Performance Improvement 101

Wednesday, February 17, 2016

About the Alliance

- 501(c)(3) non-profit research foundation

- Mission: To support research and education on the value home health care can offer to patients and the U.S. health care system. Working with researchers, key experts and thought leaders, and providers across the spectrum of care, we strive to foster solutions that will improve health care in America.

- *www.ahhqi.org*

About VNAA

- 501(c)(3) non-profit research foundation

- VNAA is a national association that supports, promotes and advances mission driven providers of home and community-based healthcare, hospice and health promotion services to ensure quality care for their communities. VNAA members share a mission to provide cost- effective and compassionate care to some of the nation's most vulnerable individuals, particularly the elderly and individuals with disabilities.

- *www.vnaa.org*

Today's Speaker

Barbara Muntz, RN, BSN, MTS
Senior Advisor, Community Healthcare Accreditation Program (CHAP)

Barbara Muntz obtained her nursing education at Texas Christian University, and holds a Master of Theological Studies from Brite Divinity School. Her clinical practice has centered on home care, hospice and healthcare quality. After many years as a home care and hospice nurse, Barbara worked for Texas Health Resources (THR), a multi-hospital health care delivery system with 14 hospitals in North Texas. While serving as THR's Corporate Vice President for Performance Improvement, she led system-wide efforts to implement evidence based practice to improve health outcomes, especially focusing on preventing re-hospitalization of older adults. More recently, Barbara served as Chief Nursing Officer for the Visiting Nurse Association of Texas, where she provided executive leadership for a variety of programs serving seniors throughout North Texas. While in Texas, Barbara served on the Board of Directors for the Texas Association of Home Care and Hospice and was listed as a Great 100 Nurse in 2005. In 2013, Barbara joined the Community Healthcare Accreditation Program (CHAP) as Senior Vice President of Accreditation, where she now serves as Senior Advisor. CHAP acts as a CMS deeming authority and accredits approximately 8000 community based health care organizations including home health agencies, hospices, home medical equipment providers and pharmacies.

Today's Webinar

- During the presentation submit questions to the moderator through the webinar chat box.

- Slides will be made available to participants following the webinar.

Home Health: Designing and Implementing a QAPI Program That Delivers Value

Today's Faculty

Barbara Muntz, RN, BSN, MTS

Senior Advisor

Community Health Accreditation Partner

Objectives

❑ Identify key components of the CMS proposed Home Health QAPI Condition of Participation (CoP) and Value Based Purchasing Pilot

❑ Identify CMS Home Health Value Based Purchasing Measures

❑ Describe 3 elements of an effective Home Health QAPI program

❑ Examine models for QAPI programs – choosing what is best for your organization

❑ Choose and design measures that matter

❑ Understand how to use QAPI to improve care: a case study

Value Based Purchasing: Key Elements

1. Standardized Performance Measurement
2. Transparency and Public Reporting
3. Payment Innovation
4. Informed Consumer Choice

Source: National Business Coalition on Health

The Value Equation in Health Care

Home Health
Value Based Purchasing Pilot

- Effective date January 1, 2016

- Nine states participating

- Ten Outcome Measures

- Six Process Measures

- Five Home Health CAHPS Measures

- Three New Measures

The Knowledgable Nine

- Massachusetts
- Maryland
- North Carolina
- Florida
- Washington
- Arizona
- Iowa
- Nebraska
- Tennessee

The rest of us go to school

Proposed Home Health COPs

❑ The proposed QAPI Condition has 5 standards
  – Program scope
  – Program data
  – Program activities
  – Performance improvement projects
  – Executive responsibilities

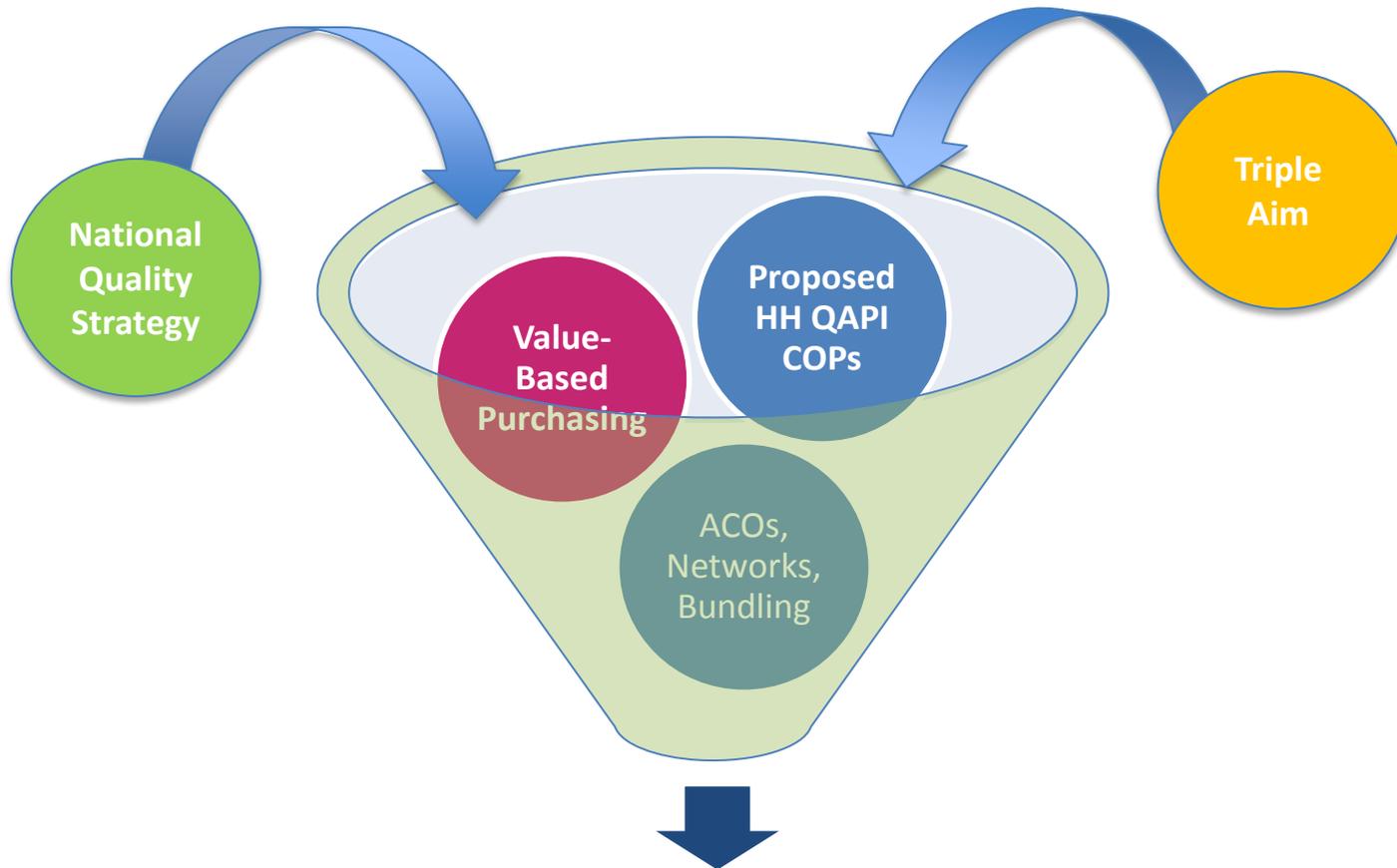❑ QAPI is also woven into other standards in other sections of the proposed CoPs.

In essence…

❑ Governing body oversight and approval

❑ PAC and/or quarterly clinical record review replaced with *agency-wide* participation

❑ Selection of a number of projects and a scope for each project, appropriate to the "scope, complexity and past performance of the HHA's services and operations."

❑ Requirements for a detailed, objective, ongoing and well-documented QAPI effort.

❑ Use of objective measures, such as data, to track agency performance.
  – Identify standards against which performance can be measured
  – Determine actions that will lead to improvement of the measures selected
  – Implement processes and (re)measure outcomes
  – Continue to track performance to ensure gains are maintained
  – Reports to governing body

The Great Convergence

National Quality Strategy

Value-Based Purchasing

Proposed HH QAPI COPs

ACOs, Networks, Bundling

Triple Aim

A New Era For Home Health Care

Producing & Demonstrating Value

QA/PI: One Coin…Two Sides

Quality Assurance

✓ **Data-driven**

✓ **Retrospective**

✓ **Reactive**

✓ **Problem-oriented**

✓ **Compliance**

Performance Improvement

✓ **Data-driven**

✓ **Proactive**

✓ **Future Focused**

✓ **Ongoing Improvement**

✓ **Sustainability**

Source: CMS.gov

Key Programmatic Aspects that Support Sustained Success

❑ An organization-wide commitment to quality improvement;

❑ Team-based approaches to identify opportunities for improvement that involve patients and personnel from all levels of the organization;

❑ Adoption of evidence-informed program goals that are measureable and linked to the organization's mission;

❑ Defined roles and responsibilities for achieving program goals;

❑ Data-driven approaches to understanding performance;

❑ A proactive approach to identifying the underlying cause(s) of error or failure;

❑ Systematic integration of findings into performance improvement activities; and

❑ Continuous review of progress against established goals and associated timeframes.
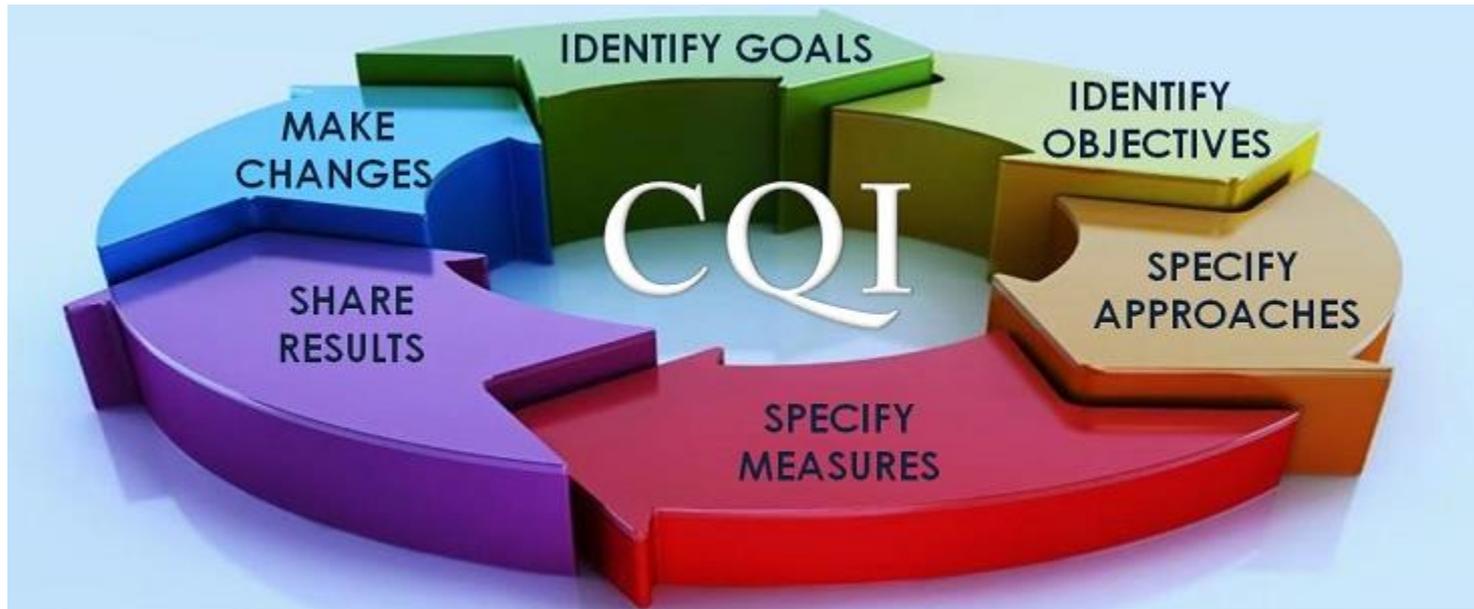
Established models that support QAPI

Common Elements

- Systematic Approach
- Use of data and information
- Ongoing cycles of improvement
- Sustain the gains

Performance Improvement Models
Continuous Quality Improvement (CQI)

Source: http://www.hornbyzeller.com/services/continuous-quality-improvement/
Also see: http://www.rwjf.org/en/how-we-work/rel/research-features/evaluating-CQI.html;
http://www.hrsa.gov/quality/toolbox/methodology/qualityimprovement/

Performance Improvement Models
Lean/Six Sigma

Lean Six Sigma: DMAIC

DEFINE	MEASURE	ANALYZE	IMPROVE	CONTROL
Define the problem.	Map out the current process.	Identify the cause of the problem.	Implement and verify the solution.	Maintain the solution.

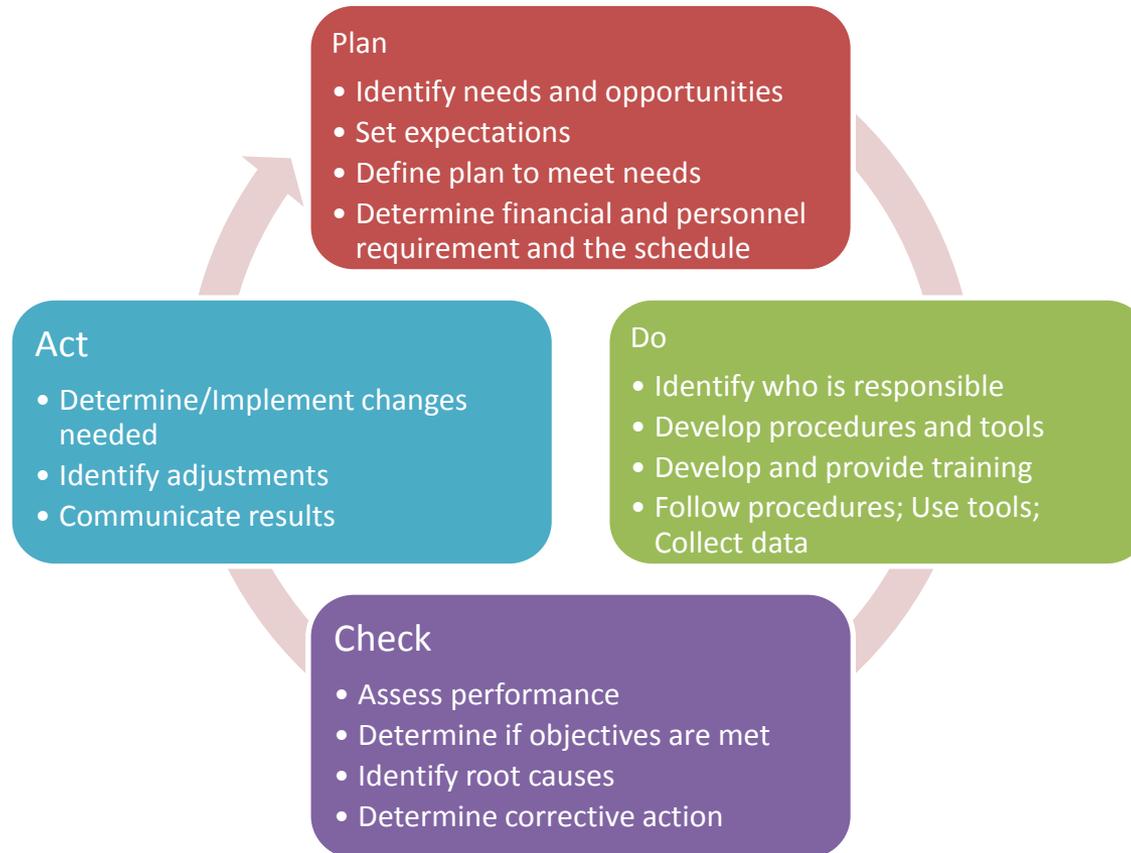Source: http://goleansixsigman.com
Also see: http://www.lean.org; http://www.isixsigma.com/dictionary/dmaic/

Performance Improvement Models
PDCA

Plan
- Identify needs and opportunities
- Set expectations
- Define plan to meet needs
- Determine financial and personnel requirement and the schedule

Do
- Identify who is responsible
- Develop procedures and tools
- Develop and provide training
- Follow procedures; Use tools; Collect data

Check
- Assess performance
- Determine if objectives are met
- Identify root causes
- Determine corrective action

Act
- Determine/Implement changes needed
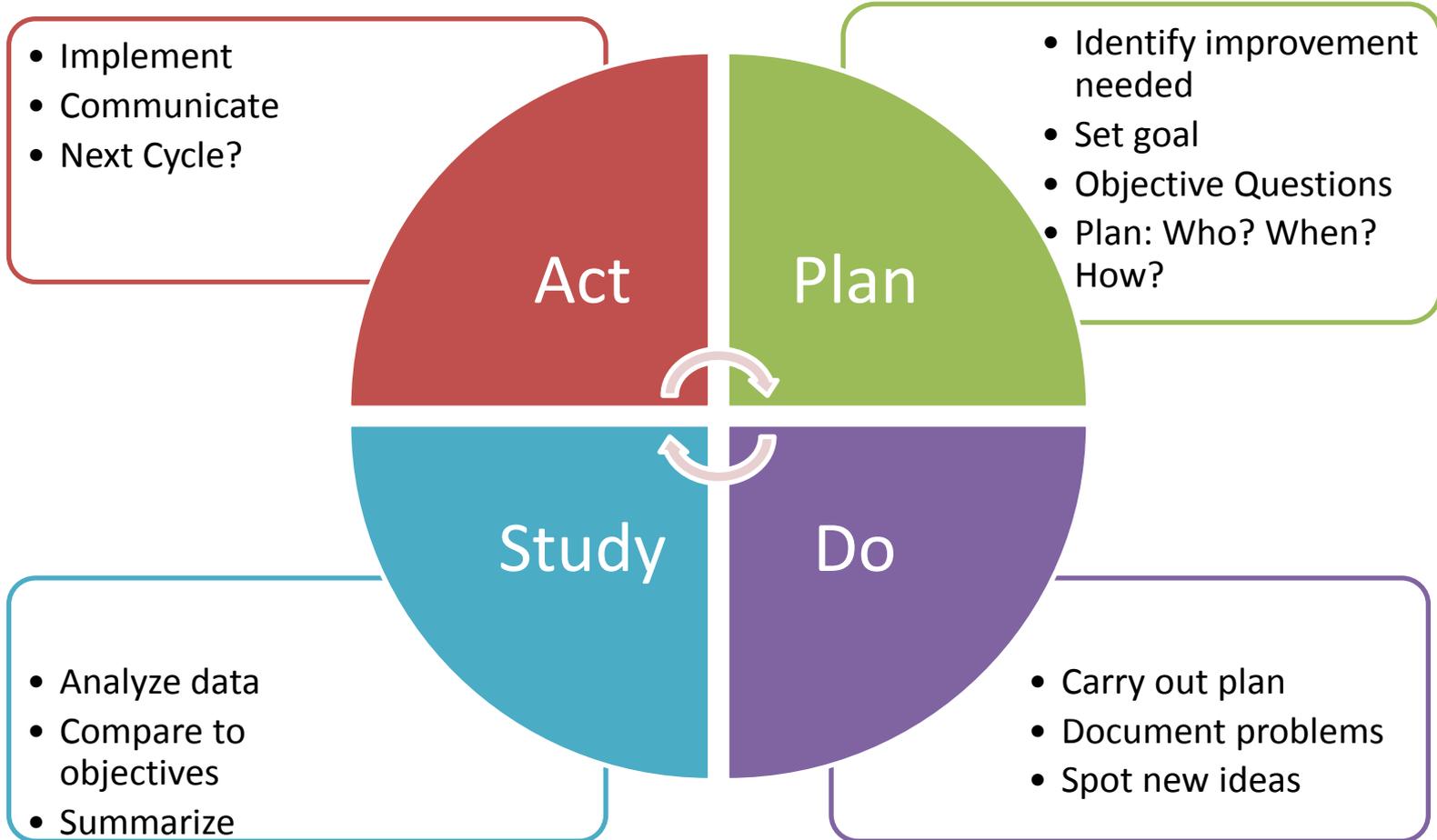- Identify adjustments
- Communicate results

Also see: http://www.washington.edu/research/rapid/resources/toolsTemplates/plan_do_check_act.pdf
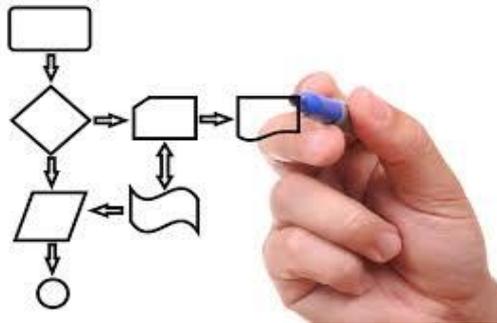
Performance Improvement Models
PDSA

- Implement
- Communicate
- Next Cycle?

- Identify improvement needed
- Set goal
- Objective Questions
- Plan: Who? When? How?

Act   **Plan**

Study   **Do**

- Analyze data
- Compare to objectives
- Summarize

- Carry out plan
- Document problems
- Spot new ideas

Also see: http://www.ihi.org/resources/Pages/HowtoImprove/default.aspx

The role of data collection, analysis and monitoring

❑ Directly related to the goals/objectives (e.g., reduced hospital (re)admissions) and a way to *evaluate* and *improve* care

❑ Foundation for data/fact-based decision making
 – Removes the guesswork
 – Is this really a problem? How large?
 – Can validate gut-instincts

❑ Promotes sustainability in effectiveness of processes implemented

❑ Serves as documentary evidence of the program and will facilitate demonstration of its operation *(Note: a CoP requirement)*

❑ Measures increasingly being tied to payment (Value-Based Purchasing, Pay-for-Performance)

Types of Measures

Process

Outcome

Patient Experience

Structure

Focus Areas for Measure Selection

- ✓ High risk, high volume, or problem-prone areas
- ✓ Adverse patient events
- ✓ Indicators related to health outcomes, patient safety, and quality of care, including hospital admissions and re-admissions
- ✓ Performance across the spectrum of care, including the prevention and reduction of medical errors.
- ✓ Measures derived from OASIS, HHCHAPS, Casper Reports or Star Ratings
- ✓ Other potential areas: Trends in claim denials, referral to admission conversion rates, field productivity and adequate staffing.

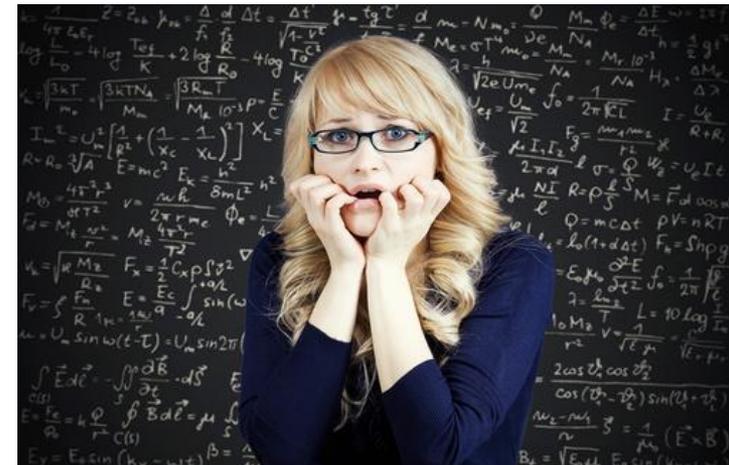# The "Simple" Approach to Measurement Math: Calculating a Rate

$$\frac{\textbf{Numerator}}{\textbf{Denominator}} \quad \textbf{X 100}$$

Example: ¾ = .75

.75 X 100 = 75%

The "Simple" Approach to Measurement Math: Calculating a Rate

Raw Numbers

"We had 4 patients admitted to the hospital this month."

Q: Is that good or bad?

Rate or Percentage

Out of 125 patients on service this month, 4 were admitted to the hospital

4/125= 0.032

0.032 X 100 = 3.2
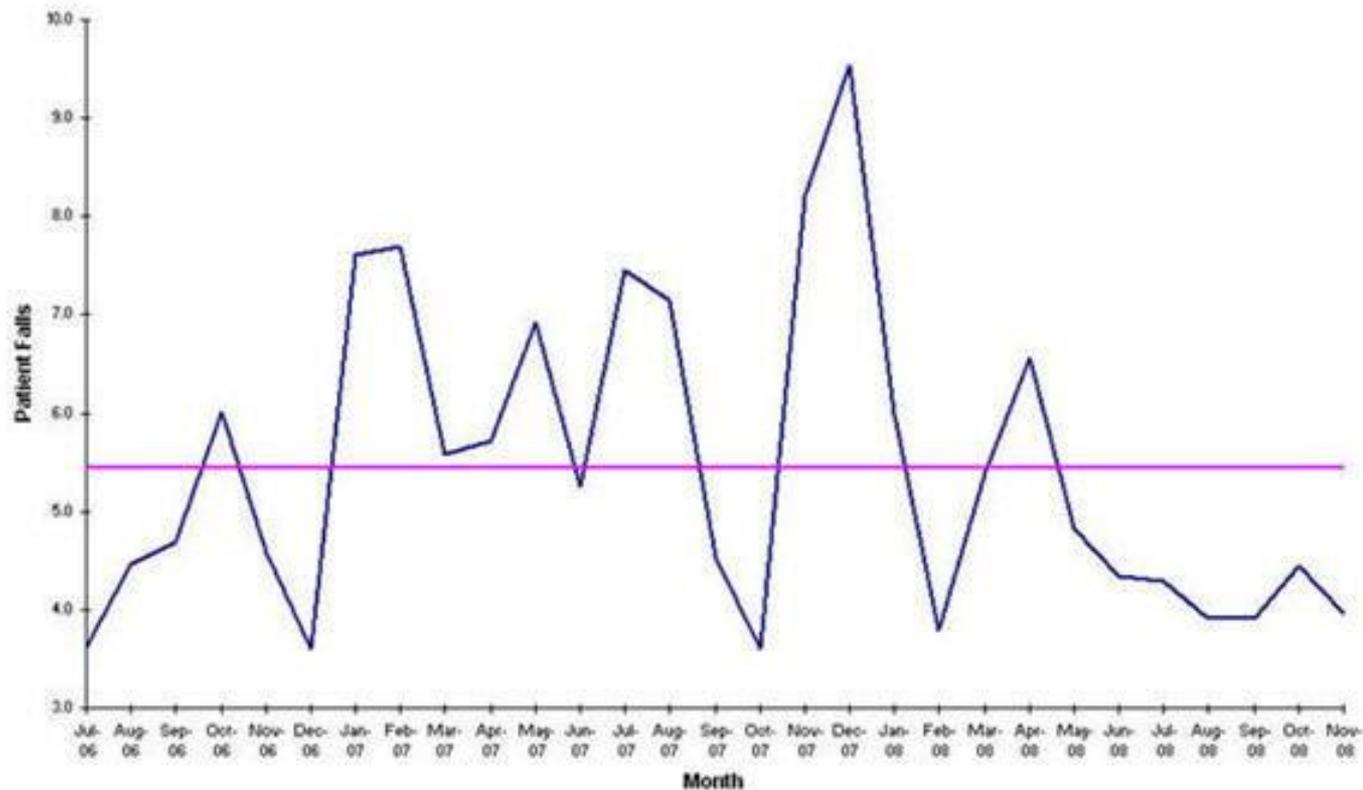
Hospitalization rate = 3.2%

Strategies for Applying Measurement Findings to Improve Performance

- An average or median can be tracked over time
  - Demonstrates how did you do in Q1 vs. Q4?; or
  - Used to compare your performance to other like providers (e.g., Home Health Compare offers state and national averages)

- Visual representations may offer a useful strategy for offering an easy to interpret "picture" of performance that can be understood by personnel at all levels of the organization
  - Run charts demonstrate progress over time;
  - Tables more likely to offer a "snapshot" of performance at a set point in time

The Problem with Averages

Patient Falls

A QAPI Story

Many patients at Fran's Home Health were being readmitted to the hospital. At its June meeting, the Board of Directors discussed the issue and made a commitment to help its patients stay at home and out of the hospital. The Board discussed the need to reduce hospitalizations as part of the new Value Based Purchasing Model being implemented in their state. The chair of the Board asked Fran to lead a QAPI project to reduce hospitalizations over the next nine months. She is to report back to the Board quarterly on her progress. This request was recorded in the meeting minutes.

Just last month Fran had learned about the PDSA model and has adopted it in her agency. Fran left the Board of Director's meeting and got to work.
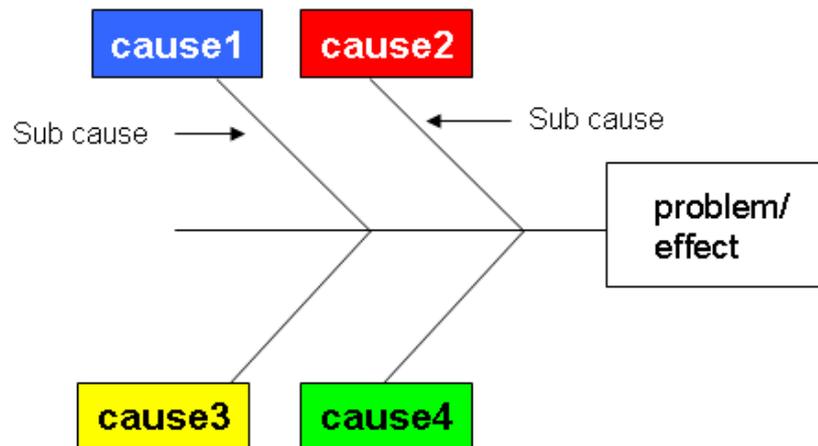
PDSA Model

Act
- Implement
- Communicate
- Next Cycle?

Plan
- Identify improvement needed
- Set goal
- Ask questions – Why?
- Plan: Who? When? How?

Study
- Analyze data
- Compare to objectives
- Summarize

Do
- Carry out plan
- Document problems
- Spot new ideas

Also see: http://www.ihi.org/resources/Pages/HowtoImprove/default.aspx

Plan: What Fran Learned

- Based on her initial analysis, Fran determined:
  - 60 day readmission was 19% in June, 2014
  - 90% of readmissions were people with heart failure (HF)
  - 60% of the readmissions occurred on Monday or Tuesday following a Friday discharge from the hospital
  - 20% of readmissions occurred on a weekend

- Lesson
  - Looking at data in multiple ways (segmentation) helps reveal root causes.
  - Thorough understanding of a problem aids decision on goal setting and the best action(s) for improvement

Plan: Fran asks why

With a fishbone analysis, Fran learned:

1) New patients referred on Friday were not admitted until Monday. They didn't understand their meds, how to get help, what to eat. By Monday, they were often already "in trouble" and had to go back to the hospital.

2) Most HF patients didn't weigh daily and did not have prn orders for meds.

3) Heart failure patients were usually admitted with orders for 2wk2, 1wk6. Not enough visits at beginning to learn self-management.

Plan: Fran's Goal

Once Fran really understood the issues, she set a goal for improvement

Reduce the 60 day readmission rate from 19% to 15% by December 31, 2015

Is Fran's goal SMART?

Do: What Fran Did

- Met with her team to describe the issues and opportunity for improving care

- Based on the initial analysis, the team decided to:
  - Increase weekend staffing by each working one weekend per month to conduct admission visits, and comprehensive assessments on the first day after hospital discharge.
  - See all HF patient daily X3 at their start of care. Focus on teaching self care to avoid returns to the hospital
  - The office manager would make daily calls to patients (for two weeks) to check on results of daily weights.
  - For each patient with HF, the primary nurse discusses prn diuretic order with the patient's physician.

- Lesson
  - Data driven decision making: Actions are targeted to most frequent identified root causes (HF patients, weekends, front loading visits, and prn meds)
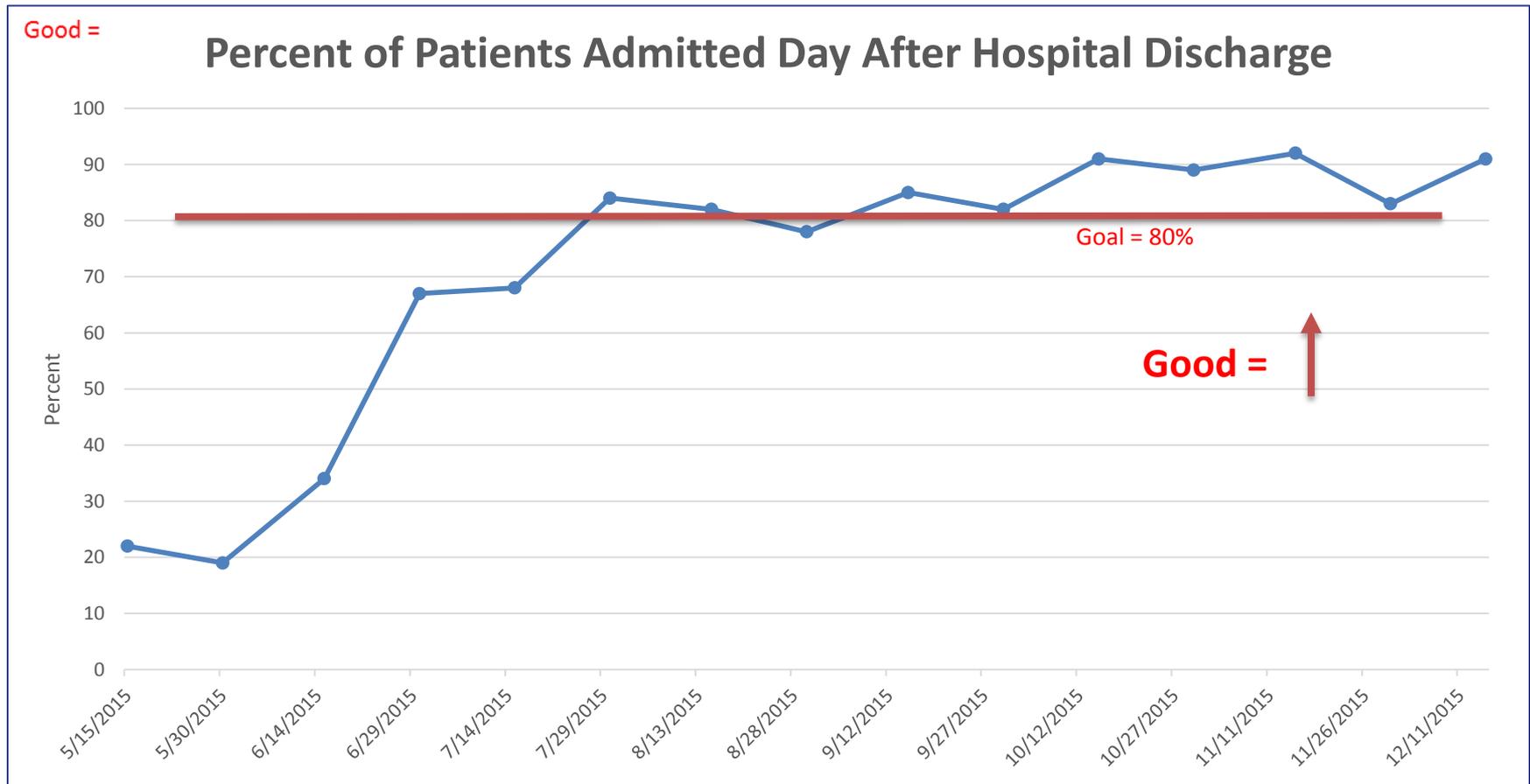 - Thorough understanding of a problem helps team members buy in to solutions
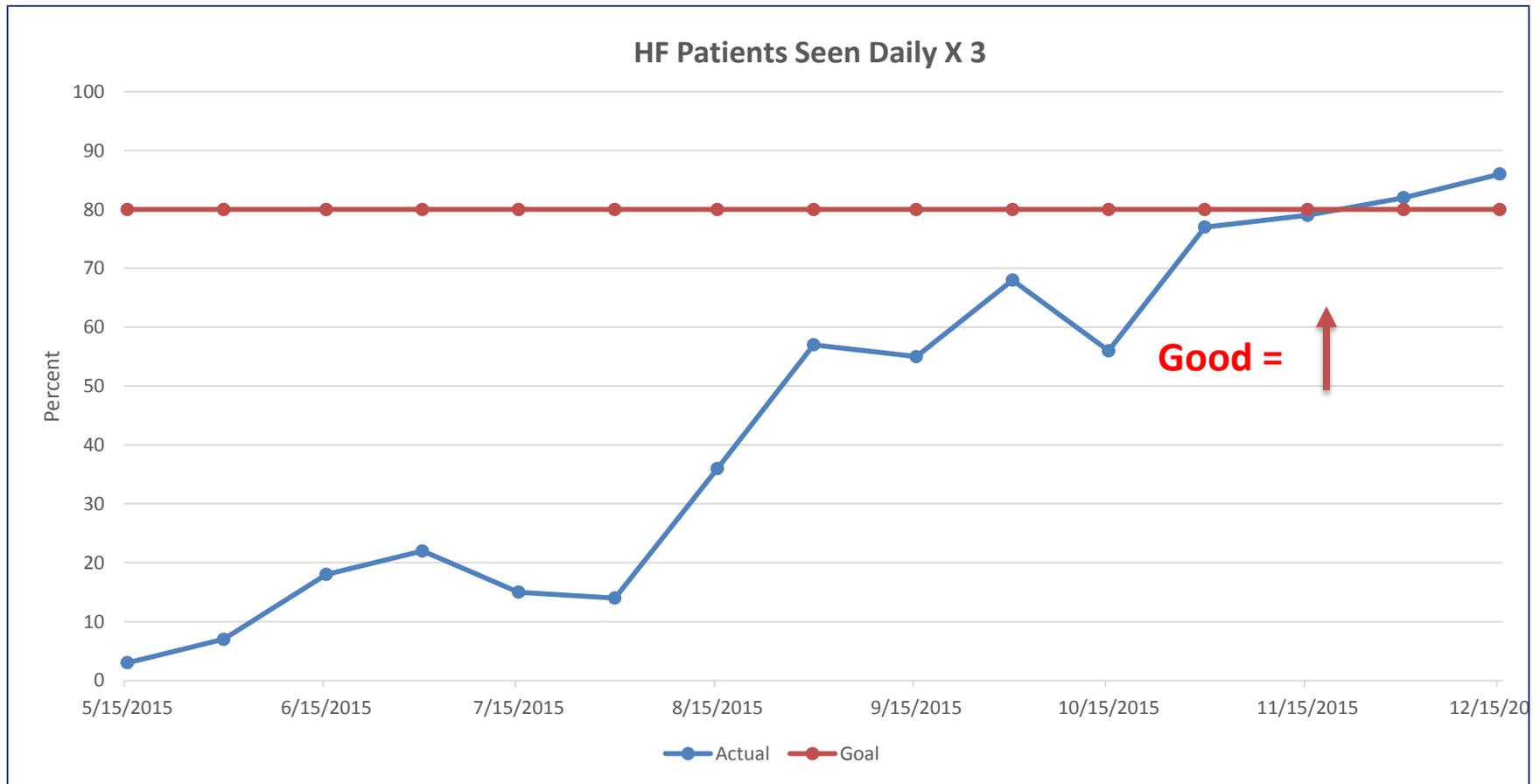
Study: What Fran Monitored

- **Process measures**
  - Percent of patients admitted to agency on day following hospital discharge.
    - Measured every two weeks
      - #pts admitted / # of pts discharged X 100

  - Percent of HF pts seen daily X3
    - Measured every two weeks
      - #HF pts see daily X 3 / #HF pts admitted X 100

  - Percent of HF pts reporting a daily weight at least 60% of the days called
    - Measured every Monday for the week prior

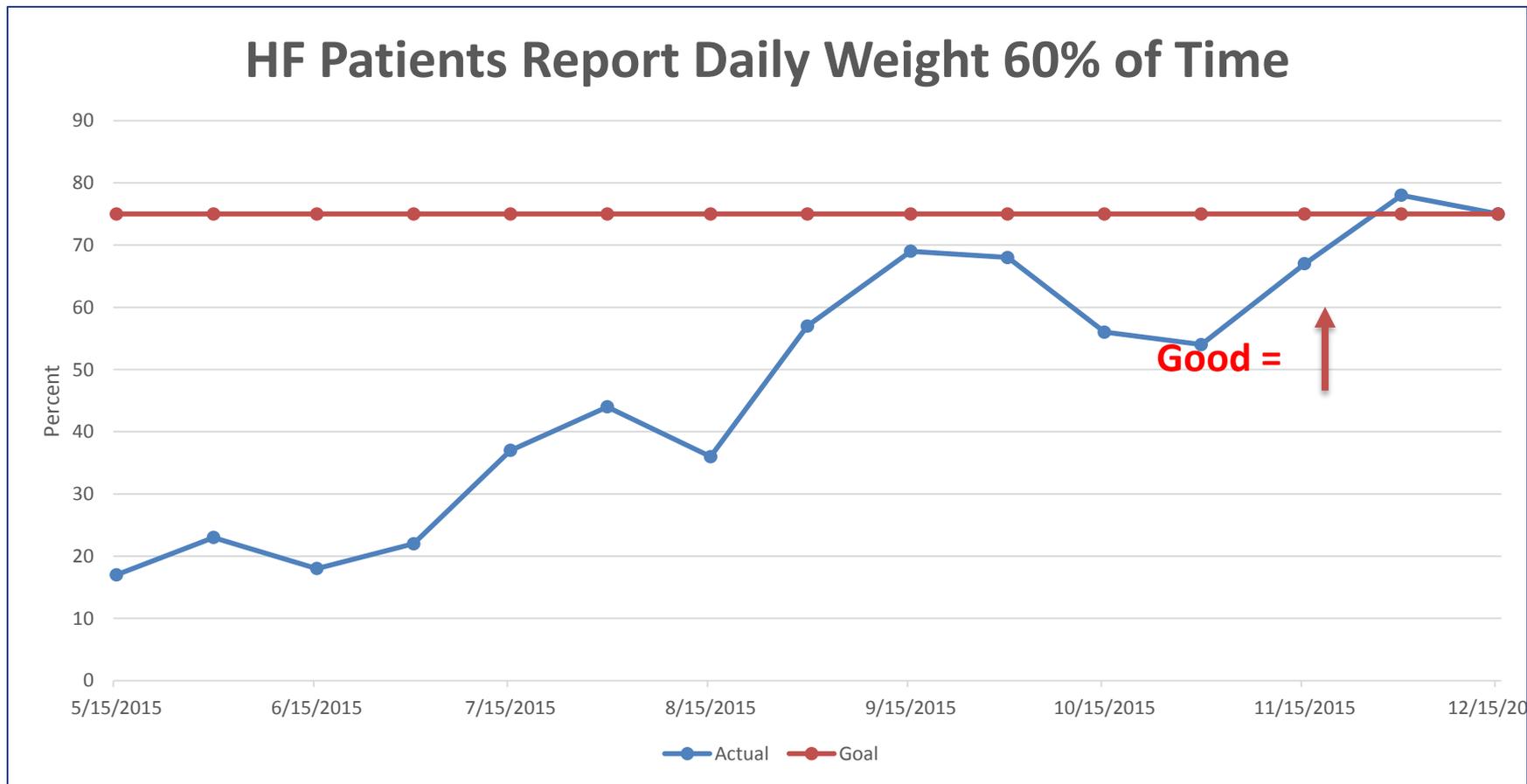- **Outcome measure**
  - Hospitalization rate

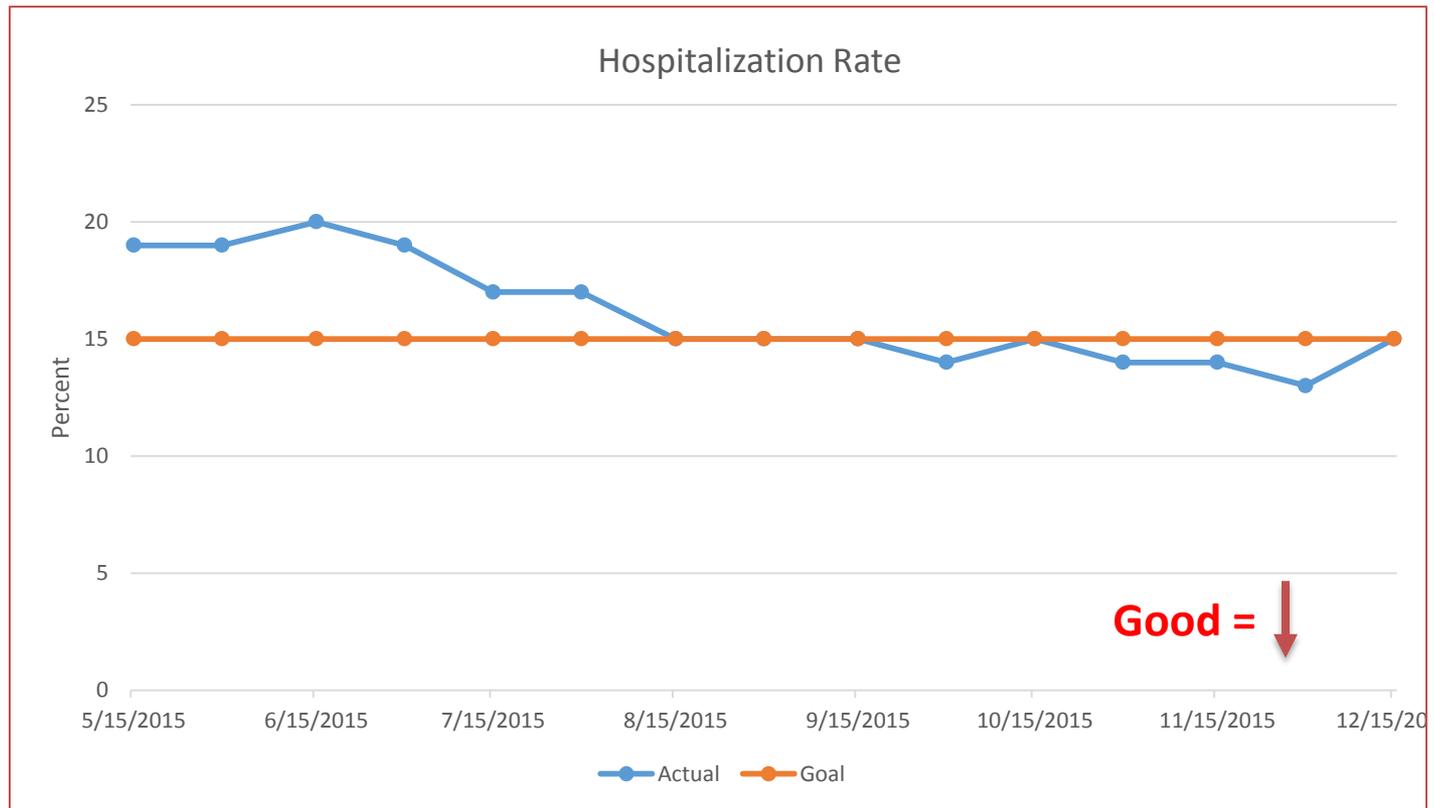# Study: How Did Fran's Team Do?

Percent of Patients Admitted Day After Hospital Discharge

Study: How Did Fran's Team Do?

HF Patients Seen Daily X 3

Study: How Did Fran's Team Do?

HF Patients Report Daily Weight 60% of Time

Good =

Study: How Did Fran's Team Do?

Hospitalization Rate

Good = ↓

Actual   Goal

CHAP
Community
Health
Accreditation
Partner

1275 K Street NW, Suite 800 / Washington, DC 20005

Act: Fran Continues to Improve

- Reduce frequency of measures but don't drop them
- Find new opportunities for improvement. Some that Fran is considering:
  - Daily X 3 visits for other patients with high-risk diagnoses (diabetes, emphysema, multiple co-morbidities)
  - Extra OASIS training for weekend staff
  - Working with local hospitals and physician partners to encourage mid-week discharge of HF patients

- Report successes to care team and the Board of Directors
- Celebrates her team's great work!!

Next Steps

Questions??

For Further Information or Questions

chapeducation@chapinc.org

And

Check the CHAP Education Webpage

CHAP

Community Health Accreditation Partner

1275 K Street NW, Suite 800 **/** Washington, DC 20005

Discussion & Questions

- As a reminder, you may submit questions to the presenter through the webinar chat box.

- The next webinar, "Measure Performance Improvement" will be on Wednesday, March 9th at noon ET. Register here: http://bit.ly/1SmbA5A