Next Steps in QI for QAPI
Human Factors

Sharon Eloranta, MD

June 4, 2013
• Qualis Health is one of the nation’s leading healthcare consulting organizations, partnering with our clients across the country to improve care for millions of Americans every day

• Serving as the Medicare Quality Improvement Organization (QIO) for Idaho and Washington

• QIOs: the largest federal network dedicated to improving health quality at the community level
Road Map

National Collaborative will also provide webinars to support QAPI changes!
What’s Next?
It’s all about improving processes

• Human Factors
  • We are all human, and humans err
  • Error and drift
What’s a process?

- How you get things done
  - Administering medications
  - Turning residents
  - Taking residents to the bathroom
  - Skin inspections
  - Admission intake
  - Responding to change in condition
  - What can you think of?
Humans make mistakes

How many digits in your phone number?
Did you ever forget…. 
We all err

Forget something?
We all “drift”
Three types of errors

• Skill based (I know what to do, but…)
  • Slips: attention failures
  • Lapses: memory failures

• Knowledge based (I don’t know what to do, or how to do it)
  • Sometimes intentional – we do it anyway, sometimes not knowing it is incorrect

• Violations (I choose not to do it)
  • Speeding, for instance
What makes us more likely to err?

• Adverse mental states (distraction, haste, mental fatigue)
• Adverse physiological and physical states (illness, fatigue, drug use)
• Systems that don’t promote good communication and teamwork
• Nonstandard processes
Error and harm in healthcare

• Not all errors lead to harm, but some do
• System responses can lead to “second victims”
  • Betsy Lehmann story
  • Children’s Hospital story
Protecting residents from harm

• Just Culture
  • Create a learning culture
  • Increase system transparency
  • Respond appropriately to errors, at-risk behavior and recklessness/violations

• Process improvement
  • Create systems that prevent errors from reaching the resident
  • Use of LEAN concepts
Customer finds the error

Suppliers -> 1 -> 2 -> 3 -> 4 -> Customers

Feedback

Error occurs

Customer finds defect
Create an inspector

1. Suppliers
2. Error occurs
3. Inspector finds defect
4. Feedback
5. Customers
Move the manager closer
Never pass on a defect

Suppliers → 1 → 2 → 3 → 4 → 5 → Customers

Error caused, detected and corrected
Mature system: no possibility of error due to process design

Process controls and design prevent error
In summary

People make mistakes

• We can prevent mistakes from leading to harm by:
  • Reducing exposure to factors that increase error
  • Understanding and improving processes
  • Never passing along a defect
• The Just Culture provides a framework for creating a learning system
Questions?

Sharon Eloranta, MD
Medical Director, Quality and Safety Initiatives
sharone@qualishealth.org
206-288-2474

For more information:

http://www.qualishealthmedicare.org/healthcare-providers/nursing-homes/quality-care-collaborative

This material was prepared by Qualis Health, the Medicare Quality Improvement Organization for Idaho and Washington, under contract with the Centers for Medicare & Medicaid Services (CMS), an agency of the U.S. Department of Health and Human Services. The contents presented do not necessarily reflect CMS policy. IID/WA-C7-QH-1145-05-13
Questions?

Traci Treasure, MS, CPHQ, LNHA
Quality Improvement Consultant -- Qualis Health, Idaho
TraciT@QualisHealth.org  208.383.5947

Jillyn G. Reid, MHA, CPHQ
Quality Improvement Consultant -- Qualis Health, WA
JillynR@QualisHealth.org
206.288.2379 (direct) 1.800.949.7536 x2379 (toll free)

For more information:
www.QualisHealthMedicare.org/NHCollaborative

This material was prepared by Qualis Health, the Medicare Quality Improvement Organization for Idaho and Washington, under contract with the Centers for Medicare & Medicaid Services (CMS), an agency of the U.S. Department of Health and Human Services. The contents presented do not necessarily reflect CMS policy. ID/WA-C7-QH-1145-05-13
Next Steps in QI for QAPI
Just Culture

Sharon Eloranta, MD

June 4, 2013
• Qualis Health is one of the nation’s leading healthcare consulting organizations, partnering with our clients across the country to improve care for millions of Americans every day

• Serving as the Medicare Quality Improvement Organization (QIO) for Idaho and Washington

• QIOs: the largest federal network dedicated to improving health quality at the community level
Errors, harm and culture

- We all make mistakes
- There is a difference between making an error and being intentionally reckless
- How do our systems respond?
- What is the culture in your building?
The Just Culture

• Designing systems to prevent errors from causing harm
• Encouraging transparency about errors and error reporting
  – Creating a learning organization
• Developing appropriate responses to errors and harms: the CULTURE is “JUST”
• Does not mean lack of accountability

Implementing Just Culture is a core element of QAPI!
Error

The resident fell on the way to the bathroom

The aide did not accompany the resident to the toilet

Caused by

The aide forgot

Caused by

The aide was distracted by a phone call from a family member and was covering extra residents
Three ways to respond

• Was it an error?
  • Inadvertent action; slip, lapse, mistake?

Response: Console and Learn

Identify and test systems fixes!
At-risk Behavior

The resident fell on the way to the bathroom

The aide did not accompany the patient to the toilet

Caused by

Decided not to

At risk behavior

Caused by

The aide had been caring for the patient for 3 weeks and felt that he sufficiently knew the patient
Three ways to respond

• Was it at-risk behavior?
  • Behavioral choice that increases risk, where risk is not recognized or is believed to be justified

Response: Coach and Learn

*Find ways to reduce these choices as options*
Reckless Behavior

The resident fell on the way to the bathroom

The aide did not accompany the patient to the toilet

Caused by

He was out in the parking lot on an unscheduled smoke break despite heavy patient load

“Yeah, I know, but people fall here all the time”
Three ways to respond

• Was it reckless behavior?
  • Behavioral choice to consciously disregard a substantial and unjustifiable risk

Response: Punish
The three behaviors

### Human Error
Product of our current system design and behavioral choices
- Manage through changes in:
  - Choices
  - Processes
  - Procedures
  - Training
  - Design
  - Environment

### At-Risk Behavior
A Choice: risk believed insignificant or justified
Manage through:
- Removing incentives for at-risk behaviors
- Creating incentives for healthy behaviors
- Increasing situational awareness

### Reckless Behavior
Conscious disregard of substantial and unjustifiable risk
Manage through:
- Remedial action
- Punitive action

---

Thanks to the Just Culture Community and David Marx for this content
To sum it all up

- People make mistakes
- Designing systems and processes can:
  - Decrease the chance that error will result in harm
  - Create a culture where we treat staff “justly” according to behavior
    - The Just Culture approach also allows us to form Learning Organizations with transparency regarding mistakes and near misses
    - The Just Culture is a key element of QAPI
Questions?

Sharon Eloranta, MD
Medical Director, Quality and Safety Initiatives
sharone@qualishealth.org
206-288-2474

For more information:

http://www.qualishealthmedicare.org/healthcare-providers/nursing-homes/quality-care-collaborative

This material was prepared by Qualis Health, the Medicare Quality Improvement Organization for Idaho and Washington, under contract with the Centers for Medicare & Medicaid Services (CMS), an agency of the U.S. Department of Health and Human Services. The contents presented do not necessarily reflect CMS policy. ID/WA-C7-QH-1145-05-13
Questions?

Traci Treasure, MS, CPHQ, LNHA
Quality Improvement Consultant -- Qualis Health, Idaho
TraciT@QualisHealth.org 208.383.5947

Jillyn G. Reid, MHA, CPHQ
Quality Improvement Consultant -- Qualis Health, WA
JillynR@QualisHealth.org
206.288.2379 (direct) 1.800.949.7536 x2379 (toll free)

For more information:
www.QualisHealthMedicare.org/NHCollaborative

This material was prepared by Qualis Health, the Medicare Quality Improvement Organization for Idaho and Washington, under contract with the Centers for Medicare & Medicaid Services (CMS), an agency of the U.S. Department of Health and Human Services. The contents presented do not necessarily reflect CMS policy. ID/WA-C7-QH-1145-05-13
Storyboards
Christian Health Care Center
Messenger House Care Center
Using the Change Package

Traci Treasure, MS, CPHQ, LNHA
Quality Improvement Consultant

June 4, 2013 Learning Session 2 Part 2
• Qualis Health is one of the nation’s leading healthcare consulting organizations, partnering with our clients across the country to improve care for millions of Americans every day

• Serving as the Medicare Quality Improvement Organization (QIO) for Idaho and Washington

• QIOs: the largest federal network dedicated to improving health quality at the community level
National Change Package Best Practice Principles

1. Lead with a sense of purpose
2. Recruit and retain a quality staff
3. Connect with residents in a celebration of their lives
4. Nourish teamwork and communication
5. Be a continuous learning organization
6. Provide exceptional, compassionate clinical care that treats the whole person
7. Construct solid business practices that support your purpose
Great, but what’s that got to do with QAPI?

Five elements of QAPI

• Design and scope
• Governance & Leadership
• Feedback, data systems, monitoring
• Performance Improvement Projects
• Systematic analysis and action

Best practice guiding principles

Lead with purpose
Quality staff
Connect with residents
Teamwork/communication
Continuous learning
Clinical care
Business practices
Changes You Can Try

CMS Best Practices Change package

QAPI at a Glance
  Focuses on the Five Elements and 12 Steps

Qualis Health Change Ideas
  Specific to our Focus Topics: AP, Falls, Pain management, Re-hospitalization, others
  Sources: CMS change package, other known best practices and literature review

www.qualishealthmedicare.org/NHCollaborative
Four Steps for Improvement

• Use your data and observe current practices
• Identify the gap from best practice
• Match the change to test to the gap/cause
• Train and support front line staff to do PI
1.a. Use Your Data

- Monitored QM rates not meeting goal
- Adverse event tracking
  - New infection, pressure ulcer, fall, other HAC
  - Unplanned readmission
  - Incident report
  - Survey citation
  - Near-miss events
  - Medication errors
- Resident/staff satisfaction scores
Internal Data

• Use data already readily available
  • Management system data
  • EHR or other system data
  • Monitor QM on QIES monthly after 10\textsuperscript{th} of month
  • Weekly logs (e.g. skin sheets)
  • Other logs (e.g. transfers, calls)

• Collect new data within usual workflow
  • One person, one shift, one time sample
  • Tally sheets
  • Days since last. . .
### Comparison Data

#### QIES

**CASPER Report**

**MDS 3.0 Facility Level Quality Measure Report**

<table>
<thead>
<tr>
<th>Measure Description</th>
<th>CMS ID</th>
<th>Data</th>
<th>Denom</th>
<th>Facility Observed Percent</th>
<th>Facility Adjusted Percent</th>
<th>Comparison Group State Average</th>
<th>Comparison Group National Average</th>
<th>Comparison Group National Percentile</th>
</tr>
</thead>
<tbody>
<tr>
<td>SR Med/Severe Pain (S)</td>
<td>NC01.01</td>
<td>11</td>
<td>48</td>
<td>22.9%</td>
<td>22.9%</td>
<td>29.1%</td>
<td>19.9%</td>
<td>62</td>
</tr>
<tr>
<td>SR Med/Severe Pain (L)</td>
<td>NC02.01</td>
<td>13</td>
<td>52</td>
<td>12.1%</td>
<td>12.1%</td>
<td>17.1%</td>
<td>9.2%</td>
<td>72</td>
</tr>
<tr>
<td>Hi-Risk Pres Ulcer (L)</td>
<td>NC03.01</td>
<td>16</td>
<td>58</td>
<td>18.0%</td>
<td>18.0%</td>
<td>23.6%</td>
<td>13.9%</td>
<td>71</td>
</tr>
<tr>
<td>New/Worse Pres Ulcer (S)</td>
<td>NC04.01</td>
<td>11</td>
<td>48</td>
<td>22.9%</td>
<td>22.9%</td>
<td>29.1%</td>
<td>19.9%</td>
<td>62</td>
</tr>
<tr>
<td>Phys restraints (L)</td>
<td>NC05.01</td>
<td>13</td>
<td>52</td>
<td>12.1%</td>
<td>12.1%</td>
<td>17.1%</td>
<td>9.2%</td>
<td>72</td>
</tr>
<tr>
<td>Falls (L)</td>
<td>NC06.01</td>
<td>16</td>
<td>58</td>
<td>18.0%</td>
<td>18.0%</td>
<td>23.6%</td>
<td>13.9%</td>
<td>71</td>
</tr>
<tr>
<td>Falls w/Maj Injury (L)</td>
<td>NC07.01</td>
<td>11</td>
<td>48</td>
<td>22.9%</td>
<td>22.9%</td>
<td>29.1%</td>
<td>19.9%</td>
<td>62</td>
</tr>
<tr>
<td>Antipsych Med (S)</td>
<td>NC08.01</td>
<td>13</td>
<td>52</td>
<td>12.1%</td>
<td>12.1%</td>
<td>17.1%</td>
<td>9.2%</td>
<td>72</td>
</tr>
<tr>
<td>Antipsych Med (L)</td>
<td>NC09.01</td>
<td>16</td>
<td>58</td>
<td>18.0%</td>
<td>18.0%</td>
<td>23.6%</td>
<td>13.9%</td>
<td>71</td>
</tr>
<tr>
<td>Anti-anxiety/Hypnotic (L)</td>
<td>NC10.01</td>
<td>11</td>
<td>48</td>
<td>22.9%</td>
<td>22.9%</td>
<td>29.1%</td>
<td>19.9%</td>
<td>62</td>
</tr>
<tr>
<td>Behav Sx affect Others (L)</td>
<td>NC11.01</td>
<td>13</td>
<td>52</td>
<td>12.1%</td>
<td>12.1%</td>
<td>17.1%</td>
<td>9.2%</td>
<td>72</td>
</tr>
<tr>
<td>Depress Sx (L)</td>
<td>NC12.01</td>
<td>16</td>
<td>58</td>
<td>18.0%</td>
<td>18.0%</td>
<td>23.6%</td>
<td>13.9%</td>
<td>71</td>
</tr>
<tr>
<td>UTI (L)</td>
<td>NC13.01</td>
<td>11</td>
<td>48</td>
<td>22.9%</td>
<td>22.9%</td>
<td>29.1%</td>
<td>19.9%</td>
<td>62</td>
</tr>
<tr>
<td>Cath Insert/Left Bladder (L)</td>
<td>NC14.01</td>
<td>13</td>
<td>52</td>
<td>12.1%</td>
<td>12.1%</td>
<td>17.1%</td>
<td>9.2%</td>
<td>72</td>
</tr>
<tr>
<td>Lo-Risk Lose B/B Con (L)</td>
<td>NC15.01</td>
<td>16</td>
<td>58</td>
<td>18.0%</td>
<td>18.0%</td>
<td>23.6%</td>
<td>13.9%</td>
<td>71</td>
</tr>
<tr>
<td>Excess Wt Loss (L)</td>
<td>NC16.01</td>
<td>11</td>
<td>48</td>
<td>22.9%</td>
<td>22.9%</td>
<td>29.1%</td>
<td>19.9%</td>
<td>62</td>
</tr>
<tr>
<td>Incr ADL Help (L)</td>
<td>NC17.01</td>
<td>13</td>
<td>52</td>
<td>12.1%</td>
<td>12.1%</td>
<td>17.1%</td>
<td>9.2%</td>
<td>72</td>
</tr>
</tbody>
</table>

#### Nursing Home Compare

**Corporate/Sister Facilities**

**Published Best Practice**

---

*Image of people*
Gather just enough data one step faster than needed outcome

- Hourly
- By shift
- Daily
- Weekly
- Monthly
- Quarterly
- Annually
1.b. Observe Current Practice

• Go to the *gemba*
• Observe carefully with “fresh eyes”
• Ask 5 people for an objective view of what usually happens and how standardized the process now is
• Use gap & cause—system assessments
• May use RCA
Questions in the Gemba

• What happened to create the negative result?
• What usually happens?
• How standardized is the process now?
• What is in place to reduce risk of errors?
• Who/where in your organization has the best results?
• How do you share the learning from success with others throughout the organization?
Gap and Cause—System Analysis

• Less formal and structured than Root Cause Analysis
• May use a formal system assessment tool
• May use standard questioning to collect organizational knowledge
System Assessments

• Use evidence-based best practice instruments

• Examples
  • Pressure Ulcer System Assessment
  • Emory Falls Management Self-Assessment
  • TeamSTEPPS Readiness Assessment
  • CLIP
  • WHO Surgery Checklist
  • Project RED
Process Flow Diagram

- Answers the question “what happened?”
- Shows GAP not CAUSE

Put bread on plate → Spread peanut butter → Spread jelly → Put bread pieces together
5 Whys Method

Event

Why?

Why?

Why?

Why?

Root Cause

Why?

Root Cause

Why?

Root Cause
Six-Factors for Human Performance

Performance System Model

Where we are

- Expectations
  - Lead Values
  - Manage Mission
  - Supervise Goals
  - Objectives
  - Actions
- Metrics
  - Quality Deliveries
  - Lead Time
  - Service Cost
- Consequence
  - Congratulations
  - Recognition
  - Celebration
  - Satisfaction
  - $$$

Where we need to be

- Resources
  - Time
  - Equipment
  - Materials
  - People
  - Process
- Feedback
  - Individual
  - Team
  - Department
  - Public
  - Private
- Competency
  - Hire
  - Train
  - Educate
  - Develop
  - Motivate

Continuously Improve

©HS1104

Howard Sommerfeld
2. Identify Best Practice

- Use a standardized system assessment
  - Pressure ulcer system self-assessment
  - QAPI self-assessment
  - Others
- Use literature
  - Change package best practice ideas
  - Qualis Health website change ideas
- Use your own best-practice leaders
3. Match Change to Test

- Include people closest to the process in decisions about which changes to try
- Identify which best practice change ideas most closely match the system issues you identified in step 1
- Make a short list of ideas to consider for testing in your organization
Selecting Changes to Test

- Requirements
- Repercussions
- Breadth of contributing factors
- Complexity of system
- Time & resources available
- Biggest impact
- Easy and low cost
4. Train and Support Front Line Staff

- Include PI tools in orientation
- Train & competency test for PI skills yearly
- Identify front-line staff PI champions
- Create space in schedules for PI activities
- Provide resources
  - Computer
  - Bulletin board
  - Meeting space & time
  - Materials
  - Learning circles/sharing boards
Four Steps for Improvement

• Use your data and observe current practices
• Identify the gap from best practice
• Match the change to test to the gap/cause
• Train and support front line staff to do PI
Online References

• Comparative Data
  • QIES CASPER Facility MDS 3.0 QM Reports
  • Nursing Home Compare
    www.medicare.gov/nursinghomecompare
  • Advancing Excellence www.nhqualitycampaign.org


• Qualis Health Nursing Home Collaborative
  www.qualishealthmedicare.org/NHCollaborative
Questions?

Traci Treasure, MS, CPHQ, LNHA
Quality Improvement Consultant -- Qualis Health, Idaho
TraciT@QualisHealth.org  208.383.5947

Jillyn G. Reid, MHA, CPHQ
Quality Improvement Consultant -- Qualis Health, WA
JillynR@QualisHealth.org
206.288.2379 (direct) 1.800.949.7536 x2379 (toll free)

For more information:
www.QualisHealthMedicare.org/NHCollaborative

This material was prepared by Qualis Health, the Medicare Quality Improvement Organization for Idaho and Washington, under contract with the Centers for Medicare & Medicaid Services (CMS), an agency of the U.S. Department of Health and Human Services. The contents presented do not necessarily reflect CMS policy. ID/WA-C7-QH-1145-05-13
Your Feedback is Important to Us!

Please complete the brief Survey Monkey evaluation when you close out of the webinar in order to provide feedback and to receive your Certificate of Participation:

https://www.surveymonkey.com/s/PZ625TG

For more information:

www.QualisHealthMedicare.org/NHCollaborative

This material was prepared by Qualis Health, the Medicare Quality Improvement Organization for Idaho and Washington, under contract with the Centers for Medicare & Medicaid Services (CMS), an agency of the U.S. Department of Health and Human Services. The contents presented do not necessarily reflect CMS policy.