QAPI
Role of the Patient

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Objective

To review regulatory framework for QAPI

To highlight new requirement for patient participation in QAPI

To review patient experiences in QI

To present tools that might be useful

To share ideas

ESRD Networks

Social Security Amendments of 1972 defined an entitlement extending Medicare to those with irreversible kidney failure

1978: PL 95292 established 32 ESRD Networks – regional organizations to assure access to dialysis, tx, and oversee quality of care

1986: OBRA – 32 Networks became 17, then 18

QAPI - Quality Assessment & Performance Improvement

42 CFR Ch IV Part 494 Subpart C Patient Care 494.110

Other sections reference QAPI:

- 494.30 (b) (3) report all IC issues to med director and QI Committee
- 494.150 (a) Medical director is responsible for the Quality Assessment and Improvement Program
- 494.180 (a)(4) Governing body appoints a CEO/administrator who allocates necessary staff, resources for QAPI
- 494.180 (c) (2) Governing body informs medical staff appointees of QAPI program
- 494.180 (h) Facility must furnish data to CMS […] relevant to […] quality improvement and quality assessment.

The dialysis facility must develop, implement, maintain, & evaluate an effective, data-driven QAPI program with participation by the professional members of the IDT. The program must reflect the complexity of the organization & services (including those under arrangement), & must focus on indicators related to improved health outcomes & the prevention & reduction of medical errors. The dialysis facility must maintain & demonstrate evidence of its QAPI program including continuous monitoring for CMS review. Refer to your ESRD Network's goals for targets for aggregate patient outcomes

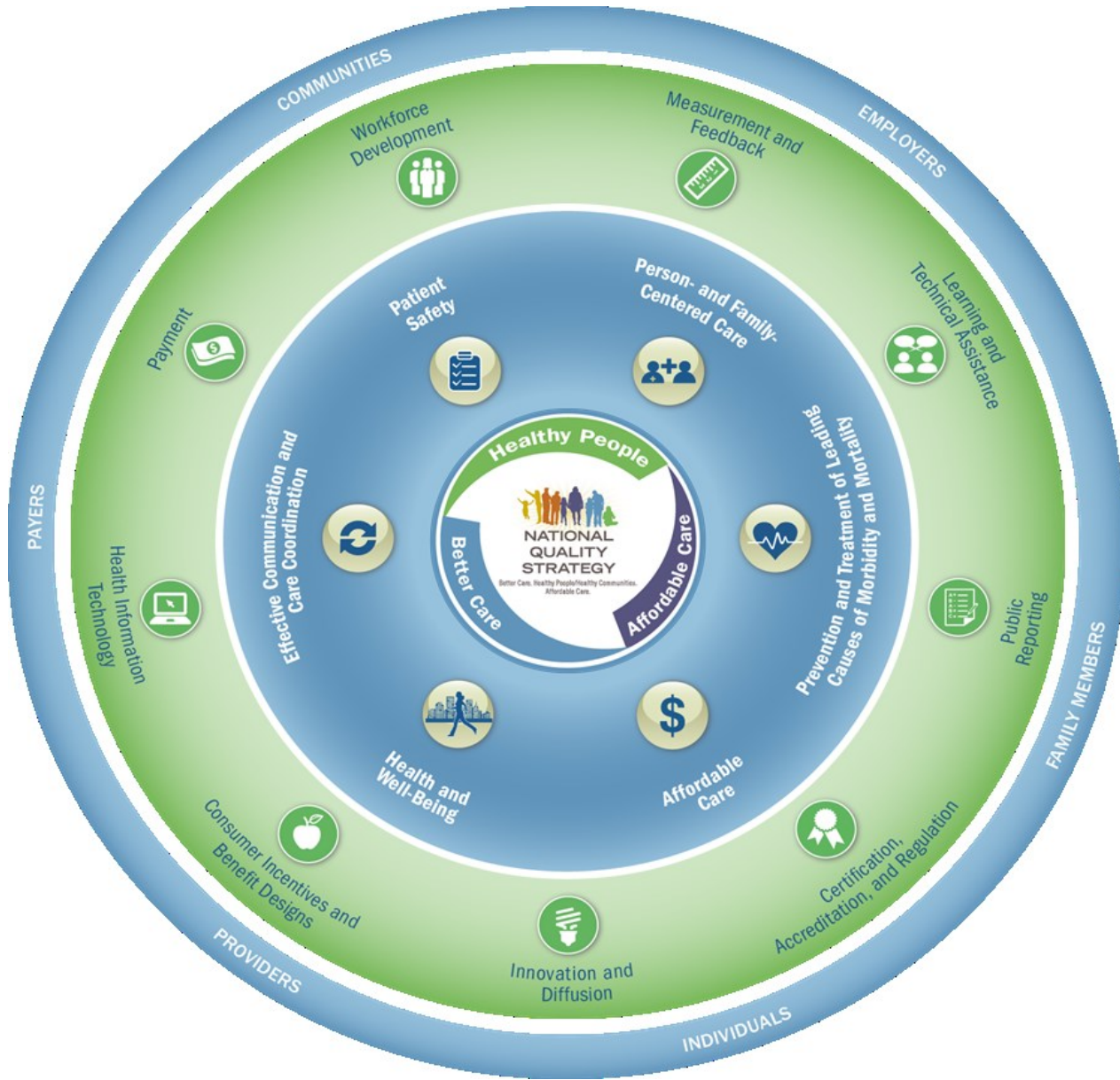# MAT

Health outcomes: Physical & mental functioning	Survey adult/pediatric patients by standardized tool, e.g. KDQOL-36 survey or age appropriate survey	Achieve & sustain appropriate status ↑ % of eligible patients completing survey	Conditions for Coverage	Records
Health outcomes: Patient hospitalization	Standardized hospitalization ratio (1.0 is average, >1.0 is worse than average, <1.0 is better than average)	↓ unplanned hospitalizations	Conditions for Coverage	DFR Records
Health outcomes: Patient survival	Standardized mortality ratio (1.0 is average, >1.0 is worse than average, <1.0 is better than average)	↓ mortality	Conditions for Coverage	DFR Records
(i) HD adequacy (monthly)	HD: Adult (patient with ESRD ≥3 mo)	↑ % with spKt/V ≥1.2 or URR ≥65% if 3 times/week dialysis and stdKt/V $\geq$2.0/week if 2 or 4-6 times/week dialysis	Conditions for Coverage NQF #0249 (adult) NQF #1423 (peds)	DFR Records
(i) PD adequacy (rolling average, each patient tested ≤4 months)	PD: Adult	↑ % with weekly Kt/V_{urea} ≥1.7 (dialysis+RKF)	Conditions for Coverage NQF #0318	DFR Records
(ii) Nutritional status	Facility set goals; refer to parameters listed in V509	↑ % of patients within lab target range on albumin and other nutritional parameters set by the facility	Conditions for Coverage; KDOQI Nutrition 2000 KDOQI CKD 2002	Records
(iii) Mineral metabolism/renal bone disease	Calcium, phosphorus, & PTH	↑ % in target range on all measures monthly	Conditions for Coverage	Records
(iv) Anemia management Monitor patients on ESAs &/or patients not taking ESAs	Anemia symptoms Blood transfusion Serum ferritin & transferrin saturation or CHr Patient education on ESAs	↓% of patients with anemia symptoms ↓ % of patients (esp. transplant candidates) transfused Evaluate if indicated ↑% of patients educated about potential risks/benefits	FDA 6/24/11 for more info re CKD 5D recommendation	DFR Records Interview
(v) Vascular access (VA) Evaluation of VA problems, causes, solutions	Cuffed catheters > 90 days AV fistulas for dialysis using 2 needles, if appropriate Thrombosis episodes Infections per use-life of access VA patency	↓ to <10%[6] ↑ to ≥65%[6] or ≥66%[7] ↓ to <0.25/pt-yr at risk forfistulas; 0.50/pt-yr at risk for (grafts ↓ to <1% (fistula); <10% (graft) ↑ % with fistula >3 yrs & graft >2 yrs	[5]KDOQI Vascular Access2006 [8]Fistula First	DFR Records
(vi) Medical injuries & medical errors identification	Medical injuries & medical errors reporting	↓ frequency through prevention, early identification & root cause analysis	Conditions for Coverage	Records
(vii) Reuse	Evaluation of reuse program including evaluation & reporting of adverse outcomes	↓ adverse outcomes	Conditions for Coverage	Records
(viii) Patient satisfaction & grievances	Report & analyze grievances for trends CAHPS In-Center Hemodialysis Survey or other survey	Prompt resolution of patient grievances ↑ % of patients satisfied with care	Conditions for Coverage	Records Interview
(ix) Infection control	Analyze & document incidence for baselines & trends	Minimize infections & transmission of same Promote immunizations	Conditions for Coverage	DFR Records
Vaccinations	Hepatitis B, influenza, & pneumococcal vaccines Influenza vaccination by facility or other provider	Documentation of education in record ↑ % of patients vaccinated on schedule ↑ % of patients receiving flu shots 10/1-3/31	Conditions for Coverage NQF #0226	Records DFR

2019 Scope of Work

National Quality Strategy

HHS Secretary Goals
◦ Opioid Crisis
◦ Health Insurance Reform
◦ Drug Pricing
◦ Value Based Care

National Quality Strategy diagram

Outer ring (stakeholders): COMMUNITIES · EMPLOYERS · FAMILY MEMBERS · INDIVIDUALS · PROVIDERS · PAYERS

Green ring (levers):
- Workforce Development
- Measurement and Feedback
- Learning and Technical Assistance
- Public Reporting
- Certification, Accreditation, and Regulation
- Innovation and Diffusion
- Consumer Incentives and Benefit Designs
- Health Information Technology
- Payment

Blue ring (priorities):
- Patient Safety
- Person- and Family-Centered Care
- Prevention and Treatment of Leading Causes of Morbidity and Mortality
- Affordable Care
- Health and Well-Being
- Effective Communication and Care Coordination

Center:
Healthy People · Better Care · Affordable Care

NATIONAL QUALITY STRATEGY
Better Care. Healthy People/Healthy Communities. Affordable Care.

Outer ring (blue): COMMUNITIES · EMPLOYERS · FAMILY MEMBERS · INDIVIDUALS · PROVIDERS · PAYERS

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Inner ring priorities: Patient Safety · Person- and Family-Centered Care · Prevention and Treatment of Leading Causes of Morbidity and Mortality · Affordable Care · Health and Well-Being · Effective Communication and Care Coordination

Center: Healthy People · Better Care · Affordable Care

NATIONAL QUALITY STRATEGY
Better Care. Healthy People/Healthy Communities.
Affordable Care.

CMS Priorities

Empower patients and doctors to make decisions about their health care

Usher in a new era of state flexibility and local leadership

Support innovative approaches to improve quality, accessibility, and affordability

Improve the customer experience

New Scope of Work

The Network shall provide technical assistance to project-participating dialysis facilities on

Incorporating patient, family and caregiver participation into the Quality Assurance Performance Improvement (QAPI) Program and governing body of the facility;

Concepts

Use innovative approaches, rapid cycle improvement incorporating boundariliness, unconditional teamwork, customer focus, emphasis on sustainability

Theoretical Considerations

- Traditional view: power is vested in the providers; beneficiaries are passive recipients
- Forces for change:
  - Public mistrust
  - Demands for transparency, accountability
  - Growing support for principles of democracy and consumerism
  - Healthcare is in reality co-produced
- Barriers to change
  - Bureaucracy – averse to power sharing
  - Tokenism, suboptimal quality of involvement, lack of resources prevents meaningful engagement
- Next steps
  - Activate the consumer – create an invited space allowing consumers to participate in decision-making by the experts

Research on patient engagement in QI

- Patient-family advisors (PFAs) were asked to participate in Rapid Process Improvement Workshops in Saskatchewan, Canada (Goodrich D, Isinger T, Rotter T. Patient family advisors' perspectives on engagement in healthcare quality improvement initiatives: power and partnership. Health Expect. 2018;21:379-386.)

- Interviews conducted of 18
  - 4 with negative experiences with the healthcare system; 5 positive; 9 mixed
  - Most experienced one or one more encounters characterized by disrespect
  - Most had felt powerless
  - 7 of the volunteers were enticed by ads; the rest were recruited
  - Motivations to join: to have agency and possible shared actions; to create a better system; to learn "insider" knowledge, (a form of power); assertion of rights (right to get well, not sicker as a result of the healthcare system); obligation to help as a civic duty; obligation to help others who cannot help themselves (altruism); gratitude (if past experiences positive)
  - Time commitment was a barrier; before participating - concerns about being heard, keeping up intellectually

What happened

- Patients shared stories
- Patients found themselves in the company of high level executives
- Patients felt encouraged to contribute.
- Patients came to recognize that they could express points of view that the staff might feel constrained to express
- PFAs redirected conversations away from impact change had on staff to impact change had on patients.

Lessons learned

- Participants should be those with lived experience within the healthcare system
- Capacity to act on the power given to speak up
- Patients generally self-selected into groups they felt they had sufficient knowledge to make a contribution
- Participants felt empowered to speak up and advocate even after their project ended
- Some participants gained a more nuanced appreciation of healthcare work
- Some participants found it took focus away from the negative aspects of their chronic illness channeling their focus on making things better.
- Some participants developed social capital – new relationships, new speaking skills
- Some were disappointed that they did not know the impact of their work – follow up.

Potential Implications for QAPI

- Recruit patients and family members whose experiences may motivate them to participate

- Orient the participants in the QAPI process, work of the committee, time commitment

- Actively encourage participation

- "Prescriptive" nature of some of what QAPI committees are required to discuss may not align with patient centered concerns.

- Nonetheless, some patients may be motivated to become advocates for a more patient centered approach to future QAPI requirements and help move QAPI activities in that direction.

- Limitation of study – qualitative research; recall of experience may have been more accurate for some. The RPIW experience may not be generalizable

Patient engagement in hospital health service planning and improvement: a scoping review*

Search review criteria: consumer participation or patient participation and (program evaluation or quality improvement or hospital administration or hospital planning or health services research)

Interventions included consulting about or engaging patients or providers in hospital service improvement activities of any type including governance, service planning, delivery, evaluation or quality improvement, or research to inform service design or improvement.

2227 full-text studies emerged as potentially relevant.

10 studies were included in the review

Only one paper described patient members of quality committees.

No study evaluated impact of PE on clinical outcomes

*Liang L, Cako A, Urquhart R, Straus se, Wodkis WP, Baker GR, Gagliardi AR. BMJ Open 2018;8:1-8

Facilitators	Barriers
• Selection of patients based on their personal characteristics and skills[24]	• Lack of knowledge among healthcare professionals on how to engage with an empowered group of questioning patients[29]
• Involving patients and staff with the desire to work together[24]	
• Involving supportive staff with leverage to navigate hospital processes to effect change[21]	• Lack of guidance on the role of patients and how they should be involved[24 27]
• Early involvement in projects so that patients were familiar with objectives and could offer meaningful contributions to shape the project's aims and activities[22]	• Healthcare professional beliefs about the relevance and representativeness of individual patient experiences[21 28]
• Meeting monthly or more frequently if needed[24]	• Healthcare professional beliefs about patient capacity to contribute given lack of criteria for inclusion or a vetting process[24]
• Small team size that was less hierarchical and more easily integrated patients[24]	
• Explicit effort to involve patients in meetings and extend value and respect for their input[22 24 29]	• Healthcare professional beliefs that patient feedback was complaining and patients were hostile and ungrateful[28 29]
• Debriefing with patients after meetings to gather feedback about how the session had gone and how interaction could be improved[22]	• Infrequent meetings[24]
	• Disagreement between patients and healthcare professionals on the role of patients[27]
• Formal interaction supplemented with informal interaction by email, telephone or other interaction to build relationships[22]	• Lack of informal opportunities outside of meetings for interaction to build trust[24]
• Formalising patient roles by labelling and recognising their position[22 24]	• Dysfunction and hierarchies among the healthcare professionals[24]
• Asking patients about feelings to prompt detailed accounts of their experiences[26]	• Pressure from senior management to achieve specific objectives that diverged from patient objectives[29]
• Joint training of patients and healthcare professionals[22]	
• Patient recommendations that align with what healthcare professionals consider appropriate[25]	

Table A1

Patient involvement in planning for quality at hospital and departmental levels

Patients are involved in	Hospital quality manager		Head of pathway								P-value*
			AMI		Deliveries		Hip fracture		Stroke		
	N	%	N	%	N	%	N	%	N	%	
Total respondents, N (row %)	72	100	64	24.4	65	24.8	65	24.8	68	25.9	
Development of quality criteria											
Never	42	56.7	22	34.3	37	56.9	31	47.6	38	55.8	0.211
Sometimes	20	27.0)	28	43.7	17	26.1	19	29.2	21	30.8	
Usually	8	10.8	4	6.2	4	6.1	8	12.3	7	10.2	
Always	2	2.7	4	6.2	6	9.2	3	4.6	2	2.9	
Missing	0	0	6	9.3	1	1.5	4	6.1			
Design/organization of processes											
Never	45	60.8	28	43.7	43	66.1	36	55.3	41	60.2	0.217
Sometimes	21	28.3	24	37.5	11	16.9	17	26.1	18	26.4	
Usually	3	4.0	5	7.8	6	9.2	8	12.3	8	11.7	
Always	2	2.7	2	3.1	4	6.1	1	1.5	1	1.4	
Missing	1	1.3	5	7.8	1	1.5	3	4.6			
Quality committees											
Never	48	64.8	30	46.8	37	56.9	44	67.6	41	60.2	0.276
Sometimes	13	17.5	16	25.0	16	24.6	10	15.3	15	22.0	
Usually	4	5.4	7	10.9	3	4.6	2	3.0	8	11.7	

Open in a separate wind

*P-value for differences in items across pathways from Fisher's exact test.

Groene O et al. Involvement of patients or their representatives in quality management functions in EU hospitals….Int J Qual Health Care 2014; 26:81-91.

Tools for PFE

AHRQ.gov

Am I Ready to Become an Advisor?

Are you thinking about becoming a patient and family advisor? Review the checklist below and check tho[se] with which you agree. If there are statements with which you do not agree, these may be things to work o[n] becoming an advisor.

I am ready to be a patient and family advisor when:

- ☐ I am willing to talk about the positive and negative care experiences I had as a patient or family member of a patient.

- ☐ If I had any negative experiences, I am coping well and am ready to respectfully share my ideas about how things could have gone differently.

- ☐ I am ready to speak up and share suggestions and potential solutions to help improve hospital care for other patients and family members.

- ☐ I am willing to think beyond my own personal experiences.

- ☐ I can bring a positive attitude to discussions.

- ☐ I can listen to and think about what others say, even when I disagree.

- ☐ I am willing to keep any information I may hear as an advisor private and confidential.

- ☐ I enjoy working with people who are different from me.

- ☐ I am willing to learn how to best serve as an advisor.

- ☐ I have time in my schedule to be an advisor. Usually advisors spend at least 1 hour a month and not more than 4 hours per month on advisor work.

Adapted from resources from the Institute for Patient- and Family-Centered Care, Bethesda, MD.

Patient and Family Advisor Orientation Manual

Confidentiality Statement for [insert hospital name] Advisors

As a patient and family advisor at [insert hospital name], you will be trusted with information about our hospital and the patients we serve. This may include information about patient care experiences, diagnoses, hospital quality and safety, and other sensitive information. It may also include **protected health information** about patients.

Protected health information includes any information about a patient's visit at [insert hospital name]. This information includes, but is not limited to, a patient's name, address, phone number, date of birth, financial information, diagnosis, and treatment.

A Federal law called HIPAA (pronounced "hip-uh") explains what health care providers must do to safeguard protected health information. HIPAA stands for the Health Insurance Portability and Accountability Act. The law requires us to define the minimum necessary information to which employees, volunteers, contracted agencies, and other individuals can have access.

As a patient and family advisor, you may have access to protected health information about our patients. It is important for you to know that protected health information can only be used and disclosed as permitted by law. This means that protected health information cannot be shared outside the hospital or health care facility, and it cannot be shared in any written, verbal, or email communications with friends or family unless specifically permitted by law.

The easiest way to remember what this law means is the saying, "What you hear or see here must remain here." We require your cooperation in following these rules.

Please sign below to let us know that you have reviewed this information, understand it, and agree to it. Signing your name means that you have read and understood the information above, that you have had a chance to ask questions, and that you agree not to share protected health information outside the hospital or health care facility in any written, verbal, or email communications.

Name (please print) _____

Signature _____

Date _____

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Agency for Healthcare Research and Quality
Advancing Excellence in Health Care • www.ahrq.gov

Using QAPI to Improve Care: Putting it to Work in the Real World

FORUM OF ESRD NETWORKS

MEDICAL ADVISORY COUNCIL

The National
FORUM of
ESRD NETWORKS
Improving Care Through Collaboration

What is quality care and why should I care?

Institute Of Medicine
- The degree to which health services for individuals and populations increase the likelihood of desired health outcomes and are consistent with current professional knowledge.
- Safe, Effective, Patient-centered, Timely, Efficient, and Equitable

What is quality care and why should I care?

CMS Definition of Quality Is…

The Right Care for Every
Patient Every Time

Improving Through Change

REMEMBER:

All improvement requires change

BUT

Not all change IS improvement!

What is Change?

Change is a departure from an existing process or way of doing something, to a new process or a different way of doing the same thing

Ezekiel Oseni, CISA, ACA, ACIP, ACS

Change Management in Process Change

Why Do We Resist Change?

Loss of control - I don't have enough information...

Loss of identity - We've always done it this way...

Loss of competence - I'm afraid I'll make a mistake...

Process Change

People

Policy

Procedure

Equipment
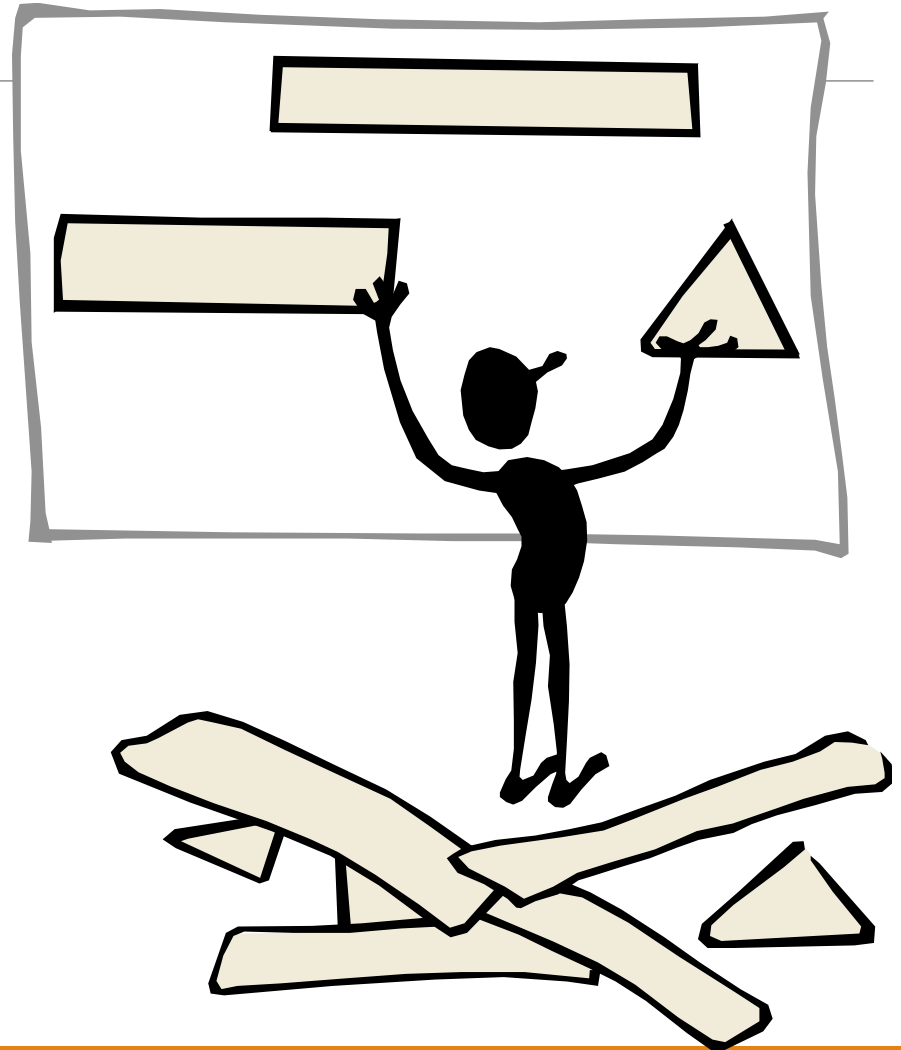
Culture Change

Corporate culture

The total sum of the values, customs, traditions and meanings that make a company unique. Corporate culture is often called "the character of an organization"

The values of a corporate culture influence the ethical standards within a corporation, as well as managerial behavior.

Process readiness

+

Culture readiness

=

Change in Outcomes

What is Change Readiness?

Category	10% Ready	50% Ready	90% Ready
Leading Change	No one in charge	Leadership clear, commitment clear in some areas	Clear management commitment
Shared Need	Most happy with status quo	Many think a change is needed	Everyone knows a change is needed
Vision	What vision?	Some consensus on what is needed, but also some apathy	Everyone knows the necessary outcome
Mobilizing commitment	A staffer might help someone	Some resources dedicated, more are needed	All needed resources are available
Monitoring Progress	Everyone has their own opinion	Some things are measured, but staff at times "gut feeling"	Clear measures and goals
Anchoring Change	Why does anything have to be done	Discussion has begun, but hasn't finished	Everyone knows what has to be done to embed change

Creating Change

Evaluate processes
- ◦ People, Policy, Procedure, Equipment

Determine barriers to change

Identify ways to overcome barriers

Seek out best practices

Create environment of collaboration
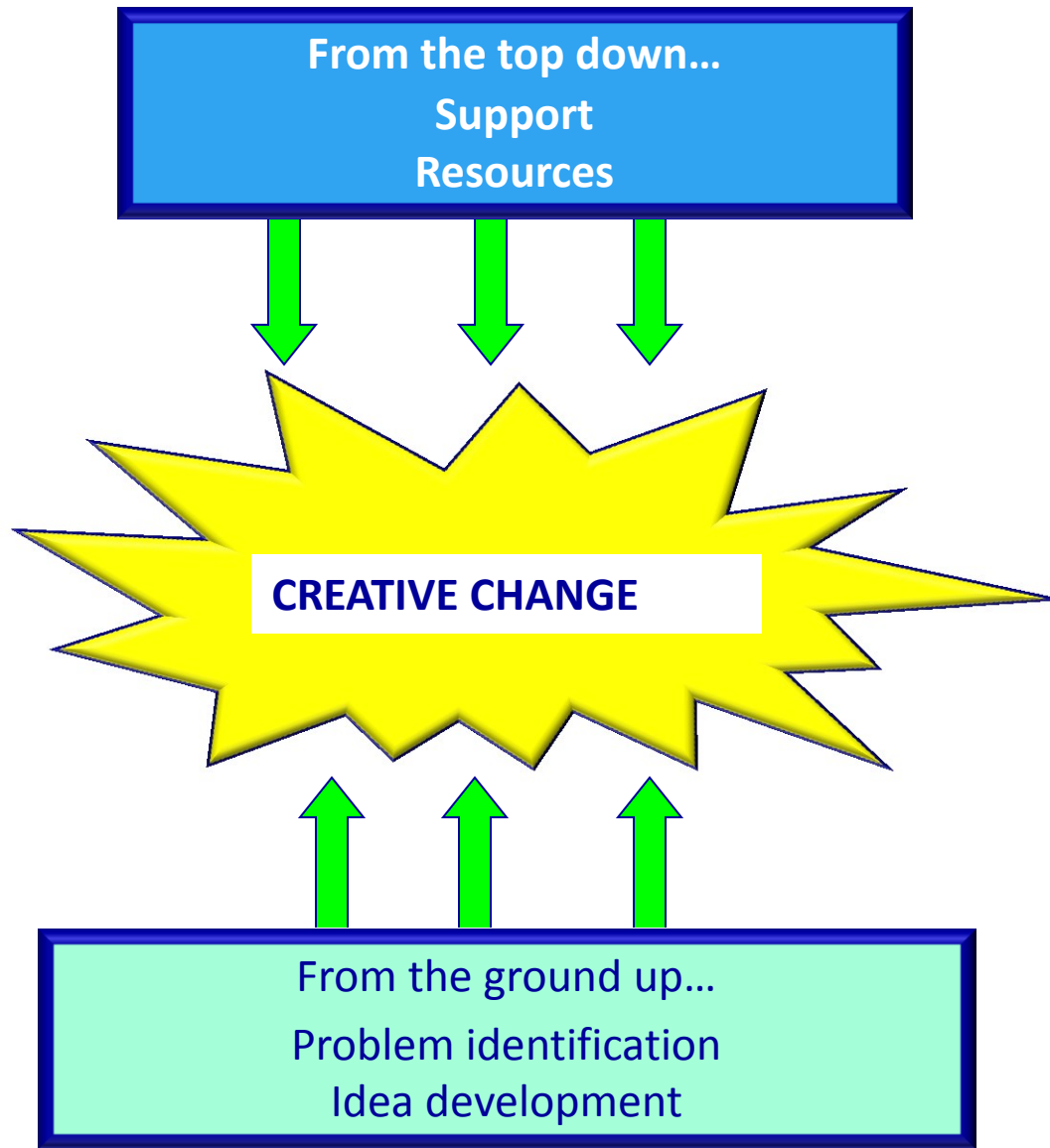
Using the Team to Drive Improvement

Multidisciplinary

Common Goal

Day-to-Day Knowledge

Physician Buy-in

The Composition of an Effective Team
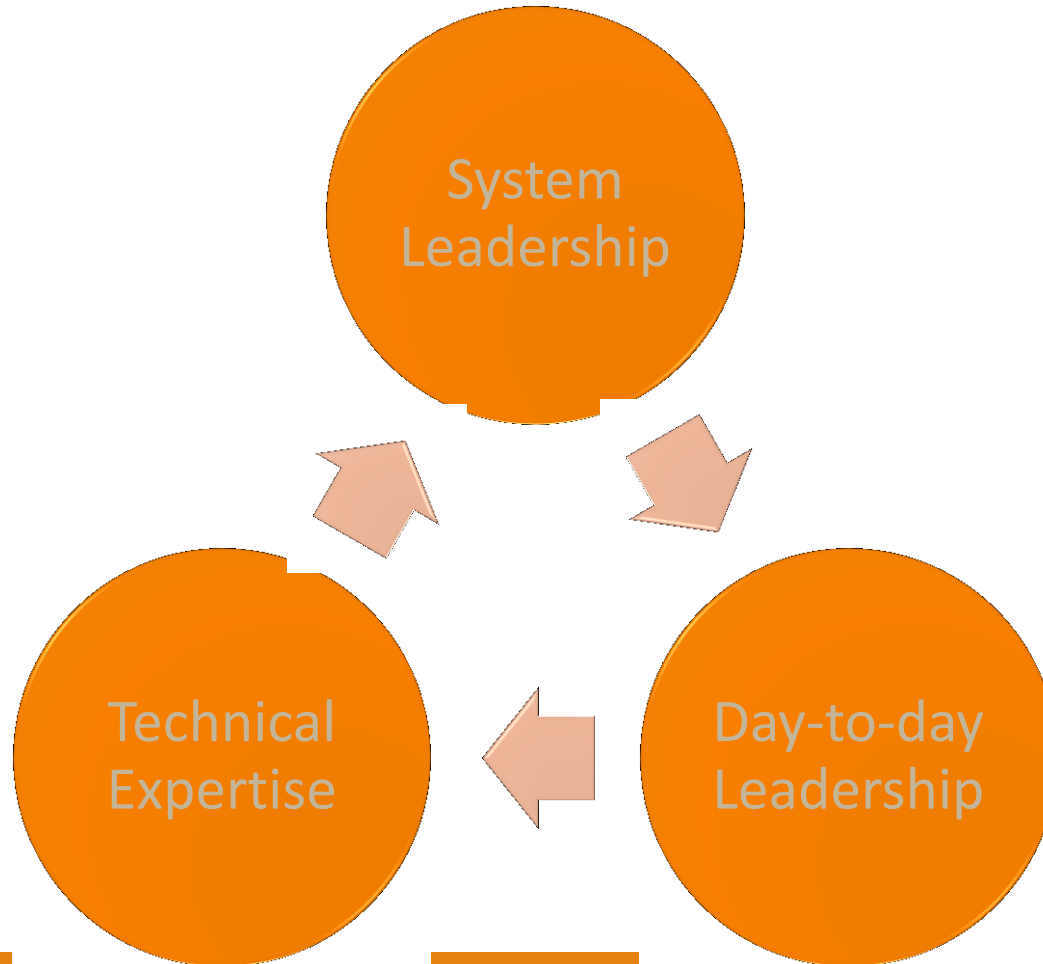
The Interdisciplinary Team

Medical Director

Nurse Manager

Dietitian

Social worker

Biomed Tech

Others
- Other nephrologists(?)
- Surgeon
- Staff members including PCTs

Changes Need to be...

Evidenced Based

Patient Centered

System Based

So How Do We Get Started?

Why Should I Care About Quality Improvement?

Improved patient outcomes

Improved patient safety

Increased customer satisfaction

Improved staff morale

Reduction of rework

Cost savings

And so…

Our approach to quality improvement in healthcare needs to be focused on identifying areas for change, creating change, and measuring change.
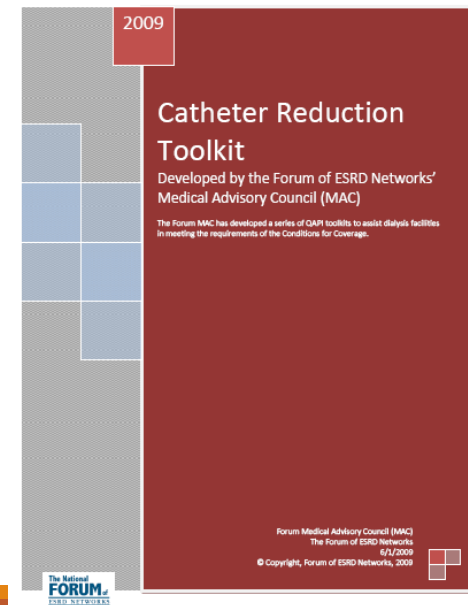
IHI Model for Improvement

What are we trying to accomplish?

How will we know that a change is an improvement?

What changes can we make that will result in an improvement?

Developing a Goal Statement

Where are we currently – why is this a problem?

- ◦ What does our data show?
- ◦ What is our trend?

Where do we want to be?

- ◦ What knowledge do we have?
- ◦ What is our goal?

QAPI: Using Knowledge to Improve

Improvement comes from the application of knowledge

Any approach to improvement must be based on building and applying knowledge

Significant, long-term, positive impact only occur when someone takes the initiative

Setting Goals

Be realistic

Be specific

Understanding CMS or Network-set goals vs. facility or corporate-set goals

Set both short term and long term

◦ In order to reach our long term goal, what do we need to accomplish monthly, quarterly, etc.

Remember "how to eat an elephant"

What Are We Trying to Accomplish? Goal/Aim Statement

Our rate for catheters >90 days is 35%

KDOQI states that the 90 day catheter rate should be < 10%

We will have a 25% catheter rate in 6 months

How will we know a change is an improvement?

Collect and trend data

Identify sources of data

Review and trend data monthly

Analyze by various characteristics

Draw conclusions with the team

Data Sources

Data is NOT a four letter word!

Data is:

- Your observations – what you hear and what you see
- Your measurements – what you keep track of
- How you report your observations and measurements

What is the benchmark?

- What data sources do you have?

Your Observations – Subjective Data

Is there an opportunity for improvement?

- Too many catheters?
- Too many access infections?
- Patient safety issues?

Is there something that everyone is complaining about?

Is there a process that is too cumbersome?

- Medication errors?

Your Measurement – Objective Data

Begin to collect information about your problem, your observation

- Collect simple points of information at regular intervals over time

- KISS – counting the number of days between episodes of infections might be simpler and more meaningful that collecting every episode of access infection

- What is the trend?

How Will We Know a Change is an Improvement?

We will collect baseline 90 day catheter rates at the beginning of the project

We will collect 90 day catheter data each month and trend

We will collect 90 days catheter data at the end of 6 months to evaluate the success of the project: Our catheter rate will be 25% or less

What changes will result in an improvement: finding root causes

Don't stop with surface issues – go deeper

Brainstorming to discover all root causes
- All disciplines – all team members

Use a root cause tool
- Fishbone diagram
- 5 Whys
- Other tools

Root Cause Analysis

Facility: _____   Number of Patients: _____

Month/Year: _____

For each patient with a CVC to be completed monthly. Put a check mark in each box that applies for the patient.

Patient initials		New patient awaiting placement of fistula/graft	New patient awaiting maturation/healing of fistula or graft	Patient has no vessels for AV fistula by mapping	Established patient with failed fistula/graft with new fistula/graft planned	Patient refuses	Unable to tolerate increased cardiac output induced by a fistula/graft due to cardiac condition	Severe peripheral vascular disease precludes fistula/graft placement	All possible graft/fistula access sites exhausted documented by vessel mapping	MD referral barrier	Vascular access surgeon barrier	Awaiting a living donor transplant	Catheter infections	Appointment made
		A	**B**		**C**	**D**	**E**	**F**	**G**			**H**		
Comments:														
Comments:														
Comments:														
Comments:														
Comments:														
Comments:														
Comments:														
Comments:														
Comments:														
Comments:														
TOTAL (Count checked boxes)														

5 Whys

Why did this occur?

But why did that occur?

So why did that occur?

And then why did that occur?

OK, so then why did that occur?
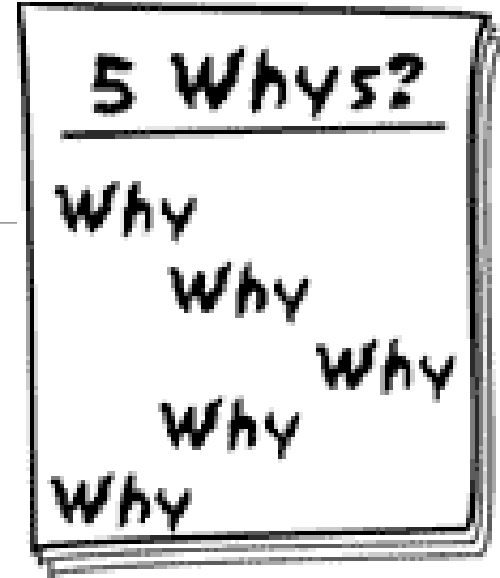
What are the barriers?

What are the barriers to overcoming these root causes?

What barriers are within your control and what are not?

What are our root causes?

Problem: 35% of patients have catheters for more than 90 days

Goal: Decrease 90 day catheter rate to 25% in 6 months

Root cause(s): Difficulty in getting new accesses placed

Developing your QAPI Plan

Identify strategies

All team members need to have a role

Someone needs to be accountable and in charge

Tasks need to be assigned and dates set to re-evaluate

Plan needs to be dynamic – needs to be reviewed at least monthly

Developing your QAPI Plan

ACT
- What changes are to be made?
- What will be the next cycle?

PLAN
- State the objective
- Develop a plan to carry out the cycle

STUDY
- Complete analysis
- Summarize what was learned

DO
- Carry out the plan
- Document observations
- Analyze the data

Act

Plan

Study

Do
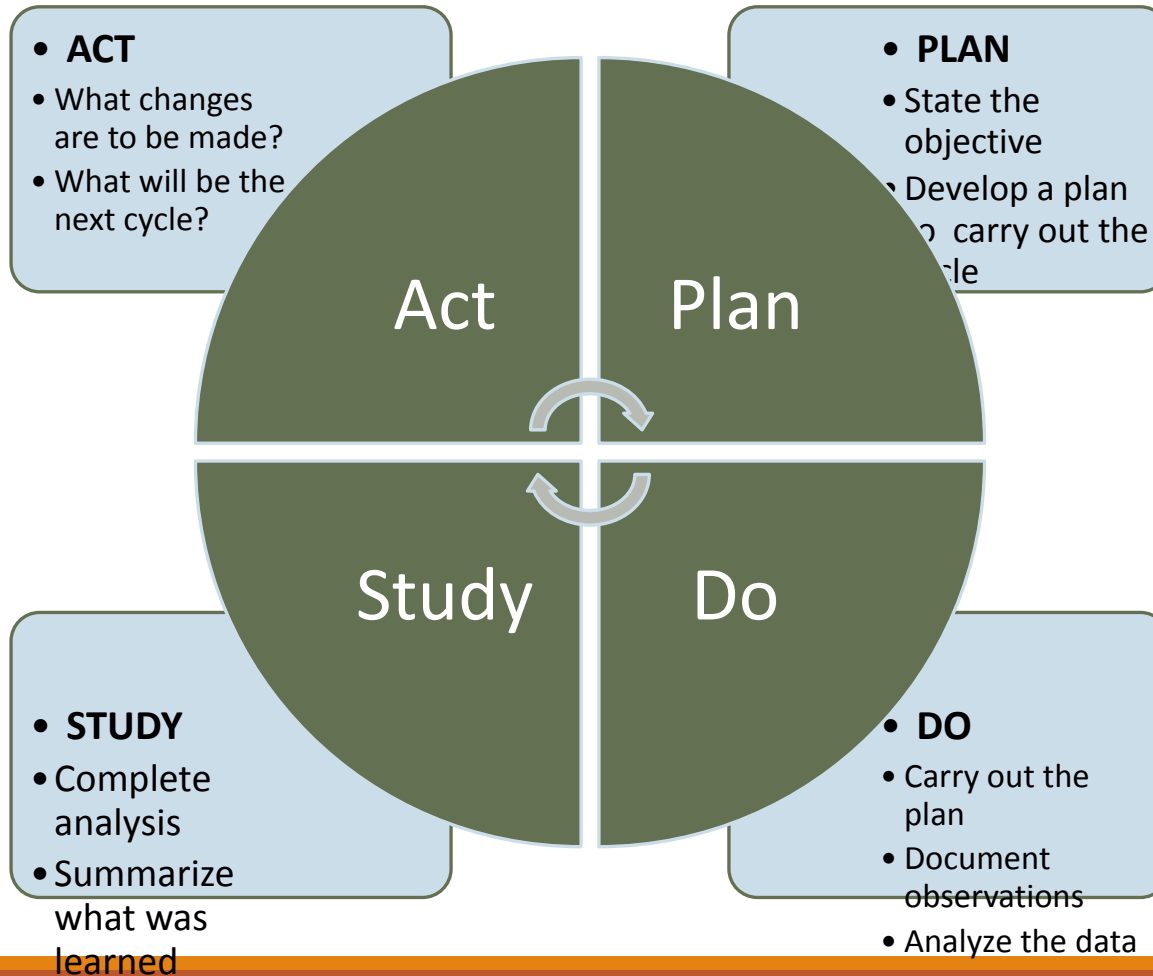
FACILITY NAME:		PROVIDER NUMBER:		
DATE COMPLETED:			**TEAM MEMBERS**	
CONTACT:			Facility	
PROBLEM STATEMENT:			1.	
			2.	
GOAL:			3.	
			4.	
ROOT CAUSE(S):			5.	
1.			6.	
2.			7.	
3.			8.	
BARRIER(S):			External	
1.			1.	
2.			2.	
3.			3.	

TASKS	RESPONSIBLE TEAM MEMBER	START DATE	ESTIMATED COMPLETION DATE	ACTUAL COMPLETION DATE	COMMENTS (STATUS, OUTCOMES, EVALUATION, ETC.)
1.					
2.					

Percent of Patients Dialyzing with
a catheter for > 90 days
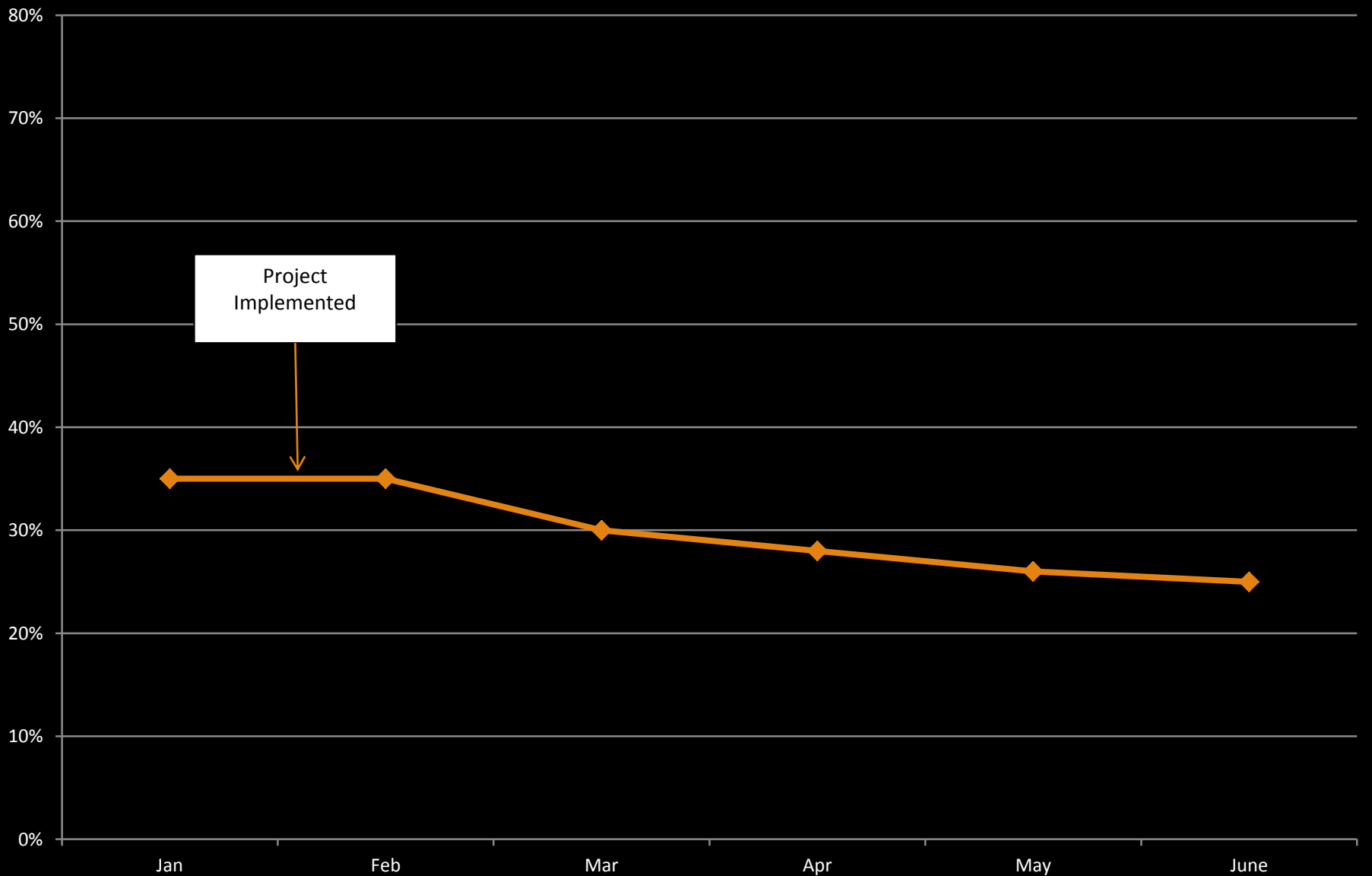
Evaluate and Re-evaluate

Review plan regularly

Use data to determine – Are we improving?

Are we seeing unintended consequences?

Does the plan need revision?

Should we bring others to the team? If so, who is t
best person to help?

What do you do at the end??

Evaluate!

- ◦ Did we achieve our overall goal?
- ◦ If not, why not?
- ◦ If so, make it a permanent change
- ◦ If not, what new strategies can we develop to try?
- ◦ Are there best practices we can adopt?
- ◦ Are there additional resources we need?
- ◦ Are there new partners we can bring to the team?

Resources

ESRD Network Resources

2009 — Catheter Reduction Toolkit
Developed by the Forum of ESRD Networks' Medical Advisory Council (MAC)

The Forum MAC has developed a series of QAPI toolkits to assist dialysis facilities in meeting the requirements of the Conditions for Coverage.

Forum Medical Advisory Council
The Forum of ESRD Networks
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The National FORUM of ESRD NETWORKS

2009 — Assurance of Dialysis Care Coordination Toolkit
Developed by the Forum of ESRD Networks' Medical Advisory Council (MAC)

The Forum MAC has developed a series of QAPI toolkits to assist dialysis facilities in meeting the requirements of the Conditions for Coverage.

Forum Medical Advisory Council (MAC)
The Forum of ESRD Networks
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2009 — Medication Reconciliation Toolkit
Developed by the Forum of ESRD Networks' Medical Advisory Council (MAC)

The Forum MAC has developed a series of QAPI toolkits to assist dialysis facilities in meeting the requirements of the Conditions for Coverage.

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The National FORUM of ESRD NETWORKS

2009 — Vaccination Toolkit
Developed by the Forum of ESRD Networks' Medical Advisory Council (MAC)

The Forum MAC has developed a series of QAPI toolkits to assist dialysis facilities in meeting the requirements of the Conditions for Coverage.

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The National FORUM of ESRD NETWORKS

www.esrdnetworks.org

ANNA Resources

www.annanurse.org

Institute for Healthcare Improvement

www.ihi.org

In Conclusion…

"Every system is perfectly designed to achieve the results that it gets."

Paul Batalden

"The definition of insanity is doing the same thing over and over again and expecting different results"

Albert Einstein

Why Do QAPI?

Because CMS says so?

Because the Network is on my tail?

Because we won't get paid if our outcomes are bad?

Because it's the right thing to do – the right care for every patient every time!

Possible Approaches

Work with PAC and Social Workers to indicate availability of participation on QAPI Committee

Have a one pager describing the role and responsibilities including handling of sensitive information and time commitment

Actively recruit candidates who are already engaged

Define how many patients to involve; rotate participation

Provide more detailed information to patients who accept and periodically debrief

Summary

Assessment of quality and improvement activities have been a feature of the ESRD program for decades

HHS, CMS establish strategies and priorities

Other organizations such as the Networks, survey agencies, and other stakeholders such as the NQF provide a framework in which the individual facilities operate their QAPI programs

With the increasing recognition of the central role of patients in shaping their care, patients now have a seat at the QAPI table

Thanks!