Cooking Up a QAPI: Recipe for Success Under the new COPs – Part 1

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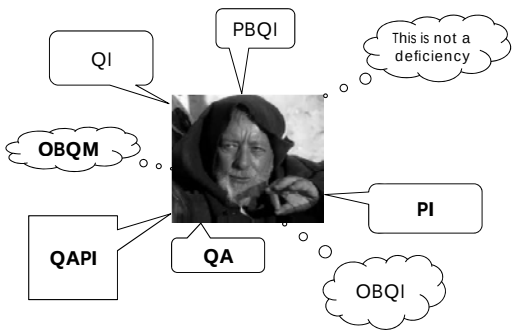
Objectives

- Describe the key components of a QAPI program as discussed in the proposed Conditions of Participation (COPs)
- Identify and prioritize areas of focus for agency QAPI programs
- Explain the key steps of QAPI using Joint Commission and Institute for Healthcare Improvement principles



Rationale for QAPI

- CMS wants to move toward "Patient-centered, data-driven outcome-oriented processes that promotes high quality patient care at all times for all patients"
- Proposed COPs published in the Federal Register Vol 79, No. 196 on 10/9/14

Changes to CoPs

- Eliminates the following requirements:
  - Annual review of agency's policies (§484.16)
  - Regular meetings of professional personnel, e.g., Professional Advisory Committee (§484.16)
  - Annual evaluation of the agency's program (§484.52)
  - Quarterly evaluation of program via chart reviews (§484.52(b))

Components of QAPI

- 5 Components / Standards
  - Program Scope
  - Program Data
  - Program Activities
  - Performance Improvement Projects
  - Executive Responsibilities

Program Scope

- Health outcomes
  - Ex: immunizations, reduced hospitalizations, pain interfering with activity
- Patient safety
  - Falls, infections
- Quality of care
  - Timeliness of care, use of evidence-based wound care, interventions to address risk of pressure ulcers

Program Data

- Quality Indicator Data
  - OBQI reports
  - OBQM reports (Potentially avoidable events)
  - Process quality measure reports

Other Agency Data – examples

- HHCAHPS
- Benchmarking reports
  - SHP (regular and top 20%), PPS+, OCS,
  - HHQI
  - MAHC Infection Surveillance Project
- Other agency audits/monitoring
  - Chart reviews
  - Fall reports
  - HHA supervisory visit frequency
  - Patient/family complaints
  - Staff concerns

Program Activities

- Develop Focus Based On:
  - High Risk
  - High Volume
  - Problem Prone
- Immediately address any issues directly or potentially affecting patient health/safety
- Track and address patient incidents and adverse events
- Monitor for sustained improvement

Performance Improvement Projects

- Reviewed and updated at least annually
- Reflect the scope, complexity and past performance of the HHA's services and operations
  - Focus on past problem areas, poor outcomes
  - High risk/high volume services
- Document the projects chosen and the reason for choosing those projects

Executive Responsibilities

- Governing Body assumes responsibility for the agency's QAPI program
  - Projects reflect scope, complexity and past performance
  - Involve all services provided
  - QAPI Program is evaluated for effectiveness
  - Establish clear expectations/goals for QI and patient safety

Infection Prevention and Control

New CoP 484.70

- Infection Prevention and Control
- Three Standards:
  - Prevention
  - Control
  - Education
- Based on new infection control standards from WHO, CDC, Joint Commission

Infection Prevention

- Use of standard precautions
  - Gloves when handling blood/blood products
- Hand hygiene best practices
  - Alcohol-based sanitizer
  - Soap and water for visible soil or for patient with infectious diarrhea
  - Key situations: prior to touching patient, performing an aseptic task, or exiting patient's care area; after contact with blood/body fluids/wound dressing or after glove removal; when moving from contaminated to clean body site during care

CDC Guidelines

Infection Control

- Agency must maintain a coordinated agency-wide program for surveillance, identification, prevention, control, and investigation of infectious/communicable diseases
  - Internal and external surveillance
- Agency must comply with state rules for reporting specific communicable diseases to department of health (handout)

Infection Education

- Provide education on current best practices for infection prevention and control to
  - Staff
  - Patients
  - Caregivers
- Specific to needs of patient, appropriate for educational level of patient/caregiver, timely and effective

Infection Control and QAPI

- Infection prevention and control must be integrated into QAPI
  - ID infectious and communicable disease problems affecting HH services
  - Track patterns and trends
  - Establish a corrective plan
  - Monitor for improvement and effectiveness of interventions

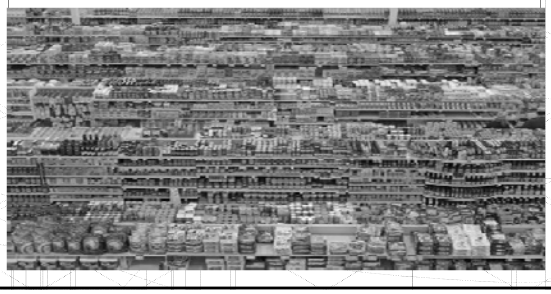
Key Elements of QAPI

- Proactive performance monitoring
- Data driven
  - Identification of opportunities
  - Measureable improvement from interventions
- Incorporate PI resulting from Infection Control Program surveillance activities
- Supervised by Governing Body
- Use of outside resources is allowed

Documentation Expectations

- Have written policies governing the HHA's approach to the development, implementation, maintenance and evaluation of the QAPI program
- HHA must maintain documentary evidence of its QAPI program and to demonstrate its operation during the survey process
  - Governing body agendas and meeting minutes reflecting their responsibilities, e.g. setting goals and approving agency QAPI plan and policy.
  - Meeting minutes that reflect the program is being implemented, evaluated, and updated as appropriate

Identify and Prioritize



What is the Focus?

High Risk	High Volume	Problem Prone
Risk for serious adverse outcome	Large % of patient population	Inconsistencies of processes or outcomes

- A topic may fall into more than one category

Examples

Issue	High Risk	High Volume	Problem Prone
Aftercare for joint replacement		X	
Pt with LVAD	X		
Timely initiation of care below average		X	X
HHA supervisory visits			X
Patients at risk for pressure ulcer		?	X
Stage 4 pressure ulcer	X		?
Heart failure	X	?	X

High Volume

Home Care Diagnoses			
Infections/parasitic diseases (%)	6.18%	4.57% ++	4.06% **
Neoplasms (%)	7.49%	8.29%	8.51%
Endocrine/nutrit./metabolic (%)	36.86%	34.00% +	42.77% **
Blood diseases (%)	10.75%	18.90% ++	8.89% **
Mental diseases (%)	12.54%	11.23%	27.43% **
Nervous system diseases (%)	19.75%	16.72% ++	25.33% **
Home Care Diagnoses			
Circulatory system diseases (%)	43.01%	42.62%	76.96% **
Respiratory system diseases (%)	13.23%	15.10% +	24.16% **
Digestive system diseases (%)	11.06%	10.13%	14.85% **
Genitourinary sys. diseases (%)	13.23%	13.89%	17.95% **
Pregnancy problems (%)	0.24%	0.18%	0.07% *
Skin/subcutaneous diseases (%)	8.69%	9.13%	11.58% **
Musculoskeletal sys. diseases (%)	53.45%	55.91%	48.22% **
Congenital anomalies (%)	0.79%	0.99%	0.57%
Ill-defined conditions (%)	64.96%	75.62% ++	35.21% **
Fractures (%)	7.21%	7.11%	5.79% **
Intracranial injury (%)	0.45%	0.37%	0.30%
Other injury (%)	2.95%	3.83%	4.73% **
Iatrogenic conditions (%)	5.87%	6.56%	3.70% **

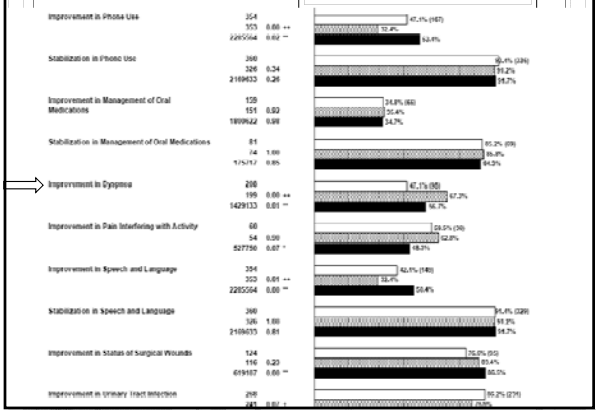
High Risk

SENSORY STATUS			
Sensory Status			
Vision impairment (0-2)	0.18	0.17	0.28 **
Hearing impairment (0-2)	0.24	0.25	0.38 **
Verbal content understanding (0-3)	0.24	0.23	0.50 **
Speech/language (0-5)	0.36	0.33 +	0.58 **
Pain interfering with activity (0-4)	2.52	2.57	2.27 **
PHYSIOLOGICAL STATUS			
Respiratory			
Dyspnea (0-4)	0.95	0.90	1.39 **
Oxygen therapy (%)	30.23%	29.58%	15.94% **
Ventilator therapy (%)	0.17%	0.18%	0.14%
CPAP / BPAP therapy (%)	7.01%	5.12% ++	2.77% **

Problem Prone

Reason for Emergent Care			
⇨ Improper medications (%)	4.76%	2.16%	1.16% **
Injury from fall (%)	8.40%	11.87%	7.66%
⇨ Respiratory infection (%)	11.76%	7.19%	8.62%
Other respiratory (%)	8.40%	7.55%	10.81%
Heart failure (%)	4.76%	4.32%	7.30%
Cardiac dysrhythmia (%)	1.40%	0.36%	2.75%
Myocardial infarction (%)	1.68%	1.08%	3.87%
Other heart disease (%)	1.12%	1.08%	1.89%
Stroke (CVA) or TIA (%)	2.24%	3.24%	2.36%
Hypo/Hyperglycemia (%)	1.40%	2.52%	1.91%
GI bleeding, obstruction, etc. (%)	3.36%	5.04%	3.83%
Dehydration, malnutrition (%)	5.88%	7.55%	4.63%
Urinary tract infection (%)	7.28%	9.35%	6.62%
IV catheter-related infection (%)	0.84%	1.08%	0.39%
Wound infection (%)	5.88%	6.83%	3.94%
Uncontrolled pain (%)	7.84%	9.35%	5.54%
Acute mental/behav. problem (%)	5.32%	4.32%	3.43%
Deep vein thrombosis (%)	2.52%	2.16%	1.21%
Other (%)	35.57%	28.06% +	37.34%
No emergent care (%)	86.59%	88.38% +	78.79% **

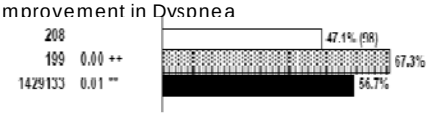
Problem Prone



Problem Prone

Risk Adjusted Outcome Report

Improvement in Dyspnea



Problem Prone

Trended Data Reports

Improvement in Dyspnea

Date	Events	Total Patients	You Observed	You RAO	SHP State (MO)	SHP National
January 2015	98	91	70.21%	69.89%	68.38%	71.66%
12 Months	1021	1,241	74.21%	71.81%	66.70%	66.66%

High Risk/Problem Prone

Potentially Avoidable Event Report

Emergent Care for Injury Caused by Fall

Complete Data Cases: 182 Number of Events: 1 Agency Incidence: 0.6% Reference Incidence: 1.3%

Patient ID	Last Name	First Name	Gender	Birth Date	SOC/ROC	DC/Transfer
654896104	Chis	Ron	M	05/11/1925	10/22/2010	01/27/2011

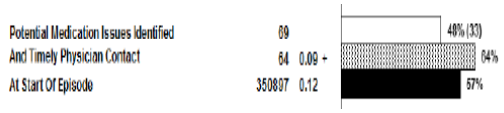
Emergent Care for Wound Infections, Deteriorating Wound Status

Complete Data Cases: 379 Number of Events: 1 Agency Incidence: 0.3% Reference Incidence: 1.2%

Patient ID	Last Name	First Name	Gender	Birth Date	SOC/ROC	DC/Transfer
601714911	Patterson	Cindy	F	10/03/1938	10/22/2011	12/23/2011

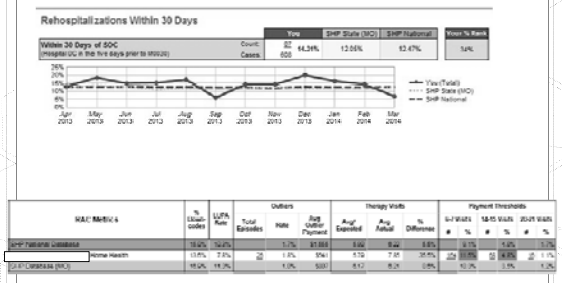
Problem Prone

Process Quality Report

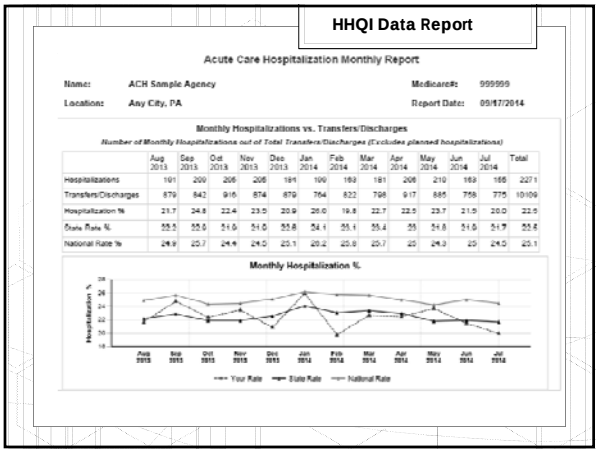


High Risk/Problem Prone

Other Benchmarking Reports



HHQI Data Report



High Volume
Problem Prone

HHCAHPS Data

A review of HHCAHPS data identified the following trend:
Q 22: In the last 2 months of care, when you contacted this agency's office did you get the help or advice you needed?

Date Range	% Yes	C2 Score	Comments
12 month average			
7/1/11 – 6/30/12	94%	90%	
7/12/12 – 6/30/13	87%	89%	
Quarterly Trends			
7/1/12 – 9/30-12	84%	90%	
10/1/12 12/31/12	93%	91%	
1/1/13 – 3/31/11	84%	87%	
4/1/13 – 6/30/13	86%	86%	

Prioritizing

Issue	High Risk	High Volume	Problem Prone
Diagnosis reporting/coding	X(a)	X	
Oxygen therapy	(TJC)	X	
Ventilator therapy	X		
Emergent care for improper meds			X
Emergent care for respiratory infection			X
Improvement in dyspnea	X		?
Timely MD contact for med issues			X
30 Day re-hospitalization		?	X
Help when calling in		X	X

Reflect the scope, complexity and past performance of the HHA's services and operations

Moving from QA to QAPI

Processes For Improvement

- Root Cause Analysis
- PDSA
- Rapid Cycle Improvement

Root Cause Analysis

- A way of looking at unexpected events and outcomes to determine ALL of the underlying causes of the event and recommend changes that are likely to improve them.

Why Root Cause Analysis Is Difficult

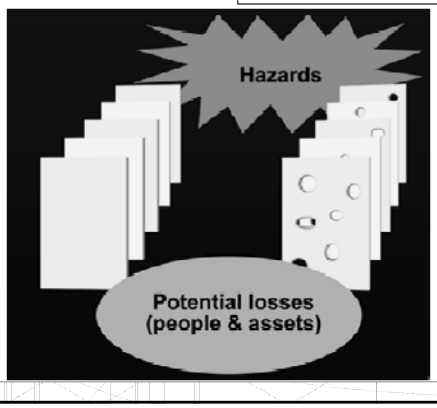
- Natural reactions to failure
- Stopping too soon
- False belief in a single reality
- "One Root Cause" Myth

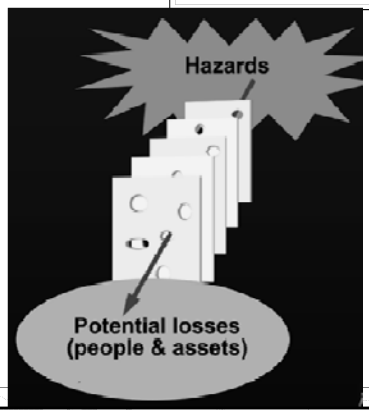
- Human error is generally NOT the cause of the events; it is an indication of a problem with the system

"The point of a human error investigation is to understand why actions and assessments that are now controversial made sense to people at the time. You have to push on people's mistakes until they make sense – relentlessly"

Sidney Dekker

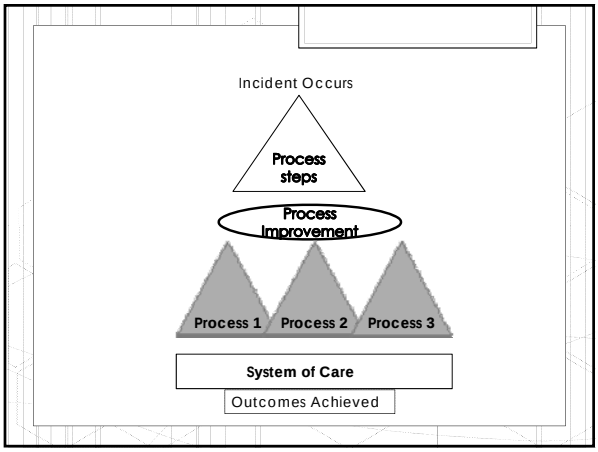
"Swiss Chees" Failure Model

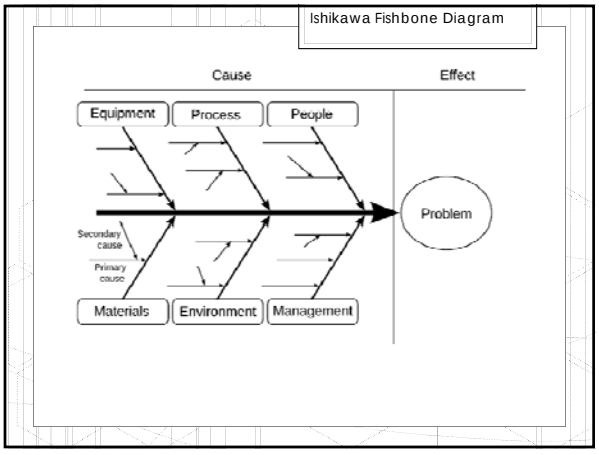




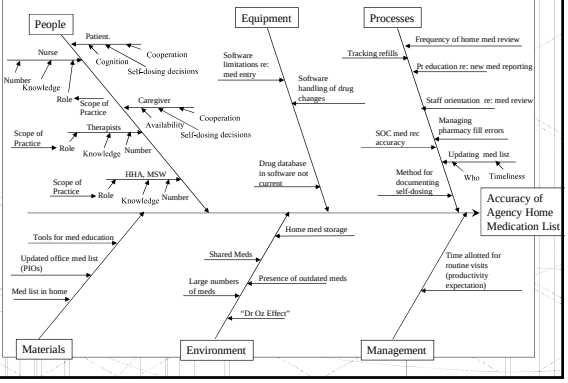
Incident vs Process Investigations

- Both look at underlying systems, human errors, and steps in the process used
- Goals of both are improving the underlying system of care and processes used to prevent adverse events and improve quality of care
- Starting points are different
  - Incident investigation starts with a single event and becomes broad
  - Process investigations starts with the trends and benchmarks and becomes narrower

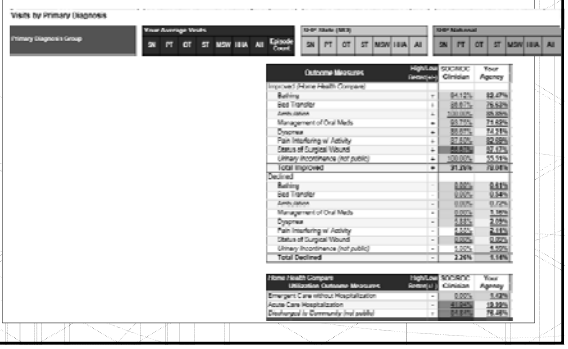




Causes of Variation



Data Sources for RCA



Prioritizing Actions: Evaluating the Risk of Failure

- Using a 1-5 or 1-10 scale, score each source of breakdown based on:
  - Severity or criticality
  - Frequency of occurrence
  - Ease of detection
- Risk priority is
  severity x frequency x detection

PDSA - Plan

- Problem statement and specific aim
  - What have to learned from your data and RCA – what seems to be the problem?
  - What is the reason this problem is a priority?
  - What are we trying to accomplish?
- Measurement
  - How will we measure the change?
  - Is the change an improvement? What is the starting point and what is the goal?

PDSA - Plan

- What are you planning to change to achieve your goal?
  - What steps are necessary to make the change happen?
  - Who is responsible for each of those steps?
  - What is the timeline for initiating and completing each of those steps?
  - What tools or training will need to be created?

PDSA - Do

- Complete your planned steps
- What happened?
  - Note problems - Were there issues completing any of the steps
  - Did you learn something new you hadn't thought of? Get feedback from the staff.

Do it…see what happens!

PDSA - Study

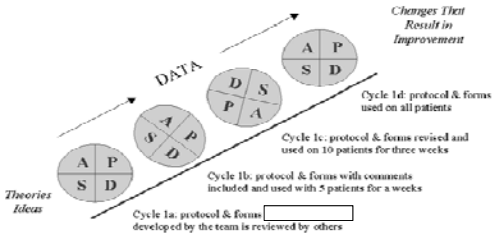
- Describe the measured results and how they compared to baseline
  - Did you see improvement?
  - Do you need to make additional/different changes?
  - Did the changes create new problems you hadn't anticipated? Made other outcomes or processes worse?

PDSA - Act

- What modifications need to be made to the plan based on what you learned?
- Did you achieve your aim and does your data reflect the desired improvement
  - If so, monitor for sustained change
  - If not, start the cycle again

Adopt – Adapt - Abandon

So What's Rapid Cycle Improvement?



Why Test?

- Increase the belief that the proposed change will result in improvement
- Identify how much improvement can be expected from the change
- Learn how to adapt the change to conditions in the local environment

Why Test?

- Evaluate the costs and side-effects of the change
- Minimize resistance upon implementation of the change

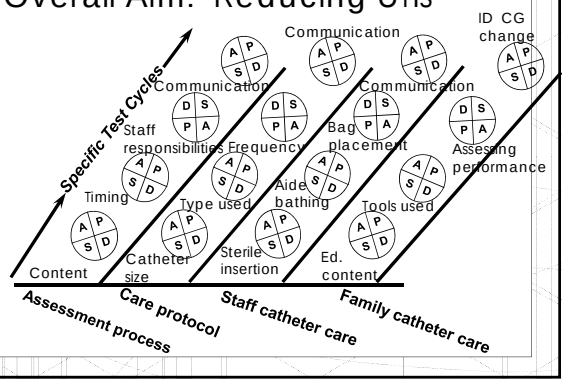
Tips for Testing on a Small Scale

- Have others that have some knowledge about the change review and comment on its feasibility
- Test the change on team members before introducing it to others
- Keep current processes in place while evaluating a new one

Tips for Testing on a Small Scale

- Conduct the test in one facility, in one department, on one shift, or with one patient
- Conduct the test over a short period of time
- Test the change on a small group of volunteers
- Develop a plan to simulate the change in some way

Overall Aim: Reducing UTIs



Challenges to PDSA

- Problem is too broad to be addressed by a single PDSA cycle or intervention
  - Focus on one piece at a time – What can we do by next Wednesday
- Getting staff buy-in for the change – do they believe there is a problem to be improved?
  - Can you identify and address their pain points?
  - Identify staff "champions" and use in training

Challenges to PDSA

- The first thing you try doesn't result in improvement – so why keep doing this?
  - Failed cycles are opportunities for learning
- Not having measurements of success
  - Outcome – e.g., clinical, staff satisfaction with change, etc.
  - Process – e.g., time to complete the process
- Committing the time to do it right
  - Must include people who are involved in the process

Sustaining Change

- Monitor the process - Is the new way still being carried out, or are people reverting to old habits?
- Monitor the data – is the improvement continuing
- Provide feedback to staff
  - Celebrate success!!

Part 2

Hungry for More?

- Developing an actual QAPI program
  - Clinical outcome improvement
  - Infection control measure improvement
  - Process measure improvement
  - Patient Satisfaction measure improvement
- Templates and Resources