Quality Assurance and Performance Improvement (QAPI) Program Toolkit

A step-by-step guide to implementing QAPI in your health care facility

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What is QAPI?

QA + PI = QAPI

QAPI merges two distinct and complementary approaches to quality management that differ in purpose and perspective: **Quality Assessment** (**QA**) and **Performance Improvement** (**PI**).

- **QA** (sometimes called quality assurance) is the systematic process of evaluating health care services **to determine whether they meet established standards** of quality, safety and effectiveness. It focuses on measuring performance, identifying gaps in care and ensuring patients receive appropriate, safe and high-quality treatment. Health care facilities may set QA thresholds that align with regulations, external comparative benchmarks or internal expectations. QA is a reactive and retrospective effort to identify if, when and why a facility failed to meet the expected standard.
- **PI** (sometimes called quality improvement [QI]) is a proactive, continuous and systematic approach to analyzing health care processes and **implementing changes to enhance the quality, safety, efficiency and effectiveness of patient care**. PI makes good quality even better.

Go to the "What is QAPI?" on-demand training.
This is a short video (2 minutes, 18 seconds) provides an overview of the Quality Assessment/ Assurance Performance Improvement (QAPI) program.

The chart below was adapted from the Health Resources and Services Administration (HRSA) and shows some key differences between QA and PI efforts.

	Quality Assessment	Performance Improvement
Motivation	Evaluating compliance with standards	Continuously improving processes to exceed standards
Means	Inspection and retroactive review	Experimentation and real-time impact analysis
Attitude	Required, reactive	Chosen, proactive
Focus	Outcomes, outliers and variances	Processes and systems
Responsibility	Few	All

With QAPI, your organization will use a systems approach to actively pursue improvement by:

- Using data to identify your improvement opportunities and measure impact of changes made.
- Bringing patient, resident and family voices into facility goals and evaluation for care delivery and experience.
- Developing interdisciplinary performance improvement project teams.
- Understanding the underlying causes to address problems at their source.
- Implementing systemic and systematic changes that are designed for human factors.
- Developing a feedback and monitoring system to sustain continuous improvement.

Why QAPI Matters

According to many published studies, significant numbers of patients are harmed physically or emotionally when receiving health care, sometimes resulting in permanent injury or death. Adopting process improvement techniques is an important first step in facilities identifying inefficiencies, areas of ineffective care and preventable errors in their systems to then improve patient safety, effectiveness and experience of care. Implementing a comprehensive QAPI program can elevate outcomes and experiences for patients and improve the work environment for staff and providers.

Go to the "Why QAPI matters" on-demand training.
This is a short video (1 minute, 56 seconds) explains why a Quality Assessment/Assurance Performance Improvement program matters to your facility.

The impact and rewards of a high-functioning QAPI program include:

- Better patient or resident outcomes, satisfaction and overall well-being.
- Improved staff, patient and resident safety and reduced incidence of harm.
- Compliance with Centers for Medicare & Medicaid Services regulations and accrediting body requirements.
- Increased staff engagement and accountability.
- Data-driven decision-making that helps avoid assumptions and biases.
- Cost reduction by streamlining use of resources and reducing waste and duplication.

QAPI is part of everyone's work.

QAPI is a data-driven, proactive system for ensuring high-quality care and services in health care facilities. Most health care facilities design a program or department to lead the implementation and activities of QAPI, but a successful QAPI program requires staff at all levels of the organization to:

- Identify opportunities for improvement.
- Address gaps in systems or processes through an improvement plan.
- Continuously monitor effectiveness of changes made to processes.

Go to the "Who is responsible for QAPI?" on-demand training.
This is a short video (1 minute, 36 seconds) talks about the responsibilities of those engaged in a QAPI program.

Though the QAPI terminology may be new, the concepts are not. Improvement is already a part of your everyday work and thought processes. You may recognize some of these daily improvement activities:

⇒ You adjust your daily processes or work plans based on what is going on that day such as supply chain interruptions or covering for a team member who is on vacation.

⇒ You create new ways to comply with new or revised regulations or accreditation standards.

⇒ You receive, investigate and respond to concerns or complaints, including adjusting processes to prevent similar issues in the future.

⇒ You prepare for and practice emergency response situations.

⇒ You ask patients and staff how you can better meet their needs.

What are the QAPI program elements?

Formalizing, restructuring or growing your QAPI program is not necessarily quick or easy, but it is important, achievable and exciting in all healthcare facilities. As staff see processes and outcomes improve, it generates more enthusiasm and dedication to a strong organizational culture of improvement.

Go to the "What is a QAPI program?" on-demand training.
This short video (2 minutes, 25 seconds) provides a high-level overview of the five elements of a QAPI program.

It's like being a new driver…

A new driver has to concentrate and coordinate so many actions and cues that driving feels nerve-wracking, confusing and intimidating. But, with practice, driving safely becomes easier and ushers in new confidence and opportunities. In the same way, with practice and experience, quality improvement efforts get easier and take health care teams to new places in quality management.

Five Elements of a QAPI Program

Five strategic elements serve as the foundation for effective QAPI programs. They are the strategic framework for developing, implementing and sustaining a QAPI program. Keep the following in mind:

- The elements are not a checklist to complete once and then set aside. They are not necessarily chronological either, as each element requires evaluation and adjustment over time.
- Your QAPI program and annual plan must be based on your facility's programs and services, the needs of your patients and your assessment of your current quality challenges and opportunities.
- Your written QAPI plan, processes and policies should address all five elements.

Element 1: Design and Scope
A QAPI program must be ongoing and comprehensive and regularly evaluate the full range of services offered by the facility, including all clinical and non-clinical departments and contracted services (e.g., services provided by external organizations). Additionally, the QAPI program must include key care operational activities and programs such as patient and environmental safety, infection prevention and control, risk management, patient experience and engagement, emergency preparedness and staff engagement and well-being. When fully implemented, the QAPI program should address all systems of care and management practices and should use the best available evidence to define and measure goals.

As part of the QAPI program, a facility must include a system that addresses patient safety, all cause harm, and high-risk, high-volume, problem-prone areas such as blood transfusions, medication safety, emergency care, surgery and/or procedures, and infection control and sterilization. The facility must foster and maintain leadership and staff commitment to safety by creating and enforcing clear policies and processes, using data to drive and monitor safety improvements, communicating improvement goals and outcomes.

To ensure all components are included and to define the structure and processes of the QAPI program, facilities create and maintain a written QAPI Plan adhering to these principles. The QAPI Plan should be reviewed and improvement priorities and goals revised at least annually.

Go to the "What is a QAPI plan?" on-demand training.
This short video (1 minute, 39 seconds) talks about the QAPI plan, a document that guides your QAPI program.

Element 2: Governance and Leadership

A health care facility's governing body and/or executive leadership is responsible for setting the expectation for quality and safety, developing a culture of accountability and continuous improvement and designing systems with input from facility staff, patients, residents and their families and/or representatives. The governing body assures adequate resources exist to conduct QAPI efforts including:

- Designating one or more person(s) to be accountable for leading the QAPI program.
- Ensuring leadership and facility-wide training on QAPI skills, tools and processes.
- Allocating resources including staff time, equipment and space as needed.

The governing body and executive leaders should foster a culture where QAPI is a core value by:

- Setting and communicating clear behavioral expectations for safety, continuous improvement and patient-centered care and experience.
- Creating an atmosphere where staff are comfortable identifying and reporting quality problems, potential problems and opportunities for improvement.
- Holding staff accountable to behaviors in line with the facility's mission, values and policies.
- Daily demonstrating these expectations and values in word and deed.

Element 3: Feedback, Data Systems and Monitoring

A facility puts systems in place to monitor care and services through data from multiple sources. This element includes using performance indicators to monitor a wide range of care processes and outcomes. Analysis includes reviewing findings against external benchmarks and/or targets the facility has established for performance and evaluating the impact of changes as each is implemented. It also includes tracking, investigating and monitoring quality and safety risks and events that must be investigated and addressed when they occur to prevent recurrences.

Go to the "What is data?" on-demand training.
This short video (2 minutes, 22 seconds) focuses on how data informs and drives improvement.

Go to the "How do we use data for QAPI?" on-demand training.
This short video (3 minutes, 41 seconds) discusses how we use metrics to define performance over time.

Feedback systems actively incorporate input from staff, patients, residents, families, community partners and others as appropriate. A facility's feedback and data system should include multiple routes to seek out and receive experience stories and improvement ideas from all key care partners.

Element 4: Performance Improvement Projects
A performance improvement project is a concentrated effort on a particular problem or area of risk. A performance improvement project involves systematic gathering information to understand issues or problems, testing changes to the process, measuring the impact of each change to determine if it resulted in improvement and formally implementing and spreading changes that are shown to lead to better results.

Go to our "QAPI Basics On-Demand Video Series" playlist for the following videos:

- How do we know what to improve? (3 minutes, 31 seconds)
- What is a PI project? (2 minutes, 3 seconds)
- How do you structure a PI project? (3 minutes, 59 seconds)
- How do you define a project aim? (3 minutes, 52 seconds)
- How do we know what change to test? (3 minutes, 8 seconds)

Element 5: Systematic Analysis and Systemic Action
A facility uses a systematic approach to determine when in-depth analysis is needed to fully understand the problem, its causes and implications of a change. A facility uses a thorough and highly organized and structured approach to determine whether and how identified problems may be caused or exacerbated by the way care and services are organized or delivered. Additionally, a facility is expected to develop policies and procedures and demonstrate proficiency in event investigation and the use of root-cause analysis (RCA). Systemic actions look comprehensively across all involved systems to prevent future events and promote sustained improvement. This element includes a focus on continuous learning and improvement.

Illustrating QAPI in Action

This scenario illustrates a non-compliance issue identified by external surveyors. The example describes improvement with a focus on a singular or specific issue. The activities described are basic corrections that only addressed the immediate problem.

Scenario 1
The Issue: Hospital ABC received a deficiency finding during a survey, because two refrigerators were found to be out of temperature range at the time of inspection. It was noted the temperatures were not consistently monitored nor documented daily.

What Hospital ABC did: The quality committee and accreditation specialist developed a plan of correction, which included the following:

- Purchase, calibrate and install digital thermometers.
- Create a new monitoring documentation form.
- Provide staff education on the new form.

The team stated they would conduct audits of daily refrigerator temperatures for three months and report results to the quality committee.

The next case study describes a facility with high-functioning comprehensive QAPI systems in place to identify and address issues proactively before trends become serious problems. The facility regularly identifies and prioritizes performance improvement projects for high-risk, high-volume and problem-prone areas and applies that learning to other areas of potential risk. Examples of QAPI activities are identified throughout the scenario.

Scenario 2

The Issue: During the monthly QAPI meeting at Hospital XYZ, **the pharmacy department shared that refrigerator temperatures were not documented for several days**.

QA

This is concerning, because several medications and vaccines need to be stored within a specific temperature range. If the refrigerators are not held within that range, stored medications and vaccines will need to be thrown out at great cost to the facility and patients. While other issues and opportunities for improvement were identified at the meeting, the QAPI committee decided to launch a performance improvement project on temperature monitoring, because it is a high-risk problem for patients and the facility.

What Hospital XYZ did: **The QAPI committee chartered an interdisciplinary performance improvement project team composed of at least one representative from pharmacy, lab, nursing, maintenance and quality/safety. The team studied the issue and then performed a root-cause analysis (RCA) to help direct a plan of action**.

PI

The RCA revealed several underlying factors, including:

- The process relied on a single employee (a technician who checked the refrigerators each morning), and no process existed for ensuring the duty was completed if he was gone for the day.
- The documentation form was confusing and stored in a book on a shelf far away from the refrigerators.
- Staff lacked an understanding of how and when to monitor temperatures and document properly.
- One of the refrigerators varied highly in temperature and was past due for annual maintenance.

Based on the identified underlying causes, **the performance improvement project team recommended the following interventions**:

PI

- Develop a process to ensure all refrigerator temperatures are monitored and documented daily, with the consideration of an electronic/automatic monitoring and alarm system.
- Update and simplify the documentation form and post a copy of the form on the front of each refrigerator.
- Educate all appropriate staff on how and when to monitor temperatures and how to document.
- Create a back-up plan for when the assigned staff member is not available to complete the daily monitoring checks.
- Revise the maintenance schedule and create a maintenance monitoring system that will provide alerts for due dates at 30 days, seven days and one day before due date.

The interventions were implemented for the pharmacy refrigerators. **The performance improvement project team collected data using the temperature monitoring sheets and the maintenance schedule**.

PI

After three months, they found both refrigerators and the maintenance plan were well monitored and documented.

QA

Hospital XYZ also **performed a failure modes and effects analysis (FMEA) to identify other potential areas of risk and decided to adopt and expand the changes to other areas of the facility that require temperature monitoring and equipment maintenance**.

PI

They received no deficiencies related to temperature monitoring or equipment maintenance at their following survey.

What are the action steps for QAPI?

The most important aspect of QAPI is effective implementation. This section details action steps that may help you on your road to implementing a QAPI program. These steps do not need to be achieved sequentially, but they are interrelated and interdependent.

STEP 1: Set Leadership Responsibility and Accountability

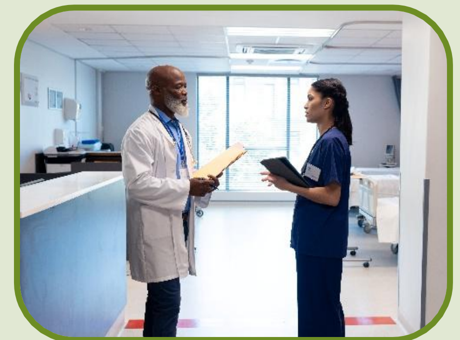
Creating a culture to support QAPI efforts begins with leadership. Support from the top is essential, and that support should foster the active participation of every employee. The administrator and senior leaders must create an environment that promotes QAPI and involves all employees.

Executive leadership sets the tone and provides resources. Their challenge is to help staff and QAPI efforts flourish in the facility.

Put a personal face on quality issues…

Leadership should:

- Give patients, family and staff the opportunity to meet board members and executive leaders to generate support for QAPI.
- Tour the organization regularly, meeting with patients and staff.
- Choose the person(s) who will lead your QAPI program in conjunction with executive management. QAPI needs champions.



Here are some ways leadership can take action:

Develop a steering committee, a team that will provide QAPI leadership.
The steering committee has overall responsibility to develop and modify the QAPI plan, review information and set priorities for performance improvement projects. The committee reviews status and results for priority metrics and performance improvement projects and helps determine the next steps – *applying systems thinking*. Systems thinking is a perspective that considers how things influence one another as a whole, rather than individual elements, or static “snapshots.”

The QAPI committee should:

- Be comprised of representatives from all key departments, services and programs.
- Meet at least quarterly (though monthly is recommended).
- Establish permanent and time-limited workgroups that report their respective performance improvement project progress and monitoring data.
- Involve executive operational and clinical leadership such as the CEO, CMO, clinical director, and/or the director of nursing.

Provide resources for QAPI, including equipment and training.
Staff and providers may need time to attend team meetings during working hours, requiring others to cover their clinical duties for a period of time. Equipment might include anything from additional computers to low-

cost supplies such as posters to create story boards or copies of resource or training materials. Leadership may want to consider sending one or more team members to a specialized training.

Establish a climate of open communication and respect.
Leadership may wish to consider:

- Having an open-door policy to communicate with staff and providers.
- Emphasizing communication across shifts and between department heads.
- Ensuring quality data and project progress are regularly shared with all staff.
- Creating an environment where staff feel free to bring quality concerns forward without fear of punishment.
- Planning for recognition and celebration of staff's efforts and contributions toward improvement

Understand your facility's current culture and how it will promote performance improvement. Create the expectation that everyone in your facility is working on improving care and services. Establish an environment where patients and families feel free to speak up to identify areas that need improvement. Expect and build effective teamwork among departments and staff.

Go to our "Leading Change for Improvement Series" playlist for the following videos:

- Intro to Leading Change for Improvement (2 minutes, 31 seconds)
- Technical vs. Adaptive Change (3 minutes, 53 seconds)
- Recognizing and Celebrating QAPI (3 minutes, 6 seconds)
- Sustaining Improvement (2 minutes, 55 seconds)

STEP 2: Identify Your Organization's Guiding Principles

It is important to lay a foundation that will help you think about what principles will guide your decision-making and help you set priorities. Health care facilities are complex organizations, with numerous departments performing different functions that interact with and depend on each other. Establishing a purpose and guiding principles will unify the facility by tying the work to a fundamental purpose or philosophy. These principles will help guide your facility in determining programmatic priorities.

Use the "Guide for Developing Purpose, Guiding Principles and Scope for QAPI" to establish the principles that will give your organization direction. Taking time to articulate the purpose, develop guiding principles and define the scope will help you understand how QAPI will be used and integrated into your organization. This information will also help your organization develop a written QAPI plan.

Go to Appendix: Guide for Developing Purpose, Guiding Principles and Scope for QAPI
This worksheet tool will help establish the purpose, guiding principles and scope for your facility's QAPI program.

STEP 3: Develop a Deliberate Approach to Teamwork

Teamwork is a core component of QAPI and is too often taken for granted. Improvement ideas and projects should be discussed with all interested and impacted parties. The perspectives and opinions of each team member are different, valuable and key to sustained success.

Characteristics of an effective team include…

- Having a clear purpose.
- Having defined roles for each team member.
- Having a commitment to work together to achieve the shared goal from each member.

QAPI relies on teamwork in several ways.

- Task-oriented teams may be specially formed to investigate a particular problem, and their work may be limited and focused.
- Performance improvement project teams, or PIP teams, are formed for work on an issue. When chartering a performance improvement project, careful consideration must be given to the project's purpose and type of members needed to achieve that purpose. Some examples include:
  - A PIP team with the goal of preventing patient and visitor falls decided grounds personnel needed to be represented so procedures for snow removal, sidewalk repair and railings could be considered.
  - A PIP team working on increasing patient access included a staffing service representative from the locum provider staffing service.
  - After a PIP team began working on the problem of anxiety among hospital patients, the members realized many of the affected patients reported reassurance from the chaplain and asked the QAPI committee to add him to the team.
  - A PIP team working on reducing falls asked the housekeeping department to be involved when it identified that clutter and cleanliness concerns in patient rooms contributed to recent falls.

Generally, each team should be composed of interdisciplinary members. For example, a concern with medication administration should include nursing and pharmacy team members. However, other disciplines such as medical records, health information technology (HIT) staff or patients and family members would bring the depth and breadth of different and valuable perspectives to the improvement team.

Family members and patients may be team members. However, for confidentiality reasons, they may not review certain data or information that identifies individuals. PIP teams need to plan for sufficient communication, including face-to-face meetings, to get to know each other and plan the work. Leadership needs to convey that being on a PIP team is an important part of the job, not something that can be put aside if other things come up. Leadership must support improvement through action and provision of resources to enable staff to provide clinical care, complete daily assignments and participate on QAPI teams as needed.

STEP 4: Complete a Self-Assessment

Use a self-assessment tool to take your QAPI program's pulse. It will help you evaluate which components of a robust QAPI program are in place within your organization and help you identify areas requiring further development.

You may develop your own facility's evaluation criteria or use an external self-assessment tool as you begin evaluation of your organization's progress. The evaluation should include 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 to establish and grow QAPI and a culture of improvement in your organization.

STEP 5: Develop Your QAPI Plan

Your QAPI Plan will assist you in achieving what you have identified as the purpose, guiding principles, scope, and gaps or areas of opportunity for further program development. This is a living document that you may revisit as your facility evolves.

A written QAPI Plan guides the facility's quality efforts and serves as the main document to support implementation of QAPI. The plan describes purpose, goals and scope of the program based on the unique characteristics and services of the facility and the current improvement priorities and goals. The QAPI Plan should also define the QAPI Committee, including membership and frequency of meetings. You should review and refine your QAPI Plan at least annually.

You may use the Guide for Developing a QAPI Plan to help you create a comprehensive plan that addresses the full range and scope of care and services provided by your organization.

Go to Appendix: Guide for Developing a QAPI Plan
This guide walks you through the steps of developing your QAPI plan to help you achieve what you have identified as the purpose, guiding principles and scope for QAPI.

STEP 6: Conduct a QAPI Campaign

Communicate with all staff and providers.

- Let everyone know about your QAPI plan – often and in multiple ways.
- Plan ongoing provider education beyond single exposures. The goal is widespread awareness of QAPI initiatives.
- Train through dialogue, examples and exercises. Transform the material in this guide into smaller pieces and easily understood ideas. Use your facility's own experiences with certain providers or patients as part of the learning materials.
- Convey the message that QAPI is about systems of care, management practices and business practices, not individual performance.
- Be sure consultants, contractors and collaborating agencies are also aware of and involved in your QAPI approach as appropriate.
- Clearly communicate that every employee is expected to raise quality concerns and suggest improvement ideas, that it is safe to do so and that everyone is encouraged to think about systems.

If systems do not exist, they may need to be developed.
If systems impede quality or safety, they must be changed.

Communicate with patients, residents and families.

- Make sure all patients and families know their views are sought, valued and considered in facility decision-making and process improvements by announcing and discussing QAPI in patient and family councils and via other venues.
- Ask patients and family members to tell you about their quality concerns. Many facilities today are using some type of customer satisfaction survey. Results should be used to identify opportunities for improvement that will proactively have an impact on all patients and their families.

- Try to view concerns through patients’ eyes. For example, getting back to a patient in 10 minutes may seem responsive, but may feel like an eternity to the patient. How would that feel to a patient waiting for help to the bathroom?
- Consider including QAPI information in routine communications to families.

Family and patient complaints are often underused for process improvement, and yet they are a valuable way of identifying more general problems.

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

Your team will decide what data to monitor routinely. Areas to consider may include:

- Patient charts and documentation.
- Incident reporting data.
- Complaints from patients, families and staff.
- Readmissions and utilization of services.
- Patient satisfaction survey results.
- Staff satisfaction survey results.
- Centers for Medicare & Medicaid Services (CMS) and accrediting body survey results and deficiencies.
- Business and administrative processes, including:
    - Billing and financial information
    - Staffing patterns and turnover
    - Provider credentialing and privileging

This data will require systematic organization and interpretation to achieve meaningful reporting and action. Compare this to an individual patient’s health. You must connect many pieces of information to reach a diagnosis. You also need to connect many pieces of information to learn your facility’s quality baseline, goals and capabilities.

Your team should set targets for performance in the areas you are monitoring. A target is a measurable and quantifiable goal. Your goal may be to reduce wrong site surgeries to zero. If so, even one instance will be too many. In other cases, you may have both short- and long-term goals. For example, your immediate goal may be reducing readmissions by 15% and then subsequently by an additional 10%. Think of your facility or organization as an athlete who keeps beating their own personal record.

Identifying benchmarks for performance is an essential component of using data effectively with QAPI. A benchmark is a standard of comparison. You may wish to look at your performance compared to facilities in your state and nationally by using Medicare Care Compare or another reliable database. Some states also have state report cards. You may compare your facility to other facilities, but because every facility is unique, the most important benchmarks are often based on your own performance. For example, you may seek to improve hand-washing compliance to 90% in three months based on a finding of 66% in the prior quarter. After achieving 90% for some period of time, the benchmark can be raised higher as part of ongoing, continuous improvement.

You will want to develop a plan for the data you collect. Determine who collects the data and how often, who reviews the data and analyzes the results and what success looks like. Collecting information is not helpful unless it is used. Be purposeful about your data collection. It is meant to be meaningful, not recreational. A project that has achieved and sustained 100% for many months is no longer a priority for improvement, meaning it is time to choose a new project.

STEP 8: Identify Your Gaps and Opportunities

This step involves reviewing your sources of information to determine whether gaps or patterns exist in your systems of care that could result in quality problems or opportunities for improvements. During this step, you may decide to spend more time discussing the quality themes you have identified with patients and staff. They may pick up patterns you have not yet identified, and they may have ideas about what is at the root of the problem. Consider hosting a series of small group meetings with your staff and arrange to meet with your patient and family engagement council (if applicable).

This step should lead to performance improvement projects. Such projects are expected to be prioritized to first deal with high-risk, high-volume, problem-prone areas related to quality of care or quality of life. Take time to notice what you are doing well and deserves recognition. While you are celebrating accomplishments, you can also begin to set priorities for improvement around issues the team identifies.

Go to the "Prompting Project Ideas" on-demand training.
This short video (3 minutes, 57 seconds) focuses on how to use prompts to awaken creative minds when embarking on quality assurance and performance improvement projects.

Go to the "Proactive Risk Assessment Through FMEA" on-demand training.
This video (4 minute, 37 seconds) explores failure mode and effects analysis (FMEA), a proactive way to identify and address risk.

STEP 9: Prioritize Quality Opportunities and Charter Performance Improvement Projects

Prioritizing opportunities for improvement is a key step in the process of translating data into action. As you continue to implement QAPI, you and your team will:

- Prioritize opportunities for more intensive improvement work.
- Consider how many performance improvement projects your facility can devote attention to at one time and prioritize which problem(s) will become the focus for a project.

All identified problems need attention and usually from more than one person, but they do not all require performance improvement projects. Begin some projects with problems or issues you think you can resolve relatively easily. A quick win is worthwhile.

Charter PIP teams.
We use the word "charter" on purpose. A performance improvement project is more than a casual effort. Chartering implies the team has been entrusted with a mission, and it reports back to the QAPI committee at specific intervals. Being part of a formally chartered PIP team must be interpreted as an important assignment that team members and their supervisors must take seriously. The development of a charter adds strength, importance and formality to the performance improvement project process.

The team typically has a leader, either appointed by leadership or by the team itself. Soon after the team begins its work, the PIP team should develop a proposed timeline, specific improvement goals and metrics and indicate the needed budget (if any).

Use the Goal Setting Worksheet in this toolkit to help your PIP team establish appropriate goals for organizational quality measures, informal improvement initiatives and performance improvement projects.

Go to Appendix: Goal Setting Worksheet
This worksheet will help your QAPI team establish appropriate goals for individual measures and performance improvement projects.

STEP 10: Plan, Conduct and Document Performance Improvement Projects

Careful planning of performance improvement projects includes identifying areas to work on through your comprehensive data review which are meaningful and important to your patients. It is important to focus your projects by defining the scope, so they do not become overwhelming.

You and your team may:

- Consider each performance improvement project a learning process.
- Determine what information you need for the performance improvement project.
- Determine a timeline and communicate it to the steering committee.
- Identify and request any needed supplies or equipment.
- Select or create measurement tools as needed.
- Prepare and present results.
- Use a problem-solving model like PDSA (plan-do-study-act).
- Report results to the QAPI committee.

Plan-Do-Study-Act (PDSA) Model
During a performance improvement project, you will try out some changes and then see whether they make a difference in the area you are trying to improve.

PLAN: The team learns more about the problem, plans for how improvement will be measured and plans for any changes that might need to be implemented.

DO: The plan is carried out, including the selected measures.

STUDY: The team summarizes what is observed and learned.

ACT: The team and leadership determine what should be done next. The change can be adapted (and re-studied), adopted (perhaps expanded to other areas) or abandoned. This decision determines the next steps in the cycle.

Go to the "Three Common Approaches" on-demand training.
This short video (4 minutes, 59 seconds) discusses three common approaches for leading quality improvement projects and offers examples for when to use each one.

STEP 11: Get to the Root of the Problem

A major challenge in process improvement is getting to the true heart of the problem or opportunity.

Starting with a solution without thoroughly exploring the problem can set up your project for failure. Multiple factors may have contributed to the issue, and/or the problem may be a symptom of a larger issue. What seems like a simple issue may involve a number of departments.

Root-cause analysis (RCA) is a term used to describe a systematic process for identifying contributing causal factors that underlie variations in performance. This structured method of analysis is designed to get to the underlying cause of a problem, which then leads to identification of effective interventions that can be implemented to make improvements. RCAs focus primarily on systems and processes, not individual performance.

RCAs help teams understand that the most immediate or seemingly obvious reason for the problem or an event may not be the real reason for why an event occurred. The RCA process leads to digging deeper and looking for the reasons behind the reasons. This process will generally lead to the identification of more than one root cause. The root cause(s) and any contributing factors can then be sorted into categories to facilitate the identification of various actions that can be taken to make improvements.

The RCA process takes practice but can be a valuable tool for performance improvement. To get familiar with RCA, you and your team may consider:

- Studying case examples of RCAs.
- Applying RCA to an adverse event and discussing this technique with the team.
- Building RCA examples into training opportunities.

Go to the "Identifying Causes of Problems Through RCA" on-demand training.
This video (5 minutes, 46 seconds) focuses on root cause analysis and the importance of understanding the problem, what factors caused the problem and not settling for a quick fix.

STEP 12: Take Systemic Action

Identifying root causes is only the first step in improving performance. Next, you will want to implement changes or corrective actions that will result in improvement or reduce the chance of the event recurring. This is often the most challenging step in the process. Common solutions such as providing more staff training/education or asking clinicians to "be more careful" do not change the process or system. These proposed solutions are based on two assumptions:

1. Lack of knowledge contributed to the event.
2. If a person is educated or trained, the mistake will not happen again.

Choosing actions tightly linked to the root causes and that lead to a system or process change are considered to have a higher likelihood of being effective. Actions that simply support the current process are considered weak and should not be selected as the sole intervention. The goal is to make changes that will result in lasting improvement. Avoiding quick fixes and weak actions is vital to achieving that goal.

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. In addition, interventions must be achievable, objective and measurable.

Pilot a test…

Start small! Think about testing or "piloting" changes in one area of your facility before launching throughout the whole department or facility. Some changes have unintended consequences that can be identified and addressed before full implementation.

The U.S. Department of Veterans Affairs [National Center for Patient Safety's Hierarchy of Actions] classifies corrective actions as weak, intermediate and strong.

Weak: Actions that depend on staff to remember their training or what is written in the policy. Weak actions enhance or enforce existing processes. Examples of weak actions include:

- New policies, procedures and memoranda.
- Training and education.
- Additional study.
- Double checks.
- Warnings and labels.

Intermediate: Actions are somewhat dependent on staff remembering to do the right thing, but they provide tools to help staff remember or promote clear communication. Intermediate actions modify existing processes. Examples of intermediate actions include:

- Decrease workload.
- Software enhancements and modifications.
- Eliminate or reduce distraction.
- Checklists and cognitive aids, triggers and prompts.
- Eliminate look-alike and sound-alike.
- Read back.
- Enhanced documentation and/or communication.
- Built-in redundancy such as two-person validation or two-identifiers for patients.

Strong: Actions that do not depend on staff to remember to do the right thing. The action may not eliminate the vulnerability but provides strong controls. Strong actions change or redesign the process. They help detect and warn so the opportunity to correct happens before the error reaches the patient. Strong actions may involve hard stops that will not allow the process to continue unless something is corrected or gives the chance to intervene to prevent significant harm. Examples of strong actions:

- Physical changes – grab bars, nonslip strips on tubs and showers.
- Visual aids – clear labeling and outlined areas for equipment or supplies storage and stocking.
- Forcing functions or constraints – design of tubing so only oxygen can be connected to oxygen lines.
- Electronic medical records – cannot continue charting unless all fields are filled in.
- Simplifying and standardizing – reduce unnecessary steps and variation.

Prevent future problems by developing and testing strong actions.

Go to the "Human Factors Systems Design" on-demand training.
This video (6 minutes, 58 seconds) focuses on how our human nature impacts how well we do any task, including the tools we use, our workplace environment, our systems and processes.

Go to the "Corrective Action Hierarchy" on-demand training.
In this short video (4 minute, 3 seconds), learn how to help improvement teams consider changes to test by using the corrective action hierarchy model.

Remember Hospital XYZ's performance improvement project in Scenario 2 about the refrigerator temperatures? Many of the QAPI action steps discussed in this guide are found in that scenario. Some key highlights include:

- The facility had a structured steering committee for directing the QAPI activities (Step 1).
- The facility established performance measures and was conducting routine monitoring (Step 6).
- The facility used data to identify gaps or opportunities for improvement (Step 8).
- The QAPI steering committee used prioritization to decide when to conduct PIPs (Step 9).
- The QAPI steering committee created an interdisciplinary team, and as seen in this example, each discipline in the team brought a unique perspective that contributed to a balanced and comprehensive analysis (Step 3).
- The QAPI steering committee gave each team member real responsibility to study the issue, analyze the data and recommend corrective actions (Step 3).
- The PIP team explored the issue and designed interventions using a PDSA model (Steps 9 and 10).
- The PIP team's investigation revealed several underlying systemic issues and made recommendations that addressed those systems, rather than focusing on individual behavior (Step 12).

QAPI Summarized

QAPI may not be new to your facility, but there is likely room for improvement. If you already have a QAPI program and/or committee, consider beginning by evaluating or re-evaluating your program.

QAPI leadership starts at the top with executive management and the governing board in each facility.

Start using systems thinking as you assess your own QAPI efforts and develop a QAPI plan. Think of your entire facility or community as you plan for monitoring, as you conduct performance improvement projects and especially as you think about the way problems might be caused and how care is organized.

Involve the people directly working in a process to improve that process. These are the people who really know what happens at any point in the process. It is crucial to focus on organization-wide inclusion, not for the sake of inclusion, but to truly understand what is going on in any given process.

Communication about QAPI should be continuous across the entire organization. QAPI principles and ongoing training should be built into a facility-wide educational effort that involves all staff, patients and families.

Patients' perspectives need to be considered in setting QAPI priorities. Solicit patients' viewpoints and talk to patients and families about quality as they experience it.

Two important components of your QAPI plan will be setting priorities and chartering PIP teams. Everyone should have an opportunity to participate in these activities.

Create a record of QAPI activities. Consider using past experience as a resource as you move ahead. Keeping an ongoing record of QAPI achievements may help to sustain the improvements regardless of crises or changes in leadership. Build it into your plan.

Celebrate and reward successes! We often forget to do this, but it is incredibly important for sustaining momentum and enthusiasm for improvement.

QAPI Tools and Resources

QAPI Process Tools

Tools that help make QAPI processes work include:

- Checklists
- Templates
- Flow charts
- Reporting forms or outlines
- Worksheet

QAPI process tools are important to:

- Organize multiple tasks.
- Enhance communication within and across teams.
- Help generate ideas and reach decisions.
- Standardize and keep information organized and accessible.
- Track successes and challenges using data.

QAPI is largely about well-functioning and tightly coordinated systems that can identify, solve and prevent problems effectively. Using QAPI can improve diverse aspects of care and services as well as patient, resident, family, provider and staff experience and satisfaction. Tools can help.

QAPI Topic Tools

QAPI topic tools are used to study and improve particular topic areas. Many tools are available to assess care processes and outcomes and to allow you to follow progress in areas you want to track and/or improve. Topic tools can take many forms, ranging from simple to complex, and they use multiple sources of information.

- Audits completed by staff and providers – Audit checklists can be used to review records of various kinds to determine all steps have been taken, for example, a discharge or fall prevention checklist.

- Rating forms completed by providers – For example, patients' mood states are rated when patients cannot respond to direct questions.

- Structured observation of interactions or physical environments – Observations are objective and made at specific times and places. Later they may be summarized into a score.

- Direct interviews with patients and family – Such tools, sometimes called patient self-report tools, can be used to better understand specific experiences or overarching impressions about the facility.

- Protocols to guide providers' behavior to improve quality in a particular area – Such protocols may include procedures and forms meant to shape provider behavior around medication administration,

respecting patients' rights, etc. This comprehensive set of tools could be considered a QAPI process toolkit as well.

Facilities may wish to select established tools that have been tested and use them consistently.

Additional QAPI Resources

Centers for Medicare & Medicaid Services (CMS) American Indian Alaska Native (AIAN) Quality Improvement Organization (QIO)
Your facility is served by the QIO. To find out more about the program, contact your quality improvement advisor, email ContactUs@aianqio.org or visit the program website at https://www.aianqio.org/.

Agency for Healthcare Research and Quality (AHRQ)
The Guide to Patient and Family Engagement in Hospital Quality and Safety is a tested, evidence-based resource to help hospitals work as partners with patients and families to improve quality and safety. https://www.ahrq.gov/professionals/systems/hospital/engagingfamilies/guide.html

Consumer Assessment of Healthcare Providers and Systems (CAHPS)
CAHPS (pronounced "caps") are national, standardized, publicly reported and compared (for hospitals) surveys of patients' perspectives of care. CAHPS measure patients' perceptions of their care experience. https://www.cms.gov/data-research/research/consumer-assessment-healthcare-providers-systems

Indian Health Service (IHS)
IHS is committed to continuing efforts to achieve and maintain accreditation of IHS direct service facilities, align service delivery processes that improve the patient experience, ensure patient safety and improve processes and strengthen communications for early identification of risks. https://www.ihs.gov/quality/

Institute for Health Care Improvement (IHI)
IHI uses the Model for Improvement as the framework to guide improvement work. The Model for Improvement, developed by Associates in Process Improvement, is a simple but powerful tool for accelerating improvement. Learn about the fundamentals of the Model for Improvement and testing changes on a small scale using plan-do-study-act (PDSA) cycles. http://www.ihi.org/knowledge/Pages/HowtoImprove/default.aspx

Institute for Patient and Family-Centered Care (IPFCC)
IPFCC advances the understanding and practice of patient- and family-centered care. In partnership with patients, families and health care professionals, IPFCC seeks to integrate these concepts into all aspects of health care. www.ipfcc.org

Appendix

Guide for Developing Purpose, Guiding Principles and Scope for QAPI

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

STEP 1. Locate or develop your organization's vision statement.

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

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

STEP 2. Locate or develop your organization's mission statement.

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

For example, Mayo Clinic's mission statement is to inspire hope and contribute to health and well-being by providing the best care to every patient through integrated clinical practice, education and research.

STEP 3. Develop a purpose statement for QAPI.

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

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

STEP 4. Establish guiding principles.

Guiding principles describe the organization's beliefs and philosophy pertaining to QAPI. The principles should guide what the organization does, why it does it and how.

For example:

- Guiding principle #1: QAPI has a prominent role in our management and board functions, on par with monitoring reimbursement and maximizing revenue.
- Guiding principle #2: Our organization uses QAPI to make decisions and guide our day-to-day operations.

- Guiding principle #3: The outcome of QAPI in our organization is the quality of care and the quality of life of our patients.
- Guiding principle #4: In our organization, QAPI includes all employees, all departments and all services provided.
- Guiding principle #5: QAPI focuses on systems and processes, rather than individuals. The emphasis is on identifying system gaps rather than on blaming individuals.
- Guiding principle #6: Our organization makes decisions based on data, which includes the input and experience of employees, patients, health care providers, families and other partners.
- Guiding principle #7: Our organization sets goals for performance and measures progress toward those goals.
- Guiding principle #8: Our organization supports performance improvement by encouraging our employees to support each other as well as be accountable for their own professional performance and practice.
- Guiding principle #9: Our organization has a culture that encourages, rather than punishes, employees who identify errors or system breakdowns.

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

STEP 5. Define the scope of QAPI in your organization.

The **scope** outlines what types of care and services are provided by the organization that impact clinical care, patient safety and experience of care. Be sure to incorporate the care and services delivered by all departments.

For example:

Emergency Department
Discharge Planning
Housekeeping
Maintenance

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

STEP 6. Assemble documents.

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

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

Guide for Developing a QAPI Plan

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

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

II. **Scope**
   a. Describe how QAPI is integrated into all care and service areas of your organization.
   b. Describe how the QAPI plan will address:
      i. Clinical care
      ii. Patient and staff safety
      iii. Patient and staff experience (e.g., individualized goals for care)
   c. Describe how QAPI will aim for safety and high quality with all clinical interventions while emphasizing autonomy and choice in daily life for patients (or patient's agents).
   d. Describe how QAPI will utilize the best available evidence (e.g., data, national benchmarks, published best practices, clinical guidelines) to define and measure goals.

III. **Guidelines for Governance and Leadership**
   a. Describe how QAPI is integrated into the responsibilities and accountabilities of top-level management and the board of directors (if applicable).
   b. Describe how QAPI will be adequately resourced.
      i. Designate one or more persons to be accountable for QAPI leadership and for coordination.
      ii. Indicate the plan for developing leadership and facility-wide training on QAPI.
      iii. Describe the plan to provide staff time, equipment and technical training as needed for QAPI.
      iv. Indicate how you will determine if resources are adequate for QAPI.
   c. Describe how your staff will become and remain proficient with process improvement tools and techniques. How will you assess their level of proficiency?
   d. Establish QAPI leadership.
      i. While everyone in the organization is involved in QAPI, you will likely have a small group of individuals who will provide the backbone or structure for QAPI in your organization. Who will be part of this group? Many of these individuals may be on your current quality assessment and assurance committee.
      ii. Describe how this group of people will work together, communicate and coordinate QAPI activities. This could include but is not limited to:
         - Establishing a format and frequency for meetings.
         - Establishing a method for communication between meetings.
         - Establishing a designated way to document and track plans and discussions addressing QAPI.

iii. Describe how the QAPI activities will be reported to the governing body, i.e., board of directors, CEO.

IV. Feedback, Data Systems and Monitoring

a. Describe the overall system that will be put in place to monitor care and services, drawing data from multiple sources.
b. Identify the sources of data you will monitor through QAPI.
   i. Input from staff, patients, families and others
   ii. Adverse events
   iii. Performance indicators
   iv. Survey findings
   v. Complaints
c. Describe the process for collecting the above information.
d. Describe the process for analyzing the above information, including how findings will be reviewed against benchmarks and/or targets established by the facility.
e. Describe the process to communicate the above information. What types of reports will be used? One way to accomplish this is to use a dashboard or dashboards for individual performance improvement projects.
f. Identify who will receive this information (i.e., executive leadership, QAPI leadership, patient/family council, facility staff), in what format and how frequently information will be disseminated.

V. Guidelines for Performance Improvement Projects

a. Describe the overall plan for conducting performance improvement projects to improve care or services.
   i. Indicate how potential topics for performance improvement projects will be identified.
   ii. Describe criteria for prioritizing and selecting performance improvement projects, areas important and meaningful for the specific type and scope of services unique to the facility require a concentrated effort on a particular problem in one area of the facility or facility-wide.
   iii. Indicate how and when performance improvement project charters will be developed.
b. Describe the process for reporting the results of performance improvement projects. Identify who will receive this information (i.e., quality committee, patient/family council, facility staff), in what format and how frequently information will be disseminated.
c. Describe how to designate PIP teams and establish and describe a process for assembling teams to work on specific performance improvement projects.
d. Define the required characteristics for any PIP team. This may include that the team be interdisciplinary (i.e., representing each of the job roles affected by the project), that the team include patient representation (as appropriate) and that a qualified team leader is selected (i.e., ability to coordinate, organize and direct all activities of the project team). Describe how PIP teams should document and report their work.
e. Describe your process for documenting performance improvement projects, including highlights, progress and lessons learned. For example, what project documentation templates will you use consistently and file electronically in a standardized fashion for future reference?

VI. Systematic Analysis and Systemic Action

a. Any change that is made has the potential to have broader impact than intended. If you are trying to make a change to a specific system or process, it is important to recognize

any “unintended” consequences of your actions. Describe how your organization will identify these consequences which may be either positive or negative.

b. Describe the process you will use to ensure you are getting at the underlying causes of issues, rather than applying quick fixes that address symptoms only.
c. Describe how you will monitor to ensure that interventions or actions are implemented and effective in making and sustaining improvements.

VII. Communications

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

VIII. Evaluation

a. Describe the process for assessing QAPI in your organization on an ongoing basis.
b. Describe the purpose of this evaluation, e.g., to help your organization expand your skills in QAPI and increase the impact of QAPI in your organization.

IX. Establishment of Plan

a. Date your plan.
b. Determine when you will revisit the plan (e.g., at least annually).
c. Determine how you will track revisions or updates to the plan.

Goal Setting Worksheet

Directions: Goal setting is important for any measurement related to performance improvement. This worksheet is intended to help QAPI teams establish appropriate goals for individual measures and with 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.

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 (e.g., count, percentage, 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 best practice/average score/benchmark?
Is the goal measure set so 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 but concise enough that it can be easily communicated and remembered. It is a good idea to post the written goal somewhere visible and regularly communicate the goal during meetings to stay focused and remind staff everyone is working toward the same aim.

[**Example:** Increase the number of patients with a vaccination against both influenza and pneumococcal disease documented in their medical record from 61% to 90% by December 31, 2027.]