Designing an Effective Quality Assurance Program

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Who Am I and Why You Should Listen to Me!

ARMED ROBBERY, EH? I'M IN FOR BEING OUT OF COMPLIANCE WITH A FEDERAL GUIDELINE.
CIA Survivor

- Third Generation Nursing Home Operators
- Facilities
  - 49 - 125 beds
  - Primarily rural
  - “Typical” regulatory history
- “Corporate” Structure

My Tale of Woe

- Maxwell Manor
  - Management contract
  - Improvements
- Federal Survey
  - 13 IJ’s
  - Subpoenas flying
False Claims Act

- Thank you President Lincoln
- Qui Tam Relator
- Settlement
  - Monetary settlement
  - CIA
    - 5 years
    - Federal Monitors

Thank You ACA for the Wisdom...

"I want to be feared as a tyrant, loved as a father, and revered as a god, but I also want them to think I'm funny."
Mandatory Compliance is coming...

HOW LONG DO WE HAVE TO GET IN COMPLIANCE?

Now What????

Mandatory Compliance: March 26, 2013
Quality Assurance and Performance Overview (QAPI)

- August 2011: First Phase/Five Elements
- September 2011: Demonstration Project
- 2012: Rule expected to be in comment period
- Late 2012/Early 2013: Final rule
- One year after final rule: Providers must have QAPI written plan in place
- 2012: Surveyor Training

Demonstration Project

- Goals:
  - To understand activities and support needed for implementation of QAPI
  - To assist SNF to develop QAPI programs and use resources to meet their unique and specific needs
  - Learn for national roll-out
Demonstration Project

- 17 nursing homes in 4 states
  - Wide spectrum
- Stratis Health
  - Participation in a structured learning collaborative
  - Access to on-line training modules, tools and resources.
  - Individually tailored technical assistance through a designated QAPI liaison

Lessons Learned from CIA

Internal Audit and QA was **key** to a successful compliance program and...

*I had no clue how to do Internal Audit and QA*
Can Feel Very Overwhelming

...And it’s as simple as that!

Goal of Today

Complexity Made Simple

CHRIS MADDEN
QAPI vs QAA

- Systems, systems, systems!
- Use data to prioritize
- Formal performance improvement plans (PIPS)
- Focus on root cause analysis
- Expected level of participation from staff and leadership
- Commitment of resources

Five Elements of QAPI

- Element 1: Design and Scope
- Element 2: Governance and Leadership
- Element 3: Feedback, Data Systems and Monitoring
- Element 4: Performance Improvement Projects (PIPs)
- Element 5: Systemic Analysis and Systemic Action
Element 1: Design and Scope

- Program should be ongoing and comprehensive
- Include all departments
- Should address:
  - Clinical care
  - Quality of life
  - Resident choice
  - Care transitions
- Written QAPI

Element 2: Governance and Leadership

- Governing body leads QA program
  - Board/owners
  - Executive leadership
- Assures its adequately resourced
- Policies to sustain program
- Setting priorities and expectations
- Non- retaliatory atmosphere
- Training and organizational climate
  - Consistent assignments
NOT!

Role of Leadership

Create a culture of change
Questions You Need to Ask?

- Free to speak up?
- Awareness of performance improvement?
- Teamwork?
- Root Cause Analysis?
- Past success?
- Using data?

Element 3: Feedback, Data Systems and Monitoring

- Systems to monitor care and services drawing data from multiple sources
- Input from staff, residents, families and others
- Tracking, investigating and monitoring Adverse Events
Where’s the Data Coming From?

- Surveys - Annuals and Complaints
- Focused Rounds (examine a particular aspect of care)
- Incident Reports
- Complaints and Lawsuits
- Sub-committee Reports
- Family/Staff Satisfaction Surveys
- 800 Hot Line
- Hospitalization rates

The Proof is in the Data

- Data Analysis
  - “In God We Trust. All others must use data.” Statistician’s Credo
  - Don’t just quote the numbers
  - Track it...Trend it...Benchmark it
  - Analysis Positive Trends
**Element 4: Performance Improvement Projects (PIP)**

- Examine and improve care or services in areas that need attention
- Concentrated effort on a particular problem
- Gathering information systemically to clarify issues or concerns
  - Prioritize topics
    - High risk, high volume, problem prone areas
- Areas that are meaningful for the specific type and scope of service

**Case Study**

- ABS Management
  - Restraint Reduction Initiative
    - Training
      - “Creating a Restraint - Free Environment”
      - “Siderails - A Hidden Danger”
      - “What are Physical Restraints”
    - Family education and involvement
    - Staff involvement
Great Restraint Reduction But…

Back to the Drawing Board!

• QA Process-Root Cause Analysis
  o Improvement needed in root cause analysis
    ▪ Admission process and assessment
    ▪ IDT Approach to Falls Management

• Training Initiative
  o “Understanding Falls”
  o “Why is your Loved One Falling”
  o “What Families Should Expect from LTC”
  o “Quality Assurance and Assessment – A Proactive Approach”
And the Results Are….

Element 5: Systemic Analysis and Systemic Action

- Systemic approach to identify problems and causes
- Proficiency in root cause analysis
- Continual learning and improvement
Root Cause Analysis

“Every problem is an opportunity. Every defect is a treasure if the company can uncover its CAUSE and work to prevent it across the corporation.”

Kilchiro Toyoda, founder of Toyota

“I need someone who’ll ask the tough questions, no matter how risky.”
The Wrong Way

- Discover a problem and rush to find a solution
- Reactive rather than proactive - blame game
- Systems based on survey findings, risk manager or insurance claims

The Right Way

- Correct or eliminate root causes, not just addressing the obvious symptoms
- Tool for identifying prevention strategies
- Contributing causes are discovered in the same way a doctor diagnosis a disease - with a goal of preventing recurrence
What Happened?

- “Stuff” happens
- To examine the “What” talk to the frontline staff, the resident and roommates
- Involve staff in fact-finding process
- Look beyond the incident report... “Go to the scene of the crime”

Why Did it Happen

- Ask the questions
- WHY x 5 = Root Cause Analysis
Honey, **WHY** won’t the car start!

Ummm...it is out of gas
Well, **WHY** did it run out of gas?

Ummm..because I didn’t buy any gas on the way to work
WHY didn’t you buy any gas this morning?

Ummm...because I ran out of money...
WHY did you run out of money!!!

Ummm..I lost it at a poker game
WHY did you lose your money at a poker game!!!

Ummm...I’m not very good at bluffing
The Case of the Lunch Crunch

- Looking beyond the individual residents-systems view
- Several falls at lunch
- Changed meal service
- Bathroom bottleneck

- WHY did the facility have increase falls at lunch?
- WHY were the residents falling in the bathroom?
- WHY didn’t they have anyone to assist them?
- WHY were the staff assisting other residents at meals?
- WHY didn’t the facility have staff allocated appropriately?
Develop a Plan of Action

May include:
• Development or revision of protocols
• Revisions of policies and procedures
• Plans to purchase or repair equipment
• Changes to the physical plant
• Staff Competency
• Staff Training

Evaluate a Plan of Action

• Benchmark
• Identify Data Collection Method
• Who is Responsible
You can run, but you can’t hide...

Give me a call!

Gambling Problem?
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