Home Healthcare QAPI CoPs
The Senior Management Role

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By the end of the session participants will be able to:

• Describe the QAPI requirements for senior management
• Create a QAPI structure that meets CoPs requirements
• Build or refine a quality key indicator system
• Choose priority areas for improvement and identify two potential Process Improvement Projects (PIPS)
• Develop mechanisms for launching and guiding PI teams
• Develop a process for sustaining improvements
This program is divided into three parts:
- Senior management accountability and program structure
- Measurement
- Improvement activities and PIP teams

Slides are geared to the managerial “how-to’s”

Handouts follow the standards and provide action plan steps

There is a self assessment/gap analysis handout for each CoPs requirement

References provide more specific models and tools
A requirement for a data-driven, agency-wide quality assessment and performance improvement (QAPI) program that continually evaluates and improves agency care for all patients at all times.

CMS.gov
<table>
<thead>
<tr>
<th>Quality Assurance</th>
<th>Process Improvement</th>
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<tbody>
<tr>
<td>Meeting quality standards and assuring that care reaches an acceptable level</td>
<td>A pro-active, continuous study and improvement of processes</td>
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<tr>
<td>• Reactive, retrospective</td>
<td>• Prevent or decrease problems</td>
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<tr>
<td>• Investigation of why standards not met</td>
<td>• Identify improvement opportunities</td>
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<td>• Solves specific problems</td>
<td>• Fix systemic problems</td>
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<tr>
<td>• QA is narrow in scope and ends when problem is solved</td>
<td>• Process for ongoing monitoring and continuous improvement</td>
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Source: HHQI QAPI Fact Sheet, February, 2017
CMS QAPI Standards

- Executive responsibility
- Program Scope
- Program Activities
- Program Data
- Performance Improvement projects (PIPS)
Executive Responsibility Specifics

- Define program scope and activities
- Structure a QAPI program and evaluate effectiveness
- Select key indicators, identify priority improvement areas and goals
- Develop a quality/patient safety culture
- Guide process improvement projects (PIP)
- Ensure patient safety and regulatory compliance
Elements of a CoPs Compliant QAPI Program

**Defined Accountability**
- Board
- Senior management
- QAPI Dept
- QAPI committee
- Managers
- Clinical staff
- PIP teams

**QAPI Structure**
- Program scope
- QAPI Plan
- QAPI Committee
- Budget
- QAPI program documentation
- Program evaluation methods

**Robust Measures**
- Key indicators
- Priority areas
- Goals
- Data collection methods/tools
- Reporting
- Report review frequency
- Analysis capability

**Improvement Processes**
- Adverse event responses
- Compliance issue fixes
- QA projects
- PIPs
- QAPI Program improvement
QAPI - What Does a Good Job Look Like?

- Clear **accountability** and focus
- **Culture** of safety and quality
- **Strong program** structure and documentation
- **Scope includes all operations**, weak spots and CMS priority areas (safety, outcomes, compliance, readmits)
- **Robust monitoring and analysis system**

- **Process for adverse events** and compliance risks
- Strong, **ongoing QA program**
- Staff and teams use a **standard QI process and tools**
- PI teams get **necessary resources and support**
- Actual improvement occurs!
- QAPI program is **continuously improved**
How Are You Feeling About QAPI CoPs?

- On a scale of 1-10, my agency readiness to implement QAPI is:

- What types of challenges will you face in implementing QAPI in your agency?
QAPI Program Scope

- All lines of business
- All services provided by the agency
- All disciplines
- Any contracted services
- Key clinical and administrative work processes
- Infection control program
- Low volume, but high risk services

- Agency clinical outcomes
  - OASIS outcome measures
  - Readmissions
  - ER visits
- Adverse events response
- Patient experience
- Complaints
- Regulatory compliance integrity

Patient safety  Outcomes  Quality of care processes  Regulatory compliance  Patient experience
What is Your QAPI Program Scope?

<table>
<thead>
<tr>
<th>Agency Services</th>
<th>Clinical Disciplines</th>
<th>Contracted Services</th>
<th>Key Work Processes</th>
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Build on Your QA Foundation

✓ QA program that meets state requirements
✓ Accountable QAPI coordinator
✓ Staff competency evaluations
✓ Audit all aspects of care and service
✓ Quality reporting and corrective action plans
✓ Adverse event response
✓ Program reports to management, PAC and the Board
✓ Procedures for compliance issues
✓ Patient safety monitoring and interventions

With a good QA program you are 50% of the way to QAPI compliance!
Build a QAPI Program Structure

- QAPI accountable staff
- QAPI committee
- Plan and timetable
- Documentation (policy, procedures, data)
- Budget and resources
- Data management system
- Process improvement training
- Process for guiding PIP teams

Check off all the elements of the program that meet requirements. Star the ones that need work.
How would each of these people describe their accountability for QAPI?
Organize the QAPI Committee

- Committee mission statement
- Membership
- Meeting schedule
- Committee procedures
- Data analysis and review schedule
- Improvement goals and actions
- Launch and guide PIP projects
- Evaluate QAPI program results

Who will you invite? How will you explain the program and expectations?
The QAPI program must meet the CoPs program scope standards:

• Agency has a program capable of **adequately assessing the quality of all its operations**

• Agency has a program capable of **showing measurable improvements in outcomes**

• Must have **documentation** to prove that the program meets these standards
Create a Quality/Patient Safety Culture

- Revise mission and vision
- Communicate goals, actions, results
- Pay attention to quality issues
- Involve employees
- Align organizational systems around quality goals
- Select a PI method and make it a best practice
- Develop data literacy and share data
Big Cheese Home Care has a functional QA program, staff and adverse events process. It monitors only core services (nursing, PT, SW, HHA) in its QA process. Senior management delegates all QA activities to staff and seldom gets involved in improvement. The agency uses manual data collection and excel spreadsheets for QA. Clinical managers review QA data monthly, create action plans and report results to senior management who pay cursory attention to the reports. Employees are not involved in the program other than to comply with improvement plans. Finance monitors regulatory compliance but is not really integrated with QA. Senior management takes the annual QA report to the Board for review. The agency has no standard method for process improvement.
PART 2
QAPI Program Data
The Data Standard “Boiled Down”

- **Key quality indicators** monitor full scope of services
- **Use available data sources** (OASIS, PEPPER, Scrubber, Chart reviews, qualitative data, CASPER)
- Monitor **care quality, service, safety, effectiveness, compliance**
- Focus on **high priority health, safety concerns and HHA goals**
- Use data to **identify opportunities for improvement** (gaps)
- Set **improvement goals** to close gaps
- Use **data to assess improvement**
Senior Management Data Responsibilities

- **Select key indicators** (input from PAC, staff, pts, board)
- **Identify gaps**; set goals for improvement
- **Create a schedule** for data collection and review
- **Approve reporting formats**
- **Allocate** data management **resources**
- **Monitor data from PIP projects**
- **Check improvement results**
Sample Key Indicators for QAPI Review

• **Home Health Compare** - star rating outcome measures
• **Home Health Compare** - 60 day readmissions, emergent care rates
• **30 day readmission rates** from data scrubber report
• **HHCAHPS** – likelihood of recommending, any indicators below state benchmark
• **Adverse event analysis**
• **Compliance audit results** and **Pepper report** review
• **QA audit indicators** with results < 90% currently, and any trending lower than 90% for 3 months or more
• **Progress report** on plan to reduce CHF readmissions from 24% to 20%
Which Key Indicators Will You Monitor?

Current Key Quality Indicators

Additional Indicators for CoPs
Monitoring Resources

Data Access
- EMR, CMS reports, HHCAHPS, incident reports, QA data and survey data

Data Tools
- Scrubber, QA software, analysis tools

Staff with Expertise
- CMS data procedures, audit procedures, use of EMR reports, data analysis, formatting reports, raw data collection

QAPI Team
- Time and training

Jot some notes about areas that need more work.

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Prioritizing Improvement Efforts

• **How big** is the problem? (incidence, prevalence, performance gap size, the level of pain and disruption)

• Is it **high risk**? – patient harm, regulatory compliance, agency cost

• Getting **better or worse**?

• Sudden **negative change**?

• Performance **compared to benchmarks**?

• **Resources and expertise** needed to solve it?
Where to Focus Your Attention

- Big or high risk performance gaps
- **Patient safety problems**
- High readmission and ER visits
- Spikes in adverse events or new performance gaps
- **Systemic issues that appear across multiple measures**
- Star rating measures that need improvement
- Compliance issues that might be considered fraud

**GAP analysis – Start improvement with your highest risk problems**
Prioritization Matrix

Score each criteria on a 1-5 scale (1 lowest, 5 highest). **Total** your score and rank order

<table>
<thead>
<tr>
<th>Quality issue</th>
<th>Compliance risk</th>
<th>Patient safety risk</th>
<th>Financial risk</th>
<th>Size/impact of the performance gap</th>
<th>Total score</th>
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<tbody>
<tr>
<td>High incidence of patient falls</td>
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<td>Readmits above state average</td>
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<td>Low HHCAHPS recommend score</td>
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<td>Not reporting changes in condition</td>
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Four Steps to Data Driven Decisions

1. ASK key questions
2. ASSEMBLE data
3. ANALYZE to turn data into information
4. ACT on your information
Bad Data Analysis

- Look at numbers → React, emote
- **Jump** to conclusions → Do some superficial analysis
- Implement quick fix, punish or reeducate → Search for easy answers or find those to blame
- Don’t improve results long term
Good Data Analysis

Look at the numbers → Form first impressions

Generate more questions ← Use analysis techniques

Drill down

Apply actions based on analysis ← Think to conclusions

Improve results long term
Data Analysis Questions

• Is the data valid and reliable? (integrity check)
• How big is the performance gap? (percentage)
• How are we doing compared to others? (benchmarking)
• Can we localize the problem to certain places, situations, people? (stratification)
• How are we doing over time? (trending)
• What are the real causes of the problem? (root cause analysis)
Our 30 day readmit rate is 18%. The state benchmark is 15%. Our goal is to reduce readmits by 3%. (performance gap)

Our readmit rate trends over 6 months are static and not improving (trending). We had a spike in the winter, but so did the state average.

Stratify readmissions by diagnosis, team, referral source

Find that CHF patient readmissions on two teams are much higher than the average internal benchmark

Many readmitted patients on one team came from 2 SNFS. On the other team, 3 nurses are driving the higher rate.

Need to collect additional data to understand root causes
Drug education
Improvement in pain
Improvement in SOB
Improvement in ambulation
Acute care hospitalization

Where to Start – What to Improve?

Agency Home Health Compare Outcomes

Drug education
Improvement in pain
Improvement in SOB
Improvement in ambulation
Acute care hospitalization

Agency  State  Four star
What is the Best Response to This Data?

Home Health Compare Outcome Scores

Improvement in ambulation
Improvement in pain
Improvement in breathing
Acute care hospitalization

Team 1
Team 2
Team 3

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PART 3 – Improvement
### Focus in the Right Places

Agency must focus on high risk, high/low volume or problem prone areas. For example, infusion therapy, medication management (especially administration and or pre-poured medications), wound care.

### Analyze the Problem

1. Check incidence (how frequent)
2. Check prevalence (how widespread or localized)
3. Check severity (how big a gap)
4. Measure trends over time
5. Compare results to benchmarks
6. Identify root causes

### Fix It

- Set an improvement goal
- Identify solutions to test
- Use PDCA cycles for small tests of change
- Implement the best solution
- Conduct follow-up data collection to ensure sustained improvement
- Assign a process owner
Select a Process Improvement Method

Step 1
Diagnose the Problem

Step 2
Plan and Implement Best Practices

Step 3
Measure Results and Analyze

Step 4
Evaluate Effectiveness of Actions Taken

Step 5
Evaluate, Standardize, and Communicate

Performance Improvement Model

Yes? Improvement
No?

Toolkit for Using the AHRQ Quality Indicators
Match the Improvement Method to the Problem

**Quality Problem Size, Scope and Impact**

- **Systemic and serious**
- **Sudden or small, but serious, quality decline**
- **Focused problem or small to moderate sized performance gap**
- **Problem with a few clinicians**

**Formal Process Improvement Team (PIP)**

- SWAT team, fast data collection, root cause analysis. PDCA solution test
- Data collection, root cause analysis, PCDA solution tests
- Staff education, performance improvement plans
Some Improvement Strategies

**Elicit staff suggestions**
- Practice closed loop communication
- Negotiate expectations with internal customers
- Develop internal consultants
- Use templates and cues in the EMR

**Improve teamwork**
- Automate parts of a process
- Standardize workflow
- Manage handoffs in the “white space” between professions and depts.
- Provide cross training and backup

**Simplify the process, reducing unnecessary complexity**
- Simplify the process, reducing unnecessary complexity

**Feed performance data back to clinicians**
- Feed performance data back to clinicians

**Educate staff about new processes**
- Educate staff about new processes

**Resolve equipment shortages**
- Resolve equipment shortages
What is the Right Improvement Method?

• There is a high incidence of infections in patients with home IVs. The IV service is contracted to a partner agency
• The agency has had a sharp rise in the number of needle sticks in the last 2 weeks
• The agency has poor scores on various measures related to med management (CAPHS, OASIS, QA audits, incident reports)
• Three nurses on one team have very poor OASIS outcome scores
• Nurses are not consistently doing timely home health aide orientations or returning aide calls
The number and scope of distinct improvement projects conducted annually must reflect: the scope, complexity, and past performance of the HHA’s services and operations.

The HHA must document:
• The quality improvement projects undertaken
• The reasons for conducting these projects
• The measurable progress achieved on these projects
Process Improvement Projects

• For serious, systemic problems
• Uses structured process and tools
• Requires group facilitation and leadership
• Formal cross functional team
• Takes time (months)
• Requires resources (time to attend, budget, space, IT and data)
• May require help with organizational issues and obstacles
• May require job and process redesign
Three Types of Process Improvement Teams

**Repair**, when the process problem is smaller or localized.

**Remodel**, when some parts of the process need a tune up and other parts, redesign.

**Gut renovation**, when the problems are very large and the process needs complete redesign.
Guiding a PIP Team Launch - The Gory Details

- Set up a preliminary investigation
- Collect baseline data
- Allocate resources
- Identify and overcome “killer concerns”
- Identify a team leader and facilitator
- Develop a script to explain the project
- Create a starter problem statement
- Invite team members
- Define team boundaries and authority
- Organize team logistics and a guidance plan

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The Quality Funnel

Do a preliminary investigation
Launch team
Problem statement, map, baseline data
Stratify data/localize problem
Root cause analysis
PDCA solution tests
Keep it solved

Yikes, we have a big problem!
It’s so overwhelming and confusing.
Now we’re sorting it out.

We need some trial and error testing.
It worked! Things are better.
Guiding PIP Teams

• Meet with the team or attend team meetings
• Monitor project data and guide with questions
• Make sure the team follows process steps
• Provide internal consulting help (HR, IT, QA, clerical, etc.)
• Suggest alternative approaches or techniques
• Praise and cheerlead
• Help overcome obstacles
• Form a team of nurses, QA coordinator is the team leader/facilitator
• Problem statement: Our readmissions are at 19%. We will lower the rate to below the state benchmark of 14% in one improvement cycle.
• Map the process and collect baseline data
• Stratify the data and find that CHF/COPD readmits are the major drivers
• “Drill down” to find that root causes are: nonadherence to best practices, not reporting patient changes and poor patient self management support
• Do localized Plan, Do, Check, Act solution tests to increase consistent use of best practices
• Rates go down to 17.5% after a management implements a new best practices program
• Plan a new PIP team to address patient self management support gaps
Help the Team Avoid Common Mistakes

- Leaving out the “little people”
- “Just talking”
- “Lost in the process”
- Not splitting the leader and facilitator roles
- Faulty data collection and shallow data analysis
- Implementing a solution widespread without testing
- Falling prey to bias, preconceived notions or internal politics
- Fixing it and forgetting it
• Assign a process owner
• Finalize policies, procedures and training materials
• Test for competency in new processes
• Create an ongoing monitoring system
• Orient new employees to the new process
• Continue to monitor results at least quarterly
• Respond to declines in performance
QAPI Common Obstacles

• Review, but don’t improve, quality
• Conflicting priorities and distractions
• Fuzzy accountability
• Insufficient staff and resources
• Lack of actionable data/analysis
• Limited skill in process improvement
• Jump to solutions
• Cultural obstacles to improvement
Now
• Review the checklist of requirements
• Score your current status on meeting requirements
• Identify QAPI requirements gaps

Back at the office:
• Prioritize items on the action plan
• Create an action plan for closing gaps
Now, Let’s Get Going on Building a Great QAPI Program!
Thank You for Coming!

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Feel free to contact me with feedback, questions, ideas and insights.
Barbara