August 11, 2022

LTC COVID-19 Update

Presented by:
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Today's Topics

- Getting back on track, QAPI – Kara Dawson
- Q&A from last week – Lori Davenport
- Survey guidance changes, QAPI – Lori Davenport
- Q&A

Insightful Root Cause Analysis for the Infection Preventionist, *a webinar on Aug. 16, details HERE*

IHCA/INCAL Annual Convention & Expo*, August 15-16, details HERE*

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QAPI Snackable – Getting Back On Track

Kara Dawson, RN, BSN, RAC-CT

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QAPI Definition

- QAPI stands for **Quality Assurance / Performance Improvement** . The ultimate goal is a "data-driven, proactive approach to improving the quality of life, care and services in nursing homes" achieved through the combined elements of both practices (QA and PI).

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Essential Elements for QAPI

- Design and Scope
- Governance and Leadership
- Feedback, Data Systems, Monitoring
- Performance Improvement Projects (PIPs)
- Systematic Analysis and Systemic Action

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QAPI Self Assessment

- When reviewing your current QAPI process utilize the self assessment to ensure
  - All elements are in place for an effective and solid QAPI program
  - Identify areas that need to be implemented/started and the progress of your facilities QAPI program
- Ensure that self assessment is done with the IDT team at least on an annual basis to

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Developing a QAPI Plan

- Identify the QAPI goals that your plan will strive to meet
  - Ensure goals are specific, measurable, actionable, relevant, have timeline for completion
- Describe how the QAPI plan will address:
  - Clinical care
  - Quality of life
  - Resident choice (i.e., individualized goals for care)
- Designate a leader for plan that will be responsible for leadership and coordination
- How will you collect needed data and from what sources
- Prioritize and select PIPs
- Ensure RCA is being done to ensure the root of the problem is being addressed/ corrected
- Evaluate your plan routinely and update as needed.

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Benefits

- An effective QAPI program can be proactive in identifying areas of missed opportunity to ensure the highest quality of care and adherence to regulations
- Assists in ensuring systems and/or processes are in place
- Ensures continual monitoring and improvement of facility systems through a data driven process
- Continuous improvement in the quality of care that is delivered to the residents.
  - Helps to decrease resident and/or family complaints

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Thank You

- Questions?

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Question:

- If you have a resident that had COVID over a month ago and we admit resident that continues to have a cough and it on breathing treatments but does not have a fever, what would protocol be for this person on admission?

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Answer:

- *Some people have a dry cough for a long time after recovering from COVID. If someone is coughing, it is always a good idea for them to wear a mask in presence of others even if not a person in TBP or even if it is not COVID.*
- *If their cough has improved significantly compared to their acute COVID-19, and do not have fever/ other suggestions of ongoing illness, they are likely noninfectious at that point. Please ask their physician /your medical director if there is a concern for the individual to be still infectious at that point. They could evaluate for general wellness and run labs if needed.*
- *Consider ID consult if available, especially if someone is moderate to severely immunocompromised and there is a concern for shedding replication-competent virus beyond 20 days after symptom onset.*

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Question:

- Regarding the positivity rate --- I am using Transmission drop down with the red map. The positivity is blank routinely.

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Answer:

- *On the data tracker, make sure to switch the drop-down option to Transmission. The color code indicates the level of transmission. Color code is determined by positivity rate and the number of cases per 100 K population.*

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Comment :

- If the hospitals would give Boosters when facilities ask, then we would not have so many residents in a yellow quarantine area.

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Response:

This was addressed in LTC Newsletter 2022-28 July 14, 2022

- *You can offer a booster upon admission; they are up to date at that time and yellow zoning is not needed.*
- *A new admission individual can come out of quarantine after receiving a booster without any waiting period as long as they meet all the following requirements:*
  - *Had no close contact (with a reliable history);*
  - *Not an immunocompromised individual; and*
  - *Not symptomatic*

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Question:

- We have pod type units, and we have COVID in a couple of the PODS, but many of the pods have not been exposed to positive staff or to positive residents, should we test all the residents in the facility?

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Answer:

- *You test all those that could have been contacts of the COVID individual, not necessarily all the residents in the facility.*
- *You expand to unit-based or whole facility-based testing in the following situations*
  - *you are not able to identify who all could have been exposed*
  - *you are finding new cases on every outbreak testing / unable to contain the spread.*

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Question:

- Can CMP money be used to offset the expense of COVID-19 testing?
- Response:

  CMS has strict parameters for the use of CMP funds and is unlikely to approve spending CMP for this purpose.

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§483.75 Quality Assurance and Performance Improvement

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F865-F868 - §483.75 – QAPI

- Requirement: Develop, implement, and maintain an effective, comprehensive, data driven QAPI program.
  - Ongoing
  - Comprehensive
  - Addressing full range of care and services (facility assessment) provided by the facility.
  - Address unique services

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Purpose of QAPI

- Care delivery is consistent, accurate, and best practices and standards are used.
- Reliable, safe and cost controlled
- Identify concerns and or deviations quickly
- Correct and improve – QAPI

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Highlights

- Leadership responsibilities
- Disclosures to surveyors may be necessary to show compliance
- Definitions updated: quality indicators, quality assurance and performance improvement

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F867 – New Policy and Procedures required

- Feedback: Establish and implement **policies and procedures for feedback** – problem areas and PI
  - Direct care staff
  - Other staff
  - Residents
  - Resident representatives
  - Other Stakeholders

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Data Collection Systems and Monitoring

- The facility **policy and procedure must address the following related to data:**
  - How data will be identified
  - Frequency with which it will be collected
  - Collection methodology

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Performance Indicators

- Policy and procedure in place for monitoring and evaluating performance indicators.
  - Policy and procedure must include:
    - Frequency the facility develops, monitors, and evaluates its performance indicators.
    - Example SS/LS QM's – CASPER Report

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Systematic Analysis and Action

- Policy and Procedure to address the following:
  - How the facility will use systematic approaches to determine underlying problems.
  - How corrective actions will be designed to impact change at a system level.
  - How the facility will monitor the effectiveness of its performance improvement activities and ensure sustainability of improvements.

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Medical Errors and Adverse Events

- Policy and procedures that allow systematically identifying and investigating medical errors and adverse events.
  - Policy and procedure to include how the facility will analyze and use data to develop activities to prevent further medical errors and adverse events.
    - Note abuse, neglect and misappropriation of resident property and exploitation were added to the list of potentially preventable events related to care. (see §483.5)

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Education

- Education must be provided to staff, residents, resident representatives, and family members on medical errors and adverse events.

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Performance Improvement Projects

- Must conduct a performance improvement project at minimum annually.

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QAA – Committee

- Functions under governing body
- Responsible for plans of improvement
- Regular review
- **Analysis of data under QAPI and drug regimen review**
- PIP when appropriate

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Regualtory requirements of §483.75(c) and §483.75(c)(1)-(4) have been relocated from F866 to F867

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Under F865 facilities maybe be cited if they fail to do one of the following:

- Maintain documentation and evidence of its ongoing QAPI program;
- Present its QAPI plan to the Federal and/or State surveyors during recertification survey or upon request;
- Present QAPI evidence necessary to demonstrate compliance with these requirements;
- Develop, implement and maintain an effective, comprehensive QAPI program, that addresses the full range of services the facility provides; or
- Ensure governing body oversight of the facility's QAPI program and activities.

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Under F867 facilities may be cited for deficient practices is they fail to do any one of the following:

- Include in its policies and procedures how it obtains and uses feedback from residents, resident representatives, and staff to identify high-risk, high-volume, or problem prone issues as well as opportunities for improvement;
- Develop and implement policies and procedures which include how it ensures data is collected, used and monitored for all departments;
- Develop and implement policies and procedures for how the facility develops, monitors and evaluates performance indicators and the frequency for these activities;
- Develop policies and procedures for how it will identify, report, and track, adverse events, and high risk, high volume, and/or problem-prone concerns;
- Establish priorities for its improvement activities, that focus on high-risk, high-volume or problem-prone areas, as well as resident safety, choice, autonomy, and quality of care;
- Ensure the QAA Committee developed and implemented action plans to correct identified quality deficiencies;
- Measure the success of actions implemented and track performance to ensure improvements are realized and sustained;
- Track medical errors and adverse events, analyze their causes, and implement preventive actions and mechanisms;
- Conduct at least one PIP annually that focuses on high-risk or problem prone areas, identified by the facility, through data collection and analysis; or
- Ensure the QAA Committee regularly reviews and analyzes data collected under the QAPI program and resulting from drug regimen reviews, and act on the data to make improvements.

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Q&A

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THANK YOU!

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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:					

Disclaimer: Use of this tool is not mandated by CMS for regulatory compliance nor does its completion ensure regulatory compliance.

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:					

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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:					

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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:					

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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:					

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