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QAPI

From theory to practice

Federal regulators continue to finalize rules for Quality Assurance and Performance Improvement programs. But already, many providers are grappling with how best to prepare. After all, QAPI will require operators to learn different skills to generate ideas, prioritize problems, make decisions, work in teams and harness data. The pages that follow show that while these challenges are daunting, they can be met.

A SUPPLEMENT TO McKnight's LONG-TERM CARE NEWS

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QAPI

Quality Assurance and Performance Improvement is a new and evolving initiative in long-term care, but providers can and should apply time-tested QAPI principles and techniques to tackle projects now.

Long-term care professionals heard this message and learned practical ways of incorporating QAPI into their operations during a recent Medline-sponsored *McKnight's* webcast featuring Barbara Baylis, RN, MSN, accreditation program director for Providigm, a quality management solutions company.

Starting the QAPI journey

Designed as an update to current Quality Assurance and Assessment regulations, the proposed QAPI guidelines for long-term care facilities are scheduled for imminent release, according to the Centers for Medicare & Medicaid Services.

"However, providers can take action by referring to lots of information that is already out there," said Baylis. Some of this information is not specific to long-term care, but involves the foundations of QAPI, which was developed decades ago.

"QAPI principles, methods and tools have been around for generations," Baylis noted. Leaders in long-term care facilities should embark on a "journey of self-education," studying the ideas of QAPI gurus such as W. Edwards Deming and Joseph Juran, she advised.

Familiarity with the theoretical underpinnings of QAPI will lead to benefits beyond effective quality improvement projects — it could provide a strategic advantage as provider networks increasingly are established across the full care continuum.

> *"Providers can take action by referring to lots of information that is already out there."*

Because many hospital quality improvement efforts also are based on the work of the QAPI trailblazers identified by Baylis, LTC leaders conversant in their ideas likely will be able to forge stronger relationships with acute care practitioners, she explained.

A proven model

Understanding the theories behind QAPI is only a first step. Many providers have questions about how to put these theories into practice, Baylis noted.

For more information

The original webcast is available at www.mcknights.com

To make QAPI operational, she recommended that long-term care providers utilize the Model for Improvement, a blueprint that hundreds of healthcare organizations have employed during the past two decades. It is described in the book "The Improvement Guide: A Practical Approach to Enhancing Organizational Performance."

The model is sometimes referred to as "Langley, Nolan and Nolan," after the last names of the book's authors.

Leaders can use the model to "walk through an improvement process" with their teams, Baylis observed.

Picking teams

Of course, before long-term care leaders can help a team tackle quality improvement, team members must be chosen. This is the first step of the Model for Improvement.

Under current regulations, the facility administrator and those directly reporting to the administrator are responsible for identifying areas for improvement and taking corrective action. These leaders will maintain this responsibility under QAPI, according to Baylis. As the facility's QAPI committee, they will review data from sources such as quality measures and customer satisfaction reports to identify opportunities for improvement.

REWARDING EXPERIENCE
Providers familiar with QAPI requirements will likely reap multiple benefits. These include stronger partnerships with acute care providers, better quality care and greater self-awareness.

Once it identifies an opportunity, the committee should select a Performance Improvement Project team.

"The people who do the work need to make the change," Baylis noted. This is why it's important to move the quality improvement effort to the PIP team, although a QAPI committee member should still have oversight, she explained.

Because the people who actually do the work "know better" how to improve processes, they are essential members of the PIP team, Baylis emphasized.

Limiting teams to supervisors or the most educated people in a facility is, therefore, a potential pitfall. Teams should include members who are familiar with all the parts of the system under evaluation.

A team leader also should be chosen; this person could be anyone who has credibility and commands respect, including front office workers or aides.

Aim for measurable changes

The next steps of the model call for the PIP team to set the aim of their project, select changes that could potentially achieve improvement, and determine how to measure results.

To set a clear aim, teams might consider overarching improvement categories, such as safety or efficiency, Baylis said. For example, reducing resident falls would improve safety, while eliminating waste would be in the efficiency category. An aim should clearly answer the question, "What are we trying to accomplish?"

Once a team decides on an aim, it also must determine quantitative measures that will show whether changes are actually leading to improvement. To identify what changes might improve the chosen quality measures, teams could consult journal articles or have discussions with other providers.

To accomplish these steps, the PIP team must be adept at generating ideas and prioritizing the ones that have broadest support.

In nominal group technique, team members write down ideas that are presented to the group anonymously, enabling people to contribute without fear of reprisal.

This can be especially useful for PIP teams, which have members at various levels of seniority, Baylis remarked.

Once a list of ideas has been compiled, rank ordering can quickly winnow the possibilities. Using this method, group members vote for their four or five top ideas.

Other techniques help guide discussion. Asking the question "why" five successive times is a way to do root cause analysis, tracing a chain of causality to determine the fundamental reasons for suboptimal performance or results.

Plan-do-study-act

Next comes the exciting step of testing some of the most promising changes. Piloting the changes in just part of the facility, or during certain times or for particular residents, allows the PIP team to identify obstacles and make adjustments until improvement is actually occurring, according to Baylis.

Small trials also help gauge cost concerns and can help win over staff and residents resistant to change.

The plan-do-study-act cycle describes how teams should approach these tests, Baylis said.

Once a carefully planned change is being executed, team members should document processes and results, she advised. The team should study this data and act on its findings to improve subsequent tests.

Scale up and out

Once the PIP team carries out a few plan-do-study-act cycles and finds that changes are having a measurable positive impact, it's time to implement the changes more broadly. A systematic approach works best for this larger scale implementation, Baylis stated. This might mean introducing the changes first to nursing units, then to assisted living or dementia units, she said. Or it might mean starting with weekday implementation and then including other shifts.

However the changes are scaled up, the facility needs to document the new way of doing work, and staff orientation and training should be revised accordingly, Baylis said.

QAPI projects generally should take no more than 90 days, Baylis believes.

Making a difference

This model is not the only way to put QAPI theories into practice, she noted, explaining that facilities and teams will have individual needs and predilections. The most important thing is to find an approach that works.

Baylis, however, has employed the process and techniques she covered in the webcast, and vouches for their effectiveness.

"I use this stuff," she said. "It makes a difference." ■

Editor's note

This McKnight's *Webinar Plus supplement is based on a similarly named webinar* McKnight's *presented on Nov. 21. The event was sponsored by Medline. The main presenter was Barbara Baylis, MSN, RN, accreditation program director for Providigm. The full presentation is available at* www.mcknights.com.