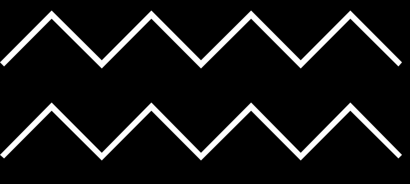
Making Your Quality Program "Stick"

A Short Case Study

Note: This is an interactive session…be prepared to talk



Objectives

Identify essentials of your QAPI program

Create tools and best practices for reporting

Establish methods for Continuous Quality Improvement

Note: This is a group discussion session.

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CQI

- What is CQI?
  - Deliberate, defined process
  - Focused on activities responsive to improving quality of care
  - Demonstrates progressive incremental improvement
- What is your hospital model?

CONTINUOUS QUALITY IMPROVEMENT PLAN

Department: Quality	
Effective Date: 2011	Approval Date: 9/16/2022
Revision Date: 9/15/2022	Approved By: Compliance Committee

Objectives of the Hospital Wide CQI Committee:

1. Assure quality patient care and reduce hospital medical malpractice and general liability through objective patient care evaluation and other CQI activities by centralizing all CQI activities.

2. Assure accountability, coordination, integration, and correction activities by centralizing all CQI activities in the CQI Committee.

3. Assure identification and correction of hospital-wide problems related to patient care and clinical performance.

4. Assure communication, reporting, and documenting CQI activities among Board of Trustees, hospital administration, Medical Staff, and support service department heads.

5. Assure that all Federal, State, and hospital CQI requirements are met.

6. To establish priorities for investigating and resolving problems using continuous monitoring of all patient care activities and services provided directly or indirectly.

QAPI Plan: Let's Start with The Reg's

Appendix W for CAHs

- https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/som107ap_w_cah.pdf

Appendix G for RHCs

- https://www.cms.gov/files/document/appendix-g-state-operations-manual

§485.641 - A CAH Must:

- Develop, implement and maintain
  - Effective
  - Ongoing
  - CAH-wide
  - Data-driven

  Quality Assessment and Performance Improvement Program

  Must demonstrate through evidence of the effectiveness of its QAPI program (show me the proof!)

C-0336 Program Design and Scope

§485.641: Quality Assessment and Performance Improvement Program

The CAH has an effective quality assurance program that:

1. Appropriate for the complexity of services provided
2. Ongoing and comprehensive
3. Involve all departments (even those under contract)
4. Use objective measures to evaluate the processes, functions and services (analysis and tracking)
5. Address the outcomes…improved health outcomes; prevention and reduction of medical errors, adverse events, CAH-acquired conditions, transitions of care, readmissions

Don’t forget C-0962 Governance and Leadership

Survey Procedures §485.627(a)

- Verify that the CAH has an organized governing body or has written documentation that identifies the individual that is responsible for the conduct of the CAH operations.
- Review documentation and verify that the governing body (or responsible individual) has determined and stated the categories of practitioners that are eligible candidates for appointment to the medical staff.
- Have the facility's operating policies been updated to fully reflect its responsibilities as a CAH (e.g., PA responsibilities, provision of required CAH direct services)?
- What evidence (e.g., minutes of board meetings) demonstrates that the governing body or the individual who assumes responsibility for CAH operation is involved in the day-to-day operation of the CAH and is fully responsible for its operations?

- §485.627(a) Standard: Governing Body or Responsible Individual
- The CAH’s governing body or responsible individual (designated in governing manual) for the CAH’s QAPI and responsible and accountable that QAPI meets the requirements
- Includes the quality of care provided to patients

C-1034

- §485.635(c) Services Provided Through Agreements or Arrangements
- *The governing body (or responsible individual) has the responsibility for ensuring that CAH services are provided according to acceptable standards of practice, irrespective of whether the services are provided directly by CAH employees or indirectly by agreement or arrangement*
- *The governing body must take actions through the CAH'S QA program to: assess the services furnished directly by CAH staff and those services provided under agreement or arrangement, identify quality and performance problems, implement appropriate corrective or improvement activities, and to ensure the monitoring and sustainability of those corrective or improvement activities.*

C-0342 (not new)

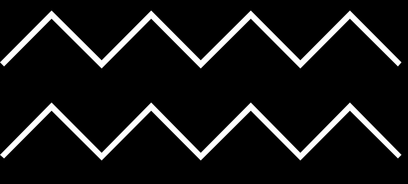
§485.641(b)(5)(ii)

- The CAH also takes appropriate remedial action to address deficiencies found through the quality assurance program.

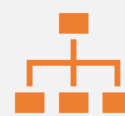
Consider for QAPI Plan

- Organization vision
- Organization mission
- Establish some guiding principles
  - What organization does, why it does it and how…as it pertains to Quality
  - Review the five elements of QAPI to capture the principles
- Define Scope of QAPI
- Guidelines for Governance and Leadership
- Data management, feedback, data systems/collection, monitoring and reporting
- Guidelines to PIPs (or your terminology)
- Overall Analysis (system-wide)
- Communicate and approve
- Evaluation of QAPI
- Plan Implementation and Ongoing Management

Purpose Statement for QAPI



What Do I Do in My Department?

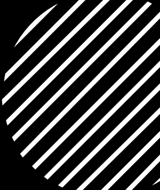


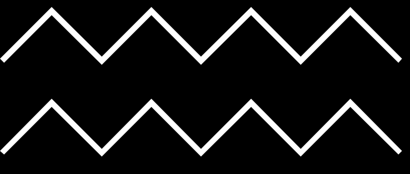
Every department **MUST** have *Quality Improvement* project(s)

Every department **MUST** have method to collect and report data

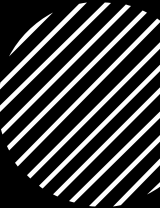
Every department **MUST** engage staff in QI

Every department **MUST** report data to the Board





What is Your Department Measuring?



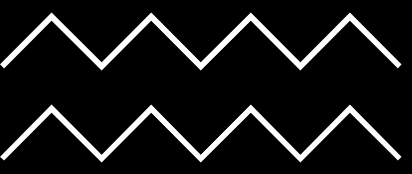
What is the 'pain' point?

- Staff engaged in identification?
- Same thing year over year?
- Does it make sense?

How are you measuring the project?

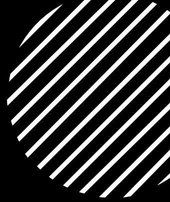
- Staff pulling data? Trending?
- Is there a target goal? Numerator/denominator?
- Graph of current performance to target?

Think about organizational framework: PDSA, DMAIC, Lean, other...are you using designated framework? How are you getting to CQI?



Is the Data Relatable? Understandable?

Presentation is Essential!



Systems and processes (e.g., flow diagrams).

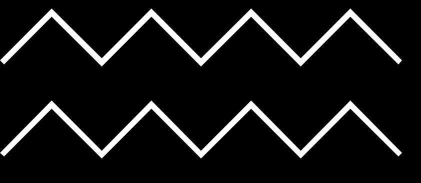
Gathering information (e.g., forms for collecting data).

Organizing information (e.g., cause and effect diagrams).

Understanding variation (e.g., run charts to determine if variation is special cause or common cause).

Understanding relationships (e.g., scatter plots).

Project management (e.g., Gantt charts).



When and Where to Report Department Data

Departmental CQI Calendar 2023

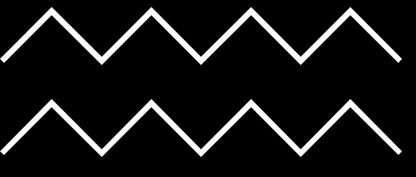
	Jan	Feb	March	April	May	June	July	August	Sept	Oct	Nov	Dec
Med Records	√			√			√			√		
Radiology	√			√			√			√		
Respiratory Therapy	√			√			√			√		
Dietary	√			√			√			√		
Human Resources	√			√			√			√		
Housekeeping	√			√			√			√		
Swing Bed	√			√			√			√		
Medical Unit		√			√			√			√	
ED		√			√			√			√	
Senior Life		√			√			√			√	
Maintenance		√			√			√			√	
IT		√			√			√			√	
Social Services		√			√			√			√	
PT/OT/ST		√			√			√			√	
Compliance/RM		√			√			√			√	
Wound Care			√			√			√			√
CFMC/WFPA/FT/CC			√			√			√			√
MORA			√			√			√			√
Pharmacy			√			√			√			√
Laboratory			√			√			√			√
Registration			√			√			√			√

When does the department review data? Performance?

Where does the data go from here?

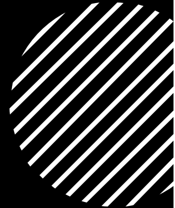
- Quality Committee?
- Med Staff?
- Board?

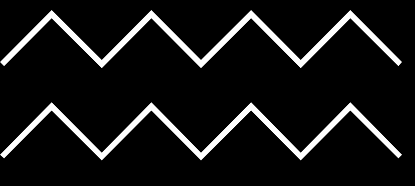
Are you reviewing with your senior leader? Quarterly? PRN?



Discussion Point: Accountability

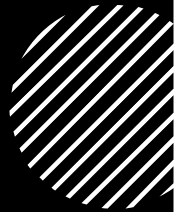
- Departments are not reporting measures
- Departments are not sharing quality measures (staff awareness)
- There are no pressures from senior manager for reporting
- Board does not recognize the role of accountability for reporting





Continuous Quality Improvement

What is the story?



How are we doing?

Can we do it better? More efficiently?

Are we effective?

Discussion: Our platform for CQI?

Current CQI Template

Tyler Holmes Memorial Hospital ~ CAH
Departmental CQI
Department: ______________

Time Frame of Study:

Indicator:

Findings:

Threshold:
Compliance:

Action Plan/Loop Closure:

Report completed by:_______________________

Model for Continuous Quality Improvement

Departmental CQI: PDSA or PDCA

GOAL: *What is your target goal? By WHEN?*

PLAN: *What are we trying to improve? WHY? What led up to this opportunity?*

DO: *What are we measuring? HOW are we measuring? Detailed description of how you will collect your data. Can others collect the data based on your description?*

STUDY/CHECK: *What is your data telling you? Are you meeting the goal? Why or why not? What is the explanation of your findings?*

ACT/ACTION: *What are your ideas for solutions? Activate a new action plan? Test new methods? DO NOT use continue to monitor!!!*

ANNUAL SUMMARY: *Summary of your year long analysis, did you meet your goals? What activities worked to make improvements? Any follow-up activities/actions? Will you continue next year? Why or why not?*

Let’s Do One Together

Tyler Holmes Memorial Hospital ~ CAH
Departmental CQI: PDSA or PDCA

Department: ______________ **Manager/Person: Responsible**___________________

GOAL: *What is your target goal? By WHEN?*

PLAN: *What are we trying to improve? Why? What led up to this opportunity?*

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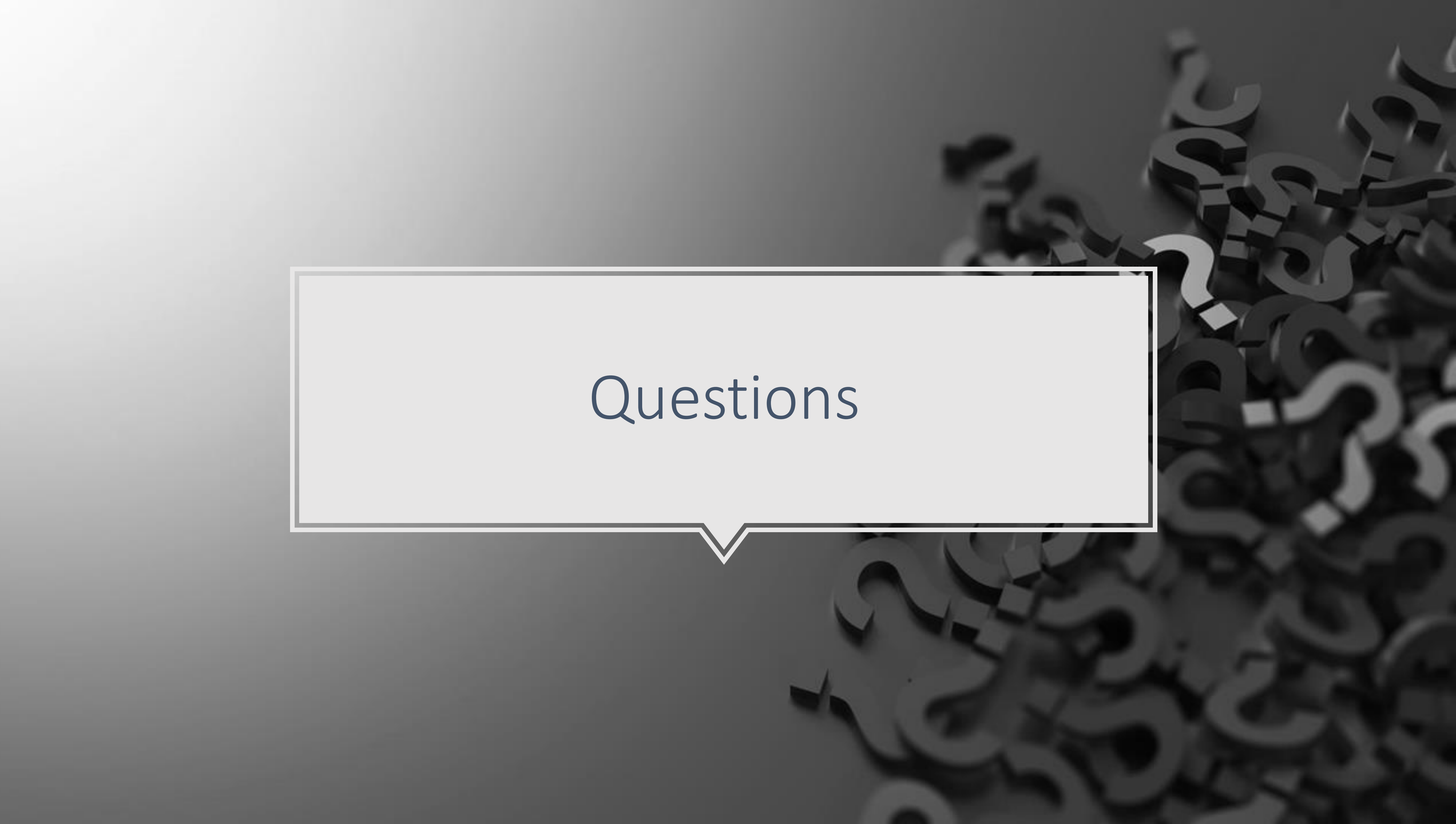
Questions

Thank You Partners!