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Quick-Start QAPI Guide

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Purpose of This Guide

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*; use it in conjunction with other materials to help your team stay on track in reaching your quality improvement goals.

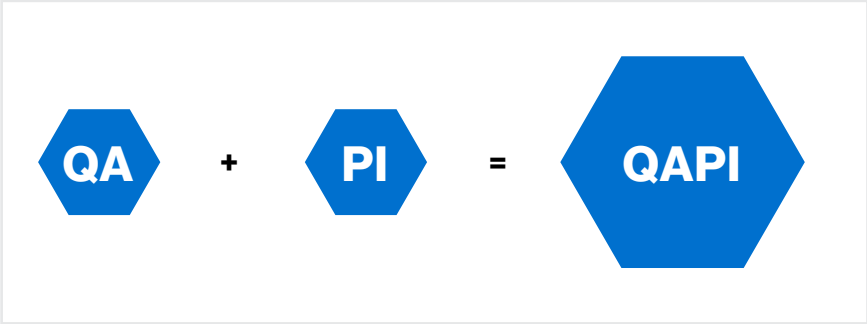
Purpose

Background

This document provides some general guidance for incorporating patients into your facility Quality Assessment and Performance Improvement (QAPI) activities. It provides a brief description of QAPI and some of the standardized quality tools and methods, as well as several checklists to help you get started.

Quality Assurance and Performance Improvement (QAPI) Overview

Under the End-Stage Renal Disease (ESRD) Conditions for Coverage every dialysis facility must develop, implement, maintain, and evaluate an effective, data-driven QAPI program with participation by the professional members of the Interdisciplinary Team (IDT). The program must reflect the complexity of the organization and services (including those under arrangement), and must focus on indicators related to improved health outcomes and the prevention and reduction of medical errors. The dialysis facility must maintain and demonstrate evidence of its QAPI program including continuous monitoring for CMS review. CMS strongly encourages patient participation in QAPI in some capacity.



What is QAPI?

Quality Assurance QA and Performance Improvement PI

Quality Assurence (QA) is ensuring compliance, and follow-up of known issues. Conducting a root cause analysis is a way to assure quality.

Performance Improvement (PI) is a focus on issues that result in poor outcomes.

- It is an ongoing evaluation of operating systems and clinical process rather than individual problems.
- It is data driven.
- It is an ongoing program that achieves measurable improvements in healthcare.

12 Steps to QAPI

According to *QAPI at a Glance*, there are 12 steps to implementing QAPI. These steps build on one another but do not need to be achieved sequentially. However, following them sequentially can be a great way to begin your strategic approach to implementing QAPI.

Step 1: Leadership & Responsibility
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
Step 7: Develop a Strategy for Collecting & Using QAPI Data
Step 8: Identify Your Gaps & Opportunities
Step 9: Prioritize Quality Opportunities and Charter PIPs
Step 10: Plan, Conduct & Document PIPs
Step 11: Get to the Root of the Problem
Step 12: Take Systemic Action

QAPI Step 1

Leadership Responsibility & Accountability

The facility leadership (i.e., medical director, facility administrator/manager) 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 Step	Who Is Responsible?	Date Completed
Develop a steering committee.		
Provide resources for QAPI, including equipment and training.		
Establish a climate of open communication and respect.		
Articulate your home's current culture, and how it will promote performance improvement.		

Questions for Team Discussion

1. Who is on our QAPI Steering Committee?

2. Is our medical director involved in QAPI?

3. How can we provide needed resources for QAPI?

4. Is our work climate open, respecting and "just" (fair)? What does our climate look like?

5. How can QAPI blend with our existing QA efforts?

Surpassing the Hurdles

1. What barriers do you anticipate with these action steps?

2. What additional information does your team need?

3. What additional resources would be helpful?

4. What structures can you create to help ensure your success with this step?

QAPI Step 1

Leadership Responsibility & Accountability

Suggestions for Implementing Step 1

- Institute an open-door policy for all levels of leadership to establish presence and consistent availability to staff.
- Provide training and gain staff, patient and family member commitment for your QAPI initiatives.
- Routinely spend time in all areas 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.
- Commit to following through on issues brought to you—keep that commitment.
- Set the example and pitch in.
- Recognize and honor staff and patient 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 efforts 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 the high expectations of the organizations. If you see an issue, take action and set the tone for high expectations.

QAPI Step 2

Develop a Deliberate Approach to Teamwork

QAPI at a Glance states that QAPI relies on teamwork in several ways. Do teams at your organization have a clear purpose? Do teams have defined roles for each team member to play? Do teams have commitment and active engagement from each member?

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.		

Questions for Team Discussion

1. How can patients and families be involved in our QAPI efforts?

2. Do we have effective teamwork? How do we know? What does it look like?

3. How does leadership support the development of effective teams?

4. Do we have effective communication in our facility? How do we know?

5. Do team members support one another?

Surpassing the Hurdles

1. What barriers do you anticipate with these action steps?

2. What additional information does your team need?

3. What additional resources would be helpful?

4. What structures can you create to help ensure your success with this step?

QAPI Step 2

Develop a Deliberate Approach to Teamwork

Suggestions for Implementing Step 2

- Set the expectation for leaders and staff to identify and share ideas for ways to grow and innovate.
- Build trust with and between your staff members (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 processes, 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 improvements, and bring those to leadership (and to the QAPI Steering Committee).

QAPI Step 3

Take Your QAPI Pulse with a Self-Assessment

Assessing your facility's current practice is a necessary part of implementing QAPI. Take the time now to find out to what degree you have already mastered the concepts of QAPI.

Action Step	Who Is Responsible?	Date Completed
Determine a date and time for completing the QAPI Self-Assessment Tool.		
Assemble the right people to complete the Self-Assessment Tool.		
Complete the QAPI Self-Assessment Tool, recording your answers for future comparison.		
Determine a date for the next QAPI Self-Assessment Tool review.		

Surpassing the Hurdles

1. What barriers do you anticipate with these action steps?

2. What additional information does your team need?

3. What additional resources would be helpful?

4. What structures can you create to help ensure your success with this step?

QAPI Step 3

Take Your QAPI Pulse with a Self-Assessment

Suggestions for Implementing Step 3

- Complete the QAPI Assessment Tool 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.

QAPI Step 4

Identify Your Organization's Guiding Principles

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

Action Step	Who Is Responsible?	Date Completed
Locate or develop your organization's vision statement.		
Locate or develop your organization's mission statement.		
Develop a purpose statement for QAPI.		
Establish guiding principles.		
Define the scope of QAPI in your organization.		
Assemble a document with these elements to serve as a guide.		

Questions for Team Discussion

1. What beliefs do we have about our facility's purpose and philosophy?

2. What beliefs do we have about our approach to QA and PI?

3. What is our mission and vision statement?

4. What are some of the ways in which we expect care to be provided?

Surpassing the Hurdles

1. What barriers do you anticipate with these action steps?

2. What additional information does your team need?

3. What additional resources would be helpful?

QAPI Step 4

Identify Your Organization's Guiding Principles

Suggestions for Implementing Step 4

- Use an inclusive process to establish, review, and reaffirm your mission. Involve staff, patients and families.
- Ensure values are considered core to the facility and to those who receive treatment there.

QAPI Step 5

Develop Your QAPI Plan

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

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.		

Questions for Team Discussion

1. What goals do we have for how QAPI will work?

2. How will QAPI be integrated into leadership's accountability?

3. How will we strive to use data and PI teams?

4. How will direct-care staff be involved in QAPI and PIPs?

Surpassing the Hurdles

1. What barriers do you anticipate with these action steps?

2. What additional information does your team need?

3. What additional resources would be helpful?

4. What structures can you create to help ensure your success with this step?

QAPI Step 5

Develop Your QAPI Plan

Suggestions for Implementing Step 5

- Base your plan on the unique characteristics and services of the dialysis facility.
- Continually review and refine your QAPI plan.
- Tailor the plan to fit your facility.
- Think of the range of patients. Do you have some younger patients? You may need to develop a distinct plan to create quality of life for those patients.

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, the goals and their roles and expectations in the process.

Action Step	Who Is Responsible?	Date Completed
Inform everyone (staff, patients, families, consultants, ancillary service providers, etc.) about QAPI and your organization's QAPI plan.		
Provide training and education on QAPI for all caregivers.		
Develop a strategy for communicating QAPI with all caregivers.		
Develop a strategy for communicating QAPI with patients and families.		

Questions for Team Discussion

1. How will we inform staff about QAPI?

2. How much education and training will be needed?

3. How will we engage patients and families in QAPI efforts?

Surpassing the Hurdles

1. What barriers do you anticipate with these action steps?

2. What additional information does your team need?

3. What additional resources would be helpful?

4. What structures can you create to help ensure your success with this step?

QAPI Step 6

Conduct a QAPI Awareness Campaign

Suggestions for Implementing Step 6

- Share the mission, vision and guiding principle with all staff.
- Include the mission, vision and guiding principles in orientation for new staff.
- Develop communication plans that use multiple approaches (email, verbal, newsletters, etc.) throughout the facility and across all shifts.
- Hold area meetings.
- Openly and transparently share your performance data with staff, board, patients and families.
- Set up a scoreboard for staff that monitors progress toward important goals (e.g., days at zero hemodialysis catheter infections). Post progress in common areas such as halls and break rooms.
- Use a storyboard to share your plan, progress and data.

QAPI Step 7

Develop a Strategy for Collecting & Using Data

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

Action Step	Who Is Responsible?	Date Completed
Determine what data to monitor routinely.		
Set targets for performance in the areas you are monitoring.		
Identify benchmarks for performance.		
Develop a data collection plan, including who will collect which data, who will review it, the frequency of collection and reporting, etc.		

Questions for Team Discussion

1. What data do our facility routinely monitor? How are these data displayed and used?

2. What benchmarks will we use when assessing our performance?

3. How can we make better use of the data we have? Do we track and trend our progress over time?

4. How is data shared with others in the organization? Staff? Patients/families? The Board or corporate office?

Surpassing the Hurdles

1. What barriers do you anticipate with these action steps?

2. What additional information does your team need?

3. What additional resources would be helpful?

4. What structures can you create to help ensure your success with this step?

QAPI Step 7

Develop a Strategy for Collecting & Using Data

Suggestions for Implementing Step 7

- Areas to consider for data monitoring include clinical care areas, medications, patient/family complaints, hospitalizations, state survey results and business and administrative processes.
- When setting targets, consider the long-term as well as short-term goals.
- When identifying benchmarks, you can look at your performance compared to dialysis facilities in your state and nationally using Dialysis Facility Compare. Generally, because every facility is unique, the most important benchmarks are often based on your own performance.

QAPI Step 8

Identify Your Gaps & Opportunities

Whether you are reviewing QIP data or quality measure reports, data from satisfaction surveys or consultant reports, or any other source, be sure you are identifying any trends in the data you review. Use this time to observe for any areas where processes are breaking down.

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 patients and caregivers.		
Notice what things your organization is doing well in identified areas.		
Set priorities for improvement.		

Questions for Team Discussion

1. When reviewing your data, what stands out?

2. How strong is your organizational capacity for assessing facility systems (e.g., policies, protocols, actual care delivery)?

3. What are some areas of strength and weakness?

4. What opportunities do you see?

Surpassing the Hurdles

1. What barriers do you anticipate with these action steps?

2. What additional information does your team need?

3. What additional resources would be helpful?

4. What structures can you create to help ensure your success with this step?

QAPI Step 8

Identify Your Gaps & Opportunities

Suggestions for Implementing Step 8

- Measure important indicators of care that are relevant and meaningful to the patients that 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 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 the dialysis facility as a learning organization in which all staff identifies areas for improvements.
- Regularly discuss processes and systems to identify areas for improvement—in meetings as well as everyday interactions.
- Empower patients to get involved in identifying areas of improvement.

QAPI Step 9

Prioritize Opportunities & Charter PIPs

Be sure you are choosing areas that you consider important (e.g., 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 Step	Who Is Responsible?	Date Completed
Prioritize opportunities for more intensive improvement work.		
Consider which problems need the focus of a PIP.		
Charter PIP teams, by selecting a leader and defining the mission.		
PIP teams should develop timelines and indicate budget needs.		
PIP teams should use the Goal Setting Worksheet to establish appropriate goals.		

Questions for Team Discussion

1. How will organizational priorities be determined?

2. Who will be responsible for monitoring the overall progress of our PIPs?

3. What education is needed for PIP teams?

Surpassing the Hurdles

1. What barriers do you anticipate with these action steps?

2. What additional information does your team need?

3. What additional resources would be helpful?

4. What structures can you create to help ensure your success with this step?

QAPI Step 9

Prioritize Opportunities & Charter PIPs

Suggestions for Implementing Step 9

- 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.

QAPI Step 10

Plan, Conduct and Document PIPs

For those areas that require a PIPs, PIP teams should use a methodic or standardized process for making improvements. PDSA is one well-known model, but there are others that may also 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 Step	Who Is Responsible?	Date Completed
Determine what information is needed for the PIPs.		
Determine timelines and communicate them to the Interdisciplinary Team (IDT).		
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 QAPI Steering Committee.		

Questions for Team Discussion

1. How can patients and families be involved in our QAPI efforts?

2. Do we have effective teamwork? How do we know? What does it look like?

3. How does leadership support the development of effective teams?

4. Do we have effective communication in our facility? How do we know?

Surpassing the Hurdles

1. What barriers do you anticipate with these action steps?

2. What additional information does your team need?

3. What additional resources would be helpful?

4. What structures can you create to help ensure your success with this step?

QAPI Step 10

Plan, Conduct and Document PIPs

Suggestions for Implementing Step 10

- Identify and support a change agent for each improvement project—i.e., a cheerleader and/or key facilitator of change in your facility.
- Use an action plan template that defines who and when to establish timelines and accountability.
- Seek creative ideas from multiple sources inside and outside the organization to foster innovation.
- Create a safe environment to test changes, and 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 get at concerns.

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 fishbone diagram or the "Five Whys" to dig below the surface.

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 that the PSDA cycles address the root cause(s).		

Questions for Team Discussion

1. What are the obvious and less obvious reason(s) the problem surfaced?

2. What is at the root of those factors?

3. What systems and processes are involved (not people)?

Surpassing the Hurdles

1. What barriers do you anticipate with these action steps?

2. What additional information does your team need?

3. What additional resources would be helpful?

4. What structures can you create to help ensure your success with this step?

QAPI Step 11

Get to the Root of the Problem

Suggestions for Implementing Step 11

- Use the root cause analysis (RCA) process to look at systems rather than individuals when something breaks down.
- If one method didn't work, identify another to try—it's a continuous process.

QAPI Step 12

Take Systematic Action

Just as pulling a weed at the ground level will not prevent it from growing back, "weak" interventions 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 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.		
Pilot test large-scale changes (through PDSA cycles) prior to launching the changes facility-wide.		

Questions for Team Discussion

1. How strong are the interventions?

2. Do the selected interventions address systems issues, or do they address individual performance?

3. Is what we're doing working? How do we know?

4. What are our next steps?

Surpassing the Hurdles

1. What barriers do you anticipate with these action steps?

2. What additional information does your team need?

3. What additional resources would be helpful?

4. What structures can you create to help ensure your success with this step?

QAPI Step 12

Take Systematic Action

Suggestions for Implementing Step 12

- Before initiating a change in the organization, meet with any staff and patients that will be impacted by the change in order to gain their support, buy-in and feedback.
- To be effective, interventions or corrective actions should target the elimination of root causes, offer long-term solutions to the problem and have a greater positive than negative impact on other processes.
- Interventions must be achievable, objective and measurable.
- Think about testing or piloting changes in one area of your facility before launching throughout. Some changes have unintended consequences.

Monthly QAPI Suggested Checklist

What is our progress on the Quality Improvement Topic?

1. Have we educated all staff on the QI process, reviewed new resources and goals? How is staff responding to the quality improvement activity (QIA)?
   - ☐ Review CMS goals
   - ☐ Complete Root Cause Analysis (RCA)
   - ☐ Discuss progress with interdisciplinary team (IDT)
   - ☐ Staff education ongoing

2. What has our data shown during this period?
   - ☐ Use data provided by Network to look for trends

3. Where are we in the P-D-S-A cycle?
   - ☐ Use PDSA Worksheet/Cycle

What are the patient partnership activities we have done this month?

1. Do we have a Facility Peer Representative (FPR)? If not, who would be a good choice at our clinic?
   - ☐ Identify FPR
   - ☐ Complete FPR Application

   a. If so, how can we engage the FPR? What are their interests in working with the team on this improvement activity?
      - ☐ Discuss with FPR their level of involvement options

   b. Would they be willing/able to attend QAPI meetings to discuss trends with QAPI team and provide ideas/feedback?
      - ☐ Invite FPR to QAPI
      - ☐ Invitation Resource

   c. How are we using the FPR to assist with this activity?
      - ☐ Attend QAPI meeting
      - ☐ Discuss topic and ideas prior to or at QAPI meeting
      - ☐ Assisting with Bulletin Boards
      - ☐ Assisting with other patient engagement activities

Allow patient to be excused once patient engagement topic has been discussed.

Engaging Patients in Quality Assurance and Performance Improvement (QAPI)

The Network encourages facilities to engage patients beyond just patient care, to include their patient voices in quality improvement and governance activities. Bringing a patient perspective to the process can help the facility to better understand issues patients may be experiencing, and in developing patient-centered interventions.

Facilities often say they are concerned that having a patient in a QAPI meeting will violate confidentiality. To preserve confidentiality, plan the agenda for the meeting so the patient representative is at the beginning of the meeting. Then, confidential topics can be discussed after the patient has left the meeting.

Benefits of Patient Engagement in QAPI and/or Governance

Benefits of engaging patients in quality improvement activities include:

- Diverse perspectives and ideas can result in solutions that appeal to a wider population. Having that patient and/or family member involved can give you another perspective to incorporate into your interventions.
- Patients are in a position that allows for the repetitive observation of most initiatives and can report back on what they are seeing. By nature of the treatment, patients spend several hours, three days a week in the dialysis facility. They are watching and listening to what is happening around them and they can share what they are observing.
- Inclusion in the team can dramatically open up a patient perspective and demonstrate the dialysis facility's commitment to solving the problem. The patient can go back and share with other patients that the facility is committed to making improvements and they see first-hand the "bigger" picture of what the facility does to not just improve their care but care for all.

Steps to Engaging a Patient in QAPI

The process of engaging your patients into the QAPI (or Governing Body) meetings can be broken down into several parts: selecting and inviting, meeting, and sharing after the meeting.

Patient Selection

Patient selection should be considered with some thought and method behind it. Look for a person who:

- Can see beyond their personal experiences
- Shows concern for more than one issue
- Has a positive outlook on life
- Listens well
- Shows respect for perspective of others
- Interacts with different people
- Speaks comfortably in a group with candor

Patient Invitation

There are several key components to successfully inviting a patient to participate:

- Make it personal—invite the patient in-person away from other patients.
- Explain the purpose of the meeting.
- Share reasons why the patient is being invited.
- Review their role during and after the meeting.
- Accommodate the patient's schedule to attend the meeting.
- If the patient agrees, educate the patient on the topic(s) covered and answer any questions they have.

Before the Meeting

- Remove any Personal Health Information from reports.
- Provide the patient with any policy and procedures that may be relevant to the discussion.
- Determine with the team what areas you would like patient input on or if the patient will participate in the entire meeting.
- Interdisciplinary team members should all prepare specific, directed questions for the patient.
- Ask the patient how long they would like to stay during the meeting.
- Set an agenda by:
  - Including introductions as part of the agenda.
  - Planning for the first 20-30 minutes to discuss the topics that are a priority for patient input.
  - Providing the patient with a copy of the agenda prior to the meeting.

During the Meeting

- Introduce all members attending by name and role.
- Ask the patient to introduce him/herself.
- Observe confidentiality requirements.
- Keep to the agenda, observing time limits set, to ensure patient feedback is included.
- Use plain language and explain any acronyms when reviewing reports and data.

- Ask the patient the prepared questions and about their experience with the topic, for example: "We have just reviewed the data we have on blood stream infections..."
  - Have you ever had an infection since starting dialysis?
  - What steps do you take personally to help you stay infection free?
  - How do you think we could help patients with this?
  - How do you think staff could improve their practices?

After the Meeting

Facility staff:

- Include patient's attendance and participation in QAPI or Governing Body Committee meeting minutes.
- Follow up with the patient directly on any hot-topic issues prior to the next meeting.
- Check in with team about what can be done to improve the process for the next meeting.

Patient:

- Update patients on the topics discussed.
- Ask for any feedback needed to share at the next meeting.

You're Invited
Patient Invitation to QAPI

On behalf of the entire care team, we would like to invite you to join us in the clinic's monthly quality improvement meeting. Our clinic calls this meeting: _____

When: _____ **Where:** _____

We would like to partner with you to review the quality and safety of dialysis care we provide and to look at what we can do to make things better. During the meeting, we will be looking at information to see how we meet standards and what we can do to improve. Just like the dietitian reviews your labs with you monthly to see if you are meeting goals, we look at the bigger picture of how all patients as a group are doing and if the clinic is meeting its goals.

What is Quality Assurance & Performance Improvement (QAPI)?

QAPI activities involve your physician and your care team at the dialysis center. They are used to help identify areas where we can improve, make a plan to correct areas that need improvement, and continuously monitor these improvements in your dialysis center.

Quality Assurance (QA) is how we make sure we are providing quality care to our patients.

Performance Improvement (PI) is the way we monitor the care we are providing to our patients, find areas that need improvement, and indentify ways to improve.

Looking at improving quality has many names. Our clinic calls it: _____.

Tips for Being Involved in QAPI

- Believe you can help
- Communicate openly
- Be honest
- Ask questions
- Be open-minded
- Avoid assumptions
- Be willing to partner and learn from others
- Be a team player
- Thank them for asking for your input
- Adapt to different situations
- Try not to complain, and instead offer suggestions on how it could have been made better.

This month we would like to get your patient perspective on this topic:

_____

During the meeting we would like you to share your thoughts on the following questions from a patient perspective:

1. What do you think is the biggest concern for patients around this topic?

   _____

   _____

   _____

2. What do you think staff could do to improve around this topic?

   _____

   _____

   _____

What do you think patients could do to improve around this topic?
How could staff help?

_____

_____

_____

Conditions for Coverage

Tag #	Regulation	Interpretive Guidance
V625	§ 494.110 Condition: Quality assessment and performance improvement.	This Condition looks at facility aggregate data and requires facility-based assessment and improvement of care, while the Plan of Care Condition expects patient-based improvement of care. Compliance with this Condition is determined by review of clinical outcomes data and the records of the quality assessment performance improvement activities of the facility, and by interviews of responsible staff including the medical director. Non-compliance at the Condition level may be warranted if a pattern of deficient practices which could impact patient health and safety is identified. Examples include, but are not limited to: • Absence of an effective QAPI program; • Failure to recognize and prioritize major problems that threaten the health and safety of patients; or • Failure to take action to address identified problems.
V755	(3) The relationship with the ESRD networks; and	The ESRD Networks are CMS contractors assigned responsibilities via a Statement of Work to: • Collect and analyze data on ESRD patients and their outcomes of care, including the information that allows patients to be enrolled into the ESRD Medicare benefit program • Provide education and oversight to improve the quality of care delivered to dialysis and kidney transplant patients • Support facilities in developing and maintaining an effective QAPI program • Respond to complaints and grievances At the time of publishing these regulations, there were 18 ESRD Networks, each covering a specified geographic area. A signed agreement between the facility and the applicable Network is required prior to the initial certification survey. The CEO or administrator is responsible to receive and act on correspondence from the ESRD Network and to promptly respond to any request from the applicable Networks. Additional requirements related to Networks are found at V772.

V772	(i) Standard: Relationship with the ESRD network. The governing body receives and acts upon recommendations from the ESRD network. The dialysis facility must cooperate with the ESRD network designated for its geographic area, in fulfilling the terms of the Network's current statement of work. Each facility must participate in ESRD network activities and pursue network goals.	The ESRD facility must respond promptly within any specified deadlines to requests for information, data, or corrective action plans from its ESRD Network. The facility must participate in Network projects and activities aimed at addressing identified needs and improving quality of care in the individual facility or the Network-wide area. Facilities may easily obtain copies of their Network's goals and objectives as each Network is required to post their annual report on their website. These reports include the individual Network's goals and activities. At the time of publication of these regulations, the goals of ESRD Networks were to: • Improve the quality and safety of dialysis-related services provided for individuals with ESRD. • Improve independence, quality of life, and rehabilitation (to the extent possible) of individuals with ESRD through encouragement of transplantation, use of self-care modalities (e.g., home peritoneal dialysis, home hemodialysis, and in-center self-care), as medically appropriate, through the end of life. • Encourage and support collaborative activities to ensure achievement of these goals through the most efficient and effective means possible, with recognition of the differences among providers (e.g., independent, hospital-based, member of a group, affiliate of an organization) and the associated possibilities/capabilities. • Improve the collection, reliability, timeliness, and use of data to: measure processes of care and outcomes; maintain the patient registry; and support the ESRD Network program.

PDSA Model for Improvement

One standard quality improvement tool that is frequently used is the Plan-Do-Study-Act (PDSA) model for improvement. The PDSA cycle is shorthand for testing a change by developing a plan to test the change (Plan), carrying out the test (Do), observing and learning from the consequences (Study), and determining what modifications should be made to the test (Act). After testing a change on a small scale, learning from each test, and refining the change through several PDSA cycles, the team may implement the change on a broader scale — for example, incorporating into the facility policy and procedure.

Learn more from the Institute for Healthcare Improvement.

Plan

1. Select the opportunity for improvement
2. Select the team
3. Study the current situation
4. Analyze the causes
5. Develop a theory for improvement

Do

6. Implement the improvement

Study

7. Study the results

Act

8. Establish a future plan
9. Standardize the improvement

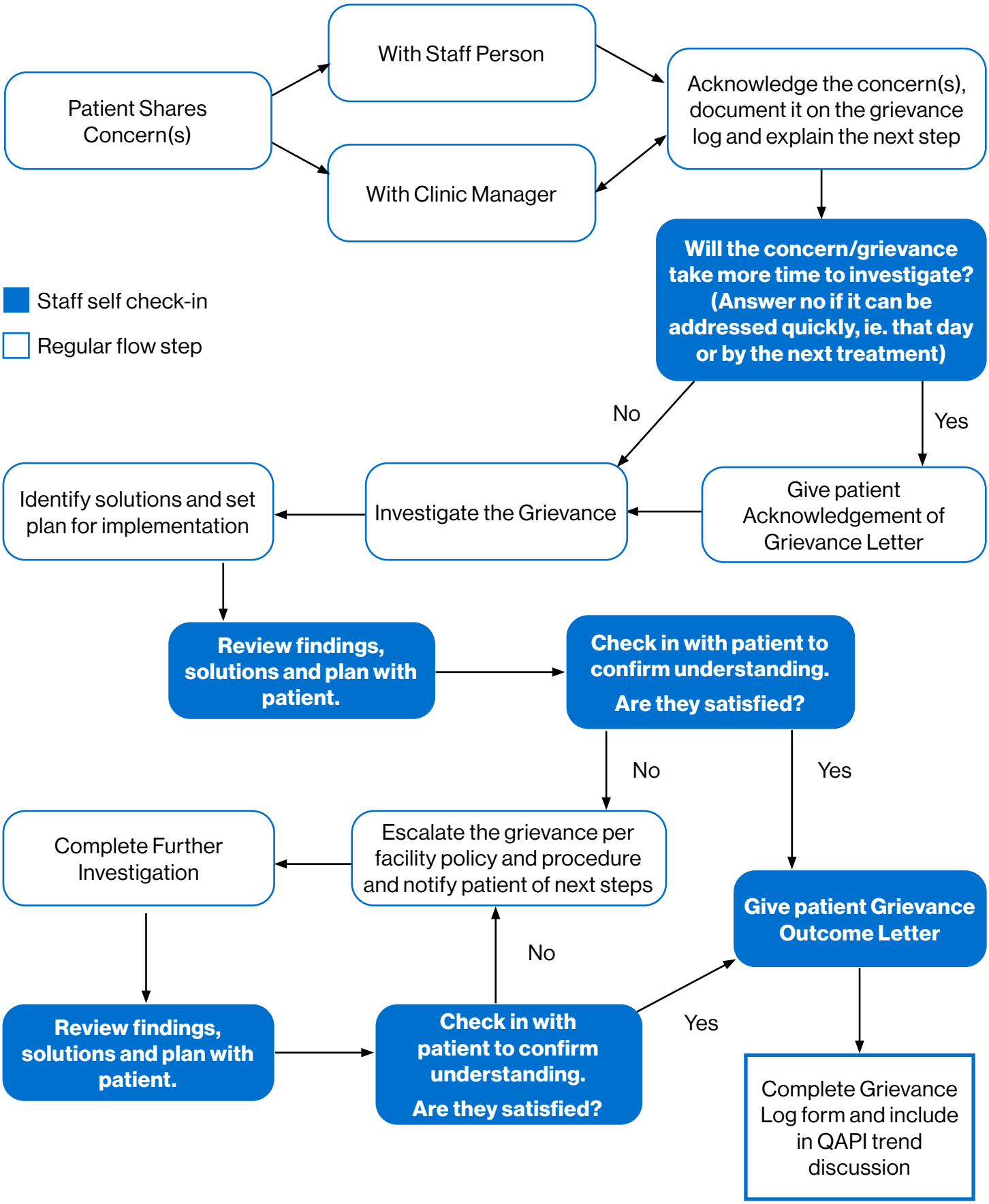
PDSA in Action

The following content gives examples of how you can put the PDSA into action. The specific example is a PDSA on how to improve the grievance process in your clinic. However, these quality improvement concepts can be applied to any QI project you may be working on.

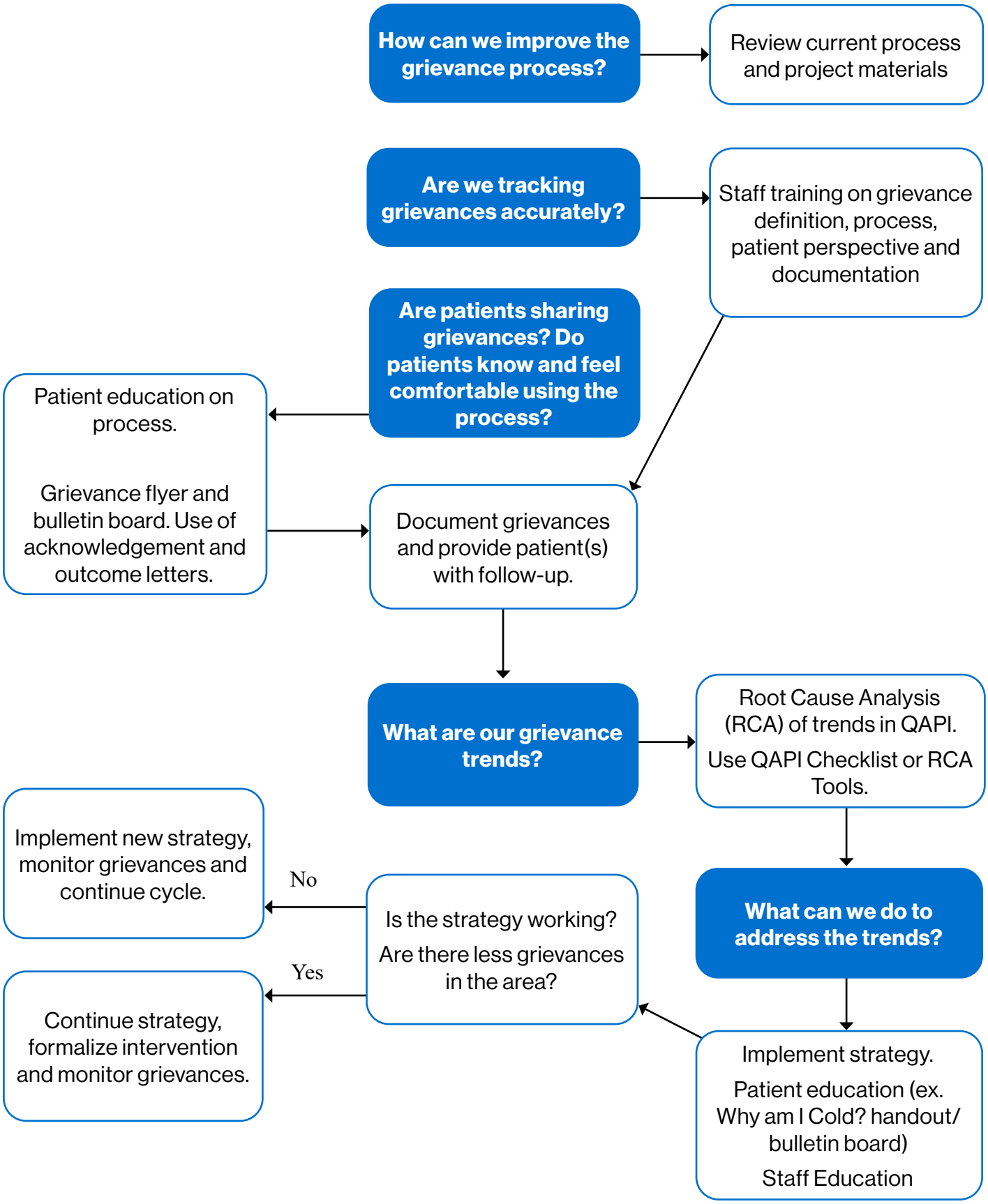
PDSA Worksheet Example: Improving the Grievance Process

Steps	Explanation	Example
1 Select team facilitator and team members.	Team members are people with personal knowledge of the processes and systems involved in investigating the grievance.	• Required QAPI team members • Patient representative • Project lead should be Facility Administrator or social worker. • All staff should document grievances.
2 Select the opportunity for improvement. Define the problem.	Events and issues can come from many sources (e.g., grievance log, patient satisfaction results). The facility should have a process for selecting events that will undergo a Root Cause Analysis.	• Patients are consistently complaining of temperature or communication concerns. • Our facility has not had any, or very few, complaints reported.
3 Study the current situation.	Gather preliminary information and collect data needed to understand the issue.	• Grievance logs, identify trends in QAPI meetings, individual grievances should not be discussed. • Patient satisfaction and facility culture of safety. Do patients feel comfortable voicing concerns? • Collect and organize the facts surrounding the grievance trends to understand what is happening.
4 Analyze the causes. Conduct a Root Cause Analysis (RCA).	A thorough analysis of contributing factors leads to identification of the underlying process and system issues (root causes) of the grievance trends.	• Use the "five whys" technique by asking "why is that?" • Use fishbone tool • If you don't have many grievances: "Why don't we have grievances?"
5 Develop a theory for improvement.	The team determines how best to change processes to reduce the chance of another similar grievance.	• How can we change the way we do things to make sure this root cause does not result in a future grievance? • Will all current and new staff be educated on the changes to prevent reverting to the old way of addressing concerns?
6 Implement Solutions.	The team determines how best to change processes to reduce the chance of another similar grievance.	• Who will implement the solutions, by when and how? • Use of patient educational resources for example the "Why am I Cold" resource
7 Measure success.	The team looks at current trends and compares to previous numbers to see how successful interventions were.	• Did we see progress? • Do we need any further interventions?
8 Establish a future plan.	The team discusses their plan to continue process or modify interventions.	• How can we incorporate this process and interventions into our policy and procedure?
9 Standardize improvements.	The team discusses their plan to continue process.	• How can we incorporate this process and interventions into our policy and procedure?

Grievance Process Flow Chart



PDSA Cycle Grievance Process Improvement



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 patients with a vaccination against both influenza and pneumococcal disease documented in their medical record from 61 percent to 90 percent by _____.]

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.

Root Cause Analysis

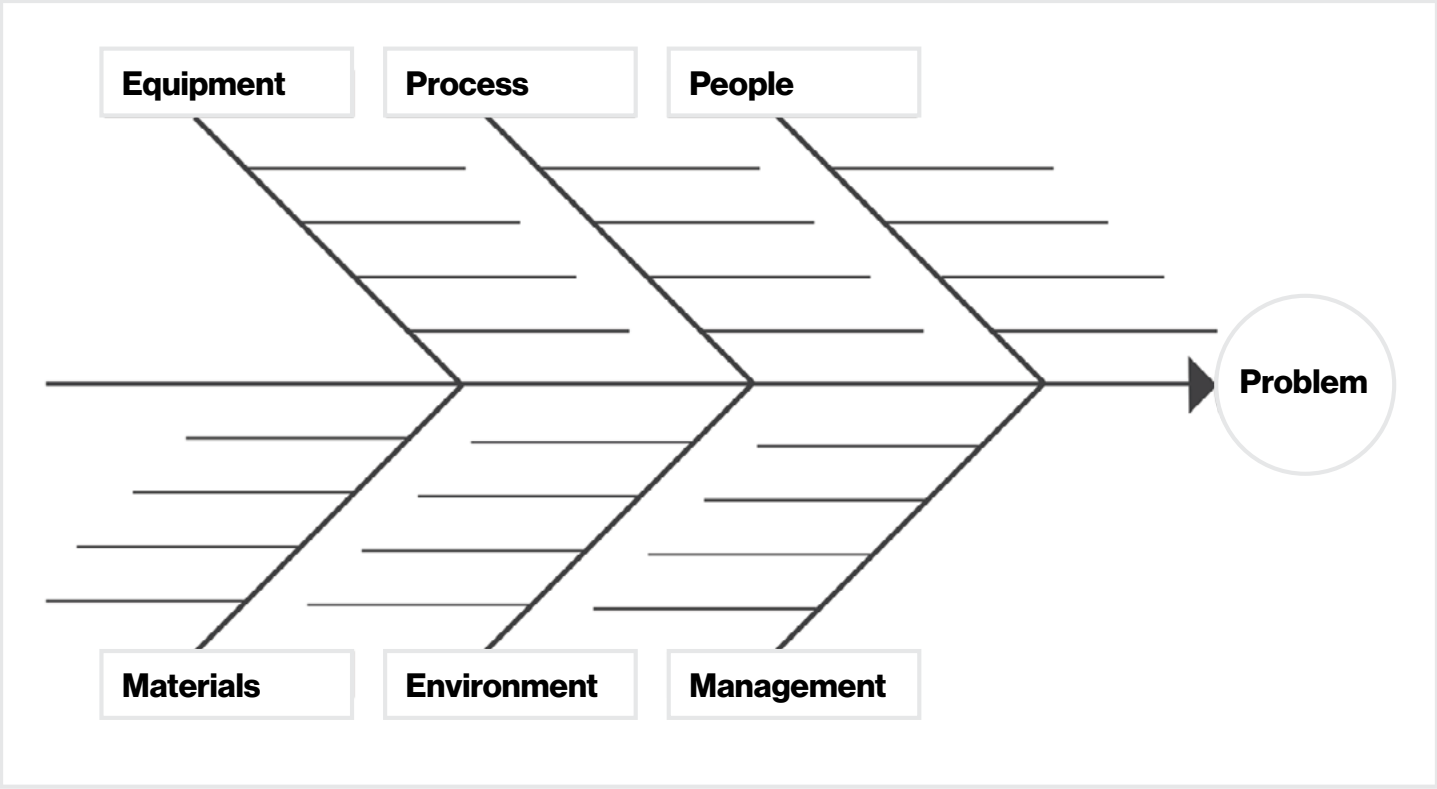
What is a Root Cause Analysis?

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 system's issue is important to prevent the problem from returning. There are many formalized root cause analysis tools.

Two easy-to-use tools are the fishbone diagram and the Five Whys.

Fishbone (Cause-and-Effect) Diagram

1. Begin the fishbone diagram by placing the problem at the head of the "fish."
2. Under each general category of the fishbone, answer the question, "Why?" for the identified problem. For example, "Why are people the cause of this problem?"
3. Once your team has completed the fishbone diagram, discuss the various causes to get to the root of the problem. It is from this discussion that the focus for the improvement plan can begin.



Five Whys

The Five Whys tool aids in identifying the root cause(s) of a problem. Begin by identifying a specific problem, and ask why it is occurring. Continue to ask "Why?" to identify causes until the underlying cause is determined. Each "Why?" should build on the previous response. There is nothing magical about the number five. Sometimes a root cause may be reached after asking "Why?" just a few times; at other times, deeper questioning is needed.

1. Define a problem; be specific.
2. Ask why this problem occurs, and list the reasons in Box 1.
3. Select one of the reasons from Box 1 and ask, "Why does this occur?" List the reasons in Box 2.

Continue this process of questioning until you have uncovered the root cause of the problem. If there are no identifiable answers or solutions, address a different problem or reason.

The Problem: _____

Why Does this occur?

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

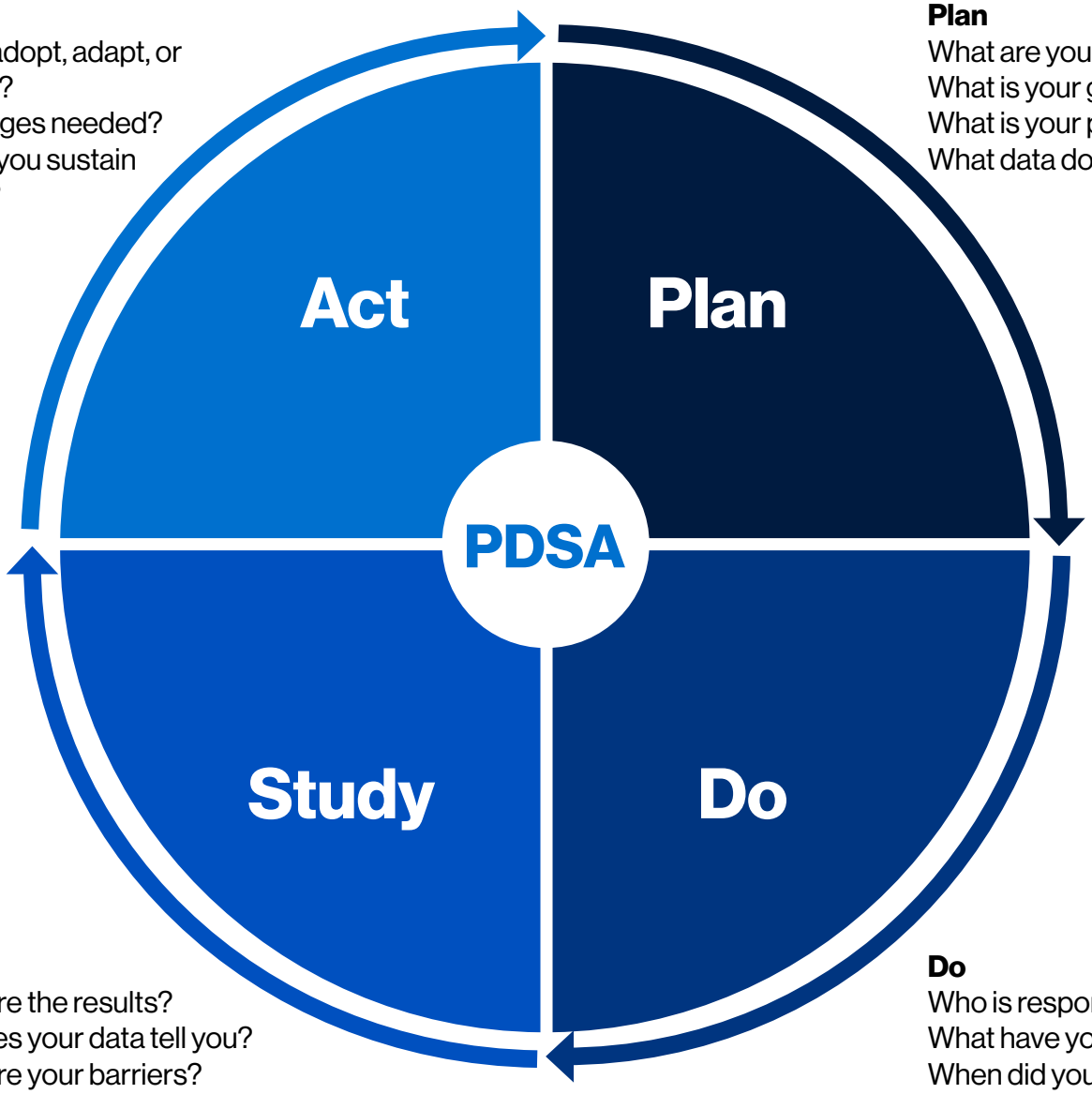
PDSA Cycle Planning Tool

Project Focus:_____

Target Date for Completion:_____

Act
Will you adopt, adapt, or abandon?
Are changes needed?
How will you sustain the plan?

Plan
What are you going to do?
What is your goal?
What is your prediction?
What data do you collect?



Study
What were the results?
What does your data tell you?
What were your barriers?

Do
Who is responsible?
What have you done?
When did you do it?
How did you do it?

PDSA Cycle

Plan:
What is your goal? What are your predictions? What data do you need to collect?

Do:
What have you done? When did you do it? Who are the responsible parties?

Study:
What were the results? What does your data tell you? What were your barriers?

Act:
How will you maintain your goal? Are further changes needed?

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