Objectives

1. Understand the role of the CMS Quality Innovation Network-Quality Improvement Organization (QIN-QIO) and how it helps providers in improving outcomes

2. Recognize why now is the time to accelerate Quality Assurance and Performance Improvement (QAPI) in your facility

3. Learn how to utilize data, identify priorities, set improvement goals, perform root cause analysis (RCA), implement rapid change using PDSA cycles, evaluate and sustain success to meet industry and facility specific quality goals

4. Explore long term care specific resources and tools to keep your QAPI process moving forward despite challenges such as turnover, competing priorities or limited quality improvement experience
1. Independent, non-profit consulting organization
   a. Focused on health care quality improvement
   b. QIN-QIO for Virginia (since 1984) and Maryland (since 2014)

2. 80 team members in Virginia, Maryland and beyond:
   a. Clinicians with subject matter expertise
   b. Experienced managers from many settings of care
   c. Credentialed quality improvement experts
   d. Communications, analytic, IT, finance and administrative professionals
Objectives:

The Program’s objectives align with the HHS and CMS Quality Strategies and are designed to support their goals

1. Promote effective prevention & treatment of chronic disease
2. Make care safer & reduce harm caused in the delivery of care
3. Promote effective communication & coordination of care
4. Make care more affordable
Our End Goal

Support a continuously evolving network of dedicated and committed experts in quality improvement, working together in partnership with multiple entities, patients and families to improve health care, support the creation of healthy people in healthy communities and lower costs through improvement.

“To change a nation...”
QIO Program Structure:

- Nationally coordinated program with local reach
- 14 QIN-QIOs serving multi-state regions
- 5-year, IDIQ contract with task orders
- Direction from COR in CMS Regional Office
- Programmatic SME from other CMS experts
- Technical assistance from QIN-QIO and National Coordinating Center (NCC)
1. Case review and quality improvement functions now performed by separate entities

2. Beneficiary and Family Centered Care QIOs (BFCC-QIOs)
   - Two organizations serve five regions nationwide
   - KePRO is the BFCC-QIO for MD and VA
   - KePRO now reviews all appeals and quality complaints
   - KePRO’s toll-free number is (844) 455-8708
# QIN-QIO Alignment with CMS Aims

<table>
<thead>
<tr>
<th>Better Health</th>
<th>Better Care</th>
<th>Lower Costs</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Improving cardiac health &amp; reducing cardiac disparities</td>
<td>• Reducing care-acquired conditions <em>(Nursing Homes)</em></td>
<td>• Quality Payment Program</td>
</tr>
<tr>
<td>• Reducing disparities in diabetes care</td>
<td>• Coordinating care to reduce hospital readmissions and adverse drug events</td>
<td>• Local QIO Projects</td>
</tr>
<tr>
<td>• Improving Immunizations</td>
<td>• Antibiotic Stewardship</td>
<td></td>
</tr>
</tbody>
</table>

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*HQI Health Quality Innovators*
Improving the Health Status of Communities

- Improving Cardiac Health
- Improving Diabetes Care
- Quality Reporting & Incentive Programs
- Improving Immunizations
Reducing Heart Attack & Stroke Risks

We have engaged primary care providers and cardiologists to improve cardiac care by implementing the evidence-based “ABCS.”

Our emphasis is on populations affected by disparities in access and outcomes. We assist their providers by:

1. Promoting the resources available from the Million Hearts® initiative
2. Providing tools and training on taking an accurate blood pressure
3. Helping them use their EHR to identify patients with unmanaged hypertension or high cholesterol for improved management
4. Offering monthly webinars featuring clinical experts
Improving Diabetes Self-Management

We have engaged with The Virginia Department for Aging and Rehabilitative Services (DARS), community organizations and providers to increase the number of minority, low-income and rural Medicare beneficiaries who complete diabetes self-management education.

HQI helps by:

1. Offering free training by our Master Trainers that qualifies community volunteers to become DSME peer leaders
2. Providing DSME resources, including materials for promoting workshops to Medicare beneficiaries
3. With beneficiary permission, collecting pre- and post-workshop clinical data from a sample of providers to assess workshop impact
As the QIN-QIO, HQI provides:

**Information** about upcoming quality reporting submission deadlines;
new or revised program and measure requirements;
recent report availability;
NHSN website access and navigation for hospitals;
QualityNet Secure Portal website access, navigation and reports; and
CMS Proposed and Final Rules.

**Assistance** to understand measures and/or methodology used to determine measures;
access and/or navigate in NHSN and/or QualityNet websites for hospitals;
meet requirements for claims-based outcome measures; and
clarify program requirements.
HQI’s team of QPP Experts provide:

1. Technical Assistance
   a. Contracted to support large groups (16+ clinicians)
   b. Both virtual TA and on-site TA
   c. Answer complex, practice specific MIPS questions
   d. Direct access to CMS
   e. Hotline: 1-844-357-0589 or email qpp@hqi.solutions

2. Webinars
   a. Live and On-Demand
   b. Relevant topics and in-depth explanations of program requirements
   c. Live chat with our team during Office Hours

3. Presentations
   a. In-person education on MIPS requirements for clinicians and administrative staff
HQI’s team of QPP Experts provide:

4. Score Analysis
   a. Review 2017 Feedback Reports and 2016 QRUR Reports
   b. Find areas for improvement

5. Educational Materials
   a. Fact sheets, newsletters, pamphlets

6. Stakeholder engagement
   a. Relationships with community members and healthcare groups
Better Healthcare for Communities

Nursing Home Improvement Network

Care Transitions

Special Innovation Projects
Nursing Home Improvement Network

1. Decrease the use of unnecessary antipsychotics
2. Prevent and reduce healthcare associated infections
3. Improve Staff stability
4. Improve long-stay quality measures
5. Decrease potentially avoidable hospitalizations

The data shows we’re improving!
Maryland-Virginia Nursing Home Improvement Network

Aligning QI Efforts

- Organizational quality goals
- Quality Assurance and Performance Improvement (QAPI)
- The Partnership to Improve Dementia Care
- AHCA Quality Awards
- CMS Nursing Home Action Plan
- National Nursing Home Quality Improvement Campaign - NNHQIC (Advancing Excellence)
1. Percent of residents with one or more falls with major injury
2. Percent of residents with a UTI
3. Percent of residents who self-report moderate to severe pain
4. Percent of high-risk residents with pressure ulcers
5. Percent of low-risk residents with loss of bowels or bladder
6. Percent of residents with catheter inserted or left in bladder
7. Percent of residents physically restrained
8. Percent of residents whose need for help w/ ADLs has increased
9. Percent of residents who lose too much weight
10. Percent of residents who have depressive symptoms
11. Percent of residents who received antipsychotic medications
12. Percent of residents assessed and appropriately given flu vaccine
13. Percent of residents assessed and appropriately given Pneumococcal vaccine
A Collaborative Approach

1. Learning from both colleagues and experts
   • Best practices from successful facilities
   • Peer mentoring program
   • Educational webinars and workshops
   • 24/7 online community of like-minded professionals
   • Improvement resources with proven effectiveness

2. Change Package of best practices, tools, and resources

3. Email & telephonic consultation with HQI quality consultants

4. Plan-Do-Study-Act (PDSA) cycles to test improvement strategies
### Unique Opportunities for Nursing Homes

**The Nursing Home Improvement Network**

<table>
<thead>
<tr>
<th>Stopping Sepsis in Virginia Hospitals &amp; Nursing Homes</th>
<th>C. difficile in Nursing Homes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Treatment &amp; Prevention</td>
<td>Surveillance, Prevention &amp; Management</td>
</tr>
<tr>
<td>• Addresses this top driver of readmissions</td>
<td>• Antibiotic Stewardship, Infection Prevention &amp; Control, Tracking</td>
</tr>
<tr>
<td>• Nursing home providers learn <em>early</em> recognition and treatment methods</td>
<td>• 70% of <em>C. diff</em> infection-related harm is preventable</td>
</tr>
<tr>
<td>• Collaborate with referring hospitals</td>
<td>• Helps reduce readmissions and lowers SNF costs</td>
</tr>
</tbody>
</table>
Goals of Stopping Sepsis

1. Providing education and resources to help licensed staff and nursing assistants recognize the signs of infections early using "Seeing Sepsis 100"

2. Reducing mortality rates, hospitalizations and healthcare costs by treating residents for infections **before they become septic**

3. Implementing infection-prevention strategies such as hand hygiene and antimicrobial stewardship that reduce infections that can lead to sepsis

4. Engaging and educating families and caregivers who can help monitor for the early signs of infection
Empower Facilities:
100-100-100 Guide for Stopping Sepsis

• Is their temperature above 100?
• Is their pulse rate above 100?
• Is their blood pressure below 100?

• Are they just not acting themselves?
  • Drowsy?
  • No appetite?
  • Stumbling, falling?
  • Confused/increased confusion?

• STOP- Go find the Nurse and ask her to ASSESS the resident for possible Sepsis
Seeing Sepsis 100 Toolkit
• Nursing Home frontline caregivers are nursing assistants
• Ensure tools are geared to the right people
C. diff Prevention Collaborative

**Why C Diff ?**

**Here in Virginia:**
Among 82 hospitals, 18% had an SIR – *standardized infection ratio* significantly higher (worse value) than the national SIR

**It’s not just a hospital issue:**

About half of *C. diff* infections show first symptoms in hospitalized or recently hospitalized patients, and **half show initial symptoms in nursing homes** or in people recently cared for in doctors’ offices and clinics

The Average Cost for *C. diff* medications in the Nursing Home = $2400 - $4800 per episode
What the Facilities Have Agreed to Do

- **Track** *C. diff* using the same method as your hospital partners – the NHSN
- **WORK together** with physicians toward Antibiotic Stewardship and reduce PPI’s
- **Disinfect** properly and learn the latest tips and best practices
- **Implement effective strategies** to quickly diagnose, treat & prevent *C. diff*
- **Enforce** hand hygiene and staff infection control precautions
- **Communicate** *C. diff status* with other healthcare partners

Empower your Infection Prevention Nurse to lead the team
NHSN Reporting of *C. diff*

**Nursing Homes in the Collaborative are ahead of the curve:**

- Using the NHSN to track infections & analyze infection data
- Enrolling & reporting THEIR FACILITY’S data in the NHSN
- Learning how the NHSN reports can benefit LTC facilities
- Benchmarking their facility against the nation, the state
- Preparing for upcoming SNF infection surveillance regs
HQI can help you find the resources you need to fight *C. diff*

### IDSA/SHEA

*Clostridium difficile* Clinical Practice Guideline

### National Nursing Home QI Campaign

(Links to 4 sets of resources)

*C. difficile* & Antibiotic Stewardship

### National Nursing Home Quality Care Collaborative QIOs

Nursing Home Training Sessions

### HQI Webinars

*C. diff.* Lessons Learned from the Field & NHSN Training
LTC Antibiotic Stewardship Resources  May 2017

Jump Start Your Antibiotic Stewardship Program (ASP)

The Centers for Disease Control and Prevention’s (CDC) The Core Elements of Antibiotic Stewardship for Nursing Homes adapts the CDC Core Elements of Hospital Antibiotic Stewardship into practical ways to initiate or expand antibiotic stewardship activities in nursing homes. Nursing homes are encouraged to work in a step-wise fashion, implementing one or two activities to start and gradually adding new strategies from each element over time. Any action taken to improve antibiotic use is expected to reduce adverse events, prevent emergence of resistance and lead to better outcomes for residents in this setting.

- The Core Elements of Antibiotic Stewardship for Nursing Homes
- Checklist: Core Elements of Antibiotic Stewardship for Nursing Homes
- Appendix A: Policy and practice actions to improve antibiotic use
- Appendix B: Measures of antibiotic prescribing, use and outcomes

Toolkits

The Agency for Healthcare Research and Quality (AHRQ) developed The Nursing Home Antimicrobial Stewardship Guide. The Guide includes a collection of instructions and turnkey materials that nursing homes can use to improve antibiotic use. Each nursing home can choose which toolkits, or parts of toolkits, best suit its needs.

- Nursing Home Antimicrobial Stewardship Guide
- Browse the Antimicrobial Stewardship Toolkit Contents

The Nursing Home Antimicrobial Stewardship Modules include four tested, evidence-based toolkits to help optimize antibiotic use in nursing homes. The modules are intended to assist nursing homes develop antimicrobial programs.

Resource List:

Antibiotic Stewardship Program Webinars on-demand:
Search HQI.Solutions/resource-center
Antibiotic Stewardship: Complete Training Sessions

https://qioprogram.org/nursing-home-training-sessions

Nursing Home Training Sessions Introduction

1. TeamSTEPPS® in LTC: Communication Strategies to Promote Quality and Safety
2. Exploring Antibiotics and their Role in Fighting Bacterial Infections
3. Antibiotic Resistance: How it Happens and Strategies to Decrease the Spread of Resistance
4. Antibiotic Stewardship
5. Clostridium difficile Part One: Clinical Overview
6. Clostridium difficile Part Two: Strategies to Prevent, Track, and Monitor C. difficile

We hope that you find these training tools and resources helpful in your work to implement antibiotic stewardship and prevent C. difficile infections in your residents. All are welcome to explore this site and use the information as applicable to you and your organization. Thank you for your dedication to preventing infections in residents (and staff, too) and promoting appropriate antibiotic use.

Training sessions and resources for nursing homes to support:

- Implementation of principles and practices of antibiotic stewardship
- Prevention and management of Clostridium difficile infections

C. difficile harms residents!

- C. difficile caused almost
Connecting Care: Care Transitions Project

- Engaging communities of clinical and local service/support partners
- Improve care for Medicare beneficiaries
  - Reduce 30-day re-hospitalizations by 20%
  - Reduce overall hospitalizations by 20%
  - Increase # of nights beneficiaries spend at “home” by 10%
  - Reduce adverse drug events (ADEs) by 35%
- Build community capacity to qualify for formal program or grant funding
- Spread successful care transitions interventions
More Simply...

1. Come together
2. Identify opportunities to improve care transitions
3. Select improvement activities
4. Test changes
5. Measure impact of tested changes
6. Spread successful activities
Community Coalition Engagement

HQI Virginia and Maryland Communities:
2014-16 Recruited and In Conversation

[Map showing communities with various colors indicating years of engagement and those in conversation.]
Sample Community Interventions

- Transition Coaching
- INTERACT
- Teach Back
- Readmission Risk Assessments
- Transfer Process Improvements
- Medication Reconciliation
- Beneficiary & Family Education
1. Quality Measure Composite Score
   • Corporate report
   • Facility report

2. Sepsis & C. diff Data
   • Corporate report
   • Facility report

3. Readmission Reports

**DRILL DOWN** to determine root causes and develop plans of action

“**Without data, you’re just another person with an opinion**”
-W. Edwards Deming
So How Does This Fit With QAPI?
**Now is the time to accelerate QAPI!**

<table>
<thead>
<tr>
<th>Phase 1</th>
<th>Phase 2</th>
<th>Phase 3</th>
</tr>
</thead>
<tbody>
<tr>
<td>Effective November 28, 2016</td>
<td>Effective November 2017</td>
<td>Effective November 2019</td>
</tr>
<tr>
<td>QAA Committee</td>
<td>Initial QAPI Plan must be provided during annual survey</td>
<td>Implementation of QAPI</td>
</tr>
</tbody>
</table>
QAPI Defined

Reactive:
An internal review process that audits the quality of care delivered and implements corrective actions to remedy any deficiencies identified.

Proactive:
Focuses on systems rather than individual performance and seeks to improve quality rather than correcting errors when thresholds are crossed.
The Five Elements of QAPI

- Systematic Analysis and Systemic Action
- Feedback, Data Systems and Monitoring
- Governance and Leadership
- Performance Improvement Projects
- Design and Scope

Quality of Care, Quality of Life, Resident Choice
1. Address all systems of care and management practices
2. Include clinical care, quality of life, and resident choice
3. Aim for safety and high quality with all clinical interventions while emphasizing resident autonomy/choice
4. Utilize the best available evidence to define and measure goals
Plan Implementation: Facility Purpose of QAPI

- QAPI will drive the decision making within the organization.

- QAPI plan is reviewed minimally on an annual basis by the QAA committee and revisions will be made and documented by the QAA committee.

- QAPI plan and revisions will be communicated to board members, residents, families, and staff through meetings and newsletters.
Plan Implementation: Scope of Services

- Each area should have a representative on the QAA committee.

- QAPI activities will cross service areas and

- On an annual basis, and as needed, a Facility Assessment will be conducted to include an overview of the services and care areas that are provided. Any new service areas or changes in population or service areas identified during the Facility Assessment will be included in the QAPI plan.
Element 2: Governance and Leadership
Plan Implementation: Adequately Source QAPI

• Establish a budget to ensure that QAPI activities are supported.

• These expenses may include, but are not limited to staff time for being involved in Performance Improvement Projects (PIPs) and meetings, monies needed for improvement projects, staff training and education, etc.

• Review budget on a monthly basis by the administrator and revise as necessary. The administrator and QAA committee will work together to review budgetary needs and share decision making regarding performance improvement projects.
Mandatory QAPI Staff Training and Orientation

• QAPI will be included in the organizational orientation and annually.

• Training to include quality improvement principles and practices, how to identify areas for improvement, updates on current performance improvement projects, and how staff can be involved in performance improvement projects.
Plan Implementation: Culture of QAPI

Framework for QAPI

• The QAA Committee will have representation from leadership, general staff, and resident and/or family representatives (if appropriate)

• Participating residents and/or family members will receive confidentiality training prior to participating in any QAPI activity.

• Report QAPI activities/outcomes during staff meetings, resident/family council meetings, and via newsletters.

• The QAA committee will report all activities to the board of directors during their regularly scheduled meetings.
Plan Implementation Example: Culture of QAPI

A Fair and Just Culture

• Managers promote staff involvement in improving quality and respond in a consistent manner to encourage staff to bring forward opportunities for improvement.

• Staff is encouraged to report errors and near misses to allow the organization to learn from those occurrences and make systemic changes to prevent recurrences.

• Staff will be held accountable for their behavioral choices and reckless behavior will not be tolerated. Our goal is to improve the systems that drive our actions.
“Quality depends on good data. It also depends on executive leadership using that data” – Juran Institute, Inc.
Suggested Data Sources

Feedback Systems

- Resident/Family Satisfaction Surveys
- Staff Satisfaction Surveys
- Resident/Family Council Meetings
- Community Partnerships
- Regulatory Surveys
- Grievance/Compliment Logs
- Hotline Contract Vendor Reports

Clinical Data

- Quality Measures
- Medication Errors
- Vaccination Compliance
- Nutrition
- Unplanned Hospitalizations
- Unexpected Deaths
- Abuse/Neglect
- Decline in Functional Status
Suggested Data Sources

Organization Elements

- Safety-related Parameters
- Employee Illnesses
- Functional Status of Alarms
  - Door
  - Fire
  - Bed/chair
- Staff Retention
- Environmental Services
- Laundry Services
- Dietary Services
- Recreational Programming
- Staff Education/Development
- Employee Immunization
- Criminal Background Checks

Monitoring Systems

- Team TSI/PointRight
- Incident Reports
- Workers Compensation Claims
- Rounds
  - Safety
  - Environmental
  - Clinical
- Focused Clinical Review
- Competency Validation
- Committees
  - Safety
  - Risk
  - Standards of Care

HQI
Benchmarking

- Against Who?
  - Peers
  - Yourself
- How Often?
  - Monthly
  - Quarterly
  - Annually
- What Should be Benchmarked?
  - Quality information consistent with strategic direction
  - Information necessary to demonstrate value
  - Information necessary to demonstrate quality of care
  - Key financial information
Benchmarking Considerations

• Measure what matters
• Take action on what it measured
• One item in isolation does not demonstrate success or failure
• Available benchmark sources
  • My InnerView
  • Team TSI/PointRight
  • CMS CASPER Reports
  • Nursing Home Compare
  • Organizational Scorecard
  • HQI QIN-QIO Quality Reports
Plan Implementation: Engagement with Data
The Need for Data

To satisfy external requirements:

- CMS’ triple aim of
  - BETTER CARE
  - BETTER HEALTH
  - LOWER COSTS
- Value Based Payment
- Community Partners
Internal Requirements

- To satisfy internal requirements
  - Because our boss said to
  - To decrease unnecessary costs and/or penalties
  - To increase safety measures
  - To understand if our quality measures are on track
  - To perfect our processes
  - Because we believe it will show us “the way”
How should we make changes with limitations?

- Busy
- Short staffed
- Short on monetary resources
- There is not a data expert on staff
Data Engagement

✓ Add data to every meeting (in fact, make it a focal point!)

✓ Create charts and graphs that are visible around the facility

✓ Coach employees on what it means to see and use data

✓ Bring employees, residents, and families into the conversation – give them a voice

✓ Create a culture based on integrity that begins with doing the right thing
Plan Implementation: Data as a Driver

• Changes are made during the process based upon preliminary data

• Data should be utilized and discussed facility-wide

• Every person should be included in the quality improvement process

• Facilities should create a culture based on integrity and accountability
Element 4: Performance Improvement Projects (PIPs)

From State Operations Manual:

• QAPI program activities would be required to conduct distinct PIPs.
• Each facility would be required to implement at least one project annually.
Plan Implementation: PIPs

• How your Organization will conduct improvement projects
• How potential topics for PIPs will be Identified
• Describe criteria for prioritizing and selecting PIPs
• Describe how and when PIP charters will be developed
• Describe how to designate PIP Teams
• Describe how the designated team will conduct the PIP
• Describe your process for documenting and communicating performance improvement and trends in performance measures
Prioritize Quality Opportunities

Choose problems or issues that you consider important; establish method to “rank” the opportunities in terms of risk

- High risk
- High frequency
- Problem prone
Evaluate Opportunity Using Data

- Clinical Outcome
- State Survey
- Public Reporting
- Customer Satisfaction
Develop a Deliberate Approach to Teamwork

- Teamwork is a core component of PI
- A group of people does not make a team

**Teamwork:** work done by several associates with each doing a part but all subordinating personal prominence to the efficiency of the whole
The Two Team Approach

Quality Improvement Committee

Performance Improvement Project Team
Chartering a PIP Team

• Process of focus
• Background
• Clearly defined team objectives
• Process boundaries and scope
• Clear description of expectation
• Team membership
• Resources
What Makes PIP Teams Successful?

• Committed and involved leadership
• Entire organization trained and educated about performance improvement methods and tools
• Teamwork
• Communication
• Data
• Project champions
• Appropriate and adequate resources
• Knowledgeable and effective facilitator
• Culture of Continuous Quality Improvement
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.
Plan Implementation: Take Systemic Action

**Weak Actions**
- Double checks
- Warnings/Labels
- New Policies/Procedures
- Memoranda
- Training/Education
- Additional Study

**Strong Actions**
- Physical changes: grab bars, non-slip strips in tubs/showers
- Forcing functions or constraints: electronic medical records-cannot continue charting unless all fields are filled in.
- Simplifying: unit dose
| **WHAT** | What are the primary issues? What components need improvement? |
| **WHEN** | When does the issue/concern occur? Relationship to activity/task/systems? |
| **WHERE** | Where does the issue/concern occur – specific neighborhood, location, etc.? |
| **WHO** | Who is involved in the concern/incident – resident, staff, visitors, etc.? |
| **WHY** | Why was the plan, direction, guidance, policy or procedure not followed? |
Root Cause Analysis

- Five Whys
- Flowcharting
- Fishbone Diagram
- Failure Mode and Effects Analysis (FMEA)
- Other

There is danger in starting with a solution without thoroughly exploring the problem. Multiple factors may have contributed, and/or the problem may be a symptom of a larger issue. What seems like a simple issue may involve a number of departments.
### Using the Model for Improvement

1. **What are we trying to accomplish?**
2. **How will we know that a change is an improvement?**
3. **What change can we make that will result in improvement?**

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<table>
<thead>
<tr>
<th>Plan</th>
<th>Do</th>
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</thead>
<tbody>
<tr>
<td>Act</td>
<td>Study</td>
</tr>
</tbody>
</table>

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Using the Model for Improvement:

1. **Plan**: Identify the problem and set goals.
2. **Do**: Implement the changes and monitor the results.
3. **Act**: Adjust the changes based on the results.
4. **Study**: Analyze the outcomes and refine the process.

---

*HQI - HEALTH QUALITY INNOVATORS*
Set SMART Goals

**Specific:** Objectives should be well-defined

**Measurable:** Objectives should have a benchmark and target to help determine whether the objective is achieved

**Achievable:** Objectives should be within reach

**Relevant:** Objectives need to be in line with organizational mission, vision, and goals

**Time-phased:** When will the objective be achieved
The PDSA Cycle

**Plan**
- Objective
- Predictions
- Plan to carry out the cycle (who, what, where, when)
- Plan for data collection

**Do**
- Carry out the plan
- Document observations
- Record data

**Study**
- Analyze data
- Compare results to predictions
- Summarize what was learned

**Act**
- What changes are to be made?
- Next Cycle?
Plan Implementation: Interventions are Implemented and Effective

- Choose indicators/measures that tie directly to the new action

- Conduct ongoing periodic measurement and review to ensure the new action has been adopted and is performed consistently

- Review some measures more frequently (even daily) by staff to show incremental changes, which can serve as a reminder for the new action and provide encouragement and reinforcement

- Based on measurement review, make changes in procedure(s) as needed to help facilitate the change
Monitor the Plan Implementation Process

Take your QAPI “Pulse” with a Self Assessment

<table>
<thead>
<tr>
<th>QAPI Self-Assessment Tool</th>
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</table>

**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**

<table>
<thead>
<tr>
<th>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.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Notes:</td>
</tr>
<tr>
<td>Not started</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>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.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Notes:</td>
</tr>
<tr>
<td>Not started</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>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 reviewed 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.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Notes:</td>
</tr>
<tr>
<td>Not started</td>
</tr>
</tbody>
</table>

<table>
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<tr>
<th>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.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Notes:</td>
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<tr>
<td>Not started</td>
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</tbody>
</table>

Disclaimer: Use of this tool is not mandated by CMS for regulatory compliance nor does its completion ensure regulatory compliance.
Putting it All Together

1. Quality of care
2. Job satisfaction
3. Nursing Home Compare
4. 5-Star Rating
5. Valued Based Payment
6. Patient Driven Payment Model
IT HAS NEVER BEEN EASIER TO ACCESS HQI’S RESOURCE CENTER

Health Quality Innovators (HQI) recently launched a new online resource center. Now clinicians, partners and patients have easy access to a wide range of quality improvement resources at no cost.

Benefits include

- **No log-in needed**: You can access all our tools and resources; no password or username required.
- **Multiple ways to search**: Either type in your search term(s) or sort by topic, audience or media type.
- **A wealth of materials covering all settings**: You will find videos, webinar recordings, tip sheets, patient education materials and more. Materials cover all settings and address a wide range of topics from quality improvement basics to strategies for engaging patients and families.
Resource Highlights

- Focuses on successful practices of high performing nursing homes
- Provides menu of strategies, change concepts, and specific actionable items
- Includes three change bundles for avoiding antipsychotic medications, promoting mobility, and preventing HAIs

Blue Bag Initiative

- Medication safety and reconciliation Program
- Separates and confines expired and/or discontinued medications
- Enhances provider-patient communication
- Empowers patients to take an active role in their health care
HQI DASHBOARD: PATIENT EDUCATION AT YOUR FINGERTIPS

Health Quality Innovators (HQI) offers a wide range of patient education materials at no cost to you. Resources, offered in English and Spanish, are designed to be easy to read and understand. Explore the links below, download and print anything that would be beneficial to your patients and families.

Diabetes Health & Education Dashboard:
bit.ly/diabeteshealthdashboard

Heart Health & Education Dashboard:
bit.ly/cardiachealthdashboard

Resources for Spanish-Speaking Patients:
bit.ly/resourcesforspanish-speakingpatients
Benefits of Participation

1. Flexible, no-cost structure for improvement
2. QAPI tools and resources
3. Latest strategies, best practices and techniques from QI experts & successful colleagues in Virginia and the nation
4. Support for participation in QI initiatives
5. A data-driven approach to quality challenges
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