Walk through a QAPI Project

Quality Assessment to Performance Improvement

Sandra Jones, CASC, CHPRM, LHRM, CHCQM, FHFMA
Sjones@aboutascs.com

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Types of Quality Measures

- Outcomes
  - Measures results of care
  - Example: Infections, transfers, falls, burns
- Process
  - How often the standard of care was met
  - Examples: Timing of prophylactic antibiotic administration, cleaning of pre-operative bays
- Perception
  - Patient satisfaction, Doctor satisfaction, Staff satisfaction

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Indicators of Quality

- Quality assessments, audits, tracers
- Sentinel events/ "caught it" events
- Unexpected events, occurrence reports
- Mandatory Reporting
  - CMS G-Codes, quality net
  - State reporting adverse events, infections

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QAPI

- Two sections
  - (1) Quality Assessment
  - (2) Performance Improvement
- QAPI
  - Incorporate the development of objective measures relating to processes and outcomes;
  - Identify gaps in performance & needed improvements/changes;
  - Implement changes;
  - Measure effectiveness of changes;
  - Make further changes if needed to close gap, meet measure

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Performance Level Analysis

- What is our performance level?
- If we have an outside source, what are others' performance levels?
- Is there a gap? How big?
- What might be causing the gap?

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Using Internal Benchmarking

- Compare staff on collection activities
  - AR days
  - Date of service collection for deductibles and co-payments
- No Shows, frequency, reason, type of case, surgeon
- Cancellations once patient is in pre-op
  - Reasons: not NPO, didn't stop meds, vital signs not stable, no responsible adult companion

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Using External Benchmark

- How bad are we?
- How good can we get?
- Am I measuring this the same as others?
- Am I getting data I can use?
- How can I learn why others are different?

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External Benchmarking

- CMS Quality Measures
  - Once a year report
- Association
  - Quarterly reporting
- Specialty focused
  - ASGE: GIQul: GI Quality Improvement Consortium
  - Cataract complications
- Buddies, non-competitors

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Internal Trending Example

City Surgery Center	Key Indicators 4th Q 2015			
INDICATORS	Target	Oct	Nov	Dec
Time out performed correctly and documented	100%			
Physician orders for all drugs and biologicals	100%			
All verbal orders signed by physicians	100%			
All drugs & biologicals locked & key with assigned staff	100%			
Hand hygiene compliance, results of observation audits	88%			
OR cleaning audited, performed correctly	100%			
Immediate Use Sterilization Frequency	.5%			

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Performance Improvement Opportunities

				ASC	Peer Group	National
# of pts w/ surgical site hair removal	11	14	17			
Appropriate surgical site hair removal	11	14	17			
% of pts w/ appropriate hair removal	100%	100%	100%	100%	99.8%	93.2%
# of pts w/ a pre-operative order IV Antibiotic	66	60	53			
Antibiotic administered on time	51	52	48			
% of pts who received antibiotic on time	77.3%	86.7%	90.6%	84.4%	98.4%	93.9%

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Improvement

- What is happening in our process that causes a difference?
- What data do we need to collect to find out?
  - Surgeon, antibiotic order, type of surgery, nurse and anesthesia staff involved, any possible reasons for greater than one hour time
- What does the data show us? Do we now understand why the gap?
  - Confer with team
  - Talk to peers if necessary

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Improvement

- What can we do to fix it?
  - Confer with team
  - What might make a difference in process?
  - If we change X, do we mess up Y?
- What implementation is needed?
  - Change in policy
  - Education of staff
  - Triggers to follow new process: posters, documentation change

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Improvement

- How will we know it worked?
  - Data collection
  - Internal and External benchmarking reports
- Did we "Maintain the Gain"?
  - Data collection trending
  - Did the gap in performance change?

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QA PI Steps

1. Identify criteria or indicator. What do you want to review?
2. Establish goals. To what will you compare? Your history or external findings?
3. Describe the data to collect. Sources. How to collect.
4. Collect the data and describe it.
5. Analyze the data
6. Compare your data to goal you set.
7. Action plan and implementation (If it is status quo, then it is only QA)
8. Re-measure. Did action work? Good enough?
9. Additional action plan and implementation. Check again.
10. Communicate findings to committees, staff, **GB**

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1. Quality Indicator: Process – Timeliness of
Antibiotic

- Trending shows we are getting better each month but we have a gap between our performance and our peers. If we can find out the reasons we are not on time, we may be able to improve our performance in the timeliness of antibiotic administration.

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2. Establish Goal

- We have our internal benchmarking and we are improving month to month. But we also have external benchmarking. We want to be as good as our peers. Our corporate peers are at 98.4% of patients with an order who receive the antibiotic on time. We are at 84.4%

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3. Data Collection

- We will design a data collection worksheet.
- Chart documentation on those that received an antibiotic
  - When ordered and given and when case started
  - Procedure
  - Surgeon
  - Nurses in pre op and in OR
- Comment sections on worksheet: When timeliness not occurring what has staff observed?

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4. Data Collection Description

- We designed a questionnaire for staff to use to gather information when an antibiotic was not timely.
- All data elements on our questionnaire were completed. Staff made notes on the form if they found some information that may need to be considered.
- We obtained data on 38 cases that did not have timely antibiotic. During this period of time we did 250 cases with antibiotic orders. Therefore, 15.2% of the time we are not giving antibiotic timely. This is worse than the previous month.

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5. Analyze the Data

- The 38 instances showed a commonality. They all occurred on two physicians' cases.
- The order was on the pre-admission order sheet.
- The antibiotic was started in pre-op within 10 minutes of the time patient was to go to the O.R.
- The case was delayed because the doctor was delayed.
- The delayed case start resulted in the antibiotic being given greater than one hour before the cut.

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4. More Data Collection

- Discuss with staff what communication they are receiving about when to start the antibiotic. Who tells them patient will go back to O.R. in 10 minutes?
- Find out from staff any issues they have seen following the process with Dr. X and Dr. Y since data shows the timeliness involves their patients.
- Contact peers about when they start antibiotics and any issues they have discovered in being timely.

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5. Data Analysis

- Discovered two surgeons had block time at the hospital across the parking lot prior to their time at the ASC.
- These two surgeons call OR to tell the charge nurse that they are on their way.
- They may get delayed as they walk through the hospital which includes a walk through the Emergency Department.

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6. Compare data to goal

- Over a three month period, our ASC has 15.6% of cases not receiving timely antibiotic when it is ordered. That equates to 84.4% of the patients receiving their antibiotic on time.
- We have improved over a three month period by we are not as good as others.
- Our goal was to be at least equal to our peers who show 98.4% compliance.
- We did not meet our goal.

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7. Action Plan and Implementation

- "Don't shoot until you see the whites of their eyes." Staff are not to start antibiotics until the physician enters the ASC and does see patient in pre-op area. This impacts timeliness of antibiotics as well as universal protocol for safe surgery and compliance with standards and policy.
- Staff educated.
- Physician education. Call from hospital as usual and staff will direct you to location of your first patient who is ready in pre-op. They will not administer antibiotic until doctor is in the building and preparing for case.

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8. Re-measure

- Data collected on timeliness shows the ASC is at 99.4% compliance, which is better than peers.
- We continue to collect timeliness of antibiotic administration data. If it shows a decrease to 98% or less compliance, we will examine again to determine why the gain was not maintained.

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9. Additional Actions

- Not necessary. First actions implemented fixed gap in performance

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10. Communicate

- Inform of
  - Quality assessment plan
  - Assessment tools and results
  - Plans for action and implementation
  - Time for re-measurement
  - Re-measurement results
  - If applicable, more actions and implementations, more re-measurement time frame and results.

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10: Communicate

- Staff
- Medical Advisory Committee
- Governing Body

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Resources

- MN Adverse Health Events Measurement Guide at
  www.stratishealth.org
- Joint Commission Resources, Publications
  www.jcrinc.com/store/publications/books-and-ebooks/
- Veteran's Administration Patient Safety
  www.patientsafety.va.gov/professionals/

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Questions?

sjones@aboutascs.com