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# Description

Quality Assurance & Performance Improvement (QAPI) takes a systematic, comprehensive, and data-driven approach to consistently maintain and improve safety and quality in nursing homes.

As a condition for participation in Component 1, in addition to attestation that a monthly meeting took place and it incorporates all goals set forth for QAPI development by CMS; providers are required to submit data related to a nursing facility (NF)-specific performance improvement project (PIP) every month.

The Centers for Medicare and Medicaid Services (CMS) defines[[1]](#footnote-1) the PIP project as a concentrated effort on a particular problem in one area of the facility or facility wide that involves gathering information systematically to clarify issues or concerns and to intervene for improvements.

See Appendix 1 for a comprehensive listing of QAPI tools and resources published by the CMS.

**While the NFs have the flexibility to determine how to develop their program and tailor their PIPs, facilities must focus on at least one CMS long-stay MDS measure published on the CMS Care Compare website for comparison.**

Refer to QMP’s QIPP Website for performance requirements, benchmarks, and submission guidelines in accordance with 1 TAC §353.1304.

General Instructions

The *Component One PIP Reporting Template* must be submitted through the QIPP Long-Term Care Services & Support (LTSS) Data Submission Portal **each month**, alongside required data submission and any supporting documentation reflected in updates from the reporting period.

While the template must be submitted monthly, some specified sections within it only need to be completed and submitted on a quarterly basis. Refer to the instructions found in the *Quality Metric Technical Requirements* document for guidance on how to properly submit data and documentation to meet the performance requirements for metrics associated with QIPP Components.

**This template is to be used to fulfill reporting requirements only. It does not provide prescriptive guidance on how to conduct QAPI activities.** The facilities are expected to conduct a PIP to examine and improve care or services in areas that the facility identifies as needing attention. Areas that need attention will vary depending on the type of facility and the unique scope of services they provide.

### Suggested Yearly Submission Schedule

* **September:** Identify your PIP Team and Goal and select at least one appropriate quantifiable measure relevant to the area of focus as you prepare and arrange staff for the upcoming program year (Sec. 1-3)
* **October:** Report the results of initial Root Cause Analysis and plans for at least one proposed intervention for the program year (Sec. 4)
* **November:** Report definitions and other information regarding all chosen quality measures and describe proposed feedback and data systems the NF will use to monitor those measures (Sec. 5, 6)
* **December Through July:** Report on the progress of interventions and regularly update quality measure and indicator performance results as available (Sec. 7-9)
* **August:** Report final measurements for quality measures and indicators, summary results of PIP, and plans for sustaining improvements (Sec. 7-10)

# Quarter 1: PIP Charter

The NF must upload this document each month along with supporting documentation relevant to each section updated during the reporting period. The sections below constitute the PIP Charter, which must be completed by the end of the first quarter of the program year.

Facilities are expected to complete the PIP charter[[2]](#footnote-2)to define key PIP charter components relevant to each nursing facility. HHSC has not specified a template for any broader charter document; however, supporting documentation must contain all information required in this document.

|  |  |
| --- | --- |
| **Nursing Facility Medicaid ID** |  |
| **Nursing Facility Name** |  |

## 1. List PIP Team

While everyone in the organization is involved in QAPI, PIP teams are formed for longer-term work on a specific issue. Many of these individuals may be on your current Quality Assessment and Assurance (QAA) committee. For example, a PIP team working on reducing falls may ask that the housekeeping department be involved after identifying equipment in the corridors and clutter in the bathrooms as contributing factors during the root cause analysis.

| Were any of the following members included in the PIP Team? (Check all that apply) | | | |
| --- | --- | --- | --- |
|  | **Board or Executive Leadership** | | |
|  | **Facility Management and Administration** | | |
|  | **Front line staff** | | |
|  | **Resident** | | |
|  | **Family members/ caregivers** | | |
|  | **Pharmacist** | | |
|  | **Key clinical staff** | | |
|  | **Other** | **ENTER TEXT HERE:** | |
| Does your facility use *Leadership Rounding* [[3]](#footnote-3) process to informally discuss quality and safety issues with staff, residents, caregivers, etc.? | | | |
| Yes | | | **No** |

## 2. Choose the PIP Topic

Specify at least one CMS Long-Stay Quality Measure as an area of focus. Only one measure must be reported on monthly through the Web portal.

Baseline data for this measure should be included in the tracking table in Section 7. **The NF is required to submit the most recently available data for the topic measure each month, even when results are not deemed significant.**

|  |  |  |
| --- | --- | --- |
|  | Quality Measure (QM) Label | CMS ID |
|  | Percent of Residents Experiencing One or More Falls with Major Injury | N013.02 |
|  | Percent of High-Risk Residents with Pressure Ulcers | N015.03 |
|  | Percent of Residents with a Urinary Tract Infection | N024.02 |
|  | Percent of Low Risk Residents Who Lose Control of Their Bowels or Bladder | N025.02 |
|  | Percent of Residents Who Have/Had a Catheter Inserted and Left in Their Bladder | N026.03 |
|  | Percent of Residents Who Were Physically Restrained | N027.02 |
|  | Percent of Residents Whose Need for Help with Activities of Daily Living Has Increased | N028.02 |
|  | Percent of Residents Who Lose Too Much Weight | N029.02 |
|  | Percent of Residents Who Have Depressive Symptoms | N030.02 |
|  | Percent of Residents Who Received an Antipsychotic Medication | N031.03 |
|  | Percent of Residents Whose Ability to Move Independently Worsened | N035.03 |
|  | Percent of Residents Who Used Antianxiety or Hypnotic Medication | N036.02 |

## 3. Define PIP Goal

This section is intended to document established goals[[4]](#footnote-4) for the PIP and provide relevant context for the selected MDS-based quality measure(s).

| Name of project | |
| --- | --- |
| *Example: Reduction in use of position change alarms* | ENTER TEXT HERE |
| Goals | |
| *Example: Decrease the number of long-term residents with position change alarms used on XX unit by 25% by August 31, 2023.* | ENTER TEXT HERE |

## 4. Systemic Root Cause Analysis

NFs must conduct a systematic analysis to determine contributing factors and root causes. The use of specific techniques is not prescribed, and facilities may report the results using any method that can assist them with identifying the root causes. Some examples are the five whys[[5]](#footnote-5), flowcharting[[6]](#footnote-6), or the fishbone diagram[[7]](#footnote-7).

**Supporting documentation for root cause analysis results is due in the QIPP Data Submission Portal for any reporting period this section is updated.**

|  |
| --- |
| Provide the results of the root cause analysis. |
| ENTER TEXT HERE |
| Describe how the root cause analysis was used to develop interventions. |
| ENTER TEXT HERE |

## 5. Data Systems and Monitoring Plan

Include in the tables below information pertaining to all quality measures and performance indicators you have identified for collection, tracking, and monitoring.

### 5A. Data Sources

The first table collects the data sources for all PIP quality measures, and the table in the following section collects data on the individual measures.

| Identify data sources that you will monitor for this PIP. (Check all that apply.) | | | | | |
| --- | --- | --- | --- | --- | --- |
| Which of the following data sources do you plan to use? | | | | | |
|  | | MDS data for problem patterns | | | |
|  | | Input from caregivers, residents, families, and others | | | |
|  | | Adverse events | | | |
|  | | Survey findings | | | |
|  | | Complaints | | | |
|  | | Nursing Home Compare | | | |
|  | | Patterns of ER and/or hospital use | | | |
|  | | **Other** | **ENTER TEXT HERE:** | | |
| You will likely want to use existing measures when possible, but there may be times when you want to develop a new measure/indicator that is specific to your needs. | | | | | |
| Are you developing a new performance measure/indicator that is specific to your needs? | | | | | |
|  | Yes | | |  | No |

### 5B. Supporting Quality Measures & Performance Indicators

Complete a column in the following table for each supporting quality measure the NF will monitor for this PIP[[8]](#footnote-8). If the quality measure is externally defined, you can borrow definitions from those data sources. For defining unique measures, consider using available development toolkits and worksheets[[9]](#footnote-9).

Baseline data for these measures should be included in the tracking tables in Section 7. **The NF is not required to submit re-measurements every month for supporting measures.**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| NAME OF MEASURE/ INDICATOR | Example | Measure 1 | Measure 2 | Measure 3 |
| *Example: Residents with a completed skin assessment within 12 hours of admission.* |  |  |  |
| **PURPOSE** | *Example: ensure consistency in process of completing a skin assessment within 12 hours of admission* |  |  |  |
| **DATA SOURCE** | *Example: Medical records, Payroll* |  |  |  |
| **SAMPLE SIZE & METHODOLOGY** | *Example: The total population admitted in the last month who were in the nursing home for at least 24 hours will be reviewed* |  |  |  |
| **FREQUENCY OF MEASUREMENT** | *Example: Monthly* |  |  |  |
| **DURATION** | *Example: Will collect this data for three consecutive months; then based on findings, will either develop corrective action and continue monitoring monthly, or consider decreasing frequency of monitoring.* |  |  |  |
| **STAFF RESPONSIBLE FOR TRACKING** | *Example: DON* |  |  |  |
| **HOW WILL DATA FINDINGS BE TRACKED AND DISPLAYED?** | *Example: DON graphs each new resident per month and tracks when assessment is completed by staff. Results are provided to QAPI committee and posted in “North” conference room.* |  |  |  |
| **NUMERATOR** | *Example: Any resident with a completed skin assessment within 12 hours of admission (numerator=19)* |  |  |  |
| **DENOMINATOR** | *Example: All residents admitted in last month. (Denominator= 23)* |  |  |  |
| **EXCLUSION CRITERIA** | *Example: exclude those residents in the nursing home for less than 24 hours because all assessment data not available. (Denominator after exclusions: 20)* |  |  |  |

## 6. Initial Planned Intervention

Based on the root cause analysis and proposed data tracking system, the NF must develop a planned intervention by the end of Quarter 1. Briefly describe in the table below what change or corrective action is being introduced to address the problem or opportunity described in the PIP goals.

| Initial Intervention |
| --- |
| ENTER TITLE HERE |
| Intervention level: Member  Provider  System |
| Intervention Description |
| ENTER TEXT HERE |
| What barriers from the root cause analysis does this intervention address? |
| ENTER TEXT HERE |
| How will the intervention be monitored for effectiveness throughout implementation? |
| ENTER TEXT HERE |

# Quarters 2, 3 & 4: Performance & Intervention Monitoring

In subsequent months, NFs must report the ongoing results of the PIP and changes in performance for each quality measure and indicator specified on the table starting on page 8 in Quarter 1.

## 7. Updated Quality Measure & Indicator Performance

Title each table below to correspond with one of the measures listed above. The first row will be completed with data from Quarter 1. Create as many tables as necessary to report all quantifiable measure performance.

For each quality measure, the facility must report at least three re-measurements over the course of the program year, at least once in each subsequent quarter. Consider reporting recent results whenever relevant to adjusted or completed interventions.

HHSC does not determine specific outcomes for meeting the PIP goals as measures of success or failure. Facilities shall determine their own criteria. If the goal is met at some point in the program year, the facility should strive for further improvement and set a higher goal.

### Topic MDS Quality Measure: Enter Title

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Goal | Measurement | Numerator | Denominator | Rate/Rate Ratio | Measurement Reporting Period |
|  | Baseline |  |  |  |  |
|  | Re-measurement 1 |  |  |  |  |
|  | Re-measurement 2 |  |  |  |  |
|  | Re-measurement 3 |  |  |  |  |
|  | Re-measurement 4 |  |  |  |  |

### Supporting Measure #1: Enter Title

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Goal | Measurement | Numerator | Denominator | Rate/Rate Ratio | Measurement Reporting Period |
|  | Baseline |  |  |  |  |
|  | Re-measurement 1 |  |  |  |  |
|  | Re-measurement 2 |  |  |  |  |
|  | Re-measurement 3 |  |  |  |  |
|  | Re-measurement 4 |  |  |  |  |

### Supporting Measure #2: Enter Title

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Goal | Measurement | Numerator | Denominator | Rate/Rate Ratio | Measurement Reporting Period |
|  | Baseline |  |  |  |  |
|  | Re-measurement 1 |  |  |  |  |
|  | Re-measurement 2 |  |  |  |  |
|  | Re-measurement 3 |  |  |  |  |
|  | Re-measurement 4 |  |  |  |  |

### Supporting Measure #3: Enter Title

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Goal | Measurement | Numerator | Denominator | Rate/Rate Ratio | Measurement Reporting Period |
|  | Baseline |  |  |  |  |
|  | Re-measurement 1 |  |  |  |  |
|  | Re-measurement 2 |  |  |  |  |
|  | Re-measurement 3 |  |  |  |  |
|  | Re-measurement 4 |  |  |  |  |

## 8. Additional Interventions

There is no requirement for additional interventions to be developed. However, if initial interventions prove unsuccessful, new directions for the PIP should be included here. Briefly describe in the table below what change is being introduced to address the problem or opportunity.

Create as many tables as necessary to report all implemented interventions made towards reaching PIP goals over the course of the program year.

| Additional Intervention |
| --- |
| ENTER TITLE HERE |
| Intervention level: Member  Provider  System |
| Intervention Description |
| ENTER TEXT HERE |
| What barriers from the root cause analysis does this intervention address? |
| ENTER TEXT HERE |
| What limitations of earlier changes (if any) does this intervention address? |
| ENTER TEXT HERE |
| How will the intervention be monitored for effectiveness throughout implementation? |
| ENTER TEXT HERE |

## 9. Intervention Monitoring

Facilities are expected to provide updates on how planned interventions are progressing on a monthly basis. Facilities will review interventions or actions currently underway to identify if the PIPs are moving along, if any have stalled, etc.

### 9A. Inventory

NFs must update the following table **each month** with ongoing progress as monitored during the facility’s monthly QAPI meeting and continuing QAPI procedures.

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Intervention  Title | Current Phase | Change(s) Initiated | Related Measures & Indicators | Status Update |
|  | *Initiation, Planning, Implementation, Monitoring, Closing* | *What actions have been put into place?* | *Which data are being tracked to show improvement?* | *What are the indicator/measure results as compared to goals or thresholds? Have any unintended consequences or barriers been identified? How are they being addressed?* |
|  |  |  |  |  |

### 9B. Assess Change

As facilities continue to follow their PIP plan and implement interventions, it is recommended that a tool be used to document progress. One example of such a tool is Plan-Do-Study-Act (PDSA)[[10]](#footnote-10). Facilities will measure results and compare them to the predicted outcome while documenting unintended consequences, surprises, successes, and failures.

Supporting documentation must be submitted for any reporting period where an intervention is implemented, adjusted, or completed.

# Quarter 4 Only: Results & Summary

## 10. Improvement Success Story

Use this CMS template[[11]](#footnote-11) to tell the story of a change your facility made that lead to a demonstrable improvement. Use as much space as needed to respond to each question or prompt below, while being mindful of keeping the story as succinct as possible. If a question is not applicable, leave it blank.

| Story title |
| --- |
| ENTER TEXT HERE |
| Organization/Nursing Facility Name: |
| ENTER TEXT HERE |
| Intervention focus (check all that apply) |
| Clinical care  Quality of life  Resident choice  Other (if checked, explain below) |
| ENTER TEXT HERE |
| Departments involved (check all that apply) |
| Administration  Facilities Management  Food Services  Housekeeping  Nursing/Medical car  Pharmacy  Rehabilitation /Therapy  Security  Transportation  Other: (if checked, explain below) |
| ENTER TEXT HERE |
| What opportunity were you pursuing or what problem were you confronting? |
| ENTER TEXT HERE |
| What change did you decide to make? |
| ENTER TEXT HERE |
| How did you decide to make the change that you did? (i.e., what data / input did you consult, what process did you follow and what best practice evidence did you rely on to inform your decision?) |
| ENTER TEXT HERE |
| Who led the change? (i.e., who was the leader and which staff members were involved? Were there other champions who were integral in facilitating the change?) |
| ENTER TEXT HERE |
| What were the major steps you took to implement the change? |
| ENTER TEXT HERE |
| What resistance/barriers did you face while implementing the change? |
| ENTER TEXT HERE |
| How did you overcome any resistance/barriers? |
| ENTER TEXT HERE |
| In what ways did leadership support the change? |
| ENTER TEXT HERE |
| How did you monitor whether the change had the desired effect? (i.e., include a description of any performance indicators/measures selected, how they were chosen and what goals you set for them) |
| ENTER TEXT HERE |
| What positive outcomes can be demonstrated as a result of the change? (i.e., how do you know the change was a success? What does the data show? What other forms of evidence do you have?) |
| ENTER TEXT HERE |
| What reactions have you heard from those affected by the change? (In addition to data, anecdotal stories from people directly affected by the change may be of interest. For example, this could be staff members seeing a difference in how they do their work or residents having a new positive experience.) |
| ENTER TEXT HERE |
| What steps have you taken to ensure this change is sustained within your organization in the long-term? |
| ENTER TEXT HERE |
| What is the biggest lesson you learned through this experience? |
| ENTER TEXT HERE |
| If you could give some advice to other facilities wanting to replicate your success, what would you tell them? |
| ENTER TEXT HERE |
| Describe the measured results and how they compared to the predicted outcome by this time. Summarize lessons learned. For example, unintended consequences, surprises, successes, failures. |
| ENTER TEXT HERE |
| Was this PIP successful? |
| Yes No |
| What are the future plans for this topic? |
| ENTER TEXT HERE |
| Additional Comments |
| ENTER TEXT HERE |

# Appendix : QAPI Reporting Requirements & Recommended Tools

**Quarter 1 (PIP Charter):** NF is required to submit documentation that constitutes the PIP charter as delineated in this *Component One PIP Reporting Template*.

* CMS. Goal Setting Worksheet: <https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/QAPI/downloads/QAPIGoalSetting.pdf>
* CMS. Worksheet to Create a Performance Improvement Project Charter: <https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/QAPI/downloads/PIPCharterWkshtdebedits.pdf>
* CMS. QAPI Leadership Rounding Guide: <https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/QAPI/downloads/QAPILeadershipRoundingTool.pdf>

**Quarter 1 (Root Cause Analysis):** NF is required to conduct root cause analysis to inform PIP charter and planned interventions.

* **CMS. Five Whys for Root Cause Analysis:** <https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/QAPI/downloads/FiveWhys.pdf>
* **CMS. Flowchart Guide.** <https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/QAPI/downloads/FlowchartGuide.pdf>
* **CMS. How to Use the Fishbone Tool for Root Cause Analysis:** <https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/QAPI/downloads/FishboneRevised.pdf>

**Quarters 2, 3 & 4:** NF must submit documentation that demonstrates ongoing monitoring of planned interventions. The intervention inventory starting on page 13 is based on and can be informed by the broader PIP Inventory tool below.

* **CMS. PIP Inventory:** <https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/QAPI/downloads/PIPInventorydebedits.pdf>
* CMS. PDSA Cycle Template. <https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/QAPI/downloads/PDSACycledebedits.pdf>

**Quarter 4 Only:** NF must submit documentation that records final tracking of completed interventions and that contains summary information as delineated above.

* **CMS. Improvement Success Story:** https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/QAPI/downloads/ImproveSuccessStorydebedits.pdf

1. Acknowledgement: This PIP reporting guidance document draws on information from the *CMS. QAPI at a Glance: A Step by Step Guide to Implementing Quality Assurance and Performance Improvement (QAPI) in Your Nursing Home*. <https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/QAPI/downloads/QAPIAtaGlance.pdf>. Accessed 7 July 2021. [↑](#footnote-ref-1)
2. Recommended Resource: CMS. Worksheet to Create a Performance Improvement Project Charter. <https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/QAPI/downloads/PIPCharterWkshtdebedits.pdf> [↑](#footnote-ref-2)
3. Recommended Resource: CMS. QAPI Leadership Rounding Guide. <https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/QAPI/downloads/QAPILeadershipRoundingTool.pdf> [↑](#footnote-ref-3)
4. Recommended resource: CMS. Goal Setting Worksheet. <https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/QAPI/downloads/QAPIGoalSetting.pdf> [↑](#footnote-ref-4)
5. Recommended resource: CMS. Five Whys Tool for Root Cause Analysis. <https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/QAPI/downloads/FiveWhys.pdf> [↑](#footnote-ref-5)
6. Recommended resource: CMS. Flowchart Guide. <https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/QAPI/downloads/FlowchartGuide.pdf> [↑](#footnote-ref-6)
7. Recommended resource: CMS. How to Use the Fishbone Tool for Root Cause Analysis. <https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/QAPI/downloads/FishboneRevised.pdf> [↑](#footnote-ref-7)
8. Recommended resource: CMS. Measure/Indicator Collection and Monitoring Plan. <https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/QAPI/downloads/MeasIndCollectMtrPlandebedits.pdf> [↑](#footnote-ref-8)
9. Recommended resource: CMS. Measure/Indicator Development Worksheet. <https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/QAPI/downloads/MeasIndicatDevWksdebedits.pdf> [↑](#footnote-ref-9)
10. Recommended resource: CMS. PDSA Cycle Template. <https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/QAPI/downloads/PDSACycledebedits.pdf> [↑](#footnote-ref-10)
11. Recommended Resource: CMS. QAPI Improvement Success Story Template. <https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/QAPI/downloads/ImproveSuccessStorydebedits.pdf> [↑](#footnote-ref-11)