BEST PRACTICES AND LESSONS LEARNED

From CAH Quality Program Reviews

QUALITY PROGRAM REVIEW

What does that even mean?

QUALITY PROGRAM REVIEW

PFE

Access, Signage, Pt Experience, White Boards, BSR, PFAC

PROJECTS

Dept Specific, Staff Knowledge, Visibility

FINANCE

Billings, Revenue Cycle, Collections, Scheduled Pre-Calls

ROUNDS

Leadership/C-Suite Visibility, Clinical, Board, and/or Safety

DATA

MBQIP, Employee Satisfaction, HCAHPS & Community Needs

Success

PATIENT AND FAMILY ENGAGEMENT

Access

- Signage
- Welcoming
- Ease of movement in facility
- What does it feel like
- How does family get a meal
- Where does family park
- Information exchanged as families need

Patient Experience

- HCAHPS
- EDCAHPS
- Swing Bed
- Home grown survey (observation or department specific)
- What do staff know about PFE/Pt Exp
- How is PFE engrained in culture/orientation/annual training

White Boards, BSR, & PFAC

- White boards: consistent information, completed each shift, pertinent information in a way a patient/family could utilize
- Bedside Shift Report: consistent information, actually completed by all shifts, pertinent information in a way a patient/family could utilize
- Patient and Family Advisory Council: Informal/project specific (discharge instructions, information in room, etc) or formal/regular meetings

PROJECTS

Department Specific

- Do front line staff know what quality project their department is working on currently
- How is this information shared w/ staff, visitors, management, and board
- How are quality projects generated/chosen?
- Front line staff asked for input for project themselves as well as measurement and reasonable goals

Staff Knowledge

- All staff know what quality is and their role in it
- Do staff know who the quality director is and how often do they see them
- Are quality discussions and quality projects integrated into daily activities (huddle or project boards)
- How is quality (QAPI) engrained in culture/orientation/annual training

Visibility

- What is being worked on
- Is there a picture of quality for all to see
- Websites
- Social media (Facebook, Twitter, Instagram)
- Newsletters
- Bulletin board
- Posting fresh, recent, and relevant

FINANCE

Billing

- Timely
- Accurate
- How many corrected claims must be sent out in a month/quarter/annually
- Easy for a patient to read/understand
- What/Who is available to assist patients/families if they have questions
- Is your phone number on the bill
- Are there convenient ways to pay the bill

Revenue Cycle

- Denied claims w/ common reasons
- Process to review bills before sent to patient
- Registration consistency – what roles have to complete patient registrations
- Training for registration staff/standard work so all do it the exact same way
- Who cleans up registration errors/ommissions

Collections/Pre-Service Calls

- How is expected payment discussed
- Is a letter mailed
- Pre-service calls – who makes those and how long after a letter is follow-up complete
- Collections at time of service – how is that explained or scripting for clarity and consistent messaging
- In-house or off sight vendor who completes

ROUNDS

Leadership

- Ask frontline staff when the last time they have seen the CEO on their unit/in their department
- Do board members come to the units
- How visible is the c-suite
- How are these done to divvy up responsibility
- Parternered or individual

Clinical

- How often are clinical staff (nursing leadership or pharmacy) rounding on patients
- How is this divvied up
- What documentation is done for the rounding (old school paper spreadsheet, survey monkey, share drive)
- Are there checklists or scripting to help
- Partnered or individual

Patient Safety

- Visiting units to talk about equipment availability
- “Do you have the equipment needed to do your job and take care of our patients safetly?”
- Documentation
- Who does this
- Frequency

DATA

MBQIP

- How do you compare to other CAHs across your state or nation
- Doing anything to improve these measures or just reporting to report
- Sharing and posting
- Would front line staff be able to explain any of the measures as relevant for their departments

Employee Satisfaction

- How often surveyed
- What is done with results
- Happy employees equal happy pateints
- How are employees recognized for a job well done
- Committee w/ front line staff participation to plan events and programs

Patient Satisfaction/HCAHPS

- Response rate
- How are they administered
- What type of information is shared w/ patient to prepare them for survey
- Do staff know the questions and how your facility scores
- Where is the information (that there is a survey, what types of questions, that you really need their input, and data) shared

OTHER ITEMS SERVICES OR ITEMS TO REVIEW

Extended hours

Services and hours patients need

Registration staff available for heaviest patient times – increases satisfaction and reduces errors that must be fixed later

Healthy information for patients

Activities and information to keep community healthy vs sick care

Walk with the Doc

Lunch with a Nurse

Sponsor or host community garden

Time it takes to get into their doctor

What can we do to keep patients out of the ED

How can we keep the patients we have

How can we advertise the easy access we offer

Complaints

Opportunity for quality improvement

Systemic concerns or just an outlier

Risk Management

Quality and Risk should be work besties

How often are these departments working together

Opportunity for quality improvement vs staff responsibility

Policies and Procedures

How to staff access

How often are they reviewed

Actually how procedures are completed vs just what is in writing

ACTION PLAN

Build in Accountability

ABC Memorial Hospital

Action Plan

Goal: Hospital P&P Review	Action Step Descriptions	Party/Dept Responsible	Date to Begin	Date Due
Have Up To Date Policies Hospital Wide and Department Specific	Ensure Policies are Reviewed Annually			
	Review Policies for Length & Understanding			
	Ensure Policies are Enforced Consistently			
* Obtain Sample/Example Policies from Outside Resources if Needed * Realistic Expectations of Staff with Policy Interpretation and Understanding	Ensure Policies are Accessible for All Staff			

Action Plan

Goal:	Action Step Descriptions	Party/Dept Responsible	Date to Begin	Date Due

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ACTION PLAN WORK

Three Items You Want to Work On

QAPI GAP TOOL

Evaluate your program

C-Tag Description	Met/Not Met	Gap/Thoughts to Ask Your Team	Responsible Person	Date Completed
Governing Body and Leadership				
Governing Body or responsible individual responsible for CAH's QAPI program and… Responsible and accountable for ensuring that the QAPI program meets the requirements as defined in SOM		• Who is designated in CAHs bylaws/org chart as responsible? How is this determined?		
The Governing Board and Senior Leaders (including Med Staff) are educated and understand the QAPI program *Note: this will also flow down to staff understanding at dept level*		• Consider annual/biannually education • Document in minutes, attendance, and method(s) to provide education		
Is Quality Director/designee determined by Governing Body? How is Quality Director/designee determined? Are there enough resources allocated for sufficient QAPI program for this Director/designee?		• Is the designee documented in minutes? • Is there sufficient education provided for designated Quality person? • Is quality person 'qualified' with necessary skills and expertise • How do you demonstrate training, education and principles including data collection, analysis, and reporting…how to use root cause analysis, pareto etc.		
There are sufficient technology resources allocated to manage an effective QAPI program		• Think about how much is done manually versus using technology		
The Governing Board reviews and approves the annual QAPI plan		• What committees are part of your plan? • Who all has to approve it before moving to the board? • Can you identify easily how governing body, CEO, Med Staff, Senior Admin, each play a role in QAPI program planning, implementation and ongoing management?		
Is there evidence that the hospital has formal QAPI program		• Includes P&P, budgeted resources, clearly identified responsibilities of staff, all approved by governing body • Must also show how CEO and med staff are providing input		

C-Tag Description	Met/Not Met	Gap/Thoughts to Ask Your Team	Responsible Person	Date Completed
The Governing Board approves prioritization criteria for the QAPI projects.		• # of distinct QAPI projects identified (in minutes) • Are these priorities and projects appropriate for the scope and complexity of the CAH? • These are all reviewed at minimum annually		
Governing Board actively reviews the results of QAPI data collection, analyses, activities, projects and makes decisions based on such review		• In minutes, signed off as approved • Review structure of what is reviewed on calendar • Reviews publicly reported data (how)		
Review of data meets, exceeds organizational targets in strategic plan and/or external benchmarks		• What input is provided? • How is this measured and provided to governing body?		
Indicators to look at: • Improved health outcomes / quality of care • Related to CAH acquired conditions • Readmission data and transitions of care • Medication and/or medical errors				
Has hospital conducted a QAPI review, including implementing preventive actions for all serious preventable adverse events it has identified? How is governing body engaged and information shared?		• How are preventable adverse events managed throughout organization • Ex. QAPI program process for staff to report blood transfusion reactions, identify errors etc.		
Quality Committee				
Role and purpose of committee and its members clearly defined; includes accountability, expectations and reporting structure		• Is this outlined in QAPI? Minutes? • Is the Quality committee ensuring by its structure to ensure meeting scope and complexity of the CAH services (how can you tell?)		
Are members educated and knowledgeable about QAPI?		• How is this completed?		

C-Tag Description	Met/Not Met	Gap/Thoughts to Ask Your Team	Responsible Person	Date Completed
Members include representation from various levels of organization		• Administration? • Medical Staff? • Infection Control? • Board (ad hoc)		
Structure in place for committee to review and update QAPI at minimum annually				
Committee role in QAPI program		• Prioritizing criteria • Benchmarks and data management • Review and provides feedback of departmental QAPI program…feedback of all metrics house wide		
Committee receives ongoing reports from various house wide initiatives; provides feedback for metrics not meeting expectations		• Departmental • Organizational priorities (on track with strategic plan?) • Publicly reported data • All outcome measures		
Committee and ultimately governing body review all contracted services and determine continuation at minimum annually; review of contracted services projected and approve them		• How is this completed? By who? • What is in the minutes? • How is data and targets being communicated from contracted services?		
Committee has responsibility of corrective action plans		• How is this managed? Communicated? • Reported to governing body? • Does a committee member take a lead role (champion an action plan) to achieve success?		
Committee reviews the data collection, analysis and reporting for the QAPI program		• Is this demonstrated in minutes? • How is it completed?		

C-Tag Description	Met/Not Met	Gap/Thoughts to Ask Your Team	Responsible Person	Date Completed
Committee ensures all departments are educated about QAPI, data collection, metric determination, analysis and reporting		• How are departments/service lines engaged in QAPI? • How is data reported? • Don't forget contracted services • How are all staff educated and/or engaged? • How are organizational goals/objectives aligned and communicated to all depts/service lines/contracted services?		
QAPI program includes population specific and service specific management…such as ICU, Swing, Infusion Center, Wound etc.		• How is this provided?		
Committee ensures following quality process…such as PDSA, DMAIC, or other variations of performance improvement		• Is there a data metric for each indicator? • Metrics, measures and sample size are appropriate for the indicator • Target is appropriate (is there a national benchmark?) • In rounds can staff speak to the QAPI program for their dept? For CAH in general? • Can managers speak to corrective actions? When this would be necessary? Process in general…		
Demonstrated reporting structure for all QAPI		• Can dept managers repeat how data is shared in organization • Can staff/manager articulate the board receives all data and ultimate responsibility of the data? • Is there a flow chart for managers to visually project how data is reported?		

C-Tag Description	Met/Not Met	Gap/Thoughts to Ask Your Team	Responsible Person	Date Completed
What other committees report quality data to this committee? • Infection Control • Antibiotic Stewardship • Patient Safety • Others such as clinics?				
How is periodic evaluation conducted and reported and aligned to the QAPI program?		• Who manages periodic eval? • Are services outlined in the review? • # patients serviced and volume of services provided?		
Quality and appropriateness of Dx and Tx furnished by med staff		Evaluate your peer review process and is it mentioned in your QAPI program?		
All patient care services and other services affecting patient health and safety?		• Nurse leader reviews quality of care outcomes? • How is this displayed in QAPI program?		

As you write/review your QAPI program be sure to speak to items like % of departments, contracted services, service lines, new services (for a yearly eval) that have at least one QAPI project; % of these departments etc. meeting benchmark, exceeding benchmark or other. How many staff are engaged in QAPI overall? By department? Any cross-functional projects? Multi-disciplinary engagement? Any strategic initiatives involving QAPI that were not met? Any new or changes in national metrics and reporting (such as MBQIP)?

Some outcomes to consider in your QAPI review: Changes/enhancement in program? Change in cycles or measurement (going from PDSA to Lean?); annual training completed…% of staff educated; Overall % of goals met (by organization and then by department); # of corrective action plans…and then completed without roll-over to next year? Any consequences or fall-outs such as reporting to state public health etc.

Consider challenges of not reporting timely…some say this should be in QAPI plan as corrective action (each CAH is different). Need to take action on depts that consistently do not report data and the impact this may ensue. How is this managed? Were any PIP teams initiated? Why and Outcome.

LEAVE IN ACTION

- Do a walk through of your facility with a new set of eyes and ears
- Work with your Quality Committee to find ways to develop an ongoing action plan to build a stronger quality program
- Complete the QAPI Gap Tool with your QAPI Plan
- Make needed changes to your QAPI Plan

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