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Quality Assurance Performance Improvement: The Journey to Excellence

Carolyn St.Charles | March 6, 2022

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Agenda

1. Introduction
2. Definitions of Quality
3. Regulatory Requirements
4. QAPI Plan
5. Organizational Priorities

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6. Performance Measures
7. Reporting
8. Organizational Engagement
9. Highly Reliable Organizations
10. Resources

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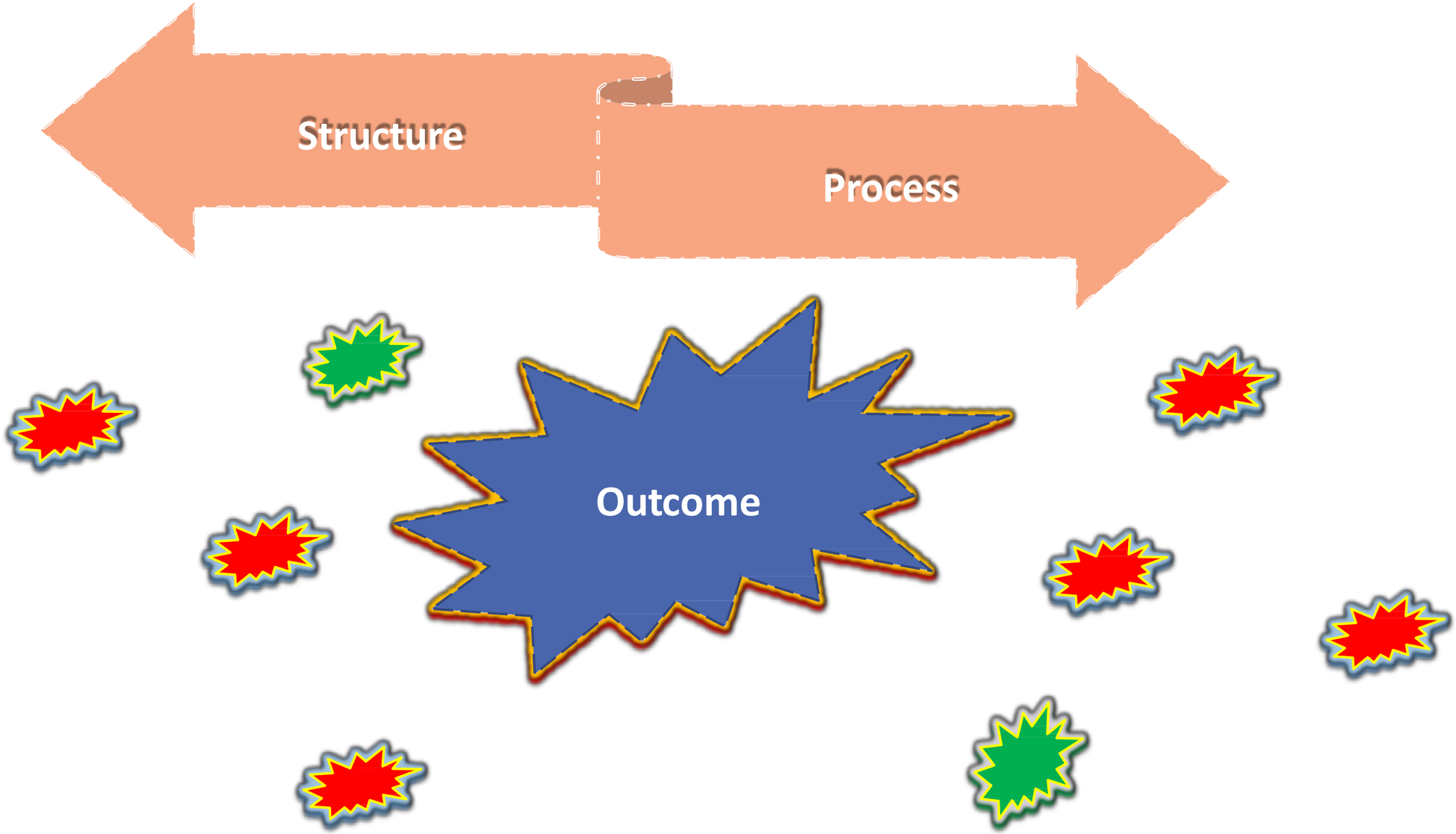
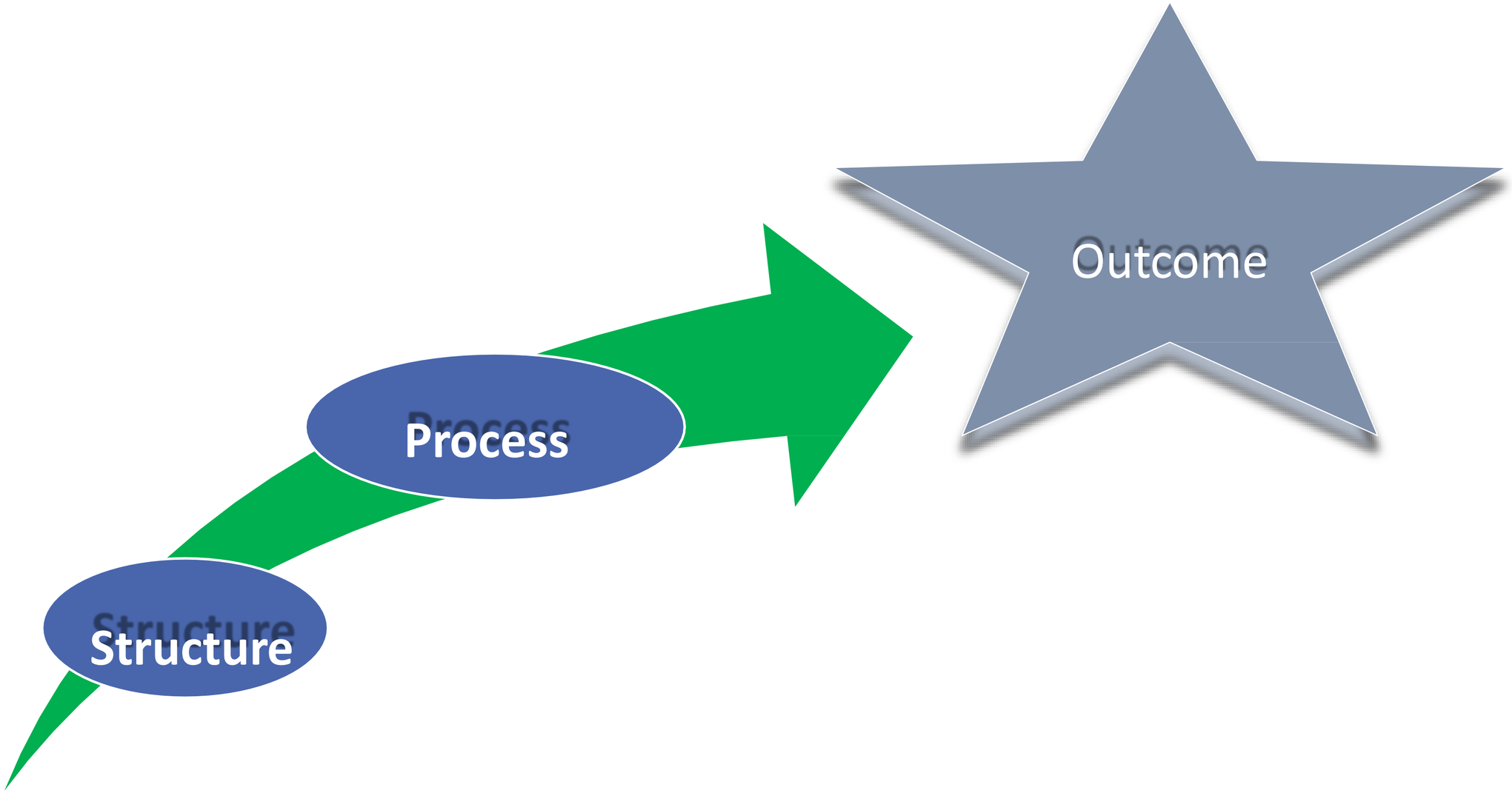
Does Your QAPI Program Look/Feel Like This?



Or This?



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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Definitions of Quality

Definitions of Quality

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.

Definitions of Quality

Quality Control – product oriented – focuses on defect identification

"An aggregate of activities (such as design analysis and inspect ion for defect s) 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" (kwäl ədē ə ˈSHoorə ns)

"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)

Definitions of Quality

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

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

Focuses on ways to meet established targets or benchmarks

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

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

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Focuses on improvement even when targets are being met and asks, *"How do we do better"*

AND/OR

Implementation of new initiatives

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Regulatory Requirements

QAPI Regulatory Requirements

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

Centers for Medicare & Medicaid
Center for Clinical Standards and Quality/Quality, Safety & Oversight Group
Ref: QSO-20-07-ALL
December 20, 2019
To: State Survey Agency Directors
From: Director Quality, Safety & Oversight Group
Subject: Burden Reduction and Discharge Planning Final Rules Guidance and Process
QSO20-07 01 Burden Reduction-Discharge Planning SOM Package121919 (1).pdf

SOM Appendix W has not been updated to incorporate the QAPI requirements
Last update Rev. 200, 02-21-20

The new QAPI regulations eliminated the requirement for an annual program evaluation for CAHs.

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Why the Change (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.

Definitions

§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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Program Design

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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Program Scope

§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.

Governance and Leadership

§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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Program Scope

§485.641 Quality assessment and performance improvement program.

(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.

(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 Plan

QAPI Plan

Your QAPI Plan should include ALL of the new requirements

There is not a specific format for a QAPI plan specified by CMS

There is not a specific committee structure specified by CMS

Steal liberally --- but don't "throw-out" the good stuff in your current plan. Concentrate on what you may be missing to meet new regulatory requirements

Resource: Elements of a QAPI Plan are included at the end of the presentation

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Organizational Priorities

Organizational Priorities

§485.641 Quality assessment and performance improvement program.

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

Priorities should be focused on:

- preventing problems
- improving current systems and services, or
- developing new approaches to care or services based on evidence-based guidelines.

IMPORTANT

Priority performance improvement projects may be adjusted throughout the course of the year, based on response to identified needs, including, but not limited to unusual or urgent events.

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Step 1: Decide what criteria you will use & scoring

	1 - LOW	2 3	4 5 – TOTAL HIGH
***High Volume:** High volume population or service			
***High 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			

Step 1: Decide what criteria you will use & scoring

Potential Organizational Priority	Problem Prone - Low performance based on data or recent event Weight 4	State, Federal or Accreditation Requirement Weight 4	High Volume – % of Patients Impacted Weight: 4	High-Risk Potential Harm Weight 4	Community Priority (e.g., CHNA) Weight 3
	High Volume, or High Risk, or Problem Prone				
	Are Required				

Step 2: Develop a list of potential initiatives

1. Problem Prone areas or services including medical errors

- Publicly reported data
  - *Example: Time from arrival to transfer (ER)*
- Medication Management
  - *Example: Medication errors*
- Risk Management reports
  - *Example: Falls*
- Infection Control
  - *Example: Hand Washing*
- Hospital Acquired Conditions
  - *Example: Falls*
  - *Example: Surgical Site Infections*

2. High- volume

- *Example: Swing Bed*
  - *Documentation*
  - *Multi-disciplinary care planning*
- *Example: Emergency Department*
  - *Leaving without being seen*

3. High-risk

- *Example: Restraints*
  - *Documentation*
- *Example: Deliveries in the ED*

4. New external performance measures or initiatives

- *Example: MBQIP*
- *Example: Hospital Compare*

Step 2: Develop a list of potential initiatives

5. Health Outcomes

- Patient Satisfaction (PROXY INDICATOR)
- Stroke Care
- Trauma Care

- Medication Management
  - *Example: Antimicrobial Stewardship*
  - *Example: Opioid Use*

6. Transitions of Care

- Readmissions – all causes
- Readmissions within 30 days after discharge from Swing Bed

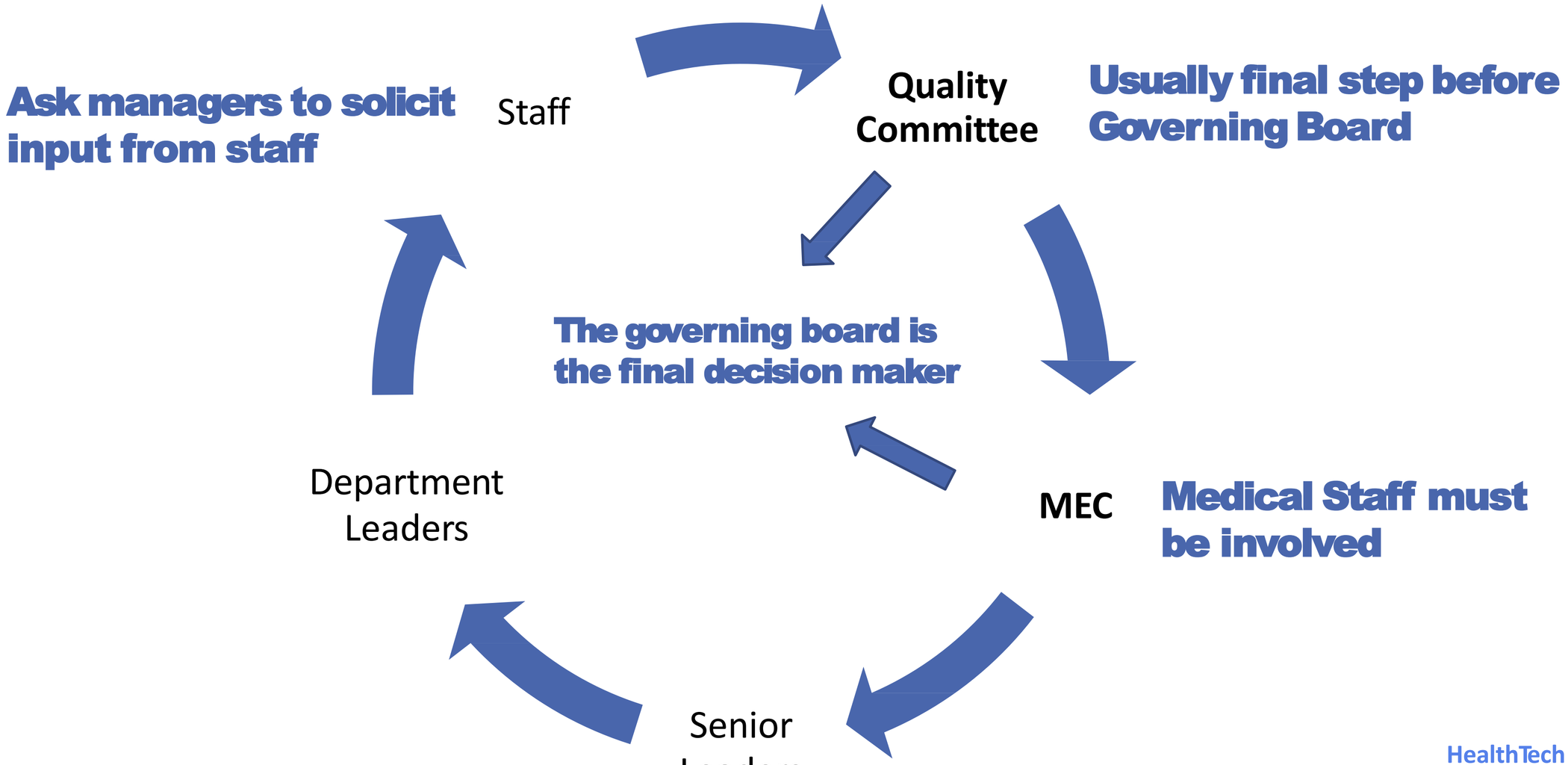
7. Performance compared to internal targets or external benchmarks that are not being met

8. New or revised evidence-based care guidelines

9. New planned services or programs

10. Recommendations from Medical Staff and Leaders

Step 3: Determine WHO will provide input



Step 4: Determine Priorities

Potential Organizational Priority	Problem Prone - Low performance based on data or recent event Weight 4	State, Federal or Accreditation Requirement Weight 4	High Volume – % of Patients Impacted Weight: 4	High-Risk Potential Harm Weight 4	Community Priority (e.g., CHNA) Weight 3
Restraints (Improve documentation)					
Patient Satisfaction					
Post Partum Hemorrhage (Implement new guidelines					
Swing Bed (Improve documentation) (Increase volume)					
STEMI (Time from arrival to transfer)					

Provide data for context

Be as specific as possible

Step 4: Determine Priorities

	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			**Provide data for context**			
***Transitions of Care:** Potential to improve transitions of care, including readmissions						
Cost: The cost incurred each time this issue occurs			**Be as specific as possible**			
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						

Word of Caution

A priority is NOT everything you monitor.

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

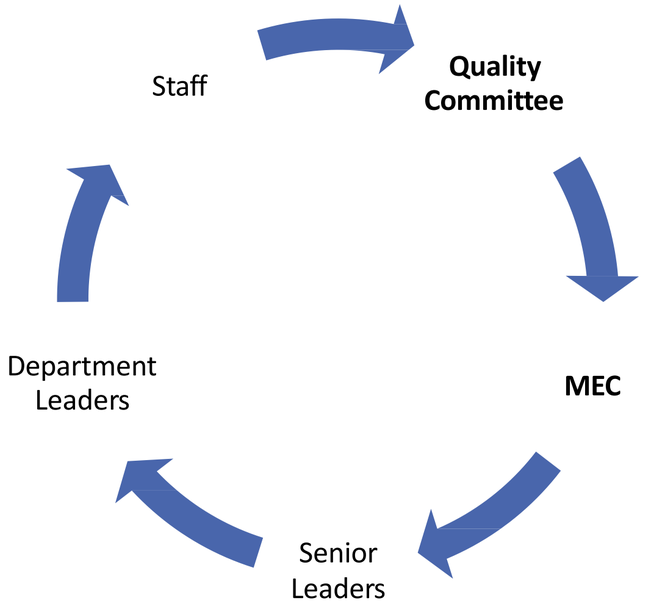
- Should Post-Partum Hemorrhage be a priority for the organization? **Maybe or YES (use prioritization grid)**

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

Step 5: Approval

Present recommendations to MEC and the Governing Board for approval

- Include who was involved in determining priorities
- Include data
- If different than medical staff initial input, explain why



Step 6: Develop Action Plan

Each goal MUST have a specific plan that includes

- Goal
- Target
- What needs to be done (action steps)
- When does it need to be done (timeline)
- Who is responsible
- How often will data be reported and to whom
  - At a minimum reports should go to quality committee and governing board quarterly

IMPORTANT: If a department is involved in an organizational goal — they <u>don't need</u> another departmental goal

IMPORTANT: Multi-disciplinary is best

IMPORTANT: Involve providers

Synergy

EXAMPLE	Provider	Lab	Imaging	ICU	Med-Surg	Regis.	ER	Mother-Baby	Pharmacy	Case Mang.	IC	Quality	Plant Security	Wound Care	Surg. Services	Cancer Center	Clinics
Goal: Reduce ER Wait Times	✓ P	✓ P	✓ P	✓ P	✓ P	✓ P	✓ L					✓ S					
Goal: Implement antibiotic stewardship	✓ P	✓ P							✓ L		✓ P	✓ S					
Goal: Implement Post-Partum Hemorrhage Initiative	✓ P							✓ L				✓ S					
Goal: Reduce Readmissions	✓ S				✓ P					✓ P						✓ P	✓ P
Goal: Implement Patient Safety Ligature Risk							✓ L					✓ S	✓ P				

The QAPI program must be appropriate for complexity and services provided.(New CoPs)
The QAPI program must involve all departments of the CAH and services, including those under contract. (New CoPs)

L = Lead
P = Primary Involvement
S = Support

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Performance Measures

Required Performance Measures

- ❑ Quality and appropriateness of the diagnosis and treatment furnished by providers (C-0339)
- ❑ Management of information including medical records (§485.635)
- ❑ Utilization of blood and blood products (CLIA)
- ❑ Medication management (Also New CoPs Medical Errors and Adverse Events)
  - Medication Errors (C-1018)
  - Adverse Drug Reactions (C-1018)
  - Antibiotic Stewardship (§485.640)
- ❑ Infection Prevention (Also New CoPs Adverse Events & Hospital acquired conditions)
  - Healthcare Acquired Infections (§485.640)
  - Infectious Diseases (§485.640)
- ❑ Organizational priorities (New CoPs)
- ❑ Health Outcomes (New CoPs)
  - Publicly reported data
  - Other Health Outcome data
- ❑ Medical errors (New CoPs)
- ❑ Adverse events (New CoPs)
- ❑ Hospital acquired conditions (New CoPs)
- ❑ Utilization management / discharge planning
  - Transitions of care including all cause readmissions (New CoPs)
- ❑ Restraints and seclusion (New CoPs – Other Relevant data – High-Risk / Low Volume)
  - Restraint episodes by type
  - Documentation
- ❑ Patient Satisfaction (New CoPs – Other Relevant data)

MAP Performance Measures

(Not everything has to be reported to the Quality Committee)

- **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.

- **Trauma Committee**
  - Activations
  - Trauma Registry

- **Credentialing**
  - Peer Review
  - OPPE / FPPE

- **Medical Records**
  - Completeness and timeliness of provider documentation

- **Anesthesia**
  - Moderate sedation
  - Deep sedation
  - Adverse outcomes sedation

- **Critical Care**
  - CPR outcome
  - Rapid response

- **Emergency**
  - Door to provider
  - Door to discharge
  - Transfers
  - Return visits (same reason)

- **Laboratory – Blood Utilization**
  - Percent cross-match to transfusion
  - Met transfusion criteria

- **Surgical Services**
  - Pre/Post op discrepancies
  - Unplanned return to surgery
  - Use of reversal agents
  - Surgical Case Review

- **Internal Medicine / Family Practice**
  - Readmissions
  - CPR outcome
  - Rapid response

- **Radiology**
  - Radiation exposure
  - Time from test to results
  - Overreads / Discrepancies

- **Obstetrics**
  - C-Sections
  - Inductions

Performance Measure Principles

1. A list of all performance measures that are being monitored in the organization, including where the performance measure is reported, should be maintained and updated by the Quality department as needed, but no less than annually.

2. Performance Measures:

- Identified to monitor care and services through multiple data sources
- Used to monitor a wide range of care processes and outcomes
- Data findings should be assessed against organizational established benchmarks and/or targets for performance
- Benchmarking to compare outcomes against other organizations, when the data is available. that measure process, services, functions and outcomes.

3.Each department, service line, and contract service should identify or participate in development, monitoring and analysis of performance measures specific to their area, and/or participate in a multi-disciplinary or organizational initiative that includes their area.

4. A data plan should be developed for each performance measure.

Performance Measure Principles

5. Measures, targets and sample sizes appropriate for the performance measure.

6. Data analyzed appropriately for the type of performance measure using the appropriate quality tools.

7. An appropriate target developed including an external benchmark, if available, for each performance measure. If a performance measure has a target that is rate based – the target is appropriate for the performance measure. (i.e. falls may not be appropriate as a rate-based measure)

8. A corrective action plan developed if the performance measure does not meet the established target. **IMPORTANT**

Data Plan

Create a data plan for every measure

Example included at the end of the presentation

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Reporting

MAP Reporting Structure

Governing Board

Medical Executive Committee

Credentialing Committee

P&T Committee
- Antibiotic Stewardship

Utilization Review Committee
- Readmissions

Infection Control Committee

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

Quality Committee

Organizational Priorities

Publicly reported data

Patient Safety
- Harm Events / Risk Management

Hospital Departments / Contract Services

Environment of Care

Collaboration Infection Control

Collaboration Antibiotic Stewardship

Reporting

Reporting Schedule

- Develop a reporting schedule for each department and service area to report to the QAPI Committee and/or MEC and Governing 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

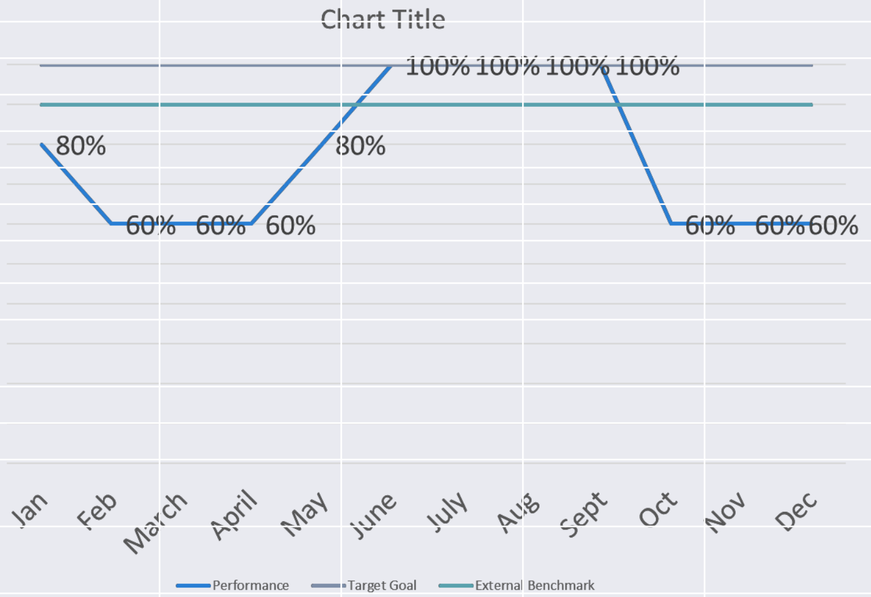
Reporting

Recommend that the improvement teams for organizational goals report monthly to the Quality Council and at least quarterly to the Governing Board. The report should include at a minimum:

1. Team Members
2. Aim / Goal of the initiative
3. Measurement parameters to identify improvement
4. Data being collected
5. Data collection system / processes including data plan
6. Interventions / Changes planned or implemented
7. Outcomes
8. Resources needed

Reporting

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	

Reporting

	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				

Reporting

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

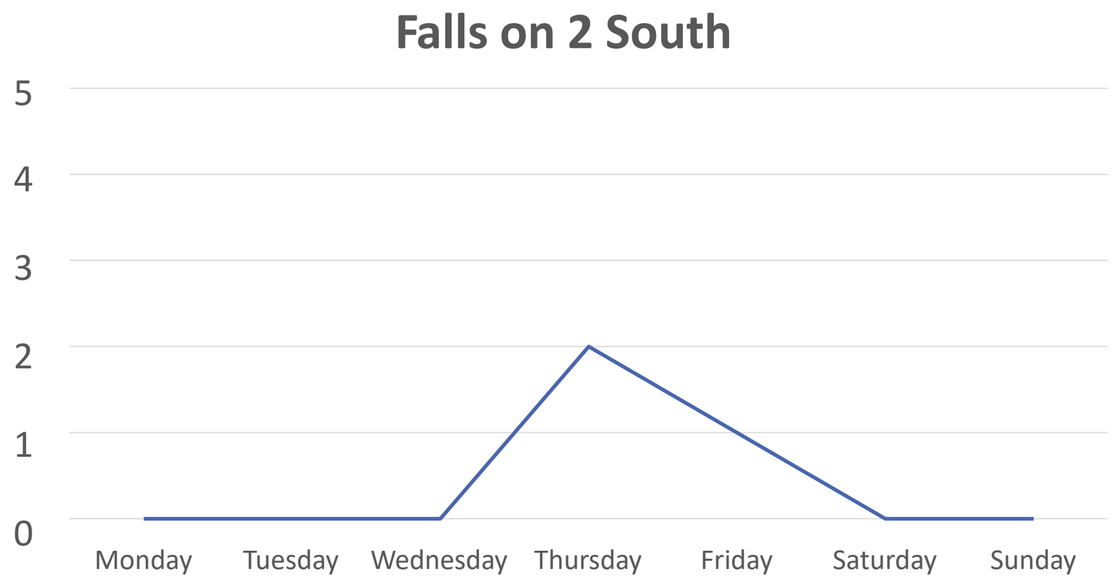
Department Scorecard

	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				

Department Scorecard

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?



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 of your time on **improvement initiatives** – removing barriers – providing support – not just measuring!!!!!!

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Organizational Engagement

We may have a problem if ….

Governing Board

- ❑ Board does not understand or cannot articulate fiduciary responsibility related to quality.
- ❑ Board does not understand link between clinical outcomes and financial outcomes
- ❑ Limited time on Board agenda for quality reports with minimal or no discussion – or – part of consent agenda
- ❑ Board is not educated regarding quality principles
- ❑ Board does not “actively” review and discuss quality reports including process, structure and outcomes
- ❑ Board agenda does not include reports from team members about priority initiatives
- ❑ Board is engaged in moving to *zero harm*

We may have a problem if ….

Medical Staff and Senior Leaders

- Medical Staff and Senior Leaders are not actively involved in identifying organizational priorities for improvement
- Medical Staff Leadership and Senior Leaders cannot articulate organizational priorities for improvement
- Medical Staff and Senior Leaders do not actively participate in identifying, participating and supporting quality initiatives
- Medical Staff and Senior Leaders are not educated regarding quality principles including use of quality tools
- A Culture of Safety has not been implemented – or is not effective
- "*Good catches*" are not captured or rewarded

We may have a problem if ….

Department Leaders

- Leaders cannot articulate organizational priorities for improvement
- Leaders do not actively participate in guiding and supporting quality initiatives as either team leaders or team members
- Department reports are not submitted on-time or are missing information
- Departments have been monitoring the “same thing” for multiple years with the same results
- A Culture of Safety has not been implemented – or is not effective
- “*Good catches*” are not captured or rewarded

We may have a problem if ….

Staff

- Staff cannot articulate organizational priorities for improvement
- Staff are not aware of improvement initiatives in their department
- Staff are not educated regarding quality principles including use of quality tools
- Staff don't "*speak up*" when they identify potential harm events
- Staff are not rewarded for "*stopping the line"*
- Staff are not active participants in getting to zero harm

Strategies

Governing Board

- Discuss meaningful examples of quality
- Discuss harm events
- Listen to team presentation on quality initiatives
- Listen to the voice of the customer (personal stories)
- Reward improvement efforts

Medical Staff

- Initiatives that make a difference
- No unnecessary meetings

Senior Leaders

- Set the goal of moving to zero harm
- Daily rounds focused on reducing barriers and identifying potential safety events
- Communication about how the organization is moving to zero harm
- Remove barriers
- Implement Culture of Safety

Department Managers

- NO busy work
- Minimize audits
- Focus on real improvement
- Implement culture of safety
- Reward any Good Catch

Staff

- Actively involved in improving quality and eliminating harm
- Identify potential harm events
- Actively involved in solutions for improvement

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Highly Reliable Organizations

Definitions of a Highly Reliable Organization

High reliability describes organizations and industries that maintain extraordinarily high levels of quality and safety over long periods of time with no or extremely few adverse or harmful events, despite operating in very hazardous conditions.

In healthcare, high reliability means that care is consistently excellent and safe across all services and settings.

Source: TJC, Zero Harm: An Achievable Goal The essential role of high reliability is solving quality and safety problems.

Collective Mindfulness

High reliability helps organizations stay safe through a culture characterized by "**collective mindfulness"** in which all workers look for, and report, small problems or unsafe conditions before they pose a substantial risk to the organization and when they are easy to fix.

Source: Managing the Unexpected: Resilient Performance in an Age of Uncertainty, Second Edition (Jossey-Bass, 2007), authored by Karl E. Weick and Kathleen M. Sutcliffe

Safety Anarchism

Anarchism in this sense refers to a group of people being able to have confidence in spontaneous cooperation and the existence of mutuality without hierarchy.

Safety anarchism is not about the total absence of authority or the absolute freedom of an individual, but instead the idea that safety is an ethical obligation rather than an obligation to rules and regulations.

This shifts an organization's focus from creating more policies and procedures, policing of staff, and gathering metrics to cultivating diversity, motivation, creativity, and autonomy to solve patient safety problems.

We can improve safety by limiting the constraints of bureaucracy and transforming passive rule-followers into those who are actively engaged in safety design.

Source: Getting to Zero Patient Harm: From Improving Our Existing Tools to Embracing a New Paradigm
Cohen, Jonathan B. MD; Patel, Sephalie Y. MD

High Reliability Healthcare Model

Three foundational domains that are **mutually reinforcing:**

1. A leadership commitment to zero harm

2. Establishment of a safety culture in which all employees speak up to prevent harm

3. Deployment of highly effective process improvement methods If Not Now, Then When?

Leadership commitment is the first and most essential step in the journey to high reliability. It requires that leaders commit to the ultimate goal of zero patient harm.

Source: Zero Harm: An Achievable Goal The essential role of high reliability is solving quality and safety problems.

Process – A Leading Indicator

A more appealing measurement to add as part of assessing the impact of a zero-harm strategy would be one that captures "the preventative activities that will lead to zero."

These are sometimes termed **leading indicators** and, along with **measures of climate or culture**, are touted as more actionable by many safety practitioners outside of health care.

And at some level these simply represent **process measures** that complement the outcome measure represented by quantifications of adverse events in a framework familiar from the health care quality literature dating back to Avedis Donabedian.

And as Donabedian said, any "causal validity resides neither in process nor in outcome, but in the link that joins them."

Given the limitations in measuring preventability of adverse event outcomes, **the process measure may be the best target to start with, as clinicians have more control over processes than outcomes.**

Source: Targeting Zero Harm: A Stretch Goal That Risks Breaking the Spring Jennifer Meddings, MD, MSc, Sanjay Saint, MD, MPH, Richard Lilford, CBE, FMedSci, Timothy P. Hofer, MD, MSc Vol. 1 No. 4 | June 17, 2020 DOI: 10.1056/CAT.20.0354

Recommendations

1. Do not treat all adverse events equally. The targeted goal and resources applied should vary by preventability and types of interventions that are successful for reducing each type of adverse event

2. Rather than broad zero-harm goals, define specific actionable goals that target the risk your team can focus on and modify.

3. Incentivize the changes in practice that help reach the specific goals your team has set.

4. Hire and promote leaders and bedside staff with a passion for evaluating and improving clinical practice

5. When the majority of adverse events measured are not preventable, trends over time are the most helpful data to study, as these can suggest areas to investigate for potentially preventable events when rates increase.

Source: Targeting Zero Harm: A Stretch Goal That Risks Breaking the Spring Jennifer Meddings, MD, MSc, Sanjay Saint, MD, MPH, Richard Lilford, CBE, FMedSci, Timothy P. Hofer, MD, MSc Vol. 1 No. 4 | June 17, 2020 DOI: 10.1056/CAT.20.0354

Five Things To Do Now

1. Complete Culture of Safety survey

2. Ask staff to “tell their story” about when harm events were avoided and when they occurred

3. Develop a plan based on principles of moving the organization to zero harm including a “*Speak Up” or “Stop the Line”* campaign

4. Invest in real process improvement not just Quality Control
(PDCA, IHI Improvement Model, LEAN, Six Sigma)

5. LEADERSHIP COMMITMENT

“We choose to go to the moon in this decade and do the other things, not because they are easy, but because they are hard,

because that goal will serve to organize and measure the best of our energies and skills,

because that challenge is one that we are willing to accept,

one we are unwilling to postpone

and one which we intend to win.”

John F. Kennedy

Quality does not exist in a vacuum.
To be successful requires the entire organization.

Communicate

Celebrate

Keep Getting Better

Please feel free to contact me

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Thank you

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Resource QAPI Plan

Section 1

Adverse event: Untoward, undesirable, and usually unanticipated event that causes death or serious injury or the risk thereof.

Error: 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: Error that occurs in the delivery of healthcare services.

Quality Assurance: 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.

Quality Control: An aggregate of activities (such as design analysis and inspection for defects) designed to ensure adequate quality especially in manufactured products

Performance Improvement: 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.

Section 1: Introduction

1. Introduction to QAPI

QAPI is the coordinated application of two mutually-reinforcing aspects of a quality management system.

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. (*Source: CMS*)

2. Mission – Vision – Values

- Hospital Mission, Vision, Values
- QAPI Mission, Vision, Values

3. Responsibility for Quality

Accountability for quality and safety is monitored and improved at all levels of the organization from the Board of Directors to unit level huddles.

Section 1: Introduction

4. Commitment

The Hospital is committed to ongoing improvement and continuingly strives to ensure safe, effective, patient-centered, timely, efficient and equitable care. (*Source Institute of Medicine)*

Safe: Avoiding harm to patients from the care that is intended to help them.

Effective: Providing services based on scientific knowledge to all who could benefit and refraining from providing services to those not likely to benefit (avoiding underuse and misuse, respectively).

Patient-centered: Providing care that is respectful of and responsive to individual patient preferences, needs, and values and ensuring that patient values guide all clinical decisions.

Timely: Reducing waits and sometimes harmful delays for both those who receive and those who give care.

Efficient: Avoiding waste, including waste of equipment, supplies, ideas, and energy.

Equitable: Providing care that does not vary in quality because of personal characteristics such as gender, ethnicity, geographic location, and socioeconomic status.

Section 1: Introduction

5. Design and Scope (*Source: CMS New)*

The Hospital will develop, implement, and maintain an effective, comprehensive hospital-wide QAPI program that is:

- Appropriate for the complexity of the organization and the services provided
- Ongoing and comprehensive
- Involve all departments and services, including those services furnished under contact or arrangement
- Use objective measures to evaluate organizational processes, functions and services

The Hospital will focus on measures that are related to:

- Improved health outcomes that are shown to be predictive of desired patient 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

The Hospital will use the measures to analyze and track performance.

The Hospital will set priorities for performance improvement, considering either high-volume, high-risk services, or problem-prone areas.

The Hospital will incorporate quality indicator data including patient care data, and other relevant data, in order to achieve the goals of the QAPI program.

Section 1: Introduction

6. Improvement Framework

The QAPI program will utilize the following improvement framework:

- *Examples*
  - *PDSA*
  - *Institute for Healthcare Improvement (Rapid Cycle and PDSA)*
  - *Lean*
  - *Six Sigma*

7. Improvement Tools

The QAPI program will utilize the following tools for analysis and problem solving as appropriate for the type of performance measure. (*Usually in an Appendix if you are going to describe each tool*)

- Affinity Diagram
- Benchmarking
- Brainstorming
- Cause and Effect Diagram (Fishbone or Ishikawa)
- Control Chart
- Decision-Making Tools
  - Multi-Voting
  - Nominal Group Technique

Section 2: Governance and Leadership

Source: CMS New except replaced responsible individual with Senior Leaders

The governing body and senior leaders are responsible for oversight and direction of the QAPI program including providing adequate and appropriate staffing, technology and other resources as needed for the QAPI program to meet the goals of safe, effective, patient-centered, timely, efficient, and equitable care.

The governing body and senior leaders are responsible and accountable for ensuring that the QAPI program is:

1. Appropriate for the complexity of the CAH's organization and services provided
2. Ongoing and comprehensive
3. Involves all departments of the CAH and services (including those services furnished under contract or arrangement)
4. Uses objective measures to evaluate its organizational processes, functions and services
5. Addresses 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

Section 2: Governance and Leadership

The governing board is responsible for:

1. Review and approval of the annual QAPI Plan

2. Review and approval of prioritization criteria for selecting organizational QAPI projects

3. Ensuring that organizational improvement priorities and projects are appropriate for the scope and complexity of the organization

4. Review and approval of organizational improvement priorities at least annually

5. Reviewing regular reports on quality outcomes 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 and adverse events
   - Outcome indicators related to CAH acquired conditions
   - Outcome indicators related to transitions of care including readmissions

Section 3: Quality Committee

The Quality Committee is composed of:

- Governing Board representative
- Medical Staff representative
- CEO, CFO, CNO, COO, CMO
- Quality Director
- Risk Manager
- Infection Control Practitioner
- Pharmacy Director

The Quality Committee meets on a monthly basis and is chaired by the CMO or medical staff representative.

Note: The membership of the Quality Committee or who chairs the committee are not specified in regulations.

Note: Some hospitals have a department quality committee and a separate governing board quality committee.

Section 3: Quality Committee

The Quality Committee is responsible for:

1. Providing education regarding QAPI, including improvement methodologies and tools, for the governing board, medical staff, hospital leaders and staff including contract staff

2. Developing the annual QAPI Plan and submitting to the governing board for approval

3. Developing prioritization criteria for selection of QAPI projects and submitting to the governing board for approval

4. Identifying and implementing organizational improvement priorities at least annually and submitting to the governing board for approval

5. Ensuring that organizational improvement priorities and projects are appropriate for the scope and complexity of the organization

6. Providing adequate resources to ensure an effective QAPI program

Section 3: Quality Committee

The Quality Committee is responsible for:

7. Overseeing and/or assisting with the development of performance measures for individual departments, service lines, contract services or teams

8. Overseeing Continuous Survey Readiness

9. Receiving and reviewing reports on performance measures that include at a minimum:
    - Organizational priorities
    - Department, service-line and contract services
    - Performance Improvement teams
    - Publicly reported data
    - Outcome indicators related to improved health outcomes
    - Outcome indicators related to reduction of medical errors and adverse events
    - Outcome indicators related to CAH acquired conditions
    - Outcome indicators related to transitions of care including readmissions
    - Infection Prevention (Current CoPs require collaboration with IC)
    - Antibiotic Stewardship (Current CoPs require collaboration with IC & P&T)

Section 3: Quality Department

The Quality department supports QAPI structures, processes and outcomes. The Quality department is responsible for:

1. Submitting quality data to external organizations

2. Working with departments, contract services and/or service lines to develop performance measures that are in alignment with organizational priorities, including developing a data plan

3. Providing support to quality teams including facilitating meetings if requested

4. Providing ongoing education to governing board, medical staff, leaders, teams and staff related to: quality principles, data collection, analysis, and reporting; use of quality tools

5. Developing a reporting schedule and facilitating reporting to the Quality Committee by departments, contract services and/or service lines

6. Developing reports for the Quality Committee, MEC and Governing Board

7. Completing an annual evaluation of the QAPI program and submitting to the Quality Council, MEC and Governing Board

8. Completing the **bi-annual** Critical Access Hospital report *(Source: CoPs Current)*

Section 4: Improvement Priorities

On an annual basis the Quality Council with input from the Medical Staff will identify priorities for improvement using prioritization criteria that includes high volume, high-risk services, or problem prone areas. (*Source: CMS New Prioritization Criteria*)

Priorities are focused on preventing problems, improving current systems and services, or developing new approaches to care or services based on evidence-based guidelines.

IMPORTANT TO INCLUDE: Priority performance improvement projects may be adjusted throughout the course of the year, based on response to identified needs, including, but not limited to unusual or urgent events.

A team will be developed to address each organizational priority. The team will include a designated Senior Leader and will be supported by the Quality Department. The team members will include those individuals closest to the issue which may include providers, staff, patients or families.

The improvement team will report monthly to the Quality Council and at least quarterly to the Governing Board. The report will include at a minimum:

1. Team Members
2. Aim / Goal of the initiative
3. Measurement parameters to identify improvement
4. Data being collected
5. Data collection system / processes including data plan
6. Interventions / Changes planned or implemented
7. Outcomes
8. Resources needed

Section 5: Performance Measures

Performance Measures will be identified to monitor care and services through multiple data sources. The facility will use performance indicators to monitor a wide range of care processes and outcomes. Data findings are assessed against organizational established benchmarks and/or targets for performance. The organization will use benchmarking to compare outcomes against other organizations, when the data is available. that measure process, services, functions and outcomes.

Each department, service line, and contract service will identify or participate in development, monitoring and analysis of performance measures specific to their area, and/or will participate in a multi-disciplinary or organizational initiative that includes their area.

Section 5: Performance Measures

At a minimum data is collected and analyzed related to: organizational priorities; high volume, high-risk, problem prone areas; or data that are required by CMS or other regulatory agencies including:

- Quality and appropriateness of the diagnosis and treatment furnished by providers
- Organizational priorities
- Publicly reported data
- Outcome indicators related to improved health outcomes
- Outcome indicators related to reduction of medical errors
- Outcome indicators related to reduction of adverse events
- Outcome indicators related to CAH acquired conditions
- Outcome indicators related to transitions of care including readmissions
- Medication management
- Utilization of blood and blood products
- Management of information including medical records
- Infection Prevention
- Restraints and Seclusion
- Patient Satisfaction

Section 5: Performance Measures

A list of all performance measures that are being monitored in the organization, including where the performance measure is reported, will be maintained and updated by the Quality department as needed, but no less than annually.

A data plan will be developed for each performance measure.

Measures, targets and sample sizes will be appropriate for the performance measure.

Data will be analyzed appropriately for the type of performance measure using the appropriate quality tools.

An appropriate target will be developed including an external benchmark, if available, for each performance measure. If a performance measure has a target that is rate based – the target is appropriate for the performance measure. (i.e. falls may not be appropriate as a rate-based measure)

A corrective action plan will be developed if the performance measure does not meet the established target.

Section 6: Education

QAPI education and training will be provided to governing board, medical staff, leaders, improvement team members and staff.

Education and training will be provided on an ongoing basis including during regularly scheduled meetings, new hire orientation and multi-disciplinary team meetings.

Section 7: Annual Review

The Quality Council will review the QAPI program structure, processes and outcomes annually. The evaluation will be presented to the Medical Staff Executive Committee and the Governing Board.

The Quality department will complete and submit a CAH report to the Quality Council, Medical Staff Executive Committee and Governing Board biannually.

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Resource Self-Assessment

Governing Board – Medical Staff – Senior Leaders

STRUCTURE (Examples of Structure)

The Governing Board, Medical Staff, 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

Governing Board – Medical Staff – Senior Leaders

PROCESS (Examples of Process)

The Governing Board and MEC reviews and approves the annual QAPI Plan

The Governing Board and MEC 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, Medical Staff, 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

Governing Board – Medical Staff – Senior Leaders

OUTCOME (Examples of Outcomes)

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

Quality Department

STRUCTURE (Examples of 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)

Quality Department

PROCESS (Examples of Processes)

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.

Quality Department

OUTCOME (Examples of Outcomes)

% 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

Quality Committee

STRUCTURE (Examples of 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

Quality Committee

PROCESS (Examples of Processes)

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

Quality Program

STRUCTURE (Examples of 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.

Quality Program

PROCESS (Examples of Processes)

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.

Quality Program

OUTCOME (Examples of Outcomes)

% 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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Quality Program

OUTCOME (Examples of Outcomes)

% 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, Reporting

STRUCTURE (Examples of 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

Data Collection, Analysis, Reporting

PROCESS (Examples of Processes)

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

Data Collection, Analysis, Reporting

OUTCOME (Example of Outcomes)

% 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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Data Plan

Data Plan Example

Department – Manager Name – 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

Data Plan Example

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?

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 – if available?

17. What is your target?

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