Mercy LIFE
A member of Mercy Health System

Implementing a QAPI Program to Successfully Pass a CMS/PACE Survey
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At the conclusion of this session the participants will be able to:

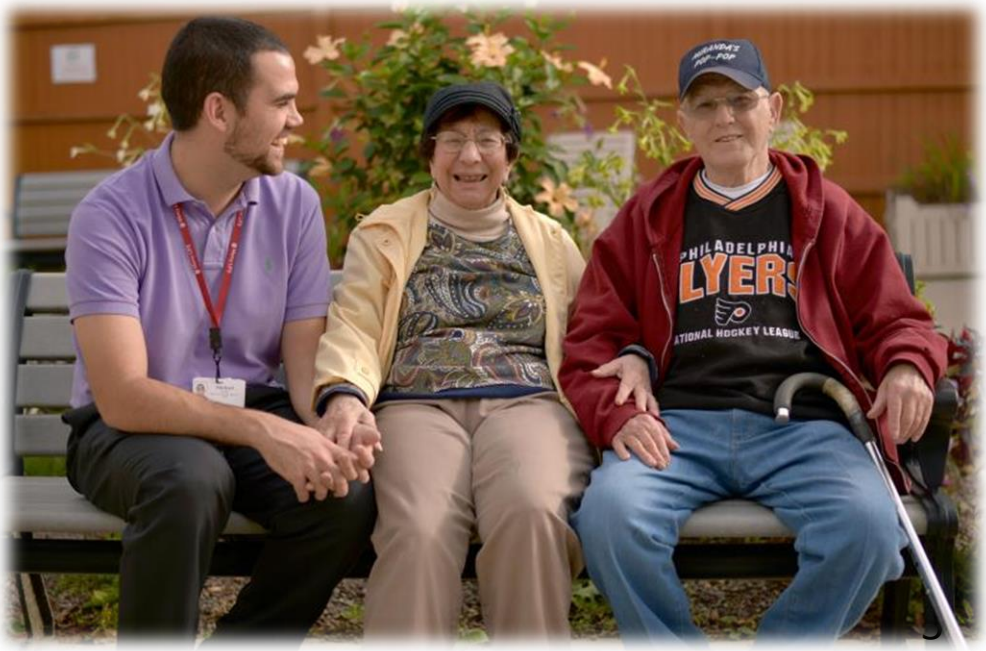
- Design and execute a comprehensive quality program while remaining in compliance with CMS regulations
- Replicate a quality program across multiple sites during periods of growth
- Track, trend and analyze quality data at the participant level across multiple PACE sites
- Understand the intent of the regulations
- Appreciate the depth of a fully developed program
- Gain understanding in areas of Performance Improvement projects

Agenda

- Background/ Overview
- Regulations for a CMS PACE organization
- Mercy LIFE's QAPI program development
  - Scorecard example
  - QAPI Committee Reporting
  - PI Project Examples & Sample
- CMS Audit Preparation

- Capitated PACE program began: 1998
- Current participants: 672
- Four Centers:
  - Two centers in city of Philadelphia
  - Two centers in Delaware County
    - One of the Delaware County centers is a residential facility deaf seniors “Home of Deaf Aged”
- Enrolled 80 homebound Sisters of St. Francis of Assisi in May 2015

- Subpart H-Quality Assessment and Performance Improvement § 460.130-136
  - § 460.130 **General Rule-** A PACE Organization (PO) must develop, implement, maintain, and evaluate an effective data driven quality assessment and performance improvement program
  - Program must reflect the full range of services
  - A PO must take action that result in improvements in all types of care



- CMS Full Range of Services:
  - Utilization
  - Caregiver and participant satisfaction
  - Outcomes measures
  - Effectiveness of and safety of staff provided and contracted services
  - Nonclinical areas

- § 460.132 QAPI **Plan**
  - PO must have a written plan in addition to a program
  - Annual review
  - **Minimal plan requirements**
    - Identify areas to improve or maintain the delivery of services and patient care
    - Develop and implement plans of action to improve or maintain quality of care
    - Document and disseminate to PACE staff and contractors

CMS QAPI Plan

2015 QAPI Work Plan

GOALS	Benchmark	2014 YTD	2015 Target		1st Q 2015	2nd Q 2015	3rd Q 2015	4th Q 2015		2015 YTD	Status and/or Comments
I. Service Utilization											
Access to Care	Acute Hosp Admissions/1000(Not LTAC/psych)										
	SNF Days/1000										
	ER Visits/1000 (includes observation)										
	LT NH % Participants Placed										
	Pharmacy Prescriptions % Generics										
II. Satisfaction/ Quality of Life											
Overall Satisfaction Rating % Excellent	How would you rate the organization (% Excellent)*										
	Would Recommend the Center*										
Monitor Voluntary Disenrollments	Preventable Voluntary Disenrollment Rate (# / census)										
III. Outcome Measures											
Enhance Pneumococcal Vaccination Administration Rates	% Participants Pneumococcal Immunized *										
Enhance Influenza Vaccination Administration Rates	% Participants Influenza Immunized *										
Prevent Falls/Minimize Injury	Falls/100 participants										
	% FRISI **										
Minimize Hospital Readmissions	Acute Medical Hosp Readmission w/in 30 days of discharge Rate										
CMS Mandatory Level 2 Reporting	Level 2 Event Reports										
Maintain or Improve Functional Mobility	Tinetti/Barthel Assessment Tool - % maintained function**										
IV. Effectiveness & Safety of Staff Provided & Contract Services											
Assure timely documentation of Advance Directives	Measure % of Advance Directives completed										
Annual Competencies - Direct Care Colleagues	Measure % Completed Competencies										
V. Non-Clinical Areas											
Encourage open communication from participants and caregivers	Measure Grievances/1000 participants										
	Measure total # participants appeals										
Performance Improvement Projects											
I. Service Utilization	Acute Care Hospitalizations 30-day All-cause Readmissions						x				
II. Satisfaction	Satisfaction with Recreation Activities					x	x				
III. Outcome Measures	Level 2 Wounds: Stage 3, 4 and Unstageable Pressure Ulcers						x	x			
IV. Effectiveness & Safety of Staff Provided & Contract Services	Colleague Safety/Workplace Violence					x	x				
IV. Effectiveness & Safety of Staff Provided & Contract Services	Quality of Services Provided by Contracted Homecare Agencies					x	x				
IV. Effectiveness & Safety of Staff Provided & Contract Services	Colleague Satisfaction with Contracted Providers						x				
V. Non-Clinical Areas	Participant Involvement in Care Planning					x	x				

- § 460.134 (a) Minimum program requirements
  - 5 Elements: Utilization/Satisfaction/Safety & Contracted Services/Non Clinical
- Outcomes Measures that are derived from data collected during assessments, including data on the following:
  - Physiological well being
  - Functional status
  - Cognitive ability
  - Social/ behavioral functioning
  - Quality of life of participants

- § 460.134 (b) Basis for outcome measures
  - Based on clinical practice guidelines
- § 460.134 (c) Minimal levels of performance
  - PO must meet or exceed CMS and state agency on standard quality measures such as influenza immunization rates
- § 460.134 (d) **Accuracy** of data.
  - Ensure data is accurate and complete

- § 460.136 QAPI a) **Internal Activities-** Identify areas of good or problematic performance
  - **Take actions** targeted at maintaining or improving care based on outcomes measures
  - Incorporate actions into standard of practice and periodically **track** performance improvement **over time**
  - **Set priorities** for performance considering prevalence and severity of identified problems and give priority to improvement that affects clinical outcomes
  - Immediately **correct** any identified problem that directly threatens the health and safety of participant

- § 460.136 Internal QAPI Activities:
  - b) QAPI coordinator
  - c) Involvement in PI activities
    - IDT and Staff
    - PACE participant or caregiver involvement including providing information about satisfaction with services
- § 460.138-460.140 (§ 460.202)
    - Committee with community input
    - Must meet requirements by CMS or State

1. QAPI **Program Description**
2. QAPI Annual **Plan**
3. QAPI Annual **Report**

- Need all **five elements** listed in each report:
  - I. Utilization
  - II. Caregiver and participant satisfaction
  - III. Outcomes measures
  - IV. Effectiveness and safety of staff provided and contracted services
  - V. Nonclinical areas

- Include data and discussion of all elements
- Confirm matches program description
  - “Did what you said you would do …”
- Include PI projects
  - Better than attaching
  - Can use annual report as past references
- Include focused sub analysis or discussion
  - State this was done in response to an area of concern or opportunity
  - i.e UTIs at one center, dental grievances
- State at end of each element “found no quality concerns”

- Quarterly
  - QAPI Meeting
    - Standing Agenda
    - Standing slides
      - Assign different disciplines to report
      - Example
        - » Element Service Utilization
- PI Projects
  - Assign a specific Quarter each PI write up is due
    - i.e QTR 2 or 3
  - Present at QAPI meeting and include in minutes

Five Basic Elements

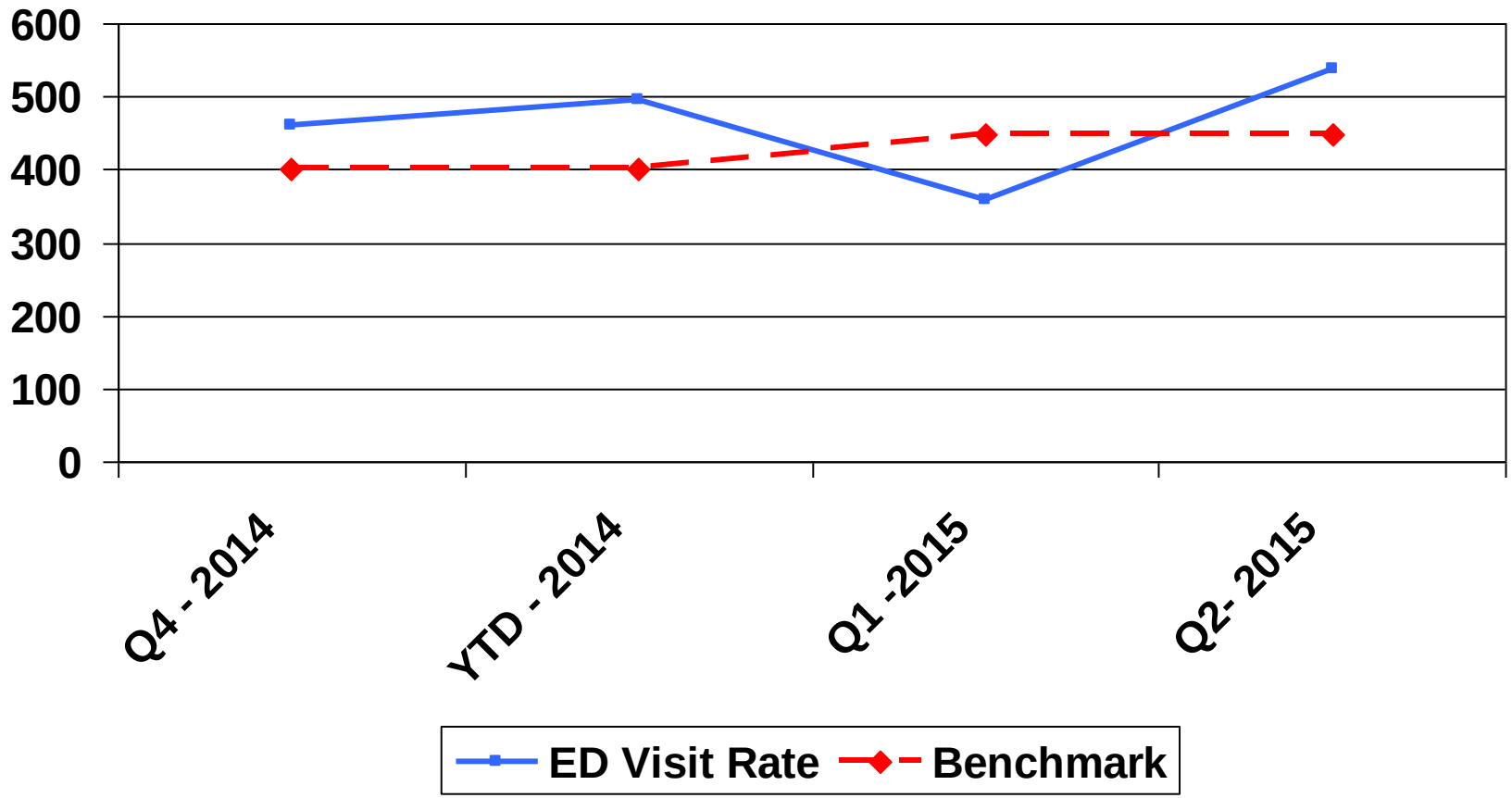
I. UTILIZATION

Utilization Scorecard Example

Utilization	2015	Target	Feb	QTR 1
ED Utilization * ER only	Finance		0	0
# ED Visits				0
ED Visits/1000		448.5		0
Acute Care Utilization				0
Total # of Hosp Admissions (Not LTAC/PSYCH/AcuteRehab)				
a. Center 1				0
b. Center 2				0
Acute Hosp Admissions/1000 (not LTACH/psych/acute Rehab)		825		0
Total # of Hospital Readmissions within 30 days of Discharge (Not LTACH or Psych)				
a. Center 1				
b. Center 2				
Total # of Hospital Readmission within 30 Days of Discharge (ALL ADMITS including psych and LTAC)				0
Hospital Readmission Rate within 30 Days of Discharge (Not LTACH or Psych) (total hospital readmissions not LTACH or Psych/Medication Admissions)		17.9%	#DIV/0!	
Total # of Hospital Discharges (not LTACH/psych/acute Rehab)				

Emergency Room Visits per 1000*

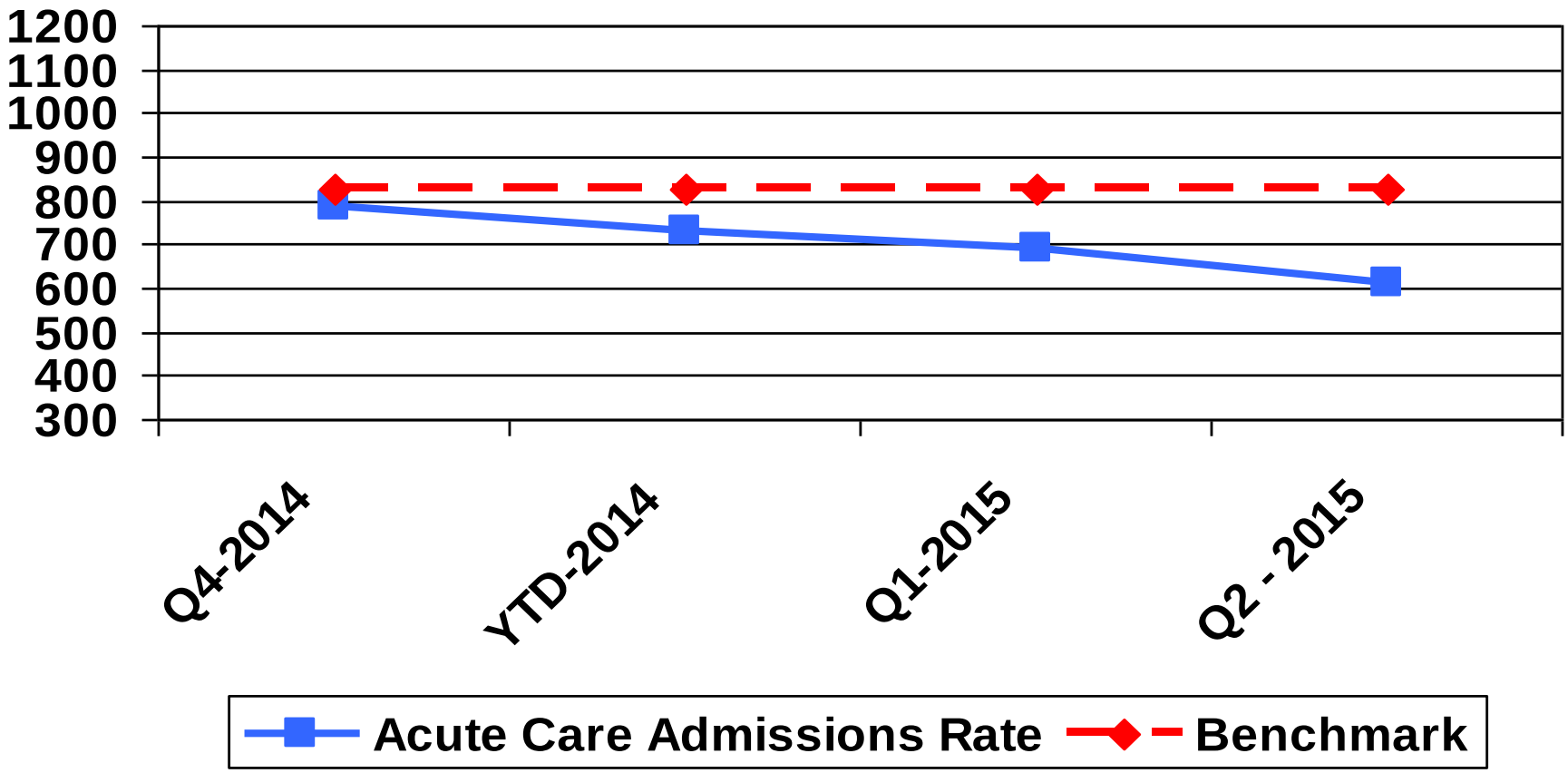
Target - 448.5



*Includes observation

Acute Hospital Admissions per 1000*

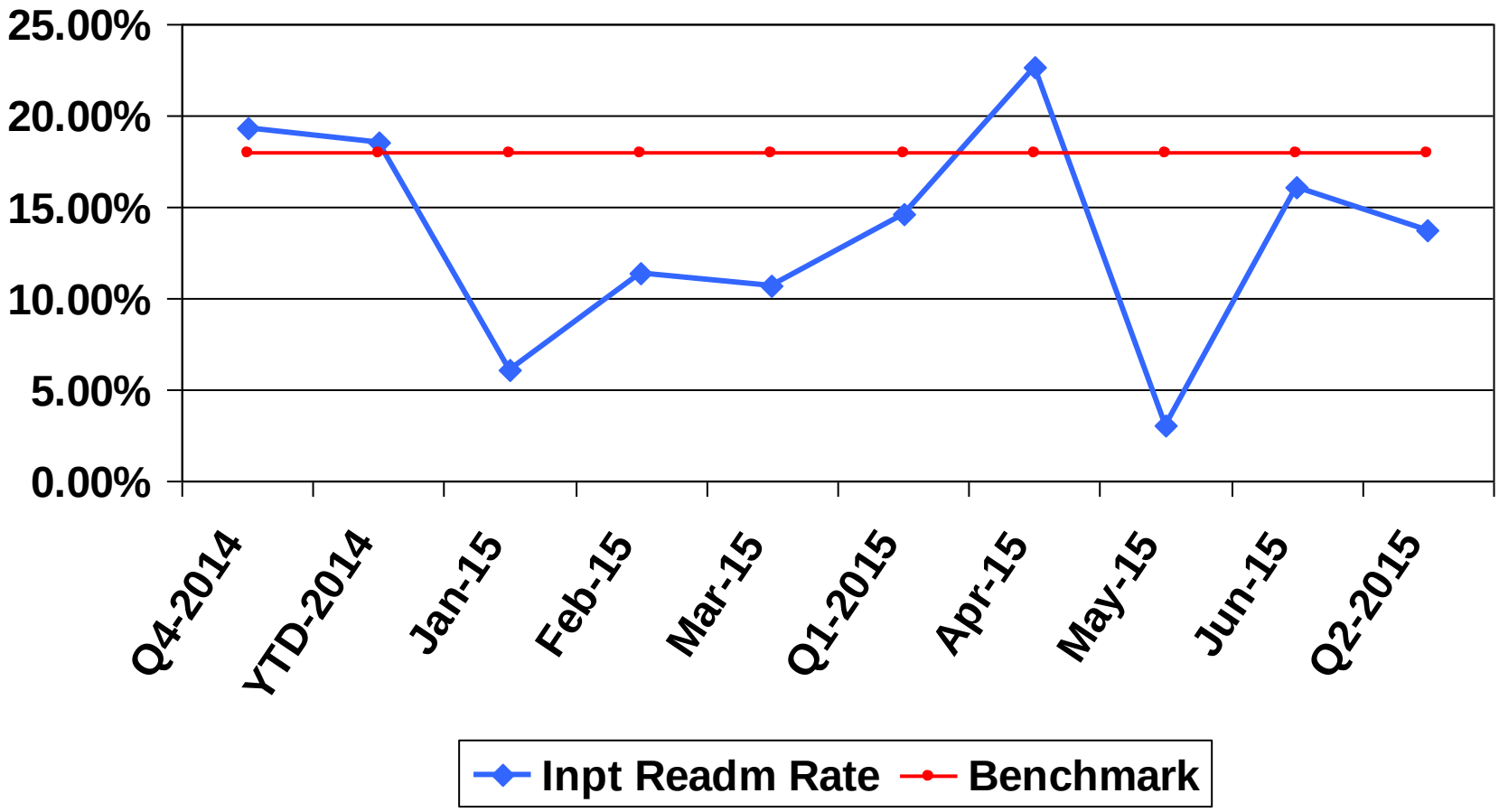
Target – 825



*Medical admissions only

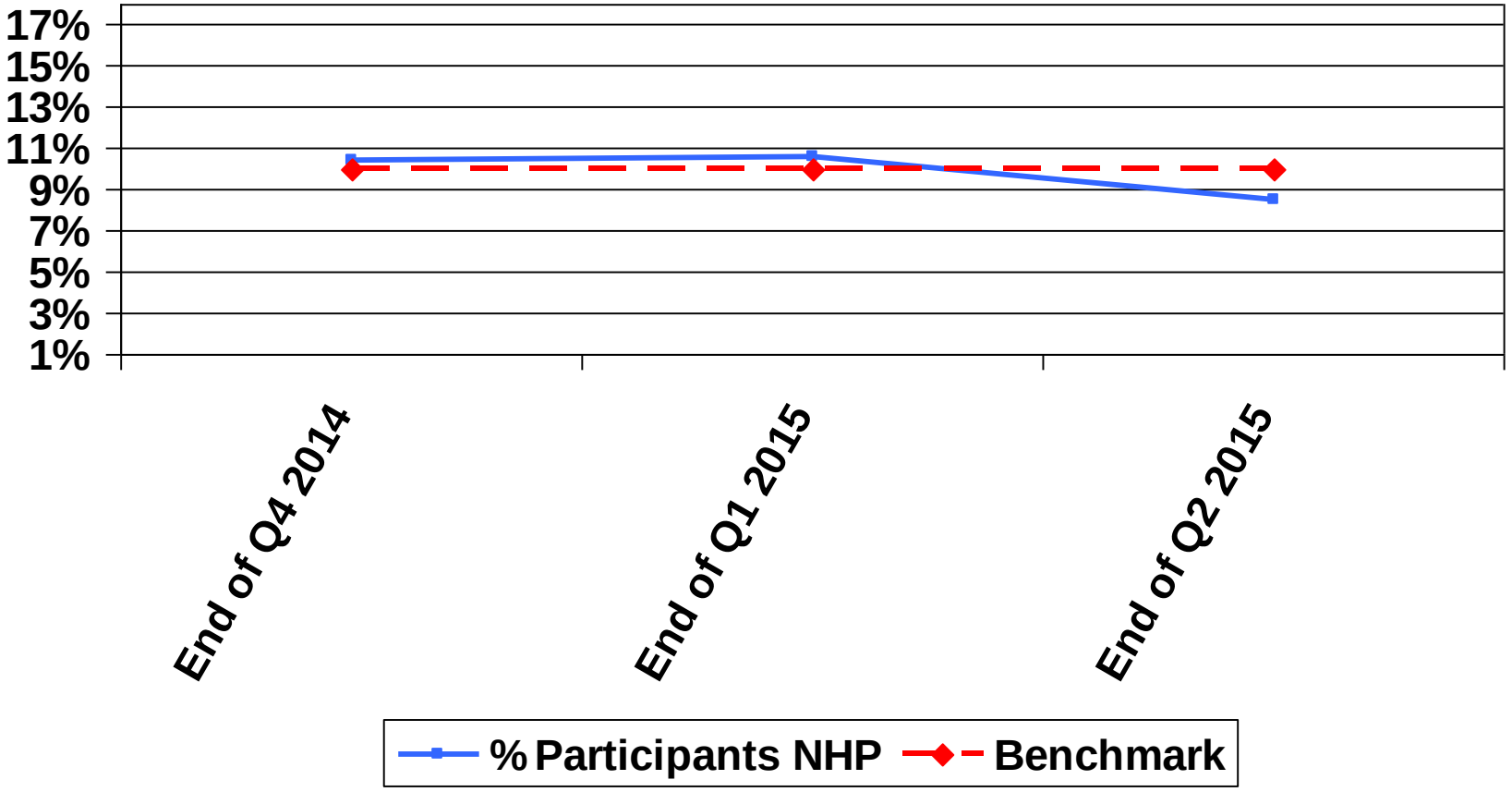
Inpatient Acute Readmission Rate

Target – 17.9%



Nursing Home Participants

Target – 10%



- Utilization is also part of QAPI, LPAC in addition to finance and board report
- Examples of trending- quarterly preferred
  - Areas of major opportunity should be formally reviewed monthly i.e. Readmissions
  - Identify at least one area of utilization to be a chosen PI project for the QAPI work plan every year
  - One area of opportunity and one area to develop

QI: Name of project and year

Persons Responsible:

Background:

Methodology:

Results:

Discussion:

Summary:

Element requirements – Examples of PI projects and Data collection

Element		Examples PI Title
I. Utilization		Appropriate Emergency Room Use & Access
I. Utilization		Acute Care Hospitalizations: 30-day All-cause Readmissions
I. Utilization		Reduction in Nursing Home Placements/Institutionalizations

QI: Appropriate Emergency Room Use and Access 2014

Persons Responsible: Donna Raziano MD, Joseph Straton MD
Background: Pace Organizations (PO) are responsible for participant's health while enrolled. The PO is responsible for educating each participant how to access emergency care. The PO can implement different strategies to address urgent and emergent issues for weekday, weeknight, and weekend time periods.

Methodology: Mercy LIFE's Medical Director and Center Directors completed a retrospective review of all emergency room (ER) only visit for a period of three months. The clinical presentation, time of visit, and referral to ER was assessed for each individual ER visit. A determination of Avoidable (A) and Potentially Avoidable (PA) and Not avoidable (NA) was made. Although there are no national benchmarks of emergency room access rates for avoidable and potentially avoidable visits, there is an historical benchmark of overall emergency access for Medicare beneficiaries. Mercy LIFE has used this ER benchmark of 420 visits per 1000 participant to include ER only and ER observations.

Utilization PI Project Sample

2014		MAY				June				July				
QTR 2		MAY	A	PA	NA	June	A	PA	NA	July	A	PA	NA	(A+PA)/total *100
Hancock	ER only	5		1	4	3		1	2	8		3	5	
	Obs	3			3	0				1			1	25.0%
Broad Street	ER only	11		3	8	10		1	9	6			6	
	Obs	2			2	1			1	0				13.3%
Grays Ferry	ER only	0				2			2	5	1	1	3	
	Obs	0				1			1	1			1	22.2%
Valley View	ER only	0				1			1	1			1	
	Obs	0				0				0				0.0%
Overall TOTAL		21		4	17	18		2	16	22	1	4	17	**18.0%**

Results: Mercy LIFE has four adult day centers: Hancock, Broad Street, Grays Ferry, and Valley View. Quarter 2 overall census was 537 participants and each center respectfully Hancock -211, Broad Street - 169, Grays Ferry - 122 and Valley View - 32 participants.

**(A) Avoidable and (PA) Potentially Avoidable and (NA) Not avoidable*

Discussion:
The Hancock day center had the highest average census for the quarter at 211 participants. None of the visits were deemed avoidable. Twenty five percent (5/20) was deemed potentially avoidable.

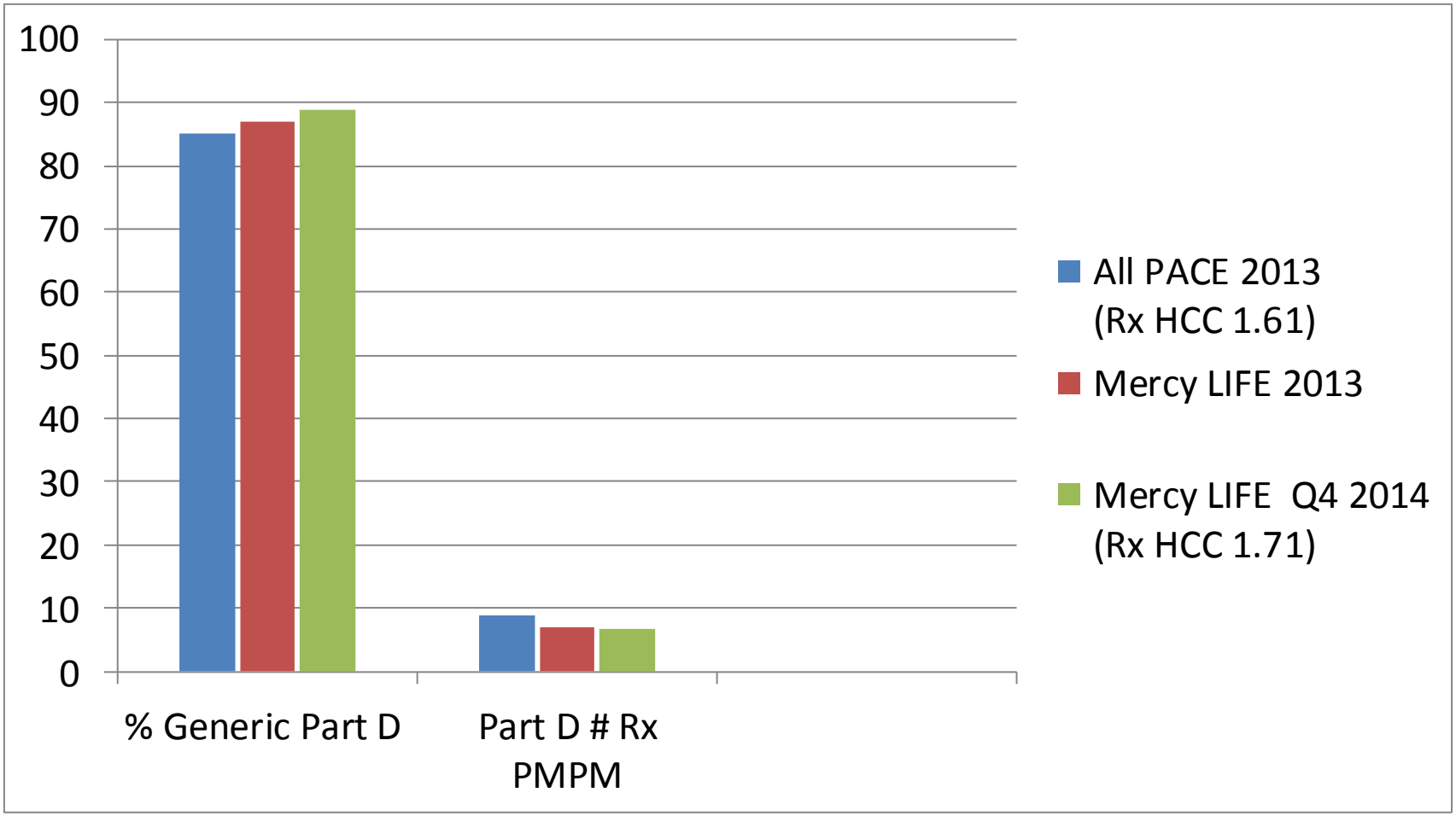
The Broad Street day center had the highest volume of ER visits (30 for the quarter) but also a very low percentage of avoidable and potentially avoidable visits at 13.3%. A case level secondary review was completed by the medical director. This analysis reported two participants had recurrent ER visits for pain and foley issues respectively. No other issues were identified.
Grays Ferry had 2 out of 9 visits or 22% potentially avoidable or avoidable. The overall number of visits were low and results reflected appropriate utilization.

Examples of appropriate access to emergency care are acute changes in condition and trauma related incidents. If Mercy LIFE staff and/or medical professionals, including the dialysis center, referred the participant to the ER it was also consider appropriate.

In 2012 Mercy LIFE reported that 32%of all visits were avoidable and/or potentially avoidable (potentially avoidable ER visits was 15% and avoidable was 17 %.) There is a strongly positive downward trend with current results at 18%.

Summary:
Mercy LIFE overall had good results showing emergency access to care to be appropriate.
The ongoing opportunity for LIFE is to educate colleagues, participants and caregivers about how and when to access LIFE timely. No quality issues have been identified.

Part D Prescription
Drugs Generic Dispensing Rate and # Rx PMPM



QI: CMS Part D: Antipsychotic Prescription Usage 2014

Persons Responsible: Dr. Donna Raziano, Dr. Joseph Straton, Robert Alesiani PharmD

Background: Regarding antipsychotic medication prescribing for participants in the Mercy LIFE program, our goal is to minimize the usage of antipsychotic medications to only those participants who require them for the management of psychotic disorders or substantial psychotic symptoms of related disorders.

Table 1.

Center	Participants Prescribed Antipsychotic Medications	Total Participants	Percent of Participants Prescribed Antipsychotic Medications
Total Feb 2009	24	255	9.4%
Total Aug 2012	47	453	10.3%
Total Nov 2013	67	496	13.5%
Total Jan 2014	66	525	12.6%

Methodology:
All antipsychotic medication prescriptions were extracted from our pharmacy database for all of our participants, by center, for the month of May 2014.
The calculation is % = (At least one Rx/ per member filled in current month) * 100

Summary Results: The results of antipsychotic prescriptions for May 2014 are presented in table below.

Table 2.
A review by each participant was conducted to confirm diagnosis. The table below is revised to address the usage only among participants with dementia.

Center	Participants Prescribed Antipsychotic Medications	Total Participants	Percent of Participants Prescribed Antipsychotic Medications
Broad Street	19	169	11.2%
Grays Ferry	6	120	5 %
North Hancock	26	205	12.6%
Valley View	10	32	31.2%
Total	61	526	11.5%

CMS Part D PI Project: Antipsychotic Use

Center	# Participants Prescribed Antipsychotic for Dementia with psychosis and/or complications	Total Participants	Percent of Participants Prescribed Antipsychotic Medications for Diagnosis of Dementia with Psychosis
Broad Street	5	169	2.95 %
Grays Ferry	3	120	2.5 %
North Hancock	6	205	2.92 %
Valley View	2	32	6.25 %
Total	16	526	3.04 %

Table 3.

Discussion:

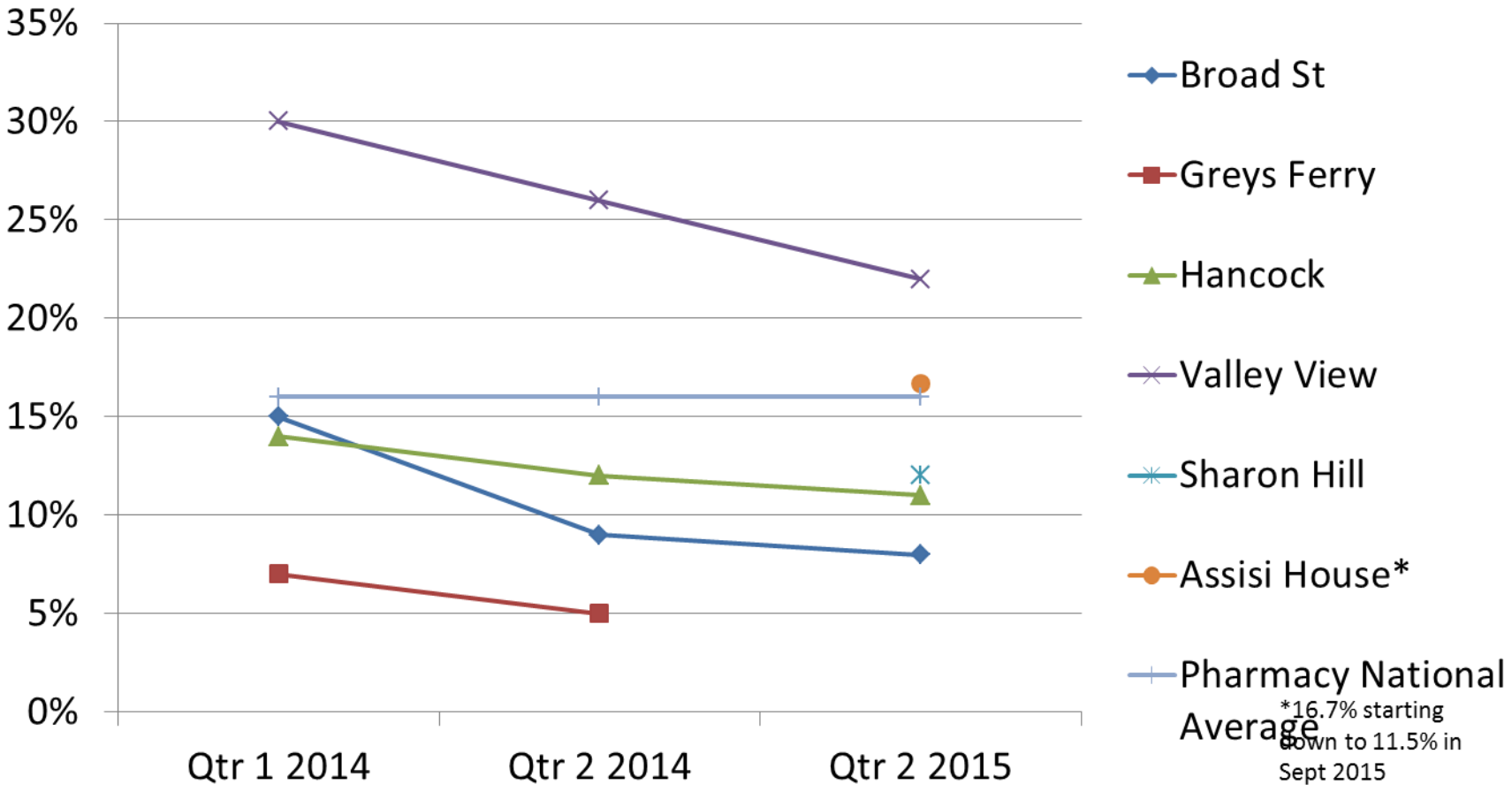
Overall rate of antipsychotic prescriptions: The overall percentage of participants prescribed antipsychotic medications in the Mercy LIFE program is 11.5% for May 2014 which is well below the national average rate of 14.5% for similar PACE older adults.

Our overall rate of antipsychotic usage with participants with dementia with psychosis and/ or complications is 15.8%. This is much lower than expected industry benchmark of 24%. In addition since we identified this PI project in early 2014 and educated primary care staff along with our consultant pharmacist we decreased our overall rate from 12.6% to 11.5%.

Antipsychotic prescriptions by center: Looking at the rates of prescriptions for antipsychotic prescriptions by center, we find there is variation. The percentage of participants prescribed antipsychotic medications is 5 % at the Grays Ferry center, 11.2% at the Broad Street center, 12.6 % at the North Hancock center, and 31 % at the Valley View center.

Summary & Goal: In summary, our project results demonstrate that we are appropriately prescribing antipsychotic medications for our participants and are satisfactory below all benchmarks.

Pharmacy Utilization: Trending Antipsychotic Use 2014-2015



Five Basic Elements

II. CAREGIVER & PARTICIPANT SATISFACTION

Caregiver & Participant Satisfaction Scorecard Example

Satisfaction					
Indicator		Target 2015	Jan	Feb	QTR 1
Participant Satisfaction	QAPI Mgr				
Total #of Completed Survey--All Centers					
How would you rate the organization (% Excellent) - All Centers					
a. Center 1					
b. Center 2					
c. Center 3					
Would Recommend the Center (Definitely Yes)--All Centers					

Element requirements – Examples of PI projects and Data collection

Element		Examples PI Title
II. Caregiver & Participant Satisfaction		Caregiver Orientation
II. Caregiver & Participant Satisfaction		Participant Satisfaction with Therapeutic Recreation Activities
II. Caregiver & Participant Satisfaction		Caregiver Support Program

Caregiver & Participant Satisfaction PI Project Sample

QI: Satisfaction with Therapeutic Recreation Activities

Persons Responsible: Elizabeth Johnson CTRS/ Rec Therapy Supervisor & Michael Johnson CTRS/ Rec Therapy Supervisor

Background: The Mercy LIFE Recreation Therapy Department strives to promote the social, emotional, spiritual, creative, cognitive, and physical health of the participants. If a participant is satisfied with the programs and activities offered, their center attendance will be more consistent, allowing them to achieve proper medical and nursing services, nutrition, and social service care.

Methodology: Results of the participant satisfaction survey conducted in December 2013 revealed the following scores for the therapeutic recreation department at each center:

Likes Activities Offered	External Survey 2ndQ 2013	Internal Survey 4thQ 2013	Comments
Mercy LIFE overall	46.8%	61%	Increased 14.2%
Broad Street	53.8%	67%	Increased 13.2%
Grays Ferry	59.4%	44%	Decreased 15.4%
North Hancock	34.2%	73%	Increased 38.8%

Caregiver & Participant Satisfaction PI Project Sample

Methodology (continued): As a result of these scores, the Grays Ferry (GF) center is the focus of a performance improvement project to improve activity satisfaction of the participants at that site. Participants will be asked to complete a brief survey regarding their leisure interests and activity program satisfaction. Survey results will be reviewed and an action plan, based on the results, will be developed. After the action plan is implemented, participants will be resurveyed to determine if satisfaction with activities has increased.

Results: Twenty-six initial surveys were completed by GF participants. Survey results revealed that only a little over half of the participants (57%) were satisfied with the activities offered. Participants indicated they would like to see a wider variety of activities including outings, focusing on special trips, and outdoor activities and exercise groups when the weather improves.

To assist the Recreation Therapist with planning activities that would appeal to the participants, two participant feedback sessions were held to solicit additional information regarding community outings and programs of interest. Participants' suggestions were implemented on the next monthly activity calendar.

After the implementation of the new activities, participants were re-surveyed. Thirty-four surveys were completed. Sixty-one percent of participants indicated they were always satisfied with the activities offered at the LIFE center.

Discussion: Changes implemented in the Recreation Therapy department at Grays Ferry resulted in increasing the participant's satisfaction with activities offered. Survey results in Q2 of 2014 revealed 64% of the participants were satisfied with the activities offered a 45% increase from Q4 of 2013 results.

Likes Activities Offered	External Survey 2ndQ 2013	Internal Survey 4thQ 2013	Internal Survey 2ndQ 2014	Comments
Grays Ferry	59.4%	44%	64%	Increased 45%

Five Basic Elements

III. OUTCOME MEASURES

- Scorecard
  - Limited to Extensive
    - Ability to add a new center and new indicator
  - Monthly reporting
    - Participant
    - Quarterly
      - Center and Plan level
  - Examples – Falls and Functional Status

Outcome Measures Scorecard Example

Total # of Falls	**Responsibility**	**Target**	**Jan-15**	**QTR1**
a. # of Falls--Center 1	Rehab Manager			0
b. # of Falls--Center 2				0
c. # of Falls--Center 3				0
Location of Falls				
Total # Center Falls			0	0
a. # Center of Falls--Center 1				0
b. # Center of Falls--Center 2				0
Total # Van Falls			0	0
a. # Van of Falls--Center 1				0
Total # Falls in Participant's home			0	0
a. # Falls in Participant's home--Center 1				0
Total # Institution Falls			0	0
a. # Falls in Institution--Center 1				0
Total # Other Falls			0	0
c. # Other Falls--Center 3				0
Total Fall Rate /100 Participants		10.5%	#DIV/0!	#DIV/0!
Fall Rate--Center 1			#DIV/0!	#DIV/0!
Fall Rate--Center 2			#DIV/0!	#DIV/0!
Fall Rate--Center 3			#DIV/0!	#DIV/0!

Total Falls by Location

Number of Falls	Q1 - 2015	April 2015	May 2015	June 2015	Q2 - 2015
Center	6	3	0	9	12
Van	2	1	2	0	3
Home	118	26	58	47	131
Institution	30	10	12	2	24
Other	17	7	5	5	17
Total Falls	**173**	**47**	**78**	**63**	**188**

Falls by Location: North Hancock

North Hancock- Number of Falls	Q1 – 2015	April 2015	May 2015	June 2015	Q2 – 2015
Center	1	1	0	6	7
Van	1	0	0	0	0
Home	27	8	12	9	29
Institution	9	0	3	0	3
Other	8	3	3	1	7
Total Falls	**46**	**12**	**18**	**16**	**46***

Falls by Location: Broad Street

Broad Street - Number of Falls	Q1 – 2015	April 2015	May 2015	June 2015	Q2 – 2015
Center	3	2	0	1	3
Van	0	1	0	0	1
Home	43	13	15	17	45
Institution	14	8	6	2	16
Other	8	2	1	2	5
Total Falls	**68**	**26**	**23**	**22**	**71**

Falls by Location: Valley View

Valley View Number of Falls	Q1 -2015	April 2015	May 2015	June 2015	Q2 -2015
Center	1	0	0	1	1
Van	0	0	0	0	0
Home	6	1	5	4	10
Institution	1	0	0	0	0
Other	1	1	0	0	1
Total Falls	**9**	**2**	**5**	**5**	**12**

Falls by Location: Sharon Hill

Sharon Hill - Number of Falls	Q1 - 2015	April 2015	May 2015	June 2015	Q2 - 2015
Center	1	0	0	1	1
Van	1	0	0	1	1
Home	42	4	26 (Assisi=20)	17 (Assisi=10)	47 (Assisi=30)
Institution	6	2	3	0	5
Other	0	1	1	2	4
Total Falls	**50**	**7**	**32**	**20**	**59**

Target – 10.5%

Fall Rate - %	Q1 - 2015	April 2015	May 2015	June 2015	Q2 - 2015
Broad Street	11.0%	12.6%	11%	10.2%	11.3%
North Hancock	7.1%	5.7%	8%	7.5%	7.1%
Valley View	8.2%	5.3%	13.2%	13.2%	10.5%
Sharon Hill	16.4%	6.1%	16.8%	10.5%	11.1%
Assisi House	n/a	n/a	30.5%	13%	22%
LIFE	**10.3%**	**8.3%**	**11.8%**	**9.6%**	**9.9%**

Fall Severity Level

	Q1 - 2015	April 2015	May 2015	June 2015	Q2 - 2015
Level I	119	25	40	35	100
Level II	38	8	25	22	55
Level III	13	2	8	2	12
Level IV	5	2	4	4	10
Level V	0	0	0	0	0

Fall Severity Level: North Hancock

North Hancock	Q1 - 2015	April 2015	May 2015	June 2015	Q2 - 2015
Level I	36	8	9	10	27
Level II	9	3	5	5	13
Level III	1	0	2	0	2
Level IV	0	1	1	1	3
Level V	0	0	0	0	0

Fall Severity Level: Sharon Hill

Sharon Hill	Q1 - 2015	April 2015	May 2015	June 2015	Q2 - 2015
Level I	36	4	17	10	31
Level II	8	1	10	9	20
Level III	2	1	4	0	5
Level IV	4	1	1	1	3
Level V	0	0	0	0	0

MHCHS Target – 2.2%

FRISI- %	Q1 -2015	April 2015	May 2015	June 2015	Q2 -2015
Broad Street	1.47%	0%	8.7%	9.1%	5.6%
North Hancock	0%	8.3%	5.9%	6.3%	6.7%
Valley View	0%	0%	0%	0%	0%
Sharon Hill	8%	14.3%	3.1%	5%	5%
- Assisi House	n/a	n/a	0%	0%	0%
Overall FRISI Rate	**2.89%**	**4.3%**	**5.2%**	**6.3%**	**5.35%**

- Outcome measures for Functional Status
  - Tinetti Balance and Gait Evaluation Assessment Tool
  - Barthel Index of Activities of Daily Living

- Tinetti tool used for all applicable participants every 6 months
  - Assign a status of maintained, improved or declined (change in category for Tinetti or +/- 2 for Barthel)
  - We then add in each category and determine per center % maintain, improve, and decline
  - Set targets to maintain, new sites need 6-12 months
  - Therefore aggregate 6 month period will give assessment of whole plan populations
  - <u>1 full year gives a more accurate % maintain</u>

Target:
70% Maintained

	Q1 - 2015	Q2 - 2015
% Maintained	**73.71%**	**78.97%**
North Hancock	89.36%	91.55%
Broad Street	68.42%	75.34%
Valley View	59.26%	78.70%
Sharon Hill	74.55%	69.95%
% Declined	**17.84%**	**16.82%**
North Hancock	8.51%	6.39%
Broad Street	21.05%	21.27%
Valley View	15.38%	17.59%
Sharon Hill	14.55%	25.12%
% Improved	**8.45%**	**4.21%**
North Hancock	2.13%	1.52%
Broad Street	10.54%	3.39%
Valley View	24.62%	3.70%
Sharon Hill	10.91%	8.93%

MHCHS Targets – Pneumovax: 95% ; Flu: 95%

% Vaccinated	Q1 2015	April 2015	May 2015	June/Q2 2015
All Centers - Pneumovax	**97%**	**98%**	**85%**	**92%**
- Flu	**97%**	**n/a**	**n/a**	**n/a**
Broad Street - Pneumovax	100%	98%	95%	96%
- Flu	98%	n/a	n/a	n/a
Hancock - Pneumovax	97%	99%	99%	97%
- Flu	97%	n/a	n/a	n/a
Valley View - Pneumovax	95%	92%	92%	92%
- Flu	94%	n/a	n/a	n/a
Sharon Hill - Pneumovax	94%	97%	56%	81%
- Flu	97%	n/a	n/a	n/a

Occurrences & Level 2 Events

Number of Events	Q1- 2015	April 2015	May 2015	June 2015	Q2- 2015
All Centers - Occurrences	**17**	**8**	**12**	**20**	**29**
- Level 2 Events	**29**	**10**	**11**	**16**	**37**
Broad Street - Occurrences	7	6	3	2	11
- Level 2 Events	10	1	4	3	8
Hancock - Occurrences	4	1	1	12	14
- Level 2 Events	9	5	3	7	15
Valley View - Occurrences	1	0	0	3	3
- Level 2 Events	2	2	0	1	3
Sharon Hill- Occurrences	7	1	8	3	12
- Level 2 Events	8	2	4	5	11

Occurrences by Type

Number of Events by Type	Q1 – 2015	April 2015	May 2015	June 2015	Q2 – 2015
Center Falls	5	2	0	9	11
Fall Related to/Observed by Transport.	Contract 1 – 0 Contract 2 – 2	Contract 1 – 0 Contract 2 – 2	Contract 1 – 0 Contract 2 – 2	Contract 1 – 0 Contract 2 – 0	Contract 1 – 0 Contract 2 – 4
Medication	0	0	3	3	6
Clinic to ED	2	2	2	3	7
Transportation	Contract 1 – 1 Contract 2 – 2	Contract 1 – 1 Contract 2 – 1	Contract 1 – 1 Contract 2 – 4	Contract 1 – 1 Contract 2 – 1	Contract 1 – 3 Contract 2 – 6
Other	4	1	2	4	7
Contracted Pharmacy Occurrences*	**2**	**1**	**2**	**0**	**3**

*Errors made by the contracted pharmacy. Not counted as a med error for Mercy LIFE.

	Q1 – 2015	April 2015	May 2015	June 2015	Q2 – 2015
Number of Occurrences	2	1	2	0	3
Total number of Dispenses	15,725	5,771	6,254	8,082	20,107
Percentage of Medication Errors	0.01%	0.02%	0.03%	0.00%	0.01%

Element requirements – Examples of PI projects and Data collection

Element		Examples PI Title
III. Outcome Measures		Falls Related to Transportation
III. Outcome Measures		Pressure Ulcers: Reduction in Level 2 Events
III. Outcome Measures		Overall Functional Improvement in Quality Therapy Services

QI: Overall Functional Improvement in Quality Therapy Services

Persons Responsible: Susy Krimker, MS, OT/L – Manager Rehab Services

Background: Mercy LIFE wants to ensure the most appropriate functional improvement tool is utilized when assessing our participant population. Currently, the LIFE Rehabilitation Department uses both the Tinetti and Barthel tools for tracking functional status changes.

Methodology: Mercy LIFE Rehabilitation Department will research functional measures to determine the best tool for the geriatric population. During this period, the Department will continue to use the Tinetti and Barthel tools.

Results: A series of tests were identified by the Rehab Department members to be used in place of the Barthel and Tinetti. The staff researched a variety of tools. They were presented, discussed and evaluated during staff meetings. Below are some of the tools considered:

Berg Balance Test: This is a 14-item objective scale designed to measure static balance and fall risk on the older adult population. This scale was tested on a variety of diagnosis
It provides good intra-rater reliability and it is able to be used with a variety of diagnosis. The test has too many items to assess and requires a large amount of time to complete. It may be better suited to be used on individuals with an appropriate medical diagnosis.

Functional Independence Measure (FIM™): This instrument is a basic indicator of severity of patient disability. FIM™ is used to track the changes in the functional ability of an individual. This measure has 18 items, grouped into 2 subscales - motor and cognition. Administration of the FIM requires training and certification. The FIM takes approximately 30 minutes to administer and score. Rather than independence or dependence, the FIM assesses physical and cognitive disability in terms of burden of care for that individual.

Timed Up and Go: The Timed Up and Go test (TUG) is a simple test used to assess a person's mobility and requires both static and dynamic balance. During the test, the person is expected to use any mobility aids that they would normally require. The TUG is used frequently in the elderly population, it is easy to administer and can generally be completed by most older adults. It provides norms for different age groups but it is not comprehensive. The TUG performance has been found to decrease significantly when mobility impairments are present. It is more appropriately used for individuals who require further testing to more accurately define the deficit.

Other tools reviewed: Romberg, One Leg Stance Test, Four Square Step Test and Chair Rise Step.

Discussion: After much discussion among the Rehab Department, it was felt that the Tinetti Assessment Tool is simple, easily administered and measures a participant's gait and balance. The test is scored on the participant's ability to perform specific tasks. This instrument is already hardwired into our electronic medical record. The Barthel scale can be used to monitor functional changes in individuals. It was decided that the Tinetti and the Barthel best meet the needs of the geriatric population and the recommendation was made to continue with these tools.

Five Basic Elements

IV. EFFECTIVENESS OF AND SAFETY OF STAFF PROVIDED AND CONTRACTED SERVICES

Element requirements – Examples of PI projects and Data collection

Element		Examples PI Title
IV. Effectiveness of and Safety of Staff Provided and Contracted Services		Colleague Safety/Workplace Violence
IV. Effectiveness of and Safety of Staff Provided and Contracted Services		Quality of Services Provided by Contracted Homecare Agencies
IV. Effectiveness of and Safety of Staff Provided and Contracted Services		Colleague Satisfaction with Contracted Providers

QI: Quality of Services Provided by Contracted Homecare Agencies: Employee Requirements

Persons Responsible: Denise Slough, Home Care Manager
Background: PACE organizations are responsible for providing all medical and supportive services for their participants, including home care services. Mercy LIFE participants receive home health services, as needed, that may include aide services for personal care and light housekeeping. Currently, Mercy LIFE utilizes both employees and contract agencies to provide these services.

Methodology: The Home Care Manager will make visits to all contracted homecare agencies to monitor compliance with contract. The Home Care Manger will audit agency files including employee and participant files and will re-visit any agency who is not at least 80% compliant with contract provisions. Corrective actions will be based on findings.

Effectiveness of and Safety of Staff Provided and Contracted Services PI Project Sample

Results: Contracted homecare agencies were visited during Q1 and Q2 in 2014. During the visit the LIFE Home Care Manager reviewed the completion of the Mercy LIFE education packet, personnel files, and participant files. Agency expectations were also reviewed.

Out of eleven (11) agencies, there were four (4) agencies, or 36%, that were 100% compliant and met all personnel file requirements. Ten (10) out of the eleven (11) agencies, or 90%, were at least 80% compliant with personnel file requirements. One (1) agency, was found to have only a 50% compliance rate. When evaluating personnel files, not including the agency with 50% compliance, Mercy LIFE had an overall compliance rate of 92%. To meet regulatory compliance, agency personnel files need to be 100% compliant.

One home care agency's compliance rate was 50%; 30 out of 62 personnel files were reviewed. The agency initially provided services to as many as 50 participants. Because the agency did not meet the compliance standard, it was put on administrative corrective action. Corrective action included phone calls, meetings, and in-services were held with staff to review expectations and participant care. The agency was very willing to review files weekly and correct non-compliance, but, since full compliance has not yet been met, many of the participant cases were removed from the agency with less than 10 cases remaining in the fall of 2014.

The audit of participant files did not continue during this project due to inconsistencies in agency policies on how they maintained Mercy LIFE participant files. Moreover, the agencies indicated Mercy LIFE referrals were missing vital information needed prior to the start of care including participant care plans and information regarding the participant's home environment.

Discussion:
The audit was helpful in identifying an educational opportunity for Mercy LIFE to re-orient contractors on our requirements to serve our participants, for example, the requirement for 2-step PPDs. A second area of opportunity was that Mercy LIFE needed to address a process to meet the requirements for the independent contractors of the staffing agencies. Mercy LIFE is committed to meeting the requirements for contracted staff. The majority of the above agencies have already been re-educated and requirements reinforced. Periodic personnel file audits will continue. In 2015, a PI project will be conducted to assess the quality of services provided to Mercy LIFE's participants by contracted home care agencies.

Periodic audits of contracted home care agency personnel files need to be conducted to ensure compliance with regulations, especially considering staff turnover at the agencies. In addition, Mercy LIFE needs to provide additional information to the agencies with referrals, including participant care plans and a summary of the home environment, prior to the start of services; this is a goal for the Mercy LIFE Home Care Department for 2015.

Five Basic Elements

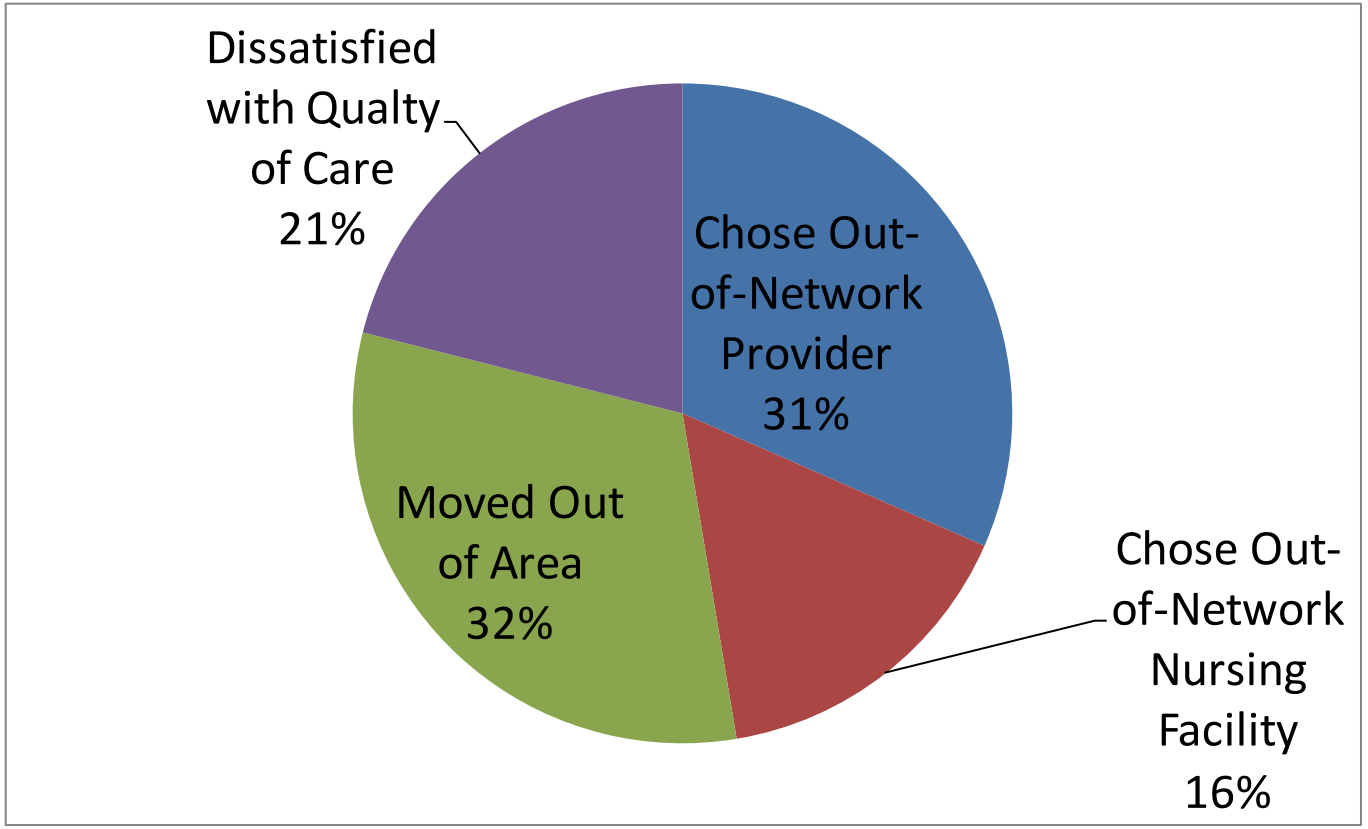
V. NON-CLINICAL AREAS

Non-Clinical Areas Scorecard Example
Disenrollemnts

Nonclinical Areas: Indicator Voluntary Disenrollments	2015	Target	Feb	QTR 1
Total # of Voluntary Disenrollment	SW Manager		0	0
a. # of voluntary disenrollment--Center 1				0
b. # of voluntary disenrollment--Center 2				0
c. # of voluntary disenrollment--Center 3				0
Reason for Disenrollment				
a. Moved				0
b. Out of Network NF				0
c. Quality of Care				0
d. Preferred own PCP				0
e. Financial				0
f. Quantity of Service				
Number of preventable disenrollments (add quality of care and quality of service)				0
Monthly Voluntary Disenrollment Rate (#preventable disenrollments for month/month census)		2.5%	#DIV/0!	

# Participants Voluntarily Disenrolled	Q1 - 2015	Q2 - 2015
All Centers	**13**	**19**
Broad Street	1	2
Hancock	10	13
Valley View	0	0
Sharon Hill	2	4

Q2 - 2015—Reasons for Disenrollment



Total = 19 Voluntary
0 Involuntary

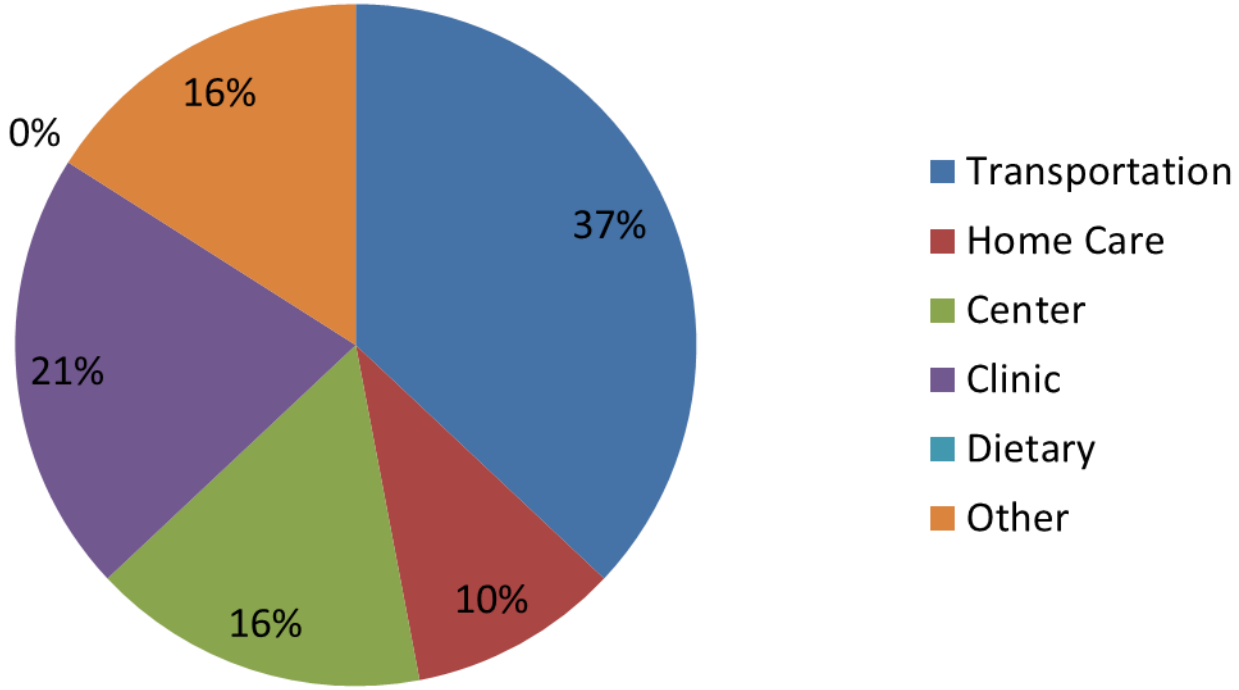
Total Grievances

Number of Grievances	Q1-2015	April 2015	May 2015	June 2015	Q2-2015
All Centers	**8**	**2**	**3**	**6**	**11**
Broad Street	1	2	1	2	5
Hancock	1	0	0	3	3
Valley View	2	0	0	0	0
Sharon Hill	4	0	2	1	3

Grievance Type: North Hancock

North Hancock # of Grievances by Type	Q1-2015	April 2015	May 2015	June 2015	Q2-2015
Transportation	1	0	0	0	0
Home Care	0	0	0	1	1
Center	0	0	0	0	0
Clinic	0	0	0	1	1
Dietary	0	0	0	0	0
Other	0	0	0	1	1

Grievance Type 2015 - YTD



Appeals

# of Appeals	Q1-2015	April 2015	May 2015	June 2015	Q2-2015
All Centers	**1**	**0**	**2**	**0**	**2**
Broad Street	0	0	0	0	0
Hancock	1	0	2	0	2
Valley View	0	0	0	0	0
Sharon Hill	0	0	0	0	0

Target - 94% Completion Rate

% Completed	Q1 - 2015	Q2 - 2015
All Centers	**95**	**95**
Broad Street	96	95
Hancock	94	96
Valley View	94	95
Sharon Hill	95	92

Element requirements – Examples of PI projects and Data collection

Element		Examples PI Title
V. Non-Clinical Areas		Reduction in Voluntary Disenrollments
V. Non-Clinical Areas		Participant Involvement in Care Planning
V. Non-Clinical Areas		Overall Satisfaction of Food Provided by Vendor: Menu Planning

QI: Reduction in Voluntary Disenrollments

Persons Responsible: Johanna Yurkow, Vice President of Operations

Background: Total program census is impacted by both enrollments and disenrollments. In addition to anticipated program growth, reduction in voluntary disenrollment rate is essential for continued growth and sustainability.

	2011	2012	2013
Number Disenrolled	46	43	54
Potentially Avoidable	27	18	31
Unavoidable	19	25	23

For the purposes of this project Mercy LIFE will be focusing on Potentially Avoidable Disenrollments that occur in participants who have been in the program for less than one year. For calendar year 2013 there were 20 participants who voluntarily disenrolled at less than one year (70% occurring within the first 4 months; average time in program = 4.5 months).

Methodology: Due to the timing of potentially avoidable disenrollments it appears as though the critical period is engagement/communication at the time of enrollment and the first 6 months of center attendance. The following action plan has been put into place:

- Education will be conducted for the IDT and the Sales/Enrollment team regarding the responsibilities of each. A copy of the Enrollment Agreement will be distributed to all staff for their review.
- Sales and Enrollment team members will shadow select participants at the time of enrollment to verify information that is given to participants at the time of the sales delivery is accurate.
- Comprehensive follow-up will be conducted with all disenrollees to determine cause of disenrollment and potential corrective action.
- The Social Worker will conduct weekly follow-up with all new enrollees.
- The Social Worker will survey all new enrollees monthly for the first six months to ensure expectations are being met.
- The services network will be enhanced to assure services that are required are available to participants.

Non-Clinical Areas PI Project Sample

	2011	2012	2013	2014
Number Disenrolled	46	43	54	75
Potentially Avoidable	27	18	31	32
Unavoidable	19	25	23	42

Although there was a 28% increase in total disenrollment over last year (2013), the increase occurred almost exclusively in the category of unavoidable disenrollments. In 2013, 57% of the total disenrollments were potentially avoidable and in 2014, 43% of the disenrollments were avoidable.

Potentially Avoidable	
Requesting paid caregiver services	7
Speaks a minority language	2
Not happy/satisfied with services	9
Not happy/satisfied with provider/med care	3
Requesting other services	5
Seeking other insurance	1
Miscellaneous	5
Unavoidable	
Out-of-network/immediate area	19
Significant moves/other state or country	12
Involuntary/refusing to follow POC	3
Not Eligible	2
Over Asset	5
Estate Recovery	1
	42

Discussion: During the year significant attention was paid to the topic of potentially avoidable disenrollments. It is suspected that the source of disenrollments are varied and as such it was decided to start with basic education to the IDT and sales/enrollment department with a full understanding of the role and expectations of each.

- Education was provided by the VP of Operations at each team meeting where the role of the IDT, sales, and enrollment was specified and the autonomy and authority of the IDT was stressed. Ways and means of preventing disenrollments was discussed. The Enrollment Agreement was distributed to staff for their review. On a monthly basis the Directors of Operations were notified of the number of budgeted disenrollments for the month and numbers were monitored very closely as the month progressed.
- The IDT and sales/enrollment team were encouraged to understand each other's roles. This was accomplished through shadowing and education programs afforded each group.
- A thorough review was conducted of all participants who disenrolled. Many met with the Directors of Operations and the Social Work Manager to discuss options. All disenrollments were reviewed by the VP of Operations and presented at the Senior Management Team meeting.
- A process was implemented in which the social worker conducted a brief survey on each new participant once a month for the first six months of enrollment. These surveys were soon discontinued as the participants complained about survey fatigue.
- Services network is continually being evaluated and expanded.

Total disenrollments as a percentage of total census was slightly increased in 2014 over 2013 (13% vs. 10%), however, the number of potentially avoidable disenrollments remained stable.

Successful Survey Preparation

- Develop initial rapport through standard meeting times
- Discuss areas of comfort (*e.g. who completes initial analysis of FRISIs*)
- Set routine process for development and review of documents and reports
- Formalize trending and analysis collaboration
- Discuss potential action plans for areas of opportunity for improvement

- Pre-survey
  - Preview documentation
    - Identify areas requiring secondary analysis (falls/100)
    - Update binders
    - Sign and date documents
  - Set agenda for survey presentation
  - Plan for presentation

- Prefer formal slides and paper copy
- Agenda
  - QAPI Program Description
  - QAPI Annual Report
    - Elective items highlighted
      - i.e. falls trending at participant level and center level
      - Infection control logs at participant and center level**
      - Infection control trending at participant and center level

*** Anticipate and have binders with tabs and marked spots*

- Board reporting
  - Include process of oversight and reporting in Program Description and include a few sentences in your prepared presentation
    - Otherwise they will go back and ask
    - For example, when you review the Program Description show how it gets approved by LPAC then Board then State or your respective process THEN
    - Note the dates signed and approved consistent with program description
  - End with needs assessment
    - State area of need and PI work plan

- What is the background of the Quality Team?
- How are outcome measures chosen?
- How are priorities identified?
- Who's responsible for aggregating analysis?
- How are employees and contractors included in the process?
- How are participant activities included?
- How are quality of care issues identified?
- What tools are used for screening?
- How are areas of improvement reported?

- CMS regulations
- Replicate a quality program across multiple sites
- Track, trend and analyze data at the participant level
- Demonstrated a robust quality program
- Examples of Performance Improvement projects
- Overview of survey preparation


Questions
Answers