QAPI – Making An Improvement

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HOSPICE FUNDAMENTALS
KNOWLEDGE • EXPERTISE • COMMON SENSE

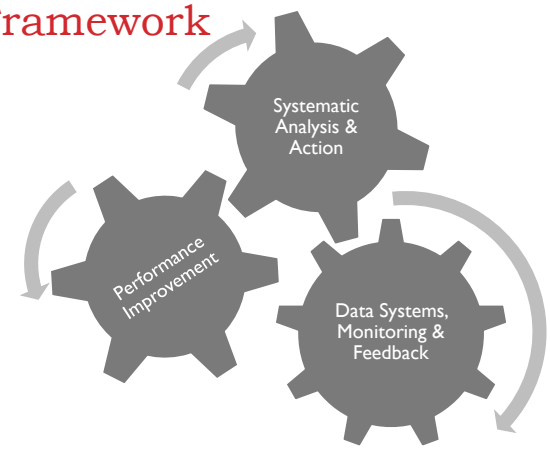
Objectives

- Describe how to use lessons learned from implementing the comfortable dying measure to improve your care
- Use the data results from the 1st quarter of collecting the Comfortable Dying Measure to improve care and at the same time improve results for the next reporting period

Quality is never an accident; it is always the result of high intention, sincere effort, intelligent direction and skillful execution; it represents the wise choice of many alternatives.

William A Foster
February 17, 1917–May 2, 1945

QAPI Framework



Design & Scope

Governance & Leadership

QAPI – A Comprehensive Approach

- Quality Assessment
  - Process of meeting quality standards and assuring that care reaches an acceptable level
  - Thresholds set to comply with regulations and standards
  - Identifies opportunities for improvement
- Performance Improvement
  - Proactive
  - On-going study of processes & systems
  - Intent to prevent or diminish chance of problems
  - Looks for opportunities & tests new approaches to solve underlying causes of troublesome systems & processes
  - Aim is to improve quality in a healthcare delivery & individuals quality of life

Definitions of Quality

- "Doing the right thing right, right away" (*W. Edwards Deming, 1982)*
  - Probably the simplest, yet most comprehensive definition
- Institute of Medicine (IOM) definition
  - *The degree to which health services for individuals and populations increase the likelihood of desired health outcomes and are consistent with current professional knowledge.*

NQF Endorsed Hospice Measures

Under Consideration For the Future

HOSPICE FUNDAMENTALS

R&C HEALTHCARE SOLUTIONS

NQF Measures Under Consideration

Pain Screening	Pain Assessment
• Percentage of hospice or palliative care patients who were screened for pain during the hospice admission evaluation / palliative care initial encounter	• Percentage of hospice or palliative care patients who screened positive for pain and who received a clinical assessment of pain within 24 hours of screening

NQF Measures Under Consideration

Dyspnea Screening	Dyspnea Treatment
• Percentage of hospice or palliative care patients who were screened for dyspnea and its severity during the hospice admission evaluation / initial encounter for palliative care	• Percentage of Patients who screened positive for dyspnea who received treatment within 24 hours of screening

NQF Measures Under Consideration

Patients Treated with an Opioid who are Given a Bowel Regimen	Family Evaluation of Hospice Care
• Percentage of vulnerable adults treated with an opioid that are offered/ prescribed a bowel regimen or documentation of why this was not needed	• Composite score derived from responses to 17 items on the Family Evaluation of Hospice Care (FEHC) survey presented as a single score ranging from 0 – 100

Consumer Assessment of Healthcare Providers and Systems (CAHPS)

- Initiative of Agency for Healthcare Research and Quality (AHRQ) to promote assessment of consumer's experience with health care
- Current CAHPS surveys implemented
  - Medicare health and drug plans
  - Inpatient hospitals
  - Home health agencies
  - In-center hemodialysis facilities
  - Nursing homes
  - Clinician and group practices
- Hospice Survey – under development
  - Supports NQS goal of Better Care & priorities
    - Ensuring each person / family engaged as partners in their care
    - Promotes effective communication & coordination of care

CAHPS – Hospice Survey

- Purpose - to understand
  - Patient experiences throughout their hospice care as reported by their family members / friends
  - The perspectives of family members /friends with regard to their own experiences with hospice
- Information to be used to help improve the quality of care patients /families and friends receive in hospice
- Will be used to help consumers make more informed decisions about providers

Getting Ready for CAHPS

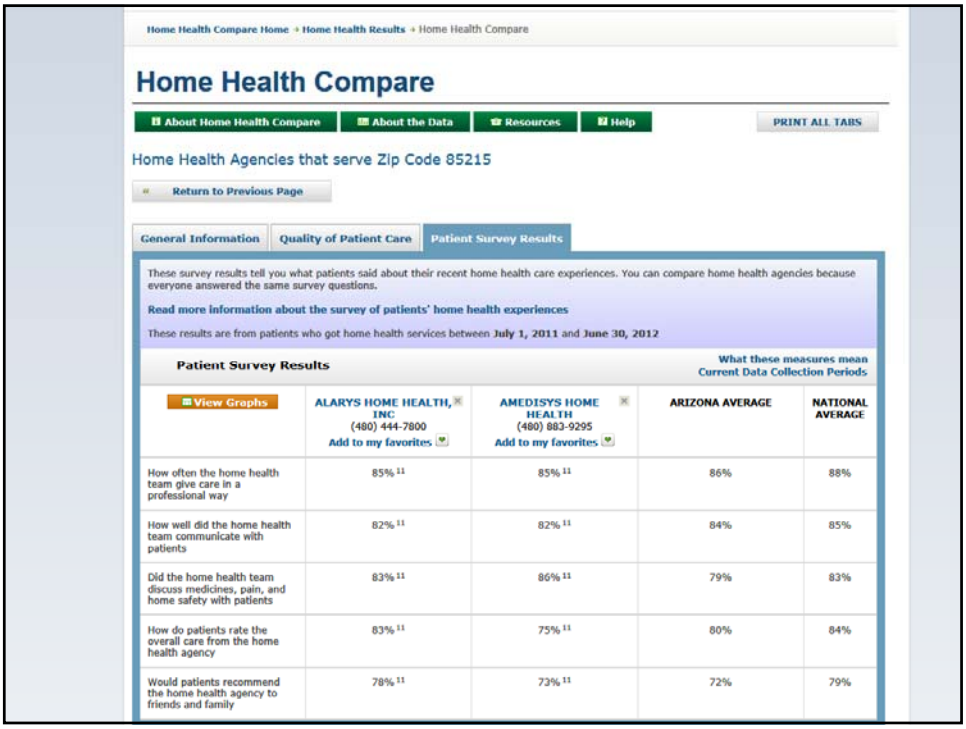
- The patient experience doesn't exist until it is provided at the call of the family / caregiver
- The experience takes up no space, can't be inventoried, and has no shelf life
- Service quality is evaluated against the satisfaction of the customer
- Patients / families don't usually know what they are getting until they don't get it

Getting Ready for CAHPS

- Focus on patient centered care becomes the cultural foundation
  - Set expectations at the start
    - Establish patient centered care as a priority in the job description
    - Patient centered care is a priority within the hospice's cultural values
    - Hire staff that want to meet patient needs
  - Build a healthy work environment
    - Stressed staff introduce stress into the patient's environment as well
  - Establish transparency
    - Make patient satisfaction matter to the individual team members
    - Set standards and benchmarks, then publish how the hospice is doing
    - Reward small successes

CAHPS-Home Health Care

- Sequence
  - October 2009 voluntary
  - 2010 Q3 required for annual payment update
  - 2012 results on Home Health Compare
- Measures of patient experience:
  - Patient care (gentleness, courtesy, problems)
  - Communication with health care providers and agency staff
  - Specific care issues related to pain and medication
  - Overall rating of care



FEHC Composite Score

Will It Become the Hospice CAHPS?

The Composite Score - FEHC

- B2) How much medicine did the patient receive for his/her pain?
- B4) Did you want more information than you got about the medicines used to manage the patient's pain?
- B6) How much help in dealing with his/her breathing did the patient receive while under the care of hospice?
- B8) Did you want more information than you got about what was being done for the patient's trouble with breathing?
- B10) How much help in dealing with these feelings did the patient receive?

The Composite Score -FEHC

- D3) How confident did you feel about doing what you needed to do in taking care of the patient?
- D4) How confident were you that you knew as much as you needed to about the medicines being used to manage the patient's pain, shortness of breath, or other symptoms?
- D5) How often did the hospice team keep you or other family members informed about the patient's condition?
- D7) Would you have wanted more information about what to expect while the patient was dying?
- D8) How confident were you that you knew what to expect while the patient was dying?
- D9) How confident were you that you knew what to do at the time of death?

The Composite Score -FEHC

- E2) Did you have as much contact of that kind as you wanted?
- E3) How much emotional support did the hospice team provide to you prior to the patient's death?
- E4) How much emotional support did the hospice team provide to you after the patient's death?

The Composite Score -FEHC

- F1) How often did someone from the hospice team give confusing or contradictory information about the patient's medical treatment?
- F2) While under the care of hospice, was there always one nurse who was identified as being in charge of the patient's overall care?
- F3) Was there any problem with hospice doctors or nurses not knowing enough about the patient's medical history to provide the best possible care?

Overall Rating of Care – FEHC

- G1) Overall, how would you rate the care the patient received while under the care of hospice?
- G2) Based on the care the patient received, would you recommend this hospice to others?

Collecting Comfortable Dying Measure

Lessons Learned for the Next Wave

Model of Improvement

Remember

- Focus is more "trial and learning" then "trial and error"
- Small scale does not necessarily equal small change
- Success / failure in one test of change does not mean success / failure in the entire project
- Success is learning from each test of change, regardless of results
- Common to have different results than what predicted

Taking Action

Solutions to problems are like round pegs in a square hole. They won't work if they are the wrong size or don't fit. If the solutions aren't the right ones, the problem does not get resolved.

Classification of Corrective Action

Weak

- Actions dependent of staff to remember training or what is written in policy
- Enhance or enforce existing processes

Intermediate

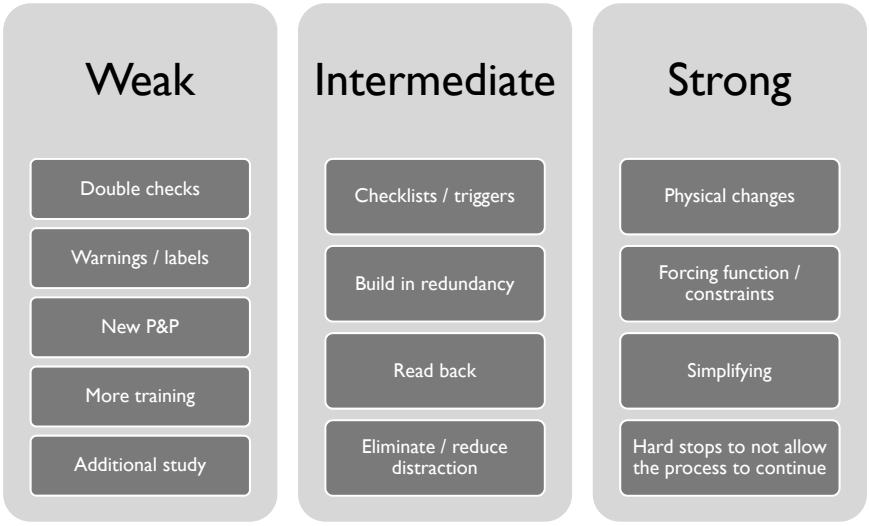
- Somewhat dependent on staff remember to do the right thing, but provide tools to help remember
- Modify existing processes

Strong

- Do not depend on staff to remember to do the right thing.
- Change or re-design the process - remove unnecessary steps
- Detect and warn so chance to correct the error before it occurs

From the Department of Veterans Affairs National Center for Patient Safety's *Hierarchy of Actions*

Examples of Each



Lessons Learned From the Comfortable Dying Implementation

- Missing information
- Lack of information obtained
- Qualitative vs. quantitative documentation
  - Severity of patient's symptoms
  - Standardized rating scales
- Vagueness/lack of clarity
- Inability to document in a manner useful for data collection
- Hard to get a solid process in place for follow up within 48 – 72 hours
- EMR – not putting in the information in a place that is easily retrievable
- Paper records documentation inconsistent

Lesson's Learned

- Make sure the data is good
- Everyone understands the indicators
- Documentation of the information is in a consistent place
- Know how your software company is keeping up
- Know how well are you doing with patient outcomes
- Identify opportunities for improvement

Comfortable Dying

- How much were your scored impacted by
  - The denominator – what happens to those patients who can not respond in 48 hours
    - They still count as part of the denominator
  - Acuity, short LOS can impact a hospice's score
  - Timeframe for re-evaluation – can it be 72 hours?
    - Numerator very specific – up to 48 hours after the initial assessment (after admission to hospice services)

To Improve the Comfortable Dying Measure, Consider Also Measuring….

- Numerator: Number of Patients whose pain was NOT brought to a comfortable level within 48 hours after the initial assessment
- Denominator: Number of patients who were uncomfortable on admission
- Why
  - Offsets negative bias introduced by inclusion of patients unable to respond at follow up
  - Provides additional context & insight for setting performance goals

What's the Difference

Comfortable Dying #0209	Not brought to comfortable level
$\frac{60}{100} = 60\%$	$\frac{15}{100} = 15\%$
Patients whose pain brought to comfortable level within 48 hours of initial assessment	Patients whose pain was not brought to comfortable level within 48 hours of initial assessment

The Details Behind the Number of Patients Not Brought to a Comfortable Level

- How many were unable to self report at 48 hours?
  - Can't really improve that number
- How many did not have the follow up within the 48 – 72 hours?
  - Review the processes – what needs to change to ensure follow up is completed timely?
- How many did not have pain brought to a comfortable level within 48 hours?
  - Improving this score will improve the quality of pain management in your organization
  - Analyze the cases further to determine the opportunity for improvement

Start Incorporating Proposed Measures Now

- Already collecting data related to Comfortable Dying
- Start now collecting data required for
  - Patients Treated with an Opioid who are Given a Bowel Regimen
  - Pain Screening
  - Pain Assessment
  - Dyspnea Screening
  - Dyspnea Treatment
- If not using FEHC, consider starting

Collecting Data

- Patients Treated with an Opioid who are given a bowel regimen
  - When was the patient first prescribed an opioid?
  - Was the patient already on a bowel regimen?
  - If not, was one offered within 24 hours of the opioid prescription?
  - If one was not offered, is there documentation as to why a bowel regimen was not needed?

Collecting Data

Percentage of patients who screened positive for pain and who received a clinical assessment of pain within 24 hours of screening

1. Patient screened positive for pain
2. Within 24 hours the following elements of the pain assessment were completed
   1. Location of pain
   2. Severity of pain
   3. Character of pain
   4. Duration of pain
   5. Frequency of pain
   6. What relieves the pain
   7. What makes the pain worse
   8. Impact on quality of life
   9. Patient's satisfaction with the current level of pain control

Review Baseline Data as a Team

If quality measures indicate opportunities to improve care practices

- Identify
- Prioritize
- Solve
- Discuss ways to improve practice
  - Not just more education & monitoring
  - Consider systematic ways to make it easier for staff to do the right thing
  - Team involvement and input – include those who actually do the work in designing the processes
  - PIPs
    - Allow team members the time to participate in the PIP as part of their "day job" not an after thought

Review Baseline Data as a Team

If quality measures indicate necessary care practices are missing or inconsistently documented

- Focus on systematic ways to record important clinical information
  - Important with EMRs

Improve Scores

Evaluate your hospice's evaluation process

- Does it include benchmarks
  - With itself over time
  - With other organizations
  - With standards
  - With known best practices

Word About Thresholds

- How do you set thresholds?
- Should it always be 100%
- What is the organization's risk tolerance?

Summary

- Hospice Compare is on its way, so get ready
- Begin now implementing elements of the proposed NQF measures into the comprehensive assessment
- Incorporate the NQF data elements into your QAPI program
- Use lessons learned from implementing the Comfortable Dying measure when implementing future quality measures

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