



# **Quality Assessment and Performance Improvement Plans**

**2019**

## **OVERVIEW AND PURPOSE**

The purpose of performance improvement (PI) is to provide a comprehensive data based program that continually assesses the quality of care provided to the patients and provides feedback that enables the organization to identify adjustments needed to improve patient care. From the Board to the bedside, the focus is providing patient centered care rooted in evidence-based practice and ensuring Medicare Condition of Participation (COPs) are followed.

The overarching goal of Covenant's QAPI program is to define patient and family needs, help design safe and effective processes to meet those needs, and ultimately achieve the highest quality of care coupled with a high level of patient/family satisfaction.

## **QUALITY STATEMENT**

The QAPI program is an ongoing, comprehensive, integrated program that provides a transparent view of the quality of services provided. The QAPI program is a critical component of Covenant's corporate wide planning process and provides the framework for the fulfillment of our mission.

- It helps ensure the uniform provision of high quality services throughout the company
- It identifies opportunities to improve patient and family satisfaction and/or experience of care
- It ensures that established policies, procedures, and guidelines are followed in the provision of care (including state, federal, accreditation, and professional standards)

## **OBJECTIVES**

- Assess the quality and appropriateness of all Home Health care
- Use standardized tools and methodology to demonstrate improvement
- Evaluate the adequacy of clinical documentation utilizing standardized audit tools
- Measure, analyze, and track quality indicators, including unexpected occurrences and/or adverse events
- Collect data to monitor and benchmark
- Identify opportunities for improvement and evaluate the effectiveness and safety of services
- Utilize patient and caregiver perception of care and satisfaction and develop Home Health services that are perceived to be of high quality and value

- Utilize standard processes to provide effective, efficient, and safe delivery of Home Health care
- Monitor and evaluate compliance with regulatory requirements and Medicare Conditions of Participation
- Assist operations with developing performance improvement projects (PIPs) when gaps are identified between current and desired status
- Conduct ongoing QAPI meetings at all levels within the organization to promote a spirit of continual improvement and associate engagement

## METHODOLOGY

Covenant follows a systematic approach to measuring quality. Indicators are measurable at the patient level and in aggregate. Data for measuring indicators are collected from clinical documentation, patient/caregiver satisfaction surveys, and administrative indicators.

Each indicator will have a level of performance established as a benchmark or threshold for evaluating care, quality, and appropriateness. When an indicator shows that improvement is needed, an action plan should be developed to evaluate the scope and effectiveness of the PI program ensuring actions taken are within the goals of the Home Health program.

Covenant adopted the LEAN methodology for continual process improvement. The guiding principles of LEAN are:

- The elimination of waste which breaks all activities into two groups: Value added and non-value added
- Respect for all people

This proven methodology is a map and a compass for continual organizational improvement. LEAN uses the following tools for process improvement:

- **Value Stream Mapping** – a tool used to analyze current state and design future state on a large scale
- **Rapid Continuous Improvement**—targeted events designed to deconstruct the process, identify areas of improvement, and reconstruct the improved process (includes those closest to the work being done)
- **Standard Work** – process steps clearly mapped out for consistent performance
- **Kamishibai** – LEAN terminology for audits
- **Real-Time Feedback** – creates a continual feedback loop that corrects the errors closest to the performer
- **Managing for Daily Improvement**—keeping top priorities in a visual format front and center for all performers

- **Gemba Walks**—allows leaders the opportunity to see how the process works at the front line

Through genuine respect for all people, LEAN promotes a culture of transparency and engagement, encouraging all employees to participate in the change process and embrace the concept of continual improvement.

## **ASSIGNMENT OF RESPONSIBILITY**

### **Governing Body**

- Ultimate responsibility for the QAPI plan and the care that is provided
- Oversees the development, implementation, and assessment of the plan
- Allocates resources as needed
- Evaluates the effectiveness of the plan
- Meets at least annually

### **Quality, Risk, Safety, & Compliance Department**

- Development and implementation of education plan regarding quality principles
- Prepares annual comprehensive report describing QAPI activities and Performance Improvement Projects
- Maintain oversight of on-going organization wide QAPI program
- Ensure the integrity of data collection and reporting
- Provide guidance and expertise in all areas of improvement throughout the organization

### **Operational Leaders**

- Ensure development of appropriate action plans to address areas of improvement
- Evaluate effectiveness of implemented actions
- Report significant findings to appropriate staff and leaders
- Identify opportunities for improvement through daily functions
- Ensure data is collected and turned in timely
- Participate in improvement events and activities when requested
- Conduct team level QAPI discussions on a routine basis

### **QAPI Steering Committee**

- Maintain leadership oversight of continual progress of all departments
- Ensure accountability for adherence to action items and plans through quarterly meetings
- Provide support and shared experience as a tool to enhance the improvement process and troubleshoot challenges

### **Quality Subcommittee of the Board of Directors**

- Meet periodically (minimum of twice a year) and ad hoc to discuss and report areas of focused improvement
- Enhance board member oversight and engagement in performance improvement
- Promote executive level accountability for ongoing continual improvement

### **Clinical and Support Staff**

- Identify opportunities for improvement through daily functions and contact with the internal and external customers
- Communicate openly with leaders regarding opportunities for improvement
- Participate in performance improvement activities when requested

## **RESPONSIBILITY OF QAPI STEERING COMMITTEE**

The QAPI Steering Committee is responsible for evaluating and prioritizing QAPI activities based on the aggregation and analysis of data collected. The QAPI committee has the authority to issue recommendations for action or further study. Committee members should include senior and executive level leaders from all departments within the organization and minutes should be kept to record meeting activities.

The Quality, Risk, Safety, & Compliance department is responsible for coordination of the meeting as well as record keeping; however, it is the departmental leaders who are responsible for the presentation and maintenance of their respective data, action plans, and reporting to the committee itself.

Minutes of the meeting should include:

- Date
- Members in attendance
- Agenda
- Reports and data presented
- Summary of activities
- Committee recommendations
- Action plans and follow up items and updates if applicable

The QAPI Steering Committee should actively participate in the development of the annual plan each year. The committee should review the plan prior to presentation to the Board of Directors.

## **CONFIDENTIALITY**

The Quality, Risk, Safety, & Compliance department maintains all QAPI related records securely and all information is protected by HIPAA regulations. While data trending is necessary to target areas for improvement, QAPI data should never be used in a punitive fashion. QAPI data should always be shared in a spirit of continual process improvement. Individual performance issues identified through performance improvement activities should be dealt with on an individual basis following Covenant's standards of performance excellence.

## **HOME HEALTH CARE DIVISION QAPI**

Covenant Home Health Care collects QAPI data and monitors results that are reported to the Quality, Risk, Safety and Compliance Department. The home health care division of Covenant Care completes clinical, therapy, medical record audits monthly for each branch. The clinical audit consists of 62 indicators, the therapy audit consists of 48 indicators, and the medical record audit consists of 23 indicators. The Home Health QAPI review also includes the summary of data results from incident reports, fall reports, infection reports, complaint reports, potentially avoidable events report, and updates of three specific action plans selected for the year. In addition to the before mentioned data and report summaries, the Key Point Indicator (KPI) report based on Medicare reported Outcome and Process Measures is updated monthly. The results of the audits, reports, action plans, and KPI are sent to the Covenant Care QAPI Coordinator for corporate review.

### **Home Health Specific Action Plans**

The home health specific action plans for 2019 will include: 1) Patient Centered Care, 2) Timeliness of Care, 3) Wound Management. These action plans are for long term, continual monitoring and revision throughout the year. In certain circumstances requiring immediate response, additional short term action plans can be developed which can become long term if necessary.

In 2018, Medicare implemented a Condition of Participation (COP) for patients to identify a personal goal as part of their home health plan of care. Patient centered care empowers the patient and promotes self-determination. This also fulfills the new COP requirement for the patient to be aware of his/her plan of care. The audit results and feedback from clinical managers indicate that most clinicians are not identifying their patients' personal goals or involving their patients in the care planning process.

Timeliness of Care is not a new COP, but an important one that can prevent re-hospitalizations. The QAPI results indicate that 94% of our patients are being seen timely; however, the results

are less than national and state levels. The patient's start of care and resumption of care are to be done within 48 hours after receiving the initial referral. If the patient is not admitted or resumed within 48 hours, the clinician is to communicate to the referral source which can lead to early intervention and prevention of re-hospitalization.

The wound management audit results are better than they were when they were first being audited three years ago; however, the results continue to be low. The number of wound deterioration is higher than the overall goal of less than ten percent. Clinicians continue not to complete the wound assessment and alert the physician when there are signs of complications. This contradicts the Medicare COP of reducing harm in delivery of care. Therefore, an action plan for wound management continues to be necessary. New wound management interventions will be implemented and revised throughout the year.

In conclusion, Covenant Home Health Care is a division within Covenant Care and is responsible for following home health specific Medicare regulatory guidelines. The data is collected and monitored as per Medicare guidelines and reported to the Quality, Risk, Safety and Compliance Department as directed for corporate review.

### **HOSPICE DIVISION QAPI**

Covenant Care must develop, implement, and maintain an effective, ongoing, hospice-wide data driven quality assessment and performance improvement program. The hospice's governing body must ensure that the program:

- Reflects the complexity of its organization and services; involves all hospice services (including those services furnished under contract or arrangement);
- Focuses on indicators related to improved palliative outcomes;
- Focuses on the end-of-life support services provided; and takes actions to demonstrate improvement in hospice performance.
- The hospice must maintain documentary evidence of its quality assessment and performance improvement program and be able to demonstrate its operation.

**Quality Assessment and Performance Improvement has the required Five Elements** and are primarily based on the National Patient Safety Goals- Communication, Oxygen Safety, Medication Reconciliation, Falls, and Infections.

**Element 1: Design and Scope** – Ongoing and comprehensive plan to encompass ALL ranges of services across our Enterprise. The Corporate Risk and Compliance department participates in each of the service lines Quality Assessment and Performance Improvement (QAPI) activities and provides data to further support the service lines. Each Branch uses the best available evidence/data to define and measure their goals.

**Element 2: Governance and Leadership** – the governing body assures adequate resources exist to conduct and support QAPI efforts. Each Branch will select and retain a QAPI team to collect,

review and conduct Performance Improvement Projects (PIP) activities in the branch. The Organization will foster a culture where QAPI is a priority by ensuring that policies are developed to sustain QAPI despite changes in the organization. The responsibilities of the QAPI team are to set expectations around safety, quality of care, patient rights and regulatory requirements. Leadership will ensure that staff are accountable, while creating an atmosphere where staff is comfortable identifying and reporting quality problems as well as any opportunities for improvements.

**Element 3: Feedback, Data Systems and Monitoring** – Operations Leadership will put into place systems to monitor care and services, drawing from multiple sources. This element includes using Organization wide performance indicators and branch level collections of data specific to each team and at times discipline. It also includes the tracking, and investigating of monitoring occurrence reports and complaints related to service care delivery. Wide survey data will be collected and used to identify areas specific to each branch/team, where the branch QAPI team will further evaluate, review and respond. Each team will maintain a Branch Action Plan – identifying results for each area monitored and the plan to continue to monitor or become a PIP.

**Element 4: Performance Improvement Projects (PIPs)** – A Performance Improvement Project (PIP) is a concentrated effort on a particular problem in one area of the branch/team or organization wide. It involves gathering additional information systematically to clarify issues or problems, and intervening for immediate improvements. The branch/team conducts PIPs to examine and improve care or services that the branch/team identifies as needing attention. Areas will vary from branch/team based on audit results or other data to support priority. It is recommended to limit PIPs to no more than 3 or 4 to be able to be effective in driving improvements.

**Element 5: Systemic Analysis and Systemic Action** - The organization uses a systematic approach to determine when in-depth analysis is needed to identify and make changes in the organization. Individual Branch/team results do not generate a change in policy/standard work without Organizational direction. The organization uses a highly organized and structured approach to determine how identified problems and issues create changes in processes. All results and findings are reported up from the Branch/team QAPI to the Administrator of Hospice and to the Risk and Compliance department in the organization.





**COVENANT HOME HEALTH CARE PERFORMANCE IMPROVEMENT ACTION PLAN  
2019**

TOPIC	FINDINGS	ACTION PLAN	FOLLOW-UP
CLINICAL AUDIT REVIEW	<p>There are five clinical audit tools: 1) clinical, 2) therapy, 3) wounds, 4) MSW, and 5) Potentially Avoidable Events. The audits are done monthly for each branch. The audits include discharged and active patients.</p> <p>The nursing audit tool has 53 indicators, the therapy audit tool has 47 indicators, the MSW audit tool has 5 indicators, and the wound audit tool has 8 indicators.</p> <p>The audit tools for Potentially Avoidable Events are specific to the type of OASIS triggered event for the auditor to investigate if the event was avoidable or not, and to define how the event could have been prevented.</p> <p>The indicators are based on documentation requirements to ensure clinicians are providing standards of care that are defined by Medicare Condition of Participation (COPs).</p>	<p>Will begin monitoring and investigating patients with discharge dispositions with unmet goals.</p> <p>Will focus on auditing and teaching patient centered care (i.e., including patient, caregiver, and/or patient representative in plan of care via patient centered goals, coordination of care).</p> <p>Will focus on improving coordination of care which is one of the COPs that is being focused on.</p> <p>Will need to improve communicating documentation education needs to the clinical managers and will need to provide consistent follow through and education to clinicians.</p> <p>Will continue to work on improving audit tools and ways of identifying and tracking trends to improve following COPs for patient centered care that is safe, cost-effective with positive outcomes.</p> <p>Will need to improve identifying documentation deficits, to identify the clinicians who require more training, and to</p>	<p>Ongoing: reviewing and editing current audit tools to help track, identify educational needs, and reinforce assessing and documenting patients' healthcare needs.</p> <p>Ongoing: monitoring documentation by using audit tools and providing education to the clinicians as the need is identified.</p>

	<p>The 2018 audits identified the need to improve documentation of pain management, vital signs, teaching, wound care, patient centered care, and coordination of care between clinicians, clinical management, and physicians. Furthermore, supervisory visits are not being completed as required for LPNs and HCAs.</p> <p>The audits also indicate the need for patient centered care plans that involve patient, caregiver, and patient representative (if any) which is a new COP requirement.</p> <p>The Potentially Avoidable Events audit results are indicating that specific events, such as falls, UTIs, worsening of wounds, and pressure ulcers could have been prevented. The clinical documentation did not indicate that in these cases, some clinicians were not following Medicare standards of care.</p> <p>The wound audits continue to indicate a decline in required documentation, such as wound measurements and assessments.</p>	<p>notify Clinical Managers of details for them to refer to when educating clinicians.</p> <p>To continue to do audits monthly to identify trends and to improve timely notification and intervention.</p> <p>To continue to audit charts as patients are discharged to ensure the OASIS and other documentation has been completed and to ensure accuracy.</p> <p>To continue to monitor wounds while patients are still active instead of waiting until the patient is discharged or waiting until quarterly review to identify documentation deficiencies and to identify deteriorating wounds, so clinical staff can intervene timelier to ensure wounds are healing and if not, to identify alternative treatment modalities to improve wound status.</p>	
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	<p>New professional clinicians continue to attend documentation and OASIS training while on orientation. The Clinical Managers review the clinicians' documentation and provide training as needed.</p>		
ADVERSE EVENTS	<p>In 2018, there were no specific trends identified with the Potentially Avoidable Event audits. There were no significant increases of any specific event. Most avoidable events were related to falls, wounds, UTIs, and pressure ulcers.</p> <p>The audit revealed the continue need for improving documentation due to the lack of documenting teaching to prevent falls, UTIs, and pressure ulcers. Some plan of cares did not include these, which is required for Medicare Best Practice Standards.</p> <p>Additional wound care training was provided by the WOCN; however, the clinicians continue not to document as per protocol.</p>	<p>The following are continually being done with the goal to improve clinical training and prevention of OASIS errors and preventable events.</p> <ol style="list-style-type: none"> <li>1. Monitoring for potentially avoidable events and investigating causes.</li> <li>2. Educating staff on Oasis documentation errors.</li> <li>4. Monitoring fall risk and pressure ulcer risk assessments and reinforcing the importance of including and following interventions in the plan of care.</li> <li>5. Monitoring documentation to ensure clinicians report a patient's change in medical condition to the physician immediately to obtain orders/instructions and to update the plan of action.</li> </ol> <p>Potential Avoidable Events are now reported monthly to provide timely follow through and education.</p>	<p>As part of the P.I. process, will continue to audit charts to monitor for patients who are at high risk for falls, skin breakdown, and other potentially avoidable events. Will continue to identify trends to identify specific needs to prevent future avoidable events.</p> <p>Clinical Managers are to continually instruct clinicians regarding how to identify when an avoidable event occurred and to determine if avoidable or not, and instruct how to answer the OASIS question correctly.</p> <p>Clinical Managers are to provide more guidance and oversight to improve wound assessment and documentation. The chart auditors will continue to notify Clinical Managers of deficiencies and the Clinical Managers will continue to provide education and training.</p> <p>When doing OASIS audits and determining if the patient is a risk for falls and skin breakdown, the Clinical Manager</p>

			is to instruct clinicians to obtain therapy and to ensure the care plan includes goals and interventions to prevent skin breakdown.
COMPLAINTS	<p>In 2018, there was a decline in the 3<sup>rd</sup> and 4<sup>th</sup> quarters in the number of complaints in both Pensacola and Crestview. This could be related to the increase in patient census, staff turnover, and clinical managers spending more time making visits in the field.</p> <p>Under reporting of complaints also indicate a need in education. Clinicians need to take more initiative to report complaints on their own instead of relying on clinical managers to write the reports.</p>	<p>Clinicians need to be educated on what is considered a complaint and the process to follow when they receive a complaint.</p> <p>Clinicians need to be encouraged to complete complaint reports.</p> <p>Clinical managers need to educate their clinicians to report complaints to</p> <p>New employee education needs to include reporting complaints and the protocol to follow.</p>	<p>Ongoing: Educational and training related to complaint protocol will be provided to all staff, clinical and administrative.</p> <p>Ongoing: Episodes of under reporting will be monitored and reported to clinical managers,</p>
MEDICAL RECORDS AUDIT	<p>The Medical Record Audit indicates that orders continue to need to be review signed timelier by the Clinical Managers so they can be sent to MDs timely and signed.</p> <p>The Home Health Advance Beneficiary Notice of Noncoverage (HHABN) compliance needs to improve in Pensacola and in Crestview. Clinicians need more guidance</p>	<p>The clinicians are being instructed to sign their orders timely and the Clinical Managers are being instructed to review sign orders more timely. Review signing orders is on the Clinical Manager daily task list. Also, Clinical Managers are to print the unsigned orders list to reinforce clinicians to sign their orders.</p> <p>A report is being done daily to track the number of unsigned orders and their dates.</p>	<p>Ongoing: Educating and training clinicians how to write and sign orders.</p> <p>Ongoing: Monitoring orders Monday through Friday to ensure they are being reviewed timely by clinical managers.</p> <p>Ongoing: Monitoring medical record trends.</p>

	<p>and follow up to ensure the HHABN is being signed.</p> <p>The Notice of Medicare Non-Coverage (NOMNC) will need to be utilized more consistently. More education and training needs to be provided to clinicians and clinical managers.</p>	<p>Review signing orders is on the Clinical Manager task sheets. The CM need to review sign orders daily as part of their routine. Further education and training will be provided and reinforced.</p>	
FALLS	<p>In 2019, the number of falls has not increased. No specific trend was identified.</p> <p>Most patients are being assessed for fall risk and fall preventions are being provided.</p>	<p>The clinicians will report falls in EMR to increase reporting of falls and to improve tracking.</p> <p>Will continue to identify the clinicians who are not assessing and teaching fall prevention and will provide education and training.</p> <p>Will continue to instruct clinicians, clinical managers, and scrubbers to see if therapy was referred when the patient was identified as a fall risk. If not, steps will be taken to obtain orders for therapy to evaluate the patient.</p> <p>Will continue completing the Potentially Avoidable Events fall investigation form and if therapy was ordered. If fall does not trigger a potentially avoidable event, the fall reported from the EMR will be investigated using the Potentially Avoidable Event audit form.</p>	<p>Ongoing: Fall prevention will be a continual part of an assessment and audit. The clinicians continue to be trained to do the fall risk assessments with SOC's, ROC's, Recerts. The cause of falls will continue to be investigated and clinical education will be provided on a continual basis.</p>

INCIDENTS	<p>In 2018, in quarters 3 and 4, there was a decrease in incident reports.</p> <p>The under reporting is possibly related to staff turnover and clinical managers making visits.</p>	<p>Potentially Avoidable Events are tracked monthly to help identify problems and concerns timelier.</p> <p>Will begin cross referencing Potentially Avoidable Events with Incidents reported.</p>	<p>Ongoing: To continue monitoring, tracking, and cross-referencing Potential Avoidable Events and Incident Reports to prevent under reporting and to improve investigating trends.</p>
REGULATORY/SURVEY	<p>New COPs began being utilized in 2018. Training was provided to clinical managers and clinicians. Policies and procedures were updated.</p> <p>CHAPs survey was completed with no conditional violations. The need to improve infection control and HCA plan of care documentation were identified.</p> <p>Training was provided and tracking for trends related to HCA care planning and implementing care is part of clinical audit.</p> <p>PDGM is to begin in 2020. Research and education has begun.</p>	<p>Will continue tracking documentation to ensure the new COPs are being followed. The clinical audit tools have been revised.</p> <p>Education and training will continue to be provided as needed.</p>	<p>Ongoing: Tracking for regulatory changes, updating policies and procedures, and providing education as needed.</p>
EMERGENCY PLAN	<p>In 2018, there were two fire drills conducted for both branches without any problems or concerns.</p> <p>There were a few inclement weather alerts that required an</p>	<p>I.T. will continue to update the patient emergency code lists and submit it weekly. The clinical managers put the list in their emergency manuals to refer to when needed.</p>	<p>Will continue to monitor and update new emergency manuals and calling system. This will be done on an ongoing basis to identify any needs for improvement.</p> <p>Will continue to conduct scheduled fire drills and monitor personnel response.</p>

	<p>emergency response team. Processes were followed without; however, not all patients were contacted via phone to ensure evacuation plans and emergency preparedness for Category 3 patients. All high-risk patients were contacted.</p>	<p>Will continue to implement staff emergency alerts to ensure timely response and improvement in the number of responses.</p> <p>Will follow up with next emergency alert that all patients are contacted.</p>	
INFECTION CONTROL	<p>There was no increase in reports of infections and no trends identified. Under reporting of infections is suspected.</p> <p>Employee infection tracking does not indicate any specific trends.</p>	<p>Patient infections will now be entered in the EMR and not on paper.</p> <p>Clinicians have been trained how to enter infection reports.</p> <p>Reports will be printed and monitored monthly.</p>	<p>Ongoing: Infection reports will be entered in the EMR and monitored for trends.</p> <p>Ongoing: The clinical managers will complete Employee Absence form when an employee calls in sick. If the absence is related to illness, the clinical manager is to complete Employee Infection report. The Director of Clinical Services will continue to receive employee absence reports. Trends will be monitored monthly.</p>
ACTION PLANS	<p>There are three selected action plans for 2019:</p> <ol style="list-style-type: none"> <li>1) Patient Centered Care,</li> <li>2) Timeliness of care, and</li> <li>3) Wound Management.</li> </ol>	<p>Plan to involve clinical managers and clinicians with developing action plans.</p> <p>The three action plans are for long term and to be implemented throughout the year. Short term action plans can be developed if an immediate need of action is identified that requires a quick resolution.</p>	<p>Ongoing: Will continue to monitor data results to determine if the action plans are working or need revised.</p>

		<p>Patient Centered Care fulfills the new Medicare COPs for clinicians to involve the patient in developing plan of care.</p> <p>Timeliness of Care promotes timeliness of care which can decrease re-hospitalizations.</p> <p>Wound Management promotes positive patient outcomes by preventing wound deterioration.</p>	
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Home Health Target Areas  
QAPI--2019

Measurement Area	Data Source	Key Indicator	Monitoring Frequency
<u>Clinical Audit</u>	Clinical Documentation	484.65 The audit indicators are based on the Medicare Condition of Participation requirements, clinical outcomes, and evidence based standards of practice. The peer review audit tools include Clinical Documentation, Therapy Documentation, and Potentially Avoidable Events tools.	Ongoing
	Clinical Documentation	484.60(b)(4) To ensure physician orders are signed timely, clinical managers are to review sign orders daily. The physician orders are tracked daily for the number that are pending and the date the orders were written.	Daily
<u>Adverse Events/Patient Safety</u>	Clinical Documentation	Reduce Potentially Avoidable Event by: 484.70 Monitoring of patient infections to include infection rate, site of infection, source of infections, return of infection, and whether the infection was acquired before or after admission	Weekly
		484.65 Monitoring of wounds while patient is active. Auditing of records for appropriate documentation of wounds	Weekly
		484.65 Implementing and monitoring fall risk assessments and educating/reinforcing staff on the importance of including interventions in the plan of care. Monitoring of falls for location, type, injury, and contributing factors.	Weekly
<u>Patient Satisfaction</u>	Complaints	484.50 (e) Investigating all customer complaints including scheduling, communication and staff performance.	Ongoing
		Integrating of occurrence reporting process for all Covenant Care	Ongoing
<u>Regulatory Compliance</u>	Agency Operations	The audit results will indicate an improvement in participating in Medicare Condition of Participation. Will continue to monitor clinical audit results to ensure compliance with the 2018 Medicare COPs. 484.55 Timeliness of Care. Will track timeliness of care is within Medicare COPs. Will begin to prepare for 2020 PDGM.	Ongoing
<u>Infection Control</u>	Infection Control Log	484.70 Patient infection reports are now entered into the EMR which will improve tracking infections and trends. Handwashing and bag techniques are continued part of skills labs, Relias training, and supervisor visits.	Weekly

**COVENANT HOSPICE PERFORMANCE IMPROVEMENT ACTION PLAN  
2019**

TOPIC	FINDINGS	ACTION PLAN	FOLLOW-UP
CLINICAL AUDIT REVIEW	<p>There are three clinical audit tools: 1) Care Planning 2) Oxygen Safety 3) Wounds Care. The audits are done monthly for each branch. The indicators are based on documentation requirements to ensure clinicians are providing standards of care that are defined by Medicare Condition of Participation (COPs).</p> <p>The 2018 audits identified the following need improvement: Falls Oxygen Infections Wound Management Care Planning Family and Patient Satisfaction</p>	<p>A Performance Improvement Project (PIP) is a concentrated effort on a particular problem in one area of the branch/team or organization wide. It involves gathering additional information systematically to clarify issues or problems, and intervening for immediate improvements. The branch/team conducts PIPs to examine and improve care or services that the branch/team identifies as needing attention. Areas will vary from branch/team based on audit results or other data to support priority.</p> <p>The PIP will focus on Patient Safety, Patient Satisfaction and Wound Management. We will audit and teach on the following:</p> <p>Falls Oxygen Infections Care Planning Wound Management Family and Patient Satisfaction</p>	<p><b>Ongoing:</b> Reviewing and editing current audit tools to help track, identify educational needs, and reinforce assessing and documenting patient's healthcare needs.</p> <p><b>Ongoing:</b> Monitoring documentation by using audit tools and providing education to the clinicians as the need is identified.</p> <p><b>Clinical Manager:</b> Will provide more guidance and oversight to improve wound assessment and documentation.</p> <p><b>Ongoing:</b> The chart auditors will continue to notify Clinical Managers of deficiencies and the Clinical Managers will continue to provide/ensure staff education and training.</p> <p><b>Ongoing:</b> Will continue improve audit tools and ways of identifying and tracking trends.</p> <p><b>Ongoing:</b> monthly audits to identify trends and to improve timely notification and intervention.</p>

ADVERSE EVENTS INFECTIONS	<p>Hospice tracking indicated a total of 1535 infections for 2018 with 305 infections occurring within 30 days of admit. Of all infections tracked for 2018, 1120 were treated with antibiotics.</p> <p>The overall infection rate for hospice for 2018 was 6.15%.</p>	<p>Monitor infections of patients both admitted with infections - and acquired post admission. Goal is to reduce infections in both and to focus on areas that are most likely to occur in the patient population.</p> <p>Improve documentation on of infections on admission - to identify patients admitted with infection.</p> <p>Educate staff on infection control guidelines and assessment of patients with high risk of infections and utilization of PPE to decrease likelihood of spreading infections.</p>	<p>As part of the P.I. process, will continue to audit charts to monitor for patients who are at high risk for Infections to improve patient outcomes</p> <p><b>Clinical Managers</b> and Case Managers will review infections in IDG meetings to ensure a positive patient outcome.</p> <p><b>Ongoing:</b> Will continue improving audit tools and ways of identifying and tracking trends.</p> <p><b>Ongoing:</b> monthly to identify trends and to improve timely notification and intervention.</p>
ADVERSE EVENTS OXYGEN	<p>Hospice tracking of Oxygen Safety indicated 85% compliance with Oxygen Safety</p>	<p>Monitor and Identify risks associated with home oxygen therapy including identifying smoking material, potential open flames, functioning smoke detectors with goal to reduce to risk and harm to patient</p> <p>Continue to educate staff on Oxygen Safety. Staff to educate the patient/caregiver on the oxygen safety risk assessment and offer solutions</p> <p>Assess the patient/caregiver level of comprehension and compliance with identified risks and suggested interventions.</p>	<p><b>Ongoing:</b> monthly audits to identify trends and to improve timely notification and intervention.</p>

ADVERSE EVENTS FALLS	<p>Hospice tracking indicated a total of 1486 falls for 2018 with 544 falls occurring within 30 days of admission.</p> <p>The 2018 hospice fall rate was 5.75 with an injury rate of 30% with a 3% severity rate.</p>	<p>Monitor fall reporting to reduce overall fall rate with emphasis on reducing injury rate and severity of fall injury.</p> <p>Improve documentation and reporting of falls to identify high risk patients Educate staff on how to identify high fall risk patients, fall prevention, MAHC Score.</p>	<p><b>Ongoing:</b> Clinical Managers and Case Managers will review Falls in IDG meetings to identify fall prevention opportunities.</p> <p><b>Ongoing:</b> Monthly audits to track and trend opportunities for patient and staff education.</p>
Emergency Planning	<p>CEMP review and monitoring</p> <p>2018 stress tested the CEMP protocols and procedures. Processes were followed during Hurricane Michael with improvement areas identified. Emergency communications and alerts, staff call back, staff relief, DME and pharmaceutical delivery challenges identified as areas of focus.</p>	<p>Comprehensive review and revision of CEMP plan with specific PIP plans areas in need of improvement: Emergency communication and alerts, Staff Call back procedures, Staff Relief plans, Emergency shelter staffing processes, DME delivery protocols, Pharmacy protocols, HR compensation and PTO guidelines.</p>	<p>Ongoing: Continued review, monitoring and update of CEMP plan by branch. Disaster drill to be conducted minimally bi-annually with risk areas identified and PIPs developed based on results of drills. .</p>
COMPLAINTS/ DEYTA SCORES	<p>Current reported DETYA/CAHPS indicated the following</p> <p>AL:</p> <p>Communication with family-81%</p> <p>Getting timely help-81%</p> <p>Treating patient with respect-89%</p> <p>Emotional/spiritual support-87%</p> <p>Help for pain/symptom-76%</p> <p>Training family-75%</p> <p>Rating of hospice-80%</p> <p>Willing to recommend hospice-83%</p> <p>FL:</p> <p>Communication=77%</p> <p>Getting timely help-73%</p> <p>Treating patient with respect-87%</p>	<p>Clinician education on evaluating the 24 quality indicators for Hospice Care, AIDET and the patient complaint process.</p> <p>New employee education will include procedure for reporting complaints and the protocol to follow for timely response time.</p>	<p><b>Ongoing:</b> Educational and training related to Deyta/complaint protocol will be provided to all staff, clinical and administrative.</p> <p><b>Ongoing:</b> Episodes of under reporting will be monitored and reported to clinical managers.</p> <p><b>Ongoing:</b> Clinical Manager to Review Deyta Results with clinicians to track and trend all opportunities for improvement</p>

	Emotional/spiritual support-85% Help for pain/symptoms-74% Training family-73% Rating of hospice-78% Willing to recommend hospice-84%		
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Hospice Target Areas QAPI--  
2019

Measurement Area	Data Source	Key Indicator	Monitoring Frequency
<u>Clinical Audit</u>	Clinical Documentation	418.58 Quality Assessment and Performance Improvement: The audit indicators are based on the Medicare Condition of Participation requirements with a focus on high risk, high volume or problem prone areas.	Ongoing
<u>Adverse Events/Patient Safety</u>	Clinical Documentation	Reduce Potentially Avoidable Event by: 418.60 Infections (NPSG) Monitoring of patient infections to include infection rate, site of infection, source of infections, return of infection, and whether the infection was acquired before or after admission. Improve documentation on admission to identify patients admitted with infection with the goal of reducing the infectin rate Review all infection control guidelines.	Monthly/Ongoing
		418.60 Oxygen (NPSG): Monitor and Identify risks associated with home oxygen therapy including identifying smoking material, potential open flames, functioning smoke detectors with goal to reduce to risk and harm to patient	Ongoing
		418.60 Monitoring of wounds while patient is active. Auditing of records for appropriate documentation of wounds	Monthly
		418.58 Falls (NPSG) Implementing and monitoring fall risk assessments and educating/reinforcing staff on the importance of including interventions in the plan of care. Monitoring of falls for location, type, injury, and contributing factors.	Monthly
<u>Patient Satisfaction</u>	Complaints	418.58 Investigating all customer complaints including staff performance, DME, and Pharmacy. Utilize CHAPS scores to improve patient/family satisfaction	Ongoing
<u>Regulatory Compliance</u>	Agency Operations	The audit results will indicate an improvement in participating in Medicare Condition of Participation. Will continue to monitor clinical audit results to ensure compliance with the Medicare COPs.	Ongoing
<u>Infection Control</u>		418.60 Patient infection reports are tracked in the EMR and reported in IDG. Handwashing and bag techniques are continued part of skills labs, the new additon of Relias training will improve opportunites to educate staff along with supervisor visits.	Ongoing