Acute Care and Critical Access Quality Assurance/Performance Improvement Guide:

What You Need to Know to Establish an Effective QAPI Program

This companion guide is designed to help your team recognize and understand the major components of the Quality Assurance/Performance Improvement Initiative. It will support your organization's quality improvement efforts. The guide is not intended to replace *QAPI at a Glance*, the Centers for Medicare & Medicaid Services' Conditions of Participation or Missouri Code of State Regulations, but it can be used in conjunction with other materials to help your team stay on track in reaching your quality improvement goals.

This guide primarily is designed for professionals who are new to their current position, organization or level of responsibility. Regardless of your experience in QAPI activities, remembering the systematic approach to sustained improvement is a skill set that requires continual development in any organization.

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MHA
MISSOURI HOSPITAL ASSOCIATION

12 Action Steps to QAPI

According to *QAPI at a Glance*, there are 12 action steps on the pathway to QAPI implementation. The steps do not need

to be achieved sequentially; however, the steps do build on one another. Following them sequentially can be a great way to begin your strategic approach to implementing QAPI.

WHAT'S NEW ABOUT QAPI?

While health care facilities have long-since been required to have quality assessment and assurance programs, regulations and reporting expectations require that a formalized approach to performance improvement is part of ongoing systems improvement.

QUALITY ASSURANCE

Quality assurance can be characterized as a focus on current outcomes, with a retrospective view of "what happened." Often, this is done out of a need to ensure compliance and proper follow-up of identified issues. While the scope of a quality assurance committee may include such actions as conducting a root cause analysis and developing action plans, current regulations do not require any specific or formal improvement processes to be used.

PERFORMANCE IMPROVEMENT

Performance improvement can be thought of as a system that makes things better. Unlike quality assurance, which focuses on compliance, performance improvement focuses on "systems issues" that cause poor outcomes. While there are many formalized performance improvement tools, *QAPI at a Glance* refers to the Plan-Do-Study-Act model for improvement.

PUTTING IT TOGETHER

When QA initiatives and PI efforts are blended together, the result can be significant improvements to important outcomes — patients can experience fewer adverse clinical effects, satisfaction rates can improve and staff can become more engaged as processes are stabilized. All of this can lead to improved operational performance for your organization.

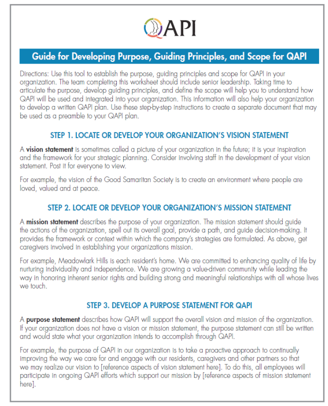
	QUALITY ASSURANCE	PERFORMANCE IMPROVEMENT
Motivation	Measuring compliance with standards	Continuously improving processes to meet standards
Means	Inspection	Prevention
Attitude	Required, reactive	Chosen, proactive
Focus	Outliers: "bad apple" individuals	Processes or systems
Scope	Medical provider	Resident care
Responsibility	Few	All
QA + PI = QAPI		

Source: QAPI at a Glance

QAPI Tools

GUIDE TO DEVELOP PURPOSE, GUIDING PRINCIPLES AND SCOPE FOR QAPI

(QAPI at a Glance, page 31)


QAPI

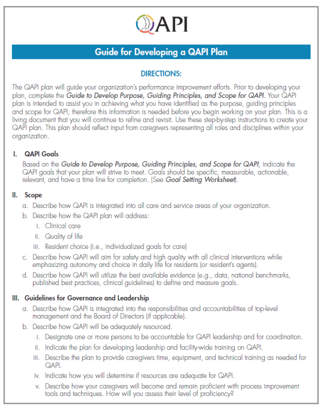
Guide for Developing Purpose, Guiding Principles, and Scope for QAPI

STEP 1. LOCATE OR DEVELOP YOUR ORGANIZATION'S VISION STATEMENT

STEP 2. LOCATE OR DEVELOP YOUR ORGANIZATION'S MISSION STATEMENT

STEP 3. DEVELOP A PURPOSE STATEMENT FOR QAPI

This important three-page guide will help you determine the manner in which your QAPI plan will be supported by your organization; it will serve as a solid foundation from which to continue building your QAPI practices. Using this tool can help guide your team through the creation of a separate document that may be used as the preamble to your QAPI plan.


QAPI

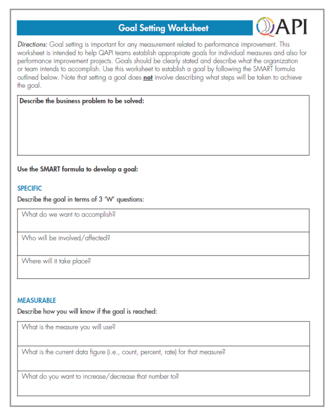
Guide for Developing a QAPI Plan

DIRECTIONS:

GUIDE TO DEVELOPING A QAPI PLAN

(QAPI at a Glance, page 34)

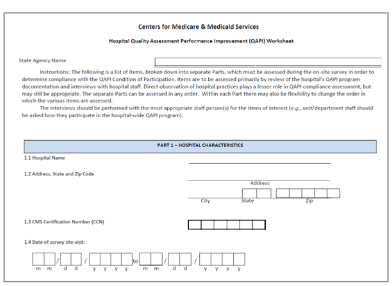
This action-based, three-page guide will help your team address the important elements of QAPI, and develop a formal QAPI plan. With concrete examples and actionable steps in a logical progression, the guide will walk you step-by-step through the creation of your plan.


Goal Setting Worksheet

QAPI

GOAL-SETTING WORKSHEET *(QAPI at a Glance, page 37)*

This worksheet will help your performance improvement project teams develop SMART performance improvement goals. Effective goals are specific, measurable, attainable, relevant and time-bound.


Centers for Medicare & Medicaid Services

Hospital Quality Assessment Performance Improvement (QAPI) Worksheet

PART 1 – HOSPITAL CHARACTERISTICS

CMS QAPI SURVEYOR ASSESSMENT WORKSHEET

This tool is a part of Step 3. The Self-Assessment Tool is found in the Appendix and will help your team determine the extent to which various QAPI practices are already established in your organization. It is recommended that you complete this self-assessment tool prior to beginning any QAPI planning, and re-assess your organization at routine intervals to show your progress.

OTHER RESOURCES

- CMS Survey and Certification Website — Policy and Memos to States and Region
- CMS Transmittals and Conditions of Participation for Hospitals
- Acute Care and Critical Access Hospital Quality Reporting Guides
- ASQ Website of Quality Tools

PDSA Model for Improvement

The success of QAPI and the PIP teams at your organization will depend on everyone's knowledge of the PDSA model for improvement. While there are several different improvement methodologies, PDSA is a simple model that is easy to follow.

To begin, make observations about the system that has been targeted for improvement. Targeted areas could be anything — staff performance, actual processes or service delivery, documentation, quality outcomes, staffing, organizational culture, reportable data, or any other aspect of care or services where the outcomes are not meeting organization expectations or standards.

As a PIP team, answer the following questions.

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

From there, follow the steps below and remember to document your team's process and decision-making.

- PLAN to improve performance.
  - What area(s) are not as strong as you would like? What can you do about it?
- DO carry out your plan.
  - Document what you see when the plan is carried out.
- STUDY the results.
  - Step back and look at the big picture. Has there been improvement?
- ACT on the basis of your findings. Continue with the change, make further changes or stop?

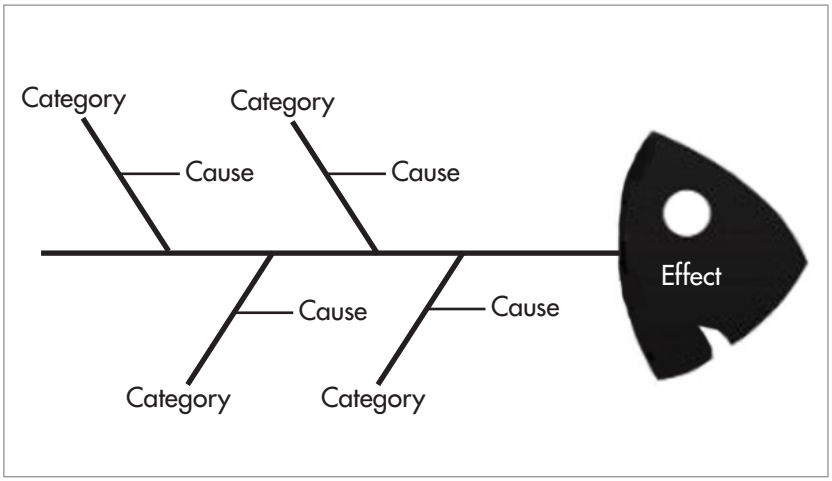
Root Cause Analysis

WHAT IS ROOT CAUSE ANALYSIS?

Just as you would pull a weed out of your garden by its root (to ensure that it doesn't grow back), getting to the "root" cause of a systems issue is important to prevent the problem from returning. There are many formalized root cause analysis tools, including the following.

CAUSE-AND-EFFECT (FISHBONE) DIAGRAM

- The Fishbone diagram starts with the problem at the head of the fish.
- Under each general category of the Fishbone, answer the question, "Why?" for the identified problem.
- Once the diagram is completed, discuss the various causes to determine the root of the problem — or the real reasons why the problem exists. It is from this discussion that the focus for the improvement plan begins.



FIVE WHYS

The Five Whys tool aids in the identification of the root cause of a problem. Begin by identifying a specific problem and ask why it is occurring. Continue asking "why" until the underlying cause is determined. Each "why" should build from the previous answer. There is nothing magical about the number five. Continue until the root cause is identified.

STEPS

- Define a problem; be specific.
- Ask why the problem occurs and list the reason(s) in Box 1.
- Select one of the reasons from Box 1 and ask, "Why does this occur?" List the reason(s) in Box 2.
- Continue the process of questioning until you have uncovered the root cause of the identified problem. If there are no identifiable answers or solutions, address a different reason.

The problem: _____

Why does this occur?

1. → Why is that?
2. → Why is that?
3. → Why is that?
4. → Why is that?
5.

12 Action Steps Expanded

QAPI Step 1: Leadership Responsibility and Accountability

Hospital leadership (i.e., CEO, COO, CNO, medical staff, pharmacists, maintenance, radiology, surgical services and other key managers) is responsible for "setting the tone" to help staff identify how to meet the organization's mission, vision, guiding principles, standards and expectations. Without strong leadership, change efforts often fail or are not sustainable.

ACTION STEPS

- Develop a steering committee/team that will provide QAPI leadership.
- Provide resources for QAPI, including equipment and training for front-line staff.
- Establish a climate of open communication and respect.
- Understand your current culture and how it will promote performance improvement.

PROBING QUESTIONS FOR TEAM DISCUSSION

- Who is on our QAPI steering committee?
- Is our medical director involved in QAPI?
- How can we provide needed resources for QAPI?
- Is our climate open, respecting and fair? What does our climate look like?
- What resources do we have in place to monitor outcomes?

SURPASSING THE HURDLES

- What barriers do you anticipate with these action steps?
- What additional information does your team need?
- What additional resources would be helpful?
- What structures can you create to help ensure success with this step?

CHECKLIST

ACTION STEP	WHO IS RESPONSIBLE?	DATE COMPLETED
Develop a steering committee/team that will provide QAPI leadership.		
Provide resources for QAPI, including equipment and training for front-line staff.		
Establish a climate of open communication and respect.		
Articulate your current culture and how it will promote performance improvement.		

QAPI Step 2: Develop a Deliberate Approach to Teamwork

QAPI at a Glance states that QAPI relies on teamwork in several ways. Do teams in your organization have a clear purpose? Do teams have defined roles for each team member? Do teams have commitment and active engagement from each member? While *QAPI at a Glance* was designed for nursing facilities, the framework also applies in the acute care setting.

ACTION STEPS

- Assess the effectiveness of teamwork in your organization.
- Discuss how PIP teams will work to address QAPI goals.
- Determine how direct care staff, patients and families can be involved in PIPs.
- Identify any communication structures that need to be implemented or enhanced.

PROBING QUESTIONS FOR TEAM DISCUSSION

- How can physicians be involved in our QAPI efforts?
- Do we have effective teamwork? How do we know? What does it look like?
- How does leadership support the development of effective teams?
- Do we have effective communication in our organization? How do we know?
- Do team members support one another?

SURPASSING THE HURDLES

- What barriers do you anticipate with these action steps?
- What additional information does your team need?
- What additional resources would be helpful?
- What structures can you create to help ensure success with this step?

CHECKLIST

ACTION STEP	WHO IS RESPONSIBLE?	DATE COMPLETED
Assess the effectiveness of teamwork in your organization.		
Discuss how PIP teams will work to address QAPI goals.		
Determine how direct care staff, patients and families can be involved in PIPs.		
Identify any communication structures that need to be implemented or enhanced.		

QAPI Step 3: Take Your QAPI "Pulse" With a Self-Assessment

Assessing your hospital's current practice is a necessary part of implementing QAPI.

ACTION STEPS

- Determine a date and time for completing the CMS Surveyor QAPI Worksheet.
- Assemble the right people to complete the worksheet and record your answers for future comparison.
- Determine a date for the next worksheet review.

PROBING QUESTIONS FOR TEAM DISCUSSION

- Who should be involved in this assessment of our current practices?
- What is our timeline for completion?

SURPASSING THE HURDLES

- What barriers do you anticipate with these action steps?
- What additional information does your team need?
- What additional resources would be helpful?
- What structures can you create to help ensure your success with this step?

CHECKLIST

ACTION STEP	WHO IS RESPONSIBLE?	DATE COMPLETED
Determine a date and time for completing the CMS Surveyor QAPI Worksheet.		
Assemble the right people to complete the worksheet and record your answers for future comparison.		
Determine a date for the next worksheet review.		

QAPI Step 4: Identify Your Organization's Guiding Principles

Is the care provided at your hospital tied to the organization's fundamental purpose or philosophy? How do you determine programmatic priorities? Take time to articulate the purpose. The guiding principles and scope of QAPI will help you integrate these efforts into your organization.

ACTION STEPS

- Locate or develop your organization's vision and mission statements.
- Develop a purpose statement for QAPI.
- Establish guiding principles.
- Define the scope of QAPI in your organization.
- Assemble the document.

PROBING QUESTIONS FOR TEAM DISCUSSION

- What beliefs do we have about our purpose and philosophy?
- What beliefs do we have about our approach to QA and PI?
- What is our mission and vision statement?
- What are some of the ways in which we expect care to be provided?

SURPASSING THE HURDLES

- What barriers do you anticipate with these action steps?
- What additional information does your team need?
- What additional resources would be helpful?
- What structures can you create to help ensure your success with this step?

CHECKLIST

ACTION STEP	WHO IS RESPONSIBLE?	DATE COMPLETED
Locate or develop your organization's vision and mission statements.		
Develop a purpose statement for QAPI.		
Establish guiding principles.		
Define the scope of QAPI in your organization.		
Assemble the document.		

QAPI Step 5: Develop Your QAPI Plan

A QAPI plan should be a document that you revisit periodically to ensure that it evolves as your organization grows in its capacity to effectively implement QAPI. This is the main document that will support your QAPI implementation.

ACTION STEPS

- Determine date(s) and time(s) for writing the QAPI plan.
- Print copies of the "Guide for Developing a QAPI Plan" for all team members.
- Work toward writing the QAPI plan until it is complete.
- Determine a future date for reviewing the QAPI plan.

PROBING QUESTIONS FOR TEAM DISCUSSION

- What goals do we have for how QAPI will work?
- How will QAPI be integrated into leadership's accountability?
- How will we strive to use data and performance improvement teams?
- How will direct-care staff be involved in QAPI and PIPs?

SURPASSING THE HURDLES

- What barriers do you anticipate with these action steps?
- What additional information does your team need?
- What additional resources would be helpful?
- What structures can you create to help ensure your success with this step?

CHECKLIST

ACTION STEP	WHO IS RESPONSIBLE?	DATE COMPLETED
Determine date(s) and time(s) for writing the QAPI plan.		
Print copies of the "Guide for Developing a QAPI Plan" for all team members.		
Work toward writing the QAPI plan until it is complete.		
Determine a future date for reviewing the QAPI plan.		

QAPI Step 6: Conduct a QAPI Awareness Campaign

Taking time to create a deliberate communication plan about QAPI will help ensure that everyone in your organization is familiar with the plan, goals and their roles and expectations in the process.

ACTION STEPS

- Inform everyone (staff, physicians, patients, families, consultants, ancillary service providers, etc.) about your organization's QAPI plan.
- Provide training and education regarding QAPI for all caregivers.
- Develop a strategy for communicating with caregivers, patients and families.

PROBING QUESTIONS FOR TEAM DISCUSSION

- How will we inform staff about QAPI?
- How much education and training will be needed?
- How will we engage patients and families in QAPI efforts?

SURPASSING THE HURDLES

- What barriers do you anticipate with these action steps?
- What additional information does your team need?
- What additional resources would be helpful?
- What structures can you create to help ensure your success with this step?

CHECKLIST

ACTION STEP	WHO IS RESPONSIBLE?	DATE COMPLETED
Inform everyone (staff, physicians, patients, families, consultants, ancillary service providers, etc.) about your organization's QAPI plan.		
Provide training and education regarding QAPI for all caregivers.		
Develop a strategy for communicating with caregivers, patients and families.		

QAPI Step 7: Develop a Strategy for Collecting and Using Data

Effective use of data will help ensure that decisions are made based on fact — not on an assumption of the truth. Just as a physician needs data on a patient to diagnose a condition, QAPI and PIP teams need data to ensure they are targeting the right areas. Data trumps emotions.

ACTION STEPS

- Determine what data to routinely monitor.
- Set targets for performance in the areas you are monitoring.
- Identify benchmarks for performance.
- Develop a data collection plan, including who will collect applicable data, who will review it, the frequency of collection and reporting, etc.

PROBING QUESTIONS FOR TEAM DISCUSSION

- What data does our organization routinely monitor? How is the data displayed and used?
- What benchmarks will we use when assessing our performance?
- How can we best make use of the data we have? Do we track and trend our progress throughout time?
- How are data shared with others in the organization (i.e., staff, patients/families, the board, corporate office)?

SURPASSING THE HURDLES

- What barriers do you anticipate with these action steps?
- What additional information does your team need?
- What additional resources would be helpful?
- What structures can you create to help ensure your success with this step?

CHECKLIST

ACTION STEP	WHO IS RESPONSIBLE?	DATE COMPLETED
Determine what data to routinely monitor.		
Set targets for performance in the areas you are monitoring.		
Identify benchmarks for performance.		
Develop a data collection plan, including who will collect applicable data, who will review it, the frequency of collection and reporting, etc.		

QAPI Step 8: Identify Your Gaps and Opportunities

Whether you are reviewing data from quality measure reports, satisfaction surveys, consultant reports, etc., be sure to identify any trends in the data you review. Use the time to observe where processes are breaking down.

ACTION STEPS

- Review information to determine if gaps or patterns exist in your systems of care, or if opportunities exist to make improvements.
- Discuss any emerging themes with key stakeholders.
- Notice what your organization is doing well in this identified area.
- Set priorities for improvement.

PROBING QUESTIONS FOR TEAM DISCUSSION

- When reviewing your data, what stands out?
- How strong is your organizational capacity for assessing organization systems (i.e., policies, protocols, actual care delivery, etc.)?
- What are some areas of strength and weakness?
- What opportunities do you see?

SURPASSING THE HURDLES

- What barriers do you anticipate with these action steps?
- What additional information does your team need?
- What additional resources would be helpful?
- What structures can you create to help ensure your success with this step?

CHECKLIST

ACTION STEP	WHO IS RESPONSIBLE?	DATE COMPLETED
Review information to determine if gaps or patterns exist in your systems of care, or if opportunities exist to make improvements.		
Discuss any emerging themes with key stakeholders.		
Notice what your organization is doing well in this identified area.		
Set priorities for improvement.		

QAPI Step 9: Prioritize Quality Opportunities and Charter PIPs

Choose areas that you consider important (i.e., areas of high risk, frequent occurrence or areas that are known problems). Remember that not all identified problems require PIPs, but for those that do, the projects need to be structured or "chartered."

ACTION STEPS

- Prioritize opportunities for more intensive improvement.
- Consider which problems will become the focus of a PIP.
- Charter PIP teams by selecting a leader and defining the mission.
- The PIP team should develop a timeline and indicate budget needs.
- The PIP team should use the Goal Setting Worksheet to establish appropriate goals.

PROBING QUESTIONS FOR TEAM DISCUSSION

- How will organizational priorities be determined?
- Who will be responsible for monitoring the overall progress of our PIPs?
- What education is needed for PIP teams?

SURPASSING THE HURDLES

- What barriers do you anticipate with these action steps?
- What additional information does your team need?
- What additional resources would be helpful?
- What structures can you create to help ensure your success with this step?

CHECKLIST

ACTION STEP	WHO IS RESPONSIBLE?	DATE COMPLETED
Prioritize opportunities for more intensive improvement.		
Consider which problems will become the focus of a PIP.		
Charter PIP teams, by selecting a leader and defining the mission.		
The PIP team should develop a timeline and indicate budget needs.		
The PIP team should use the Goal Setting Worksheet to establish appropriate goals.		

QAPI Step 10: Plan, Conduct and Document PIPs

For areas that require PIPs, PIP teams should use a methodical or standardized process for making improvements. PDSA is one well-known model, but there are others that also may work for your organization. The important point is to use a strategic methodology and not a haphazard, "throw it at the wall and see if it sticks" approach.

ACTION STEPS

- Determine what information is needed for the PIP.
- Determine a timeline and communicate it to the steering committee.
- Identify and request any needed supplies or equipment.
- Select or create measurement tools.
- Prepare and present results.
- Use a problem-solving model (i.e., PDSA).
- Report results to the steering committee.

PROBING QUESTIONS FOR TEAM DISCUSSION

- According to our data, on what area(s) do we need to work?
- Who should be involved? What is the timeline?
- What resources are needed?
- What ideas can we test?

SURPASSING THE HURDLES

- What barriers do you anticipate with these action steps?
- What additional information does your team need?
- What additional resources would be helpful?
- What structures can you create to help ensure your success with this step?

CHECKLIST

ACTION STEP	WHO IS RESPONSIBLE?	DATE COMPLETED
Determine what information is needed for the PIP.		
Determine a timeline and communicate it to the steering committee.		
Identify and request any needed supplies or equipment.		
Select or create measurement tools.		
Prepare and present results.		
Use a problem-solving model (e.g., PDSA).		
Report results to the steering committee.		

QAPI Step 11: Get to the "Root" of the Problem

Prevent recurring problems by ensuring that all possible root causes have been identified and addressed. Remember to use systematic tools, such as the Cause & Effect Diagram or the "Five Whys" to dig below the surface.

ACTION STEPS

- Using a methodical approach, determine all potential root cause(s) underlying the performance issue(s).
- Determine which factors are controllable.
- Ensure that the PDSA cycles address the root cause(s).

PROBING QUESTIONS FOR TEAM DISCUSSION

- What are the obvious and less obvious reason(s) the problem surfaced?
- What is at the root of those factors?
- What systems and processes are involved (not people)?

SURPASSING THE HURDLES

- What barriers do you anticipate with these action steps?
- What additional information does your team need?
- What additional resources would be helpful?
- What structures can you create to help ensure your success with this step?

CHECKLIST

ACTION STEP	WHO IS RESPONSIBLE?	DATE COMPLETED
Using a methodical approach, determine all potential root cause(s) underlying the performance issue(s).		
Determine which factors are controllable.		
Ensure that the PDSA cycles address the root cause(s).		

QAPI Step 12: Take Systemic Action

Just as pulling a weed at the ground level will not prevent it from growing back, weak interventions, such as staff education, new policies or reminders, often do not prevent the recurrence of the original problem. Whenever possible, use strong interventions, such as simplifying a process or making physical or environmental changes, to "hardwire" the change into the existing system.

ACTION STEPS

- Implement changes or corrective actions that will result in improvement or reduce the chance of the event recurring.
- Target the root cause(s) with strong interventions.
- Test large-scale changes (through PDSA cycles) prior to launching changes organizationwide.

PROBING QUESTIONS FOR TEAM DISCUSSION

- How strong are the interventions?
- Do the selected interventions address systems issues or individual performance?
- Is what we're doing working? How do we know?
- What are our next steps?

SURPASSING THE HURDLES

- What barriers do you anticipate with these action steps?
- What additional information does your team need?
- What additional resources would be helpful?
- What structures can you create to help ensure your success with this step?

CHECKLIST

ACTION STEP	WHO IS RESPONSIBLE?	DATE COMPLETED
Implement changes or corrective actions that will result in improvement or reduce the chance of the event recurring.		
Target the root cause(s) with strong interventions.		
Test large-scale changes (through PDSA cycles) prior to launching changes organizationwide.		

Suggestions for Implementing QAPI Steps

The following strategies were excerpted from the National Nursing Home Quality Care Change Package, available at https://www.cms.gov/medicare/provider-enrollment-and-certification/qapi/downloads/nnhqcc-package.pdf. They were adapted for the acute care setting.

STEP 1: LEADERSHIP RESPONSIBILITY AND ACCOUNTABILITY

- Institute an open-door policy for all levels of leadership to establish presence and consistent availability for staff.
- Provide training and gain staff, resident and family member commitment for your QAPI initiatives.
- Routinely spend time in all neighborhoods and during all shifts.
- Talk directly to staff and patients. Establish a practice to ask how they are doing, what they need to do their best work and provide excellent care, and how you can help reduce frustrations that prevent them from doing their best work.
- Follow-through on issues brought to you — keep that commitment.
- Set the example and pitch in.
- Recognize and honor staff and resident opinions. Demonstrate your sincere appreciation.
- Credit others for their contributions that positively affect your performance.
- Ensure necessary equipment is readily available and in good working order.
- Involve all staff in changes and improvement to increase the feeling of ownership and accountability.
- Build leadership skills through training, support and coaching to help staff be effective.
- Openly admit your unintentional errors so people are less afraid to admit theirs.
- As a leader, uphold high expectations of the organization. If you see an issue, take action and set the tone for high expectations.

STEP 2: DEVELOP A DELIBERATE APPROACH TO TEAMWORK

- Set the expectation for leaders and staff and share ideas for ways to grow and innovate.
- Build trust with and between your staff (do what you say you are going to do). Celebrate successes — it's the "little" things that matter.
- Establish the use of learning circles and huddles to foster relationships and create an opportunity for all to be heard.
- Remove boundaries between departments (hold neighborhood meetings that all disciplines attend, use interdisciplinary teams for problem-solving, etc.)
- Use templates or methods for consistency and to support shared expectations of process (agendas, minutes and a place to share information with the team).
- Encourage and reward staff for supporting each other.
- Expect that the medical director/providers listen to nurses, aides and other staff, and actively seek their suggestions, assessments and recommendations.
- Encourage the medical director and physicians to keep track of opportunities for improvement, and share them with leadership and the QAPI steering committee.

STEP 3: TAKE YOUR QAPI "PULSE" WITH A SELF-ASSESSMENT

STEP 4: IDENTIFY YOUR ORGANIZATION'S GUIDING PRINCIPLES

- Use an inclusive process to establish, review and reaffirm your mission. Involve staff, patients and families.
- Ensure values are considered core to the organization and those who work there.
- Translate the mission into action.

STEP 5: DEVELOP YOUR QAPI PLAN

STEP 6: CONDUCT A QAPI AWARENESS CAMPAIGN

- Share the mission, vision and guiding principles with all staff, as well as with new staff during orientation.
- Develop communication plans that use multiple approaches (email, verbal, newsletter, etc.) throughout the organization and across all shifts.
- Hold neighborhood meetings.
- Openly and transparently share your performance data with staff, physicians, other key stakeholders, the board, patients and families.
- Set up a scoreboard for staff that monitors progress toward important goals. (Example: days at zero pressure ulcers.) Post progress in common areas, such as halls, staff room, etc.

STEP 7: DEVELOP A STRATEGY FOR COLLECTING AND USING DATA

STEP 8: IDENTIFY YOUR GAPS AND OPPORTUNITIES

- Measure important indicators of care that are relevant and meaningful to the patients you serve.
- Guide and empower staff to solve problems. For example, leaders should respond to problems that are raised not by proposing a solution, but instead by asking the team to investigate and determine what they believe would work best.
- Hold short stand-up meetings with managers and staff for each shift to identify concerns, resources, needs, etc.
- Establish a learning organization in which all staff identifies areas for improvement.
- Discuss processes and systems to identify areas for improvement regularly — in meetings and everyday interactions.
- Empower patients to get involved in identifying areas of improvement.

STEP 9: PRIORITIZE QUALITY OPPORTUNITIES AND CHARTER PIPs

- Get everyone involved in setting goals: patients, staff, family members and board members.
- If practices are not making sense or are frustrating to staff, patients or family, do not settle for "this is just the way it has to be." Challenge and sort out what you have control over and look for ways to address improvements.

STEP 10: PLAN, CONDUCT AND DOCUMENT PIPs

- Identify and support a change agent for each improvement project (i.e., a cheerleader and/or key facilitator of change in your organization).
- Use an action plan template that defines who and when, to establish timelines and accountability.
- Seek creative ideas from multiple sources within and outside the organization to foster innovation.
- Create a safe environment to test changes to try new ways to meet patient needs.
- Include "all voices" that have a stake in what is being discussed. Use methods that encourage open and honest communication, especially to find out concerns.

STEP 11: GET TO THE "ROOT" OF THE PROBLEM

- Use the root cause analysis process to look at systems rather than individuals when something breaks down.

STEP 12: TAKE SYSTEMIC ACTION

- Before initiating a change in the organization, meet with staff and patients who will be impacted by the change to gain their support, buy-in and feedback.

Appendix A: QAPI Tools

Disclaimer: Use of these tools is not mandated by CMS for regulatory compliance nor does their completion ensure regulatory compliance.

QAPI Self-Assessment Tool

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	Not started	Just starting	On our way	Almost there	Doing great
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. Notes:					
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. Notes:					
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 revised 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. Notes:					
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. Notes:					

Rate how closely each statement fits your organization	Not started	Just starting	On our way	Almost there	Doing great
QAPI is considered a priority in our organization. For example, there is a process for covering caregivers who are asked to spend time on improvement teams. Notes:					
QAPI is an integral component of new caregiver orientation and training. For example, new caregivers understand and can describe their role in identifying opportunities for improvement. Another example is that new caregivers expect that they will be active participants on improvement teams. Notes:					
Training is available to all caregivers on performance improvement strategies and tools. Notes:					
When conducting performance improvement projects, we make a small change and measure the effect of that change before implementing more broadly. An example of a small change is pilot testing and measuring with one nurse, one resident, on one day, or one unit, and then expanding the testing based on the results. Notes:					
When addressing performance improvement opportunities, our organization focuses on making changes to systems and processes rather than focusing on addressing individual behaviors. For example, we avoid assuming that education or training of an individual is the problem, instead, we focus on what was going on at the time that allowed a problem to occur and look for opportunities to change the process in order to minimize the chance of the problem recurring. Notes:					
Our organization has established a culture in which caregivers are held accountable for their performance, but not punished for errors and do not fear retaliation for reporting quality concerns. For example, we have a process in place to distinguish between unintentional errors and intentional reckless behavior and only the latter is addressed through disciplinary actions. Notes:					

Rate how closely each statement fits your organization	Not started	Just starting	On our way	Almost there	Doing great
Leadership can clearly describe, to someone unfamiliar with the organization, our approach to QAPI and give accurate and up-to-date examples of how the facility is using QAPI to improve quality and safety of resident care. For example, the administrator can clearly describe the current performance improvement initiatives, or projects, and how the work is guided by caregivers involved in the topic as well as input from residents and families. Notes:					
Our organization has identified all of our sources of data and information relevant to our organization to use for QAPI. This includes data that reflects measures of clinical care; input from caregivers, residents, families, and stakeholders, and other data that reflects the services provided by our organization. For example, we have listed all available measures, indicators or sources of data and carefully selected those that are relevant to our organization that we will use for decision making. Likewise, we have excluded measures that are not currently relevant and that we are not actively using in our decision making process. Notes:					
For the relevant sources of data we identify, our organization sets targets or goals for desired performance, as well as thresholds for minimum performance. For example, our goal for resident ratings for recommending our facility to family and friends is 100% and our threshold is 85% (meaning we will revise the strategy we are using to reach our goal if we fall below this level). Notes:					
We have a system to effectively collect, analyze, and display our data to identify opportunities for our organization to make improvements. This includes comparing the results of the data to benchmarks or to our internal performance targets or goals. For example, performance improvement projects or initiatives are selected based on facility performance as compared to national benchmarks, identified best practice, or applicable clinical guidelines. Notes:					
Our organization has, or supports the development of, employees who have skill in analyzing and interpreting data to assess our performance and support our improvement initiatives. For example, our organization provides opportunities for training and education on data collection and measurement methodology to caregivers involved in QAPI. Notes:					

Rate how closely each statement fits your organization	Not started	Just starting	On our way	Almost there	Doing great
From our identified opportunities for improvement, we have a systematic and objective way to prioritize the opportunities in order to determine what we will work on. This process takes into consideration input from multiple disciplines, residents and families. This process identifies problems that pose a high risk to residents or caregivers, is frequent in nature, or otherwise impact the safety and quality of life of the residents. Notes:					
When a performance improvement opportunity is identified as a priority, we have a process in place to charter a project. This charter describes the scope and objectives of the project so the team working on it has a clear understanding of what they are being asked to accomplish. Notes:					
For our Performance Improvement Projects, we have a process in place for documenting what we have done, including highlights, progress, and lessons learned. For example, we have project documentation templates that are consistently used and filed electronically in a standardized fashion for future reference. Notes:					
For every Performance Improvement Project, we use measurement to determine if changes to systems and process have been effective. We utilize both process measures and outcome measures to assess impact on resident care and quality of life. For example, if making a change, we measure whether the change has actually occurred and also whether it has had the desired impact on the residents. Notes:					
Our organization uses a structured process for identifying underlying causes of problems, such as Root Cause Analysis. Notes:					

Rate how closely each statement fits your organization	Not started	Just starting	On our way	Almost there	Doing great
When using Root Cause Analysis to investigate an event or problem, our organization identifies system and process breakdowns and avoids focus on individual performance. For example, if an error occurs, we focus on the process and look for what allowed the error to occur in order to prevent the same situation from happening with another caregiver and another resident. Notes:					
When systems and process breakdowns have been identified, we consistently link corrective actions with the system and process breakdown, rather than having our default action focus on training education, or asking caregivers to be more careful, or remember a step. We look for ways to assure that change can be sustained. For example, if a policy or procedure was not followed due to distraction or lack of caregivers, the corrective action focuses on eliminating distraction or making changes to staffing levels. Notes:					
When corrective actions have been identified, our organization puts both process and outcome measures in place in order to determine if the change is happening as expected and that the change has resulted in the desired impact to resident care. For example, when making a change to care practices around fall prevention there is a measure looking at whether the change is being carried out and a measure looking at the impact on fall rate. Notes:					
When an intervention has been put in place and determined to be successful, our organization measures whether the change has been sustained. For example, if a change is made to the process of medication administration, there is a plan to measure both whether the change is in place, and having the desired impact (this is commonly done at 6 or 12 months). Notes:					

Guide for Developing Purpose, Guiding Principles, and Scope for QAPI

Directions: Use this tool to establish the purpose, guiding principles and scope for QAPI in your organization. The team completing this worksheet should include senior leadership. Taking time to articulate the purpose, develop guiding principles, and define the scope will help you to understand how QAPI will be used and integrated into your organization. This information will also help your organization to develop a written QAPI plan. Use these step-by-step instructions to create a separate document that may be used as a preamble to your QAPI plan.

STEP 1. LOCATE OR DEVELOP YOUR ORGANIZATION'S VISION STATEMENT

A **vision statement** is sometimes called a picture of your organization in the future; it is your inspiration and the framework for your strategic planning. Consider involving staff in the development of your vision statement. Post it for everyone to view.

For example, the vision of the Good Samaritan Society is to create an environment where people are loved, valued and at peace.

STEP 2. LOCATE OR DEVELOP YOUR ORGANIZATION'S MISSION STATEMENT

A **mission statement** describes the purpose of your organization. The mission statement should guide the actions of the organization, spell out its overall goal, provide a path, and guide decision-making. It provides the framework or context within which the company's strategies are formulated. As above, get caregivers involved in establishing your organizations mission.

For example, Meadowlark Hills is each resident's home. We are committed to enhancing quality of life by nurturing individuality and independence. We are growing a value-driven community while leading the way in honoring inherent senior rights and building strong and meaningful relationships with all whose lives we touch.

STEP 3. DEVELOP A PURPOSE STATEMENT FOR QAPI

A **purpose statement** describes how QAPI will support the overall vision and mission of the organization. If your organization does not have a vision or mission statement, the purpose statement can still be written and would state what your organization intends to accomplish through QAPI.

For example, the purpose of QAPI in our organization is to take a proactive approach to continually improving the way we care for and engage with our residents, caregivers and other partners so that we may realize our vision to [reference aspects of vision statement here]. To do this, all employees will participate in ongoing QAPI efforts which support our mission by [reference aspects of mission statement here].

STEP 4. ESTABLISH GUIDING PRINCIPLES

Guiding Principles describe the organization's beliefs and philosophy pertaining to quality assurance and performance improvement. The principles should guide what the organization does, why it does it and how.

For example:

- Guiding Principle #1: QAPI has a prominent role in our management and Board functions, on par with monitoring reimbursement and maximizing revenue.
- Guiding Principle #2: Our organization uses quality assurance and performance improvement to make decisions and guide our day-to-day operations.
- Guiding Principle #3: The outcome of QAPI in our organization is the quality of care and the quality of life of our residents.
- Guiding Principle #4: In our organization, QAPI includes all employees, all departments and all services provided.
- Guiding Principle #5: QAPI focuses on systems and processes, rather than individuals. The emphasis is on identifying system gaps rather than on blaming individuals.
- Guiding Principle #6: Our organization makes decisions based on data, which includes the input and experience of caregivers, residents, health care practitioners, families, and other stakeholders.
- Guiding Principle #7: Our organization sets goals for performance and measures progress toward those goals.
- Guiding Principle #8: Our organization supports performance improvement by encouraging our employees to support each other as well as be accountable for their own professional performance and practice.
- Guiding Principle #9: Our organization has a culture that encourages, rather than punishes, employees who identify errors or system breakdowns.

Add any additional Guiding Principles that may be important to your nursing home. Review the five QAPI elements to ensure you identify and capture guiding principles for your organization.

STEP 5. DEFINE THE SCOPE OF QAPI IN YOUR ORGANIZATION

The **Scope** outlines what types of care and services are provided by the organization that impact clinical care, quality of life, resident choice, and care transitions. Be sure to incorporate the care and services delivered by all departments.

For example:

Post-acute care
Dementia care and services
Dietary
Dining

Once the list of care and service area has been identified, you can determine how each will use QAPI to assess, monitor and improve performance on an ongoing basis.

STEP 6. ASSEMBLE DOCUMENT

Once you've completed steps 1-5, assemble the vision and mission statements, guiding principles, and scope of QAPI into a separate document that may be used as a preamble to your QAPI plan. This document will help you articulate the goals and objectives of your organization; QAPI will help you get there. Consider posting for all to see.

The next step is to develop a written QAPI plan that will meet your purpose, guiding principles and comprehensive scope described above. See *"Guide for Developing a QAPI Plan."*

Guide for Developing a QAPI Plan

DIRECTIONS:

The QAPI plan will guide your organization's performance improvement efforts. Prior to developing your plan, complete the *Guide to Develop Purpose, Guiding Principles, and Scope for QAPI.* Your QAPI plan is intended to assist you in achieving what you have identified as the purpose, guiding principles and scope for QAPI, therefore this information is needed before you begin working on your plan. This is a living document that you will continue to refine and revisit. Use these step-by-step instructions to create your QAPI plan. This plan should reflect input from caregivers representing all roles and disciplines within your organization.

I. QAPI Goals

Based on the *Guide to Develop Purpose, Guiding Principles, and Scope for QAPI*, indicate the QAPI goals that your plan will strive to meet. Goals should be specific, measurable, actionable, relevant, and have a time line for completion. (See *Goal Setting Worksheet*).

II. Scope

a. Describe how QAPI is integrated into all care and service areas of your organization.

b. Describe how the QAPI plan will address:

   i. Clinical care

   ii. Quality of life

   iii. Resident choice (i.e., individualized goals for care)

c. Describe how QAPI will aim for safety and high quality with all clinical interventions while emphasizing autonomy and choice in daily life for residents (or resident's agents).

d. Describe how QAPI will utilize the best available evidence (e.g., data, national benchmarks, published best practices, clinical guidelines) to define and measure goals.

III. Guidelines for Governance and Leadership

a. Describe how QAPI is integrated into the responsibilities and accountabilities of top-level management and the Board of Directors (if applicable).

b. Describe how QAPI will be adequately resourced.

   i. Designate one or more persons to be accountable for QAPI leadership and for coordination.

   ii. Indicate the plan for developing leadership and facility-wide training on QAPI.

   iii. Describe the plan to provide caregivers time, equipment, and technical training as needed for QAPI.

   iv. Indicate how you will determine if resources are adequate for QAPI.

   v. Describe how your caregivers will become and remain proficient with process improvement tools and techniques. How will you assess their level of proficiency?

c. QAPI Leadership

i. While everyone in the organization is involved in QAPI, you will likely have a small group of individuals who will provide the backbone or structure for QAPI in your organization. Who will be part of this group? Many of these individuals may be on your current QAA committee.

ii. Describe how this group of people will work together, communicate, and coordinate QAPI activities. This could include but is not limited to:

- Establishing a format and frequency for meetings
- Establishing a method for communication between meetings
- Establishing a designated way to document and track plans and discussions addressing QAPI.

iii. Describe how the QAPI activities will be reported to the governing body; i.e., Board of Directors, owner.

IV. Feedback, Data Systems, and Monitoring

a. Describe the overall system that will be put in place to monitor care and services, drawing data from multiple sources.

b. Identify the sources of data that you will monitor through QAPI

i. Input from caregivers, residents, families, and others

ii. Adverse events

iii. Performance indicators

iv. Survey findings

v. Complaints

c. Describe the process for collecting the above information.

d. Describe the process for analyzing the above information, including how findings will be reviewed against benchmarks and/or targets established by the facility.

e. Describe the process to communicate the above information. What types of reports will be used? One way to accomplish this is to use a dashboard or dashboards for individual performance improvement projects.

f. Identify who will receive this information (i.e., executive leadership, QAPI leadership, resident/family council, and a center's caregivers), in what format, and how frequently information will be disseminated.

V. Guidelines for Performance Improvement Projects (PIPs)

a. Describe the overall plan for conducting PIPs to improve care or services.

i. Indicate how potential topics for PIPs will be identified.

ii. Describe criteria for prioritizing and selecting PIPs: areas important and meaningful for the specific type and scope of services unique to the facility, requires a concentrated effort on a particular problem in one area of the facility or facility wide.

iii. Indicate how and when PIP charters will be developed.

iv. Describe the process for reporting the results of PIPs. Identify who will receive this information (i.e., quality committee, resident/family council, and a center's caregivers), in what format, and how frequently information will be disseminated.

b. Describe how to designate PIP teams and establish and describe a process for assembling teams to work on specific PIPs.

c. Define the required characteristics for any PIP team. This may include that the team be interdisciplinary (i.e., representing each of the job roles affected by the project), that it include resident representation (as appropriate), and that a qualified team leader is selected (i.e., ability to coordinate, organize and direct all activities of the project team). Describe how PIP teams should document and report their work.

d. Describe your process for documenting PIPs, including highlights, progress, and lessons learned. For example, what project documentation templates will you use consistently and file electronically in a standardized fashion for future reference.

VI. Systematic Analysis and Systemic Action

a. Any change that is made has the potential to have broader impact than intended. If you are trying to make a change to a specific system or process, it is important to recognize any "unintended" consequences of your actions. Describe how your organization will identify these consequences which may be either positive or negative.

b. Describe the process you will use to ensure you are getting at the underlying causes of issues, rather than applying quick fixes that address symptoms only.

c. Describe how you will monitor to ensure that interventions or actions are implemented and effective in making and sustaining improvements.

VII. Communications

Outline the audiences for QAPI communications and the frequency and format of these communications.

VIII. Evaluation

a. Describe the process for assessing QAPI in your organization on an ongoing basis. (See *QAPI Self-Assessment Tool*.)

b. Describe the purpose of this evaluation – to help your organization to expand your skills in QAPI and increase the impact of QAPI in your organization.

IX. Establishment of Plan

a. Date your plan.

b. Determine when you will revisit the plan (i.e., at least annually).

c. Determine how you will track revisions or updates to the plan.

Goal Setting Worksheet

Directions: Goal setting is important for any measurement related to performance improvement. This worksheet is intended to help QAPI teams establish appropriate goals for individual measures and also for performance improvement projects. Goals should be clearly stated and describe what the organization or team intends to accomplish. Use this worksheet to establish a goal by following the SMART formula outlined below. Note that setting a goal does **not** involve describing what steps will be taken to achieve the goal.

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?

Write a goal statement, based on the SMART elements above. The goal should be descriptive, yet concise enough that it can be easily communicated and remembered.

[*Example:* Increase the number of long-term residents with a vaccination against both influenza and pneumococcal disease documented in their medical record from 61 percent to 90 percent by December 31, 2011.]

Tip: It's a good idea to post the written goal somewhere visible and regularly communicate the goal during meetings in order to stay focused and remind caregivers that everyone is working toward the same aim.

Appendix B: QAPI Definitions

Performance Improvement (PI)

PI (also called Quality Improvement - QI) is a pro-active and continuous study of processes with the intent to prevent or decrease the likelihood of problems by identifying areas of opportunity and testing new approaches to fix underlying causes of persistent/systemic problems. PI in nursing homes aims to improve processes involved in health care delivery and resident quality of life. PI can make good quality even better.

Performance Improvement Project (PIP)

A PIP project typically is a concentrated effort on a particular problem in one area of the facility or facility wide; it involves gathering information systematically to clarify issues or problems, and intervening for improvements. PIPs are selected in areas important and meaningful for the specific type and scope of services unique to each facility.

Quality Assurance and Performance Improvement (QAPI)

QAPI is a data-driven, proactive approach to improving the quality of life, care, and services in nursing homes. The activities of QAPI involve members at all levels of the organization to: identify opportunities for improvement; address gaps in systems or processes; develop and implement an improvement or corrective plan; and continuously monitor effectiveness of interventions.

Quality Assurance (QA)

QA is a process of meeting quality standards and assuring that care reaches an acceptable level. Nursing homes typically set QA thresholds to comply with regulations. They may also create standards that go beyond regulations. QA is a reactive, retrospective effort to examine why a facility failed to meet certain standards. QA activities do improve quality, but efforts frequently end once the standard is met.

Root Cause Analysis (RCA)

Root cause analysis is a term to describe a systematic process to get to the underlying cause of a problem.

Systems Thinking

Systems thinking is a perspective that considers how things influence one another as a whole, rather than individual elements, or static "snapshots."

The Joint Commission

Crosswalk to Performance Improvement

CMS Quality Assurance Performance Improvement (QAPI) Elements	The Joint Commission Standards & Elements of Performance
Element I: Design and Scope A QAPI program must be ongoing and comprehensive, dealing with the full range of services offered by the facility, including the full range of departments. When fully implemented, the program should address all systems of care and management practices and should always include clinical care, quality of life, and resident choice. It aims for safety and high quality with all clinical interventions while emphasizing autonomy and choice in daily life for residents (or residents' agents). It utilizes the best available evidence to define and measure goals.	Leadership (LD) LD.01.03.01 Governance is ultimately accountable for the safety and quality of care, treatment, and services. EP 2: Governance provides for organization management and planning. EP 3: Governance approves the organization's written scope of services. EP 5: Governance provides for the resources needed to maintain safe, quality care, treatment, and services. EP 6: Governance works with other leaders to annually evaluate the organization's performance in relation to its mission, vision, and goals. LD.03.03.01 Leaders use organization-wide planning to establish structures and processes that focus on safety and quality. EP 3: Planning is systematic, and it involves designated individuals and information sources.
Element 2: Governance and Leadership The governing body and executive leadership of the nursing home develops and leads a QAPI program, working with input from facility staff, as well as from residents and their families and/or representatives. The governing body assures the QAPI program is adequately resourced to conduct its work. They are responsible for: establishing policies to sustain the QAPI program despite changes in personnel and turnover; setting priorities for the QAPI program and building on the principles identified in the design and scope; setting expectations around safety, quality, rights, choice, and respect by balancing a culture of safety and a culture of resident-	Leadership (LD) LD.01.03.01 Governance is ultimately accountable for the safety and quality of care, treatment, and services. EP 2: Governance provides for organization management and planning. EP 3: Governance approves the organization's written scope of services. EP 5: Governance provides for the resources needed to maintain

CMS Quality Assurance Performance Improvement (QAPI) Elements	The Joint Commission Standards & Elements of Performance
centered rights and choice; and for ensuring that while staff are held accountable, there exists an atmosphere in which staff are encouraged to identify and report quality problems as well as opportunities for improvement.	safe, quality care, treatment, and services. EP 6: Governance works with other leaders to annually evaluate the organization's performance in relation to its mission, vision, and goals. LD.03.05.01 Leaders implement changes in existing processes to improve the performance of the organization. EP 1: Structures for managing change and performance improvements exist that foster the safety of patients and residents and the quality of care, treatment, and services. EP 3: The organization has a systematic approach to change and performance improvement. EP 7: Leaders evaluate the effectiveness of processes for the management of change and performance improvement. LD.04.04.01 Leaders establish priorities for performance improvement. EP 1: Leaders set priorities for performance improvement activities and patient and resident health outcomes. EP 3: Leaders reprioritize performance improvement activities in response to changes in the internal or external environment. EP 4: Performance improvement occurs organization-wide.
Element 3: Feedback, Data Systems, and Monitoring The facility puts in place systems to monitor care and services, drawing data from multiple sources. Feedback systems actively incorporate input from staff, residents, families, and others as appropriate. This element includes using Performance Indicators to monitor a wide range of care processes and outcomes, and	Leadership (LD) LD.03.02.01 The organization uses data and information to guide decisions and to understand variation in the performance of processes supporting safety and quality. EP1: Leaders set expectations for using data and information to

CMS Quality Assurance Performance Improvement (QAPI) Elements	The Joint Commission Standards & Elements of Performance
reviewing findings against benchmarks and/or targets the facility has established for performance. It also includes tracking, investigating, and monitoring Adverse Events that must be investigated every time they occur, and action plans implemented to prevent recurrences.	improve the safety and quality of care, treatment, and services. EP5: The organization uses data and information in decision making that supports the safety and quality of care, treatment, and services. EP6: The organization uses data and information to identify and respond to internal and external changes in the environment. EP 7: Leaders evaluate how effectively data and information are used throughout the organization. Performance Improvement (PI) PI.01.01.01 The organization collects data to monitor its performance. EP 1: The leaders set priorities for data collection. EP2: The organization identifies the frequency for data collection. The organization collects data on the following: EP3: Performance improvement priorities identified by leaders EP9: The use of restraints EP 12: Behavior management and treatment EP 13: Quality control activities EP 14: Significant medication errors EP 15: Significant adverse drug reactions EP 16: Patient and resident (and, as needed, the family) perception of the safety and quality of care, treatment, and services. EP 30: The organization considers collecting data on the following:

CMS Quality Assurance Performance Improvement (QAPI) Elements	The Joint Commission Standards & Elements of Performance
	Staff opinion and needs, staff perceptions of risk to individuals, staff suggestions for improving patient and resident safety, staff willingness to report adverse events.
Element 4: Performance Improvement Projects (PIPs) The facility conducts PIPs to examine and improve care or services in areas that are identified as needing attention. A PIP project typically is a concentrated effort on a particular problem in one area of the facility or facility wide; it involves gathering information systematically to clarify issues or problems, and intervening for improvements. PIPs are selected in areas important and meaningful for the specific type and scope of services unique to each facility.	Performance Improvement (PI) PI.03.01.01 The organization improves performance. EP 2: The organization takes action on improvement priorities. EP 3: The organization evaluates whether action(s) taken resulted in improvement. EP 4: The organization takes action when it does not achieve or sustain planned improvements.
Element 5: Systematic Analysis and Systemic Action The facility uses a systematic approach to determine when in-depth analysis is needed to fully understand the problem, its causes, and implications of a change. The facility uses a thorough and highly organized/ structured approach to determine whether and how identified problems may be caused or exacerbated by the way care and services are organized or delivered. Additionally, facilities will be expected to develop policies and procedures and demonstrate proficiency in the use of Root-Cause Analysis. Systemic Actions look comprehensively across all involved systems to prevent future events and promote sustained improvement. This element includes a focus on continual learning and continuous improvement.	Performance Improvement (PI) PI.01.01.01 The organization collects data to monitor its performance. EP 1: The leaders set priorities for data collection. PI.02.01.01 The organization compiles and analyzes data. EP 3: The organization uses statistical tools and techniques to analyze and display data. EP 4: The organization analyzes and compares internal data over time to identify levels of performance, patterns, trends, and variations. EP 5: The organization compares data with external sources, when available. EP 8: The organization uses the results of data analysis to identify

CMS Quality Assurance Performance Improvement (QAPI) Elements	The Joint Commission Standards & Elements of Performance
	improvement opportunities. EP 12: When the organization identifies undesirable patterns, trends, or variations in its performance related to the safety or quality of care (for example, as identified in the analysis of data or a single undesirable event), it includes the adequacy of staffing, including nurse staffing, in its analysis of possible causes. EP 13: When analysis reveals a problem with the adequacy of staffing, the leaders responsible for the organization-wide patient or resident safety program (as addressed at LD.04.04.05, EP 1) are informed, in a manner determined by the safety program, of the results of this analysis and actions taken to resolve the identified problem(s). EP 14: At least once a year, the leaders responsible for the organization-wide patient or resident safety program review a written report on the results of any analyses related to the adequacy of staffing and any actions taken to resolve identified problems. PI.03.01.01 The organization improves performance. EP 2: The organization takes action on improvement priorities. EP 3: The organization evaluates whether action(s) taken resulted in improvement. EP 4: The organization takes action when it does not achieve or sustain planned improvements. LD.04.04.05 The organization has an organization-wide, integrated patient and resident safety program. EP 7: The leaders define “sentinel event” and communicate this definition throughout the organization.

CMS Quality Assurance Performance Improvement (QAPI) Elements	The Joint Commission Standards & Elements of Performance
	EP 8: The organization conducts thorough and credible root cause analyses in response to sentinel events. EP 10: At least every 18 months, the organization selects one high-risk process and conducts a proactive risk assessment.
Source: CMS, "QAPI at a Glance, 2013"	*Source: The Joint Commission Comprehensive Accreditation Manual for Nursing Care Centers, January 2014*

Centers for Medicare & Medicaid Services

Hospital Quality Assessment Performance Improvement (QAPI) Worksheet

State Agency Name _____

Instructions: The following is a list of items, broken down into separate Parts, which must be assessed during the on-site survey in order to determine compliance with the QAPI Condition of Participation. Items are to be assessed primarily by review of the hospital's QAPI program documentation and interviews with hospital staff. Direct observation of hospital practices plays a lesser role in QAPI compliance assessment, but may still be appropriate. The separate Parts can be assessed in any order. Within each Part there may also be flexibility to change the order in which the various items are assessed.

The interviews should be performed with the most appropriate staff person(s) for the items of interest (*e.g.*, unit/department staff should be asked how they participate in the hospital-wide QAPI program).

PART 1 – HOSPITAL CHARACTERISTICS

1.1 Hospital Name

_____

1.2 Address, State and Zip Code

_____
Address

_____ _____ _____
City State Zip

1.3 CMS Certification Number (CCN)

1.4 Date of survey site visit:

_____ / _____ / _____ to _____ / _____ / _____
m m d d y y y y m m d d y y y y

1.5 Total number of State Agency surveyors who participated on the combined PSI survey: ☐☐

1.6 Approximate time spent on site performing the combined PSI surveys (total number of hours): ☐☐

1.7 Does the hospital participate in Medicare via accredited "deemed" status?

- ◯ YES
- ◯ NO

1.8a If YES, which AO(s)? (Check all that apply)

- ◯ American Osteopathic Association (AOA)/Healthcare Facilities Accreditation Program (HFAP)
- ◯ Center for Improvement in Healthcare Quality (CIHQ)
- ◯ Det Norske Veritas Healthcare (DNV)
- ◯ The Joint Commission (TJC)

1.8b If YES, according to the hospital, what was the end date of the most recent accreditation survey?

		/			/				
m	m		d	d		y	y	y	y

PART 2: DATA COLLECTION AND ANALYSIS - QUALITY INDICATOR TRACERS			
Instructions for Part #2 Questions: **Select 3 distinct quality indicators (not patient safety analyses) and trace them answering the following multipart question. Focus on indicators with related QAPI activities or projects. At least one of the indicators must have been in place long enough for most questions to be applicable.**			
Elements to be Assessed	**Indicator #1**	**Indicator #2**	**Indicator #3**
Write in indicator selected:			
2.1.a Can the hospital provide evidence that each quality indicator selected is related to improved health outcomes? (e.g., based on QIO, guidelines from a nationally recognized organization, hospital specific evidence, peer-reviewed research, etc.)	○ YES ○ NO	○ YES ○ NO	○ YES ○ NO
2.1.b Is the scope of data collection appropriate to the indicator, e.g., an indicator related to labor and delivery might be appropriate to all areas of that unit and the ED, but indicators related to hand hygiene would require data from multiple parts of the hospital.	○ YES ○ NO	○ YES ○ NO	○ YES ○ NO
2.1.c Is the method (e.g., chart reviews, monthly observations, etc.) and frequency of data collection specified?	○ YES ○ NO	○ YES ○ NO	○ YES ○ NO

Elements to be Assessed	Indicator #1	Indicator #2	Indicator #3
2.1.d Is there evidence that the data are actually collected in the manner and frequency specified for this indicator? For example, is there evidence of late, incomplete, or wrong data collection?	○ YES ○ NO	○ YES ○ NO	○ YES ○ NO
2.1.e If unit staff play a role in data collection, is collection consistent with the specifications for how the data are to be collected?	○ YES ○ NO ○ N/A	○ YES ○ NO ○ N/A	○ YES ○ NO ○ N/A
2.1.f Are data that have been collected aggregated in accordance with the hospital methodology specified for this indicator?	○ YES ○ NO	○ YES ○ NO	○ YES ○ NO
2.1.g Are the collected data analyzed?	○ YES ○ NO	○ YES ○ NO	○ YES ○ NO
2.1.h If the indicator is the type that measures a rate, are rates calculated for points in time and over time, and are comparisons made to performance benchmarks when available (e.g. established by nationally recognized organizations)?	○ YES ○ NO ○ N/A	○ YES ○ NO ○ N/A	○ YES ○ NO ○ N/A

Elements to be Assessed	Indicator #1	Indicator #2	Indicator #3
2.1.i When feasible, are aggregated data broken down into subsets that allow comparison of performance among hospital units covered by the indicator? For example, a hand hygiene indicator should allow comparison among different inpatient units.	◯ YES ◯ NO ◯ N/A	◯ YES ◯ NO ◯ N/A	◯ YES ◯ NO ◯ N/A
If no to any of 2.1.a through 2.1.i, cite at 42 CFR 482.21(a)(1),(a)(2), (b)(1), & (b)(3) (Tag A-273)			
2.1.j If the data analysis identified areas needing improvement, is there evidence that the hospital instituted interventions (activities and/or projects) to address them? • Check N/A if analysis did not lead to interventions, but the hospital could demonstrate that other areas were of higher priority. • Check NO if analysis did not lead to interventions and the hospital could not demonstrate that other improvement activities were of higher priority.	◯ YES ◯ NO ◯ N/A	◯ YES ◯ NO ◯ N/A	◯ YES ◯ NO ◯ N/A

Elements to be Assessed	Indicator #1	Indicator #2	Indicator #3
2.1.k Are interventions evaluated for success?	○ YES ○ NO ○ N/A	○ YES ○ NO ○ N/A	○ YES ○ NO ○ N/A
2.1.l If interventions taken were not successful, were new interventions developed?	○ YES ○ NO ○ N/A	○ YES ○ NO ○ N/A	○ YES ○ NO ○ N/A
2.1.m If interventions were successful, did evaluation continue longer to assess if success was sustained?	○ YES ○ NO ○ N/A	○ YES ○ NO ○ N/A	○ YES ○ NO ○ N/A

If no to any of 2.1.j through 2.1.m, cite at 42 CFR 482.21(b)(2)(ii), (c)(1), & (c)(3) (Tag A-283)

PART 3 – APPLYING QUALITY INDICATOR INFORMATION - ACTIVITIES AND PROJECTS		
Elements to be Assessed		**Space for Surveyor Notes (if needed)**
3.1 Can the hospital provide evidence that its improvement activities focus on areas that are high risk (severity), high volume (incidence or prevalence), or problem-prone?	○ YES ○ NO	
If no to 3.1, cite at 42 CFR 482.21(c)(1)(i) & (ii) (Tag A-283)		
3.2 Can the hospital provide evidence that it conducts distinct performance improvement projects?	○ YES ○ NO	
3.3 Is the number of projects proportional to the scope and complexity of the hospital's services and operations? No fixed ratio is required, but smaller hospitals with a smaller number of distinct services would be expected to have fewer projects than a large hospital with many different services.	○ YES ○ NO	
3.4 Does the scope of projects reflect the scope and complexity of the hospital's services and operations? For example, if the hospital offers more complex services, such as neonatal intensive care, or open heart surgery, have there been QAPI project(s) related to any of those services?	○ YES ○ NO	
If no to any of 3.2 through 3.4, cite at 42 CFR 482.21(d)(1)(Tag A-297)		
3.5 Can the hospital provide evidence showing why each project was selected? (NOTE: If the project is a QIO cooperative project or an IT project, such as computerized physician order entry or an electronic medical record, no rationale is required. Check N/A in these cases.)	○ YES ○ NO ○ N/A	
If no to 3.5, cite at 42 CFR 482.21(d)(3) (Tag A-297)		

PART 4 – PATIENT SAFETY – ADVERSE EVENTS AND MEDICAL ERRORS		
Elements to be Assessed		**Space for Surveyor Notes (if needed)**
4.1 Evaluation regarding whether the hospital's leadership sets expectations for patient safety:		
4.1.a Is there evidence of widespread staff training or communication to convey expectations for patient safety to all staff? (e.g. training related to steps to take in a situation that feels unsafe, how to report adverse patient events, medical errors, near misses/close calls, etc. that they are expected to report internally)	○ YES ○ NO	
4.1.b Is there evidence that the hospital has adopted policies supporting a non-punitive approach to staff reporting of adverse patient events, medical errors, near misses/close calls, etc. , and situations they consider unsafe?	○ YES ○ NO	
4.1.c On each unit surveyed, can staff explain what the hospital's expectations are for their role in promoting patient safety?	○ YES ○ NO	
If no to 4.1.a, 4.1.b, or 4.1.c, cite at 42 CFR 482.21(e)(3) (Tag A-286)		
4.2.Evaluation regarding hospital processes to identify adverse patient events, medical errors, near misses/close calls, etc.:		
4.2.a On each unit/program surveyed, can staff describe the types of adverse patient events, medical errors, near misses/close calls, etc. they are expected to report internally?	○ YES ○ NO	
4.2.b On each unit/program surveyed, can staff explain how and/or to whom they are expected to report adverse patient events, medical errors, near misses/close calls, etc.?	○ YES ○ NO	

Elements to be Assessed		Space for Surveyor Notes (if needed)
4.2.c Does the hospital employ methods, in addition to staff incident reporting, to identify possible adverse patient events, medical errors, near misses/close calls, etc.? (Examples of other methods include, but are not limited to, retrospective medical record reviews, review of claims data, unplanned readmissions and patient complaints/grievances, interview or survey of patients, etc.)	○ YES ○ NO	
4.2.d Can the hospital provide evidence of adverse patient events, medical errors, near misses/close calls, etc. identified through staff reports or other methods?	○ YES ○ NO	
If no to any of 4.2.a through 4.2.d, cite at 42 CFR 482.21(a)(2) &482.21(c)(2) (Tag A-286)		
4.3 Is there QAPI program collaboration with infection control officer(s) to identify and track avoidable healthcare-acquired infections?	○ YES ○ NO	
4.4 Is there evidence that problems identified by infection control officer(s) are addressed through QAPI program activities?	○ YES ○ NO	
If no to 4.3 or 4.4, cite at 42 CFR 482.42(b)(1) (Tag A-756) and 482.21(a)(2) (Tag A-286)		

Elements to be Assessed		Space for Surveyor Notes (if needed)
4.5 Does the QAPI program identify and track medication administration errors, adverse drug reactions, and drug related incompatibilities?	○ YES ○ NO	
If no to 4.5, cite at 42 CFR 482.25(b)(6) (Tag A-508) and 42 CFR482.21(a)(2) (Tag A-286)		
4.6 Is there a QAPI program process for staff to report blood transfusion reactions, and reviews of reported blood transfusion reactions to identify medical errors (including near misses/close calls) and/or adverse events?	○ YES ○ NO	
If no to 4.6, cite at 42 CFR 482.23(c)(4) (Tag A-410) and 42 CFR 482.21(a)(2) (Tag A-286)		
4.7 Did the survey team have prior knowledge of, or identify while on-site, serious preventable adverse events that the hospital failed to identify?	○ YES ○ NO	
If yes to 4.7, cite at 42 CFR 482.21(a)(2) (Tag A-286)		
4.8 Has the hospital conducted a QAPI review, including implementing preventive actions for all serious preventable adverse events it has identified? Use as your sample all serious preventable events identified by the hospital in the period 12 months prior to the survey date? (Note: for events that occurred less than 2 months prior to the survey date, the hospital may have started, but not yet completed its review.)	○ YES ○ NO ○ N/A	
If no to 4.8, cite at 42 CFR 482.21(a)(2) (Tag A-286)		

PART 4: PATIENT SAFETY TRACERS

Instructions for Questions #4.9 and 4.10: If the answer to Question #4.9 is "yes", the Surveyor should select up to three significant adverse events or close calls/near misses the hospital reviewed for QAPI purposes during the last 12 - 24 months ("cases"). Do not let the hospital select the adverse events/close call reviews to be used for the Tracer.

The reviews may be of single events/close calls (e.g., a wrong site surgery that actually occurred or that came close to occurring on a particular patient), groups of similar kinds of events/close calls (e.g., all inpatient falls with injury during the first quarter), or a combination of both types of review.

Answer all of the questions in #4.10 for each "case" selected. (For at least one, there should be sufficient time after implementation of preventive measures for the hospital to have evaluated the impact of those measures.)

4.9 Has the hospital conducted any QAPI reviews of adverse patient events/close calls in the 12 – 24 months prior to the survey date?	◯ YES - **IF YES, CONTINUE.** ◯ NO - **IF NO, SKIP ALL 4.10 SUB-QUESTIONS.**

Elements to be Assessed	Case #1	Case #2	Case #3
4.10 Select the number of hospital conducted QAPI reviews of adverse events/close calls that were reviewed for this survey.	◯ One "case" reviewed.	◯ Two "cases" reviewed.	◯ Three "cases" reviewed.
Write in a general description of each case. Avoid using any identifiable information on this worksheet. Answer all of the questions below for each "case."	Case #1 General Description:	Case #2 General Description:	Case #3 General Description:
4.10.a Has the hospital identified potential underlying causes or contributing factors?	◯ YES ◯ NO	◯ YES ◯ NO	◯ YES ◯ NO

Elements to be Assessed	Case #1	Case #2	Case #3
4.10.b Has the hospital identified all parts of the hospital utilizing similar processes/at similar risk?	YES NO	YES NO	YES NO
4.10.c Has the hospital developed and implemented preventive actions based on its review in at least one area of the hospital?	YES NO	YES NO	YES NO
4.10.d Has the hospital evaluated the impact of the preventive actions, including tracking reoccurrences of similar events/close calls/near misses?	YES NO	YES NO	YES NO
4.10.e If evaluation showed the intervention(s) did not meet goals, did the hospital implement a revised intervention(s) and evaluate it?	YES NO N/A	YES NO N/A	YES NO N/A
4.10.f For preventive actions the hospital found to be effective, has the hospital implemented them in all parts of the hospital utilizing similar processes/at similar risk, unless there are documented reasons for not doing so?	YES NO	YES NO	YES NO
If no to any of 4.10.a through 4.10.f, cite at 42 CFR 482.21(a)(1) & (a)(2) & (c)(2) (Tag A-286)			

PART 5 – BROAD QAPI REQUIREMENTS AND LEADERSHIP RESPONSIBILITIES		
Elements to be Assessed		**Space for Surveyor Notes (if needed)**
5.1 Is there evidence that the hospital has a formal QAPI program - including written policies and procedures, budgeted resources, and clearly identified responsible staff - approved by the governing body after input from the CEO and medical staff leadership?	○ YES ○ NO	
If no to 5.1, cite at 42 CFR 482.21(e)(1) & (2) (Tag A-309)		
5.1.a Has the hospital maintained and made available for surveyor review sufficient evidence of its QAPI program to allow compliance assessment?	○ YES ○ NO	
If no to 5.1.a, cite at 42 CFR 482.21 (Tag A-263)		
5.2 Evaluation regarding whether the QAPI program is hospital-wide:		
5.2.a Using information on services offered from the Hospital/CAH Data Base Worksheet, can the QAPI manager provide evidence of QAPI monitoring related to each service?	○ YES ○ NO	
If no to 5.2.a, cite at 42 CFR 482.21 (Tag A-263 or A-308)		
5.2.b Using information from the hospital identifying services provided under arrangement (contract), can the QAPI manager provide evidence of QAPI monitoring for each service related to clinical care provided under contract or arrangement? (Exclusively administrative contractual services, e.g., payroll preparation, are not required to be included in the QAPI program.)	○ YES ○ NO ○ N/A	
If no to 5.2.b, cite at 42 CFR 482.12(e) and 482.21 (Tags A-083 and either A-263 or A-308)		

Elements to be Assessed		Space for Surveyor Notes (if needed)
5.3 Is there evidence that the governing body, hospital CEO, Medical Staff leadership, and other senior administrative officials, e.g., Director of Nursing, each play a role in QAPI program planning and implementation?	○ YES ○ NO	
If no to 5.3, cite at 42 CFR 482.21(e)(2) (Tag A-309)		
Is there evidence, e.g. in minutes, that the hospital's governing body:		
5.4.a Approves QAPI program indicators selected and frequency of data collection?	○ YES ○ NO	
If no to 5.4.a, cite at 42 CFR 482.21(b)(3) (Tag A-273)		
5.4.b Ensures the QAPI program annually determines the number of distinct QAPI projects to be conducted in the coming year?	○ YES ○ NO	
5.4.c Actively reviews the results of QAPI data collection, analyses, activities, projects and makes decisions based on such review?	○ YES ○ NO	
If no to either 5.4.b or 5.4.c, cite at 42 CFR 482.21(e)(2) & (e)(5) (Tag A-309)		
5.4.d Holds the CEO accountable for the effectiveness of the QAPI program?	○ YES ○ NO	
If no to 5.4.d, cite at 42 CFR 482.21(e)(2) and 482.12(b) (Tags A-309 & A-057)		

Elements to be Assessed		Space for Surveyor Notes (if needed)
5.5 Regarding resource allocation:		
5.5.a Is there evidence of the amount of resources (funding and personnel) dedicated to the hospital's QAPI program and the functions for which those resources are used?	○ YES ○ NO	
If no to 5.5.a, cite at 42 CFR 482.21(e)(4) (Tag A-315)		
5.5.b If there are condition-level QAPI program deficiencies, is there evidence that lack of QAPI resources are a significant contributing cause of these deficiencies?	○ YES ○ NO ○ N/A	
If yes to 5.5.b, cite at 42 CFR 482.21(e)(4) (Tag A-315)		
5.6 Did the hospital at any time during the course of this survey refuse to provide requested information, claiming it was protected Patient Safety Work Product under the Federal Patient Safety and Quality Improvement Act?	○ YES ○ NO	
For information only; no citation risk.		

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