Local Quality Assurance Resource Manual

Chapter 6

Improving Quality

NOTE: This Resource Manual is a product of the Research and Evaluation contract between the University of Oregon's Educational and Community Supports unit within the College of Education and the Department of Human Services, Seniors and People with Disabilities, State of Oregon (Agreement # 108857, Amendment 1). This chapter presents some of the quality assurance program requirements, as well as items that are not specifically required but offered as suggestions or examples. All CDDPs must remember that their role is to implement a Quality Assurance program that supports the state's current Quality Assurance Plan. The Resource Manual includes requirements for Quality Assurance Programs that are current as of June 2005. Because Administrative Rules and Contract requirements change, CDDPs should always check for and apply more current rules and contracts developed after the publication of this workbook.

Improving Quality

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Improving Quality

Objectives:
- Define requirements for quality improvement activities.
- Discuss methods for selecting and carrying out improvement efforts.
- Present sample formats for documenting corrective action and improvement efforts.

Requirements: Taking action to improve the quality of services, and evaluating the effect of corrective actions are required by the Oregon Administrative Rule for CDDPs.

This excerpt from the CDDP rule is current as of May 2005. Be sure to check the DHS website for any changes and updates. That website is:

http://www.dhs.state.or.us/policy/spd/alpha.htm

411-320-40 Community Developmental Disability Program (08/03/04)

(Sections deleted)

(9)   Local quality assurance program. Each CDDP must implement and maintain a local quality assurance system in accordance with these rules.

   (a)   QA system purpose and scope. The local quality assurance system will:

      (A)   Ensure the development and implementation of a quality assurance system by:

         (Sections deleted)

         (ii)   Generally improving the quality of services by evaluating service delivery and outcomes and adjusting local planning and performance where needed.

      (Sections deleted)

      (E)   Maintain a record of conclusions and recommendations that have been drawn from analysis of the information gathered.

      (F)   Take management actions as needed to improve service quality or to correct deficiencies; and

(G) *Maintain records that document:*

(Sections deleted)

    (iii) *The CDDP's findings, corrective actions and the impact of its corrective actions that have been reviewed at a policy level within the CDDP's department structure within the County; and*

(Sections deleted)

(d) *Corrective actions. The CDDP will act to correct deficiencies and poor performance through management actions.*

    (A) *Deficiencies and substandard performance found in services that are operated or subcontracted by the county will be resolved through direct action by the CDDP.*

    (B) *Deficiencies and substandard performance found in services that are operated by the state or through direct state contracts will be resolved through collaboration with the Department.*

    (C) *Deficiencies and substandard performance found in services provided through a Region will be resolved through collaboration between the regional management entity and the affected CDDPs.*

(Sections deleted)

    (B) *Activities of the committee will include:*

        (i) *Providing review and comment on CDDP plans for local QA plan activities;*

        (ii) *Providing review and comment on data gathering instruments and methods; and*

        (iii) *Providing review and comment on the results of information gathered by the CDDP and the effectiveness of corrective actions.*

QUALITY MANAGEMENT

PROGRAM DESIGN

Program Design sets the stage for achieving desired outcomes. Program Design addresses such topics as service standards, provider qualifications, assessment, service planning, monitoring participant health and welfare, and critical safeguards (e.g., incident reporting and management systems).

QUALITY MANAGEMENT

Quality Management gauges the effectiveness and functionality of Program Design and pinpoints where attention should be devoted to secure improved outcomes. Centers for Medicare and Medicaid Services (CMS) and others use the following phrases to characterize the three major functions of Quality Management.

- **Discovery:** Collecting data and direct participant experiences in order to assess the ongoing implementation of the program, identifying strengths and opportunities for improvement.

  - "Quality Components" such as SERT, Licensing, and Service Coordinator Monitoring are processes used for Discovery.

- **Remediation**: Taking action to remedy specific problems or concerns that arise.

  - Corrective Actions or Plans of Correction are used to remedy specific problems or concerns found during Discovery.

- **Continuous Improvement:** Utilizing data and quality information to engage in actions that lead to continuous improvement.

  - Continuous improvement includes an ongoing process of studying patterns and trends, finding root causes, selecting and planning strategies for improvement, taking action and evaluating the results.

Program Design features and quality management strategies will vary from program to program, depending on the nature of the program's target population, the program's size and the services it offers, its relationship to other public programs, and other factors."

--adapted from the HCBS Quality Framework

Two fundamental strategies for improving quality discussed in this chapter are:

- Corrective Actions (Remediation) — steps taken or required to remediate deficits, particularly when practices or policies do not meet standards set by rule or contract; and

- Continuous Improvement — systematic efforts to study the causes of gaps in performance and imbed improved practices in systems to remediate those gaps.
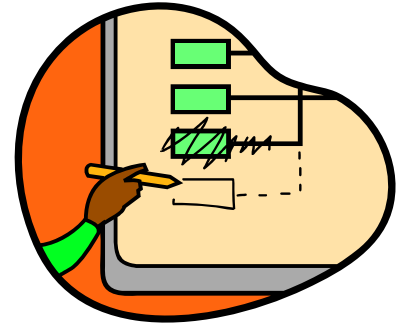
In our work, we make many changes, but many of them are just that — changes. The purpose behind using a Quality Management strategy is to ensure that the *changes* we make result in real and lasting *improvements* in our processes and outcomes.
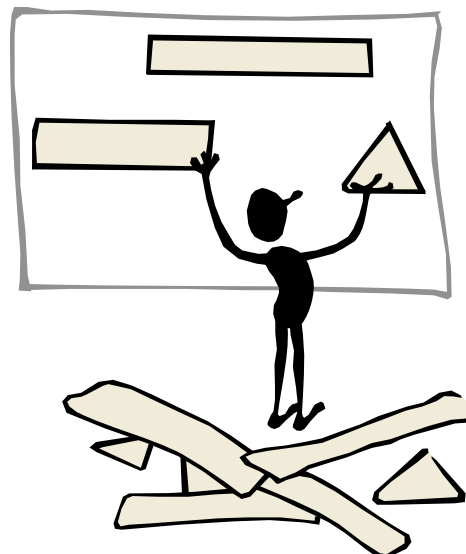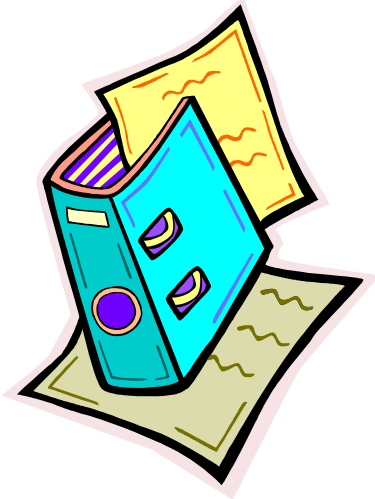
CORRECTIVE ACTIONS

CDDPs are very experienced in identifying and providing follow-up related to corrective actions required as a result of licensing or certification visits, service monitoring, or other quality assurance components. The CDDP OARs related to the Quality Program expect that CDDPs will maintain records documenting these and also review the corrective actions and their impact at a policy level within the CDDP's department structure.

In a Quality Management program, it is important to take advantage of the opportunity that Corrective Actions offer at two levels:

- As a strategy for ensuring that a specific agency or site improves its practices related to particular deficiencies identified during a Discovery process. The result of the Corrective Action, then, should be compliance with the required rule or practice at that site. This use of Corrective Actions is very familiar to CDDPs.

- As information that may assist the CDDP and the QA Committee to find ways to improve systems beyond that of the specific site or agency cited. The result of Corrective Actions used in this way should be information about where to best target system-wide improvement efforts, as well as potential improvement strategies. This is the use of Corrective Actions that is the focus of this section of the Resource Manual.

Guidelines and Suggestions

There are many possible ways to review Corrective Actions and their impact at a systems level. How you organize the data for review will provide support for the analysis.

- It will be very useful to summarize the nature of Corrective Actions that have been implemented For example, you might develop a **Pareto Chart** that displays the types of deficiencies requiring

Corrective Actions in foster care certifications during a particular time period. (See Chapter 4 on data for how to do a Pareto Chart.) Do another Pareto Chart for deficiencies in 24-hour residential programs, and another for Employment/Community Inclusion programs. This type of chart also could summarize errors on foster care tests, placing the item with the most errors across candidates on the left. Pareto Charts emphasize the areas most in need of systemic attention — perhaps an improvement in a specific aspect of the training materials or training curricula, in this case.
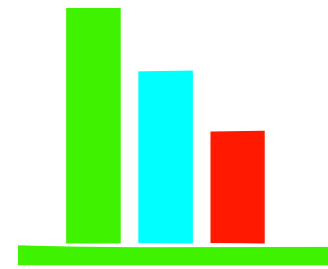
Pareto Chart: a special type of bar

Pareto Charts are used for frequency or "Count" data. They help to draw focus to the most common issue by placing the item with the highest count on the left, and others in descending order after that. Based on the principle developed by Italian economist Vilfredo Pareto that 80% of the results are due to 20% of the factors, Pareto Charts help us to move above individual detail to see patterns in data. While they are often used for displaying negative items such as categories of issues, problems, or complaints, they also can be used for positive items. You could display compliance with certification items—putting the item on the left that had the most sites in compliance, and the other items in descending order after that. The way you develop the graph would depend on the purpose for which you are using it. Do you want to make a decision about "what is working well" or a decision about "what needs to change?"
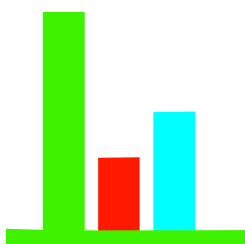
- You could do another type of bar graph (known as a **histogram**) of the length of time it takes for providers to fulfill Corrective Actions during a particular time period. In this case, for example, if 30 Corrective Actions were completed within 14 days, 10 within 1 month, and 15 more within 6 weeks, the graph would look something like the graph on the left. The axis across the bottom displays the number of days, from zero on the left to the maximum number on the right, and the vertical axis displays the count of items that falls within each range of days.

Use a histogram to display data across a <u>continuous</u> variable, such as number of days, or number of corrective actions. Always display the data in a histogram in order of that variable. Usually, the variable across the horizontal axis is divided into equal "bins," so there are fewer groupings of the data. So, for example, number of Corrective Actions per review might be broken into bins 0-5, 6-10, 11-15, 16-20, and 20-25. Then the number of sites falling into each of those "bins" is what is graphed. (The Pareto Chart displays data across a set of <u>non-continuous</u> categories — such as types of Corrective Actions, or types of errors on a test.)

Using graphs such as these will help you, the QA Committee, and CDDP staff to pinpoint areas needing the most attention.

- Maintain a record of conclusions and recommendations that have been drawn from analysis of the information gathered. This may be done through QA Committee meeting minutes or through tables designed for the purpose. For example, SPD is using the following chart to document management decisions about strategies for improving performance after the 2004 Field Review of Support Services. For a CDDP, the table could list the Inventory results on the left and include a column to identify potential improvement projects, or other strategies such as provider meetings, or materials development.
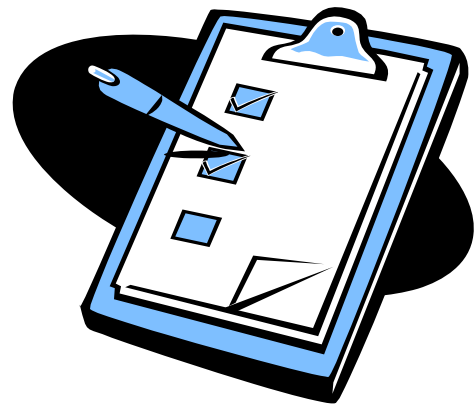
Documentation Issue	Policy Issue or Expectation Clarification Needed?	Comprehensive Training Needed?
Clear documentation of follow-up on serious issues including Incident Reports	X	X
Maintaining current proof of guardianship		
Documenting when individuals allow family members to make decisions on their behalf	X	
Etc.		

A main point related to these suggestions is to find a way to summarize data that will provide more information to CDDP staff and to the QA Committee than is available through the individual pieces of information. It may be surprising, but our perceptions of generalizations from individual data often are not correct. Perceptions are affected by what has happened most recently, what was the most salient, or historical events that just stay in our minds. So, taking the time to actually summarize data — whether that means summarizing data that are kept in individual files, or pulling data from a database — will yield more accuracy and a clearer picture of patterns and trends than will our memories.

Sample Report Format

The following pages present a sample format used in the Columbia County Quality program for summarizing results of Quality Components, and Corrective Actions. Using a reporting format that includes Corrective Actions helps to ensure that the QA Coordinator remembers to include information about these in their report. Additional examples of these forms are included in the *Critical Questions Workbook*.

SAMPLE FORMAT
QUALITY IMPROVEMENT INDICATOR REVIEW

Department: Developmental Disability Dept.   Date: February 2005

Person(s) Responsible: ____,Program Manager; ____,Quality Assurance Coordinator;

____, Case Manager; ____, Case Manager; ____, Administrative Support

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ASPECT OF CARE/SERVICE: Customer Satisfaction

INDICATOR: Clients, family members of clients, providers, and community partners will be satisfied with D.D. funded services.

RATIONALE FOR INDICATOR: Assure quality services.

THRESHOLD: 75% Satisfaction of those surveyed.

FREQUENCY OF REPORTING: Annually.

METHOD OF MONITORING INDICATOR	YES	*NO*	COMMENTS
1) 50 Satisfaction Surveys given or mailed to • Clients • Family members of clients • Providers • Community partners	X X X X		

CORRECTIVE ACTION TAKEN:
351 surveys were mailed out to clients, families, advocates, group home staff, professional colleagues and collaborators the first week of January, 2005.

COMMENTS:
QA Coordinator currently collating data and will present initial results in March.

QUALITY IMPROVEMENT INDICATOR REVIEW

**Department: Developmental Disability Dept.   Date: February 2005**

Person(s) Responsible: ____,Program Manager; ____,Quality Assurance Coordinator;

____, Case Manager; ____, Case Manager; ____, Administrative Support

ASPECT OF CARE/SERVICE:			
INDICATOR:			
RATIONALE FOR INDICATOR:			
THRESHOLD:			
FREQUENCY OF REPORTING:			

METHOD OF MONITORING INDICATOR	YES	NO	COMMENTS

CORRECTIVE ACTION TAKEN:

COMMENTS:

CONTINUOUS IMPROVEMENT
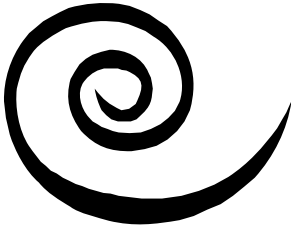
"Continuous Improvement" or "Quality Improvement" is a phrase that has meaning at many levels. It is as simple as improving the quality of the things we do, in little ways, every day. And, it represents an entire set of management philosophies and approaches to systematically improving the quality of work produced and the quality of work environments.

Some of the key features of a Quality Improvement program are:

- <u>Data</u>. A Quality Improvement program uses data to define the issues that need to be addressed, and to document the changes that are achieved by improvement efforts.

- <u>Systems-focused</u>. Quality Improvement efforts understand that the outcomes—or lack of outcomes—that we achieve are largely because of the systems that are implemented. Therefore, rather than focusing on a single employee or data point, Quality Improvement efforts target aspects of systems for improvement.

- <u>Systematic</u>. Quality Improvement programs use a set of step by step procedures for identifying targets to work on, and addressing those issues. They are characterized by order and planning.

- <u>Customers define quality</u>. In human services, CDDP customers include citizens with disabilities, state Seniors and People with Disabilities, and others. Quality Improvement programs ask for customer's opinions of the quality of services, and build these into their efforts. State administrative rules are another way in which one set of customers defines quality. Involving QA Committee members is a good way to engage customers in Quality Improvement efforts.

- <u>Collaborative</u>. By involving employees and stakeholders in solving problems, Quality Improvement efforts are assured a richer understanding of the problem. By not using the project to find fault or place blame, individual and agency providers and employees are more willing to contribute to the project. Achieving results in Quality Improvement efforts requires the fearless cooperation of all who are involved.

A QUALITY IMPROVEMENT MODEL

Fundamentally, Quality Improvement can be characterized in a few basic steps:

1. **Define** the target of the improvement effort.

2. **Measure** the current status—how is it doing now?

3. **Analyze** possible reasons why the process does not currently produce what is wanted.

4. **Improve** the process so that it does produce the desired output.

5. Document the changes and incorporate them into "business as usual" (**Control**).

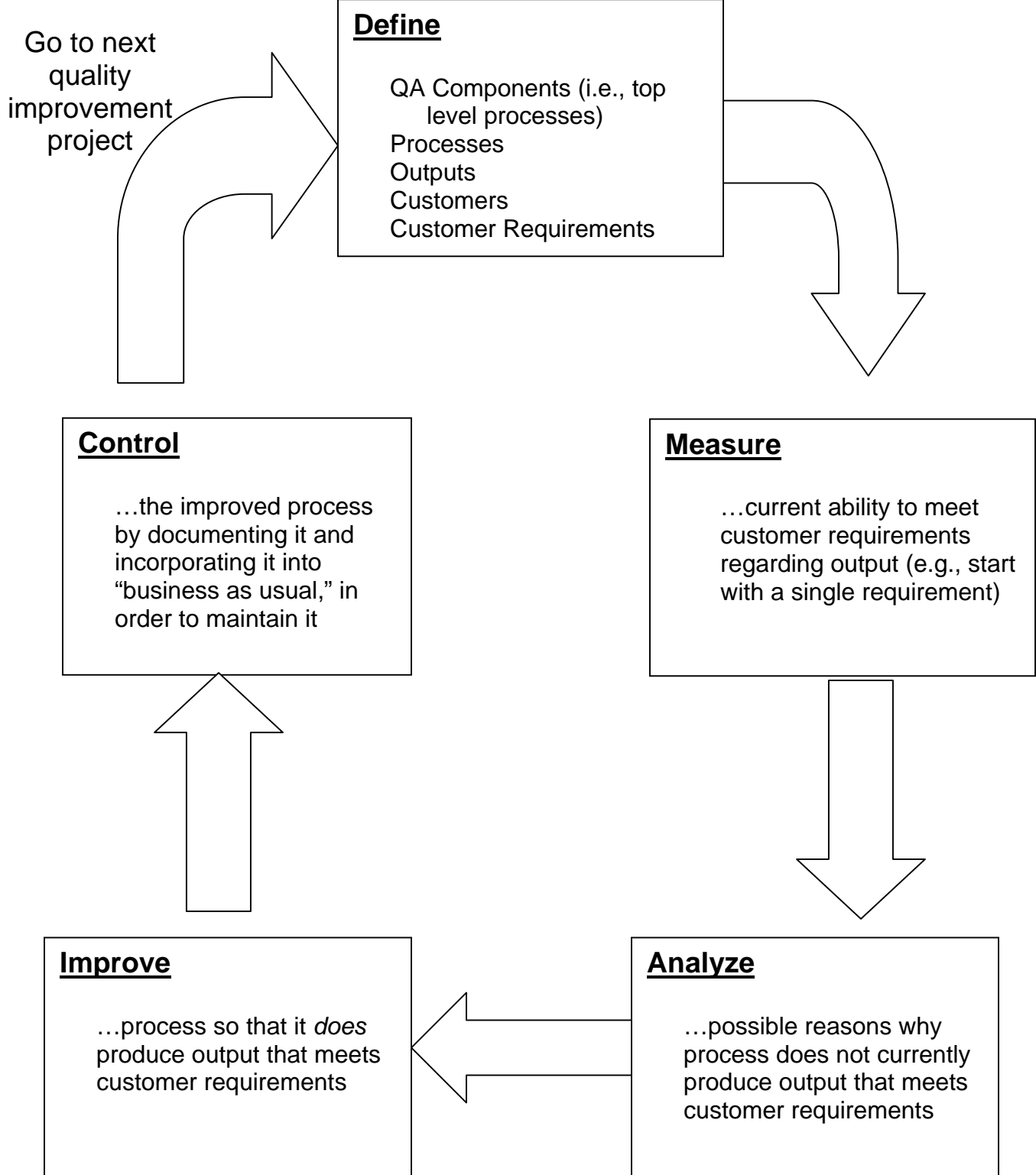6. Go on to the next Quality Improvement project.
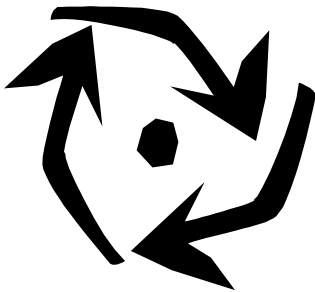
These steps have been established as a **Quality Improvement Model** used in many industries and is presented in the figure on the next page. Referred to by its acronym, "**DMAIC**", this quality improvement model suggests an improvement strategy that can be used by CDDPs and Quality Assurance Coordinators in many different situations.

A Quality Improvement Model

Define

QA Components (i.e., top
    level processes)
Processes
Outputs
Customers
Customer Requirements

Go to next
quality
improvement
project

Control

…the improved process
by documenting it and
incorporating it into
"business as usual," in
order to maintain it

Measure

…current ability to meet
customer requirements
regarding output (e.g., start
with a single requirement)

Improve

…process so that it *does*
produce output that meets
customer requirements

Analyze

…possible reasons why
process does not currently
produce output that meets
customer requirements

MORE ABOUT DMAIC

- Define. Identify the Quality Component (e.g., licensing, SERT), the related processes, the outputs that are produced by the component, the people or groups who are the customers of those outputs, and their requirements for the outputs. Many Quality Improvement efforts are unsuccessful because they fail to start with a clear definition of what they are targeting. For CDDPs, outputs might be, for example, the results of site monitoring visits, or results of follow-up on Corrective Actions.

- Measure. In this step, measure the current ability to meet customer requirements regarding an output. It is a good idea to start with a single requirement, such as how well the CDDP is meeting requirements for the number of service monitoring visits per year, or the performance of sites during service monitoring visits. This defines a baseline against which improvement may be measured. The resulting difference between current performance and the customer requirement defines the "Gap" that needs to be improved.
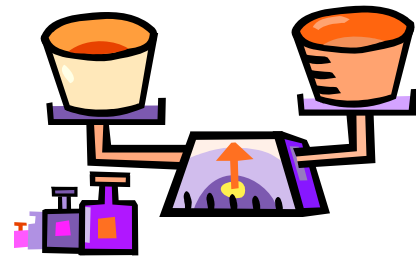
- Analyze. The purpose of this step is to determine what is causing the "Gap" between actual performance and customer requirements. Formal quality improvement approaches use tools such as flowcharts and "Cause and Effect Diagrams" to help with this step. However, you also may brainstorm possible reasons, or collect further data to help with the analysis. The result of this step — which may take the majority of the time required for the improvement effort — is clarity about why you are getting the results you are getting. Understanding the root causes of the problem will help you to select the most effective improvement strategy.

- Improve. Based on the results of "Analyze," determine what actions should be taken to improve performance on the targeted component. If the reason staff members aren't keeping up with service monitoring visits is simply that they lose track of which sites they have visited and when, developing a database report that summarizes past visits and schedules future ones might be the answer. If staff is not documenting the visits well, the process improvement may require staff training, samples of good documentation, or a set of guidelines for how to document. Whatever improvement strategy is selected, however, it must be tied to correcting one or more of the most important <u>reasons</u> for the gap that was identified in "Measure."

- Control. We often find that changes we make to improve situations are fleeting. Staff members forget to use the new form, or otherwise fail to keep the change going. If a "change" is going to really be an "improvement," it must be built into "business as usual." Instead of dealing with a problem and moving onto the next issue, the "Control" step requires that QA Coordinators document the change and look for ways to make it the normal way to do business. There are many ways to do this — written procedures, staff training, staff meetings, reminder notices, accompanying staff when they are first trying new ways, flowcharts, including instructions and definitions right on the new forms, and posters are just some of the ways that organizations do the "Control" step.

SOME BASIC GUIDELINES FOR APPLYING DMAIC

- Inventory. As suggested in Chapter 2 on Local Quality Plans, it may be useful to conduct an "inventory" of the Quality Components and quality indicators that are required, to determine a more complete list of the gaps that need to be addressed. This will give a more complete picture of possible development projects.

- Prioritize. There are always many possible targets for improvement efforts. Ask the QA Committee to help with establishing criteria for prioritizing projects. Especially for initial efforts, chose targets that are easier to carry out and have a high likelihood of success. Early success will help to build momentum for the Quality Assurance Program.
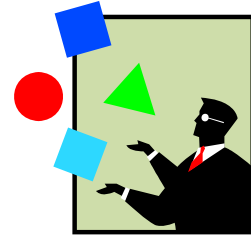

Sample Criteria for Prioritizing Possible Improvement Projects

- High prevalence — the improvement would affect many people.
- High impact — the improvement will influence important consumer outcomes.
- High probability of success — a quality improvement effort is likely to lead to improvements.
- Low cost — Improvements will not require significant resources or funds
- Project duration — the project will require limited time to implement and achieve desired results.
- Measurable — there are data sources available to measure changes related to the project.

- Define the Project Clearly. If you are using SPD's Goals and Desired Outcomes as a way to organize your Plan and Committee work, then tie the project to a specific Desired Outcome, and define specifically, what you will target.

- Determine the type of project. Projects can be categorized into basically three types:

  - Design/Development Project. Develop a new system or process, e.g., a form, a method to report compiled data on PSIs, a way to compile important data from the home visits.

  - Remedy Project. Address an aspect of participant safeguards that falls in the "Priority Problem Area" or "Needs Improvement" range. (See the *Critical Questions Workbook* for how to define "Priority Problem Area" and "Needs Improvement.")

- ▪ <u>Quality Improvement Project</u>. Address an aspect of participant safeguards that falls in the "Meets Standards" or "Exceeds Standards" range. (See the *Critical Questions Workbook* for these definitions as well.)
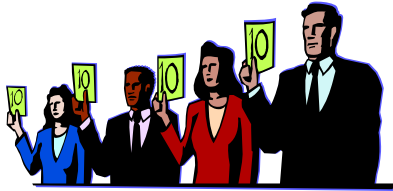
- • <u>At the start, determine how you will know that the project is successful</u>. Be clear about the purpose of the project. How will you measure success? Define clearly what it is that you want to accomplish. How much of an improvement are you looking to achieve?

- • <u>Decide how you will carry out that project</u>. For example, will it be done in QA Committee meetings, by a special work group, or CDDP staff? Who should be involved? What political barriers need to be addressed to ensure success? What will the work group need to do? What steps will be used? Will you apply the DMAIC process? What resources will they need to carry out the project? How much time do you expect it to require? When do you expect to complete the project? Answering questions such as these at the start will help to keep the project team on track and increase the likelihood of success.

- • <u>Document, Document, Document</u>. Before starting on a project, document the current status so that you will be able to show what progress has been made. Document how you approach doing the project. Document the procedures that you use for improvement. Once they are documented, it will be easier to do the "Control" step to ensure they are built in everywhere. And, you may be able to learn from this project as you begin to work on others.
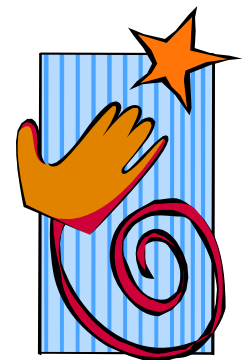
- Summarize the Project. Treat the improvement effort like a trip that you want to remember fondly. Prepare a brief summary of the data collected, the steps that were taken, and the results achieved. Present the results to the QA Committee, staff members, or other stakeholders who may be interested in your improvement efforts. This will give more importance to the project and help to gain support for the Quality Assurance Program.

The *Critical Questions Workbook* and the sample pages provided with it are designed to be useful to QA Coordinators in reporting to QA Committees and defining improvement projects.

Quality Improvement Projects require discipline, data, and hard work. However, the benefits can be great. By working together with stakeholders, studying patterns and trends, and systematically addressing root causes of issues, QA Coordinators can achieve great changes in the processes and outcomes achieved in their communities. It does take time. And there are many, many possible things to do. It is easy for QA Coordinators to be overwhelmed by it all. But if you select one thing at a time, address it systematically, make sure it is built into business as usual, a year from now you will see how things have changed. And a year later, they will have changed even more. Yes, it is hard work. Your alternative is not to do it. But, if you don't do Quality Improvement Projects, what will things be like in two years? We encourage you to use this Resource Manual to support you in your ongoing efforts to improve the quality of services for people with disabilities in your communities.