Redlands Community Hospital

Caring for Generations.

QAPI – Rethinking Getting to Quality

CAHF San Bernardino County Chapter RAP Session
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Presented By: Kathy P. Hurst BSN, MSN, JD, Esq., RN, CHC
Compliance Director
Redlands Community Hospital
khurst@redlandshospital.org

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Objectives

At the end of the presentation, the participant will be able to:

1. Differentiate between QA and QAPI
2. Identify inputs, Activities and Results for a hypothetical QAPI Plan
3. Identify the Components of AIM.
4. Identify five (5) resources to pull QAPI data

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General

Quality Assurance (QA) is nothing new.

Quality Assessment Performance Improvement (QAPI) is really just an extension of QA/QAA.

The difference between QA/QAA and QAPI is simply the refocus of the entire process when the "PI" is added.

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QA vs. QAPI

QUALITY ASSURANCE

1. Individual focused
2. Perfection myth
3. Solo practitioners
4. Peer review ignored
5. Errors punished

QUALITY IMPROVEMENT

1. Systems focused
2. Fallibility recognized
3. Teamwork
4. Peer review is valued
5. Errors are opportunities for learning

Health care has two major processes/activities:

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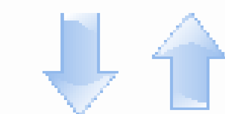
1. What is done (what care is provided); and
2. How it is done (when, where, and by whom is care delivered)?

Model for Improvement

What are we trying to accomplish? → Determine which ***specific*** outcomes you are trying to change

How will we know that a change is an improvement? → Identify appropriate measure(s) to track your success (i.e. MDS, QM, QASP, Incident Reports, Resident/EE Satisfaction Surveys, Consultant Reports, etc.)

What change can we make that will result in improvement? → Identify key changes you will actually make to achieve the measures



Act	Plan
Study	Do

Inputs/Resources
1. People
2. Infrastructure
3. Materials (i.e. vaccine)
4. Information
5. Technology

Activities (Process)

WHAT is done
HOW it is done

Results (Output/Outcome)
1. Health services delivered
2. Change in health behavior
3. Change in health status
2. Resident satisfaction

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Case Study

Puppy Love Post Acute Care Center is a 110 bed facility in a semi-rural area of Southern California. There are few nursing homes around to compete with. Despite this, the census is consistently low. The CMS 5-Star Rating is 4, Staffing is 4, and QM's are 5. The facility receives few referrals from the 4 local hospitals.

Susan, the Administrator, and Jeff, the Director of Nursing Services, sit down to discuss the issue. Neither are aware of resident and family complaints. There is moderate to staff turnover because census is low and there are always cancellations. Neither of them can figure out why there are few referrals or why residents go out do not return.

Susan, frustrated, meets with Directors overseeing case management in all four local hospitals. The Administrator is told that the facility may not be providing the necessary care and services. She is told by all the Directors she may need to review her transfers/readmissions.

Susan returns and has Jeff pull all the transfer/readmission data. Jeff finds that the return to hospital rate is 35%. Of those, 88% go back to the hospital for an infection related event (sepsis, urosepsis, wound infection, pneumonia). Most all residents are readmitted on average of 20 days. The benchmark is 18%.

got questions

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