Quality Assurance and Performance Improvement Critical for Access Hospitals: A Deep Dive

Building Leaders – Transforming Hospitals – Improving Care
## Who We Are

### Our Company
Formerly known as Brim Healthcare we have a 45 year track record of delivering superior clinical & operating results for our clients.

### Our Team
Our Executive Team has experience in managing hospitals from multi-billion $ healthcare systems to community hospitals.

### Our Mission
We believe that the combination of People, Process & Technology transforms healthcare & provides the required results.

### Management
- Turnaround Strategy
- Financial
- Operations
- Corporate Compliance
- Board Development

### Consulting
- Regulatory Compliance and Accreditation Preparation
- Lean Process Improvement
- Community Health Needs Assessments

### Placement
- Executive Recruiting
- Interim Executive Placements
- Mid-level and Specialty Placements

### Technology
- Gaffey Revenue Cycle Management
- CrossTX Population Health Platform
- Optimum Productivity

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Building Leaders – Transforming Hospitals – Improving Care
Carolyn St. Charles, RN, BSN, MBA
Regional Chief Clinical Officer

Carolyn began her healthcare career as a staff nurse in Intensive Care. She has worked in a variety of staff, administrative and consulting roles and has been in her current position as Regional Chief Clinical Officer with HealthTechS3 for the last fifteen years.

In her role as Regional Chief Clinical Officer, Carolyn St. Charles is the lead consultant for development of Community Health Needs Assessments and conducts mock surveys for Critical Access Hospitals, Acute Care Hospitals, Long Term Care, Rural Health Clinics, Home Health and Hospice. Carolyn also provides assistance in developing strategies for continuous survey readiness and developing plans of correction.
Instructions for Today’s Webinar

• You may type a question in the text box if you have a question during the presentation

• We will try to cover all of your questions – but if we don’t get to them during the webinar we will follow-up with you by e-mail

• You may also send questions after the webinar to Carolyn St. Charles (contact information is included at the end of the presentation)

• The webinar will be recorded and the recording will be available on the HealthTechS3 web site

www.healthtechs3.com

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The Regulations – Current and Proposed

CAH CoPs - 10/9/15

Federal Register
A Proposed Rule by the Centers for Medicare & Medicaid Services on 06/16/2016
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.

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
- Measures to improve quality on a continuous basis
The program requires that –

1) All patient care services and other services affecting patient health and safety, are evaluated.

2) Nosocomial infections and medication therapy are evaluated.
Since May 26, 1993 (58 FR 30630), the “Periodic evaluation and quality assurance review” CoP (§ 485.641) has not been updated to reflect current industry standards that utilize the QAPI model (§ 482.21) to assess and improve patient care.

The focus of a QAPI program is to proactively maximize quality improvement activities and programs, even in areas where no specific deficiencies are noted. A QAPI program enables the organization to review systematically its operating systems and processes of care to identify and implement opportunities for improvement.

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

We propose to revise § 485.641 to set forth new explicit requirements for a QAPI program at a CAH.

We believe that much of the work and resources that are currently required under the existing periodic evaluation and quality assurance CoP would be utilized to adhere to the new QAPI requirement.

Source: June 2016 – Federal Register
§ 485.641(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.

• “Medical error” means an error that occurs in the delivery of healthcare services.
§ 485.641(b) Program Design and Scope

- QAPI program that would be **appropriate for the complexity of the CAH's organization and services**. (This means that every CAH would utilize performance improvement measures that would be sensitive to that CAH's specific context)

- The QAPI program would be designed to monitor and evaluate performance of **all services and programs** of the CAH

- QAPI program would be **on-going and comprehensive**, involving all departments of the CAH and services, including those services furnished under **contract or arrangement**

- Use **objective measures** to evaluate its organizational processes, functions, and services

- **Address outcome indicators** related to improved health outcomes and the prevention and reduction of medical errors, adverse events, hospital-acquired conditions, and transitions of care, including readmissions
§485.641(c) Governance & Leadership

CAH's governing body or responsible individual is ultimately responsible for the QAPI program

- Ensuring that **clear expectations for safety** are communicated, implemented, and followed throughout the CAH

- Ensuring that **adequate resources** are allocated for measuring, assessing, improving, and sustaining the CAH's performance and reducing risk to patients

- Annually determining the **number of distinct quality improvement projects** the CAH would conduct

- Developing and implementing **policies and procedures for QAPI that address what actions the CAH staff should take to prevent and report unsafe patient care practices, medical errors, and adverse events**

QAPI efforts must address priorities for improving quality of care and patient safety.

All improvement actions evaluated and modified as needed by the designated CAH staff.
485.641(d) Program Activities

For each of the areas discussed in paragraphs (b) and (c) of this section, the CAH would be expected to:

- Focus on measures related to **improved health outcomes** that are shown to be predictive of desired patient outcomes
- Use the measures to **analyze and track** its performance
- **Set priorities for performance improvement**, considering either high-volume, high-risk services, or problem-prone areas
- **Analyses** would be expected to be conducted at **regular intervals** to enable the CAH to identify areas or opportunities for improvement
§ 485.641(e) Performance Improvement Projects

Conduct **distinct performance improvement projects** that are proportional to the scope and complexity of the CAH's services and operations.

Maintain and demonstrate written or electronic evidence and documentation of QAPI projects.
§ 485.641(f) Program Data Collection and Analysis

- Demonstrate that the **data collected measures the quality of patient care**

- **Incorporate quality indicator data** including patient care data, quality measures data, and other relevant data

- **Use the data collected to monitor the effectiveness and safety of services provided and quality of care**

- **Identify opportunities for improvement** and changes that will lead to improvement

- **CAH's governing body or responsible individual must approve the frequency and the details of data collection**

To the extent that the **MBQIP** meets the proposed requirements for incorporating quality indicator data in its QAPI program, CAH adherence to the requirements of MBQIP is one such way that the CAH's QAPI program data collection requirements can be satisfied. MBQIP uses a rural-relevant subset of data based on Medicare quality reporting program.

[https://www.ruralcenter.org/tasc/mbqip](https://www.ruralcenter.org/tasc/mbqip).
2016 Field Guide

http://www.healthtechs3.com
QAPI Worksheet

1+1= [ ]
1+2= [ ]
1+3= [ ]
1+7= [ ]
1+4= [ ]
1+8= [ ]
1+9= [ ]
1+10= [ ]
1+5= [ ]
1+6= [ ]

NAME______________________
HealthTechS3 Lean Culture Program

1. Lean Workshop Train the Trainer Program

2. Executive and Management Coaching Development

3. Continuing Education Networks for the onsite trainers and Lean executive champions
§ 485.640 Condition of participation: Infection prevention and control and antibiotic stewardship programs

As we proposed for hospitals, we are also proposing new infection prevention and control and antibiotic stewardship requirements for CAHs. The infection control requirements for CAHs have remained unchanged since 1997.

We are adding a new infection prevention and control (as well as antibiotic stewardship) CoP for CAHs because the existing standards for infection control do not reflect the current nationally recognized practices for the prevention and elimination of healthcare-associated infections.

Federal Register June 2016
Contact Information

Carolyn St.Charles
Regional Chief Clinical Officer

carolyn.stcharles@healthtechS3.com
360-584-9868
Upcoming Webinars

September 20, 2016
Advance Care Planning Process And Reimbursement Opportunities
12:00 – 1:00 p.m. CDT
Hosted By: Faith M Jones, MSN, RN, NEA-BC


September 26, 2016
Overview And Key Elements Of Population Health Management
12:00 – 1:00 p.m. CDT
Hosted By: Diane Bradley, PhD, RN, NEA-BC, CPHQ, FACHE, FACHCA

Register here http://bit.ly/1sTHcVE
And Here’s Celeste!
Quality Assurance and Performance Improvement (QAPI) in a Critical Access Hospital

PI Coordinators in Critical Access Hospitals
Objectives

By the end of this session you should be able to:

- Understand the relationship between Quality Assurance (QA) & Performance Improvement (PI)
  - QA+PI = QAPI
- Be familiar with the 5 Elements that provide a Foundation for a QAPI Program
- Review the PDSA/PDCA Cycle – Change process used in a QAPI program
- Understand what QAPI looks like in a Critical Access Hospital (CAH)
  - How to build a plan
WHAT IS QAPI?

Quality control (QC)
• Procedure or set of procedures
• Checks a product, device or service to ensure is performing the way that it is supposed to

   Ex: monitoring ABx use/appropriate ABx used; checking glucometers

Quality Assurance (QA)
• Process of meeting quality standards
• Assuring a defined standard of care is met
• Thresholds are typically set to comply with regulations

QA is a reactive, retrospective effort to examine why a facility failed to meet certain standards. QA activities do improve quality, but efforts frequently end once the standard is met

   Ex: monitoring hand hygiene; monitoring HAI rates

Performance Improvement (PI)
• Study of processes and process improvement

PI is a pro-active and continuous study of processes with the intent to prevent or decrease the likelihood of problems by identifying areas of opportunity and testing new approaches to fix underlying causes of persistent/systemic problems

• PI can make good quality even better

   Ex: Educating staff on correct ways to perform Hand hygiene; monitoring HAI’s to see if HAI rates go down after hand hygiene education
Contrasting Quality Assurance/Performance Improvement

<table>
<thead>
<tr>
<th>QUALITY ASSURANCE</th>
<th>PERFORMANCE IMPROVEMENT</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Attitude</strong></td>
<td>Required, reactive</td>
</tr>
<tr>
<td><strong>Focus</strong></td>
<td>Outliers: “bad apples” Individuals; Sometimes punitive</td>
</tr>
<tr>
<td><strong>Information</strong></td>
<td>Episode or Event based</td>
</tr>
<tr>
<td><strong>Means</strong></td>
<td>Inspection</td>
</tr>
<tr>
<td><strong>Motivation</strong></td>
<td>Measuring compliance with standards; Prevent Recurrence</td>
</tr>
<tr>
<td><strong>Responsibility</strong></td>
<td>Few</td>
</tr>
<tr>
<td><strong>Scope</strong></td>
<td>Audit Based Monitoring</td>
</tr>
</tbody>
</table>

The chart was adapted from the Health Resources and Services Administration (HRSA) and shows some key differences between QA and PI efforts.
PUTTING IT TOGETHER

Quality Assurance (QA) and Performance Improvement (PI) - QA/PI is the merger of these two complementary approaches to quality management

QA + PI = QAPI
So - what is QAPI?

QAPI is a quality management system that …

• Is ongoing, systematic, comprehensive, and data-driven

• Engages everyone in the facility to continuously identify problems and opportunities for improvement

• Develops interventions that address the underlying system and process issues as opposed to blaming individuals

• Continuously monitors performance
Why does it matter?

• Because it helps us to identify areas that need improvement and how we can go about making these improvements
• To improve Patient and Staff Satisfaction
• To address high volume, high risk, and/or problem prone areas
• Because it is required by Law
• Because it works!
• Because it’s the Right thing to do!
5 Elements of QAPI

1. Design and Scope
   - Comprehensive – covering the whole range of services

2. Governance and Leadership
   - Setting expectations regarding safety, quality, rights and respect
   - Ensuring staff accountability
   - Creating “Organizational Culture” where staff is comfortable identifying and reporting issues
   - Assuring that there are adequate resources and training

3. Feedback, Data Systems, and Monitoring
   - Draw data from multiple data sources
   - Feedback System
   - Establish thresholds

4. Performance Improvement Projects (PIPs)
   - Gathering information systematically to clarify issues or problems, and intervening for improvements

5. Systematic Analysis and Systematic Action
Parts of the PDSA cycle

The PDSA cycle is a process for testing an idea or a change:

- **Plan** - develop a plan to test the change
- **Do** - Implement the plan, execute the process
- **Study** - Study the actual results and compare against the expected results
- **Act** - If you met your objectives – Yeah! If you didn’t, determine what changes need to be made and begin the cycle again
QAPI in CAH

1. Hospitalwide QAPI program
   - Several differing facilities (May include SNF; Clinic etc)
   - Many hats
   - Few resources

2. Your Role
   - Communication
   - Improving Quality
   - Promoting CHANGE

3. The role of the Quality Committee
   - Developing and maintaining the QAPI program
   - Assisting QAPI Coordinator in identifying areas for improvement
   - Ensuring adequate resources and education for staff
## Patient Safety Dashboard 2016

<table>
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<tr>
<th>Measure</th>
<th>Benchmark*</th>
<th>MMC FYQ3</th>
<th>MMC FYQ4</th>
<th>MMC FYQ1</th>
<th>MMC FYQ2</th>
<th>MMC 2016 Averages</th>
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<tr>
<td><strong>CalHEN/HRET</strong></td>
<td>Targets or 2015 MMC Aves</td>
<td>Jan-Mar</td>
<td>Apr-June</td>
<td>July-Sept</td>
<td>Oct-Dec</td>
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<tr>
<td>Adverse Drug Reaction (Prospective)</td>
<td>0</td>
<td>0.00</td>
<td>0.00</td>
<td>0.00</td>
<td></td>
<td></td>
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<tr>
<td>Catheter Acquired - UTI</td>
<td>0</td>
<td>0.00</td>
<td>0.00</td>
<td>0.00</td>
<td></td>
<td></td>
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<tr>
<td>Central Line Acquired - Blood Stream Infection</td>
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<td>0.00</td>
<td>0.00</td>
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<tr>
<td>Acute Falls/Immobility</td>
<td>2.95/0</td>
<td>3.43/0</td>
<td>0/0</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Acute Pressure Ulcer's</td>
<td>0.00</td>
<td>0.00</td>
<td>0.00</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Inpt Readmissions within 30 days</td>
<td>5.78%</td>
<td>7.10%</td>
<td>3.00%</td>
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<tr>
<td>Surgical Site Infections</td>
<td>0%</td>
<td>0%</td>
<td>0%</td>
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<tr>
<td>Venous Thrombolytic Embolism</td>
<td>0%</td>
<td>0%</td>
<td>0%</td>
<td></td>
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<tr>
<td>Computerized Pharmacy Order Entry (CPOE)</td>
<td>98.3%</td>
<td>95.7%</td>
<td>96.3%</td>
<td></td>
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</tbody>
</table>
QAPI at MMC

Making a Plan

P - Select opportunity for improvement
DS - Identify where there is a gap between what we are doing and what we want to do
A - Bridge the gap

Simple Plan

Needed/Requested: A new ROOT CAUSE ANALYSIS AND ACTION PLAN document

Plan
Develop or locate an RCA form that was more user friendly and would provide the information needed.

Do
requirement that the template chosen must align with regulatory requirements
researched RCA approaches and templates online
Calls made to QAPI coordinators for ideas
A list of possible templates generated and reviewed
The list was narrowed down to two possible formats

Study
The only study that was done was presenting the two formats to the persons who requested the change and to Quality Council. Pros and cons were discussed and a format was chosen for use. The CMS 5 Why’s was the chosen format.

Act
The format was distributed for use
Pending: evaluation of use after a specified time period
Not so Simple Plan

Plan

1. Incorporation of Quality Assurance/Performance Improvement (QA/PI) initiatives related to section 6102 © of the Affordable Care Act for Nursing Homes

2. Warnerview (SNF) - LTC QIP Requirements – to be enacted by regulation by 1/1/17

Do

1. Development and implementation of an in-depth QA/PI program in the SNF, to include five (5) elements as outlined by the Center for Medicare and Medicaid Services (CMS)
   - PI and WLT to complete QAPI self-assessment tool by Dec 31st, 2015
   - PI to attend WLT meetings at least quarterly
   - Promote the use of Advancing Excellence (AE) program as recommended by LTC QIP

2. Develop Action plan to address LTCQIP requirements by 3/31/16
Study

1. QAPI plan for SNF developed based on regulatory requirements and guidelines. SNF Self-Assessment Tool completed and opportunities for improvement identified. PI in attendance at WLT meetings. LTC QIP or NNHQCC; these programs were reviewed and it was determined to pursue QAPI through the Advancing Excellence (AE) Program.

2. LTC QIP Requirements:

   a. Percent of high risk residents with pressure ulcers - Data abstracted from MDS (10 pts)
      High risk res w/PU / High Risk Residents - Threshold <= 5.9%

   b. Percent of residents who lose too much weight - Data abstracted from MDS (5 pts)
      LTC Res with weight loss as defined / LTC Res except those with planned weight loss – Threshold <= 7%.
      Monitor for patients with a weight loss of 5% or more in one month and 10% or more in 6 months.
      Weights: Weight loss identified by criteria specified; nutritional recommendations followed; I&O monitored by MDS; Interventions care planned; Addressed at IDT. (MDS)

   c. Dementia with Feeding Tube in place - Facility to report via template 1 by 8/31/16 for Jan-June & 2/28/17 for July-Dec via Template 2 (5 pts)
      LTC Res w/FT in place w/dementia / LTC Res with dementia - Threshold = None
d. Falls with Major injury - Data abstracted from MDS (10 pts)
   LTC Res with Falls w/major injury / LTC Res - Threshold \( \leq 3.2\% \)

e. Catheter inserted and left in bladder - Data abstracted from MDS (10 pts)
   LTC Res with catheter in past 7 days / All LTC Res - Threshold \( \leq 3.1\% \)

f. Inpatient Admissions (10pts) - Facility to report via template 1 by 8/31/16 for Jan-June & 2/28/17 for July
   # LTC Res with ED Visits / # LTC Res in 6 months - Threshold = None

g. ED Visits (10 pts) - Facility to report via template 1 by 8/31/16 for Jan-June & 2/28/17 for July-Dec via Template 2.
   # LTC Res with ED Visits / # LTC Res in 6 months - Threshold = None

h. CMS Audit Results - Info Abstracted (15 pts) - 15 pts for 4 stars or more; 7.5 pts for 3 stars
   Improve to 3-star rating by Jun 30th, 2017

i. Quality Program Implementation - Advancing Excellence (AE) (10 pts)
   Improve overall quality to achieve a “3 star” rating with CMS by June 30th, 2016.
   Facility to report via Part 1 by 8/31/16 & Part 2 by 2/28/17

j. Attend Training by HSAG (15 pts)
   Facilities send 2 or more persons to attend PHC approved training conducted by HSAG
   (Schedule of trainings TBA)
An Agreement was signed with AE and also with NNHQCC per LTCQIP requirements. The quality measures required for review through AE, NNHQCC and LTCQIP have been integrated into Warnerview metrics.

Metrics required reviewed with CNO, DON and MDS Coordinator. Plan as written reviewed and approved by DON. MDS Coordinator will provide data for LTC QIP related informatics. QAPI Coordinator will enter data into applicable websites. Track and trend.

Ongoing – Continuous monitoring. Establishing baselines for a-g over next two quarters. Awaiting CMS survey/audit. AE data elements entered and Part I facility report submitted. One of two HSAG approved trainings attended by 1 staff member. Second approved training needs to be located.
Suggestions

- **Organize** - Look for ways to limit variation in the process, streamline, and simplify
- **Documentation** – *I know we like to skip written documentation, but it has many benefits including keeping you aligned with your purpose. Don’t skimp in this area.*
- Learn what has worked at other facilities
  - COPY, COPY, COPY
- Remember, you don’t need a perfect solution the first time
  - PDSA is a CYCLE
- **COMMUNICATION**
QUESTIONS?
Celeste R Wilder, Alphabet Soup - RN, BA, BSN, MPA,MscD, HRMCP, NPSF-PSC

RM/PI/Compliance/EM

530-233-5131 x 1411

c.wilder@modocmedicalcenter.org
REFERENCES:

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https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/QAPI/qapiresources.html

Institute for Healthcare Improvement: Plan-Do-Study-Act. 
www.ihi.org/resources/pages/tools/plandostudyactworksheet.aspx