Transcript: April 2017 UP Network Webinar

Patient Safety: All in a Day's Work

Misty Kevech: Good afternoon everybody. We're so glad that you were able to join us today for the Underserved Population Networking Call, Patient Safety, All in a Day's Work. I'm Misty Kevech, one of the RN coordinators with HHQI. Also joining us today is Crystal Welch and Sharon Miller, RN Coordinators. We also have, from our team, Misty Dyke and Andrea Lefkay, our communications specialist. We are thankful that you're able to spend some time today and this is a two hour webinar and it will be a virtual workshop so a little different format than we normally do. We really want you to be able to get a lot out of today's presentation. I'm going to do some housekeeping first, all of the phones are in a listen mode because of the volume of people that will be on the line, as usual.

We also want you to locate, if you joined early, you probably saw the polling question that popped up on the right side. If you've just joined us and haven't taken the polling question, it should be on your right side. If you look towards the top right, you'll notice some little blue icons and there is one that says participants, one that says chat, Q and A and polling and we're going to use a lot of this today. Click the polling question and go ahead and answer the question that talks to you about where you are in your quality improvement or your QAPI process right now, so go ahead and take that but do notice that you should have a chat box that you can click on the chat icon, that it will open up and you'll be able to see information that's being provided.

We're going to have you do a lot of typing into chat today, as well as the Q and A box where you can put your questions in in either the chat or the Q and A. We are going to stop intermittently for questions because this is a longer workshop and we want to address those as close to the time point of when that material is covered but if you forget and put it in a little bit later, we'll hold that question and catch that on the next stop. There are 2.25 hours of nursing CEs available and I'll provide details for you at the end of the workshop. We have a lot to do and a lot of information so let's make sure that we're all ready for the workshop.

Did you print off the needs assessment worksheet? We posted the link in the chat window so make sure that you have been able to download and print off the sheet. If for some reason, you're not able to print off the sheet, you can use a plain piece of paper, it won't matter. The idea of today's workshop is to jumpstart your QAPI program and plan related to patient safety so we're going to have you do some activities as we go along. We want you to think about and if you're with others with your organization, you can work together as a team

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and if you're listening to this as a recording, we want you to also be working on your needs assessment worksheet during the allotted time.

We're going to be playing some hold music in the short stops that we do to show you about how long that you'll be working on your sheet, if you're listening to the recording. Let's go ahead and make sure there are many handouts for you to download and you can do those afterwards. There are the slides there, downloadable and all the links will be included in those. There is that needs assessment template that you're going to use now. Learn from the defects to what's posted separately and then the other handout, they're all put together in one file for you, so there are several for you to download. We also want you to really be present during the workshop.

Avoid multitasking or we want you to try to envision what your patient safety work is going to look like at your organization. We want you to share ideas and your thoughts through the chat feature as they pop in to your head and as you'll be prompted by our speaker today. There'll be a variety ... A variety of information is going to be provided and the speaker also has included some examples that are interwoven through the workshop. We want you to think, outside of the box, maybe that isn't an issue or a problem for your organization. For example, she's talking about medications, you can apply that to hospitalizations or to other infection control issues that you're having but she's going to address many different topics for you so we want you to think about all of the information in the framework of your organization.

Please ask questions while we have the patient safety expert with us. This is a great opportunity for us. We're very excited to be able to introduce our speaker for you today, which is Tina Hilmas and she is our ... She has a diverse nursing background for the Center for Patient Safety. She spent over 20 years in the nursing profession both within hospital walls and outside in home health arena. Tina has spent 10 years in operations and quality improvement in home health prior to joining the center for patient safety. Her current work includes collaborating on quality improvement projects that includes incorporating a strong patient safety culture.

You're going to hear that throughout the presentation today too. She also reviews patient safety events, that report to the center and analyzes those for trends and causal factors and assist these organizations with changing their culture and improving patient safety. Ms. Hilmas holds a bachelor's degree in the science of nursing from the Ohio State University and is currently finishing her master's degree at the University of Missouri Health Informatics. She's a certified just culture trainer and is also a master trainer in TeamStepps. She has experience with helping organizations to implement CUSP and she'll talk about that in a little bit too.

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She's a member of the American Nurses Association and the American Society of Professionals in Patient Safety. Tina has been a great partner with HHQI for several years. She's a member of our stakeholder work group and has served as a technical expert panelist for our best practice intervention package and she has presented on national webinar last year called Patient Safety Culture, the foundation for QAPI. Now, that webinar is included in the resource slides near the end of the presentation, if you've missed that because it was an excellent presentation. It is with my great pleasure for me to turn over our workshop to Tina.

Tina Hilmas: I hope that you are too. I'm looking for the results of the polling question, there we go and it looks like many of you are really prepared. It looks like there is a handful of you who are still in the either the last approach or you're taking the Scarlett O'Hara level of, "It's been delayed so I will worry about that tomorrow." I am hoping that no matter where you are on your journey, that you will get some good solid information from this webinar. It should hopefully help guide those who are just now getting started and not certain how to put the pieces together and for those of you who have already put something together, it'll give you some more ideas of how to sustain your QAPI project and maybe give you some reassurance that you're headed in the right direction.

The objectives for today are to be able to describe patient safety culture, what it is. I will be covering why this is important early on in this workshop. We will define the role of leadership in developing a QAPI program and leadership's role in patient safety and culture. By the time the webinar ends, I'm hoping you'll be able to identify two quality improvement models of which you can integrate into your QAPI program and then that you should also be able to explain how the communication process in your organization can affect not only your QAPI project but also patient safety. Before we kick off the program, let me tell you a little bit about myself and the Center for Patient Safety.

The Center for Patient Safety is a federally designated independent not-for-profit patient safety organization. We were established in 2005 and our mission is to be a leader in providing creative solutions and to improve patient safety. Our vision is a healthcare environment that is safe for all patients and healthcare providers in all processes all the time. We work across the continuum of care with home health agencies, medical offices, EMS agencies, long term care and hospitals. We protect patient safety and quality work under the umbrella of being a federally designated patient safety organization so we are at best to then learning why things happen so that we can help organizations to prevent patient harm from reoccurring.

We also do that through patient safety culture. We administer surveys on patient safety culture and work with organizations to improve their culture so that they can help promote an environment of sharing your misses, unsafe

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conditions and mistakes so they don't reoccur. To kick off our journey today and I look upon QAPI as a journey, I want to share a slide with you regarding Lincoln's journey to the White House. I'm not going to read this whole slide but what I want you to pay attention to is that he started on his journey to becoming one of the most successful president in our history back in 1831. His journey over 30 years involved many challenges, many barriers along the way but by keeping his eye on the end goal, he was able to be successful.

What I'd like to say about QAPI is that by keeping your eye on the end goal, hopefully, this will be a program or a project that will help you look at your processes and streamline them, improve your quality of care and improve patient safety. I believe that QAPI could also help you to reengage your staff which will help you to retain your staff. While it is very much a challenge and I know that home health has been safe with many challenges and change over the last few years, this is something that while I think the initial reaction was, "Oh my gosh, another change," it could actually be integrated into your home care organization and be looked upon as something that could set some positive trends some place.

Let's look first at what QAPI is. QAPI is quality assurance and performance improvement. They are very different but they feed into each other. I thought before we really kick in to some of the foundational components, let's take a look at these and see how they do that because the overall goal of QAPI is a comprehensive data-driven proactive approach to providing high quality care. The quality assurance component, that is usually measuring your compliance with standards. That's like, are you following the requirement for admitting the patient within 48 hours? It's looking at are you meeting that? Whereas the performance improvement part isn't looking at if you're meeting it, it's looking at your processes you've put in play to meet those standards.

With quality assurance, you're looking at inspection. You're looking at checking it retroactively, you're not looking at it ahead of time, whereas on the performance improvement side, you're looking at it ahead of time. You're trying to be proactive so you're trying to make certain. You're putting into play processes that will help you meet that 48 hour admit time. The quality assurance aside the attitude is, this is something that's required. It's reactive. The standard is required that is something that's put down in black in white. The performance improvement is the processes that you put in play, those are chosen. That's what you as an organization choose to put into play to help you meet that required standard.

It's a proactive point of view. With quality assurance, you don't know about it until afterwards so you're looking more at individuals, the outliers. Usually you're doing this through chart audits or review after a patient has already been admitted to your organization, again with performance improvement, you're

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looking at your processes and systems overall. Are they good processes? Do we have a good system in play? The scope for quality assurance always rest with the medical provider so usually the nurse or the team that is taking the referral which is handing the patient to the nurse. You're looking at specific individuals, whereas with performance improvement, you're looking at the patient care as a whole.

The responsibility for quality assurance lies with just a couple of people whereas with performance improvement, you're bringing everyone onboard because it's also what happens to the patient and it's what's going on in the organization as a whole so you're involving everyone. One of the end products as you put these two together is to like I said earlier, streamline your processes so that hopefully you will make them more efficient which can help improve your outcomes which then increases your patient safety and promotes higher quality care. If you're using QAPI appropriately going forward, what this can do is it can help your home healthcare agency become what is termed a high reliability organization.

That might be something that hasn't been heard much in home health but it is a term that's been becoming more popular in healthcare over the last five years or so. What is a high reliability organization or as we ... you might hear them called an HRO? Basically an HRO is a concept that has been introduced into healthcare recently. These are organizations that operate in complex, high hazard domains without serious accidents or catastrophic failures. They do this not only through standardization of their processes but they do it by cultivating a culture prioritizing safety over some of their other performance measures. There are five components that go into a high reliability organization, the first one is preoccupation with failure.

Everyone is aware in thinking about the preoccupation ... of the potential with failure and they understand that there is always the potential for a failure. They act proactively and they think about ahead of time what could go wrong so to keep it from happening and they are alert to small signs of potential problems. If you think about the admission requirement again, as a nurse is getting a patient and she's maybe getting the information about a potential patient, maybe she's getting information that this is a patient who has many comorbid diagnosis, is very fragile, very frail and the patient is being discharged on a weekend with very little family support.

A person who is meeting this requirement would be thinking ahead of there are many potential causes for maybe her to be readmitted almost right away due to the weekend admission and lack of support in the community. Another component of HRO is a reluctance to simplify. This is where the members, your staff understand that the work processes ... they understand how they succeed or fail in your system so they understand that their work is very complex, it's

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dynamic and it interacts with many others in your organization, maybe with PT, with speech therapy, with the people in the office and with the patient and the patient's family. They understand that work around aren't always the best way so they are reluctant to simplify their processes.

They are sensitive to the operation. They understand that their organization is complex. They understand that healthcare is complex and so they strive to keep a high awareness of the complexity of the care that they're providing and who all should be included in that care. HROs also defer to expertise. They appreciate the fact that the people who are the most knowledgeable are the ones closest to the work so this is very important in these types of organizations because they tend to seek out those people and use their advice and suggestions. This could be really helpful as you go forward with your QAPI to get with those experts out in the field, your field staff, your physical therapist, occupational therapist, speech therapist, your nurses, LPN.

Find out what is truly going on out in the home and get their input and buy in into your QAPI project. Then, the last component of an HRO is commitment to resilience and this is rooted in the fundamental understanding of the unpredictable nature of mistakes. Even if a mistake happens, even if you have some good QAPI project going or a good process improvement project going, you might have mistakes or errors. These types of people understand that this might happen. We are humans, let's take a look at what happened, what went into it, what were the factors contributing to it, what was going on in the environment and see if there is something we need to change but let's go on, we can still make this a success.

That's just something to keep in mind as a goal to strive for. You might be thinking, as you're thinking about these goals, why do we really need to improve? There has been a lot of changes in home health. We've had a lot of put down on us and we've been really working towards becoming high quality care with all of the home health compare and everything else that's been expected of us. Here is a quote I like to share. This is from Sir Cyril Chantler who is a British medical doctor, who has worked quite a bit in pediatric nephrology and also in improving leadership and healthcare. He states that, "Medicine used to be simple, ineffective and relatively safe but now it is complex, effective and potentially dangerous."

For those of you who have been in home health for many years, I'm certain you can think of how we've changed over the years, 30 years ... discharge a complex patient. Well, changes have come about, reimbursement has changed and so 30 years ago, the idea of ventilators, you might see one or two, the idea of discharging a patient home on oxygen, definitely tried not to do it. One VAC that was all done in the home or in the hospital, IV antibiotics done in the hospital. Now, you're seeing all of that in the home, you're seeing one VACs, IV

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antibiotics, chemotherapy done outpatient and in the home. It is much more effective, we're seeing leukemia now that has a 95% cure rate whereas it didn't 30 years ago.

With advancing medical care, there has been trade-off and the fact that it is much more complex so let's move forward and start thinking about these five components that CMS put down for QAPI. I've put a circle here because I look at it as a cycle, it's an ever going cycle. Where do we start? I start with a component that's called executive responsibility but I put it as leadership here. Leadership is to take responsibility for developing, implementing, modifying and monitoring the QAPI policies and procedures and they need to create a culture to support a QAPI program. This is very important and it will be very vital not only to getting your QAPI program off the ground and started but for its sustainability.

The next step at the leadership and executive responsibility is program scope. This is where you can review some data sources to identify potential problem areas. You don't want to make your QAPI project too broad and you don't want to try and tackle too many issues at once. You need to try and look at what you're tracking already, look at those measures that you are and you want to communicate to your staff that QAPI is about focusing on systems. It's not about focusing on the individual. They're going to be a little nervous as you start forward and you start implementing this that it'll be focusing on individual mistakes and so what's very important is that you communicate that this is looking at your processes, not individual mistakes.

Once you've looked at what you're tracking and you're reviewing your data sources to identify problem areas, and you identify a gap, determine what data it is you want to collect and monitor, who you want to collect it, how often and establish benchmark. As you're going through and you're making this decision you should also try and limit it to one data source that you're going to use for your benchmarking. It will just lead to confusion if you try to use too many data sources for your benchmarking because they are all different and you have a multitude to choose from. You have the HHQI data system, you have CASPER, you have Home Health Compare.

If you're using an electronic software, documentation system, you probably have reports and ... that you've already developed in your system yourself. Those are all areas that you can look forward for data but as you go forward, limit it to just one specific data source for your QAPI project that you will use for your benchmarking. Once you've identified your gap and problem area, you want to perform a root cause analysis and that sounds like a really scary conflict together but it really doesn't have to be a lengthy process. I'll review this a little bit later but root cause analysis are a tool to identify contributing factors within the system of any events or problem areas.

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You'll find, if you go online to look for root cause analysis forms, you will find many different types of forms and some of them are even 20 pages long. It doesn't have to be that long and I'll go over this like I said, a little bit later. The next step in your QAPI is to develop your performance improvement project. This is where you can use and implement a process improvement model such as PDSA or the DMAIC model which is define, measure, analyze, improve and control. This is where you'll put into play those tools and resources to improve that gap or problem area that you've identified and then once you've put those tools and resource that you've taken those actions, you'll use your quality improvement model to help see, is it effective and where was it effective.

Maybe where do I need to change it a little bit so let's step forward a little bit to the next slide. We've discussed some of the components and I mentioned how leadership would be very important in going forward with the culture in your organization and with developing your QAPI program so I'd like you, it just take about 15 seconds and type into the chat box what comes to mind when you think about patient safety culture and I'll give you about 10 or 15 seconds to do that. Well, I'm not seeing too much in the chat right now so please feel free to answer, to put anything in that comes to mind with patient safety culture, that's on patient safety at home.

Misty Dyke: Tina. Let me jump in real quick. It looks like everybody is replying to me privately, this is only going to the host so Tina cannot your see answers in the chat box so if you can select all panelist from the drop down and then that way all the panelist will be able to see what you're typing in there. I can read some of them off here for you Tina.

Tina Hilmas: Okay.

Misty Dyke: It looks like ...

Tina Hilmas: Awesome, I'm seeing it now, putting patient safety first. Team effort, high reliabilities. We got programs, staff approach to patient care interaction. Everyone in the organization thinking patient safety first. I love it, I love the fact that you guys are all thinking about this. This is phenomenal. Fall prevention program, home safety, this is great. These are things you need to think about and these are all definite components of patient safety culture and one of the things that is the base of patient safety culture is making certain that your leadership have thought into it and that your organization has a culture where you feel free to discuss near misses or mistakes.

Let's pull out your needs assessment forms and I want to start in with the first three questions here. The first three question is, I want you to identify, what it is you're currently doing well, because as you start to look for projects to work on, those are things you can eliminate from your list of potentials. Start thinking

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about what you currently measure and then start thinking about how would you describe your current organizational climate or culture. I'll give you all about two minutes to start writing down and jotting down some notes.

Misty Dyke: I'm going to go ahead and prompt some hold music during that two minute period and I'll come back on and give everybody about a 15 second warning when we're ready to get started again. Okay, we're going to give you about 10 to 15 more seconds.

Tina Hilmas: All right, so I am seeing some answers even in the chat box and I saw a question about what worksheet? There was a worksheet provided in the ... I think it's in the Q and A, there is a website for the worksheet, there were some forms put out that go with this PowerPoint so if you want to look at that but I'm looking at some of the things that people measure, measure outcomes related to star ratings that ... I'm seeing that people, I think they're scrolling really fast, do signs and symptoms to report, emergency preparedness, they do well. They're asking about ... some of them are reporting about cultures saying that it's safe to report errors but few reports.

We'll go into some of these. I went ahead also and filled out one and so here is some of my answers. I see that many of you have some of the other ... has similar answers to what you currently measure and what you're doing well and what the culture is. I put down about culture and this is based on my experience working in home health that the culture is somewhere in between. I kind of pretended I was back in a home health company and I said, "Well, as a supervisor I like to think my nurses would tell me if they made a mistake. I'm not certain they feel safe admitting they made one. I think they may feel that they would be punished for it."

Let's go on ... Thinking about these questions, let's go on to the next slide. Safety culture, it looks like many of you, few have an idea of safety culture and what it is and how it pertains to home health and I'm really excited about that because I know a few years ago, when I was in home health it was just really kind of being started mentioning and there wasn't a big concepts about what safety culture was so safety culture came out of the IOM report in 1999 titled Too Err is Human. It went in to great detail about the number of death due to medical errors and also the patients who were ... who has suffered serious harm from medical errors.

The report also went into detail in regards to the fact that most of these errors were, contributing factors, were associated to human factors and to systems errors and that nobody really want to cause patient harm. It's just because of either a faulty system or some sort of human error like distraction that went along with the error. This report encourage organizations to focus ... a culture that focus on patient safety and to encourage organizations to identify errors

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and begin surveillance of them and to begin evaluating the causes within the system and their procedures and their policies and to take appropriate actions to improve performance in the future and then to measure the impact of those changes implemented.

The ultimate outcomes of looking at your safety culture is safer patient care which reflects not only positively on the patients but also on your staff. I put a little cycle up here that shows that a positive safety culture is ... it improves your patient safety but it also improves staff engagement which then leads to increased staff retention, which leads to increased quality of care because they really feel like they're doing something. They feel like they're doing what they went to healthcare to do and that is to provide patient care and to improve the quality of someone's life. The culture kind of feeds into your organization and feeds into your care and it feeds into how your staff feels and it feeds into the quality of your care.

How do we define it though? Well, I'm not going to read the definition here, you can read this. This is the definition that came out of I believe a UK group and Advisory Committee on Safety of Nuclear Installments. It was a study group on human factors and the agency for healthcare research and quality, and I believe also the IOM have incorporated this safety culture definition but basically, safety culture is how your organization does things. It kind of makes things easy. The culture is how you treat each other, how you work together, how you live your values. How do you and your staff feel when you come to work? How do your patients feel while they're on service with you?

How comfortable are your staff members talking with other staff members about concerns or problems? Do they talk with their supervisors? Do they come to you if you're a supervisor and talk with you about concerns they have about maybe, it's a system or a process or an unsafe condition. How comfortable do you think your patients and their family members are talking with you and the staff members about their concerns? How comfortable are your staff on patients and families talk with them or ask questions or share a concern? How does leadership act when these concerns are brought to them and how does leadership react to patients and families asking questions or voicing concerns?

This is what safety culture is and with safety culture, as you integrate it into your QAPI program, I like to kind of look at different components of QAPI and get in the sustainability and that's where I'm kind of focusing now with safety culture and process improvement. Those actions that you take for your QAPI program, now, it's physical like tasks that you designate to help improve whether it's medication reconciliation or re-hospitalization. Those are technical change. Those are more clinical and with nurses especially, and even physical therapist and those of us in healthcare, those clinical changes are usually easier to implement, we want to know why and so you usually have some sort of

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evidence based reason for why you're doing that clinical change, so the needs for change is understood.

The know-how, the expertise, the foundation is understood so you have nurses who have a clinical background. It's within their expertise to put that change in place. Usually, something like this can be relatively fixed but the challenge will be, as you start looking at your systems and your processes, and you start trying to make an environment that's more open to share gaps or problems areas, that's an adaptive change and that's culture and speaking at the former ICU nurse, that kind of gets into that "touchy feeling area," that a lot of healthcare providers are not real comfortable with because it isn't black and white. It isn't based on ... evidence based.

You don't have that black and white solid to put it forward and a lot of times it's experimentation. It's an ongoing effort. This is behavior and attitudinal change by people. It's trying to pull them out of that pinnacle, "Oh my gosh, one more regulation coming down the line. I don't know if I can handle anymore." It's working with those and trying to get the buy in and this is a change that occurs over a longer period of time and it's something that works only if it's modeled by leadership on them. That's some things to think about as you're going forward with your QAPI project and that some of the technical changes will be easier to implement than the actual cultural change of getting everyone to buy in.

Now, that I've talked about safety culture and how leadership is such an important part, I'd like you to take just a ... I put few minutes, I meant few seconds and type into the chat box some adjectives that to you describe what a strong leader is, what do you think of? I'm seeing a lot, has a vision for the agency, is open and honest, guides fast, they're decisive, understanding, fair, smart, facilitator not a dictator, active, visible, listens and acts, transparency, mentor, visionary. These are awesome. As you are going through and thinking about these, write them down as to what you think about as a leader, what a leader is. Here is a quote that I really like about leaders and it seems like many of you have the same type of idea, compassionate, goes out into the field to see what is going on.

"A good leader inspires people to have confidence in the leader but a great leader inspires people to have confidence in themselves." I'm loving what I'm seeing here. You guys all have some great ideas, nice thought on for what a leader is. Honest, open, good listener, able to empower staff, leads by example, provides a safe environment for communication, collaborative. These are all wonderful adjectives for describing a leader. For QAPI to be successful, management and senior decision makers need to be engaged just like what you were saying. They need to know what's going on. They need to be visible and they need to interact with staff.

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They need to put safety as a key strategy and priority, not just another project. They need to have it underlying, every project. A good leader, a strong leader who's also involved in patient safety culture will work to improve the work life and the working conditions. Then, they will also fill partnerships with not only their staff but with their patient and their families. Now, that I've kind of introduced the idea of leadership and how that plays into culture, before we go on any further with discussing leadership, I want you to pull off those needs assessment form real quick and let's take another couple of minutes and let's talk about first off, what processes are you doing but not very well?

Identify two or three things that leaders in your organization could do differently to improve or to better support your patient safety culture or your QAPI program. Then, start thinking about some barriers in your organization that maybe prevent your organization from improving into culture and we'll just give you about two minutes here to work on that.

Misty Dyke: Okay, we'll resume the presentation in about 10, 15 seconds. Okay, I think our two minutes is up, Tina you may jump right in.

Tina Hilmas: Okey-dokey. Yes, okay, so I have been reading many of your answers that you've put into the chat box. I'm going to go to the next slide and show some of the answer that I wrote but I'm going to discuss some of these also that I saw on the chat box. I put on some of the process, are we doing but not very well, that our re-hospitalization rate is not the greatest and also our medication management isn't very good. Identify two or three things leaders could do differently to improve or better support your patient safety culture and QI program. I put down our leader could truly engage field nurses to see how policies work in the field. It would be nice if senior management participated at least monthly in our weekly patients rounds.

I'm not certain they really understand the day-to-day processes or flow. Then, current barriers from improving your culture, I put down, I think nurses and other staff would just roll their eyes and see it as the new flavor of the month. We've had so many changes in home health that another one might just seem like one more piled on top of all the other regulatory changes. We would need to see leadership making an effort and respecting us and what we do to really start true changes. Those are some of mine and it's interesting that I'm seeing several responses that kind of are similar and so maybe, I'm going to read off some of these if I can read my handwriting here but I did see that medication management seem to be a big issue with several responses.

I also saw a person who put down continuity of proper documentation and then there is also productivity challenges that there seem to be shortcuts being taken and maybe staff not exactly taking the time to truly assess because of productivity challenges. These are things to start keeping in mind as you're

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going through in time to develop a QAPI program because a lot of these go back to then your processes and so as you're going through your QAPI and you're trying to implement it, start looking at what are the reasons why they are taking shortcuts, why they are the productivity challenges. Again, going along with that, I saw several that said, we had very little step and limited time.

I saw some answer that said, staff forget about the interdisciplinary approach and I saw a few that also said it would be good if we could share positive successful stories with staff and that's always very good, that's very important as your going on and trying to change your culture and promote a more positive patient safety culture, if you have to share those success stories because as you share those success stories that starts to ... then it starts to seem real to your staff because they see that it truly is working. I saw a couple of comments about the old mindset of this is how we've always done it. I work in multiple different states and I will say my question, I'm always a person to ask why.

I always was asking so why do you do it this way? It wasn't that I was trying to make them feel bad or anything else, it just for me, I wanted to understand why they did it and I can't tell you the number of times I got told, "Well this is the way we've always done it." Sometimes if you start getting that too many times, ask them well, why do you think we ... that was put into play? What was the rationale or reason behind it. That's always something to start discussing them because then it brings to the table, it opens the mind but it makes the staff start thinking about why did we start it this way and is there a better way to do it? Let's go on then and this bring us then the dreaded keyword as we're talking about all of this.

The dreaded keyword is change. Change, have we have a lot of it recently? I don't think we've had any of that in home health recently. We've had a ton in home health and it gets very difficult to deal with all the change we've had. Let's ... To help you, why don't you take some time, I'm not going to review all the responses right now, but take some time to write in the chat box what you think of when you think of change? Do you hate it, do you love it? Is it necessary, are you tired of it? Just some things that come to mind about how you feel about change. I'm going to go on then and start talking about how leadership can really help with change.

Many of you were talking about leadership and adjectives that go along with being a good leader and so there are several books out there that talk about leadership and what comprises leadership but leadership is basically made up of character and competence. The character part is your personal focus, values, integrity, courage, creativity. This is ... Are you ethical? Do you set a good example? Do you walk the walk or do you just talk the talk? These are the character components that go along with leaders. Then competence is, are they professional? Are they focused? Do they have the knowledge base? Do they

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have the skills based? Do their behaviors match the skills and do they follow through with methods and tools.

These are some components of what leadership is. Then, leadership, many might think that leadership is just something that's just natural, that you have born leaders, but leadership is actually a learnable, teachable and measurable set of behaviors and processes. What strong leaders do is they model the way, they inspire a shared vision which that was one of the comments that was brought up as you guys were talking earlier. They challenge the process, then they enable and empower others to act and they encourage the heart of their followers. What leaders do then to helping with change is leadership is looked upon as a set of processes that creates organizations in the first place and then defines what the future should look like and inspires people to make it happen.

Now, I'm going from Kotter here, from his book ... It's about 20 years old now but it's an excellent book to look at what leadership is and it also provides some steps to working with change. What leaders do and this is part of his change, his eight steps of change to help make it possible but they establish a direction. They develop their vision and they lead by values. Then, they help to align people and build commitments. They inspire people to overcome obstacles to bring about change and they engage in open dialog. They communicate more in action and in words than done in words.

What leaders also do when it comes to change is they create a sense of urgency. They help others to see the needs through or change. They help to build that coalition to help guide the change. They help to form with their people a strategic vision and then they not only inspire people but they enlist a volunteer army who are engaged and they buy in to the needs for the change. Then, they also work with their staff to remove barriers. They identify them and they remove them. Then, they generate and they share the short term wins and that's so important for change and then if they see the positive moment and they see the change coming about, they sustain the acceleration.

They keep pressing after the first success. They ask what truly was successful, what might we need to change and so they keep looking at their policies. They are pre-occupied with failure and they keep that sustainability going. Then, they look at how they can make that change intuitive. They look at how do we make it so that this new behavior becomes an old habit. That's what leadership and leaders can do to help with change. Keeping that in mind, I'm looking at some of these things and it's very true that change is necessary to grow. It is continual and it doesn't stop. It can be refreshing and a time saver in the long run after education is given and understood and that is so true.

Change is important as society progresses and I might even say that change is important as healthcare progresses. Healthcare is changing in an ever rapid

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mode. When I think back to when I first got into healthcare, back in mid to late 80s, research articles were coming out at the rate of maybe one or two articles a month in journals. Now, they're coming out and you'll see 15 to 20 articles in the journal. It's constantly changing. I see a comment here about home health is always changing. Take it as a change for the better. New processes can decrease work and increase performance and then change is inevitable. It really depends on whether or not the change is a knee-jerk reactive change or a well-thought out change for actual process improvement and that is so true.

That is one of the things I'm trying to help you with in this webinar, is to make certain, as you're putting in your QAPI program, that you're taking the steps necessary to make certain that whatever project you implement, will not only be a project that will help improve your processes but it will help streamline them and that it will improve the performance and also, decrease the workload of your staff. That will provide you the opportunity to look back at some of the changes that has been put down by CMS and the regulations over the past years and maybe incorporate them into more streamlined processes.

Let's move on and we're going to go into now, start talking about the quality improvement model. Now, that we've discussed how leadership and culture combined, let's move on to talking about quality improvement models. The first quality improvement model I'm going to discuss is the PDSA or the plan, do, study, act. This is the one that is very common and I'm certain you've probably heard of it. It came out of IHI but it's been around in different forms for many years. It's been called different names. It had its different components, name differently but basically it's a rapid cycle framework for testing a change. You plan it, you implement it, you observe the results and then you act on what is learned.

Did the change result in the desired action or doesn't need revisited. The PDSA, even though it is a rapid cycle framework, it's still can't be implemented without some forethoughts. You need to think about ahead of time what it is you want to change. The aim of what you're implementing needs to be specific, it needs to be measurable and you need to define the specific population of patients that will be affected. For example, if you are using it say, to work on medication management, you need to define what patient population you're really focusing in on. Are you going to focus in on patients who are taking Opioids? Are you going to focus in on patients who are on anti-coagulants?

Are you going to focus in on all medication but patients that are taking five or more oral medications? These are things you need to define and then you need to establish your measures and be consistent. I mentioned at the beginning of the webinar that as you are looking at the scope of your plan and looking at your QAPI project and you're thinking about what benchmarks to use, to be consistent and use the same set of data throughout the project. That's the only

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way you'll really be able to tell if you are making a change or not because otherwise, that's like you're comparing apples to oranges. You need to be utilizing the same set of data. Then, as you study the effect of the change, make certain that it is resulting in improvement and if it's not let's see why it isn't.

As the saying goes, "All improvement requires changes but not all change results in improvement." Identify those processes that are truly helping to improve the outcome or improve your quality of care and improve your patient safety and then act on that and so then, readjust your plan and set it down again and go through the cycle again. Another quality improvement model is the DMAIC. This one is a combination of the lean program and six sigma framework. You start off by defining the problem, what is the scope of my problem? How bad is it? What is the key metric? What is important and then who are the stakeholders? Again, if you compare it to the plan, do, study, act, this should be defining what your problem is and who the patient population is associated with it.

Measure, what data is available. How do you know it's the problem? What data is it you're using? What benchmarking are you going to use? Is the data accurate that you're using? If you want to do graphs, what type of graphs should you use? That's what the measure part is, is really digging into that data so that you have a baseline to compare your improvement to and then analyze, you analyze the problem. This is looking at the root causes of the problem. What causal factors go into it? Have they've been verified? Where should we really focus our efforts? Then you setup to improve the care or that's where you start putting into your task to improve like your medication management.

You start thinking about do we have the right solutions? How will we verify that these solutions are working? Have they've been piloted before? Do we need to pilot them? Then, lastly control what is the recommendation, is there support for a suggestion after we've done maybe a small pilot? If we did do a small pilot, how do we implement the changes organization line? Are the results from this change sustainable? Can we put processes in play that are simple, concise and effective and can be easily incorporated into our daily flow? That's what the control part is. These you should be using either one of these during your QAPI project to make certain that the task that you're putting forward are successful and they are resulting in a change.

Now, I'm going to go on to root cause analysis. I mentioned that in the DMAIC and I'm going to spend some time talking about it because it's really not as big and overwhelming as what sometimes it's made out to be. Root cause analysis does not have to be lengthy and there are a variety of tools. The big thing about root cause analysis is that it is designed to get away from the practice and have it blaming the individual for an event and instead looking at the environment and looking at the human factors in the systems that are involved with an event. The main concept is to ask why. Ask why five times or more, as you get into the

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process and you start streamlining your processes, you might not need to ask why five times, you might only need to ask it three or four but as you start this process, start doing, asking at least five times.

I put up here a really, I don't know cute, I guess humorous example of the why five times. Why were you late to work? My electricity was out and I couldn't see to get ready. Why was your electricity out? I didn't pay my electric bill. Why didn't you pay the bill? I didn't have the money in my checking account. Why didn't you have the money, you've been working, you haven't taken off? Well, I spent it on a tattoo. Why did you spend it on a tattoo? My boyfriend and I want a matching tattoos. It's kind of humorous but I was trying to think of an example that maybe everyone can relate to and the concept of wanting matching tattoos, that's a whole different topic.

Let's look at it in kind of a home health environment. We're going to put up a polling question here in just a minute but here is an example. Let's say you admit a patient and they have a suprapubic catheter and the nurse is suppose to change it. When the nurse attempts changing the suprapubic catheter, complications occur and the patient ends up in the emergency room. Your initial investigation shows that the RN didn't follow the standard procedure that most of the other RNs in the agencies do when changing the suprapubic catheter and when looking at the 485, changing the suprapubic catheter wasn't on the 485. What should the action be here? Should the nurse be counseled? Should ... Let's see, is the polling question up?

Can we put up the polling question? All right, should we counsel the nurse? Should the nurse be disciplined? Should we terminate the nurse? Should we do something else other than those three choices given? I'll give you a couple of seconds to answer the polling question. This will lead into kind of why we should do ... always look at root cause analysis, because like I said, root cause analysis gets you to asking why. Why this happened? What was the underlying reason? It gets away from looking at the individual, rather than looking at the events and the underlying reasons. The majority of you said, counsel and then a handful also said, other.

Those were the two top and then there were a couple that said either discipline or terminate. Let's look a little deeper at this scenario. Upon further investigation into this event, it turns out the doctor had written in discharge notes back over to the agency that the suprapubic catheter needed to be changed but for some reason it didn't make it on to the 485. He also hadn't specified, decide the type of catheter to use and he hadn't called in any supplies for the patients. It turns out this was a brand new suprapubic catheter and the patient was struggling with body image and accepting that they needed the catheter so they didn't want to bring up the fact that the doctor hadn't sent over any instructions or supplies so they didn't bring it up.

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Then, it turns out also that the organization did not have a clear policy or procedure for changing a suprapubic catheter. These are all things that come out when you do a root cause analysis. Knowing these facts would that change what you think should happen with the RN. Maybe instead ... You know, I think counseling would be a good idea but maybe the organization should look at making certain they have a clear cut policy for changing a suprapubic catheter and maybe they need to look at some of their processes on making certain that things that ... of what gets on to the 485. Those are just like some real life examples that we've run into just to kind of get your brain thinking there.

As you are doing the root cause analysis there are some tools that I handed out to you and I just saw a chat about needing ... maybe the nurse needed additional training. In counsel you should ask more questions and that is so true. Do ... Need to understand why the nurse did not follow the protocol and so that is ... I think those are all great, you guys were thinking outside of the box. This is where home health organizations, I think really need to get to and healthcare in general. We're struggling with this across the whole continuum from, still in hospitals to EMS, to home care agencies, to long term care, we're struggling to get away from the concept of the event that's due to a bad apple or a bad employee.

Instead of thinking that way, organizations are starting to look more at what was going on when this mistake was made and what are some of the contributing factors that did contribute to this mistake? It's been a real cultural shift for healthcare because typically, one, we don't like to admit we made a mistake, we like to sweep it under the rag because two, we're worried about liability and if we open up and talk about we made a mistake then we worry that it opens us up for lawsuits and other things like that but if we really want to improve in the quality of care that we're given, we need to start looking into the human factors that play into mistakes that are made.

Then also the systems and with your QAPI project, looking at those systems is so important because that's where you can really start with improving the process. Let's go on and look at some of the things with ... for root cause. I have given to you a couple of different tools to use for a root cause analysis. The fishbone diagram, I gave you a blank one but basically, what that does is it helps you identify, some of the categories of ... that might play into an event that happened. It starts by looking at what are your policies, what are the procedures, who were the people involved? What was the environment like, what resources were available and who was the patient? Then, it's got like two open categories that you can name yourself.

Then, you look ... you can kind of go down the fishbone to the bold line and it all plays into then, that adverse or unanticipated outcome are potentially adverse event and so you could start looking at what went into it and it helps you then

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to identify not only human factors but also maybe systems. Now, when it comes to the people or to the nurse, in home health, you do still have people who are on call because you have to have someone on call 24 hours and so, exhaustion can play into things. Does your nurse who was on call, does she still work a regular day, is she working like a regular ... seeing patients eight to five on call and maybe even going out to see patients late but then having a full schedule of patients the following day.

Looking at things like that, helps you to not only look at those into your adverse event but it starts getting you looking at your processes again. The other one that I didn't put up on the slide because it's a couple of pages but it's a table, this is a tool that's from the CUSP project put out by AHRQ and CUSP stands out for Comprehensive Unit-Based Safety Program. It was originated by John Hopkins Hospital, this CUSP program but it's been widely developed by hospitals throughout the nation and it is hospital based but there are many tools that could be developed or modified for home health. This is one of the tools that I think could be modified for home health and I did modify it.

The first page kind of goes through how to use the tool, it explains what it is. It tells you that it will help you to provide a clear thorough objective explanation of what happened. It helps you to review the list of factors that contribute to the incident and it helps you to describe how you can reduce the likelihood of this happening again. It looks at some of the contributing factors like maybe the patient was at home but they were still acutely ill. Maybe they have multiple comorbid diagnosis. Maybe there is a language barrier with the patient. Maybe their primary language is Spanish. They know enough English to talk to but they sometimes don't understand.

Maybe there were personal or social issues going on. It looks at, if there was a protocol available. Was there test results, for example if they're on anticoagulants. If you're trying to make a decision and you're reporting to the doctor, do you have the most recent PT INR. Do you know that they're accurate? It looks at things like was the provider fatigued, was your home health nurse fatigued? It looks at communication between like your primary care physician and your home health team. It looks at was your nurse distracted with personal issues?

It's a table that looks at all of these factors and you can mark whether it negatively contributed to the event or whether it positively contributed to the event because it could be things like communication between the PCP, primary care physician and your home health organization. You could have really strong communication. With that, I kind of like to stop a little bit to see if there is some Q and A going on.

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Misty Kevech: Wonderful. This is Misty so if you have any questions, you can put them into the chat box or the Q and A box. We had a few that came in during the earlier part of the presentation. I'm going to give you Tina one from Julianna. It was actually a comment, not that you might be able to comment on that. It says that we change from PDSA to PDCA, plan, do, change, adjust. Which seems to keep us fine tuning until we decide the process is as good as it can be.

Tina Hilmas: I really like that. I think that's a great modification of that, because what you're doing is you are ... you're doing exactly what the model should do, is that you're looking at what you're putting into the place, if you need to change it, you're changing it, you're adjusting it and you're looking ... you're doing that fine tuning and making certain that your new process is ingrained and what you're doing then is you're making it so that that new behavior becomes an old habit. I think that's great.

Misty Kevech: We had a couple of questions that came in and comments about change when you were talking about change. Someone had asked, were there some ideas that you could use to help prepare staff for change?

Tina Hilmas: That's always a tough one but for organizations that I've worked with, it's always been preparation and being transparent with your staff, letting them know a timeline and that helps them prepare. The final conditions of participation were assigned in January and I believe technically, you had until January of 2018 to get your QAPI project implemented. Sitting down and being totally transparent with your staff, letting them know what the new changes were, letting them know what the timeline is, engaging them in the change. Letting them have a voice, because then they feel like they might have a little bit of control. I think one of the things that makes change so scary especially to staff is that sometimes they feel like they don't have a voice in the decisions that are made.

That it's someone telling them what to do. Where if they are brought in and engaged, and sat down in a brainstorming session, they start feeling like they can contribute to it and that they are truly part of the organization and then they have a little bit of control over what's going on and then timelines are always important also. That helps them to know when the change is coming down, what it might be, when they need to get prepared for it. These are some of the things that you can do to help get your staff not so fearful of change.

Misty Kevech: Those are great points and I think we saw along some of the chat which has been wonderful, thank you everyone. Also, I worked with an agency this morning too. A lot of agencies do employee surveys to get input but you may want to take even some of the questions that Tina has post to you about what is leadership? What does safety mean to you? What does quality mean to you? To find out what they have to say and get that information to help drive because then they have better buy in because they're part of deciding what some of the

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barriers are, perhaps helping to get that vision of where you're going to go. Now, we did have another comment that came in on communication or I'm sorry, on change.

Thank you for providing insight on the book, the Kotter book. It's a great reference for change and I actually had a couple two cents to throw in and I thought maybe we could open chat up as we go along if anyone else has some great books that are out there on change and change management where I have worked with many organizations where we have read the book as a team. Even at HHQI, we did this a few years ago too. John Kotter also has Our Iceberg is Melting, Changing and Succeeding Under Any Conditions. It's about a group of penguins and you will see your staff and your managers in all of these penguins. It's kind of a child's book but adds such a huge message integrating Kotter's eight principles and then there was another book I read a few years ago too, How Stella Saved the farm.

It's about llamas and sheep. Again, a fun interesting way to look at things but man, I could really see the healthcare connection. I'll throw those two titles into chat and if anyone else has had some really good resources or books on change management, feel free to share or on anything else that Tina is covering in today's presentation. I'm not seeing any other question. How about you Misty D?

Misty Dyke: Looks like everything is all clear on my side too.

Misty Kevech: All right, great. All right Tina. We'll turn it back over to you.

Tina Hilmas: All right. As we're talking about change, there is a slide ... there is quote that I really like by Einstein and that, "Insanity is doing the same thing over and over again, and expecting different results." Then, the other quote I like is that, "We cannot solve our problems with the same thinking we used when we created them." This is so true. I think especially in healthcare because with each medical advance we have, it's a great advance but it also does create a new complication and so to deal with that complication, we can't use the same thinking that we used for developing the medical advancement. As we go forward, let's pull out that needs assessment again and I want you to go back to thinking about the barriers you listed and kind of think a little bit more about them and see, are they the same?

Have you thought of any others? Start thinking about now what you, as an organization maybe need to start doing, going forward. Then, I want to know have you looked into measuring the patient safety culture at your organization. There is ... if you're a home health agency that's maybe affiliated with a hospital, you may have taken AHRQ survey on patient safety or we at the center here actually do have a survey on patient safety that has been developed specifically

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for home health. I was just wondering if any of you out there have taken a patient safety culture survey and if so, are you using the results of that survey to help drive your process improvement project. Let's stop for a couple of minutes while you answer these on your needs assessment form.

Misty Dyke: Okay, we'll give you about 10, 15 more seconds before we resume the presentation.

Tina Hilmas: All right. These are the last handful of questions in the needs assessment form that I sent out to you. Before we go on, I'd like to share a quote that was shared over to chat with us and I really like it because it just reminds me of where we are going in home health or in healthcare overall. The quote is, Demi said, "Every system is perfectly designed to create the results it gets." That is so true, that's one of the reasons why I think ... we'll, QAPI I realized it's another challenge for home health but I really see for home health that QAPI is an opportunity to take all of those other requirements that have been put down and compile them together and start looking at your processes to get them together and so that's why I am kind of excited about this and the opportunity for home health.

It looks like there are a couple of people who have taken a culture of safety survey and are working on the results to help drive their project, their process improvements. Here are some of the answers that I had put down. The barriers I kept the same and I put down what do we need to start doing. We need to start looking at our educational materials regarding diagnosis. Maybe working more with patients to help keep them out of the hospital. I put down that we need to understand that as nurses we can help patients take some accountability for their health, their health. Just because we are providing care in their home, it doesn't relieve us of the responsibility to promote safe healthy behavior.

That we also need to look at our processes regarding preventing re-hospitalizations and medication management and then we need address medication hoarding by our elderly fixed income population. Then, we did take a survey on patient safety and the three dimensions that were listed as our weaknesses were communication openness, handoffs and transitions and then non-punitive response to errors and that we have started working on tools to improve our communication and are also developing a standardized tool with our community hospital regarding information we need as a patient transitions from hospital to home care. That management has also started reviewing policy regarding actions when mistakes occur.

The thing about, if you haven't taken a patient safety culture, what is really helpful in regards those is it, is a survey that identifies 11 dimension and what it does is it promotes ... it gives you a snap shot of where your organization is because many times in administration there is one conceptualization of the

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organization but yet the perception by the staff who are out in the field is very different. It allows them to see where the organization is as a whole, not just with leadership and not just with staff. Then, it also identifies areas of weakness to start working on, and as you look upon those things like communication, you can see where that really plays into your QAPI project.

Communication is vitally important, which then brings me to our next slide. Communication. We had a question earlier about how to help staff deal with change and how to get them to maybe buy into it a little bit more. A lot of it is not only your culture that we talked on earlier but a lot of it also comes down to communication. Then, communication needs to be transparent and it needs to be open. Communication and I took much of this information from the Teamstepps program which is somewhat interesting as Misty mentioned the book by Kotter and we mentioned the eight principles of change by Kotter. Kotter, many of his principles were the basis for some of the Teamstepps.

If you've ever taken a Teamstepps, you'll see the little penguins that take you through the Teamstepps program and so those penguins came from some of the Kotter's book so just a side note. Anyways, communication is the process by which information is exchanged between individuals, community partners or organizations. Standards are that your communication should be complete so you need to make certain you're including all relevant information. You need to ensure that it is clear, that it is understood. You need to keep it brief. You need to keep it concise. Don't ramble because if you start rambling or talking about other things or bring in other ideas, then the person whom you're communicating with loses ... gets confused about the point you're trying to make and then their attention strays.

Then, you need to also make certain that the information you're giving is presented in a timely manner, that it's authenticated and it's validated. This all goes into communication, to make certain that it is understood. With communication, you need to start thinking about some of the challenges that come along with communication. I listed here some things to think about as you're thinking about disseminating your QAPI project or sharing it with your staff. Think about a language barrier. Maybe you do have a staff member who has English as a second language. Maybe their primary language is something else and so they sometimes don't understand some of the slang or shortcuts that we take. Are there any distractions going on?

What is the physical proximity? Are you talking face to face or through email. Sometimes email, it can be difficult to convey like fatty language or other things like that. Personalities. We all know within every organizations, there are some personalities that are more difficult to communicate than with others. What is the workload that the time that you're trying to communicate with the other person. What are the communication styles? Everyone has their own

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communication styles so trying to identify how the other person communicates, making certain that you communicate in a way that they hear it. Is there any conflict going on, because if there is disagreement and conflict, then that can't help the flow of communication. Then, you need to make certain again that your information is verified and validated.

As you are thinking about rolling out and sharing your project improvement, your QAPI with your staff, think about some of these communication techniques. These are just things I share with you that maybe you could implement in different areas throughout your organization. Every organization is different in how they are setup and the home health agency that I worked in, we have weekly staff meetings to communicate any changes and we also did a case review at that time. Maybe this is an opportunity to share and to communicate any changes and to present any ideas or to get ideas from the staff is during these weekly meetings if you have that or approach some of your senior nurses.

As you are thinking about communicating your QAPI project, start thinking about some of these communication techniques and see if you need to implement them in any certain area. The SBAR is always good foundational technique for sharing information. The situation, background, assessment, recommendation. This is something that can be used in many situations like, as a nurse is calling a doctor. It gives her the opportunity to synopsize the information as she's calling the doctor. A call-out is something that's used to communicate important or critical information. This would be I think something that's good to have some sort of strategy or process put into play that nurses in the field can use to communicate back to the office when one of their patients maybe is having a crisis or turned critically ill and needs to go to the emergency room. We've all have this situations in home health.

I know in the agency I worked in, we had situations where we have to call the ambulance or sometimes it was, something to do in the home and needed to call the authorities. Having a process in play for something critical like that is very important that you have a standardized process. A check-back is closed loop communication that verifies the information is being communicated. This is something that's also good when taking orders like say from a physician, if you're those verbal orders, if a nurse calls in with a PT INR result to the doctor's office and the doctor's office says, "Okay, I'd like to change the Coumadin to this dosage" and the nurse goes back, "I am hearing that you want Mrs. Smith to be on five milligrams of Oroferon daily."

Then, the doctor's office verifies, "Yes, that's correct." Then, handoffs, making certain you have some sort of standardized forms to transfer information across the continuum of care. This type of form standardized but it should also include opportunities for the receiving end to ask questions and to clarify and confirm.

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What we've been discovering as hospitals and the healthcare community in general or overall has been looking at adverse events. So many adverse events happen as a patient is transferring from one area of care to another. As they're being transferred say, from an EMS to the ED or from the emergency department to a floor in the hospital or from the hospital to home health or from the hospital to long term care.

It's because of there is so much information that needs to be shared at that point in time and there seems to be still some walls going up between the different continuums of care. Developing maybe some collaboratives with your healthcare agencies to help develop forms so that the hospital understands what you as a home health agency need information wise or what the hospital might need information wise if your patient does have to go back to the hospital. It's always good to standardize it. We have covered a lot of material. Let's really kind of summarize it here. We talked about the five components of what goes into a QAPI project. We've talked about leadership and culture and how they play together.

We've talked about change theory and we've talked about communications. Let's put all of those together and start thinking about like an action plan. You should have a form that looks like this in your downloads. I'm going to walk you through some of the steps with this. As you think back upon the questions that I had you look at, the needs assessment, those first three questions on the needs assessment, they were designed to get you thinking about what your successes are, what you can celebrate as an organization, what you do really well? It also should have gotten you thinking about what you measure and what the culture is like in your organization so that you can start thinking about what are the viable options on the table for a project improvement.

It also gets you thinking about how maybe you need to approach it with your staff. Then, the next three questions that I had you look at, those were questions then, since you could take certain areas off the table for project improvement, and had you starting to think about what some of your problem areas were and as you go forward starting to improve maybe those problem areas, what you'd like to see from your leadership. Then, it also got you started thinking about what are those barriers that you might run into in implementing this project and how might you be able to overcome some of these barriers.

Then, the last two questions that I had you thinking about or had you answering was to get you prioritizing those problem areas and have you thinking about what is maybe a greater priority over the other or what is one we could work on that maybe might play into another. Then, to also look at your organization's culture and how that might play into it. Maybe if there is some place where you need to start working on in improving your culture along with your QAPI project. I did put an action plan together as an example and I'll kind of walk you through

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what I did. What I did under the action step descriptions is I went back to those five components of the QAPI program so the program's scope.

What I did is I looked at them, the person responsible but first what I did is up at the very top where it says goal statement, my goal, I'm using this and this action plan, it's a generic one so it can be used for just about anything that you'd like to do. My goal statement was I wanted to develop a framework for my QAPI project and I started to think about it for re-hospitalizations but the program's scope and this is more, the quality people and I have them starting it on 5/1 so the dates to begin and then the dates due, I just kind of made up some dates in there so when I looked at ... and then the resources required for the program scope or I needed to look at my reports that I got, the HHQI reports, the CASPER reports, my software vendor reports, my organizational reports.

I started looking at where our problems were and I started looking at some contributing factors or why these were problems and then I was calculating what our re-hospitalization rate and I put out my fishbone for my contributing factors. Then, what I did, the next step is to share the results. Again, this is probably your quality person who's going to be doing this but they're going to want to be sharing it not just with leadership but they would want to share these results with everyone. Be transparent, be open and so then, the desired outcome of this sharing of the results is to get some open communication and some brainstorming going and to start developing some goals.

Develop a list of ideas for interventions and start narrowing your benchmarking data source down to just one. Then, the next stop is the program data and this is ... I put all because everyone will need to decide which benchmarking data collection you want to use. Again, you're going to your reports here and you want to develop what benchmark you want to use. You want to develop how frequently you want to collect the data and you want to designate who will be doing the collecting. Then, you might even need to look at some of your forms to include field for data collection.

As you're looking at how to collect your data, start thinking in ... a phrase I like to use is working smarter, not harder. Start seeing how maybe you can incorporate it into, like your electronic visit notes or your ... if you're still on paper, your notes that you fill out in the home. See how you can incorporate the data that you will need within the paperwork that you are completing at the home. Try and streamline this process and start thinking about then how to sell this project to your staff. How to get buy in and how to engage your staff in this project. Then, you get to the action step of developing, your process improvement project and again, this is all.

This communication should be open and transparent and everyone should have some input in this, from your home health aides, to your nurses, to your LPNs or

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LVNs, to leadership, PT, OT, speech therapy, IT, everyone should be contributing to this. This should be framing out your actual formal plan. This is ... The desired outcome is to frame out those actual steps. We're going to develop a poster, we're going to make certain it's a required step in the admission paperwork. We're going to make it so that it's revisited on every visit. I would suggest to look on the HHQI, they've got two tip examples. Use these examples as a foundation and a framework. There is no reason for you all to recreate the wheel, as you're putting these process improvement projects together.

If someone developed a framework, use it, that's what it's there for. It's open-source. Then, once you've developed this plan, again, share it with all and I suggest making this like a party. In the home health agency where I worked in, we did do a process improvement project and to kick it off we brought in ... we kind of "closed" the office for half a day and we brought in ... we took the desk out and that for once, at a place in town and we had it catered in and we kind of made it a party. We really want to improve on this but we want everyone to participate. Make it positive and then the very last thing I put down there is my action step descriptions, was the executive responsibility but mainly leadership and it is all staff but leadership is what needs to really work for the staff.

I kind of look at it like when you have an organization, like a philanthropic organization that has a board of directors, that board of directors is supposed to work for that philanthropic organization and really help to go out into the community and promote that organization. This is where leadership really needs to be working for its staff and for the organization. They need to become engaged and involved with staff. I put down that leadership would meet monthly with staff. Leadership also needs to begin like outreach for the agency. Maybe they need to go setup ... meet with clinical leaders, go with their clinical leaders of the home health agencies to meet with hospital discharge coordinators and leaders, to setup a potential collaborative to work together.

The leader should be working out to communities, reaching out to community stakeholders such as pharmacies, clinic physicians, rehab facilities, SNF's, EMS agencies and they need to really actively engage with the staff. This is kind of like a plan to help you walk through and set that foundation for what's going on and I'm hoping that this kind of helps you. As we come to the end and you have any ... I have some final thoughts and that I wanted to say QAPI really doesn't have to be difficult. I think once you start thinking about it and sit down, things will come together. You probably actually have the data, you just need to organize it.

I think QAPI is an opportunity to put those process improvements in place that you've really been wanting to for a while but it's just one of those things of, "Well, I don't have to do it and it can wait until another day." Use this as an

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opportunity and then use it to streamline, to work smarter, not harder. With that, I'd like to open it up for any questions.

Misty Kevech: Thank you so much Tina. Please everyone send in specific questions and actually I've had several people that had asked about the safety culture survey. Is there someone that you could recommend or where may they find one?

Tina Hilmas: Well, as far as I know, we have the only one that's geared towards home health. Now, AHRQ has multiple ones on their website for hospitals, for long term care or nursing homes, for pharmacies, for medical offices, and there is one more, I can't remember off the top of my head but as far as I know we have the only one that's geared specifically towards home care.

Misty Kevech: Okay, any additional questions and I do know that the ... if you have more questions related to the safety culture, you can contact Tina, personally her contact information is on the next slide.

Tina Hilmas: I forgot to ... I've handed over to you Misty.

Misty Kevech: I was just looking to see who had the balls so I will that up next. Let's see and we're still are getting a lot ... is there a patient safety culture separate from home health agencies ... for home health agencies for hospice?

Tina Hilmas: There is not. We designed the home ... it's called a home care survey so we designed it so that hopefully, it would fit with all home care areas, with hospice, home health, in home and private duty.

Misty Kevech: Very good. All right and you're getting some nice thank yous. I'm going to go ahead and let the questions come in but I'm going to go ahead and go over the resources real quick and then tell you how to complete for your CEs. This is our listing of our QAPI resources. We have lots of tools that we have created based upon the federal registered language. We have university courses that you can take on four different areas and I've also listed the conditions of participation if you need a link to the final rolling. We also ... Our best practice intervention packages are what we call BPIPs have a lot of interventions and ideas and strategies to help you on specific topic areas.

We have ... All of our BPIPs really has some element of safety related but I take the handful to put on this slide that are linked ... that might help you with very common areas. Now, on our QAPI resources, I'm going to go back one slide, even in our tools, our hospitalization, we have medication management, cardiovascular health, those are specific for performance improvement project tools so we give you some common issues, barriers. We also give you some ideas to get you jump started on what intervention strategies you can do and

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that we have it all hyperlinked with lots of resources that are available. I also included another slide on some resources of previous webinars.

The one I mentioned at the beginning Patient Safety Culture, Foundation for QAPI, is one that Tina did last year so it dives a little bit more into that patient safety culture, a little bit more into TeamStepps, into CUSP and so I think you'll find some great information there. Two others that I thought were very safety oriented is the Compulsive Hoarding for Care managers. It's a two hour previous webinar and the Gravity of Falls, Evidence-Based Preventative Strategies that we had as a national call. On data resources, as Tina has mentioned that's critical as part of your QAPI. We at HHQI provides some data. If you've not used any of our data, it's all free for any Medicare certified agency.

It's been there, it's housed, been in house for almost 10 years for you. There are some samples to show you some of the sample reports and if you just click on the data resource link and it'll take you to the page and you can read about it or you can always contact us and we'll help provide the information on getting access to your data. For the continuing education, you will be sent as you leave the course today or click on to HHQI University. It is our free standing platform for education. You will receive 2.25 hours of nursing CEs from ANCC. You've already watched this webinar, you will have to register for the course and I'll show you those quickly on the next couple of slides.

There is an evaluation and two reflective questions to answer and then once you complete that, you can download and print your certificate. Any questions or anything that you need at any point in time, contact us at HHQI@qualityinsights.org. Here are the step by steps and they are on the slides that you can download. You'd have to go in to HHQI University. If it's your first time, you'll need to register and setup a password like four or five questions, but if you've been here before, it's different than the general campaign site or the data site. If you have registered once before and can't remember your username, just email us at the HHQI@qualityinsights.org.

We'd be happy to look you up. We like you to keep just one registration so that all your certificates are in one location. There is a I forgot my password feature because we all need that on any given day. Then, the second thing you will do is you're going to go look in a course catalog. It is in the underserved population catalog so you'll click there and then you'll look for Patient Safety, All in a Day's Work course. You're going to click on the enroll which is the little apple and then it's going to open a box that says go to my account, you click the my account and you'll look for the little green book icon that will be on your right, the in the view column.

Very simple then once you get into that, you click the little green book again and it will start the Lesson One. All you're going to have there is the evaluation, the

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two reflective questions and then when you're finished, you will exit out of it by clicking the exit button and your certificates will be housed in your My Account tab. That is what I have here. Let's see if there are any other questions. I'm getting a lot of ... see a lot of thank yous and very good information, Tina. Excellent presentation. Is this ... Do you have anything on safe patient handling? HHQI does not have anything on that. I don't know. Tina is your website have anything that possibly might be on patient safe handling?

Tina Hilmas: We might have something in our resources but I don't know off hand. On our website, we do have a resource library.

Misty Kevech: If that person would like ... if you would like just to even send me an email, I can take a look around for you to see what I might be able to find. All right. If there is ... I see, if there is any additional last questions, Misty in the Q and A tab?

Misty Dyke: I am not getting anything.

Crystal: This is Crystal. I do see one that's referring to the patient safety culture. One of the question said when you say we, do you mean HHQI or the center for patient safety? Tina, I believe you were referring to the survey that the center have.

Tina Hilmas: Right, the Center for Patient Safety has developed a survey. It's home care survey on patient safety and you can always go to our website and shoot us an informational question in regards to that, you can shoot me an email, if you're interested in that.

Misty Kevech: I'll put up Tina's information and it is included in your ... the PowerPoints too but I'll that up for you there as well. I'm going to go ahead and go ahead and close. I want to first thank everyone that has attended today. I mean, that's a two hour virtual workshop. We had such great input from you on the chat and working on your worksheets and posting things into the Q and A. We thank you, we hope this will help jump start your work and HHQI cannot thank a great partner Tina. You did an excellent presentation and to be able to continue to speak for two hours continuously, Crystal had even texted me on that. The information you provided was just so spot on for home health agencies. You know the fields, your expertise, from your experiences have really led you to a wonderful work that you're doing with the centers for patient safety.

Tina Hilmas: Thank you. It was a pleasure to present. I am always very passionate about patient safety and patient safety culture.

Misty Kevech: Wonderful. Wonderful. Well, we thank everybody. Our next Underserved Population Call is for July the 20th and look for some upcoming information on that in a few weeks. Thank you again for attending.

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