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Applying CMS Process Tools

for the New QAPI Regulations

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MANAGEMENT CONNECTION

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The certified dietary manager, in collaboration with the registered dietitian nutritionist, plays a key role in achieving Quality Assurance and Performance Improvement (QAPI) in dietary/nutrition services, as mandated by the federal regulations for both hospitals and nursing homes/long-term care (LTC).

On November 28, 2016, phase one of the newly-revised LTC regulations was implemented, including the long-awaited QAPI regulations. This article discusses the CMS Process Tools for compliance with QAPI regulations, and encourages CDMs to more effectively apply these tools to performance improvement.

In the July/Aug 2012 issue of Nutrition & Foodservice Edge, I authored an ANFP Position Paper titled, "The Role of the CDM in Quality Assessment and Performance Improvement." It discussed the newly-released CMS 5 Elements of QAPI, and gave some background on how healthcare organizations were to expand their QAPI efforts. The article identified areas that CDMs could develop their role. At the end were 10 Task Statements, with the last stating, "*CDM continues to seek information in order to implement the best practices and recognized standards of practice for QAPI while promoting job enjoyment, satisfaction, and a quality environment for nutrition and foodservice staff.*"

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Five years later, how are you doing? Have you been seeking new information to implement more effective QAPI? Let's review the actual description and expectations of the two parts of QAPI: the QA part and the PI part. Then let's look at the Process Tools (and resources) that have been posted recently by the Centers for Medicare & Medicaid Services.

A DESCRIPTION OF QAPI

In regulations, "QA" may be called Quality "Assessment" or "Assurance" and these are interchangeable. The latest description of QAPI follows and is found at https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/QAPI/qapidefinition.html

"QAPI is the merger of two complementary approaches to quality, Quality Assurance (QA) and Performance Improvement (PI). Both involve seeking and using information, but they differ in key ways:

- **QA is a process of meeting quality standards and assuring that care reaches an acceptable level.** Nursing homes typically set QA thresholds to comply with regulations. They may also create standards that go beyond regulations. QA is a reactive, retrospective effort to examine why a facility failed to meet certain standards. QA activities do improve quality, but efforts frequently end once the standard is met.

- **PI (also called Quality Improvement—QI) is a proactive and continuous study of processes with the intent to prevent or decrease the likelihood of problems by identifying areas of opportunity and testing new approaches to fix underlying causes of persistent/systemic problems.** PI in nursing homes aims to improve processes involved in health care delivery and resident quality of life. PI can make good quality even better."

CMS PROCESS TOOLS AND RESOURCES

CMS had a federal mandate to provide technical assistance and help nursing home staff by demonstrating *how* to establish and maintain accountability for effective QAPI process (end result: sustain quality of care and quality of life).

This author had the opportunity to consult with one of the 17 nursing homes in the pilot project which resulted in the CMS Process Tools and resources. If you are a CDM working in a hospital setting, this is extremely valuable information for you as well. Let's start with the CMS QAPI Crosswalk between the 5 Elements and Goals. Each has QAPI Process Tools to accomplish the goals.

"**QAPI at a Glance**" is also called the "nuts and bolts" guide and resources. This article cannot do justice to all these resources, but encourages CDMs and RDNs to study these in detail. In Appendix A of QAPI at a Glance, there is a "Guide for Developing Purpose, Guiding Principles, and Scope for QAPI" with Steps 1-4 being Locate or Develop Your Organization's Vision Statement, Mission Statement, Purpose Statement for QAPI, and Establish Guiding Principles for QAPI. Has your department ever had a vision or mission statement posted for all staff to see? *Example*: "We strive to provide safe, nutritious food to meet the assessed needs of patients/residents in our care."

Step 5 defines the Scope of QAPI in your organization. This would outline what types of care and services are provided that might impact clinical care, quality

of life, resident choice, and care transitions. It emphasizes the need to incorporate the care and services delivered by all departments. Examples given include Dietary and Dining. Once the list of care and service area has been identified, you can determine how each will use QAPI to assess, monitor, and improve performance on an ongoing basis.

The completed steps 1-5 help you articulate the goals and objectives of your organization; QAPI will help you get there. Post for all to see.

The next step is to use the "**Guide for Developing a QAPI Plan**" that will meet your purpose, guiding principles, and comprehensive scope you established.

On the CMS website there is also a listing of QAPI Resources and it states, "CMS strives to provide nursing home providers with access to resources (materials or websites) to support QAPI implementation. Use of these resources is not mandated by CMS for regulatory compliance nor will their use ensure regulatory compliance." https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/QAPI/qapiresources.html

One of the resources is called the "**Change Package**" from the National Nursing Home Quality Care Collaborative (NNHQCC) that provides a menu of strategies and actionable items that have been demonstrated to actually work. https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/QAPI/Downloads/NNHQCC-Package.pdf

Since retiring as a dietitian and state surveyor in California, this author has provided many mock surveys and QA reviews for CDM colleagues in hospitals and nursing homes. They are diligent and hardworking, but sometimes lack an understanding of the QAPI process. It is a bit intimidating and perhaps difficult to fathom *how* to implement QAPI. But those who eventually grasp the basic concepts have had tremendous success.

A very practical Process Tool is the "**Guidance for Performing Root Cause Analysis (RCA) with Performance Improvement Projects (PIPs)**," which states as its objective: "RCA is a structured facilitated team process to identify root causes of an event that resulted in an undesired

Where to Find Regulations and Interpretive Guidance

REVISED FEDERAL REGULATIONS

and surveyor interpretive guidance can be found at cms.gov> (top right) Regulations> (top left) Manuals>Online>100-07 State Operations Manual, scroll down to "Appendices."

(Note: Don't depend on an outdated PDF; always access current regulations.)

HOSPITALS

Access the latest A tags on QAPI: A-tags 263-302 Condition of Participation: Quality Assessment and Performance Improvement. A-tag 302 states: "The hospital must document what quality improvement projects are being conducted, the reasons for conducting these projects, and the measurable progress achieved on these projects."

LONG-TERM CARE

Below is the website for the Survey & Certification (S&C) letter from CMS providing the draft for new revised regulations. (In 2017, Appendix PP will be updated.) Scroll down to QAPI: F-tags 520 (formerly called QAA: Quality Assessment and Assurance) states: "Quality assurance and performance improvement (QAPI) program. Each LTC facility... must develop, implement, and maintain an effective, comprehensive, data-driven QAPI program that focuses on indicators of the outcomes of care and quality of life...Maintain documentation and demonstrate evidence of its ongoing QAPI program includes... systems and reports demonstrating systematic identification, reporting, investigation, analysis, and prevention of adverse events; and documentation demonstrating the development, implementation, and evaluation of corrective actions or performance improvement activities."

Google: cms s&c letter 17-03-nh. Or access at https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/SurveyCertificationGenInfo/Downloads/Survey-and-Cert-Letter-17-07.pdf

Model for Improvement

ASK THESE THREE QUESTIONS

1. **What are we trying to accomplish?**

   State your aim (review your PIP charter—and include your bold aim that you will improve resident health outcomes and quality of care).

2. **How will we know that change is an improvement?**

   Describe the measurable outcome(s) you want to see.

3. **What change can we make that will result in an improvement?**

   Define the processes currently in place; use process mapping or flow charting. Identify opportunities for improvement that exist (look for causes of problems that have occurred—see Guidance for Performing Root Cause Analysis with Performance Improvement Projects; or identify potential problems before they occur—see Guidance for Performing Failure Mode and Effects Analysis with Performance Improvement Projects—see Root Cause Analysis tool):

   • Points where breakdowns occur

   • "Work-a-rounds" that have been developed

   • Variation that occurs

   • Duplicate or unnecessary steps

   Decide what you will change in the process; determine your intervention based on your analysis

   • Identify better ways to do things that address the root causes of the problem

   • Learn what has worked at other organizations (copy)

   • Review the best available evidence for what works (literature, studies, experts, guidelines)

   • Remember that solution doesn't have to be perfect the first time

outcome and develop corrective actions. The RCA process provides you with a way to identify breakdowns in processes and systems that contributed to the event and how to prevent future events. The purpose of an RCA is to find out what happened, why it happened, and determine what changes need to be made. It can be an early step in a PIP, helping to identify what needs to be changed to improve performance. Once you have identified what changes need to be made, the steps you will follow are those you would use in any type of PIP. Note there are a number of tools you can use to perform RCA, described below."

Then it continues, "Use this guide to walk through a Root Cause Analysis (RCA) to investigate events in your facility (e.g., adverse event, incident, near miss, complaint). Facilities accredited by the Joint Commission or in states with regulations governing completion of RCAs should refer to those requirements to be sure all necessary steps are followed."

Steps your QAPI team might use to develop PIPs and conduct RCA can be found at https://www.cms.gov/medicare/provider-enrollment-and-certification/qapi/downloads/guidanceforrca.pdf.

Steps include identify the event, collect and organize the facts surrounding the event and contributing factors to understand what happened, identify the root cause, and implement changes to eliminate the root causes.

Let's go back to the description of QAPI and its two parts: QA and PI. First, the CDM (with the RDN) should establish QA standards or criteria (which are in your approved policies and procedures) to comply with national standards of care or regulations.

QA is a reactive, retrospective effort to examine why a facility failed to meet these standards. This is especially important when this "adverse event" or dietary problem could greatly impact the resident/patient with a negative outcome. *Examples*: Any unsafe food handling (potential for foodborne illness) or any error in the ordered diet that did not meet the assessed need for therapeutics (texture, thickened liquid) could potentially cause a negative outcome, including death.

Given the perspective that a dietary "problem" or error is serious, it emphasizes the need for effective QAPI

procedures. Have you given your staff this perspective of how critical their job is, and how important it is to follow approved procedures? This author could tell you of the extreme difficulty and sadness of investigating a death as a direct result of dietary staff actions or lack of training. As a CDM leader, you would not want to have this happen in your facility, ever. Some poor practices (*Example*: Not giving the resident a voice in care planning about his/her dietary desires, like not wanting to have a diet restriction) may result in the "negative outcomes" of low food intake or the new "psychological harm" of feeling hopeless and helpless.

PI develops Performance Improvement Projects (PIPs), with a proactive and continuous study of dietary staff practices with the intent to prevent or decrease the likelihood of problems (using Root Cause Analysis) and testing new approaches or looking for "gaps" to underlying causes of dietary problems. The key is continuously monitoring effectiveness of staff practices. Basically, is your staff competent and performing the practices that you have approved in your policies and procedures manual?

Mini QAPIs to Track Improvement

USE THE FOLLOWING mini QAPIs to track improvement after weaknesses have been found in monitoring audits.

- Accuracy of diets served, compared to diet tray card and actual physician's orders.
- Staff not following the diet manual on the fortification diet.
- Staff not following the recipe for making the puree diets to ensure protein is the same as in regular diets.
- Nursing unsure of approved diets, not sure how to obtain or use diet manual.
- RDN not monitoring I&Os or comparing intake with assessed fluid needs for residents with dehydration risk.
- Social services unaware and not seeking dental or denture evaluation to bring residents with texture modified diets to highest practicable level.
- Dietary and social services not following up on lost dentures (revised regulations give a 72 hour deadline for starting this process).
- Untimely implementation or lack of documentation for RDN recommendations for interventions of high-risk residents.
- Lack of competency criteria and checklists/evaluation of staff.
- Lack of training (including consultant dietitian) that is required in revised regulations.
- Lack of a comprehensive cleaning schedule with specific staff assigned and staff initialing to document.
- Lack of Manufacturer's Guidelines (MFG) for cleaning and sanitizing all equipment and log for monitoring ice machine, juice machine, soda machine, yogurt machine, meat slicer, tomato slicer, etc.
- Lack of log or monitoring of red sanitizing buckets for effective sanitizer use.
- Staff unsure of proper use of three compartment sink and its use when dish machine breaks down.
- Staff unsure of new procedures for activating the new wet chemical hood suppression system and then, as secondary device, using new wet chemical K Class silver extinguisher per fire marshal guidelines.
- Staff not trained on new Material Safety Data Sheets (MSDS) or no designated area for mandated protective gear required to be offered for chemicals in use.

Another very useful Process Tool is the "**Fishbone or Cause and Effect Diagram,**" using the Root Cause Analysis to assist in identifying the underlying causes of a dietary problem (adverse event). Understanding the contributing factors or causes of a dietary system failure can help develop actions that sustain the correction. A cause and effect diagram, or "fishbone" visual diagram, can help in brainstorming to identify possible causes of a problem. It is a structured approach for brainstorming causes and can be used with the Five Whys process tool. The problem or negative outcome is displayed at the head or mouth of the fish. Possible contributing causes are listed on the smaller "bones" under various cause categories. It is important to include team members who have personal knowledge of the processes and systems involved in the dietary problem to be investigated. It also helps staff to "buy-in" to prevention if they participate in this RCA process. The "**Plan-Do-Study-Act (PDSA) Cycle Template**" has a simple three questions format that CMS wants answered:

- *What are we trying to accomplish?* (identified problem or weakness to improve)
- *How will we know that change is an improvement?* (using Root Cause Analysis)
- *What change can we make that will result in an improvement?* (for sustainability)

The team using the Fishbone Diagram tool should carry out the steps listed:

Clearly define the problem, major categories of causes of the problem, why it is happening, and identify root

Examples of Performance Improvement Projects (PIPs)

THE FOLLOWING are brief examples of PIPs in Dietary Services/ Nutrition Care: Applying PDSA Template.

1. PROBLEM

Untimely dietitian's (RDN) assessment and recommendations for nutrition interventions, and untimely implementation of interventions for high risk patients/ residents.

Root Cause Analysis (RCA)

Has there been established criteria/ facility standards and a timeframe for informing the dietitian of changes of conditions (weight loss/ gain or pressure ulcer)? What is the timeframe for implementing the RDN's recommendations for interventions? Remember: If it is important enough for an RDN to recommend an intervention, it is important enough to follow up and get that intervention in place to meet the needs of the resident. Is there an Auditing Tool for compliance to this criteria? Usually this becomes the CDM's role. *Example:* Every Monday, a check on the RDN's recommendations for the previous week. How was the RDN informed of a high risk patient/ resident? Note: This is usually the *cause* of untimely assessment. Are there weekly skin reports for new or existing pressure ulcers? Are there monthly weights, and when necessary, weekly weights, to monitor status of significant losses and gains? Are significant lab results given to the RDN? Is there a method for monitoring input and output for high risk? (Note: This is monitoring "input" with the assessment for hydration needs.) If the RDN is a part-time consultant, is there effective communication between the day-to-day CDM and the RDN to ensure opportunities for telecommunication and timely interventions? What happens to the RDN's recommendations (what nursing personnel is responsible for contacting the physician and implementing the interventions)? Is there monitoring of this? Are care plans updated regularly to reflect changes in care and interventions?

2. PROBLEM

Untimely tray delivery and complaints of cold food.

Root Cause Analysis

Change is resisted. Trays have always followed a certain schedule for delivery to each floor. Nursing is not ready to pass when trays are delivered, so trays sit and food gets cold. How can dietary services staff and nursing staff brainstorm and find a solution for timely delivery?

3. PROBLEM

Sanitation audit identifies that there are no systems to ensure the cleaning and sanitizing of ALL equipment according to their Manufacturer's Guidance (MFG) such as ice machine, juice machine, yogurt machine, and meat slicer. *Example:* **Are there clearly defined practices to ensure the internal ice making component and the bin of the ice machine are cleaned according to the MFG by the contract company.**

Root Cause Analysis

Do you have a copy of the MFG? Does the contract company (or Maintenance Dept. leadership who oversee this contract) have a copy of the MFG? Is there documentation that it is followed (on invoice) and the two required chemicals—Ice Machine Cleaner and Chlorine-based Sanitizer (to kill Norovirus)—are used? Is there a log of when this is done (required every 6 months for internal cleaning and per MFG for bin)? How do you monitor this? Safe production of ice in the facility is ultimately your responsibility.

4. PROBLEM

Some of the diet, interventions, and assessed dining needs are not met for residents, especially in the RNA Dining Program.

Root Cause Analysis

Is there auditing to ensure the correct diet, interventions as ordered (at meal times and in between), and adaptive equipment is given? Some states require that licensed nursing personnel ensure the ordered diet is served to the resident. How does each CNA or RNA who assist in feeding know the individual assessed needs of the resident they are assisting? Is the Diet List and additional Supplements/Interventions List posted at all stations? Is there reference info in a binder (including any Speech or Occupational Therapy assessed needs) or for reference in digital it is a requirement that nursing provide oversight to ensure assessed needs?

Note: A simple audit is to do what the surveyors do:

• Review the orders, assessments, and care plans of sampled.
• Then observe what is actually happening with feeding assistance.
• Finally, ask staff and volunteers to describe the feeding needs as they understand them.

5. PROBLEM

Staff not effectively trained on food safety, or on when they must not come to work if they have symptoms of foodborne illness (FBI), and when to return to work.

Root Cause Analysis

Does your Policy and Procedure Manual define the Employee Health guidelines according to national standards? Have current resources been used to train staff? Does staff know what symptoms may indicate FBI and the 5 Big FBI or those identified in your state? (*Example:* California requires a sixth FBI: Entamoeba histolytica.) Have you considered using the FDA form for staff signing and documenting they have received the training on FBI symptoms and exposure, and what they are to do for reporting or when they are safe to return to work? Find these resources in *FDA Employee Health and Personal Hygiene Handbook and Interactive Disc* with examples and discussion (on Chapter Two of FDA Food Code) Google title or http://www.fda.gov/Food/GuidanceRegulation/RetailFoodProtection/ucm266434.htm

Do staff workers, coming from many countries with wide cultural backgrounds, grasp how important their day-to-day practices are in preventing foodborne illness? Have the recent and powerful visual posters developed by FDA been downloaded to use in training staff and in their own language? Is the poster of the 4 basic symptoms posted (vomiting, diarrhea, sore throat with fever, jaundice)? *Use of FDA Oral Culture Learner Project Posters*: Google title or http://www.fda.gov/Food/GuidanceRegulation/RetailFoodProtection//ucm212661.htm

cause to prevent future problems. Find the Fishbone document at https://www.cms.gov/medicare/provider-enrollment-and-certification/qapi/downloads/fishbonerevised.pdf

SUMMARY OF QAPI DIETARY SYSTEMS

Standards, Policies and Procedures (P&P) aka QA Thresholds

Ensure there are current, approved P&P (based upon national standards of practice in dietary services, like the latest FDA Food Code and nutrition). Know every word of your P&P. If you use a corporate or commercial P&P, customize it to ensure these are the practices you expect your staff to follow. If you disagree with your P&P, decide to either change it or follow it. Note: Surveyors will hold you to your P&P. **Establish Criteria for all Policies & Procedures (QA Thresholds) and to measure your staff practices**. *Examples*: Every sanitation procedure should have criteria. Every nutrition standard should have criteria to measure it by. (See some of the mini QAPIs provided.)

Training

Ensure there is a detailed in-service plan to train staff. First, during orientation of a new hire, there is a competency checklist. Then, ongoing in-services to ensure all staff receive training in areas they work.

• **Weekly Huddle Training**: It is highly recommended that CDMs and RDNs develop weekly short stand up "Huddle In-services" as part of your yearly plan and on focus topics, including those found to be weak in QAPI. Staff learn more effectively than in a once a month sit

down (throw it at them and hope it sticks type of meeting).

• **Laminated P&P Posters**: It is highly recommended that laminated posters (easily developed 8$\frac{1}{2}$" x 11" size) are posted or on a ring, as a Huddle Teaching Tool or as reference to staff on the P&P. Reduce the need for memorizing. Staff can become frustrated in survey and hardly remember their own name. Empower staff to reference these procedures. Have them say, "When I do this task, I often reference the poster; let me show you."

Monitoring

Have detailed QAPI forms to audit staff practices.

a. Audits: Monthly or quarterly QA audits should be done in high-risk dietary/nutrition areas such as Sanitation, Diet Audits (does the diet tray card match the ordered diet?), Tray-Line Audits, Dining Room Audits, Room Tray Audits, Satisfaction Audits, Clinical Chart Audits.

b. Scoring and Measuring Improvement: Having a scoring method allows you to measure your progress. There can be minus points for repeat failures.

c. Criteria: Establish specific criteria for each audit, so staff and leadership who evaluate know what is expected for the QA threshold. The laminated posters and weekly "Huddles" can be used to effectively reinforce the criteria.

Effective QAPI

The monitoring or auditing forms should identify the dietary problems or weakness. (Is it a lack of defined P&P, lack of training, or was there training but staff did not understand

or refused to do the approved practice?) Often, audits will identify a problem, but it ends there without accountability to what was done. There should be what this author calls "Mini QAPIs" for identified problems, often directly under the control of the CDM and RDN. Citations have been given because the problems were identified but not addressed. **A simple Mini QAPI format is: Problem, Root Cause Analysis, Corrective Actions, Monitoring (who), and Status (progress)**.

CMS does *not* want the survey process to be your QAPI (ie, CMS/state surveyors finding your weaknesses and giving deficiencies where you then must provide Plans of Corrective Actions). You don't either. Part of this CMS effort is to enable you, the department leader, to improve your QAPI processes by identifying your deficiencies or weak areas and by using CMS Process Tools to work toward improving performance.

Here is a very clear statement from CMS in the new revised F-tag 520: *Good faith attempts by the (QAPI) committee to identify and correct quality deficiencies will not be used as a basis for sanctions.* When a deficiency is identified during survey, the survey team is to offer every opportunity to the facility to defend its processes of monitoring staff practices and performance improvements. *If the facility has identified the deficiency practice prior to survey and can demonstrate aggressive, "good faith effort" at improving through QAPI, the surveyors are to give credit.*

Now that sounds like a fine idea, right? May you implement effective QAPI systems to ensure all positive outcomes and provide outstanding dietary services and nutrition care. **E**

CE Questions: Management Connection

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1. The abbreviation QAPI stands for:
   A. Quality Assurance and Performance Improvement
   B. Quality Assurance and Performance Interrogation
   C. Quality Assessment and Premium Improvement

2. The QAPI regulations for both hospitals and nursing homes have the following expectation:
   A. Dietary leaders don't need to worry about weaknesses, as surveyors will find them and then they can be corrected
   B. Dietary leaders should be developing performance improvement, and not depend on the survey to identify weak areas
   C. Dietary leaders can't be given credit for performance improvement, even if the effort is being made for corrective actions

3. Quality assurance is:
   A. A process of meeting quality standards and assuring that care reaches an acceptable level
   B. A continuous study of processes intending to prevent or decrease persistent problems
   C. A strategy to keep customers from complaining about the food quality

4. Where can revised LTC federal regulations and surveyor interpretive guidance be found?
   A. The U.S. Food & Drug Administration website
   B. The U.S. Department of Agriculture website
   C. The Centers for Medicare & Medicaid Services website

5. RCA stands for:
   A. Regulations Central to Administration
   B. Rare Conflicts & Assessment
   C. Root Cause Analysis

6. PIP stands for:
   A. Performance Improvement Projects
   B. Prepare Informative Proposal
   C. Preempt Investigation Protocols

7. The Plan-Do-Study-Act Cycle Template includes the following questions:
   A. What are we trying to accomplish? And how will we know that change is an improvement?
   B. What change can we make that will result in an improvement?
   C. All of the above

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