Leveraging Quality Assurance Performance Improvement (QAPI) for Success

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What's Your QAPI Superpower?

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Objectives

- ✓Participants will learn about the regulatory requirements of QAPI
- ✓Participants will understand the QAPI methodology
- ✓Participants will review the Five Star Rating System
- ✓Participants will begin a personal Plan Do Study Act (PDSA) project
- ✓Participants will gain QAPI insight from Lowry Hills and Ridgeview

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483.75 Quality Assurance and Performance Improvement Updates to the Requirements of Participation (ROP) Phase III

UPDATED Definition "Quality Assurance and Performance Improvement (QAPI)" is the coordinated application of two mutually-reinforcing aspects of a quality management system: Quality Assurance (QA) and Performance Improvement (PI). QAPI takes a systematic, interdisciplinary, comprehensive, and data-driven approach to maintaining and improving safety and quality in nursing homes while involving residents and families in practical and creative problem solving.

- ✓ F865 QAPI Program/Plan, Disclosure/Good Faith Attempt
- ✓ F867 QAPI/QAA Improvement Activities
- ✓ F686 QAA Committee

A data-driven, proactive approach to improving the quality of life, care and services in nursing homes.

Surveyors will begin using this guidance to identify noncompliance beginning October 24, 2022.

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The Regulation States

- Maintain documentation and demonstrate evidence of ongoing comprehensive QAPI program
- **Establish and implement written policies and procedures** for feedback, data collection systems, and monitoring, that includes adverse events
- Take actions and set priorities aimed at performance improvement
- Implement actions, measure success, and track performance to ensure improvements are realized and sustained
- Designate governing body and/or executive leadership to be responsible for ongoing QAPI program
- Maintain a Quality Assessment and Assurance (QAA) committee

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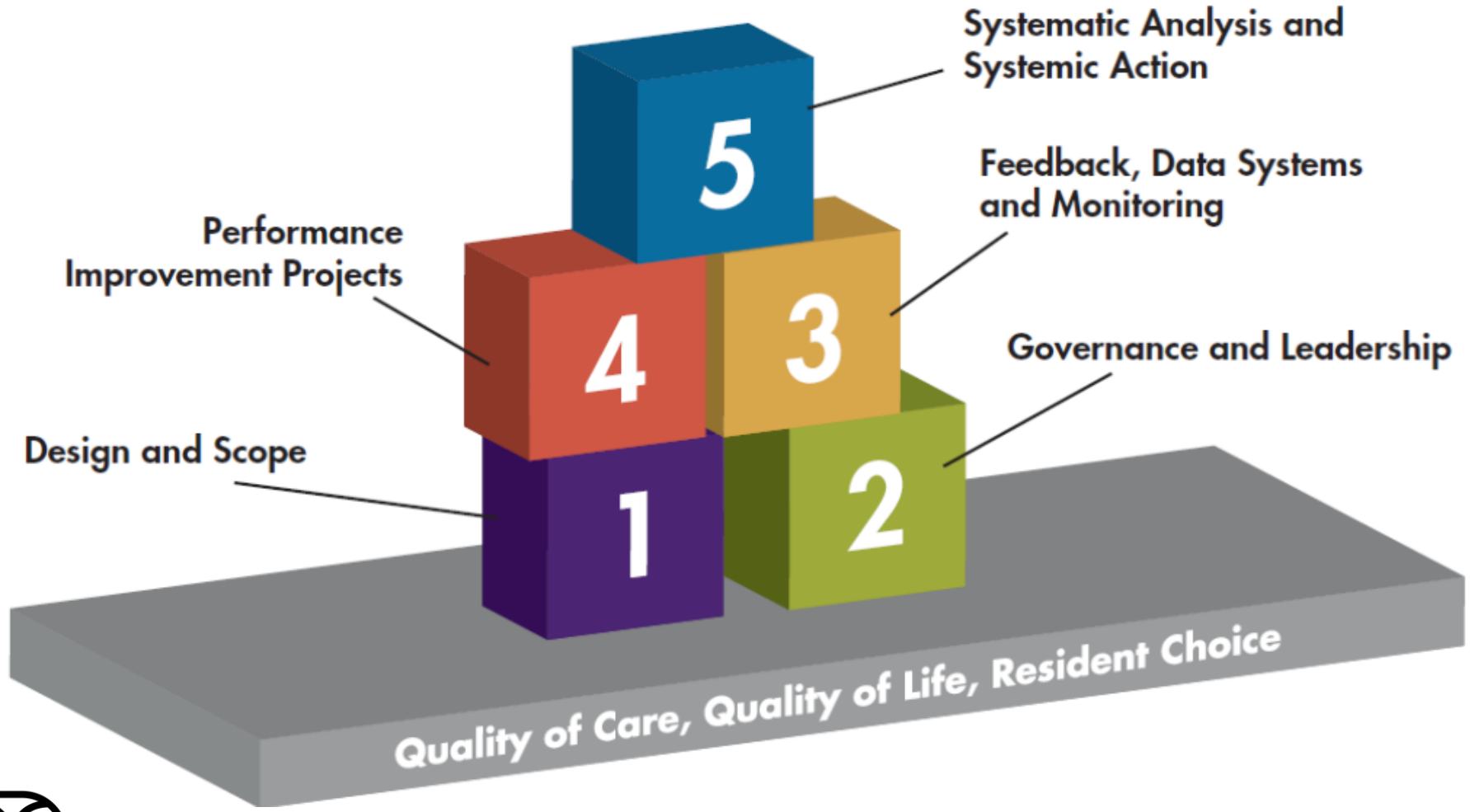
QAPI Methodology



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Design and Scope

- Explains how you will develop, implement, and maintain a QAPI program that is:
  - Effective and comprehensive
  - Data-driven and focuses on indicators for outcomes of care and quality of life
- Describes how systems and reports will demonstrate:
  - Systematic identification, reporting, investigation, and analysis to prevent adverse events
  - The development, implementation, and evaluation of corrective actions and performance improvement activities in your documentation

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Design and Scope Tools

QAPI

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 time line 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. Quality of life
   iii. Resident choice (i.e., 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 residents (or resident'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).

FACILITY ASSESSMENT TOOL

Facility Name	
Persons (names/ titles) involved in completing assessment	Administrator: Director of Nursing: Governing Body Rep: Medical Director: Other:
Date(s) of assessment or update	
Date(s) assessment reviewed with QAA/QAPI committee	

Part 1: Our Resident Profile

Numbers

1.1. Indicate the number of residents you are licensed to provide care for: (enter number of beds) ____.

Consider if it would also be helpful to differentiate between long-stay and short-stay residents or other categorizations (e.g., unit floors or specialty areas or units, such as those that provide care and support for persons living with dementia or using ventilators).

1.2. Indicate your average daily census: (enter a range) ____.

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QAPI Self-Assessment Tool

Directions: Use this tool as you begin work on QAPI and then for annual or semiannual evaluation of your organization's progress with QAPI. This tool should be completed with input from the entire QAPI team and organizational leadership. This is meant to be an honest reflection of your progress with QAPI. The results of this assessment will direct you to areas you need to work on in order to establish QAPI in your organization.

Date of Review: _____ Date of Next review: _____

Nursing Home Name _____ CCN _____

Element #1 Design and Scope

Rate how closely each statement fits your organization

	Not Started	Just Starting	On our Way	Almost There	Doing Great
1. Our organization has developed principles guiding how QAPI will be incorporated into our culture and built into how we do our work. For example, we can say that QAPI is a method for approaching decision making and problem solving rather than considered as a separate program.	☐	☐	☐	☐	☐
2. Our organization has identified how all service lines and departments will utilize and be engaged in QAPI to plan and do their work. For example, we can say that all service lines and departments use data to make decisions and drive improvements, and use measurement to determine if improvement efforts were successful.	☐	☐	☐	☐	☐
3. Our organization has developed a written QAPI plan that contains the steps that the organization takes to identify, implement and sustain continuous improvements in all departments; and is revised on an ongoing basis. For example, a written plan that is done purely for compliance and not referenced would not meet the intent of a QAPI plan.	☐	☐	☐	☐	☐

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Government and Leadership

- Develops and leads a QAPI program that involves leadership, works with input from facility staff, as well as from residents and their families and/or representatives
- Develop facility-wide training on QAPI
- Foster a culture where QAPI is a priority

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Governance and Leadership Goals

- Understand the QAPI business case
- Promote a fair and open culture where staff are comfortable identifying quality problems and opportunities
- Create a culture that embraces the principals of QAPI
- Promote engagement of staff, residents and families in QAPI
- Involve residents and families

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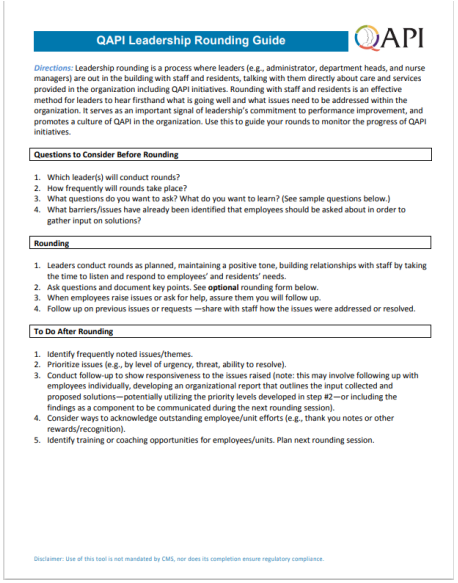
Tools to Support Governance and Leadership



QAPI Leadership Rounding Guide QAPI

Directions: Leadership rounding is a process where leaders (e.g., administrator, department heads, and nurse managers) are out in the building with staff and residents, talking with them directly about care and services provided in the organization including QAPI initiatives. Rounding with staff and residents is an effective method for leaders to hear firsthand what is going well and what issues need to be addressed within the organization. It serves as an important signal of leadership's commitment to performance improvement, and promotes a culture of QAPI in the organization. Use this to guide your rounds to monitor the progress of QAPI initiatives.

Questions to Consider Before Rounding

1. Which leader(s) will conduct rounds?
2. How frequently will rounds take place?
3. What questions do you want to ask? What do you want to learn? (See sample questions below.)
4. What barriers/issues have already been identified that employees should be asked about in order to gather input on solutions?

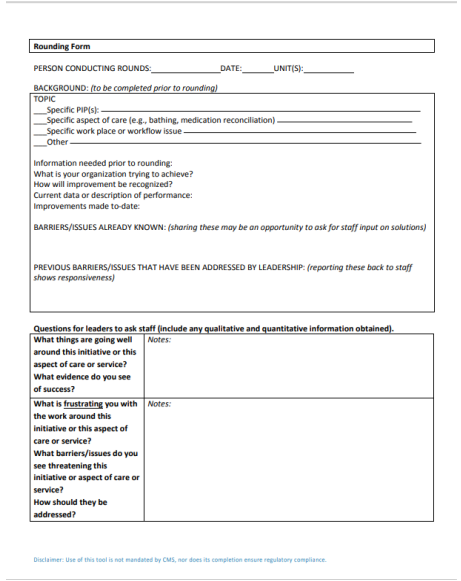
Rounding

1. Leaders conduct rounds as planned, maintaining a positive tone, building relationships with staff by taking the time to listen and respond to employees' and residents' needs.
2. Ask questions and document key points. See **optional** rounding form below.
3. When employees raise issues or ask for help, assure them you will follow up.
4. Follow up on previous issues or requests —share with staff how the issues were addressed or resolved.

To Do After Rounding

1. Identify frequently noted issues/themes.
2. Prioritize issues (e.g., by level of urgency, threat, ability to resolve).
3. Conduct follow-up to show responsiveness to the issues raised (note: this may involve following up with employees individually, developing an organizational report that outlines the input collected and proposed solutions—potentially utilizing the priority levels developed in step #2—or including the findings as a component to be communicated during the next rounding session).
4. Consider ways to acknowledge outstanding employee/unit efforts (e.g., thank you notes or other rewards/recognition).
5. Identify training or coaching opportunities for employees/units. Plan next rounding session.

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



Rounding Form

PERSON CONDUCTING ROUNDS:_____DATE:_____UNIT(S):_____

BACKGROUND: *(to be completed prior to rounding)*

TOPIC
___Specific PIP(s): _____
___Specific aspect of care (e.g., bathing, medication reconciliation) _____
___Specific work place or workflow issue _____
___Other _____

Information needed prior to rounding:
What is your organization trying to achieve?
How will improvement be recognized?
Current data or description of performance:
Improvements made to-date:

BARRIERS/ISSUES ALREADY KNOWN: *(sharing these may be an opportunity to ask for staff input on solutions)*

PREVIOUS BARRIERS/ISSUES THAT HAVE BEEN ADDRESSED BY LEADERSHIP: *(reporting these back to staff shows responsiveness)*

Questions for leaders to ask staff (include any qualitative and quantitative information obtained).

What things are going well around this initiative or this aspect of care or service? What evidence do you see of success?	*Notes:*
What is frustrating you with the work around this initiative or this aspect of care or service? What barriers/issues do you see threatening this initiative or aspect of care or service? How should they be addressed?	*Notes:*

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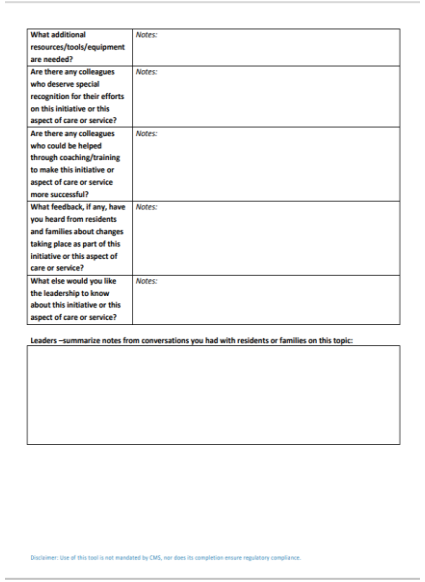

What additional resources/tools/equipment are needed?	*Notes:*
Are there any colleagues who deserve special recognition for their efforts on this initiative or this aspect of care or service?	*Notes:*
Are there any colleagues who could be helped through coaching/training to make this initiative or aspect of care or service more successful?	*Notes:*
What feedback, if any, have you heard from residents and families about changes taking place as part of this initiative or this aspect of care or service?	*Notes:*
What else would you like the leadership to know about this initiative or this aspect of care or service?	*Notes:*

Leaders –summarize notes from conversations you had with residents or families on this topic:

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QAA/QAPI Meeting Agenda
<Name of Nursing Home>
<Date of Meeting>

Participants

Name	Title

Updates or Outstanding Items From Last Meeting

Item	Current status

5 Star Rating

Overall	Health Inspection	Staffing	Quality of Resident Care	Directed Plan of Correction Issued (Yes or No)	Cited for Abuse (Yes or No)

Discussion:

Actions:

Current Quality Assessment and Assurance Activities

Data Review (CMS/CASPER)	Facility Rate	State Rate	National Rate	PIP? Yes or No

Type your answer here

What have we talked about today that will make the lives of our residents and/or staff better by the next time we meet?

Review of QAPI Plan
- Date of last review:
- Any changes needed to QAPI Plan?

Review of Facility Assessment
- Date of last review:
- Any changes needed to Facility Assessment?

Review of QAPI Self-Assessment
- Date of last review:
- Any changes needed to QAPI Self-Assessment?

QAPI Leadership Rounding Guide

QAA/QAPI
Meeting Agenda

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Your QAA Committee

- Must maintain QAA committee consisting at a minimum of:
  - The director of nursing services
  - The Medical Director or his/her designee
  - At least three other members of the facility's staff, at least one of who must be the administrator, owner, a board member or other individual in a leadership role
  - The infection preventionist
- Report activities, including implementation of the QAPI program, to the entity functioning as governing body
- Meet at least quarterly and as needed to oversee QAPI program activities
  - Identify quality issues, coordinate QAPI activities including performance improvement projects (PIPs)
  - Develop and implement plans of action to correct identified quality deficiencies

What Does the QAA Do?

- Regular data review and analysis
- Act on available data to make improvements
- Not required to disclose committee records except when related to committee compliance
- Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions

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Feedback, Data Systems and Monitoring

- Data determines need for improvement
- Data indicates progress
- Data demonstrates sustainment

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Using Data to Drive Decisions

1. Identify what you need to monitor
2. Decide on measures/indicators for what needs to be monitored
3. Find the standard rate, range or perimeter for the selected measures/indicators
4. Set benchmarks, and thresholds for measure/indicators being monitored
5. Prioritize goals, benchmarks and thresholds that are not being met
6. Establish SMARTIE goal to improve each prioritized benchmark and threshold that is not being met

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Drawing Data from Multiple Sources

- Facility's internal data sources
  - Electronic healthcare records
  - Billing/Claims Data
  - Dashboards
  - Healthcare setting specific data reports
  - Incident/adverse event reports
  - Complaints
  - Staff and resident/family survey
- Information from other sources
  - Lab reports/Pharmacy Reports
  - CMS (Centers for Medicare & Medicaid Services)
  - CDC (Centers for Disease Control and Prevention) & NHSN (National Healthcare Safety Network)

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Measures and Indicators

Enable decision-makers to assess progress towards outcomes or goals

- Process measures
  - Focus on actions
  - Assess the steps or activities to deliver care or services
- Outcome measures
  - Focus on the product (or outcome) of a process or system of care or services
  - Can identify different or more complex underlying causes

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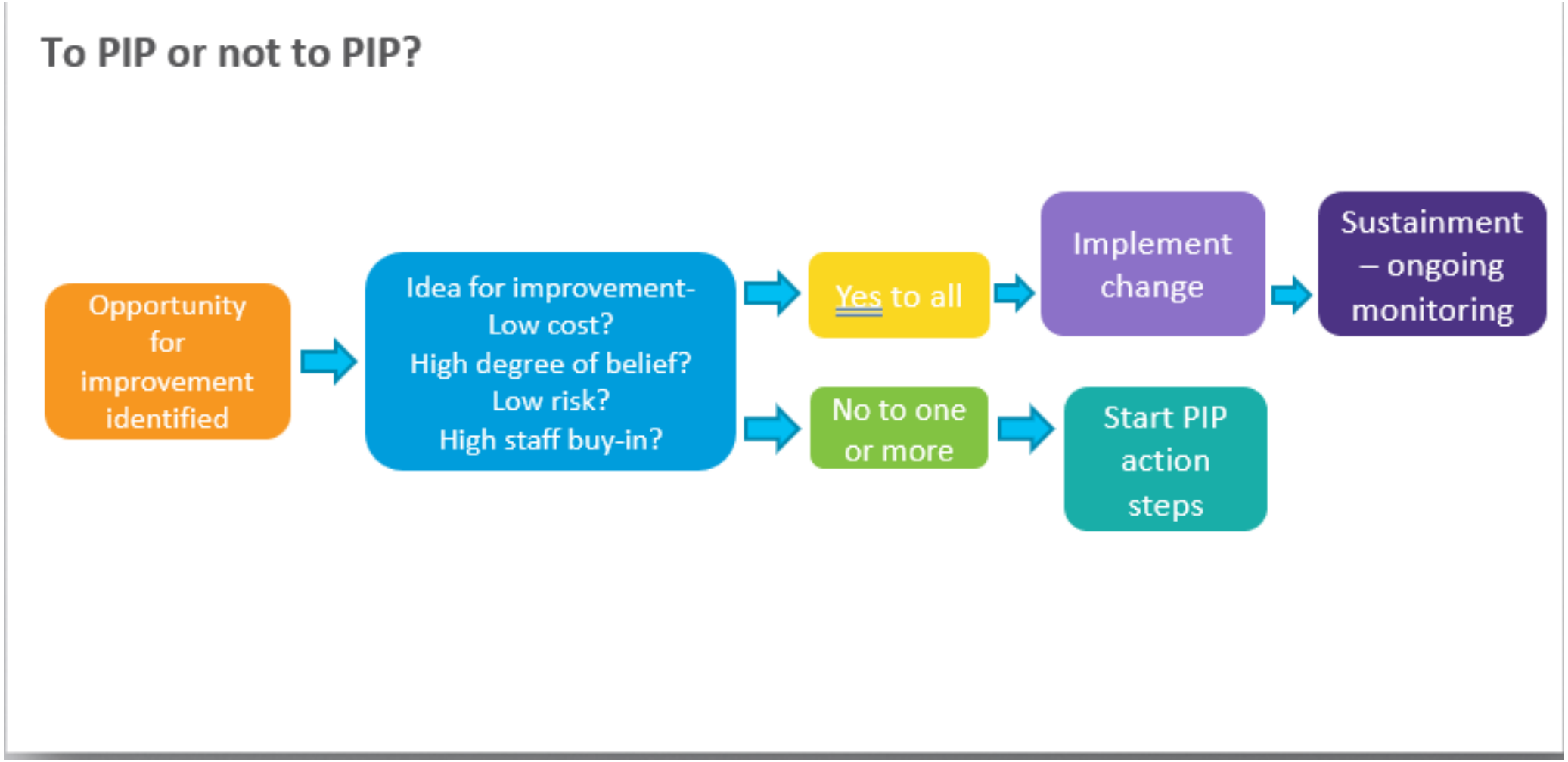
Systematic Analysis and Systemic Action



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Performance Improvement Project (PIP) Team

- Identify a champion, spend the next 3-4 weeks guiding/mentoring this champion
  - Nurse manager, social services director, IP nurse, etc….
- Establish expectations
  - Champion schedules meetings with team
  - Meeting norms/roles/responsibilities
  - Clear and concise picture of project
- Gather feedback from those who are doing the work
  - Allow them to lead
  - Challenges and required resources
- Be open to change and innovation
  - Think outside the box and encourage this type of thinking

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Think SMARTIE Goals

Specific
- Clear, unambiguous

Measurable
- Defined Measure of progress, data

Attainable
- Possible to achieve, within reach

Relevant
- Realistic, applicable to needs

Time-Bound
- Planned timeline, target date

Inclusion and Equity

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How Will We Know Change Is an Improvement?

- Use measures to determine if a specific change leads to an improvement
  - Quantitative measure is data that can be put into numbers such as counts or tallies
  - Qualitative measure is data collection through sensory observation
- Describe the desired, predicted or expected results
- Be specific and select a quantifiable or measurable target: “from this amount to that amount”
  - Not ‘some’ or ‘about’
  - Not ‘increase’ or ‘decrease’ without setting limits

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Team Charter

As you pass this off to the PIP team be sure to share your "why"

- How will improving this measure improve the overall care of the residents?
- What systems and measures will this impact?

SMART Goal e.g.: Reduce short stay readmission rates from 47.5% to 20% (below the national average on Care Compare) by December 1, 2022

SMART Goal e.g.: Reduce emergency department visits from 35.9% to 9% (below the national average on Care Compare) by December 1, 2022

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Performance Improvement Project (PIP) Documentation

Team Charter

Nursing Home Name: Readmission Busters Start Date: 03/07/22

PIP Team Project

Quality Measure (QM) or Area of Focus	Baseline Data (include time period)
30 day Readmissions	October 1, 2021 - March 7, 2022

SMART Goal (Specific, Measurable, Attainable, Relevant and Time Bound)

Example: Reduce the long-stay quality measure rate for UTI from 4.2% to 2.5% (the national average on Care Compare) by December 31, 2022.

Reduce short stay readmission rates from 47.5% to 20% (below the national average on Care Compare) by December 1, 2022.

Executive Sponsor: Belinda James

PIP Team Members

Staff Name	Title
Leader: Nora Jones	DON
Janet Smith	Charge Nurse
Lisa Jones	IP
Sally Case	RN
Dustin Bates	Admissions Coordinator

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Team Charter

Nursing Home Name: Readmission Busters

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Root Cause Analysis (RCA) Summary

slow response time in communication for change in condition on the 100 wing; we didn't ask the hospital about a wound infection at the time of admission; discharge instructions very scattered throughout the paperwork; delay in reporting poor food and fluid intake

Goal Monitoring

Current Date	Current Rate	Current Date	Current Rate	Current Date	Current Rate
03/07/22	47.5%				
07/18/22	35%				
10/20/22	25%				

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Interventions: The following are the interventions implemented based on the planning and completion of a PDSA process.

Start Date	Intervention Description	PDSA Cycle (1,2,3)	Outcomes	Adapt, Adopt or Abandon
03/07/22	educate 100 wing staff on change in condition response time; audit compliance	cycle 1	3/14 education & competency checks completed; will start audits	TBD after audits complete
03/07/22	review food/fluid intake logs; determine a process for routine monitoring	cycle 1	3/21 noted 3 new residents w/intake concerns; Sally to f/up and routine monitor	Adopt
03/14/22	Update admission checklist to include communication infections; set up mtg with hosp to discuss DC/admit needs	cycle 2	3/21 checklist is helping to collect the needed info; hosp mtg set for 3/23	Adopt

Outcomes: Use the table below to document what has worked, what has not, or lessons learned.

Intervention Success	Intervention Barriers	Lessons Learned
setting a process to monitor food/fluid intake	none noted at this point	we have been missing potential residents for concern with change of intake
improving admit checklist for consistency in process	struggled with how to ensure checklist is followed	created a new way to communicate
education was completed by all on 100 wing	staff were negative about time challenges	needed to share the "why" this is important

Sustainability: How are you going to sustain the improvements that were made? (Example: Update policies and procedures, educate staff, update onboarding process, identify a champion to monitor the data and interventions being carried out at routine intervals, etc...)

pull into orientation of new hires; admissions team will meet to follow data 1x/mth; Sally is our Champion

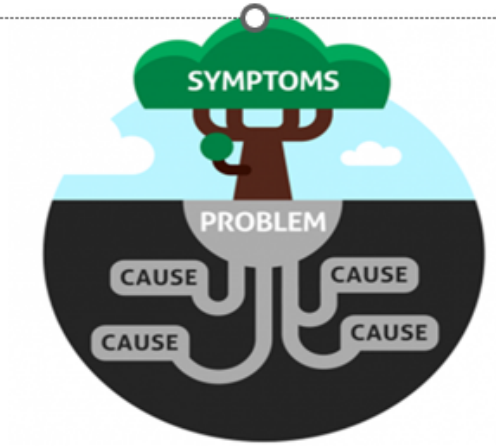
Resources: Five Whys Worksheet, Root Cause Analysis (RCA) Pathway, PDSA Template and Sustainability Decision Guide.

https://www.telligenqiconnect.com/resource/performance-improvement-project-pip-documentation/

Root Cause Analysis (RCA)

Root Cause Analysis (RCA)

A systematic process for identifying **unseen factors** that contribute to **undesirable outcomes**



Root causes are the core issues that set-in motion the cause-and-effect that ultimately leads to the problem

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RCA: A Team Decision

[When to Use Root Cause Analysis]

[CMS Guidance for performing RCAs with performance Improvement projects]

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When to Use Root Cause Analysis

Root cause analysis (RCA) is a problem solving method or process for investigating an incident, failure, actual or potential problem or concern. RCA should be considered for "close calls" or "near misses" that have the potential for serious or negative outcome. Events that are chronic, recurring, involving communication breakdown, and are systemic in nature are best for this type of in depth problem solving. The root cause analysis process is performed by a team to identify breakdowns in processes and systems that contributed to the event and how to prevent them from recurring. Events that can be investigated using the RCA process can be identified from many sources, such as:

- Incident reports
- Any feedback or any type of survey
- An unexpected occurrence that led to individual or staff harm
- A repeating problem

Root cause analysis can be used in many situations, below are a few situations and examples:

Type of Situation	Example
An adverse or sentinel event is an unexpected occurrence involving serious injury or death of an individual	An individual falls, resulting in a serious head injury requiring hospitalization
Near miss, unacceptable risk or chronic failure	The wrong medication dose is found in the medication cart
Recurring complaints	A family member complains that it took 30 minutes for his mother's call light to be answered. Another family member reports that staff didn't appear for 15 minutes after turning on the call light
Repeating event	75% of all falls occur between 6 and 8 PM
Any time a performance gap is identified	A plan of care was not followed

RCA also is not necessary for every concern, incident or problem that arises. Some situations can be managed and resolved quickly such as:

- If it is unlikely to recur based on unique circumstances
- If negative consequences may be minor or non-existent
- If there is no pattern of previous similar events or trends

It's also important to understand that RCA is not intended to find "who is at fault". Problem solving that is focused on finding and blaming an individual is ineffective. RCA is focused on what systems led individuals to make the choices they did, and changing the systems to change behavior.

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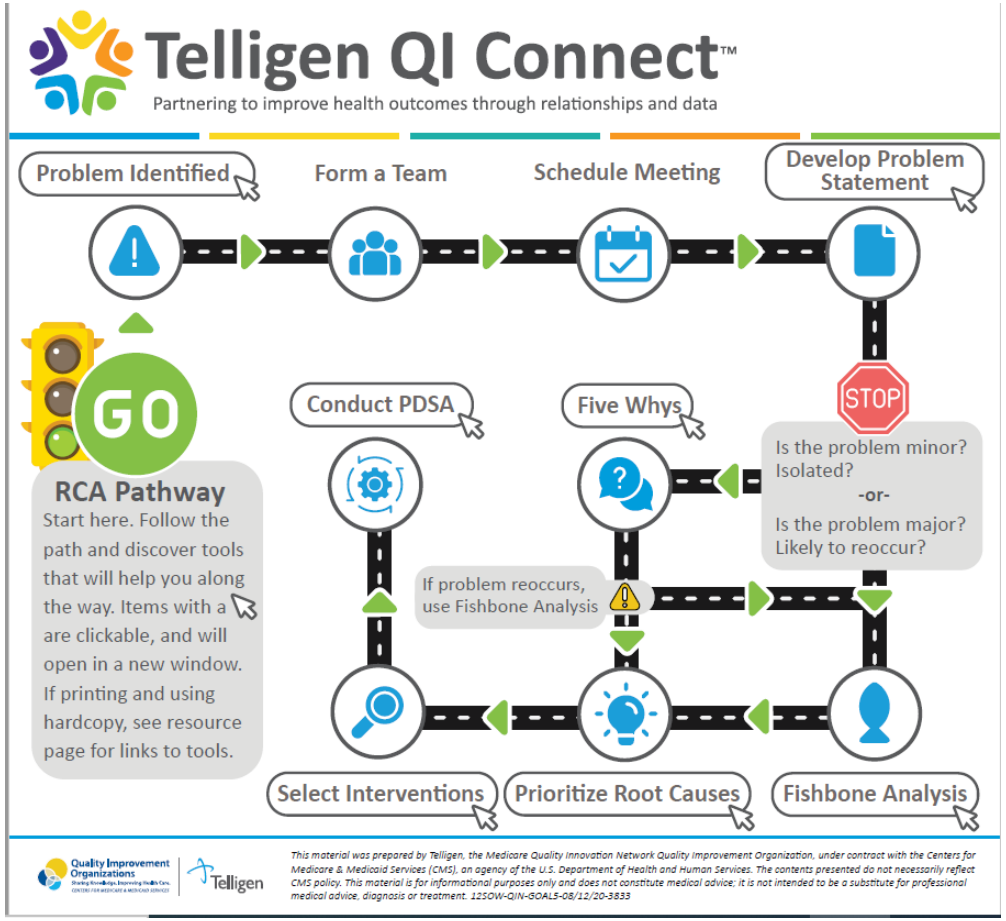
RCA Pathway Tool

RCA Pathway Tool



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RCA Templates

Five Whys Worksheet

Accurately state the problem (Five Whys is used in trouble shooting, quality improvement and problem solving. It is best suited for simple or moderately complex problems).

PROBLEM:

Why is this happening? Enter all the reasons why. You may need more boxes. For each reason, begin asking WHY.

WHY? REASON #1	WHY? REASON #2	WHY? REASON #3
WHY?	WHY?	WHY?
WHY?	WHY?	WHY?
WHY?	WHY?	WHY?
WHY?	WHY?	WHY?

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Five Why Worksheet

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Problem Statement:

Environmental

Staff/People

Equipment/Supplies

Rules/Policies/Procedures

Nursing home name:

CMS Certification Number (CCN):

For additional information completing the RCA:
http://www.ihi.org/education/IHIOpenSchool/resources/Pages/AudioandVideo/Whiteboard16.aspx

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Fishbone Diagram

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	QAA Committee	QAPI Steering Committee
Requirements	Federally required https://www.ecfr.gov/cgi-bin/text-idx?SID=f64b6edcc2b2ee52bf5de8e19a340569&mc=true&node=sp42.5.483.b&rgn=div6#se42.5.483_175	Not required but recommended QAPI at a Glance, Step 1 QAPIAtaGlance.pdf (cms.gov)
Attendees	Required: DON, Med Dir, NHA + 2 other leadership, IP	Can be ANY facility staff member including CNAs, activities, dietary, environmental services, etc.
Meeting Frequency	At least quarterly	As often as needed to achieve goals
Goals	Review and evaluate all facility data sources to determine areas of focus for QAPI Steering Committee	Review data (including resident level) to determine how best to utilize QAPI elements to improve

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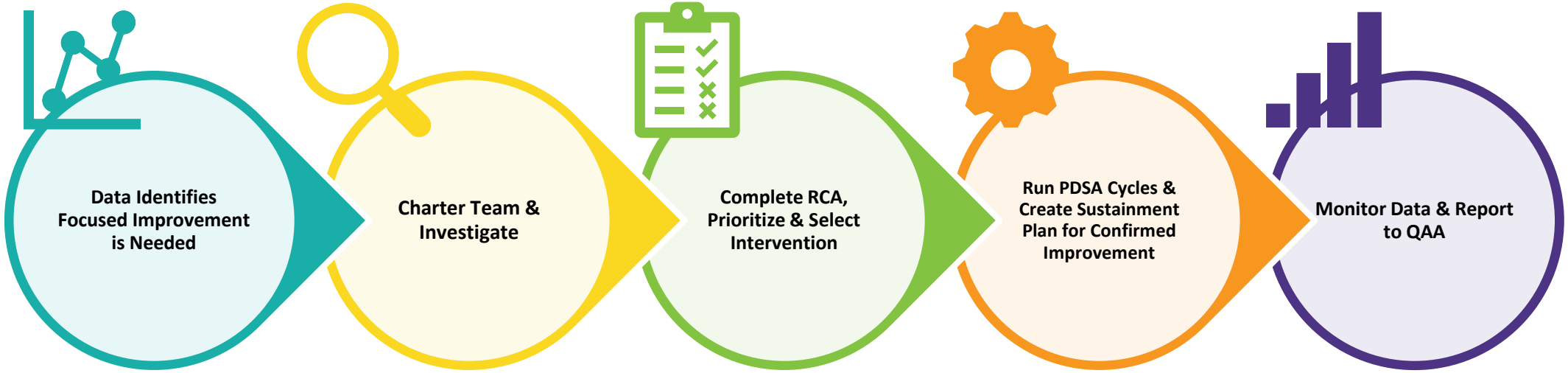
★ QAPI Flow Chart

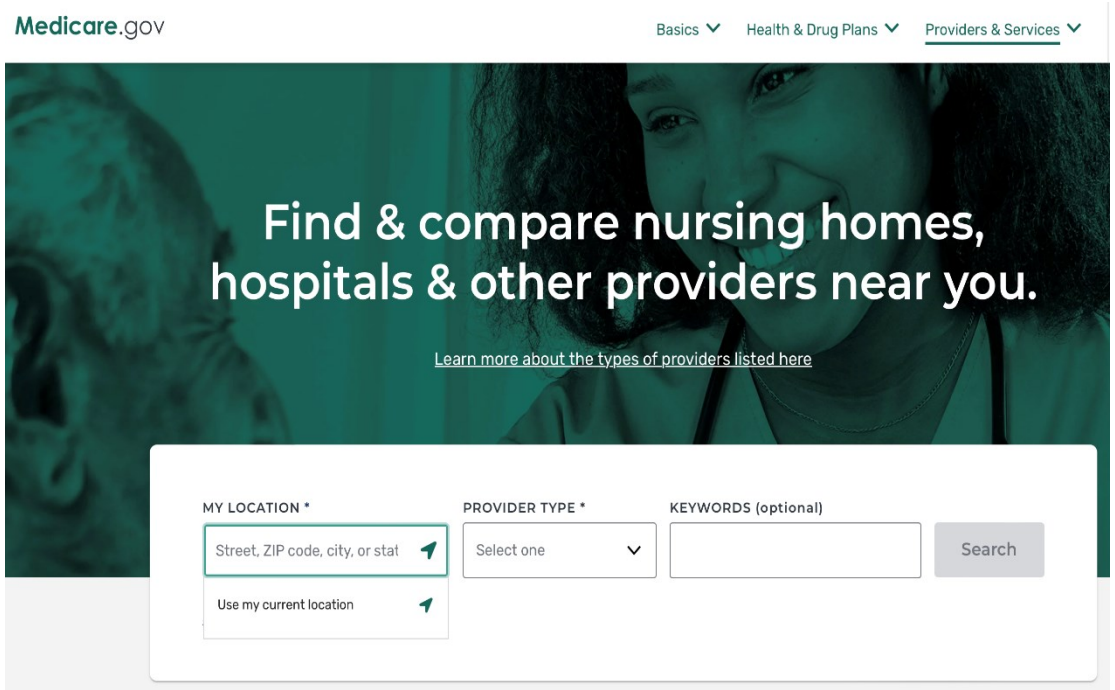


Five Star Quality Rating System

It features an Overall Quality Rating of one to five stars based on nursing home performance on three domains, each of which has its own rating:

- ✓ Health inspection
- ✓ Staffing
- ✓ Quality Measures

Nursing Home Care Compare



https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/CertificationandComplianc/Downloads/usersguide.pdf

https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/CertificationandComplianc/Downloads/cutpointstable.pdf

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1. Select a personal area you want to work on (aka create a PIP).
2. Set up your data:
   1. Benchmark-where are you starting?
   2. What is your goal?
   3. What is your timeframe?
3. Select several interventions.
4. Review your PIP.

Consider facilitating this exercise with your IDT.

PDSA (plan-do-study-act) Worksheet

TOOL: **STEP:** **CYCLE:**

PLAN

I plan to:

I hope this produces:

Steps to execute:

DO

What did you observe?

STUDY

What did you learn? Did you meet your measurement goal?

ACT

What did you conclude from this cycle?

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Let's Hear From Others!

Questions?

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