Home Health Solutions, LLC

Partners in Care

Quality Improvement and Performance Improvement

CoP-484.65

Objectives

- Review the new Quality Assessment and Performance Improvement Standards
- Identify the current state of home health quality and why systematic improvement is necessary
- Identify CMS suggested phases of implementation.

What Is QAPI?

- QAPI is the merger of two complementary approaches to quality management, Quality Assurance (QA) and Performance Improvement (PI). Both use quality-based information but differ in key ways.
  - QA is a process of meeting quality standards and assuring that care reaches an acceptable level. QA is a reactive, retrospective effort to examine why a facility fails to meet certain standards. QA activities do improve quality, but efforts frequently end once the standard is met.
  - PI (also called Quality Improvement - QI) is a pro-active, 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.

What Is QAPI?

- QAPI is defined by CMS as "an initiative that goes beyond the current Quality Assessment and Assurance (QAA) provision, and aims to significantly expand the intensity and scope of current activities in order to not only correct quality deficiencies (quality assurance), but also to put practices in place to monitor all nursing home care and services to continuously improve performance."
- **Quality Assurance (QA)** = the process of meeting quality standards and assuring that care reaches an acceptable level.
- **Performance Improvement (PI)** = continuously analyzing your performance and developing systematic efforts to improve it; also known as Quality Improvement.

New CoPs regarding QAPI

- §484.65-Requires HHAs to develop, implement, maintain and evaluate an effective, data driven quality assessment and performance improvement program.
- Five Standards
  - Program Scope
  - Program Data
  - Program Activities
  - Performance Improvement Projects
  - Executive Responsibilities

Time and Cost

Standard	Time per HHA	Total Time	Cost per HHA	Total Cost
Identify Domains and measures (yr. 1)	9 hours	68.670 hours	$738	$5,630.940
Train staff (yr 1 and ongoing)	24 hours	183,120 hours	$1,824	$13,917,210
Aggregate data (1st year and on-going)	48 hours	366,240 hours	$1,248	$9,522,240
Update domains and measures (on-going)	3 hours	22,890 hours	$246	$1,876,980
TOTAL 1st year	81 hours	618,030 hours	$3,810	$29,070,300
TOTAL yearly ongoing	75 hours	572,250 hours	$3,318	$25,316,340

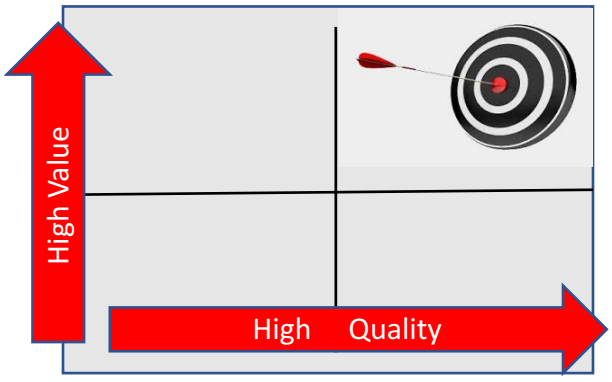
Concerns to agency

- Home Health Line's 2017 Trends Survey shows that QAPI is the biggest concern for agencies-
- 33.6% concerned regarding QAPI (257)
- 4.5% concerned with infection control
- 62.8% needs more QI training (235)
- 35.7% using more data analytics (235)

Program Scope

- Show measurable improvement in indicators for which there is evidence for improvement of health outcomes
- Measure, analyze, and track quality indicators, including adverse patient events and other performance indicators

Quality Improvement



Program Data

- Use quality indicator data, including measures derived from OASIS or other relevant data
- Focus on quality assessment efforts, including data collection on high priority safety and health conditions and other goals identified by your agency
- Identify opportunities for improvement
- Monitor the effectiveness and safety of your agency's services and quality of care

Agency Characteristic Report

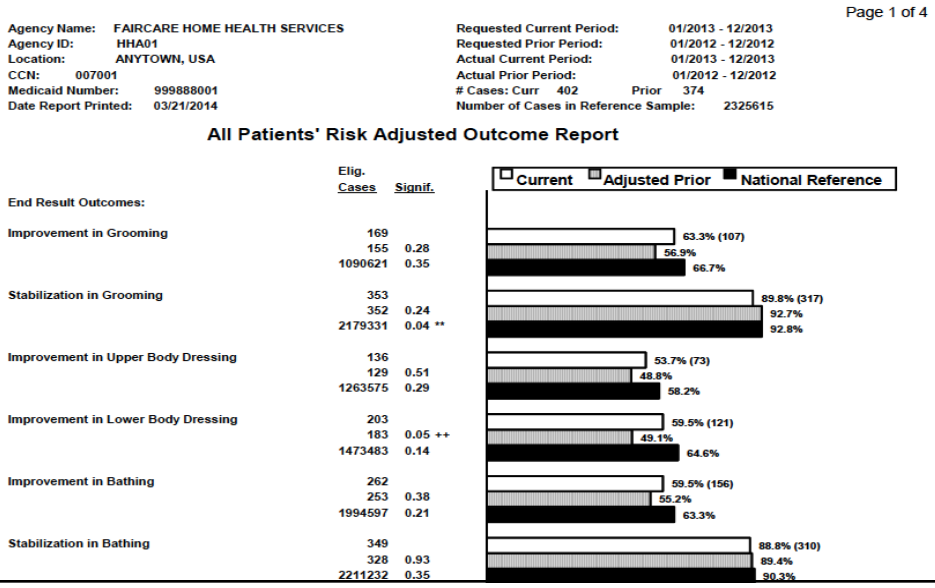
TABLE 2.2: Excerpt – Agency Patient-Related Characteristics Report.

	Current Mean	Ref. Mean
PATIENT HISTORY		
Demographics		
Age (years)	70.75	72.78*
Gender: Female (%)	69.4%	62.9%**
Race: Black (%)	1.7%	10.7%**
Race: White (%)	97.5%	85.5%**
Race: Other (%)	0.8%	3.8%**
Payment Source		
Any Medicare (%)	80.4%	82.6%
Any Medicaid (%)	12.9%	14.3%
Any HMO (%)	3.0%	5.8%**
Medicare HMO (%)	1.3%	2.2%
Private third party (%)	19.9%	21.9%
Episode Start		
Episode timing = Early (%)	74.7%	78.7%*
Episode timing = Late (%)	20.5%	14.1%**

	Current Mean	Ref. Mean
LIVING ARRANGEMENT/ASSISTANCE		
Current Situation		
Lives alone (%)	33.3%	32.4%
Lives with others (%)	34.7%	34.9%
Lives in congregate situation (%)	32.0%	32.7%
Availability		
Around the clock (%)	39.0%	38.2%
Regular daytime (%)	0.9%	3.9%
Regular nighttime (%)	0.5%	2.0%
Occasional (%)	22.0%	21.3%
None (%)	37.7%	34.5%**
CARE MANAGEMENT		
ADLs		
None needed (%)	63.4%	71.9%**
Caregiver currently provides (%)	21.9%	16.9%
Caregiver training needed (%)	10.0%	7.4%
Uncertain/Unlikely to be provided (%)	3.7%	2.8%
Needed, but not available (%)	1.0%	1.8%

Outcome Report

FIGURE 3.1: Illustrative Page from Sample All Patients' Risk Adjusted Outcome Report.



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Agency Name: FAIRCARE HOME HEALTH SERVICES
Agency ID: HHA01
Location: ANYTOWN, USA
CCN: 007001
Medicaid Number: 999888001
Date Report Printed: 03/21/2014

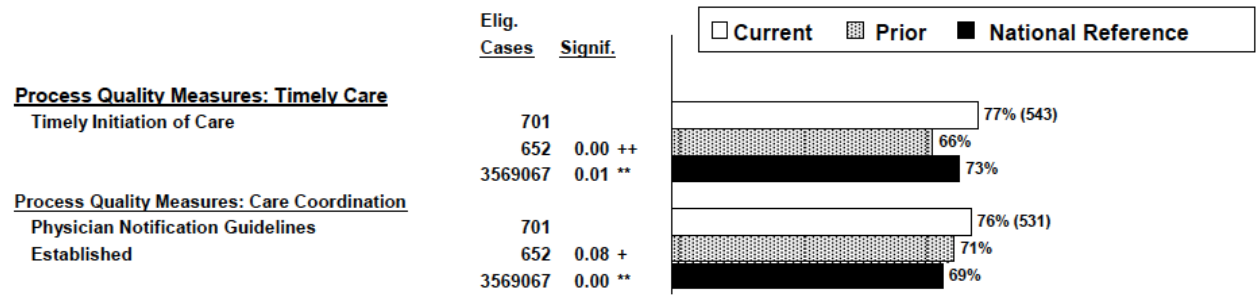
Requested Current Period: 01/2013 - 12/2013
Requested Prior Period: 01/2012 - 12/2012
Actual Current Period: 01/2013 - 12/2013
Actual Prior Period: 01/2012 - 12/2012
Cases: Curr 402 Prior 374
Number of Cases in Reference Sample: 2325615

All Patients' Risk Adjusted Outcome Report

	Elig. Cases	Signif.	Current	Adjusted Prior	National Reference
End Result Outcomes:					
Improvement in Grooming	169		63.3% (107)		
	155	0.28		56.9%	
	1090621	0.35			66.7%
Stabilization in Grooming	353		89.8% (317)		
	352	0.24		92.7%	
	2179331	0.04 **			92.8%
Improvement in Upper Body Dressing	136		53.7% (73)		
	129	0.51		48.8%	
	1263575	0.29			58.2%
Improvement in Lower Body Dressing	203		59.5% (121)		
	183	0.05 ++		49.1%	
	1473483	0.14			64.6%
Improvement in Bathing	262		59.5% (156)		
	253	0.38		55.2%	
	1994597	0.21			63.3%
Stabilization in Bathing	349		88.8% (310)		
	328	0.93		89.4%	
	2211232	0.35			90.3%

Process Quality Measure

FIGURE 2.4: Excerpt – Process Quality Measure Report.



	Elig. Cases	Signif.	Current	Prior	National Reference
Process Quality Measures: Timely Care					
Timely Initiation of Care	701		77% (543)		
	652	0.00 ++		66%	
	3569067	0.01 **			73%
Process Quality Measures: Care Coordination					
Physician Notification Guidelines	701		76% (531)		
Established	652	0.08 +		71%	
	3569067	0.00 **			69%

Potentially Avoidable Event

TABLE 3.1: Sample (Tabular) Potentially Avoidable Event Report. (cont'd)

Agency Name: Faircare Home Health Services
Agency ID: HH01
Location: Anytown, USA
CCN: 0 0 9 0 0 1 **Branch: All**
Medicaid Number: 9 9 9 8 8 8 0 0 1

Requested Current Period: 01/01/2011-12/31/2011
Actual Current Period: 01/01/2011-12/31/2011
Number of Cases in Current Period: 402
Number of Cases in Reference Sample: 2325615
Date Report Printed: 03/21/2012

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Potentially Avoidable Event Report
Patient Listing

Substantial Decline in Management of Oral Medications

Complete Data Cases: 372 Number of Events: 4 Agency Incidence: 1.1% Reference Incidence: 0.7%

Patient ID	Last Name	First Name	Gender	Birth Date	SOC/ROC	DC/Transfer
502513146	Burke	Brenda	F	06/10/1924	11/01/2011	12/20/2011
315654132	Elkins	Moe	M	01/01/1918	11/15/2011	12/30/2011
118840231	Elsen	Jean	F	01/20/1923	10/06/2011	10/15/2011
932752042	Martin	Sylvia	F	07/23/1915	12/28/2011	12/31/2011

Discharged to the Community Needing Wound Care or Medication Assistance

Complete Data Cases: 246 Number of Events: 1 Agency Incidence: 0.4% Reference Incidence: 0.4%

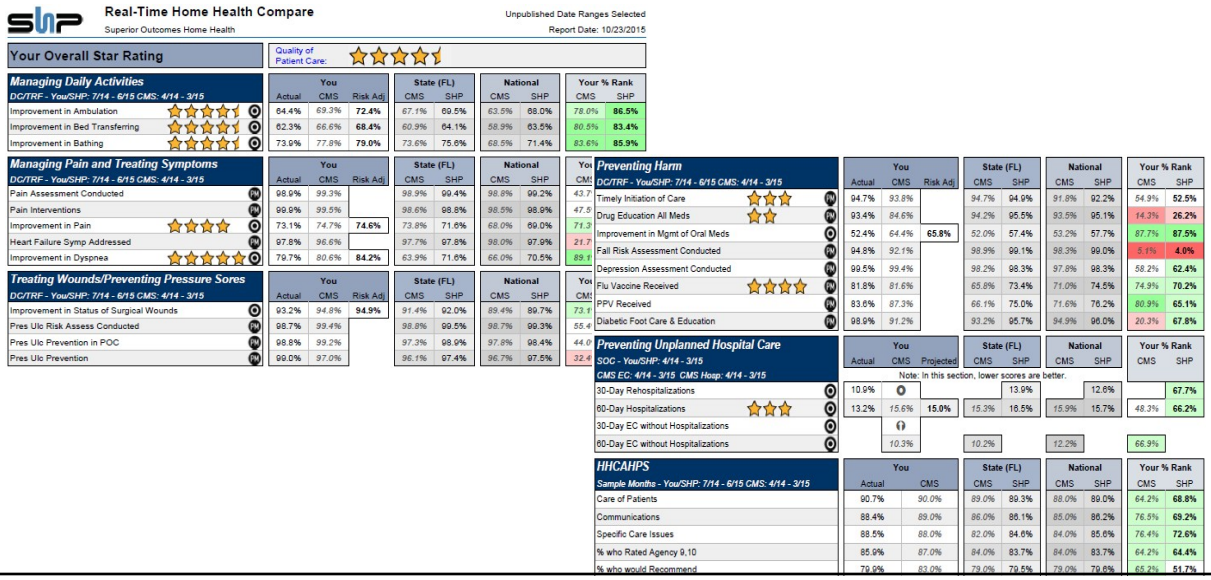
Patient ID	Last Name	First Name	Gender	Birth Date	SOC/ROC	DC/Transfer
197215357	Lincoln	Andrew	M	11/05/1937	10/11/2011	10/16/2011

Home Health Compare-Quality of Patient Care

	x ACE HOMECARE (727) 536-0100 Add to my Favorites	x ADVANCED HOME HEALTH INC (813) 994-2505 Add to my Favorites	x GREYSTONE HOME HEALTH (813) 228-0206 Add to my Favorites	FLORIDA AVERAGE	NATIONAL AVERAGE
Quality of patient care star ratings	2.5 stars	1.5 stars	5 stars	4.5 stars	3.5 stars

	ACE HOMECARE (727) 536-0100 Add to my Favorites	ADVANCED HOME HEALTH INC (813) 994-2505 Add to my Favorites	GREYSTONE HOME HEALTH (813) 228-0206 Add to my Favorites	FLORIDA AVERAGE	NATIONAL AVERAGE
How often patients got better at walking or moving around	67.2%	40.4%	72.2%	68.5%	65.2%
How often patients got better at getting in and out of bed	55.7%	33.1%	66.8%	63.2%	60.8%
How often patients got better at bathing	72.6%	35.3%	84.7%	74.6%	69.7%

SHP Reporting



shp Real-Time Home Health Compare

Superior Outcomes Home Health

Unpublished Date Ranges Selected

Report Date: 10/23/2015

Your Overall Star Rating — Quality of Patient Care: ★★★★½

Managing Daily Activities — DC/TRF - You/SHP: 7/14 - 6/15 CMS: 4/14 - 3/15

	You Actual	You CMS	You Risk Adj	State (FL) CMS	State (FL) SHP	National CMS	National SHP	Your % Rank CMS	Your % Rank SHP
Improvement in Ambulation	64.4%	69.3%	72.4%	67.1%	69.5%	63.5%	68.0%	78.0%	86.5%
Improvement in Bed Transferring	62.3%	66.6%	68.4%	60.9%	64.1%	58.9%	63.5%	80.5%	83.4%
Improvement in Bathing	73.9%	77.8%	79.0%	73.6%	75.6%	68.5%	71.4%	83.6%	85.9%

Managing Pain and Treating Symptoms — DC/TRF - You/SHP: 7/14 - 6/15 CMS: 4/14 - 3/15

	You Actual	You CMS	You Risk Adj	State (FL) CMS	State (FL) SHP	National CMS	National SHP
Pain Assessment Conducted	98.9%	99.3%		98.9%	99.4%	98.8%	99.2%
Pain Interventions	99.9%	99.5%		98.6%	98.8%	98.5%	98.9%
Improvement in Pain	73.1%	74.7%	74.6%	73.8%	71.6%	68.0%	69.0%
Heart Failure Symp Addressed	97.8%	96.6%		97.7%	97.8%	98.0%	97.9%
Improvement in Dyspnea	79.7%	80.6%	84.2%	63.9%	71.6%	66.0%	70.5%

Treating Wounds/Preventing Pressure Sores — DC/TRF - You/SHP: 7/14 - 6/15 CMS: 4/14 - 3/15

	You Actual	You CMS	You Risk Adj	State (FL) CMS	State (FL) SHP	National CMS	National SHP
Improvement in Status of Surgical Wounds	93.2%	94.8%	94.9%	91.4%	92.0%	89.4%	89.7%
Pres Ulc Risk Assess Conducted	98.7%	99.4%		98.8%	99.5%	98.7%	99.3%
Pres Ulc Prevention in POC	98.8%	99.2%		97.3%	98.9%	97.8%	98.4%
Pres Ulc Prevention	99.0%	97.0%		96.1%	97.4%	96.7%	97.5%

Preventing Harm — DC/TRF - You/SHP: 7/14 - 6/15 CMS: 4/14 - 3/15

	You Actual	You CMS	You Risk Adj	State (FL) CMS	State (FL) SHP	National CMS	National SHP	Your % Rank CMS	Your % Rank SHP
Timely Initiation of Care	94.7%	93.8%		94.7%	94.9%	91.8%	92.2%	54.9%	52.5%
Drug Education All Meds	93.4%	84.6%		94.2%	95.5%	93.5%	95.1%	14.3%	26.2%
Improvement in Mgmt of Oral Meds	52.4%	64.4%	65.8%	52.0%	57.4%	53.2%	57.7%	87.7%	87.5%
Fall Risk Assessment Conducted	94.8%	92.1%		98.9%	99.1%	98.3%	99.0%	5.1%	4.0%
Depression Assessment Conducted	99.5%	99.4%		98.2%	98.3%	97.9%	98.3%	58.2%	62.4%
Flu Vaccine Received	81.8%	81.6%		65.8%	73.4%	71.0%	74.5%	74.9%	70.2%
PPV Received	83.6%	87.3%		66.1%	75.0%	71.6%	76.2%	80.9%	65.1%
Diabetic Foot Care & Education	98.9%	91.2%		93.2%	95.7%	94.9%	96.0%	20.3%	67.8%

Preventing Unplanned Hospital Care — SOC - You/SHP: 4/14 - 3/15; CMS EC: 4/14 - 3/15 CMS Hosp: 4/14 - 3/15

Note: In this section, lower scores are better.

	You Actual	You CMS	You Projected	State (FL) CMS	State (FL) SHP	National CMS	National SHP	Your % Rank CMS	Your % Rank SHP
30-Day Rehospitalizations	10.9%				13.9%		12.6%		67.7%
60-Day Hospitalizations	13.2%	15.6%	15.0%	15.3%	16.5%	15.9%	15.7%	48.3%	66.2%
30-Day EC without Hospitalizations									
60-Day EC without Hospitalizations		10.3%		10.2%		12.2%		66.9%	

HHCAHPS — Sample Months - You/SHP: 7/14 - 6/15 CMS: 4/14 - 3/15

	You Actual	You CMS	State (FL) CMS	State (FL) SHP	National CMS	National SHP	Your % Rank CMS	Your % Rank SHP
Care of Patients	90.7%	90.0%	89.0%	89.3%	88.0%	89.0%	64.2%	68.8%
Communications	88.4%	89.0%	86.0%	86.1%	85.0%	86.2%	76.5%	69.2%
Specific Care Issues	88.5%	88.0%	82.0%	84.6%	84.0%	85.6%	76.4%	72.6%
% who Rated Agency 9,10	85.9%	87.0%	84.0%	83.7%	84.0%	83.7%	64.2%	64.4%
% who would Recommend	79.9%	83.0%	79.0%	79.5%	79.0%	79.8%	65.2%	51.7%

PPS Quality Measures Report

PPS PLUS
OASIS analysis software made by nurses for nurses

Home Health Quality Measures

From Date: 1/1/2015 To Date: 6/3/2016

Outcome Measure	Referenced	Affected	PPS Plus %	HHC %	State Avg %	National Avg %
Improvement in Ambulation/Locomotion *	25	13	52.0%	51.2%	58.8%	65.2%
Improvement in Bed Transferring *	22	10	45.5%	48.0%	51.2%	60.8%
Improvement in Pain Interfering with Activity *	24	11	45.8%	47.9%	59.1%	69.2%
Improvement in Bathing *	25	17	68.0%	58.8%	63.6%	69.7%
Improvement in Management of Oral Medications *	23	12	52.2%	43.6%	47.7%	54.9%
Improvement in Dyspnea (Shortness of Breath) *	17	10	58.8%	38.1%	52.6%	68.1%
Acute Care Hospitalization **	60	31	51.7%	19.0%	14.9%	16.0%
Emergency Department Use without Hospitalization **	59	4	6.8%	13.7%	12.4%	12.3%
Improvement in Status of Surgical Wounds *	6	6	100.0%	87.3%	87.1%	89.6%

* - HHC, State, and National averages come from OASIS information collected by CMS during the time period of October 2014 - September 2015.

Pepper Reports

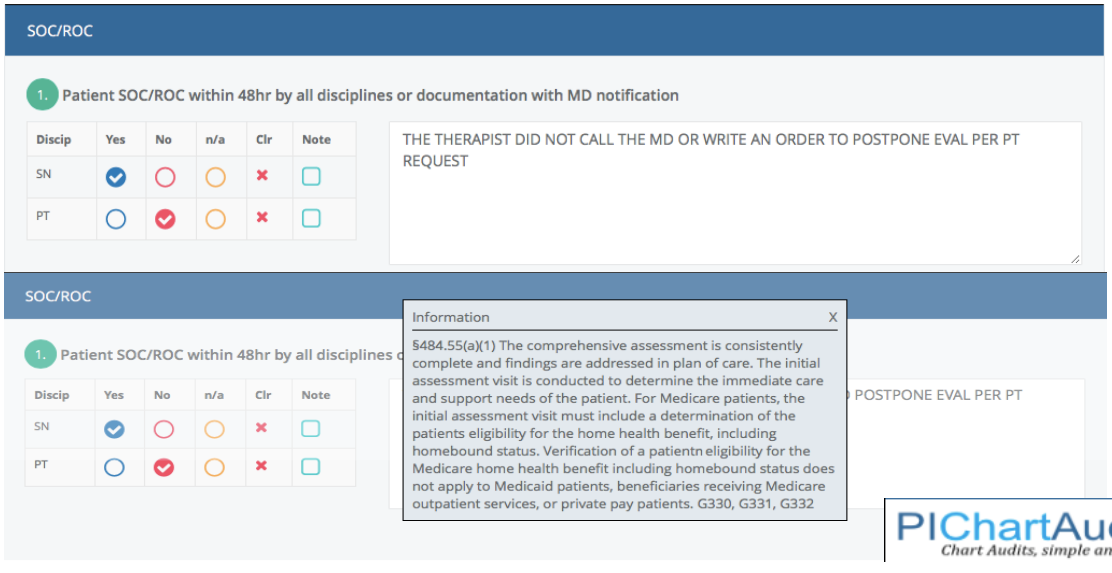
- Target Area Analysis for Home Health Agencies: Provides national-level statistics for areas identified as at-risk for improper payments in HH agencies for the most recent three years.
  - Average Case Mix
  - Average Number of Episodes
  - Episodes with 5 or 6 visits
  - Non-Lupa Payments
  - High Therapy Utilization Episodes
  - Outlier Payments

Quarterly monitoring and reporting-Chart Audits

PIChartAudit
Chart Audits, simple and complete.

25	Medication profile present with proof of reconciliation with MD if appropriate to include potential adverse reactions/duplicated therapy	100%	14	0	14	100%	14	0	14
26	Is the med profile complete and agree with the 485	73%	11	4	15	73%	11	4	15
27	Does plan of care include interventions and goals for all process measured marked yes in M2250?	59%	10	7	17	59%	10	7	17
28	Documented discharge plan at SOC	52%	13	12	25	52%	13	12	25
29	Aide care plan created/revised to include parameters for VS	100%	5	0	5	100%	5	0	5
30	OASIS functional questions justify homebound status and need for therapy if applicable	94%	16	1	17	94%	16	1	17
31	Standardized fall risk tool completed	100%	18	0	18	100%	18	0	18
RECERTIFICATION									
32	Evidence of care coordination between disciplines in the case conference performed at least once in the 60 day period and evidence it is sent to the MD	11%	1	8	9	11%	1	8	9
33	60 day summary present, sent to MD before beginning of new 60 day period and reflects need for continued care to include synopsis of previous 60 day care	11%	1	8	9	11%	1	8	9
34	MD notified with name of who approved the recert at the MD office	11%	1	8	9	11%	1	8	9
35	Is the med profile complete and updated and agree with the 485	25%	2	6	8	25%	2	6	8
36	Documented discharge plan at Recert	70%	7	3	10	70%	7	3	10
37	Patient specific interventions listed in the POC	89%	8	1	9	89%	8	1	9
38	Measurable patient specific goals listed on the POC to include met by dates	22%	2	7	9	22%	2	7	9
39	Documented knowledge deficit to justify any teaching	0%	0	4	4	0%	0	4	4
40	Assessment and narrative support homebound status	63%	5	3	8	63%	5	3	8
41	Vital signs present on Recert	100%	8	0	8	100%	8	0	8
42	Pain scale 0-10 with relief measures noted	100%	8	0	8	100%	8	0	8
43	Parameters for HTN present in orders if applicable	75%	3	1	4	75%	3	1	4
44	Parameters for diabetes present in orders and BS results in Recert if applicable	0%	0	3	3	0%	0	3	3
45	Parameters for CHF present in orders and wt results in Recert if applicable	100%	1	0	1	100%	1	0	1

Quality monitoring with Guidance



PIChartAudit
Chart Audits, simple and complete.

Quality Monitoring-Trending

1. ***Are orders followed in the notes-Are there orders for all skills performed and information taught?*** [194]
:: A 'No' response was recorded **65** times which is 25 % of the response rows associated with this probe.
This probe was considered an opportunity 257 times. (SN 55/95, SLP 3/8, HHA 3/21, PT 2/70, OT 1/57, MSW 1/6, LPN/LVN 0/0)

2. ***Orders signed and dated within 30 days of creation*** [148]
:: A 'No' response was recorded **63** times which is 27 % of the response rows associated with this probe.
This probe was considered an opportunity 230 times. (SN 26/95, PT 19/67, OT 11/49, SLP 3/8, MSW 3/6, HHA 1/5, LPN/LVN 0/0)

3. ***Consent form completed with signature, date & witness*** [83]
:: A 'No' response was recorded **39** times which is 43 % of the response rows associated with this probe.
This probe was considered an opportunity 90 times. (SN 35/81, PT 4/9, LPN/LVN 0/0, OT 0/0, SLP 0/0, HHA 0/0, MSW 0/0)

4. ***Documentation that the patient was notified of the payments of Medicare and other sources, and to the extent of which payment is expected from the patient.*** [88]
:: A 'No' response was recorded **37** times which is 42 % of the response rows associated with this probe.
This probe was considered an opportunity 89 times. (SN 33/80, PT 4/9, LPN/LVN 0/0, OT 0/0, SLP 0/0, HHA 0/0, MSW 0/0)

PIChartAudit
Chart Audits, simple and complete.

PI Activities	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
Patient Infections	x			x			x			x		
Staff Infections	x			x			x			x		
Patient Incident Tracking	x			x			x			x		
Staff Incident Tracking	x			x			x			x		
Patient Complaint	x			x			x			x		
Medication Errors	x			x			x			x		
Quality Med Record Review	x			x			x			x		
PAE	x			x			x			x		
Outcome Measures	x			x			x			x		
HHCAHPS	x			x			x			x		
HR Audits		x			x			x			x	
Pepper Reports							x					
Supervisory Visits	x	x	x	x	x	x	x	x	x	x	x	x

Program Activities

- Focus on high-risk, high-volume, or problem-prone areas of service, and consider the incidence, prevalence, and severity of problems in those areas
- Correct any immediate problems that directly or potentially threaten the health and safety of patients

Program Activities

- Track and analyze incidents and adverse patient events so your agency can implement preventative actions and mechanisms
- Continue to monitor the area(s) to assure that improvements are sustained over time
- Conduct a QAPI Awareness Campaign

Performance Improvement Projects

- January 13, 2018-Proposed July 13, 2018
- Conduct PIPs (reviewed at least annually by Governing Body) reflecting the scope, complexity, and past performance of your agency's services and operations
- Utilize data collection and analysis to select focus areas
- Document QAPI projects and progress, including reason for project and measurable progress

Executive Responsibility

- Require your agency's governing body to assume responsibility for your QAPI program, ensuring it reflects your agency's complexity covers all provided services, including contracted staff and prevention/reduction of medical errors
- Define, implement, and maintain an ongoing agency-wide program for quality improvement and patient safety developed from evidence-based best practices

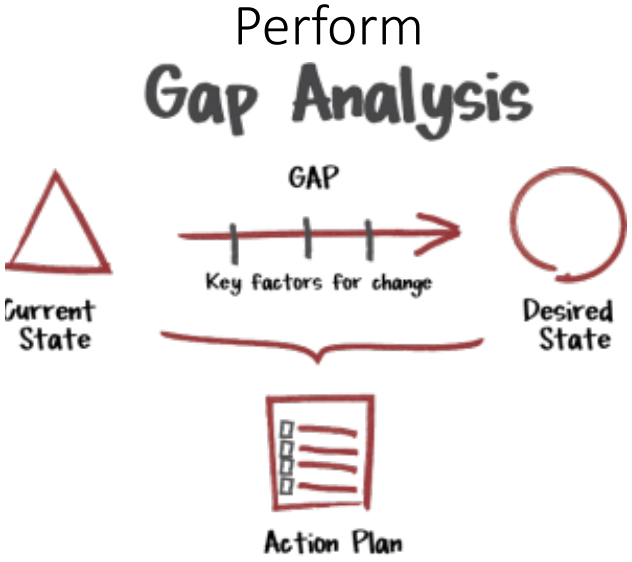
Executive Responsibility

- Ensure that performance improvement efforts are prioritized and evaluated for effectiveness to promote your agency's integrity and quality
- Include your governing body to approve the frequency and level of detail to be used in data collection
- Demonstrate clear expectations for patient safety
- Address any findings of fraud and waste to assure resources are appropriately used for patient care and that the patient is receiving the right care to meet their needs

Executive Responsibility

- Maintain documentary evidence of your agency's QAPI program to demonstrate to state surveyors

- First, identify the objectives that you need to achieve. This gives you your future state – the "place" where you want to be once you've completed your project.
- For each of your objectives, analyze your **current situation**.
- Once you know your future state and your current situation, you can think about what you need to do to bridge the gap and reach your project's objectives.



Simple Example

Future State	Current Situation	Next Actions/Proposals
Effective and manageable QAPI program	Quarterly chart audits put into a spreadsheet No way to track employee infections No QAPI "Lead"	1. Identify Data available to agency 2. See what policies are in existence for agency regarding QAPI or pieces of QAPI program

More Complex Gap Analysis

Project: Implement QAPI Best Practice: Quarterly mtg

Individual completing: JG

Best Practice	Best Practice Strategies	How Your Practices Differ From Best Practice	Barriers to Best Practice Implementation	Will Implement Best Practice (Yes/No; why not?)
QAPI program with effective PIPS that meets quarterly	Identify methods of collecting and analyzing data	Currently auditing charts quarterly to meet guidance	Lack of staff dedicated to determining, tracking and implementing	Yes; will shift some clinical manager duties to the new QAPI personnel.

Program Scope

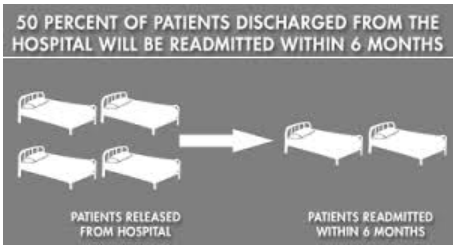
- Communicate the message that the focus of QAPI is on identifying gaps in systems and processes, rather than individual performance
- Access all available data sources to look at the bigger picture to identify potential problem areas
- Trend outcome and process improvement indicators

Program Data

- Determine potential data available to collect or monitor
- Review, compare, and interpret data from various sources
- Establish benchmarks for comparisons against programs with high performance ratings
- Determine a plan for data collection (who, what, and how often)
- Gather additional input
- Identify areas of improvement, consolidate, prioritize, and set goals

Program Data

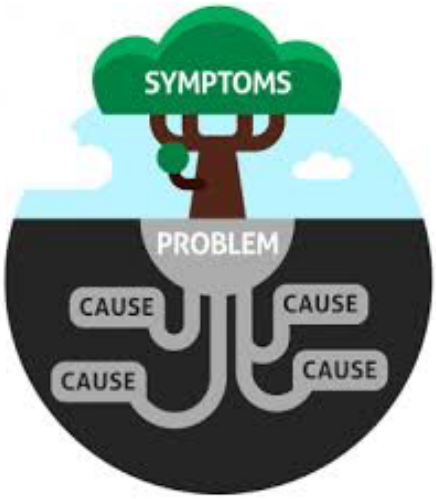
- What is agency baseline to measure?
- Objective data will give you concrete information on improvement, decline or maintenance of goals!
- Focusing on current national priorities and key indicators of quality care
- What are your disease-specific re-hospitalization rates?



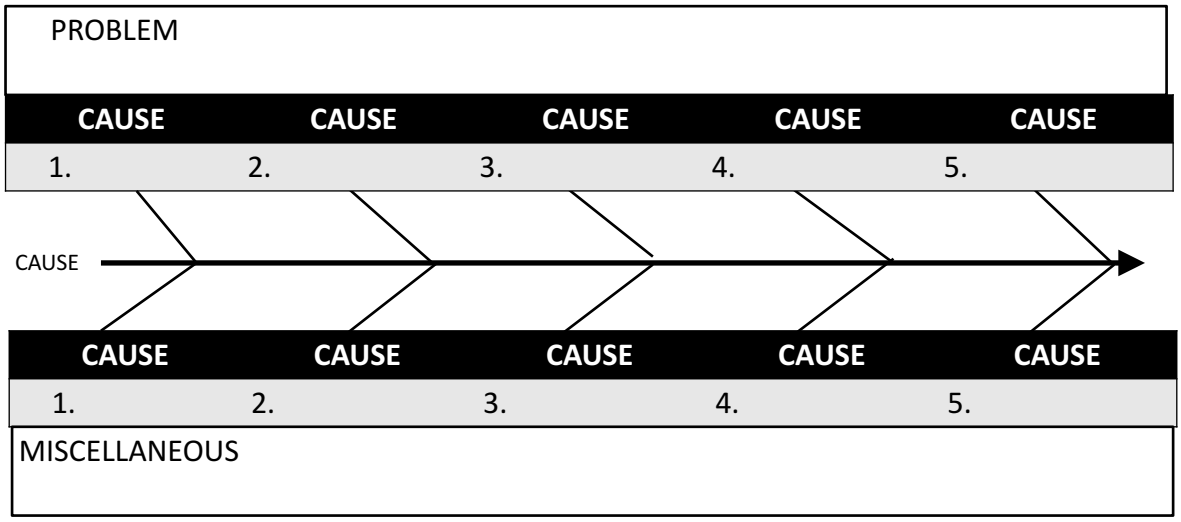
Program Activities

- Use Root Cause Analysis (RCA) or another formal systematic process to identify contributing causal factors that lead to variations in performance
- Reference clinical standards to identify deviations
- Implement changes or corrective actions that will result in improvement

Root Cause Analysis



Root Cause Analysis-Fishbone template



What is Root Cause Analysis

- **WHAT IS A ROOT CAUSE ANALYSIS (RCA)?** Root cause analysis (RCA) is a class of problem solving methods aimed at identifying the root causes of problems or events. The practice of RCA is predicated on the belief that problems are best solved by attempting to correct or eliminate root causes, as opposed to merely addressing the immediately obvious symptoms. RCA is a critical feature of any safety management system because it enables answers to be found to the questions posed by high risk, high impact events (including near misses) — what happened, why it occurred, and what can be done to prevent it from happening again.

What is Root Cause Analysis

- **WHEN SHOULD RCA USED?** RCA is normally only performed on high risk, high impact events, such as sentinel events. A reportable near miss sentinel event is managed using the same processes as an actual event.
- ***Sentinel Events*** are relatively infrequent, clear-cut events that occur independently of a patient's condition that result in unnecessary outcomes for patients.
- *An incident* is any event, occurrence, situation or circumstance, which is unusual or inconsistent with the policies, practices and routine operation of the community. An incident may be an accident or a situation, which may or may not result in bodily injury and/or property damage.

Writing Root Cause Statements

- Root cause statements are written as conclusions. Conclusions can be either:
  - Cause and effect statements
  - Example: Cause and effect - The lack of staff training on the management of patients with falls resulted in the patient being readmitted
- Prophetic statements (predictions)
  Example: Prophetic - The unavailability of guidelines for the management of falls at home will continue to contribute to the delivery of sub-optimal care.

The Five Rules of Causation

- Causal statements must clearly show the cause and effect relationship. When describing why an event has occurred, show the link between the root cause and the undesirable outcome
- Negative descriptors are not used in causal statements. To force clear cause and effect descriptions (and avoid inflammatory statements) do not use negative descriptors.
- Each action cause must have a corresponding conditional cause. For every human error in the causal chain, there must be a corresponding condition cause that combined to contribute to the undesired effect.
- Each procedural deviation must have a preceding cause. Identify the cause of a procedural violation, not the violation.
- Failure to act is only causal when there was a pre-existing duty to act. The duty to perform might arise from standards and guidelines for practice or other duties to provide patient care.

Program Activities

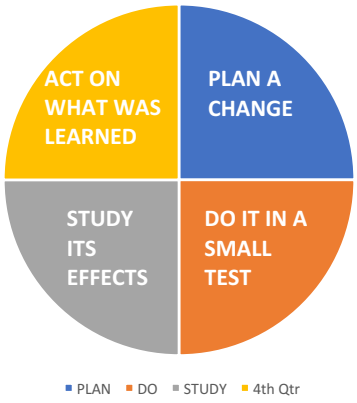
- Choose actions that address or target root causes
- Avoid quick fixes and focus on lasting/sustaining improvement
- Test in small pilots before rolling out to entire agency
- Review QAPI Plan every year (continuing to show improvement)

Performance Improvement Projects

- Consider each PIP as a learning process
- Create a timeline and communicate to leadership
- Identify any tools or resources needed, including clinical standards and best practices
- Test Changes
- Prepare and present results to executive leadership, including governing body

Performance Improvement Projects

- Utilize the Rapid Cycle Improvement



PDSA Worksheet for Testing Change

- 1. What is your overall goal you want to achieve?

Every goal will require multiple smaller tests of change

Describe your first (or next) test of change:	Person Responsible	When to be done	Where to be done

PDSA Worksheet for Testing Change

- What is your plan?

List the tasks needed to set up this test of change:	Person Responsible	When to be done	Where to be done

Predict what will happen when the test is carried out	Measures to determine if prediction succeeds

PDSA Worksheet for Testing Change

- What do you do now?

Describe what ACTUALLY HAPPENED when you ran the test

PDSA Worksheet for Testing Change

- How do you study the results?

Describe the measured results and how they compared to the predictions

PDSA Worksheet for Testing Change

- Now what do we do and how do we act?

Describe what modifications to the plan will be made for the next cycle from what you learned

Sample PDSA for Falls

PLAN	DO	STUDY	ACT
Fall risk assessment is completed timely and accurately	All clinicians responsible for admitting patients will be in- serviced on the fall risk assessment	Admission clinician completes fall risk assessment within time frame	Reduction in the number of falls
Admission assessment – complete 8 hours	Medication reconciliation	Accuracy to be completed fall risk assessment	Continue to monitor falls
Complete 14 days after admit	Time frame in which to complete the fall risk assessment		Continue education of staff
Complete 30 days after admission			Discuss and report any changes to team
Complete post fall			
Complete at significant change			

Steps to PDCA

- **Plan Step-** *Recognize the problem and establish priorities*. Problem may be outlined in very general terms based on information from several sources.
- *Form the problem-solving team.* Interdisciplinary teams of individuals close to the problem are best.
- *Define the problem and its scope clearly.* Who, What, Where and When.
- *Analyze the problem/process.* Process flowcharts can be useful a useful tool.
- *Determine possible causes.* Cause-and-effect diagrams are helpful in identifying root causes of a problem.
- *Identify possible solutions*.
- *Evaluate potential solutions.*

Steps to PDCA

- **Do Step-** Implement the solution or process change
- Monitor results and collect data

Steps to PDCA

- **Study Step-** Review and evaluate the result of the change
- Measure progress against milestones
- Check for any unforeseen consequences

Steps to PDCA

- **Check Step-** Standardize process changes
- Communicate to all involved
- Provide training in new methods

Executive Responsibilities

- Develop, implement, modify, and monitor QAPI policies and procedures
- Create a culture to support QAPI efforts (top down)
- Review and modify your vision, mission, values, and purpose statements to convey vision of QAPI
- Demonstrate the importance of QAPI and maintain its priority even with competing priorities or busy caseloads

Executive Responsibilities

- Develop a steering committee to provide QAPI leadership
- Provide resources for the QAPI team
- Create a climate of open communication and respect
- Ensure that all agency employees and contractors are educated on QAPI requirement, philosophy, policies, and processes

Executive Responsibilities

- Select various teams
- Ensure all staff are involved in a collaborative, cross-departmental, and interdisciplinary approach
- Leverage technology to improve interdisciplinary communications
- Meet regularly and document all meetings and QAPI activities in meeting summaries

TIPS FOR BEGINNING

ASSESS WHAT YOU CURRENTLY HAVE IN PLACE

- Initial QAPI plan will take time to create. It will be much easier going forward
  - Review and revise on a quarterly basis
  - Revise goals and other areas as needed on a yearly basis
- Identify your vision statement, mission statement, purpose, guiding principles and scope for QAPI prior to writing your plan
  - Attach these as a “preamble” to the QAPI plan
- Are you part of a system wide QAPI plan? How will you meet these requirements?

TIPS FOR BEGINNING

- Statements that provide a foundation to help guide decision making and setting priorities for QAPI
- Beliefs and philosophy regarding QAPI
- Team completing this should include senior leadership and governing body rep-Assign a person responsible to lead

TIPS FOR BEGINNING

- Create a written plan and establish goals

TIPS FOR BEGINNING

- Goals should be SMART
  - **S**pecific
  - **M**easurable
  - **A**ctionable
  - **R**elevant
  - **T**imeline
- How will you infuse quality into your culture?
- Assess quality in all areas

TIPS FOR BEGINNING

- Aim for safety and high quality while emphasizing autonomy and choice
- Utilize the best available evidence to determine appropriate care and to define and measure goals

Example

- QAPI is incorporated into our culture throughout all disciplines and service lines:
  - QAPI training is an integral component of new employee orientation.
  - QAPI is included in all staff job descriptions and in annual evaluations.
  - Employees understand and can describe their role in identifying opportunities for improvement.
  - All staff attend an annual mandatory inservice for a review of the agency's goals and results of PIPS

TIPS FOR BEGINNING

- Describe the systems you have in place to monitor care and services from multiple sources of data
- How are you going to designate PIP teams?
- How will PIPs be documented?
- How will you observe for positive and negative consequences resulting from changes?
- What methods will you use to get to the root cause of issues?

TIPS FOR BEGINNING

- How will QAPI activities be communicated?
- How will you evaluate your QAPI plan on a regular basis?
- How will the governing body be involved?

References

- www.homehealthquality.org
- www.ihi.org
- www.cms.gov

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