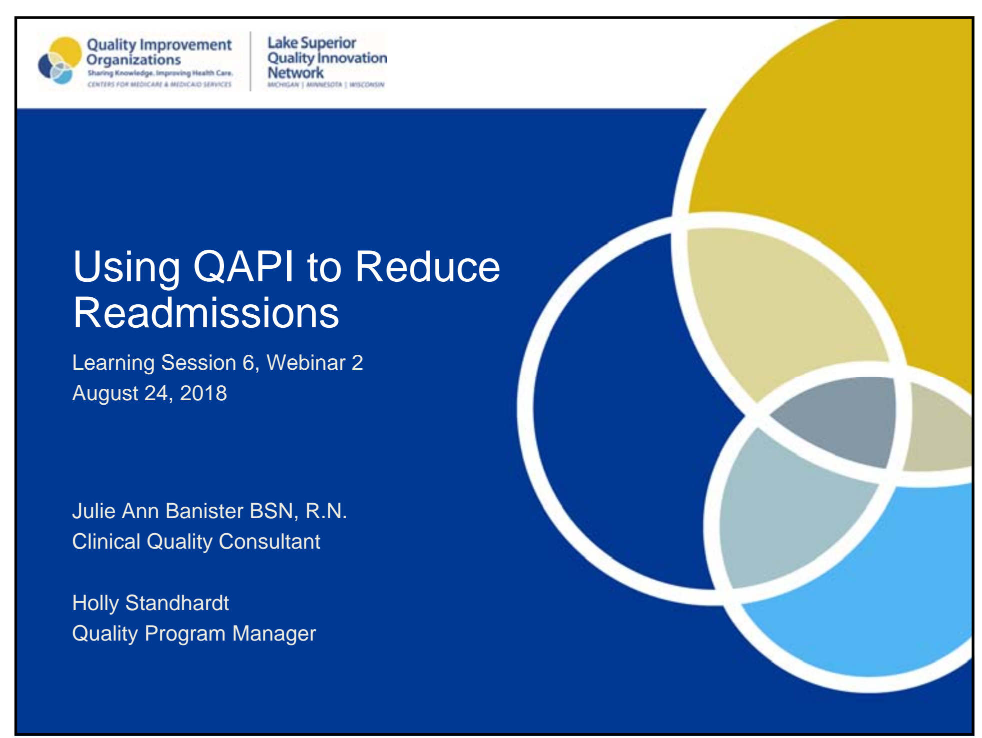


Objectives

- Describe the five key elements of Quality Assurance Performance Improvement (QAPI) in nursing homes
- Describe the steps and processes needed to apply QAPI elements to your facility's rehospitalization reduction program

National Nursing Home Quality Care Collaborative (NNHQCC) Change Package

- **Strategy 6:** Provide exceptional compassionate clinical care that treats the whole person
- **6.c. change concept**: Transition with care (between shifts, departments and all care settings)

NNHQCC Change Package

- **Attachment 6. change bundle:** To build capacity for QAPI success
- **Five point bundle:**
  1. Believe that strong and effective QAPI is necessary for success
  2. Picture a desirable future
  3. Develop a culture for QAPI
  4. Effectively use quality improvement tools and techniques
  5. Measure performance

QAPI

- **Coordinated application of two aspects of a quality management system - quality assurance (QA) and performance improvement (PI)**
- **Overreaching quality improvement model with five elements:**
  1. Design and scope – key design elements
  2. Governance and leadership
  3. Feedback, data systems and monitoring
  4. Performance improvement projects (PIPs)
  5. Systematic analysis and systemic action

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

QAPI at a Glance: Twelve Action Steps

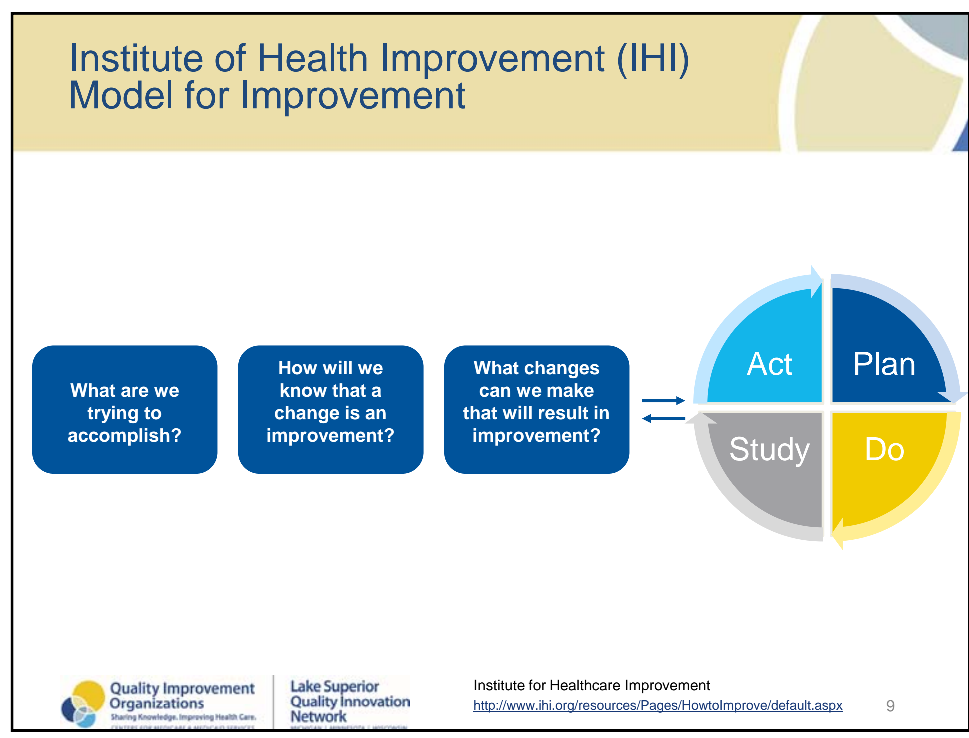
Step 1: Leadership responsibility and accountability
Step 2: Develop a deliberate approach to teamwork
Step 3: Take your QAPI "pulse" with a self-assessment
Step 4: Identify your organization's guiding principles
Step 5: Develop your QAPI plan
Step 6: Conduct a QAPI awareness campaign
Step 7: Develop a strategy for collecting and using QAPI data
Step 8: Identify your gaps and opportunities
Step 9: Prioritize quality opportunities and charter PIPs
Step 10: Plan, conduct and document PIPs
Step 11: Getting to the "root" of the problem
Step 12: Take systemic action

So, What Do You Do?

- High rehospitalization rate
  - You know it's there
  - You know it's a problem
- Addressing the problem requires focus, structure, *and a systems approach that is data-driven*
- Use QAPI as a framework

QAPI and Rehospitalization

- Facility QAPI committee identifies increased trend in residents being rehospitalized within 30 days of admission
- Further research reveals rehospitalization rate has increased above national benchmark
- PIP is chartered and PIP team assembled:
  - Nurse manager
  - Admissions director
  - Social worker
  - Medical director
  - CNA



Examine Your Status: Do You Know Your Rehospitalization Rate?

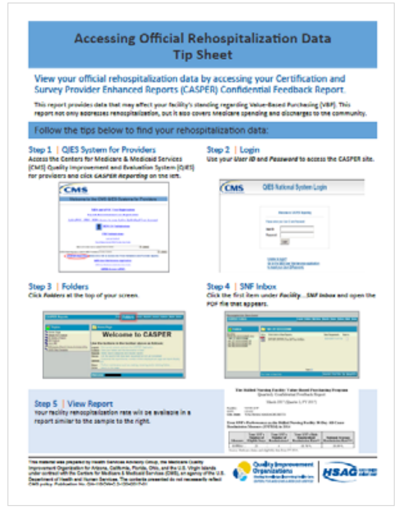
Look at the data:

- Lake Superior QIN quarterly readmission reports
- Corporate readmission reports
- Certification and Survey Provider Enhanced Reports (CASPER) confidential feedback report - your nursing home's official rehospitalization data

Compare the data:

- How does your rate compare to state and national rates?
- What readmission rate is the goal of your referring hospital system?

CASPER Confidential Feedback Report



Accessing Official Rehospitalization Data
Tip Sheet

View your official rehospitalization data by accessing your Certification and Survey Provider Enhanced Reports (CASPER) Confidential Feedback Report.

This report provides data that may affect your facility's standing regarding Value-Based Purchasing (VBP). This report not only addresses rehospitalization, but it also covers Medicare spending and discharges to the community.

Follow the tips below to find your rehospitalization data:

Step 1 | QIES System for Providers
Access the Centers for Medicare & Medicaid Services (CMS) Quality Improvement and Evaluation System (QIES) for providers and click *CASPER Reporting* on the left.

Step 2 | Login
Use your *User ID* and *Password* to access the CASPER site.

Step 3 | Folders
Click *Folders* at the top of your screen.

Step 4 | SNF Inbox
Click the first item under *Facility…SNF Inbox* and open the PDF file that appears.

Step 5 | View Report
Your facility rehospitalization rate will be available in a report similar to the sample to the right.

https://www.hsag.com/globalassets/care-coordination/rrppaccessrehospitalizationinst508.pdf

Examine Your Current Processes: Ask These Questions

In the pre-admission process:

- Do you have a listing of services/capabilities to ensure your facility meets the specific acuity level of the resident?
- Are the hospital discharge instructions complete and include advance directives?
- Does your facility have a process in place to ensure readiness for admissions?

In the post-admission process:

- Are you doing quality rounding for at least the first seven days? Is upper management involved?
- Are nurses proficient in clinical assessment skills? How do you educate your staff members?
- Are you using situation, background, assessment, recommendation (SBAR) or an equivalent system to ensure proper communication?

Examine Your Current Processes: Ask These Questions

In the discharge planning process:

- Are you starting the discharge process upon admission? Is it interdisciplinary?
- Are you properly discharging residents with clear/concise instructions?
- Is social services completing a post-discharge follow-up to ensure resident well-being?

Should I reference the INTERACT® program to help me address these questions?

- INTERACT® is a quality improvement program that focuses on the management of acute change in resident condition. It includes clinical and educational tools and strategies for use in every day practice in long-term care facilities.

Examine Your Current Processes: Do a Readmission Self-Assessment Using Probing Questions

Safely Reduce Hospitalizations

Probing Questions

November 21, 2016

National Nursing Home

What patterns do we see in our hospitalization rates?

- Is there a particular day that has a high frequency of hospitalizations?
- What time of day are most of our admissions from the hospital occurring?
- What time of day are most of our discharges to the hospital occurring?
- What day of the week are most of our admissions from the hospital occurring?
- What day of the week are most of our discharges to the hospital occurring?

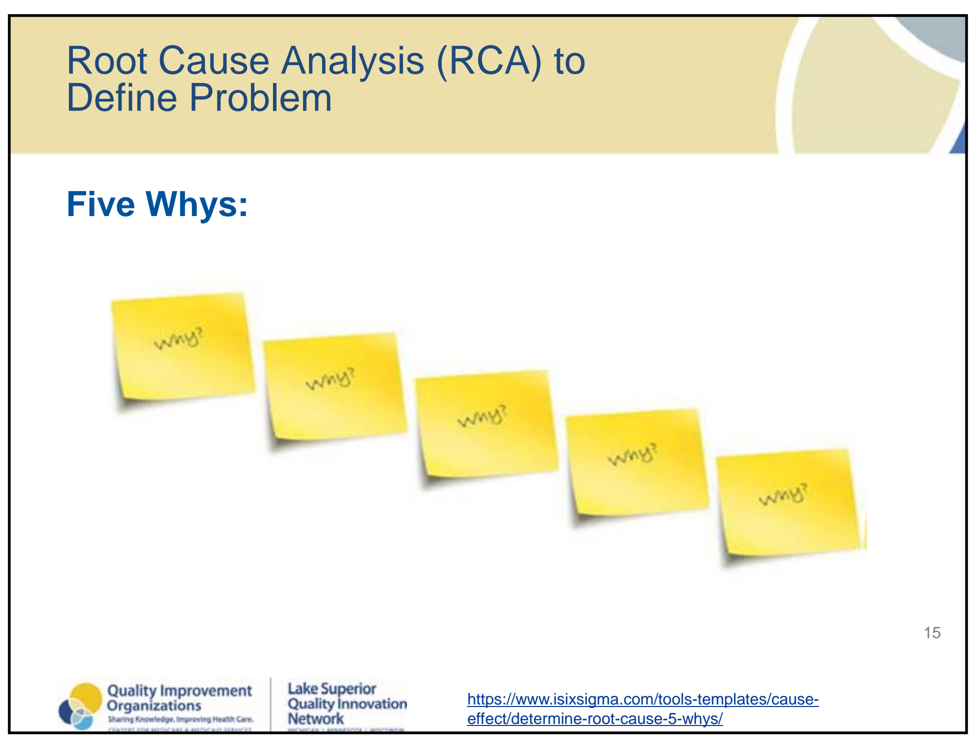
Which groups are most affected?

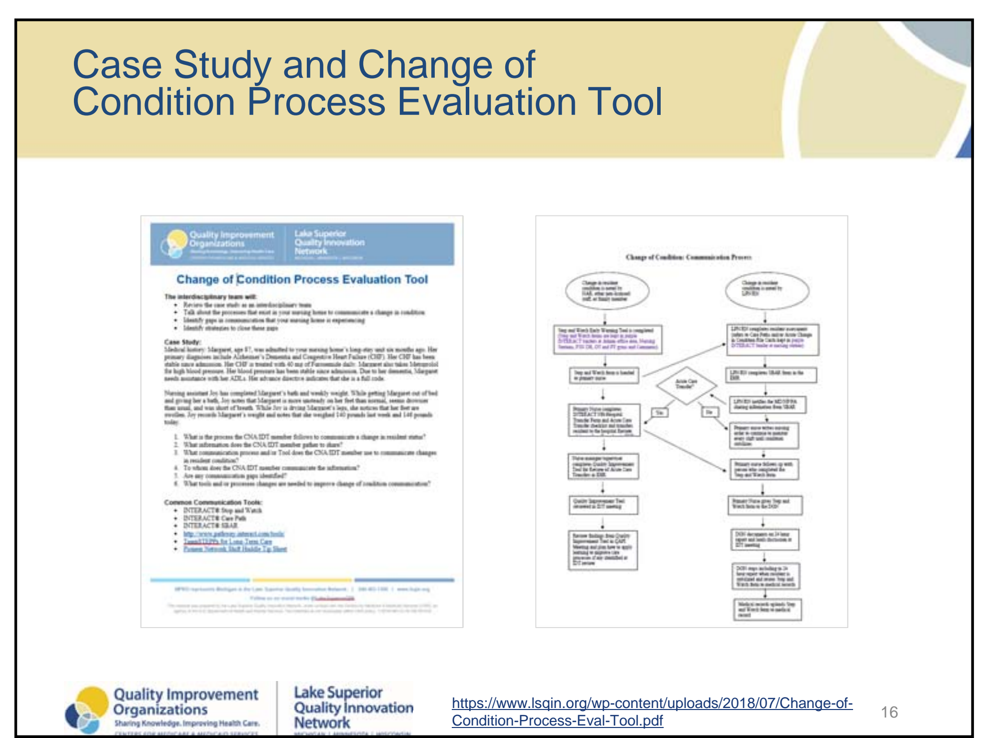
- What proportion of our transfers has dementia?
- Is there a pattern of clinical causes for transfer to the hospital?
- Of the individuals that were admitted to the hospital,
  - How many of them died?
  - How soon after the transfer did they die?
- Is this primarily a problem of:
  - Readmissions (i.e., hospitalizations),
  - Primary hospitalizations, or
  - Both?
- Are most of the decisions for hospital admission made by the medical director, a covering physician, or by the individual's physician?
- Is there a particular practitioner that is requesting that his or her patients get admitted to the hospital?
- Are residents calling 911 because they are worried about their condition?
- Are we experiencing a spike caused by something like the Flu or epidemic diarrhea that is currently going on in our nursing home?
- How many of our admissions are taking an antipsychotic or psychoactive drug?
- Has there been an increase in falls with injury?
- Has the number of other incidents changed?

Processes and Resources to Consider

Are we collecting and analyzing our data?

- Do we track and analyze admission and transfer data?
- What is the volume of admissions we get from each hospital? How many residents are transferred back?
- Do we routinely analyze the causes of all hospital/emergency room transfers?
- What are nurses and CNAs saying about these hospitalizations, e.g. do they agree that a resident should have been transferred?
- Do we get all the information we need from the hospital at admission?
- What specific data does the hospital have on tracking our readmissions?
- Do the admissions from the hospital challenge our capacity to care for them?
- What happens to residents when they are transferred to the hospital?
  - Are they admitted?


Root Cause Analysis (RCA) to Define Problem
Five Whys:
why?
why?
why?
why?
why?
15
Quality Improvement Organizations
Sharing Knowledge. Improving Health Care.
Lake Superior Quality Innovation Network
https://www.isixsigma.com/tools-templates/cause-effect/determine-root-cause-5-whys/


Case Study and Change of Condition Process Evaluation Tool
Change of Condition Process Evaluation Tool
Quality Improvement Organizations
Sharing Knowledge. Improving Health Care.
Lake Superior Quality Innovation Network
https://www.lsqin.org/wp-content/uploads/2018/07/Change-of-Condition-Process-Eval-Tool.pdf
16

Root Cause Analysis (RCA) to Define Problem

Example:
Our nursing home readmission rates are higher than the state and national rates

- Why? • Harder to care for higher acuity residents
- Why? • At-risk patients not properly identified at • hospital discharge
- Why? • Lack of disease-specific protocols
- Why? • Lack of communication between hospital and NH
- Why? • No current process in place for pre-admission assessment of resident clinical status and needs

What Are We Trying to Accomplish?

- Establish your goal
- Craft a goal statement to guide the work
  - Goal statements communicate what a team hopes to accomplish and the magnitude of the change
  - Goal statements have four parts:
    - What the team expects to do
    - Goal completion date
    - Intended population
    - Measurable goal to be achieved

Goal Setting Worksheet

Goal Setting Worksheet

QAPI

Describe the business problem to be solved:

Use the SMART formula to develop a goal:

SPECIFIC

Describe the goal in terms of 3 'W' questions:

What do we want to accomplish?

Who will be involved/affected?

Where will it take place?

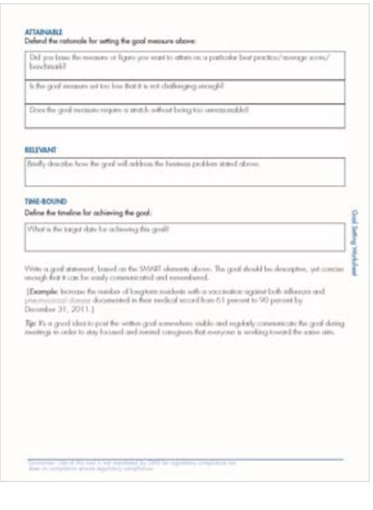
MEASURABLE

Describe how you will know if the goal is reached:

What is the measure you will use?

What is the current data figure (i.e., count, percent, rate) for that measure?

What do you want to increase/decrease that number to?



ATTAINABLE

Defend the rationale for setting the goal measure above:

Did you base the measure or figure you want to attain on a particular best practice/average score/benchmark?

Is the goal measure set too low that it is not challenging enough?

Does the goal measure require a stretch without being too unreasonable?

RELEVANT

Briefly describe how the goal will address the business problem stated above.

TIME-BOUND

Define the timeline for achieving the goal:

What is the target date for achieving this goal?

Goal Setting Worksheet

Quality Improvement Organizations
Sharing Knowledge. Improving Health Care.

Lake Superior Quality Innovation Network

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

Establish a Goal – Be Specific: What, Who, Where?

Use the SMART formula to develop a goal:

Specific, Measurable, Attainable, Relevant and Time-Bound

SPECIFIC

Describe the goal in terms of three 'W' questions

What do we want to accomplish?
Who will be involved and affected?
Where will it take place?

Lake Superior Quality Innovation Network

Establish a Goal – Define Measures

MEASURABLE

Describe how you will know if the goal is reached:

What is the measure you will use?
What is the current data figure (i.e., count, percent, rate) for that measure?
What do you want that number to (increase/decrease)?

Establish a Goal – Is it Attainable?

ATTAINABLE

Define the rationale for setting the goal measure above:

Did you base your goal on a particular best practice, average score or benchmark?
Is the goal measure set too low that it is not challenging enough?
Does the goal measure require a stretch without being unreasonable?

Quality Improvement Organizations
Sharing Knowledge. Improving Health Care.
Lake Superior Quality Innovation Network

Establish a Goal –
Is it Relevant and Time-Bound?

RELEVANT

Briefly describe how the goal will address the business problem stated above.

TIME-BOUND

Define the timeline for achieving the goal.
What is the target date for achieving this goal?

Sample Goal Statements

1. By December 2018, the nursing facility will reduce readmissions for all residents as measured by a decrease in 30-day all-cause readmission rate by 15 percent from 27 percent to 23 percent or less.

2. The nursing facility will improve transitions for residents discharged from the hospital and admitted to the nursing home as measured by a reduction in unplanned 30-day readmissions from 25 percent to 15 percent or less by Dec. 31, 2018.

Quality Improvement Organizations
Lake Superior Quality Innovation Network

How to Select Pilot Units or a Pilot Population

- Based on what you learned about 30-day all-cause readmission data, select one or two skilled nursing units where readmissions occur the most.
- If one resident population accounts for a large percent of the readmissions (e.g., residents with infections), it may help to initially focus on that resident segment.

Form an Improvement Team

A typical front-line improvement team includes:

- A day-to-day leader for each pilot unit who will drive the work
- Residents, family members or resident caregivers
- Physician or nurse champion
- Nurse practitioner or physician assistant
- Nurse manager, staff nurses, case managers, CNAs, dietician and PT/OT
- Nurse educators
- Social workers and/or discharge planners
- Clinicians and staff from other care settings and/or community-based organizations (e.g., acute care, home health care, Area Agency on Aging, other SNFs)

Creating a Charter

- Once you have formed your interdisciplinary team (IDT), create a PIP charter
- A PIP charter should include:
  - Clearly established goals, scope, timing, milestones, and team roles/responsibilities
  - Provides a clear understanding of what the PIP team is being asked to do

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

How do You Know Change is an Improvement? Establish Measures!

Process: % compliance with prevention protocols

Process: % of residents with risk assessment documented

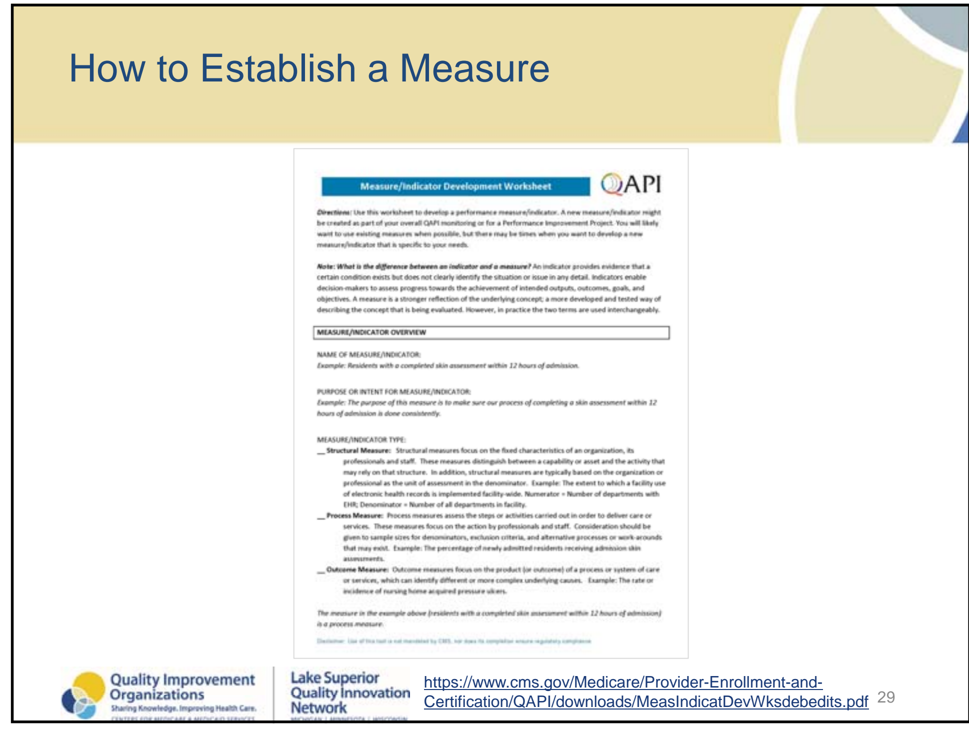
Process: % reconciled med lists received from the hospital

Outcome: % 30-day all cause readmissions

Examples:

Process Measure: Prior to all resident admissions, the SNF admission nurse will receive information from the hospital to determine appropriateness for admission to the SNF.

Outcome Measure: By Dec. 2018, nursing facility will reduce readmissions for all residents as measured by a decrease in 30-day all-cause readmission rate by 15 percent from 27 percent to 23 percent or less.



How to Establish a Measure

Measure/Indicator Development Worksheet QAPI

Directions: Use this worksheet to develop a performance measure/indicator. A new measure/indicator might be created as part of your overall QAPI monitoring or for a Performance Improvement Project. You will likely want to use existing measures when possible, but there may be times when you want to develop a new measure/indicator that is specific to your needs.

Note: What is the difference between an indicator and a measure? An indicator provides evidence that a certain condition exists but does not clearly identify the situation or issue in any detail. Indicators enable decision-makers to assess progress towards the achievement of intended outputs, outcomes, goals, and objectives. A measure is a stronger reflection of the underlying concept; a more developed and tested way of describing the concept that is being evaluated. However, in practice the two terms are used interchangeably.

MEASURE/INDICATOR OVERVIEW

NAME OF MEASURE/INDICATOR:
Example: Residents with a completed skin assessment within 12 hours of admission.

PURPOSE OR INTENT FOR MEASURE/INDICATOR:
Example: The purpose of this measure is to make sure our process of completing a skin assessment within 12 hours of admission is done consistently.

MEASURE/INDICATOR TYPE:

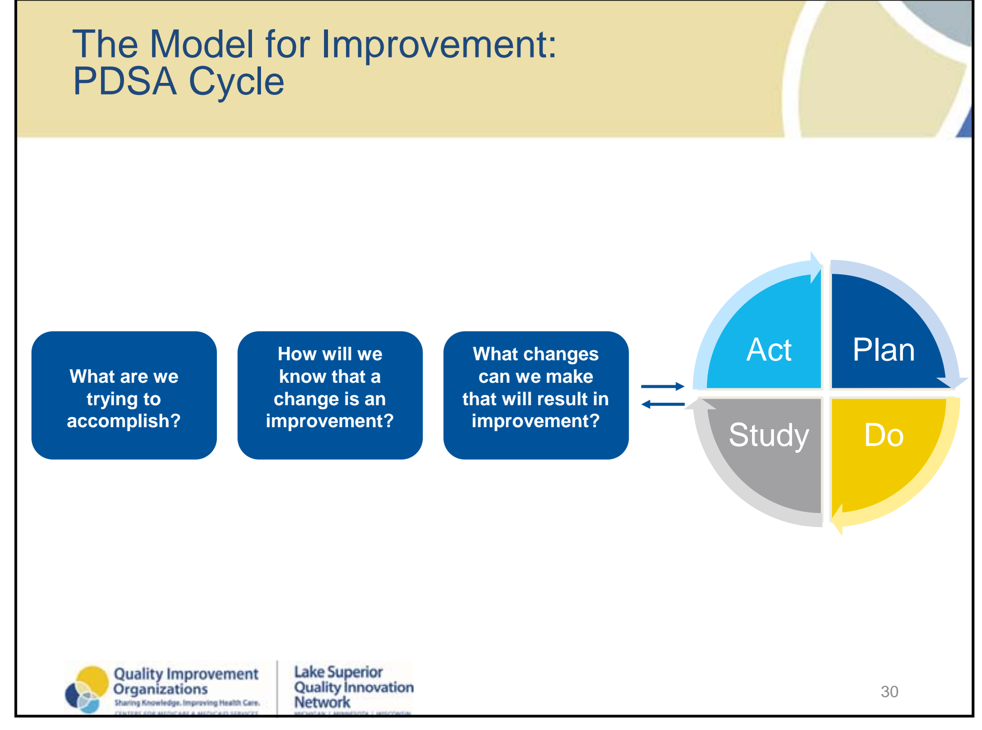
__ **Structural Measure:** Structural measures focus on the fixed characteristics of an organization, its professionals and staff. These measures distinguish between a capability or asset and the activity that may rely on that structure. In addition, structural measures are typically based on the organization or professional as the unit of assessment in the denominator. Example: The extent to which a facility use of electronic health records is implemented facility-wide. Numerator = Number of departments with EHR; Denominator = Number of all departments in facility.

__ **Process Measure:** Process measures assess the steps or activities carried out in order to deliver care or services. These measures focus on the action by professionals and staff. Consideration should be given to sample sizes for denominators, exclusion criteria, and alternative processes or work-arounds that may exist. Example: The percentage of newly admitted residents receiving admission skin assessments.

__ **Outcome Measure:** Outcome measures focus on the product (or outcome) of a process or system of care or services, which can identify different or more complex underlying causes. Example: The rate or incidence of nursing home acquired pressure ulcers.

The measure in the example above (residents with a completed skin assessment within 12 hours of admission) is a process measure.

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



PDSA Plan

***"Plan"** the test, including a plan for collecting data*

- State the question you want to answer and make a prediction about what you think will happen.
- Develop a plan to test the change. (Who? What? When? Where?)
- Identify what data you will need to collect

Why Test Changes?

- To instill the belief that change can result in improvement
- To decide which of several proposed changes will lead to the desired improvement
- To evaluate how much improvement can be expected from the change
- To decide whether the proposed change will work in the actual environment of interest
- To decide which combination of changes will have the desired effects on the important measures of quality
- To evaluate costs, social impact, and side effects (unintended consequences from a proposed change)
- To minimize resistance upon implementation

PDSA: Do

"Do" by running the test on a small scale

- Carry out the test
- Document problems and unexpected observations
- Collect and begin to analyze the data

Gather Data and Information

Draw data from multiple sources:

- **Quality Measures -** What is our rate of antipsychotic medication (AP) use and how does it compare to our targets/benchmarks?
  - How many attempts have been made for each resident on an AP medication to reduce or discontinue it?
  - How many of our residents have an order for an AP medication without a mental illness diagnosis?
- **Chart reviews -** Does our documentation match our systems and processes?
- **Observation -** How are staff responding to challenging behaviors?
- **Interviews -** Solicit feedback from staff, residents, families and others as appropriate

PDSA: Study

"Study" the data

- Team should complete data analysis together
- Compare results to initial predictions and goals.
- Did the change result in the expected outcome?
- Summarize and reflect on findings and process

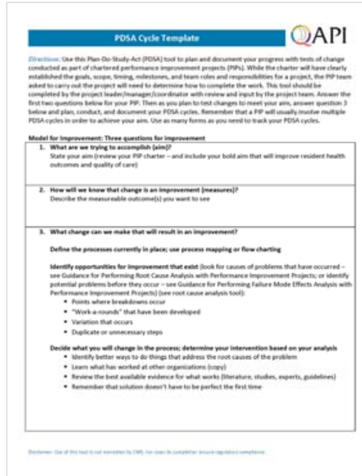
PDSA: Act

"Act" on what was learned from the test and make a plan.

- **Adapt** - make modifications and run another test
- **Adopt** - test the change on a larger scale
- **Abandon** - don't do another test on this change idea

Continue to **Act**: Change your approach, identify a new strategy, and begin a new PDSA cycle

CMS QAPI PDSA Template



PDSA Cycle Template QAPI

Directions: Use this Plan-Do-Study-Act (PDSA) tool to plan and document your progress with tests of change conducted as part of chartered performance improvement projects (PIPs). While the charter will have clearly established the goals, scope, timing, milestones, and team roles and responsibilities for a project, the PIP team asked to carry out the project will need to determine how to complete the work. This tool should be completed by the project leader/manager/coordinator with review and input by the project team. Answer the first two questions below for your PIP. Then as you plan to test changes to meet your aim, answer question 3 below and plan, conduct, and document your PDSA cycles. Remember that a PIP will usually involve multiple PDSA cycles in order to achieve your aim. Use as many forms as you need to track your PDSA cycles.

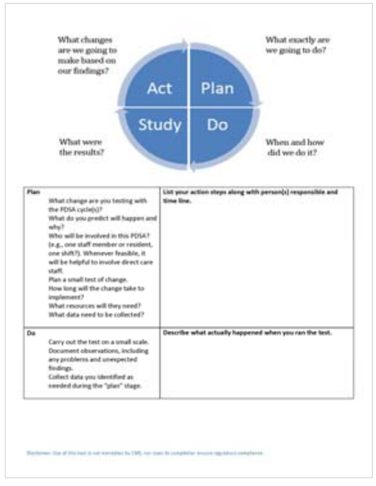
Model for Improvement: Three questions for improvement

1. **What are we trying to accomplish (aim)?**
   State your aim (review your PIP charter – and include your bold aim that will improve resident health outcomes and quality of care)
2. **How will we know that change is an improvement (measures)?**
   Describe the measureable outcome(s) you want to see
3. **What change can we make that will result in an improvement?**

   Define the processes currently in place; use process mapping or flow charting

   Identify opportunities for improvement that exist (look for causes of problems that have occurred – see Guidance for Performing Root Cause Analysis with Performance Improvement Projects; or identify potential problems before they occur – see Guidance for Performing Failure Mode Effects Analysis with Performance Improvement Projects) (see root cause analysis tool):
   - Points where breakdowns occur
   - "Work-a-rounds" that have been developed
   - Variation that occurs
   - Duplicate or unnecessary steps

   Decide what you will change in the process; determine your intervention based on your analysis
   - Identify better ways to do things that address the root causes of the problem
   - Learn what has worked at other organizations (copy)
   - Review the best available evidence for what works (literature, studies, experts, guidelines)
   - Remember that solution doesn't have to be perfect the first time



Plan	List your action steps along with person(s) responsible and time line.
What change are you testing with the PDSA cycle(s)? What do you predict will happen and why? Who will be involved in this PDSA? (e.g., one staff member or resident, one shift?). Whenever feasible, it will be helpful to involve direct care staff. Plan a small test of change. How long will the change take to implement? What resources will they need? What data need to be collected?	
Do	**Describe what actually happened when you ran the test.**
Carry out the test on a small scale. Document observations, including any problems and unexpected findings. Collect data you identified as needed during the "plan" stage.	

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

Standardizing the Improved Process

- Leaders should plan for spreading the improvement developed in the pilot during the early initiative. After successful implementation of the key changes, leaders will need to develop a "spread plan".
- Although changes have been tested and implemented in a limited population, the spread plan allows for testing and adaptation (using PDSA cycles) in new resident units, populations and/or organizations.
- Successful spread of reliable processes requires leaders to commit sufficient resources to support spread.
- A key responsibility of leaders is to develop a plan and timetable for spread and to monitor progress.
- Once the spread has taken place throughout the desired population with proven results, the process should be standardized as part of normal work

Tips for Ensuring Sustained Change

- Provide continual leadership support
- Make environmental changes
- Develop and follow policies/protocols that support systems changes
- Communicate aims and successful changes that achieved the desired results (e.g., newsletters, storyboards, patient stories, etc.)
- Hardwire processes so they are difficult to reverse (e.g., IT template, yearly competencies, role descriptions, policies and procedures)
- Assign ownership for oversight and ongoing quality control to "hold the gains"
- Assign responsibility for ongoing measurement of processes and outcomes
- Ongoing periodic measurement

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

Resources

CMS QAPI website: https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/QAPI/NHQAPI.html

How-to Guide: Improving Transitions from the Hospital to Skilled Nursing Facilities to Reduce Avoidable Rehospitalizations: http://www.ihi.org/Topics/Readmissions/Pages/default.aspx

Institute for Healthcare Improvement (IHI) PDSA Template How-to Guide: Improving Transitions from the Hospital to Skilled Nursing Facilities to Reduce Avoidable Rehospitalizations (Tip: Registration is required) http://www.ihi.org/resources/Pages/Tools/HowtoGuideImprovingTransitionHospitalSNFstoReduceRehospitalizations.aspx

NNHQI Hospitalizations Goal Tools & Resources: https://www.nhqualitycampaign.org/goalDetail.aspx?g=hosp#tab3

QAPI Sustainability Decision Guide https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/QAPI/downloads/SustainDecisGdedebedits.pdf

Determine the Root Cause: 5 Whys /https://www.isixsigma.com/tools-templates/cause-effect/determine-root-cause-5-whys/

Next Steps

Join us at our next event!

Communication Strategies to Reduce Readmissions

- Thursday, Aug. 30, 2018
- https://www.lsqin.org/event/ls6-comm-readm/

Download the Change of Condition Process Evaluation Tool

https://www.lsqin.org/wp-content/uploads/2018/07/Change-of-Condition-Process-Eval-Tool.pdf

Questions?

Michigan:

Holly Standhardt

248-912-6709 hstandha@mpro.org

Minnesota:

Kristi Wergin

952-853-8561 kwergin@stratishealth.org

Wisconsin

Toni Kettner

608-441-8290 tkettner@metastar.com

This Photo by Unknown Author is licensed under CC BY-SA

Quality Improvement Organizations
Sharing Knowledge. Improving Health Care.
CENTERS FOR MEDICARE & MEDICAID SERVICES
Lake Superior Quality Innovation Network
MICHIGAN | MINNESOTA | WISCONSIN
Thank you.
Follow us online @LakeSuperiorQIN
This material was prepared by Lake Superior Quality Innovation Network, under contract with the Centers for Medicare & Medicaid Services (CMS), an agency of the U.S. Department of Health and Human Services. The materials do not necessarily reflect CMS policy. 11SOW-MI/MN/WI-C2-18-141 081518