lake Superior QIN Data Reports
  - Benchmark

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“Without data, you’re just another person with an opinion.”
— W. Edwards Deming


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2. Establishing Goals and Thresholds for Performance Measurement

Setting SMART Goals
- Specific
- Measurable
- Attainable
- Realistic
- Time Bound
Set SMART Goals

Bad Examples:

- **Specific**: We want to increase our quality of care
- **Measurable**: We want to increase our quality of care, no unit of measurement available, and we don’t plan on collecting data
- **Attainable**: We will be fully staffed, 24/7
- **Relevant**: My goal is to serve steak and lobster to the residents; it’s my favorite food. No resident has ever asked for this
- **Time Bound**: Our C. difficile infection rates will decrease from 10 to five percent

3. Identifying and Prioritizing Quality Deficiencies

“High Risk, High Volume, Problem-Prone”

- **“High risk”**: Refers to care or service areas associated with significant risk to the health or safety of residents, e.g., tracheostomy care; pressure injury prevention; administration of high risk medications such as warfarin, insulin, and opioids.
- **“High Volume”**: Refers to care or service areas performed frequently or affecting a large population, thus increasing the scope of the problem, e.g., transcription of orders; medication administration; laboratory testing.
- **“Problem-prone”**: Refers to care or service areas that have historically had repeated problems, e.g., call bell response times; staff turnover; lost laundry.

Performance Improvement Project Prioritization

Performance Improvement Prioritization

High Risk

High Volume

Problem-prone

[Handout in Folder!]

4. Systematically Analyzing Underlying Causes of Systemic Quality Deficiencies

Root Cause Analysis
http://www.stratishealth.org/providers/rca-toolkit

Other Tools:
- Fish Bone Diagram
- Five Whys
- Flowcharting
- Brainstorming

Brainstorming
Five Whys

Example: Resident received a skin tear during an assisted transfer

Flowcharting
Plan-Do-Study-Act

The Plan-Do-Study-Act (PDSA) cycle is shorthand for testing a change in the real work setting — by planning it, trying it, observing the results, and acting on what is learned. This is the scientific method adapted for action-oriented learning.

http://www.ihi.org/resources/Pages/HowtoImprove/ScienceofImprovementHowtoImprove.aspx

Activity Objectives

• Explain how to conduct small, rapid PDSA cycles
• Discuss why theory and prediction are critical to learning when conducting a PDSA cycle
• Collect real-time data for measurement

IHI Coin Spinning Game

Coin Spinning Discussion

• What’s your theory about what makes a coin spin the longest? Was your theory different before you started spinning coins?
• What did you learn by collecting data on the length of time your coin was spinning? Do you think you would have arrived at the same result without data collection?
• In your own words, what is the value of each step of the Plan-Do-Study-Act cycle? Use examples from the game, if possible
• Could you teach others about P-D-S-A via this activity?

Eight Tips for Using Quality Improvement Methods

1. Be creative in generating ideas for improvement
2. Make a prediction and articulate a theory for each change idea
3. Don’t forget to collect the data!
4. Collect just enough data to build your degree of belief in a change
5. Use testing to explore questions without judgement
6. Document your tests so you have evidence of what worked
7. Use simple data collection to make measurement easy
8. Redesign the system when you reach the limit on results
5. Developing and Implementing Corrective Action or Performance Improvement Activities

Performance Improvement Projects

Performance Improvement Project (PIP) Guide

<table>
<thead>
<tr>
<th>Project name</th>
<th>Project short description</th>
<th>Target Date</th>
<th>Status</th>
<th>Key Responsible</th>
<th>Comments</th>
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6. Monitoring or Evaluating the Effectiveness of Corrective Action/Performance Improvement Activities, and Revising as needed

PIP Guide

<table>
<thead>
<tr>
<th>Benchmark/Method</th>
<th>Beneficiary Date</th>
<th>Final Measurement Date</th>
<th>Revised Measurement Date</th>
<th>Final Recommendation Date</th>
<th>Comments</th>
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QAPI Sustainability Guide

QAPI Sustainability Guide

- How does the change affect **systems** in our organization?
- How are **people** affected by the change? Are they equipped with skills needed to make the change?
- How does the change affect the our **environment** and culture?
- Do we have a plan for periodic **measurement**?

§ 483.75(c)

A facility must establish and implement written policies and procedures for feedback, data collections systems, and monitoring, including adverse event monitoring. The policies and procedures must include, at a minimum, the following:

Translation: Need to write policies (could use some information from the QAPI Plan)
F866  § 483.75(c)(1)
Facility maintenance of effective systems to obtain and use of feedback and input from direct care staff, other staff, residents, and resident representatives, including how such information will be used to identify problems that are high risk, high volume, or problem-prone, and opportunities for improvement.

Translation: Implement Opportunity to Share; Staff Check-Ins, Suggestion Box (anyone), Anonymous (or not) Blog, Opportunity to Add to Agendas

F866  § 483.75(c)(2)
Facility maintenance of effective systems to identify, collect, and use data and information from all departments, including but not limited to the facility assessment required at § 483.70(e) and including how such information will be used to develop and monitor performance indicators.

Translation: How data from one department affects another (Ex: Dietary (poor intake) and Nursing (develop pressure injury); Share data in common place (dashboard); CASPER Reports - not just for nursing

F866  § 483.75(c)(3)
Facility development, monitoring, and evaluation of performance indicators, including the methodology and frequency for such development, monitoring, and evaluation.

Translation: When do we decide to track something? How often do we ask this of ourselves? “Key Performance Indicators”
Facility adverse event monitoring, including the methods by which the facility will systematically identify, report, track, investigate, analyze and use data and information relating to adverse events in the facility, including how the facility will use the data to develop activities to prevent adverse events.

Translation: How do we define adverse events in our organization? (See F867 as well); Data for Adverse Event input tracking (Discharge notes/identified near miss)

§ 483.75 (d) Program systematic analysis and systemic action

Translation: How we identify causes and how we address them (effectively)
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.

“The facility must take actions aimed at performance improvement”

Translation: We have to do something to improve!

“After implementing those actions, measure its success, and track performance to ensure that improvements are realized and sustained”

Translation:
- Do it
- Measure it
- Adopt, Adapt, Abandon
- Measure periodically
<table>
<thead>
<tr>
<th><strong>§ 483.75 (d)(2)</strong></th>
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<tr>
<td>The facility will develop and implement policies addressing: (i) How they will use a systematic approach to determine underlying causes of problems impacting larger systems.</td>
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<tr>
<td>Translation: Root Cause Analysis</td>
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<tr>
<th><strong>§ 483.75 (d)</strong></th>
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<td>(ii) How they will develop corrective actions that will be designed to effect change at the systems level to prevent quality of care, quality of life, or safety problems; and</td>
<td></td>
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<tr>
<td>How we decide WHAT to do</td>
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<th><strong>§ 483.75 (d)</strong></th>
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<td>(iii) How the facility will monitor the effectiveness of its performance improvement activities to ensure that improvements are sustained.</td>
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<tr>
<td>Translation: QAPI Sustainment Tool</td>
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§ 483.75(e) Program activities

§ 483.75(e)(1) The facility must set priorities for its performance improvement activities that focus on high-risk, high-volume, or problem-prone areas; consider the incidence, prevalence, and severity of problems in those areas; and affect health outcomes, resident safety, resident autonomy, resident choice, and quality of care.

Performance Improvement Project Prioritization Tool

§ 483.75(e)(2) Performance improvement activities must track medical errors and adverse resident events, analyze their causes, and implement preventive actions and mechanisms that include feedback and learning throughout the facility.

Adverse Events

An adverse event is defined as an untoward, undesirable, and usually unanticipated event that causes death or serious injury, or the risk thereof, which includes near misses.
Deficiency Categorization - Level 4

Examples of Severity Level 4 Non-compliance Immediate Jeopardy to Resident Health or Safety include but are not limited to:

Evidence showing one or more residents received third degree burns from hot water temperatures in the month prior to the survey. QAA review showed there was no system in place for routine monitoring of hot water temperatures throughout the facility, yet no action had been taken to correct the systemic, high risk issue. (Cross-referenced at F689, Accidents)

Deficiency Categorization - Level 4

Evidence showing the facility failed to monitor their system for communicating each resident’s code status. This resulted in staff having inaccurate and inconsistent information to use in emergency situations. QAA review showed the QAA committee was not aware of this systemic issue, and the QAA committee was not monitoring facility practices related to accurate and consistent communication of residents’ advance directives and code status.
Examples of Severity Level 3 Non-compliance
Actual Harm that is Not Immediate Jeopardy include, but are not limited to:
Evidence showing the facility had repeat deficiencies for the past two surveys related to their failure to ensure residents’ post discharge needs were care planned and met upon discharge. During the current survey it was determined that a resident was discharged with no education about how to manage his new onset diabetes, resulting in his rehospitalization. The QAA review showed the QAA committee was not aware of the issue, and was not monitoring its practices around discharge.

Example of Severity Level 2 Considerations: No Actual Harm with Potential for More Than Minimal Harm that is Not Immediate Jeopardy includes, but is not limited to:
Facility failed to identify an unresolved quality deficiency involving inaccurate weights, which was previously cited on the last annual survey. This issue has the potential to cause more than minimal harm.

Example of a Severity Level 1: No actual harm with potential for minimal harm includes but is not limited to:
Facility failed to ensure that monitoring occurred as planned for an identified quality deficiency. On interview it was determined that the facility’s corrective action involved monitoring monthly for three months to ensure the issue was corrected, however, documentation showed that for the second month, there was no evidence that monitoring had occurred. The QAA coordinator explained that she was out of the facility during that period.
Why QAPI?

- Section 6102 (c) of the Affordable Care Act
- Minimize risk to residents AND your organization
- Opportunity to include staff in the success of the organization
- Build on current Quality Program—more proactive and innovative

Because it is important!

QA vs. QAPI
Quality Assurance vs. Performance Improvement

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<tr>
<th>QUALITY ASSURANCE</th>
<th>PERFORMANCE IMPROVEMENT</th>
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<tbody>
<tr>
<td>Motivation</td>
<td>Continuously improving processes to meet standards</td>
</tr>
<tr>
<td>Attitude</td>
<td>Processes or systems</td>
</tr>
<tr>
<td>Focus</td>
<td>&quot;best apples&quot; methodology</td>
</tr>
<tr>
<td>Scope</td>
<td>Medical provider</td>
</tr>
<tr>
<td>Responsibility</td>
<td>Accountability</td>
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QA + PI = QAPI
QA and PI combine to form QAPI, a comprehensive approach to ensuring high-quality care.

Engage Others in QAPI

What strategies can you use to market QAPI?

• Posters
• Newsletters
• Include in all meeting agendas
• Include in resident council meetings
• Include in job descriptions and orientation materials
• Hold a QAPI Fair

References
