QAPI and Person-Centered Care

David Farrell, MSW, LNHA

Background

- QAPI program in Nursing Homes required in Affordable Care Act of 2010
- Legislation requires CMS to
  - establish QAPI program standards
  - provide technical assistance
- Opportunity for CMS to launch QAPI program before regulation

Context

- QAPI in other Federally certified programs
  - hospitals, transplant programs, dialysis centers, ambulatory care, hospice
- QAPI to be consistent with other settings
- Considers issues unique to NH setting
QAPI Development

- University of Minnesota with Stratis Health
- Activities include:
  - Demonstration project to test tools and resources
  - Technical Assistance & Learning Collaborative
  - On-Line Resource Library
  - Development of “best practices”
  - TEP to review and advise

Together = QAPI

<table>
<thead>
<tr>
<th>Quality Assurance:</th>
<th>Performance Improvement:</th>
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<tbody>
<tr>
<td>• Retrospective analysis</td>
<td>• Internal management process</td>
</tr>
<tr>
<td>• Process to meet standards</td>
<td>• Proactive analysis designed to detect problems early</td>
</tr>
<tr>
<td>• Limited involvement</td>
<td>• Broad focus on organizational systems and outcomes</td>
</tr>
<tr>
<td>• Driven by external forces</td>
<td>• High involvement</td>
</tr>
<tr>
<td>• Narrow focus on clinical measures</td>
<td>• Driven by quality leaders and their search for better ways</td>
</tr>
<tr>
<td>• Needed to stay licensed</td>
<td>• Evidence-based leadership</td>
</tr>
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<td>• Regulations currently exist</td>
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5 Core Components

1) Design and Scope
2) Governance and Leadership
3) Feedback, Data, Monitoring
4) Performance Improvement Projects
5) Systematic Analysis and Action

QAPI/PCC
Design and Scope

- Comprehensive, ongoing program
- Includes all departments
- Addresses safety and quality of life
- Based on best available evidence
- QAPI plan in compliance

Governance and Leadership
QAPI Awareness Campaign

- Formal plan
- Communicate with stakeholders
- Asking for quality concerns
- Process to get feedback
  - How easy do you make it for customers to tell you about what’s frustrating them?

QAPI Awareness Opportunities

- Family councils
- Quarterly town hall meetings
- Care conferences
- Learning circles
- Letters and notes
- Support groups
- Community meetings
- Stand-up meetings
- Newsletters
- Quality updates

Feedback, Data Systems and Monitoring
Measurement Components

- Structural measures –
  - the capacity to provide quality care
- Process measures –
  - performance necessary to achieve quality of care
- Outcome measures –
  - the result

Structural Measures of Quality

- Staffing levels
  - Total nursing hours per patient day = 3.80
  - RN hours PPD = .55
- # of vacant positions = 0
- # of shifts worked by agency staff = 0
- # of shifts understaffed = 0

Structural Measures

- Staff turnover
  - Total departures/average number of staff = 30%
- Staff retention
  - Staff with one year of service/avg. number of staff = 80%
High Turnover = Low Quality

- Physical restraints
- Catheter use
- Contractures
- Pressure ulcers
- Psychoactive drug use
- Quality-of-Care deficiencies

Castle, N., et al., 2005
Castle, N., 2010

Structural Measure of Quality

- Staff Satisfaction
  - Overall satisfaction = 90% “Excellent/Good”
  - Recommendation to others = 90% “Excellent/Good”

Power of Staff Satisfaction

Influences
- Staff turnover
- Quality of life
  - Relationships - co-workers, residents, families
- Quality of care
- Regulatory compliance

Castle et al., 2007
Staff Satisfaction = Family Satisfaction

- Satisfied employees report:
  - Better supervision
  - Better training
  - Better work environments
- Satisfied families report:
  - Quality of life
  - Quality of care
  - Quality of service


Process Measures of Quality

- The % of new admissions with risk assessments complete and care plan initiated within the first 72 hours = 100%
- Presence of physicians = 10 hours per week
- Consistent Assignment = 85%

- Employee absenteeism = less than 30 call-outs per month per 100 staff
- Call light response time = 5 minutes
- The % of new admissions seen by their attending physician in the first 24 hours = 90%
### Outcome Measures of Quality
- OBRA compliance = Less than state average
- Clinical outcomes of care = QM targets
- Lawsuits = 0
- Formal complaints/compliments = 0
- Re-hospitalization rate = 10%
- Occupancy and mix = 94% and 35%

### Sentinel/Adverse Events
- Unexpected deaths = 0
- Adverse drug reactions = 0
- Medication errors = 0
- Falls with injuries = 0
- Avoidable pressure ulcer = 0

### Outcome Measures
- Resident and family member satisfaction
  - Overall satisfaction = 90% “Excellent/Good”
  - Recommendation to others = 90% “Excellent/Good”
- Physician satisfaction
  - Overall satisfaction = 90% “Excellent/Good”
  - Recommendation to others = 90% “Excellent/Good”
QAPI Data Dashboard

Outcome Measures
Process Measures
Structural Measures

Performance Improvement Projects

QAPI/PCC Steering Committee

Safety Team
Employee Engagement Team
Clinical Care Team
Marketing and Community Relations Team

Quality of Life Team
Identify and Prioritize Your Quality Problems

- Structural measures
- Process measures
- Outcomes
- Observations
- Feedback/comments

Survey Deficiency Score: Weights for Different Types of Deficiencies

<table>
<thead>
<tr>
<th>Severity</th>
<th>Isolated</th>
<th>Pattern</th>
<th>Widespread</th>
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</thead>
<tbody>
<tr>
<td>Immediate jeopardy to resident health or safety</td>
<td>J 50 points (75 points)</td>
<td>K 100 points (125 points)</td>
<td>L 150 points (175 points)</td>
</tr>
<tr>
<td>Actual harm that is not immediate jeopardy</td>
<td>G 20 points</td>
<td>H 35 points (40 points)</td>
<td>I 45 points (50 points)</td>
</tr>
<tr>
<td>No actual harm with potential for more than min. harm that is not IJ</td>
<td>N 4 points</td>
<td>O 8 points</td>
<td>P 16 points (20 points)</td>
</tr>
<tr>
<td>No actual harm with potential for min. harm</td>
<td>A 0 point</td>
<td>B 0 points</td>
<td>C 0 points</td>
</tr>
</tbody>
</table>

Measurement Triggers Action

- What are we going to change?
- How will we know if it works?
- When will it start?
- How can I assist?
- When will we get people involved?
- How will we keep people informed?
Root Cause Analysis

- Used to examine adverse events
- Used to learn about poor outcomes
- Used to identify why produced good outcomes
- Used to help staff understand causes and effects
- Used to build teams and relationships
  and move organizations forward

Uncover the Root Causes

- Identify all possible causes
  - Brainstorming
  - Keep asking - what else? What have we missed? Are there other factors?
  - Arrange these causes along “bones”
- Avoid discussing solutions
- Vote on the most influential
Root Cause Analysis

How to get teams un-stuck …

- Conduct more interviews
  - Staff, residents, families
- Get those most affected at the table
- Ask better questions
- Simulate the current process
- Go and watch

Root Cause Analysis

QAPI Leadership Paradigm

- Causes are many
- Solutions multi-faceted
- Root cause analysis - a path to knowledge
- Stakeholders involved
- Need cooperation
Good to Great

Confront the brutal facts
- Good decisions
- Distinctive process
  - Collected data
  - Seek deep understanding
  - Determine the truth

Collins, J. 2001

Creating Climate Where the Truth is Heard

Four key leadership practices:
- From data to knowledge to action
- Conduct autopsies without blame
- Engage in dialogue
- Lead with questions

Collins, J. 2001

PCC Leadership and QAPI

- Humility
- Listen to others perspectives
- Stakeholders –
  - Who is effected?
  - Who can help us understand this better?
- Involvement = success of changes
  - Spread
  - Sustainability
CNA Participation - Evidence

- Satisfaction with involvement in decision making = Greater intent to stay  
  Parsons et al., 2003
- Involvement in decision making and care planning = Decreased turnover  
  Lean et al., 2001
- Influence on resident care decisions = Increased social engagement  
  Barry et al., 2005

<table>
<thead>
<tr>
<th>PIP Teams – The Heart of QAPI</th>
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<tbody>
<tr>
<td>First 2 Hours Checklist -</td>
</tr>
<tr>
<td>- Bring the white board</td>
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<tr>
<td>- Write down all the ideas</td>
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<tr>
<td>- Prompt people</td>
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<tr>
<td>- Role – Facilitate</td>
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<tr>
<td>- Set rules</td>
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<tr>
<td>- Enhance problem solving competence</td>
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<tr>
<td>- Stay with it</td>
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<thead>
<tr>
<th>Key Changes in Oakland</th>
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<tbody>
<tr>
<td>- Read 24 hour nursing report and TO's daily</td>
</tr>
<tr>
<td>- Just-in-time IDT meetings</td>
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<tr>
<td>- Collect, monitor and share performance metrics</td>
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<tr>
<td>- Allocated resources</td>
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Key Systems Implemented 1st 100 Days

Post-Discharge Call
So We Can Check-In

Measure Satisfaction Day 2,7,10
So We Can Make Changes

Personally Yours
So Together We Exceed Residents Expectations

Consistent Assignment
So We Know the Residents Individually

Anchor the Changes
Communicate - Cause and Effect

Pressure Ulcers - Incidence
The Impact of Leaders

Healthcare organizations

- Leader’s actions influence:
  - Culture
  - Relationships
  - Staff engagement
  - Clinical outcomes
  - Quality of life

Person-Centered Leadership

Performance Compassion

Human Beings are Flawed

Factors that influence their behavior:

- Workload, fatigue
- Procedure design
- Lighting, noise, distractions
- Personal issues
- Co-workers’ behavior
- Equipment, environment
Three Behaviors

<table>
<thead>
<tr>
<th>Human Error</th>
<th>At-Risk Behavior</th>
<th>Reckless Behavior</th>
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<tbody>
<tr>
<td>Product of Our Current System Design</td>
<td>A Choice: Risk Believed Insignificant or Justified</td>
<td>Conscious Disregard of Unjustifiable Risk</td>
</tr>
<tr>
<td>Manage through changes:</td>
<td>Manage through changes:</td>
<td>Manage through changes:</td>
</tr>
<tr>
<td>- Processes</td>
<td>- Remedial action</td>
<td>- Remedial action</td>
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<tr>
<td>- Procedures</td>
<td>- Disciplinary action</td>
<td>- Disciplinary action</td>
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<tr>
<td>- Coaching</td>
<td>- Creating incentives for healthy behaviors</td>
<td>- Creating incentives for healthy behaviors</td>
</tr>
<tr>
<td>- Design</td>
<td>- Environmental factors</td>
<td>- Environmental factors</td>
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<tr>
<td>- Environment</td>
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Goal – Person-Centered Culture

All Staff -
- Looking for the risks around them
- Balance risk and resident choice
- Respectfully catching each others mistakes and correcting them
- Feel safe reporting errors
- Making safe, person-centered choices

PCC Leaders who Trigger Quality

- Design systems of communication
- Paint graffiti and thin charts
- Keep staff informed
- Build community
- Speak with conviction
Drivers of Staff Engagement

- Management cares
- Management listens
- Help with job stress

QAPI/PCC Leadership Practices
To demonstrate that management cares about the staff:
- Share evidence-based “best practices"
- Show staff data
- Staff participate in identifying the “root-causes"
- Charts are audited to collect data
- Quality is noticed - recognition

Person-Centered Leadership
Rounds to trigger quality performance -
- Engage the staff
  - Meet and greet, linger
  - Praise, build self-esteem
  - Create trust, personally follow through
  - Foster teamwork
  - Prevent disorder
<table>
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<th>QAPI/PCC Surveillance Daily</th>
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<tbody>
<tr>
<td>- Monitor structural measures</td>
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<td>- Staffing and assignments</td>
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<tr>
<td>- Shift to shift report</td>
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<tr>
<td>- Observe, listen</td>
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<tr>
<td>- Ask good questions after greetings</td>
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<tr>
<td>- Say, “I’m worried about…”</td>
</tr>
<tr>
<td>- And, “I’m proud about…”</td>
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<tr>
<td>- Ask, “What's frustrating you today?”</td>
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<table>
<thead>
<tr>
<th>Systematic Analysis</th>
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<tr>
<td>and Systematic Action</td>
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<table>
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<tr>
<th>Leadership Paradigm Shifts</th>
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<tr>
<td><strong>From:</strong></td>
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<tr>
<td>• Tolerance</td>
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<td>• Directing</td>
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<td>• Employee expendable</td>
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<tr>
<td>• Reactive</td>
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<tr>
<td>• Tradition and safety</td>
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<tr>
<td>• Busyness</td>
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<td>• Manager</td>
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<td>• Survey results</td>
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<td>• QAA</td>
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<td><strong>To:</strong></td>
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<td>• Higher standards</td>
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<td>• Listening</td>
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<td>• Employee is a customer</td>
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<tr>
<td>• Proactive</td>
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<td>• Person-Centered risk taking</td>
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<tr>
<td>• Results</td>
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<td>• Entrepreneur</td>
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<td>• Consumers perceptions</td>
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<tr>
<td>• Performance Improvement</td>
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Model for Improvement

- What are we trying to accomplish?
- How will we know that a change is an improvement?
- What change can we make that will result in improvement?

Act  Plan  Study  Do

Enhancing QAPI Competence

- Learn, teach and utilize
  - Ice breakers
  - Root-cause analysis
  - Brainstorming
  - Flow chart
  - Learning circle

The PDSA Cycle for Learning and Improvement

- Act
  - Implement?
  - Spread?

- Plan
  - Root-causes
  - Tests of change
  - Plan to carry out the changes

- Do
  - Carry out the changes
  - Document results

- Study
  - Analysis of change
  - Compare data to predictions

Organizational Change Process
QAPI

A checklist for effective PCC leadership -
- Enhances my competence
- Reminds me to listen
- Triggers me to include stakeholders
- Keeps me humble
- Improves my outcomes

Science of Change:
QAPI Practices
- Root-Cause analysis
- Evidence-based solutions
- Evaluation and re-evaluation
- Mid-course adjustments
- PDSA Cycles

Psychology of Change:
PCC-Based Practices
- Build on intrinsic motivation
- Improve relationships
- Start where people are
- Build capacity for change
- Trust, trustworthiness

Path to Performance Improvement

<table>
<thead>
<tr>
<th>Staff Stability and Engagement</th>
<th>Improved Quality and Satisfaction</th>
<th>Better Census and Resources for More Improvement</th>
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<tr>
<td>People and Systems Development</td>
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High Quality, Person-Centered Care is Never an Accident

QAPI/PCC

1) Design and Scope
2) Governance and Leadership
3) Feedback, Data, Monitoring
4) Performance Improvement Projects
5) Systematic Analysis and Action

National QAPI Rollout Plans

- Release of toolkits
- Outreach to national and state stakeholders
- Continued identification of resources
- Continued enhancements to web library

Contact Information

David J. Farrell, MSW, LNHA
Director of Organizational Development
Regional Director of Operations
Administrator
SnF Management
dfarrell@snfmgt.com
(510) 725-7409
Root-Cause Analysis Using the Fishbone Diagram

1. The cause and effect diagram (fishbone) starts with a problem at the head of the fish. In this case, one of the satisfaction survey questions that scored low listed in the My InnerView Priority Action Agenda.

2. Under each general category of the fishbone, list all of the possible “root-causes” in regard to the problem identified.

3. Once the fishbone diagram is done, the various causes are discussed to determine the root of the problem. The results of this discussion drive the focus for the improvement plan.

4. There may be several causes of the problem. The team should prioritize which causes are within their control to solve and, if solved, would have the most positive impact on the largest number of residents.