HealthTech

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:
   - o Organizational priorities
   - o Department, service-line and contract services
   - o Performance Improvement teams
   - o Publicly reported data
   - o Outcome indicators related to improved health outcomes
   - o Outcome indicators related to reduction of medical errors and adverse events
   - o Outcome indicators related to CAH acquired conditions
   - o Outcome indicators related to transitions of care including readmissions
   - o Infection Prevention (Current CoPs require collaboration with IC)
   - o 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.