



# CMS 2012 Tri-Regional PACE CONFERENCE

Programs of All-Inclusive Care for the Elderly

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## TRANSCRIPT

### Quality Assessment/Performance Improvement (QAPI)

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Good morning. When my account manager asked me to talk about quality at this conference, I said, "Well, what do you want me to talk about? I can talk all day." And he said, "Well, make it entertaining." Make quality entertaining. Oh, I could sing it. Okay, you want me to sing about the QAPI plan? No, you don't want that. How about Shakespeare? To fall or not to fall, is it nobler to fracture a hip in the center or in the home? Perhaps not.

It was terrific when Edwina called me because she helped me come up with these objectives. I want to share how we monitor our QAPI plan. I want to talk a little bit about some of our projects. And I want to share how we document our success. And along the way, I'm going to throw in a few of our quality tools and I'm just going to kind of mention them.

Let me tell you a little bit about who we are. This is our center. It was a former car dealership back in the 1950s and '60s. The HUD grant helped remodel it and one of the neatest things in there are these huge skylights that allow the light in. And that was originally set up so that you could put your cars under it in the showroom and you would have your natural light. We are located in Lynchburg, Virginia, which is in the foothills of Virginia right at the foot of the Blue Ridge Mountains. We opened on February 2nd, 2009, and we had one participant. We were so lucky. Currently we have 83 participants. We service an area of about 200,000 people. Lynchburg is about 75,000. It's a small city. We are hopeful to be able to open another site in Farmville, Virginia, which is about 55 miles away from the Lynchburg site, and so that will have some interesting new challenge for us. We're hoping to do that the end of the year.

Okay, I've told me about me. Now I want to learn a little bit like you. Now we've heard all about the lights, so I'm hoping these are going to help, okay. Let's see, yeah, this is much better. All right now tell me a little bit. How many of you, your primary focus is on the clinic, clinical areas. Can I see a show of hands? Let me see some hands. Okay, how about home care? What's your primary focus? Home care. Okay, I see a few hands. Social work? Any social workers here? Do I see hands?

How about quality? How many of you have primary focuses on quality? Why isn't everyone's hand up? All right. Isn't quality our primary focus for everybody, regardless of where we work? You know that's one of the fabulous things about Central PACE. It's a team approach. It truly is. We have a QAPI plan. And, as I said yesterday, it's worked on paper. But those words are centered around our commitment to

our organizational pillars of success: people, efficiency, service, quality and finance. We also have our commitment to our organizational operation code of ethics to prevent fraud, waste and abuse. Like I said, this is our team's plan. Our team is responsible for quality, not Kim. I've never heard it said it's Kim's quality plan.

Now, how do we monitor it? This is our dashboard. This is updated monthly. And it is also aggregated quarterly. It is reviewed monthly at the quality team meeting and quarterly by our Participant Advisory Committee. We set the targets based on last year's performance and in a way that we can improve it, or and some corporate goals as they've been given to us. This displays the rate for the period of time and the year to date. It also has a spark line. And Edward R. Tufte kind of originated the phrase "sparkline." And he believes that you should be able to tell your story by simply looking at a graph. This is not a quantifiable graph, it just merely tells you your trend. Are you getting better, are you getting worse? How are you doing on it? This is all powered by Excel. And the reason it was designed on one page - and you can't see it very well because it's kind of tiny and we'll see some of the breakouts of it a little later on - but it was designed to be an elevator speech. You know we've all heard about the elevator speech. My son just graduated from Longwood University, a day I thought may never come. But one of his final exams was an elevator speech. He met the professor on level one and had the opportunity to answer the exam question as the elevator went to the 10th floor. That was all the time he had. If I have this sheet of paper and the CEO of Central in an elevator, I can tell him everything I want to tell him about how our organization is doing by this sheet of paper.

All right, so how do we pick projects? The first project that we did right after we opened was a hospitalization project. It was in 2009. And you'll notice the peak right at the beginning there. Can you guess what that was? I think that was when we had about six participants, and yep one of them went to the hospital. No, he didn't bother to call Center PACE before he went, he just went. He's always done it that way. And you know what? It was the most disorganized fiasco I think I've ever seen. No bad outcomes or anything, it was just disorganized.

Right there we needed to fix it. So we started off with the quality tool of a root cause analysis. That helped us to really focus on two areas. One was the ED and the other was the family. The targets we used were set in 2011. And okay, for those of you who are looking, you've seen that December wasn't a good month. We had a lot of special calls going on in December.

And how did we know that? Well, let me tell you this is a little bit of how we document our projects. We utilize the DMAIC method, which DMAIC means Define, Measure, Analyze, Improve and Control. It's part of the Six Sigma methodology. And I'm going to tell you a secret here. Don't tell any of my black belt buddies, but this is a lot like PDSA. Shhh, my secret.

All right, but using DMAIC, we put together just again a one-sheet piece of paper. It gives everybody talking points. All of the team has been involved in this in one way or another, but this gives an easy way to refresh their memory. It's placed on the bulletin board. We have a bulletin board, and a couple of my colleagues have cubbies near that bulletin board. And it's great. They can do my introduction to a new employee speech as we as I can now because they're heard it because I always bring them back to that board as a starting point.

Some of our improvement efforts have been educating participants and families on how to call. We have worked with the ED staff. And because the hospital is centrally located and the majority of our patients go to the same hospital, we've been able to actually develop an icon on the ED board. So when

a participant comes in, they have a board that the icon comes up that lets them know it's a PACE participant. And either they've received a call from our physician or they give our physician a call to let them know what's going on and that they have a participant of ours in the ED.

We also have - one of the other things we do is we report this at the monthly participant council meeting. Curing our Participant Advisory Committee, the advisory committee is made up of participants, family members, community leaders, a board member, those type of people. And one of our participants said, "You know, you bring these statistics to this meeting but you never tell us on the participant counsel these statistics." She was right. So we always take three statistics to the participant counsel meeting. We take falls, we take ED visits, and when we take a statistic of the month from that big dashboard. And I try and rotate them through and explain that statistic and why we track it, but ED visits and it's great. Now we never tell who went to the ED but I will say we had five ED visits, and that's better or worse than last month and you're right where we want you to be or don't forget to call before you come. And you'll see participants going, "That was me but I called." Yes you did.

So another tool that we've been using as we closed out this project was we developed a grid or a log where we track every ED with the critical elements that we want to track. And we also find that this grid has been an excellent resource for our quarterly quality call so that we can refer to it. It also helped us determine that those three people went to the ED on Christmas Eve, Christmas Day and New Year's Eve. It's probably going to surprise you that these three people lived alone and they didn't have any family and they didn't call PACE before they went. And we're going to try and develop some corrective actions before Easter comes.

All right. Another project we worked on was what we talked about yesterday. And I'm not going to reiterate a lot of what we talked about yesterday except that we did look at end of life. Again, we began January of 2010. And we recognized we didn't have any standardized process in place. A quality tool that we used was a SIPOC diagram. And that means Suppliers, Inputs, Process, Outcomes, Customers. And that SIPOC diagram was really, really great.

I'm sure this has never happened to you. Have you ever been in team meeting where it's like herding cats and you've got your medical director and your social worker arguing over here on what is end of life. And you've got your home care nurse and the director with - the home care nurse has brought in a whole basket of things, and she wants to make this a basket that we bring to the participant when they get their hospice orders. And the director is going, "I'm not spending that kind of money." And then you've got your chaplain who's going, "Okay, everybody, let's calm down, koombaya, peace." So, you know, then you have to be a quality professional, put on your cape. And you come in and you pull a tool out. And SIPOC is really good. It really helped our group focus on where we wanted to go with this project and actually, what the key steps in this project were.

The control element that we use is participants with end of life decisions. And give you a picture of that. The end of life decisions, we believe in making that happen at the beginning of the enrollment period. At the enrolment period, during that first enrolment period, if we have let's say four people enroll, three of them have their end of life decisions made. Doesn't mean they've signed a DNR, just what do they want, how do they want to leave with dignity. The fourth person, let's say, says, "Hmm, let me take this home and think about." Well we've got three out of four, so we scored 75 percent for the month. An action item from our quality team meeting is the social worker is responsible for getting that fourth person to make those end of life decisions. That continues to be an action item, regardless if it takes one

month or six months. So we keep on track of that, we stay on top of that knowing who has not made end of life decisions.

Go ahead and give you another project that is current for 2012. November 2010, I came to this conference. And there was a great presentation on request for services. And you know, I had this thought that if CMS is giving a presentation on request for services, they must think it's pretty important. How are we doing? I couldn't answer that at that meeting. But you know, I went back and I did some studies because we've been tracking. We've been tracking our request for services, how many were denied, how many were approved, how many compromises. On wait, we didn't really have a compromise section. Hmm, maybe a compromise is another section we ought to start. That was one of the things we did is we developed the compromise.

And then we found that we're really, really good about bringing that request to the table. The IIDT team really does a good job with that. We're not really good at getting it documented in the chart within one week's time. The biggest problem was the specialty visits, you know, when you want to go to a dentist or the cardiologist. Well, we've done some reorganization with who does that. We finally gave that to someone who would take responsibly for it all the time. We, after a little mis-start, we got that back on track. And now one person makes those appointments and logs them into the chart. And we, in February, we were at 95 percent, I think. And that was we had one and she just - it just slipped off her radar. And so, you know, we did a little corrective action, help it stay on her radar. And hopefully March we'll be at 100 percent.

One of the things that we have used that's been really helpful is a request and decision tool. It's a piece of paper that's like an "S" bar. And it really brings all of the facts to the table for the staff so that they've got it, they know exactly all the background and alternatives and things like that.

Our projects are data-driven. We have two other projects that we're working on this year. And I'm not going to go into those in great detail. Our medication errors, I'm currently doing an analysis on all of our medications areas. We have two basic areas we're going to be focusing on in this project. One will be our delivery where we have had omissions due to - okay I'm going to admit it. We had medications stay on the bus. They had a nice night on the bus. They should have been in the participant's home but that happened. I'm sorry. We're looking to make sure that doesn't happen again. So we've had some delivery flaws. We're looking to make sure that those don't happen and what can we put in place to assure that. Falls is another big one. I'm really looking forward to staying a little while this afternoon to see what the falls presentation has in store for us.

All right, another 2012 project we have is our clinic flow project. And this one is basically from listening to our participants. Some of the quality tools that we used for this are the affinity diagram, the 5S time study. We utilize a satisfaction survey. We do it quarterly. It is homegrown, but it's based on Bob E. Hayes. Mr. Hayes wrote a book back in the '90 about the methodology of surveys. So we try and utilize his methodology while we created the survey. We made sure we included some of the HCAHPS questions. Our hospital organization is very big on the HCAHPS. And so we wanted to make sure we included some of those types of questions, and especially regarding pain. We have separate survey that's very quick that we use for respite visits. When every participant goes to a respite, we want a little feedback about how that experience was.

One of the things we did with this project was we brainstormed all the problems we were having in what were the barriers to clinic flow. And we came up with about 50. And each member of that

brainstorming team was given five votes. That's about ten percent of all of those barriers. And we were asked to put one vote on the one that we - one vote each on the five top things we felt were the biggest barriers. We then, by elimination on that voting process, focused on those top projects or top problems.

Another thing we have done is a 5S. We did a time study, and we saw that we really were wasting a lot of time back and forth looking for things. So the clinic took one afternoon that was quiet. Yeah, we had one afternoon, just one, that was quiet. And they cleaned out. They rearranged. They 5S'd: Sort, Set in order, Shine, Standardize and Sustained. Does that sound a little bit about what your mom used to tell you, go clean up your room? You know, sort it out, put it in order, make it clear, get everything in a place for everything and everything in its place and then keep it that way. And the clinics had said that they even did some rearranging of things like needle boxes and glove boxes on the walls that have made them easier to reach.

All right, now a mini-project we did, and this was just a very small project when we started off, was from an NPA presentation I attended on pressure ulcers. I went back and did a detailed analysis of all our participants and took a look at pressure ulcers and how many had pressure ulcers and how many were on oxygen, where pressure ulcers were. And if you can cite a cause of a pressure ulcer that there an event prior to it, those type of things. And really that gave us a clarification on our acquired and prevalence. We did a little work on how we wanted to make sure we were defining these consistently. And then we did have a pressure ulcer that was a level 2. It went from a stage 2 to a stage 3, unfortunately. And during our debriefing question, the question was verification of wound checks. Well, on this one I was absolutely certain, because I'd done the root cause analysis, that we were doing regular wound checks and we were measuring the size and the thickness and the color and all that good stuff. And I'd seen it but I couldn't say that about the ones we had now. So I made sure. And so that's one of the things that we check regularly now. In 2012 we're looking at is how are we documenting our wounds. Are they being regularly documented?

I have to share a little story with you. If you've read the bio, I used to be at the hospital. And I spent about 15 years at the hospital in quality. And I had this wonderful experience. I had this young nurse. She was sweet. She was straight out of school, and this was her first project. And she brought me this piece of paper. It was a printout of her spreadsheet. And she had been tracking nurse-assisted deliveries for a year. This was a delivery where the doctor wasn't present, that the nurses actually made the delivery. And she had every hour, every cause, every minute, what day of the week, whether it a holiday, not a holiday. She was gorgeous. I said, "What did you do with it?" "Well, I can tell you what shift it occurred on." I said, "Yeah, what did you do with it?" "Well, we showed into to the doctors." "And what did you do with it?" "Well." "Did you change anything?" "Was I supposed to change something?" I said, "Maybe I didn't do such a good job educating you on what quality improvement projects were. So you need to take any project you're doing and make sure, even if it's just confirming we're doing this right, make sure you don't need to improve your process."

Other resources that we have used are hot topics. You know you can find those on the National Quality Forum, National Priorities Partnership, IHI, the Star Initiative, health care reform issues. Re-admissions within 30 days is an example of one of those. That's a really hot topic now. And we have something we're calling in our organization "Move the Cheese." Our annual retreat had a presentation on moving the cheese. And I'm not going to go into that. But at the end of it, we decided that what we wanted to do is each of our disciplines have a small project in which they move the cheese. They're going through the victim aid project, but they've got six months to move the cheese. One of the ones is readmissions

within 30 days. Our activities has a project, transport, CNAs, clinic, finances, kitchen and therapy. Each of those groups has their own little teeny, tiny project. CNAs, I think it has to do with skin care. The activities are going to introduce two new activities every month and analyze those. So we're moving our cheese.

Okay. I practice Lent. This is the season of Lent and I observe it. It is a time of recognizing where I fall short in repenting or changing the direction. And here in front of CMS I'm about to admit we fell short. But we're all repenting and we are changing our direction, okay. I really strongly recommend that you do analyze new processes when you put them in place. And you may find that I did your quality tool may have to be the bottle of Tums. Okay, I ate a lot of Tums when I looked at this project.

We had two participants that found out that you can unbuckle your seatbelt. And if you unbuckle your seatbelt you can move around, which is great except the bus is moving, which is not so great, which means you have to pull the bus over and risk the person falling down and put them back in their seat. And so we were looking at ways to prevent this from happening. And we were discussing escorts or turning the buckles or we discussed a variety of different things when a team member came up with buckle guards. And a buckle guard is the best way to define it, it's a child safety cap for the seatbelt. And the buckle guard is a restraint because the participant can't release it. So we did a lot of work.

One of the first projects my director and I ever did back when we both worked in the hospital was introduction of the changes that came about in the late '90s regarding restraints and how there was no longer a PRN order for restraints. So we really worked hard on making sure that we were going to keep out participants as safe as possible in these restraints. We discussed it with the physician. We developed the order so that it would be with rationale. It wasn't going to be done higgly-piggly. We educated, educated, educated. We educated our drivers on that buckle guards could only be used with a doctor's order and only on these two participants. They could only be used and in the event that you had a traffic delay, that within 30 minutes that participant had to be gotten up and walked around a little bit and moved around and not kept in the buckle guard. Every time we had a limo driver in the center, I quizzed them on that. Our drivers are good. They had that, they knew that. We even have a competency in place for use of that buckle guard.

And so we let it go for about three months. And I did a chart on it. I did a chart on it and bad things. This is when I started using the Tums. We found that things weren't being a chart. And so I go the transportation coordinator. And he goes, "Well, you know let me check in with my drivers." Come to find out, the drivers had stopped using the buckle guards. We had done such a good job of educating the drivers on how to use the buckle guards, we didn't educate them on not using them. Because after all, we had a doctor's order in place. And it was going to take care of the situation. Well things changed. One of the participants is now a wheelchair transport. And he doesn't try and get out of the wheelchair with the straps on the wheelchair transport. So they couldn't use a buckle guard anyway. Oops, the chart didn't tell me that. The other one has gotten a little combative when you go to up the seatbelt on anyway. And apparently only her daughter and one CNA can snap her buckle. I didn't see that in the chart either.

So we've gone back, we've done a little reeducation. The other thing we did was, you know I noticed that there weren't any goals for restraints. The reason why was because they weren't being used. We also had - part of our process was that the physician's order was only good for six months or until the next - which would be the next - assessment period. And guess what happened? The physician didn't redo the order either. So our process that we had set up so well and we were so sure it was going to

work fell apart. So my - you know I'm sure this has never happened to anybody out there. My suggestion is those new processes you put in place, make sure you're monitoring them because bad things can happen to good people.

All right. Okay we heard yesterday Margaret Wilbur was fabulous. I was like, "Oh yes, this is exactly what happened to us." One of the advice she gave us was don't wait if you know you have a problem with your infections. Go ahead and get on top of them. As you can see in January, we had a little bit of a problem there. If we had waited until February when we got our infection control report in, we may have had a bigger one. The quality tool I used was the stress ball. I needed a lot of that. During this period of time we had a problem and we didn't know exactly how to fix it. Well yes we did because we've got a lot of smart people in our organization. And sometimes it doesn't take a whole big team. It just takes a few, three or four people, getting together and deciding we're going to fix this and we need to do it now and it's going out to everybody.

And you got two pages of what we did but I'll let you read through that when you're bored. Oh, you're reading it now, okay. You know, we put those actions into place. And it really seemed to turn it around. And one of the things we're thinking about doing, we discussed it, is we're probably going to put some type of trigger in place. In October, beginning in October we're probably going to put like a trigger in place where if we have five clinic visits in a week which have upper respiratory symptoms, we might start to put those - really focus on our infection control. The same types of things that we just did here in January, we're going to probably bring those back again in October and really have that focus on infections.

A little something that's just going to give you a little tip here. Shhh. Yesterday Peggy talked about trending by participant. I thought, hmm, that's an idea. And you know, one of my earlier suggestions was if CMS says it, from the mouth of CMS to my hand, I'm probably going to do that. So probably in the next two weeks you're going to see a spreadsheet in my computer that's going to be infections by participant. And probably that's going to be one of those things that I supply the assessment team every six months when they go in and do their regular assents.

All right,. So PACE, monitor its quality plan using data presented in a dashboard format. Our projects are determined in response to lack of standardization, learning from others, level 2 events, hot topics, new processes and specific situations. Our success is data-driven and documented in a project summary or minutes.

Now, I've done all the talking. It's your turn. Do you have any questions?

That was a great talk. Thank you. You brought up a good point about the safety and driving on the vans and the whole issue of restraints. And we, like you, have encountered the same issue and dilemma. Interestingly, the data on restraints and the reason we don't restrain is not really done in that setting. And the whole safety balance of what happens to an unrestrained person wandering around in a moving vehicle is different than a restrained person in a bed at a nursing home, which is where we extrapolate that desire to not restrain. What are your thoughts about both documentation and influencing policy or suggestion regarding - because in my opinion, it's like you. A wandering person on a moving van maybe at high speeds is probably statistically, frequently and severity of injury, is greater than the risk of restraining them and having an accident and they can't be released or whatever.

That was the discussion our team had was what is the best thing to do because we cannot have the participant wandering the bus while the driver's driving. And so that was the solution we found was the best. I agree it's not a typical restraint and what we think of in a nursing home, you know. As I said, back in the '90s we were having those horrible events where the person was in the vest restraint and would suffocate because they actually kind of hung themselves. And certainly this is not a restraint like that. But it does inhibit the movement of a participant with - and they cannot release it themselves. So that does technically meet the restraint. But it's the least. It's a level 1. It's the least invasive.

Yeah I guess my point is that that's based on no data, that that's better for the patient or the participant. And so, given this conference's objectives of what is in the best interest, given that we don't practice - we don't provide care just in the home or just in the center or just in the van. We really have to create essentially a whole new set of standards for something like that where I think it's really not clear.

You're right.

Kimberly, thanks for that presentation. I wondered if you had a process for self-evaluation of your quality process.

Oooh, like other people looking at - you know our team getting together and determining -

Self-evaluation.

Well not a process, no. But we do look at it every - you know, we're certainly looking at our quality program every month to see how we're going as part of our monthly. But as the end of the year, no I don't think we do really have something like that. That's a really neat idea and definitely something to try.

[inaudible]

Oh yeah, oh yeah. I'm in the chart every month. Oh go ahead.

And my second question or a second aspect is when do you move from - when do you decide you no longer have to do this routine audit?

Well we've only been open for three years.

Us too.

So the routine audits, I usually I have discontinued looking at measures when we've gotten 100 percent for a year. And still though, we're spot-checking them regularly to assure that it's happening. One of the things, we're in the chart every month. We're looking at key assessments we're looking at. We have several other indicators that are in there. We look at our MMEs. When we first started out, we were inconsistent. I no longer check to see if we've done the MMSE. But I do look to see if our MMSE had dropped. Now, with our population, we expect it to drop. But if we have a participant who has dropped more than six points - more than five points, which would be six or more points on an assessment period, we take a little closer look. Have we done something medication-wise? Have they had an event? We had a participant that did that. And we come to find out what had happened was her husband, who is a very devoted individual, he was pouring out her cough medicine. And since she had a



really bad cough, he was pouring out four doses a day right there where she could take it. And he did it all in the morning, you know. Well, our home health nurse visited after she had taken all four doses. So her MMSE was very low. It had dropped. And so, as we began to investigate, you know that was an alarm bell right then for that home health nurse. And she's like, "You know, what's going on here? She shouldn't have dropped. We haven't noticed this. How did we miss this?" And, in talking with the husband, together they discovered the cough medicine. And so what they did was they changed her to Mucinex. And that seemed to be doing a little better job. And that was only done twice a day. And we also did a little reeducation with the husband that maybe that was a medication you needed to not pour out for her to take.

Any questions? All right. What are some other problems that you might have seen? Just out of curiosity, are there some elements that you might be tracking that you find unique to your organization that you might want to share that would strengthen all of our organizations? Do you have a quality plan? Is it words on paper or is it more? I'll sing. All right. Well, I guess if there's no further questions.