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Are You Ready for QAPI?

Montana Flex Program Regional Conference

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FORTY - EIGHT YEARS OF
Building Leaders | Transforming Hospitals | Improving Care

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Areas of Expertise

Strategy - Solutions - Support

Governance & Strategy

- Executive management & leadership development
- Community health needs assessment
- Lean culture

Finance

- Performance optimization & margin improvement
- Revenue cycle & business office improvement
- AR outsourcing

Recruitment

- Executive and interim recruitment
- CEOs, CFOs, CNOs
- VP and Department Directors

Clinical Care & Operations

- Continuous survey readiness
- Care coordination
- Swing bed consulting

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ALL WEBINARS ARE RECORDED

2020 QUARTER 4 WEBINARS

Medical Staff Credentialing and Privileging: The Basics and Beyond
Presenter : Carolyn St.Charles, RN, BSN, MBA – Chief Clinical Officer
Date : October 9, 2020 **Time :** 12pm CST
https://bit.ly/36kIT5G

Care Coordination Staffing Strategies
Presenter : Faith M Jones, MSN, RN, NEA-BC - Director of Care Coordination and Lean Consulting, HealthTechS3
Date : October 29, 2020 **Time :** 12pm CST
https://bit.ly/3kSmK2S

Keeping Your Swing Bed Program Survey-Ready
Presenter : Carolyn St.Charles, RN, BSN, MBA – Chief Clinical Officer
Date : November 6, 2020 **Time :** 12pm CST
https://bit.ly/2GjPHWz

The Role of a Rural Hospital's Board in a Time of Crisis: Part 2
Presenter : Peter Goodspeed, Vice President of Executive Search
Date : November 13, 2020 **Time :** 12pm CST
https://bit.ly/3l4Hogl

It's Not If, But When: Is Your Organization Prepared for the Next Emergency Event
Host: : Carolyn St.Charles, RN, BSN, MBA – Chief Clinical Officer
Presenter Ernie Allen, **ARM, CSP, CPHRM, CHSP**
Date : November 17, 2020 **Time :** 12pm CST
https://bit.ly/3n13Ybo

The Critical Early Days of a New Hospital Executive - Interim or Permanent
Presenter : Mike Lieb, FACHE – Vice President
Date : December 4, 2020 **Time :** 12pm CST
https://bit.ly/3cIY4XG

Advance Care Planning: Are Your Patient's Wishes Being Communicated?
Presenter : Faith M Jones, MSN, RN, NEA-BC - Director of Care Coordination and Lean Consulting, HealthTechS3
Date : December 7, 2020 **Time :** 12pm CST
https://bit.ly/3ihndtB

National Patient Safety Goals – What's New for 2021
Presenter : Carolyn St.Charles, RN, BSN, MBA – Chief Clinical Officer
Date : December 18, 2020 **Time :** 12pm CST
https://bit.ly/2GjPUJl

Disclaimer

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Presenter

Carolyn St.Charles,
Chief Clinical Officer
HealthTechS3

Carolyn began her career in healthcare as a staff nurse in Intensive Care. She has worked in a variety of staff, administrative and consulting roles. Carolyn has been employed by HealthTechS3 for more than 20 years and is currently the Chief Clinical Officer.

In her role as Chief Clinical Officer, Carolyn conducts mock surveys for Critical Access Hospitals, Acute Care Hospitals, Rural Health Clinics, Home Health, and Hospice. Carolyn also assists in developing strategies for continuous survey readiness and developing plans of correction.

Carolyn has extensive experience in working with rural hospitals to both develop, and strengthen, Swing Bed programs.

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What We'll Cover

- ✓Quality Definitions
- ✓CMS QAPI Requirements for Critical Access Hospitals
- ✓QAPI Self-Assessment
- ✓Setting Priorities
- ✓Data Collection, Analysis and Reporting
- ✓Organizational Engagement
- ✓Next Steps

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QUALITY DEFINITIONS

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Quality Definitions

The Institute of Medicine defines health care quality as
"the degree to which health care services for individuals and populations increase the likelihood of desired health outcomes and are consistent with current professional knowledge."

Institute of Medicine (IOM) Domains

Effectiveness. Relates to providing care processes and achieving outcomes as supported by scientific evidence.

Efficiency. Relates to maximizing the quality of a comparable unit of health care delivered or unit of health benefit achieved for a given unit of health care resources used.

Equity. Relates to providing health care of equal quality to those who may differ in personal characteristics other than their clinical condition or preferences for care.

Patient centeredness. Relates to meeting patients' needs and preferences and providing education and support.

Safety. Relates to actual or potential bodily harm.

Timeliness. Relates to obtaining needed care while minimizing delays.

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Quality Definitions

Quality Control – product oriented – focuses on defect identification
"An aggregate of activities (such as design analysis and inspection for defects) designed to ensure adequate quality especially in manufactured products" (Merriam-Webster)

Quality Assurance – process oriented – focuses on doing the right things the right way
"*The maintenance of a desired level of quality in a service or product, especially by means of attention to every stage of the process of delivery or production" (kwäl͟ədē əˈSH o͝orəns)*

"QA is the specification of standards for quality of service and outcomes, and a process throughout the organization for assuring that care is maintained at acceptable levels in relation to those standards. QA is on-going, both anticipatory and retrospective in its efforts to identify how the organization is performing, including where and why facility performance is at risk or has failed to meet standards." (CMS)

Performance Improvement – focuses on improvement of current processes and identification of new approaches
"PI (also called Quality Improvement - QI) is the continuous study and improvement of processes with the intent to better services or outcomes, and prevent or decrease the likelihood of problems, by identifying areas of opportunity and testing new approaches to fix underlying causes of persistent/systemic problems or barriers to improvement. PI aims to improve processes involved in health care delivery and quality of life." (CMS)

Quality Assurance / Performance Improvement (QAPI) – coordination of QA and PI
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, comprehensive, and data-driven approach to maintaining and improving safety and quality while involving all caregivers in practical and creative problem solving. (CMS)

The focus of a QAPI program is to proactively maximize quality improvement activities and programs, even in areas where no specific deficiencies are noted. **(CMS)**

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Examples

Quality Control – product oriented – focuses on defect identification - monitoring

- Temperature checks
- Code cart checks
- Documentation audits

QC may become a QA project if not meeting targets

Quality Assurance – process oriented – focuses on doing the right things the right way - reactive

- Ventilator Acquired Pneumonia (VAP)
- Readmissions
- Urinary Tract Infections

QA focused on meeting established targets

Performance Improvement – focuses on improvement of current processes and identification of new approaches - proactive

- Antibiotic Stewardship
- Opioid reduction
- SEPSIS
- Post-Partum Hemorrhage

PI focused on improvement even when meeting targets – how do we do better? – or new initiatives

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CMS QAPI REQUIREMENTS
CRITICAL ACCESS HOSPITALS

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Federal Register / Vol. 84, No. 189 / Monday, September 30, 2019

The regulations at §485.641 regarding Quality Assessment and Performance Improvement Programs (QAPI) in critical access hospitals (CAHs) must be implemented by March 30, 2021

SOM Appendix W has not been updated to incorporate the QAPI requirements as of September 2020

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Why the change from QA to QAPI - *according to CMS*

1. CoPs have not been updated to reflect current industry standards that utilize the QAPI model to assess and improve patient care.

2. The existing annual evaluation and quality assurance review requirements at §485.641 are reactive; that is, once a problem has been identified, the health care facility takes action to correct it. The focus of a QAPI program is to proactively maximize quality improvement activities and programs, even in areas where no specific deficiencies are noted.

3. An effective QAPI program that is engaged in continuous improvement efforts is essential to a provider's ability to provide high quality and safe care to its patients, while reducing the incidence of medical errors and adverse events.

4. A QAPI program would enable a CAH to systematically review its operating systems and processes of care to identify and implement opportunities for improvement.

5. We also believe that the leadership or governing body or responsible individual of a CAH must be responsible and accountable for patient safety, including the reduction of medical errors in the facility.

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Quality Assurance in Appendix W NOW

C-0336 §485.641(b) Standard: Quality Assurance
The CAH has an effective quality assurance program to evaluate the quality and appropriateness of the diagnosis and treatment furnished in the CAH and of the treatment outcomes. The program requires that–

Interpretive Guidelines §485.641(b) There is nothing in this requirement to preclude a CAH from obtaining QA through arrangement. Whether the CAH has a freestanding QA program or QA by arrangement, all of the requirements for QA must be met.

If a CAH chooses to have a freestanding QA program, the QA program should be facility wide, including all departments and all services provided under contact.

For services provided to the CAH under contract, there should be established channels of communication between the contractor and CAH staff.

"An effective quality assurance program" means a QA program that includes:

- Ongoing monitoring and data collection;
- Problem prevention, identification and data analysis;
- Identification of corrective actions;
- Implementation of corrective actions;
- Evaluation of corrective actions; and
- Measures to improve quality on a continuous basis.

Other CoPs related to Quality and/or QAPI are at the end of the presentation.

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New CAH CoPs (Federal Register)

C-1300 (Rev. – Effective March 30, 2021)
§485.641 Quality assessment and performance improvement program.

The CAH must develop, implement, and maintain an

- Effective,
- Ongoing,
- CAH-wide,
- Data-driven,

quality assessment and performance improvement (QAPI) program.

The CAH must maintain and demonstrate evidence of the effectiveness of its QAPI program.

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New CAH CoPs: Definitions (Federal Register)

§485.641 Quality assessment and performance improvement program.

(a) Definitions

Adverse event means an untoward, undesirable, and usually unanticipated event that causes death or serious injury or the risk thereof.

Error means the failure of a planned action to be completed as intended or the use of a wrong plan to achieve an aim. Errors can include problems in practice, products, procedures, and systems; and

Medical error means an error that occurs in the delivery of healthcare services.

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New CAH CoPs: Program Design and Scope (Federal Register)

§485.641 Quality assessment and performance improvement program.

(b) The QAPI program must:

(1) Be appropriate for the complexity of the CAH's organization and services provided.

(2) Be ongoing and comprehensive.

(3) Involve all departments of the CAH and services (including those services furnished under contract or arrangement).

(4) Use objective measures to evaluate its organizational processes, functions and services.

(5) Address outcome indicators related to improved health outcomes and the prevention and reduction of medical errors, adverse events, CAH-acquired conditions, and transitions of care, including readmission.

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New CAH CoPs: Governance and Leadership (Federal Register)

§485.641 Quality assessment and performance improvement program.

(c) The CAH's governing body or responsible individual is ultimately responsible for the CAH's QAPI program and is responsible and accountable for ensuring that the QAPI program meets the requirements of paragraph (b) of this section.

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New CAH CoPs: Program Activities (Federal Register)

§485.641 Quality assessment and performance improvement program.

(d) For each of the areas listed in paragraph (b) of this section, the CAH must

(b)(1) Be appropriate for the complexity of the CAH's organization and services provided.
(b)(2) Be ongoing and comprehensive.
(b)(3)Involve all departments of the CAH and services (including those services furnished under contract or arrangement).
(b)(4)Use objective measures to evaluate its organizational processes, functions and services.
(b)(5)Address outcome indicators related to improved health outcomes and the prevention and reduction of medical errors, adverse events, CAH-acquired conditions, and transitions of care, including readmission.

(1) Focus on measures related to improved health outcomes that are shown to be predictive of desired patient outcomes.

(2) Use the measures to analyze and track its performance.

(3) Set priorities for performance improvement, considering either high volume, high-risk services, or problem prone areas.

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New CAH CoPs: Data Collection and Analysis (Federal Register)

§485.641 Quality assessment and performance improvement program.

(e) The program must incorporate quality indicator data including patient care data, and other relevant data, in order to achieve the goals of the QAPI program.

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QAPI News

Good News: You probably already have most – if not all – of the components of a QAPI program already in place!

Maybe Not So Good News: Your QAPI program may not be as comprehensive as it needs to be to meet the new regulatory requirements.

Good News: You still have some time!

Important News: Assess your program ASAP and develop a plan.

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QAPI ASSESSMENT

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Step 1: Identify the Team

- ❑ Get the right people to the table
  - Board Member (if possible)
  - Medical Staff Leaders 
  - Senior Leaders
  - Clinical Leaders: Don't forget Infection Control and Pharmacy
  - Staff representatives - it's not just leaders

- ❑ Start with your Vision ---- What do you want your Quality program to look like 12 months from now? What outcomes do you hope to achieve?

- ❑ Educate the team about the new QAPI requirements (important)

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Step 2: Identify WHAT you are going to assess and tools you are going to use

- Conditions of Participation
  - There are NO Interpretative Guidelines

- Centers for Medicare & Medicaid Services Hospital Quality Assessment Performance Improvement (QAPI) Worksheet
  - https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/SurveyCertificationGenInfo/Downloads/Survey-and-Cert-Letter-15-12-Attachment-2.pdf

- Structure – Process – Outcome (assessment tool provided as separate document)
  - What are the structures that support the QAPI program?
  - What are the processes that support the QAPI program? Are they efficient and effective?
  - What are the outcomes of the QAPI program? How do you know the QAPI program is efficient and effective?

- Organizational assessment
  - Interviews of key stakeholders
    - What's working? What's not working? Opportunities to improve?
  - Survey (Survey Monkey)

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Step 3: Complete the Assessment and Analyze Results

- Present assessment to Team
- Be as objective as possible in reviewing results
- Identify key themes
- Identify areas to follow-up on **now** to meet QAPI regulatory requirements and those that are important but can wait

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Step 4: Develop a Plan

- Develop a plan based on the assessment and GAP analysis
  - Goals
  - Specific Actions that are measurable
  - Accountability
  - Timeline

- **If you have to prioritize …….. Look at what needs to be done now and what can wait! Ensure there are sufficient resources to implement the plan you create**

- Report results of GAP analysis & action plan to the Quality Committee, Senior Leaders, and Governing Board

Goal 1:			
WHAT	**WHO**	**WHEN**	**FOLLOW-UP**

IT'S NOT THE QUALITY DEPARTMENTS JOB TO DO EVERYTHING
THEY ARE THE COACH AND CHEERLEADER

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Step 5: Implement the Plan

- Report at least monthly to the Quality Committee, Senior Leaders and Governing Board
- If you're off track – ***Ask Why (think root cause)*** – and how do you get back on track

Goal 1:			
WHAT	**WHO**	**WHEN**	**FOLLOW-UP**

IT'S NOT THE QUALITY DEPARTMENTS JOB TO DO EVERYTHING
THEY ARE THE COACH AND CHEERLEADER

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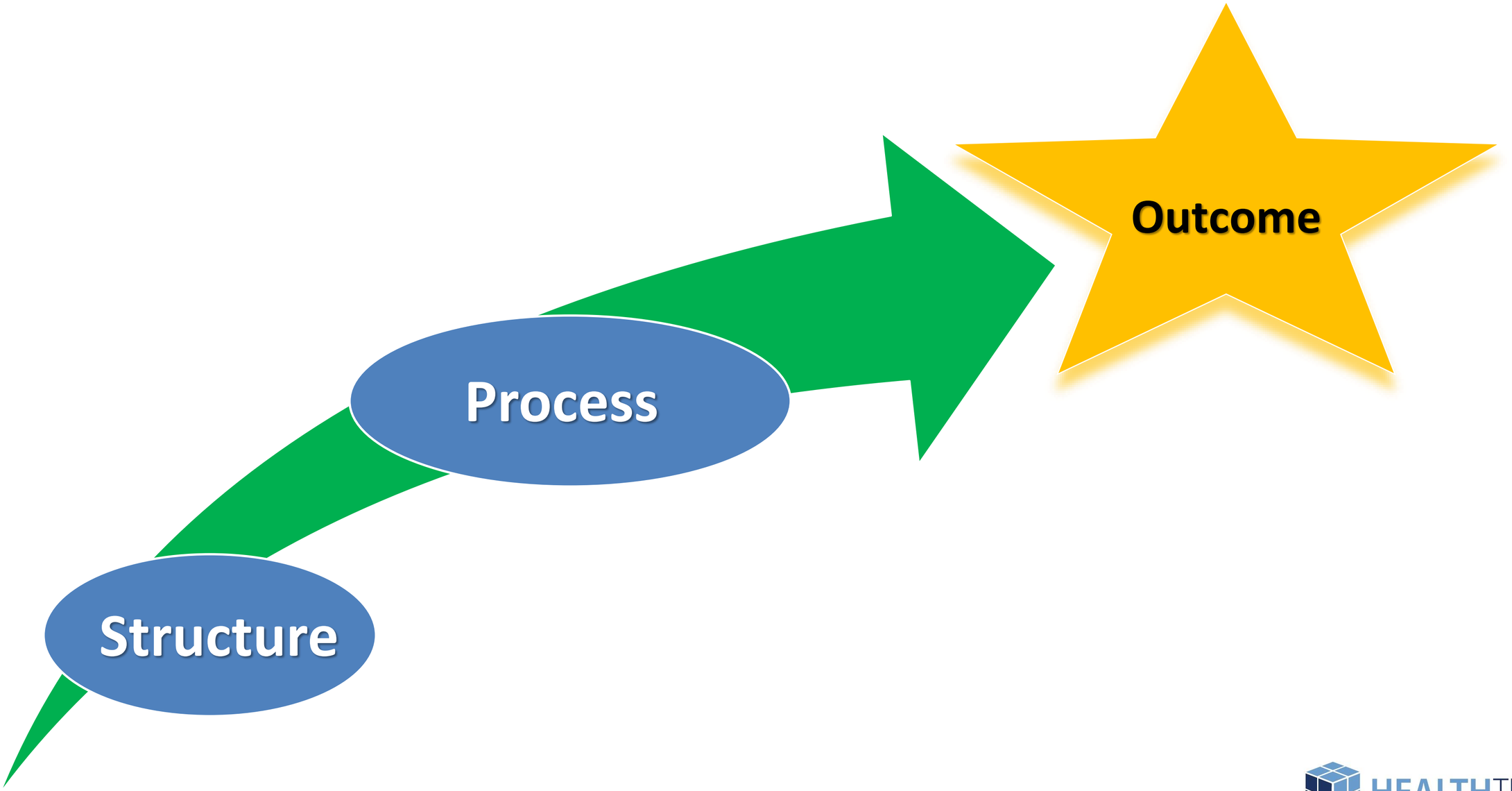
Assessment Framework



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Donabedian's Quality Framework

STRUCTURE

What are the structures that support your QAPI program?

Structure includes all of the factors that affect the context in which care is delivered. This includes the physical facility, equipment, and human resources, as well as organizational characteristics such as staff training and payment methods. These factors control how providers and patients in a healthcare system act and are measures of the average quality of care within a facility or system. Structure is often easy to observe and measure and it may be the upstream cause of problems identified in process.

PROCESS

What are the processes that support your QAPI program?

Process is the sum of all actions that make up healthcare. These commonly include diagnosis, treatment, preventive care, and patient education, but may be expanded to include actions taken by the patients or their families. Processes can be further classified as technical processes, how care is delivered, or interpersonal processes, which all encompass the manner in which care is delivered.

OUTCOME

What are the outcomes of your QAPI program?

Outcome contains all effects of healthcare on patients or populations, including changes to health status, behavior, or knowledge as well as patient satisfaction and health-related quality of life. Outcomes are sometimes seen as the most important indicators of quality because improving patient health status is the primary goal of healthcare.

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Governing Board & Senior Leaders

STRUCTURE

- ☐ The Governing Board and Senior Leaders are educated and understand QAPI principles
- ☐ The Governing Board and Senior Leaders allocate or ensure sufficient staffing needed for an effective QAPI program
- ☐ The Governing Board and Senior Leaders allocate or ensure sufficient technology resources for an effective QAPI program
- ☐ The Governing Board and Senior Leaders allocate or ensure sufficient resources for QAPI

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Governing Board & Senior Leaders

PROCESS

- The Governing Board reviews and approves the annual QAPI Plan
- The Governing Board approves the prioritization criteria for QAPI projects
- The Governing Board ensures that the organizational improvement priorities and projects are appropriate for the scope and complexity of the organization
- The Governing Board reviews and approves organizational improvement priorities at least annually
- The Governing Board and Senior Leaders receive regular reports that include at a minimum:
  - Organizational priorities
  - Publicly reported data
  - Outcome indicators related to improved health outcomes
  - Outcome indicators related to reduction of medical errors
  - Outcome indicators related to CAH acquired conditions
  - Outcome indicators related to transitions of care including readmissions

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Governing Board & Senior Leaders

OUTCOME

- ☐ Organizational priorities are met
- ☐ Publicly reported data meets or exceeds organizational targets or external benchmarks
- ☐ Health outcomes meet or exceed organizational targets or external benchmarks
- ☐ Reduction in medical errors meet or exceed organizational targets or external benchmarks
- ☐ Reduction in CAH-acquired conditions meet or exceed organizational targets or external benchmarks
- ☐ Transitions of care, including readmissions, meet or exceed organizational targets or external benchmarks

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Quality Department

STRUCTURE

- ☐ There are sufficient staff in the quality department for the scope and complexity of the organization

- ☐ Staff in the quality department have the necessary skills and expertise to help guide the organization's QAPI program including: education of staff and providers; managing teams; supporting data collection, data analysis, and data reporting

- ☐ Staff in the quality department have quality certification, **and/or**
- ☐ Staff in the quality department have training and education in quality principles including managing teams; data collection, analysis, and reporting; use of quality tools such as root cause analysis, pareto, etc.

"Quality is not a Department…..

The Quality Director is basically the coach, facilitator and cheerleader. His or her job is to instill principles of quality at all levels, helping everyone in your organization---every employee, executive, caregiver, and consultant--- feel driven to exceed." (IHI)

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Quality Department

PROCESS

- Quality department works with departments, contract services and/or service lines to develop quality projects and support documents, including data plan for any metrics

- Quality department develops a reporting schedule and facilities reporting to the Quality Committee by departments, contract services and/or service lines

- Quality department provides support to quality teams

- Quality department provides ongoing education to teams and staff including: quality principles, data collection, analysis, and reporting; use of quality tools such as root cause analysis, pareto, etc.

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Quality Department

OUTCOME

- % of staff in quality department with certification or training / education
- Number of organizational-wide improvement projects supported directly by the quality department
- % of organizational staff that receive education annually
- % of established goals met
- % of time reports are submitted on time by departments and/or services
- % of time agendas are revised due to reports not available
- % of time corrective action plans are completed within required timeframe

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Quality Committee

STRUCTURE

- ☐ The role of the committee is clearly defined with responsibilities, accountabilities & expectations
- ☐ The members of the committee are educated and knowledgeable about QAPI including: framework; data collection, analysis, reporting; quality tools; multi-disciplinary teams; organizational engagement, etc.)
- ☐ The committee meets on a regular basis (at least quarterly but ideally monthly)
- ☐ The right people are on the committee including ideally a governing board member and a representative of the medical staff
- ☐ The people on the committee are advocates for the QAPI program
- ☐ There is a mechanism / structure for each department or service line to report to the Quality Committee
- ☐ All HAIs and other infectious diseases identified by the infection prevention and control program are addressed in collaboration with the QAPI leadership
- ☐ Antibiotic use issues identified by the antibiotic stewardship program are addressed in collaboration with the CAH's QAPI leadership.

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Quality Committee

PROCESS

- ☐ The committee reviews and updates the QAPI Plan annually
- ☐ The committee develops prioritization criteria for QAPI projects for approval by the governing board
- ☐ The committee ensures that the organizational improvement priorities and projects are appropriate for the scope and complexity of the organization
- ☐ The committee submits organizational improvement projects to the governing board for review and approval at least annually
- ☐ The committee reviews and approves department and contract services quality improvement projects. As part of the review, the committee identifies the opportunities for multi-disciplinary and/or multi-department projects.
- ☐ The committee receives regular reports that include at a minimum:
  - Organizational priorities
  - Publicly reported data
  - Outcome indicators related to improved health outcomes, medical errors, CAH acquired conditions and transitions of care including readmissions
- ❑ The committee addresses and/or requests feedback for any metrics not meeting the established target
- ❑ The QAPI committee receives regular reports from the leader(s) responsible for infection Prevention and Control
- ❑ The QAPI committee receives regular reports from the leader(s) responsible for Antibiotic Stewardship

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Quality Committee

OUTCOME - Same as Governing Board

- Organizational priorities are met
- Publicly reported data meets or exceeds organizational targets or external benchmarks
- Health outcomes meets or exceeds organizational targets or external benchmarks
- Reduction in medical errors meets or exceeds organizational targets or external benchmarks
- Reduction in CAH-acquired conditions meets or exceeds organizational targets or external benchmarks
- Transitions of care, including readmissions, meets or exceeds organizational targets or external benchmarks

OUTCOME - <u>Infection Control and Antibiotic Stewardship</u>

- % of meetings with a report from the Infection Control Committee
- % of Infection Control goals met
- % of meetings with a report from the Antibiotic Stewardship Committee
- % of Antibiotic Stewardship goals met

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Quality Program Scope

STRUCTURE

- The QAPI program include all depts., including those that are not traditional hospital depts. such as hospital-based clinics

- The QAPI program includes contract services

- The QAPI program includes population-specific or service-specific areas such as Peds / Obstetrics / Wound Care / Swing Bed / Cancer Center, etc.

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Quality Program Scope

PROCESS

- Organizational priorities are shared annually with departments and contract services, by Senior Leaders and/or Quality Committee

- Each department, contract service and/or service line identifies at least one improvement project that supports one or more of the organizational priorities

- Each department, contract service and/or service line identifies at least one improvement project specific to their department or service (Note: this may be a multi-disciplinary project that includes more than one department or service.)

- Department, contract services and/or service line projects are reviewed and approved by the Quality Committee.

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Quality Program Scope

OUTCOME

- % of departments, contract services and/or service-lines that have defined QAPI projects
- % of departments, contract services and/or service-lines that are involved with a multi-disciplinary QAPI project
- % of line-staff that are directly involved in QAPI projects
- % of department, contract services and/or service-line quality projects that meet or exceed QAPI goals

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Data Collection, Analysis, and Reporting

STRUCTURE

☐ There is a plan for data collection, analysis, and reporting (may be included in the Quality Plan)

☐ Department managers and service lines are educated about data collection, analysis, and reporting

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Data Collection, Analysis, and Reporting

PROCESS

- ☐ There is a MAP -- description of all quality measures / metrics in the organization, and the committee(s) to which data is reported
- ☐ There is a data plan developed for each metric
- ☐ Metrics, measures, targets and sample sizes are appropriate for what is being monitored
- ☐ Data is analyzed appropriately for the type of metric using the appropriate quality tools
- ☐ There is an appropriate target including an external benchmark, if available, developed for each metric. If metrics have a target that is rate based – the target is appropriate for the metric (i.e. falls may not be appropriate as a rate-based measure)
- ☐ A corrective action plan is developed if the metric does not meet the target

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Data Collection, Analysis, and Reporting

OUTCOME

- % of measures with a comprehensive data plan
- % of measures that are analyzed
- % of measures with a corrective action plan if target is not met

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HOW WOULD YOU RATE YOUR PROGRAM?

- ❑ Governing Board and Senior Leaders
  - ❑ Structure
  - ❑ Process
  - ❑ Outcome
- ❑ Quality Department
  - ❑ Structure
  - ❑ Process
  - ❑ Outcome
- ❑ Quality Committee
  - ❑ Structure
  - ❑ Process
  - ❑ Outcome
- ❑ Quality Program Scope
  - ❑ Structure
  - ❑ Process
  - ❑ Outcome
- ❑ Data Collection and Analysis
  - ❑ Structure
  - ❑ Process
  - ❑ Outcome

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SETTING PRIORITIES

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Prioritization

§485.641: Prioritization criteria must include:

- **High Volume** (HV), **High Risk** (HR) or **Problem Prone** (PP) areas

Identify Priorities at least Annually

- Document that priorities may be adjusted throughout the course of the year, based on response to identified needs, including, but not limited to unusual or urgent events

- When documenting identified priorities make certain there is a link to rationale for selection (HV, HR, PP, etc.)

- Review/update QAPI Plan to describe how priorities are identified and how/when priorities may be adjusted throughout the course of the year

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Prioritization Criteria

Identify Potential Areas of Improvement. For each category score from 1 (low) to 5 (high)

	1 - LOW	2	3	4	5 - HIGH	TOTAL
***High Volume:** High volume population or service						
***Hight Risk:** The level to which this issue poses a risk to patients, providers, visitors, staff						
***Problem Prone:** The level to which this issue has the potential to prevent or reduce medical errors, adverse patient outcomes, or CAH-acquired conditions						
***Transitions of Care:** Potential to improve transitions of care, including readmissions						
Cost: The cost incurred each time this issue occurs						
Responsiveness: The likelihood an initiative on this issue would address a need expressed by patients, family, staff, medical staff, senior leaders, governing board						
Continuity: The level to which an initiative on this issue would support organizational goals and priorities						

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Priorities

How Many Is Too Many?

How Many Is Not Enough?

How Many is Just Right?

Better to have a few priorities that are achieved than to have many priorities that are not!

Another criteria may be the capacity of the organization to undertake the initiative

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What is a Priority?

A Priority MAY NOT be everything you are monitoring

Think about the difference between QC and QA and PI

For example:
You are monitoring CAUTI – and you are exceeding national benchmarks?

- Should CAUTI continue to be monitored? **YES**
- Should CAUTI be a priority for the organization to "improve"? **Probably Not (use prioritization gird)**

For example:
You have implemented an antibiotic stewardship program but it is not very effective and not meeting internal or external targets

- Should antibiotic stewardship be a priority for the organization? **YES**

For example:
New best practice such as Post-Partum Hemorrhage or Opioid Reduction

- Should Post-Partum Hemorrhage be a priority for the organization? **Maybe or YES (use prioritization grid)**
- Should Opioid Reduction be a priority for the organization? **Maybe or YES (use prioritization grid)**

REMEMBER: Priorities must be appropriate for the complexity of the CAH's organization and services provided

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Review Outcomes to Identify Priorities - MBQIP Example

MBQIP - Patient Safety / Inpatient	Meeting Benchmark	Not Meeting Benchmark
• Influenza Vaccination Coverage Among Healthcare Personnel (HCP)		
• Antibiotic Stewardship		
Healthcare Associated Infections • CLABSI • CAUTI • CDI • MRSA • SSIs		
Perinatal Care • Elective Delivery		
• Falls		
• Adverse Drug Events		
• Patient Safety Culture Survey		
• Inpatient Influenza Vaccination		

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Data Collection
Analysis
Reporting

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Data Collection, Analysis & Reporting

"An effective quality assurance program" means a QA program that includes:

- Ongoing monitoring and data collection
- Problem prevention, identification and data analysis
- Identification of corrective actions
- Implementation of corrective actions
- Evaluation of corrective actions ------ and
- Measures to improve quality on a continuous basis

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MAP Organizational & Reporting Structure

Governing Board

Medical Executive Committee

Credentialing Committee

P&T Committee
- Antibiotic Stewardship

Utilization Review Committee

Infection Control Committee

Medical Staff Departments
- Anesthesia
- Critical Care
- Emergency
- Trauma
- Surgical Services
- Internal Medicine / Family Practice
- Radiology

Quality Committee

Environment of Care

Patient Safety

Hospital Departments / Contract Services

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MAP What Data is Being Collected & Reported to MEC

- Credentialing
  - Peer Review
  - OPPE / FPPE
- P&T Committee
  - Medication Safety
  - Antibiotic Stewardship
  - Opioids
- Infection Control Committee
  - Nosocomial Infections
  - Surveillance
    - Surgical Site Infections
    - Other targeted surveillance (i.e. Cauti, MDRO, MRSA, VAP, etc.
- Utilization Review Committee
  - Length of Stay
  - 96 hour certification
  - Denials
  - Readmissions
  - Patient notices (IM, MOON, NOMNC, etc.

Departments / Service Lines

- Anesthesia
  - Moderate sedation
  - Deep sedation
  - Adverse outcomes sedation
- Critical Care
  - CPR outcome
  - Rapid response
- Emergency
  - Patient Flow
  - Door to doc
  - Door to discharge
  - Transfers
  - Return visits (same reason)
- Trauma
  - Activations
  - Trauma Registry
- Surgical Services
  - Pre/Post op discrepancies
  - Unplanned return to surgery
  - Surgical Case Review
- Internal Medicine / Family Practice
  - Readmissions
  - CPR outcome
  - Rapid response
- Radiology
  - Radiation
  - Time from test to result
  - Overreads / Discrepancies

IMPORTANT NOTE:
THESE ARE QC (MONITORING) & MAY OR MAY NOT BE PRIORITIES FOR IMPROVEMENT
Some committees / functions may report thru the Quality Committee

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MAP What Data is Being Collected & Reported to Quality Council

- **ORGANIZATIONAL PRIORITIES**

- Environment of Care
  - Utilities & Fire Safety
  - Security
  - Emergency Mang.
  - Medical Equipment
  - Hazardous Material
  - Safety & Safe patient handling

- Patient Safety Committee
  - Patient safety events
  - Staff safety events
  - National Patient Safety Goals

- Hospital Department & Contract Services

- Monitors & Priorities for Improvement

IMPORTANT NOTE:
EOC, Patient Safety Committee and some departmental metrics MAY BE monitors and not improvement opportunities

IMPORTANT NOTE:
Some committees / functions may report thru the MEC

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!Synergy!

	Provider	Lab	Radiology	ICU	Med-Surg	Regis.	ER	Mother-Baby	Pharmacy	Case Mang.	Infection Control	Quality	Plant Security
Goal: Reduce ER Wait Times	✓ P	✓ P	✓ P	✓ P	✓ P	✓ P	✓ L					✓ S	
Goal: Implement antibiotic stewardship program	✓ P	✓ P							✓ L		✓ P	✓ S	
Goal: Implement Post-Partum Hemorrhage Initiative	✓ P							✓ L				✓ S	
Goal: Reduce Readmissions	✓ S				✓ P					✓ P			
Goal: Implement Patient Safety Ligature Risk Initiative							✓ L					✓ S	✓ P

L = Lead

P = Primary Involvement

S = Support

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Data Plan

Department

Date

1. Short description of what you are trying to achieve / process you are trying to improve.

2. Who was involved in identifying the indicator / project?

3. How will staff be involved in the monitoring or improvement process?

4. Will other depts. be involved in the monitoring or improvement process? If so, which departments?

5. This indicator / project is aligned with: (choose one)

☐ Quality Control
  - product oriented – focuses on defect identification – monitoring only

☐ Quality Assurance
  - focused on improving a current process that is not meeting established targets

☐ Performance Improvement
  - focused on improvement of a current process or identification of new approaches to improve)

6. This indicator / project supports the following areas (choose at least one)

☐ Hospital Quality Priority
☐ High-Volume
☐ High-Risk
☐ Problem-Prone
☐ Improved health outcomes
☐ Prevention and reduction of medical errors
☐ Prevention and reduction of adverse events
☐ Prevention and reduction of Hospital Acquired Conditions
☐ Transitions of Care, including readmissions

STOP

TALK TO THE QUALITY DEPARTMENT ABOUT YOUR ANSWERS 1 -6 BEFORE YOU PROCEED WITH DECIDING ON DATA COLLECTION

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Data Plan

7. What data will you collect?

8. Who will collect data?

9. How often will data be collected?
- ☐ Daily
- ☐ Weekly
- ☐ Monthly
- ☐ Quarterly
- ☐ Other – please list

10. Who will analyze data?

11. Who will report data?

12. How often will data be reported?
do you need for this project?

13. What is the sample size? (Sample size must be at least 30 for each reporting period. If less than 30 may use rolling average to obtain sample size of 30.)
- ☐ 100%
- ☐ Random sample (If random – please indicate how random sample will be obtained)

14. What is the numerator and denominator including inclusions and exclusions? It is critical to be as clear as possible.

Numerator:

Denominator:

15. What is your baseline data – if available?

16. What is the external benchmark / target – if available?

17. What is your target?

18. What resources or support, if any will you need?

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Reporting

Reporting Schedule

- Develop a reporting schedule for each department and service area to report to the Quality Oversight Committee and ultimately the MEC and Board

- **Develop a Standardized Reporting Template – analysis, action, etc.**
  - Dashboard?
  - PowerPoint?
  - Other?

- **Define what flexibility/variation is allowed** and who is authorized to allow that variation

Important – Bottom Line: Not documented, didn't happen

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Reporting & Analysis

Department Name

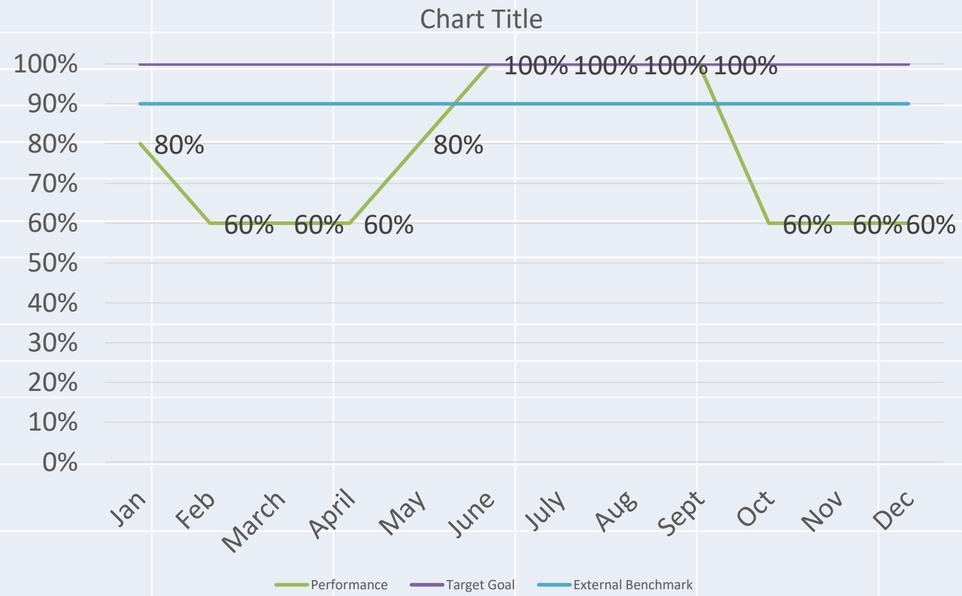
Managers Name

Performance Improvement Goal

Improvement Opportunity

Data Collection Methodology

	Jan	Feb	Mar	April	May	June	July	Aug	Sept	Oct	Nov	Dec
Denominator	4	3	3	3	4	5	5	5	5	3	3	3
Numerator	5	5	5	5	5	5	5	5	5	5	5	5
Performance	80%	60%	60%	60%	80%	100%	100%	100%	100%	60%	60%	60%
Target Goal	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
External Benchmark	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%



Summary of Findings & Analysis of Data	What's Being Done - Action to Improve Performance - By Whom and By When
Quarter 1	
Quarter 2	
Quarter 3	
Quarter 4	

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PDSA Reporting & Analysis

Department Name | Date | Study Time Frame

Study Title | Department Leader

What is the goal of the study?

Members of the Team

PLAN

- Briefly describe the problem(s) / opportunities for improvement
- How will you know if the change is an improvement?
- What driver does the change impact?
- Patient safety and care outcomes
- What do you predict will happen?

OTHER ELEMENTS OF PDSA TEMPLATE AT END OF SLIDE PRESENTATION FOR YOUR REFERENCE

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Analysis

- Point in Time Data Reports – should be minimal and only to indicate/confirm “Hey, we might have a problem here”. This is QC – not QAPI.

- Analysis – Why?
  - **Important** – “Why” is not a restatement of the data (i.e. statement of data is in discussion)
  - Use statistical process control (SPC) when appropriate (at a minimum, identify those indicators which will include SPC)
  - Action – who, what, when, follow-up

- Spend MOST time on **improvement initiatives** – removing barriers – providing support

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Target Zero Scorecard – Harm Events

	External Benchmark	Internal Target	DATA	ANALYSIS / CORRECTIVE ACTION
DEVICE RELATED INFECTIONS CAH ACQUIRED CONDITIONS				
CAUTI				
CLABSI				
VAP				
HEALTHCARE ASSOCIATED INFECTIONS CAH ACQUIRED CONDITIONS				
MRSA				
C-Diff				
MDRO				
ADVERSE EVENTS / MEDICAL ERRORS				
Falls with Injury				
Medication Errors that reached the patient				

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Organizational Scorecard

	External Benchmark	Internal Target	DATA	ANALYSIS / CORRECTIVE ACTION
DATA REPORTED EXTERNALLY				
ORGANIZATIONAL PRIORITIES				
TRANSITIONS OF CARE **Readmissions**				

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Department Scorecard

	External Benchmark	Internal Target	DATA	ANALYSIS / CORRECTIVE ACTION
Ambulance • Scene time < 20 minutes • Documentation accuracy				
Emergency Dept. • Medication Reconciliation • Readmit within 48 hours • Triage time < 5 minutes • Vital Signs at Discharge				
Clinic • Patient Satisfaction • No Show Rate				
Nursing • IV starts • Falls				

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We may have a problem if……

- ❑ Departments are only reporting QC
- ❑ Department(s) have been tracking the same indicator for multiple years with 100% (or close to 100%) compliance
- ❑ Departments can't figure out what they should be working on to improve
- ❑ Only the department manager is involved in identifying indicators – and tracking – and reporting
- ❑ Reports from department managers are usually late – (require nagging by Quality dept.)
- ❑ Reports from department managers consistently don't include corrective actions

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ORGANIZATIONAL ENGAGEMENT

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Engaging the Organization

Governing Board
- Educate
- Provide meaningful examples
- Discuss harm events
- Team presentation on quality initiatives
- Voice of the customer (personal stories)

Medical Staff
- Initiatives that make a difference

Senior Leaders
- Daily rounds
- Meetings that always focus on quality -- how the organization is improving
- Focus on removing barriers

Department Managers
- NO busy work
- Minimize audits
- Focus on real improvement
- Reward “Good Catch”

Staff
- Educate on improvement initiatives
- Involve staff in solutions
- Reward “Good Catch”
- Make quality “visible”

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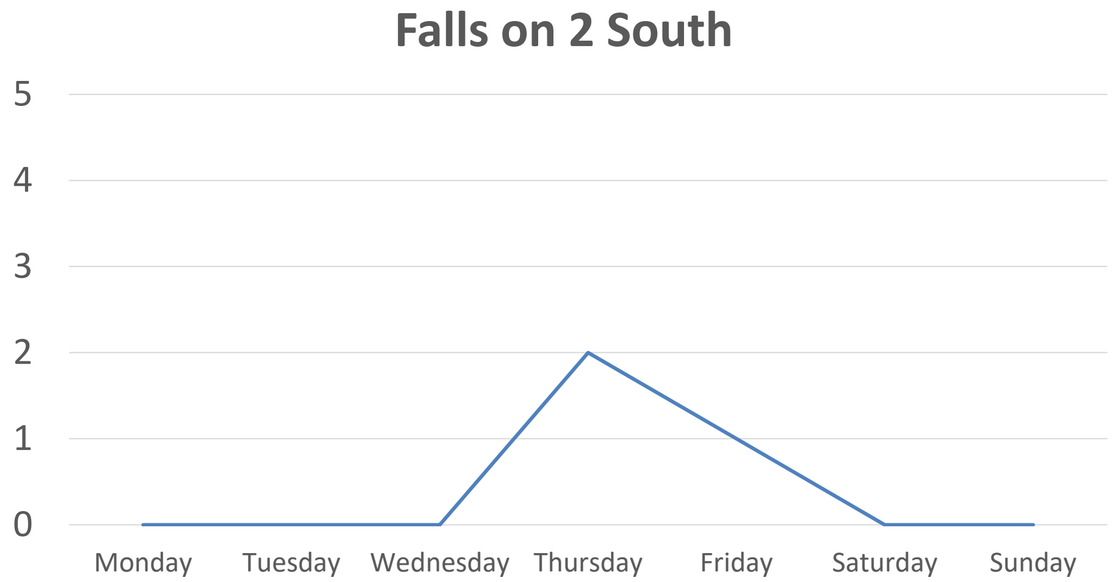
Department Scorecards

Department Scorecards that are posted and reviewed once or twice each day during huddles!
(RATHER THAN MONTHLY DATA REPORTED BY MANAGER)

How many falls did we have yesterday?
Why?
What can we do today?
What do we need to do tomorrow?



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NEXT STEPS

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Complete a thorough GAP Analysis (Assessment)

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Build on What You Have – Don't Start from Scratch

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It's About Teamwork

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Slow and Steady Wins the Race

Be the Tortoise – Not the Hare

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Thank You

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Reference – CAH CoPs related to Quality or QAPI

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What's in the CoPs NOW with Quality References (CAH)

C-0339 §485.641(b)(3)
The quality and appropriateness of the diagnosis and treatment furnished by nurse practitioners, clinical nurse specialists, and physician assistants at the CAH are evaluated by a member of the CAH staff who is a doctor of medicine or osteopathy or by another doctor of medicine or osteopathy under contract with the CAH;

C-0340 §485.641(b)(4)
The quality and appropriateness of the diagnosis and treatment furnished by doctors of medicine or osteopathy at the CAH are evaluated by—
(i) One hospital that is a member of the network, when applicable;
(ii) One QIO or equivalent entity; (iii) One other appropriate and qualified entity identified in the State rural health care plan;
(iv) In the case of distant-site physicians and practitioners providing telemedicine services to the CAH's patients under a written agreement between the CAH and a distant-site hospital, the distant-site hospital; or
(v) In the case of distant-site physicians and practitioners providing telemedicine services to the CAH's patients under a written agreement between the CAH and a distant-site telemedicine entity, one of the entities listed in paragraphs (b)(4)(i) through (iii)of this section;

C-0342 §485.641(b)(5)(ii)
The CAH also takes appropriate remedial action to address deficiencies found through the quality assurance program.

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What's in the CoPs NOW with Quality References (CAH)

C-0962 §485.627(a) Standard: Governing Body or Responsible Individual
The governing body (or responsible individual) must ensure that the medical staff is accountable to the governing body (or responsible individual) for the quality of care provided to patients. The governing body (or responsible individual) is responsible for the conduct of the CAH and this conduct would include the quality of care provided to patients

C-1018 §485.635(a)(3)
The policies include the following:] (v) Procedures for reporting adverse drug reactions and errors in the administration of drugs.
Interpretive Guidelines §485.635(a)(3)(v) Quality Assurance/Improvement Reporting:
Reduction of medication administration errors and ADRs may be facilitated by effective internal CAH reporting that can be used to assess vulnerabilities in the medication process and implement corrective actions to reduce or prevent reoccurrences. To facilitate reporting, the CAH must educate staff on medication administration errors and ADRs including the criteria for those errors and ADRs that are to be reported for quality assurance/improvement purposes, and how, to whom and when they should be reported. Reporting for quality assurance/improvement purposes covers all identified medication errors, regardless of whether or not they reach the patient, and those ADRs meeting the criteria specified in the CAH's policies.

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What's in the CoPs NOW with Quality References (CAH)

C-1034 §485.635(c)

The governing body (or responsible individual) has the responsibility for ensuring that CAH services are provided according to acceptable standards of practice, irrespective of whether the services are provided directly by CAH employees or indirectly by agreement or arrangement.

The governing body must take actions through the CAH'S QA program to: assess the services furnished directly by CAH staff and those services provided under agreement or arrangement, identify quality and performance problems, implement appropriate corrective or improvement activities, and to ensure the monitoring and sustainability of those corrective or improvement activities

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What's in the CoPs NOW with QAPI References (CAH)

§485.640 Condition of Participation: Infection Prevention and Control and Antibiotic Stewardship Programs
The CAH must have active facility-wide programs, for the surveillance, prevention, and control of HAIs and other infectious diseases and for the optimization of antibiotic use through stewardship. The programs must demonstrate adherence to nationally recognized infection prevention and control guidelines, as well as to best practices for improving antibiotic use where applicable, and for reducing the development and transmission of HAIs and antibiotic-resistant organisms. Infection prevention and control problems and antibiotic use issues identified in the programs must be addressed in coordination with the facility-wide quality assessment and performance improvement **(QAPI)** program.

§485.640(c)(1)(ii) Leadership responsibilities
All HAIs and other infectious diseases identified by the infection prevention and control program as well as antibiotic use issues identified by the antibiotic stewardship program are addressed in collaboration with the CAH's **QAPI** leadership.

§485.640(c) Leadership responsibilities
(2) The infection prevention and control professional(s) is responsible for:]
(iii) Communication and collaboration with the CAH's **QAPI** program on infection prevention and control issues.

§485.640(c) Leadership responsibilities
(3) The leader(s) of the antibiotic stewardship program is responsible for:]
(iii) Communication and collaboration with medical staff, nursing, and pharmacy leadership, as well as the CAH's infection prevention and control and **QAPI** programs, on antibiotic use issues.

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Reference – MBQIP

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Review Outcomes to Identify Priorities - MBQIP Example

MBQIP - Patient Safety / Inpatient	Meeting Benchmark	Not Meeting Benchmark
• Influenza Vaccination Coverage Among Healthcare Personnel (HCP)		
• Antibiotic Stewardship		
Healthcare Associated Infections • CLABSI • CAUTI • CDI • MRSA • SSIs		
Perinatal Care • Elective Delivery		
• Falls		
• Adverse Drug Events		
• Patient Safety Culture Survey		
• Inpatient Influenza Vaccination		

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Review Outcomes to Help Identify Priorities - MBQIP Example

MBQIP - Patient Engagement	Meeting Benchmark	Not Meeting Benchmark
• HCAHPS		
• Emergency Department Patient Experience		

MBQIP - Care Transitions	Meeting Benchmark	Not Meeting Benchmark
• Emergency Department Transfer Communication (EDTC) 1 composite; 8 elements		
• Discharge Planning		
• Medication Reconciliation		
• Swing Bed Care		
Claims Based Measures • Reducing readmissions • Complications • Hospital Return Days		

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Review Outcomes to Help Identify Priorities - MBQIP Example

MBQIP - Outpatient	Meeting Benchmark	Not Meeting Benchmark
AMI • OP-2: Fibrinolytic Therapy Received within 30 minutes • OP-3: Median Time to Transfer to another Facility for Acute Coronary Intervention		
Chest Pain / AMI • Aspirin at Arrival • Median Time to ECH		
ED Throughput • OP-18: Median Time from ED Arrival to ED Departure for Discharged ED Patients • OP-22: Patient Left Without Being Seen • Door to diagnostic evaluation by a qualified medical professional		

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Reference – PDSA

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PDSA Reporting & Analysis

Department Name | Date | Study Time Frame

Study Title | Department Leader

What is the goal of the study?

Members of the Team

PLAN

- Briefly describe the problem(s) / opportunities for improvement
- How will you know if the change is an improvement?
- What driver does the change impact?
- Patient safety and care outcomes
- What do you predict will happen?

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PDSA Reporting & Analysis

PLAN

List the tasks necessary to complete the test (What)	Person responsible (Who)	When	Where
1.			
2.			
3.			
4.			
Plan for collection of data			

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PDSA Reporting & Analysis

DO

Was the cycle carried out as planned? (Yes or No)			
Record data and observations (Attach all supporting documentation			
What did you observe that was not part of your plan?			

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PDSA Reporting & Analysis

STUDY

Did the results match your predictions? (Yes or No)			
Compare the result of your test to your previous performance			
What did you learn?			

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PDSA Reporting & Analysis

ACT

❑ **Adapt: Improve the change and continue testing the plan.** **Plan / changes for next test (Start new worksheet)**			
❑ **Adopt:** Select changes to implement on a larger scale and develop an implementation plan and plan for sustainability			
❑ **Abandon:** Discard this change idea and try a different one			

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