The National Nursing Home Quality Care Collaborative and QAPI In Action Webinar

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Director, Nursing Homes,
Health Services Advisory Group (HSAG)
Objectives

- Gain an overview of the National Nursing Home Quality Care Collaborative (NHQCC)
- Receive information on how to develop a Quality Assurance & Performance Improvement (QAPI) program as aligned with the updated regulations
- Identify successful practices related to QAPI implementation, fall prevention, and reducing antipsychotics from nursing home leaders
Nearly 25 percent of the nation’s Medicare beneficiaries

HSAG is the Medicare Quality Innovation Network-Quality Improvement Organization (QIN-QIO) for Arizona, California, Florida, Ohio, and the U.S. Virgin Islands.
What is a QIN-QIO?

- Funded by the Centers for Medicare & Medicaid Services (CMS)
  - QIN-QIO in each state
  - Dedicated to improving health quality at the community level
  - Ensures people with Medicare get the care they deserve, and improves care for everyone
QIN-QIO Areas of Focus
Patient is at the center of care

Transforming Clinical Practice
Cardiac Health
Disparities in Diabetes
Disease Management Through Meaningful Use
Healthcare-Associated Infections in Hospitals
Coordination of Care
Behavioral Health
Healthcare-Acquired Conditions in Nursing Homes
Value-Based Payment (VBP) Program

*ASC=Ambulatory Surgical Center
What and Who Make up the NNHQCC?

- The NNHQCC is a nationwide CMS* initiative focused on improving quality of care in nursing homes (NHs).
- 915** NHs have joined the California NHQCC.
- 186 NHs enrolled in the CDC NHSN*** Clostridium difficile Infection (CDI) project

*CMS=Centers for Medicare & Medicaid Services  
**Nursing homes with signed participation agreements as of March 2017  
***CDC=Centers for Disease and Control and Prevention, NHSN=National Healthcare Safety Network
National NHQCC Aims

- Ensure every NH resident receives the highest quality of care and improve resident satisfaction
- Instill quality assurance & performance improvement (QAPI) practices
- Support the implementation of QAPI
  - Complete a QAPI self-assessment for Collaborative II
- Helps NHs achieve a quality measure (QM) composite score of 6 percent or lower by January 2019
- Eliminates healthcare-acquired infections (HAIs)
- Reduce antipsychotic medication use
California NHQCC Successes

53% of CA NHQCC nursing homes achieved a Quality Measure Composite Score of no more than 6.00 to date.

Antipsychotic Rate is 11.39%. 30.4% RIR* from baseline rate of 16.35%

*RIR=Relative Improvement Rate
Source: Minimum Data Set (MDS) 3.0 National Coordinating Center (NCC) Scorecard. Antipsychotic Rate baseline 1/1/13—12/31/13. Antipsychotic Rate and RIR metric calculated using the timeframe of 10/1/15—9/30/16. Composite Score metric calculated using the timeframe 4/1/15—9/30/16.
Collaborative Approach: All-Teach, All-Learn Model

Broadcast: One Speaker, Nine Listeners

Peer-to-Peer: Seven Speakers, Seven Listeners

VS.
The NHQCC Collaborative II: Learning Sessions and Action Periods

California Nursing Home Quality Care Collaborative Structure

Learning Session

Learning Session 1
April–June 2017

Learning Session 2
Sept.–Nov. 2017

Learning Session 3
April–June 2018

Action Period
occurs between learning sessions

Outcomes Congress: August–September 2018

ACT
PLAN
STUDY
DO
HSAG Assistance During Action Periods

- Conduct webinars and phone conferences.
- Communicate through e-mails.
- Present at company meetings via webinar or in-person.
- Review HSAG-developed nursing home data reports.
- Help finalize performance improvement projects and assist with developing PDSA* cycles.

*PDSA=Plan, Do, Study, Act
### Table 2: 13 Long-Stay Nursing Home Quality Measures

<table>
<thead>
<tr>
<th>Condition</th>
<th>Your Facility*</th>
<th>Reporting Period (Jul 16-Dec 16)**</th>
<th>CA</th>
<th>Glendale</th>
<th>Nation</th>
</tr>
</thead>
<tbody>
<tr>
<td>N</td>
<td>D</td>
<td>%</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>One or More Falls with Major Injury</td>
<td>2</td>
<td>88</td>
<td>1.76%</td>
<td>1.33%</td>
<td>3.33%</td>
</tr>
<tr>
<td>Self-Report Moderate to Severe Pain</td>
<td>0</td>
<td>74</td>
<td>4.33%</td>
<td>2.98%</td>
<td>7.20%</td>
</tr>
<tr>
<td>High-Risk Residents with Pressure Ulcers</td>
<td>1</td>
<td>52</td>
<td>6.27%</td>
<td>5.82%</td>
<td>6.27%</td>
</tr>
<tr>
<td>Flu Vaccine***</td>
<td>6</td>
<td>87</td>
<td>5.22%</td>
<td>4.77%</td>
<td>5.43%</td>
</tr>
<tr>
<td>Pneumococcal Vaccine***</td>
<td>0</td>
<td>88</td>
<td>4.26%</td>
<td>4.11%</td>
<td>6.66%</td>
</tr>
<tr>
<td>Urinary Tract Infection</td>
<td>3</td>
<td>86</td>
<td>2.55%</td>
<td>2.49%</td>
<td>3.66%</td>
</tr>
<tr>
<td>Lose Control of Bowel or Bladder</td>
<td>9</td>
<td>15</td>
<td>41.21%</td>
<td>38.17%</td>
<td>47.50%</td>
</tr>
<tr>
<td>Catheter Inserted and Left in Bladder</td>
<td>0</td>
<td>85</td>
<td>3.49%</td>
<td>3.82%</td>
<td>2.92%</td>
</tr>
<tr>
<td>Physical Restraints</td>
<td>21</td>
<td>88</td>
<td>0.77%</td>
<td>1.75%</td>
<td>0.46%</td>
</tr>
<tr>
<td>Need for Help with Activities of Daily Living Increased</td>
<td>5</td>
<td>76</td>
<td>11.06%</td>
<td>9.18%</td>
<td>15.49%</td>
</tr>
<tr>
<td>Weight loss</td>
<td>6</td>
<td>86</td>
<td>6.04%</td>
<td>5.44%</td>
<td>7.50%</td>
</tr>
<tr>
<td>Depression</td>
<td>0</td>
<td>85</td>
<td>0.86%</td>
<td>0.46%</td>
<td>5.36%</td>
</tr>
<tr>
<td>Antipsychotic Medications</td>
<td>18</td>
<td>74</td>
<td>10.90%</td>
<td>11.58%</td>
<td>15.34%</td>
</tr>
</tbody>
</table>

* N = Numerator, D = Denominator, % = Rate

Rates that are performing worse than their corresponding national average are color coded with red.

The direction of the two vaccination measures should be reversed since they are directionally opposite of the other measures. This is done by subtracting the numerator from the denominator to obtain a “new” numerator. By keeping all measure directions consistent, the Composite Score can be interpreted as: the lower the better. The flu vaccine measure is only calculated once a year with a target period of October 1 of the prior year to June 30 of the current year and is reported for the October 1 through March 31 influenza season.
Table 1: Quality Measure Composite Scores

<table>
<thead>
<tr>
<th>Your Facility</th>
<th>Reporting Period (Rolling 6 Months)**</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Feb 16-Jul 16</td>
</tr>
<tr>
<td>N</td>
<td>D</td>
</tr>
<tr>
<td>Glendale</td>
<td>71</td>
</tr>
<tr>
<td>CA</td>
<td>6.02%</td>
</tr>
</tbody>
</table>

* N = Numerator, D = Denominator, % = Rate

** Rates that are performing worse than their corresponding national averages are color coded with red.
ND indicates that no data were available.

Figure 1: Nursing Home, Region, State, and National Quality Measure Composite Scores

Figure 2: One or More Falls with Major Injury

Figure 3: Antipsychotic Medications
Peer Coach Support

- Help instill quality improvement methods in nursing homes
- Share success stories and best practices through
  - The NHQCC newsletter
  - Learning sessions
  - One-on-one basis with nursing homes
  - A Resident’s Perspective on Quality Improvement YouTube Video: https://goo.gl/3he7Jp

Let HSAG know if you would like to receive peer coach support.
Final Rules–Reform of Requirements for Long-Term Care Facilities (LTCFs)

QAPI Implementation Dates

Phase 1
November 28, 2016

Phase 2
November 28, 2017

Phase 3
November 28, 2019

Phase 1
Quality Assessment and Assurance (QAA) Committee

Phase 2
QAPI Plan

Phase 3
QAPI Implementation and Include Infection Prevention and Control Officer (IPCO) in QAA Committee

Effective Date
November 28, 2016

Quality Assurance & Performance Improvement (QAPI) (§ 483.75)

To develop, implement, and maintain an effective comprehensive, data-driven QAPI program that focuses on systems of care, outcomes of care, and quality of life.
Final Rules–QAPI

NH will...

• Maintain documentation and demonstrate evidence of its QAPI program.

• Submit the QAPI plan to the State Agency or federal surveyor at the first annual recertification survey 1 year after the effective date.

• Present the QAPI plan at each annual recertification survey and upon request.

• Assure program addresses all services and programs.

QAPI at a Glance

• Step-by-step guide to implementing QAPI, including the steps to write a QAPI plan
• Excellent problem-solving models (e.g., RCA) outlined in this resource

The CMS QAPI Guide: What You Need to Know
A Companion to QAPI at a Glance

This companion guide is designed to help your team recognize and understand the major components of the Quality Assurance/Performance Improvement Initiative (QAPI). Refer to it often as a support tool in your facility’s quality improvement efforts. This resource is **not intended to replace** QAPI at a Glance; it can be used in conjunction with other materials to help your team stay on track in reaching your quality improvement goals.

**Background**

In December 2012, the Centers for Medicare & Medicaid Services (CMS) issued a memo announcing the release of QAPI at a Glance, a step-by-step guide detailing 12 key action steps to establish a foundation for quality assurance and performance improvement in nursing homes. QAPI at a Glance is available online at [http://tiny.cc/QAPI](http://tiny.cc/QAPI).

<table>
<thead>
<tr>
<th>TOPIC</th>
<th>PAGE</th>
</tr>
</thead>
<tbody>
<tr>
<td>12 Action Steps to QAPI</td>
<td>2</td>
</tr>
</tbody>
</table>

https://goo.gl/Y4VazW
Five Elements of QAPI

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

Quality of Care, Quality of Life, Resident Choice
**PIP Charter Steps**

- Review and analyze data, and assess for trends.
- Use MDS 3.0 Certification And Survey Provider Enhanced Reporting (CASPER) reports.
- Set Specific, Measurable, Attainable, Relevant, Time-bound (SMART) goals.
PIP Charter Steps

1. Identify problem or opportunity
2. Select team members
3. Set SMART goals
4. Start PIP Charter
   - Add your resources and budget
5. Root cause analysis
6. Action plan
7. Spread the intervention
8. Performance Improvement Project (PIP) Completed
• What PIPs have you successfully implemented?
• What were your top three success factors?

Enter your response into the chat box on your screen.
Click on “send” to share your response.
QAPI Action Steps 1 to 6

**STEP 1:** Leadership Responsibility & Accountability

**STEP 2:** Develop a Deliberate Approach to Teamwork

**STEP 3:** Take your QAPI “Pulse” with a Self-Assessment

**STEP 4:** Identify Your Organization’s Guiding Principles

**STEP 5:** Develop Your QAPI Plan

**STEP 6:** Conduct a QAPI Awareness Campaign
QAPI Action Steps 7 to 12

**STEP 7:** Develop a Strategy for Collecting & Using QAPI Data

**STEP 8:** Identify Your Gaps and Opportunities

**STEP 9:** Prioritize Quality Opportunities and Charter Performance Improvement Projects (PIPs)

**STEP 10:** Plan, Conduct and Document PIPs

**STEP 11:** Get to the “Root” of the Problem

**STEP 12:** Take Systemic Action
What is your facility’s QAPI implementation status?

- Not Started
- Just Started
- On Our Way
- Almost There
- Doing Great

https://www.surveymonkey.com/r/QAPIsaCA2
Other QAPI Tools: QAPI SA Long Version

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

<table>
<thead>
<tr>
<th>Not started</th>
<th>Just starting</th>
<th>On our way</th>
<th>Almost there</th>
<th>Doing great</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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:

https://goo.gl/yLn2YH
• What PIP projects are you planning to implement?
  – Share two of your PIP project topics.
Develop Your QAPI Plan

- Tailor the plan to fit your NH including all units, programs, and resident groups
- Some large organizations or corporations may choose to develop a general plan for all NHs in the group (e.g., a corporate Quality Plan)
Key Components of a QAPI Plan

- Vision
- Mission
- Purpose
- Guiding Principles
  - Scope and Design
  - Governance and Leadership
  - Feedback, Data Systems, and Monitoring
  - PIPs
  - Systematic Analysis and Systemic Action
- Communications
- Evaluation
- Establish of Plan

Creating a Quality Assurance & Performance Improvement (QAPI) Plan for Your Facility

https://www.hsag.com/ca-qapi-plan
Other QAPI Tools: 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?

https://goo.gl/J1z9XA
Develop SMART Goals

- **Specific**: What, who, and where?
- **Measurable**: Count, percent, rate?
- **Attainable**: Rationale for setting the goal.
- **Relevant**: How will the goal address the problem?
- **Time-bound**: Set target date to achieve goal.

By December 2017, Green Acres, with leadership from the Antipsychotic Medication Reduction PIP Team, will decrease the long-stay antipsychotic quality-measure rate at Green Acres from the baseline rate of 25 percent (December 2016) to 10.0 percent, based on the MDS 3.0 CASPER Reports, and thereby improve the quality of care for residents with discontinued antipsychotics, especially those with dementia.
• What is your strategy for completing your QAPI plan by November 2017?
  – Share your top three strategies.
NNHQCC Change Package Components

Source: National Nursing Home Quality Care Collaborative Change Package
1. Lead with a sense of purpose.
2. Recruit and retain quality staff.
3. Connect with residents in a celebration of their lives.
4. Nourish teamwork and communication.
5. Be a continuous learning organization.
6. Provide exceptional compassionate clinical care that treats the whole person.
7. Construct solid business practices that support your purpose.
Strategy 6
Provide exceptional compassionate clinical care that treats the whole person

**Change Concepts**

Transition with care (between shifts, departments, and all care settings).

**Action Items**

6.c.2 Ensure that all changes in resident status have been communicated by having staff (for examples, nurses and nursing assistants or nursing assistants and nursing assistants) round together at the change of shift.
Best Practice Bundle: To Build Capacity for QAPI Success

Ensure healthy, safe residents. Build capacity for QAPI success.

*Quality Assurance & Performance Improvement
Source: National Nursing Home Quality Care Collaborative Change Package (https://go.usa.gov/zh3KhoR)
Best Practice Bundle: Steps to Prevent HAIs

QAPI*
Performance Improvement Projects (PIPs)

Apply the Change Bundle to Your PIP Action Plan!

Steps to Prevent Healthcare-Associated Infections

- Promote hand hygiene.
- Prevent transmission of infections by staff members, families, and residents.
- Establish and implement systemwide environmental cleaning policies.
- Identify and treat infections appropriately.
- Avoid indwelling catheter use, unless appropriately indicated.

Ensure healthy, safe residents. Prevent harmful infections.

*Quality Assurance & Performance Improvement
Source: National Nursing Home Quality Care Collaborative Change Package (https://goo.gl/2KH3qR)

Best Practice Bundle: Steps to Avoid Unnecessary Antipsychotics

Apply the Change Bundle to Your PIP Action Plan!

- Design and create a calming environment.
- Create meaningful relationships.
- Provide meaningful activities.
- Identify and treat physical and mental conditions.
- Define a consistent approach to minimize the use of antipsychotic medications.

Ensure healthy, safe residents. Minimize antipsychotic use.

*Quality Assurance & Performance Improvement
Source: National Nursing Home Quality Care Collaborative Change Package (https://goo.gl/zhK3oR)
NCC Nursing Home Training Sessions

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

Nursing continuing education certificates available.

https://www.hsag.com/NHtrainingsessions
What is TeamSTEPPS®?*

• An evidence-based framework that optimized resident care by improving communication and teamwork skills

• Includes specific tools and strategies that can help reduce the chance of error and help provide safer care

• TeamSTEPPS in Long-term Care Environment Video

https://www.youtube.com/watch?v=oGDrvvQDhDc

*Team Strategies and Tools to Enhance Performance and Patient Safety
Situation Background Assessment Recommendation (SBAR)

A framework to communicate about a situation that needs action and designed to reduce errors with miscommunication or lack of information.

- **Situation**
  - What is happening to the resident?

- **Background**
  - What is the clinical background?

- **Assessment**
  - What do I think is the problem?

- **Recommendation**
  - What would I recommend?

### SBAR

**Physician/NP Communication**

<table>
<thead>
<tr>
<th>Field</th>
<th>Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>Resident Name</td>
<td>____________________________</td>
</tr>
<tr>
<td>DOB:</td>
<td>____________________________</td>
</tr>
<tr>
<td>Unit/Room:</td>
<td>____________________________</td>
</tr>
<tr>
<td><strong>Situation:</strong></td>
<td>Reason for the call (e.g., change in condition); include date of onset, frequency, and duration:</td>
</tr>
<tr>
<td>Vital signs; note baseline value, if different: Temp: ____ BP: ____ / ____ P: ____ RR: ____</td>
<td></td>
</tr>
<tr>
<td><strong>Background:</strong></td>
<td>Primary diagnosis or reason resident is in facility: ____________________</td>
</tr>
<tr>
<td>Pertinent history (e.g., precipitating, aggravating, alleviating factors):</td>
<td>____________________</td>
</tr>
<tr>
<td>Has reason for call occurred before? Describe:</td>
<td>____________________</td>
</tr>
<tr>
<td>Recent lab or diagnostic test results:</td>
<td>____________________</td>
</tr>
<tr>
<td>Medication allergies and reactions:</td>
<td>____________________</td>
</tr>
<tr>
<td>Advance directives / POLST:</td>
<td>____________________</td>
</tr>
<tr>
<td><strong>Assessment:</strong></td>
<td>What do you think is going on (e.g., dehydration, medication problem)?</td>
</tr>
<tr>
<td></td>
<td>Or – I’m not sure what is going on.</td>
</tr>
<tr>
<td><strong>Request:</strong></td>
<td>□ Visit? Specify:</td>
</tr>
<tr>
<td></td>
<td>□ Medication change? Specify:</td>
</tr>
<tr>
<td></td>
<td>□ New order? Specify:</td>
</tr>
<tr>
<td></td>
<td>□ Just providing information.</td>
</tr>
<tr>
<td>Instructions or questions from physician/NP:</td>
<td>____________________</td>
</tr>
</tbody>
</table>
CA NHQCC II Go For the Gold Qualification Criteria

**Bronze Level**
- Sign Participation Agreement
- Submit facility team roster
- Complete QAPI self-assessment for Collaborative II
- Complete QAPI Plan
- Complete PIP Charter

**Silver Level**
- Meet bronze-level criteria
- Attend at least two learning opportunities*
- Achieve PIP goal established in the Charter

**Gold Level**
- Meet silver-level criteria
- Achieve a Quality Measure Composite Score of 6 percent or less at least once during the collaborative

*Education opportunities include HSAG in-person learning sessions, webinars, and onsite staff visits. Education may also include partner opportunities.
• Meet bronze, silver, and gold-level criteria
• Achieve ≤ 5% on antipsychotic medication rates among long-stay residents during the Collaborative*.

*The nursing home antipsychotic data will be reviewed based on the data from the NCC for Collaborative II.
Collaborative I Recognition

Platinum Level

Autumn Hills Healthcare
Country Manor Healthcare
Quality Assurance & Performance Improvement (QAPI)

QAPI Homepage
The Centers for Medicare & Medicaid Services homepage for QAPI programs, which are critical to improving the quality of life, and quality of care and services delivered in nursing homes.

View Resource

QAPI At A Glance
This Centers for Medicare & Medicaid Services step-by-step guide explains how to implement QAPI in nursing homes.

View Resource

QAPI Description and Background
This Centers for Medicare & Medicaid Services website provides a description of QAPI, as well as its development history.

View Resource

QAPI Process Tool and Guidance
This Centers for Medicare & Medicaid Services (CMS) process tool provides a crosswalk between each CMS Process Tool and the QAPI Five Elements

View Resource
Are You Receiving Monthly Email Updates?

Email us to be added!

canursinghomes@hsag.com
CMS QAPI Tools

In a collaborative effort with the University of Minnesota and Stratis Health, subject matter experts, consumer groups, and nursing home stakeholders, CMS created “process” tools that may be used to implement and apply some of the basic principles of QAPI.

A Process Tool Framework has been created to crosswalk each CMS Process Tool to the QAPI Five Elements. This framework includes a description of the purpose or goal for each tool that is hyperlinked within the framework. Click here for A Process Tool Framework.

Page last Modified: 02/20/2014 2:21 PM
Help with File Formats and Plug-Ins
QAPI: You Can Do It, Too!

Ilana Springer
CEO/Administrator
Joyce Eisenberg Keefer Medical Center
June 27, 2017
Our Facility

The Los Angeles Jewish Home

Mission: Excellence in senior care reflective of Jewish Values.

Core Values: Quality, Charity, Dignity, Jewish Values, Fiscal Responsibility

The Joyce Eisenberg-Keefer Medical Center

239 Bed Distinct Part Skilled Nursing Facility

10 Bed Acute Geriatric Psychiatric Unit

Types of Residents:

Average age is 91, complex, co-morbidities, polypharmacy, 50% dementia, and most high risk for falls
The Story: QAPI in Our Facility

Main Challenge

Falls with Major Injuries at 3.9% (National Avg. 3.2%) September 2013
Aims/Goals

**Short Term Goals**

By January 31, 2014, JEK will reduce falls with major injury from 3.9% (baseline Sept. 2013) to 2.6%.

**Long Term Goals**

By April 30, 2014, JEK will reduce falls with major injury from 3.9% (baseline Sept. 2013) to 1.6%.
Interventions and Changes Implemented

• Contacted Jocelyn Montgomery at CAHF

• Called Sue Ann Guildermann
  ▪ Paradigm shift
  ▪ Implemented 4Ps
  ▪ Implemented RCA Tools, including FSI—Fall Scene Investigation Report
  ▪ Eliminated all alarms
Interventions and Changes Implemented

• Dedicated RN Quality Director
  ▪ Trends mapping
  ▪ Education to clinical nurses on RCA and fishbone
  ▪ Participate in post fall IDT

• RCA tools used post fall
  ▪ Ten Questions, FSI Report, Fishbone, and/or 5 Why’s

• Frontline staff letter to DON on “What I could have done to prevent incident”
Measures/Results

% of residents experiencing one or more falls with major injury
# Performance Improvement Project (PIP)

<table>
<thead>
<tr>
<th>Current PIPs</th>
</tr>
</thead>
<tbody>
<tr>
<td>Fall Prevention (Ongoing): MD, Administrator, DON, DOQ, Medical Record Manager, RN Unit Supervisors, Charge Nurses, CNAs, and other departments as required</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Resolved PIPs</th>
</tr>
</thead>
<tbody>
<tr>
<td>Loss of Hearing Aids (3 months): Administrator, DON, DOQ, Director of Social Services, Housekeeping, Laundry department, RN Unit Supervisors and CNAs</td>
</tr>
<tr>
<td>Food Services: Ticket does not match meal (1 month): Administrator, DON, DOQ, Director of Food Services, Housekeeping, RN Unit Supervisors, Charge Nurses and CNAs</td>
</tr>
</tbody>
</table>

47 Total PIPS done
Outcomes and Lessons Learned

• Not recreating the wheel, learn from resources in LTC community
• Take ACTION and implement best practices
• Culture and Paradigm Change
• Accountability and responsibility for safety of our residents
• All departments involved
• No Blame Policy (Residents and Staff)
• Teamwork
• Staff Empowerment
• Be open to listen to ideas from all team members
• Brainstorming: thinking outside the box
• Shift from QA to PI
• The more you do QAPI, the easier it becomes
Plans to Sustain Improvement

QAPI is part of our everyday operations and has become a part of our culture.
Success Story Author Contact

Ilana Springer
CEO/Administrator
Joyce Eisenberg Keefer Medical Center
Ilana.Springer@jha.org
(818) 774-3069
A Better Life Without Anti-Psychotic Medication

Hugo Gozos
Mesa Verde Post - Acute Care Center
661 Center St., Costa Mesa
CA 92627
Mr. Gozos has no relevant financial relationships with commercial interests to disclose.
Area of Opportunity

Based on the MDS 3.0 Facility Level Quality Measure Report (period 07/01/15 - 12/31/15), Mesa Verde Post Acute Center scored 7.5% for anti-psychotic medication utilization for long term residents.
SMART Goal

• Reduce the anti-psychotic medication utilization rate to less than 2% by May 2016 (based on the MDS 3.0 Facility Level QM Report)
• Focus on residents with dementia
Team Members and Leadership support

- Facility Administrator
- Director of Nursing
- Medical Director
- Social Services Director
- Activity Director
- Director of Rehabilitation
- Clinical Dietary Manager
- Psychiatrist
- Psychologist
- Residents/Responsible party
- QA, Activity and Social Services Consultants
Resistance and Barriers

- Interdisciplinary team (IDT), family members and responsible parties hesitation to discontinue Rx
- Lack of awareness
- No existing system to monitor and review residents’ utilization of anti-psychotic Rx
- No committee to review behavioral symptoms
- Failure to incorporate the QA & A Committee
Interventions and Changes Implemented

- Involvement of the IDT
- IDT clinical review
- Implementation of non-pharmacological interventions based on resident preferences and past life history
- Increase resident’s participation with activities, including implementing the Music and Memory Program
- Create a home-like environment with resident memorabilia.
Music and Memory Program
Music and Memory Program
Overcoming Barriers

• IDT, family education
• Re-introduction of therapeutic activities
• Formation of a Behavior Management Committee, including a psychiatrist
• Involvement of the QA & A Committee to monitor compliance
• Continuing staff education
Anti-psychotic rate for LS residents based on MDS Facility Level Quality Report:

- 2.3% as of 3/31/16
- 0% as of 6/30/16
Plans to Sustain the Improvement

We plan to continue...

• monitoring of anti-psychotic utilization
• implementation of individualized care and activities
• family member involvement
• involvement of the QA&A to monitor system performance
• education and training on care for residents with Dementia
Anti-psychotic (LS) rate Based on MDS 3.0 Level Quality Measure Report remains at 0% from July 2016 to May 2017 (National : 15.8 %, State: 12.3 %).
### CASPER Report Period: 05/01/16-05/31/17

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Tips for Success

- Use data to identify opportunities for improvement
- Conduct root cause analysis
- Utilize existing best practices
- Involve residents, family members, staff, and IDT members. Ask for suggestions.
- Monitor existing system and compliance
- Continuously monitor the success by checking if the team’s goals were achieved
Lesson Learned

Residents with behavioral symptoms diagnosed with Dementia do not always require psychotropic medications but an in-depth understanding of the cause and nature of the behavior and be provided non-pharmacological approaches and individualized activities.
Author: Hugo Gozos, RN, BSN
Director of Nursing Services
Call to Action

• Start developing your QAPI plan.
• Complete your QAPI self-assessment.
• Apply elements of the best practices resources.
• Aim high and achieve the platinum level in the *Go For the Gold* recognition program.
NHQCC Web Resources

Discover National Resources
• Quality Assurance & Performance Improvement (QAPI)
• Quality Measure Composite Score
• Antipsychotic Medication
• Care Coordination
• Healthcare-Associated Infections
• Mobility and Physical Restraints
• And more!

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After the webinar, please take a moment to complete a short evaluation. This should take no more than 5 minutes to complete.

https://www.surveymonkey.com/r/June27QAPIwebinar

The evaluation link will be open until Tuesday, July 18, 2017. After the link closes continuing education certificates will be issued via email within two weeks of the close date.

Health Services Advisory Group is the CE provider for this event. Provider approved by the California Board of Registered Nursing through the American Nurses Credentialing Center, Provider Number 16578, for 1.0 contact hour. There is no charge for attendance of this event. Provider approved by the California Nursing Home Administrator Program #CEP 1729, for 1 continuing education credit.
Thank You!

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