CARP

Continuous Accreditation Readiness Program

15th Annual Direct Service Tribes National Meeting:
Utilizing People, Partnerships, Quality and Resources to Strengthen our Communities

July 11th, 2018

ALBUQUERQUE AREA CARP TEAM

Introductions

- CARP Team
  - CAPT Brian Hroch, MPH, CIH, CSP, REHS — *Industrial Hygiene and Safety Manager*
  - Vanessa Vicenti, MT — *Area Laboratory Consultant*
  - Olowañ de Herrera, RN, BSN — *Public Health Nurse Consultant and Acting-Area Nurse Consultant*
  - Jennifer Nañez — *Behavioral Health Consultant*
  - Alleyne Toya — *Health Systems Specialist*
  - CAPT (ret) Tom Plummer, PE — *Director, Division of Health Facilities*
  - CAPT Wil Darwin — ABQ Area Clinical Application Informaticist
  - Jeanette Garcia — Credentialing Consultant
- Supporters and Contributors
  - Leonard Thomas, MD — *Albuquerque Area Director*
  - Sandra Winfrey — *Executive Officer*
  - Russel Pederson — *Regional OEHE Director*
  - Debra Grabowski — *Director, DEHS*
  - Betty Namingha — *Santa Fe SU QA Manager*
  - LT Helen Chavez — *Mescalero SU Lab Director*
  - CAPT (ret) Greg Powers — *Mescalero SU QA Manager*
  - CAPT Rebecca Grizzle — *Zuni SU QA Manager*
  - CAPT Jeff Salvon-Harman, MD — *Headquarters, Office of the Director*

Prelude

A long time ago in a galaxy far, far, away…

What is CARP?

CARP is the Albuquerque Area's proactive approach at ensuring continuous accreditation readiness and preparedness among all of its Service Unit healthcare facilities.

The C's have it:

- Comprehensive
- Collaborative
- Competency based
- Continuous
- Communication focused
- Culture

100% accreditation success rate among all ABQ Area healthcare facilities during the 2015-2016 accreditation survey cycle. Never-ending preparations for the 2018-2019 accreditation survey cycle.

v.2018-04-23

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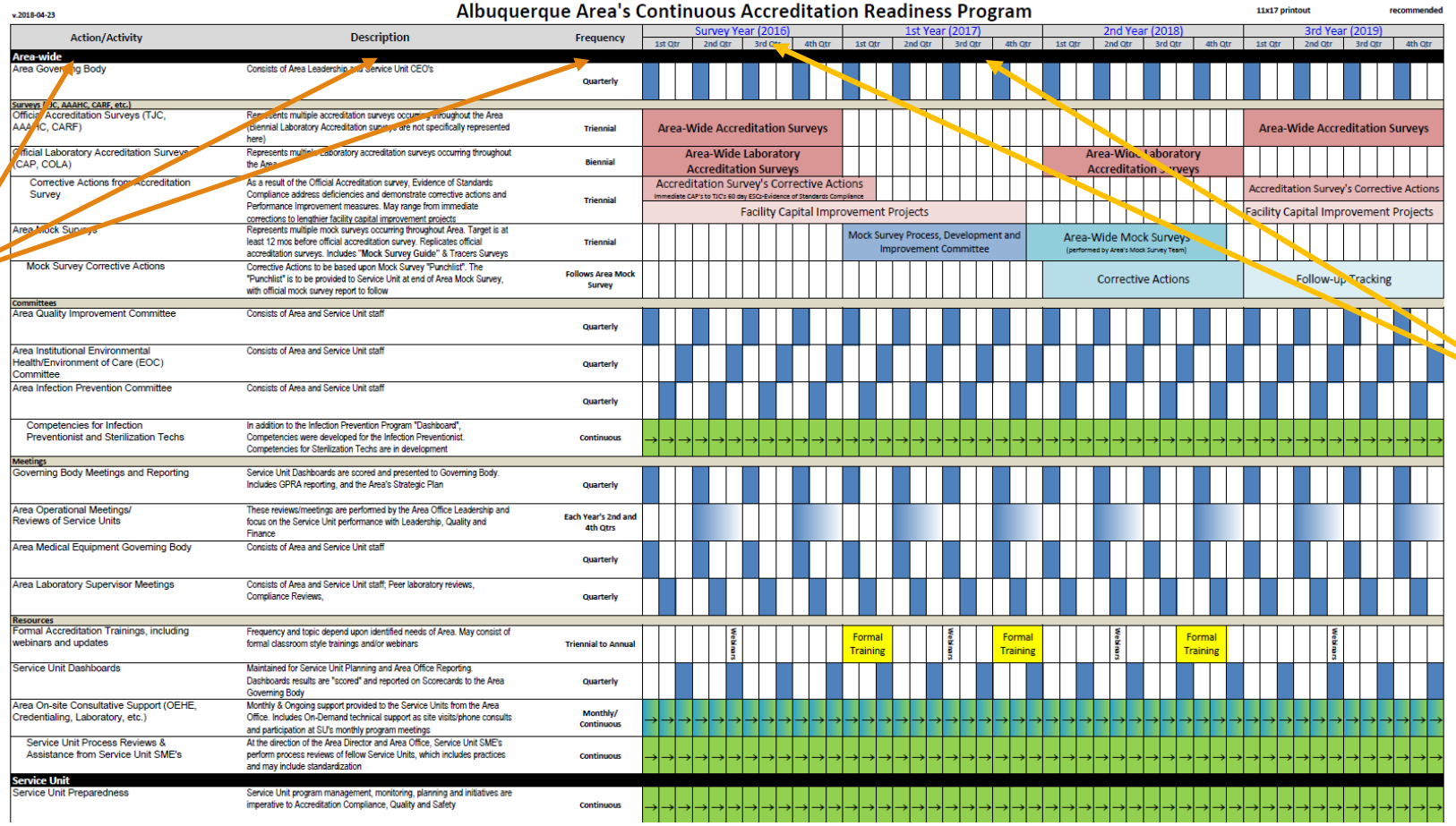
Service Unit Process Reviews & Assistance from Service Unit SME's	At the direction of the Area Director and Area Office, Service Unit SME's perform process reviews of fellow Service Units, which includes practices and may include standardization	Continuous	→	→	→	→	→	→	→	→	→	→	→	→	→	→	→	→
Service Unit																		
Service Unit Preparedness	Service Unit program management, monitoring, planning and initiatives are imperative to Accreditation Compliance, Quality and Safety	Continuous	→	→	→	→	→	→	→	→	→	→	→	→	→	→	→	→
Intracycle Monitoring	Includes Focused Standards Assessment (FSA)	Continuous	→	→	→	→	→	→	→	→	→	→	→	→	→	→	→	→
WebCident, Patient/EOC/IC Tracers, Risk Assessments, Electronic Statement of Conditions (eSOC)	Ongoing processes and activities to assess and monitor conditions for quality and environment of care	Continuous	→	→	→	→	→	→	→	→	→	→	→	→	→	→	→	→
SU Programs and Meetings- QAPI/PDSA/GPRA/ Infection Prevention/EOC	Monthly/Quarterly meetings for SU Implementation of Area's Strategic Plan, QAPI, GPRA, Infection Prevention, EoC, PDSA, "AAAHC 1-Step", Improving Patient Care Home Model	Monthly																
Management Plan Evaluations & Policy Reviews/Revisions	Annual Evaluations of Managements Plans	Annual																
Environmental Rounds	Biannually for Patient Care Areas, Annually for Non-Patient Care Areas. Includes Infection Control, Environment of Care, Life Safety, Emergency Management	Bi-Annual																
Corrective Actions from Environmental Rounds	Various options for implementation exist which may be performed independently or may be performed in conjunction with Environmental Rounds	Bi-Annual Varies																

How it works

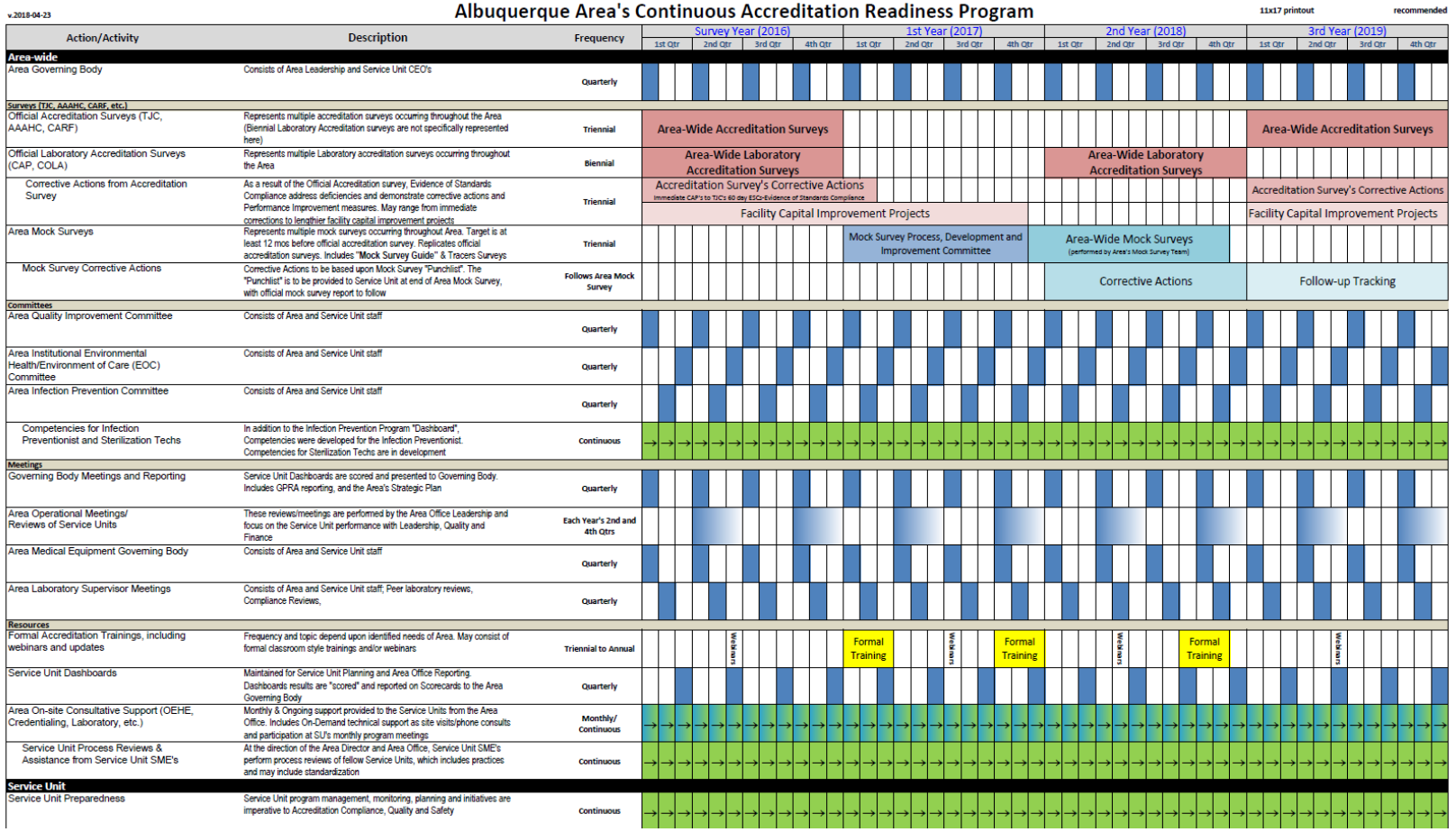
Action/Activity, Description, and Frequency



4 Year scope broken down by Quarters

How it works - continued

Area-wide activities rely on the foundation of **Service Unit activities**



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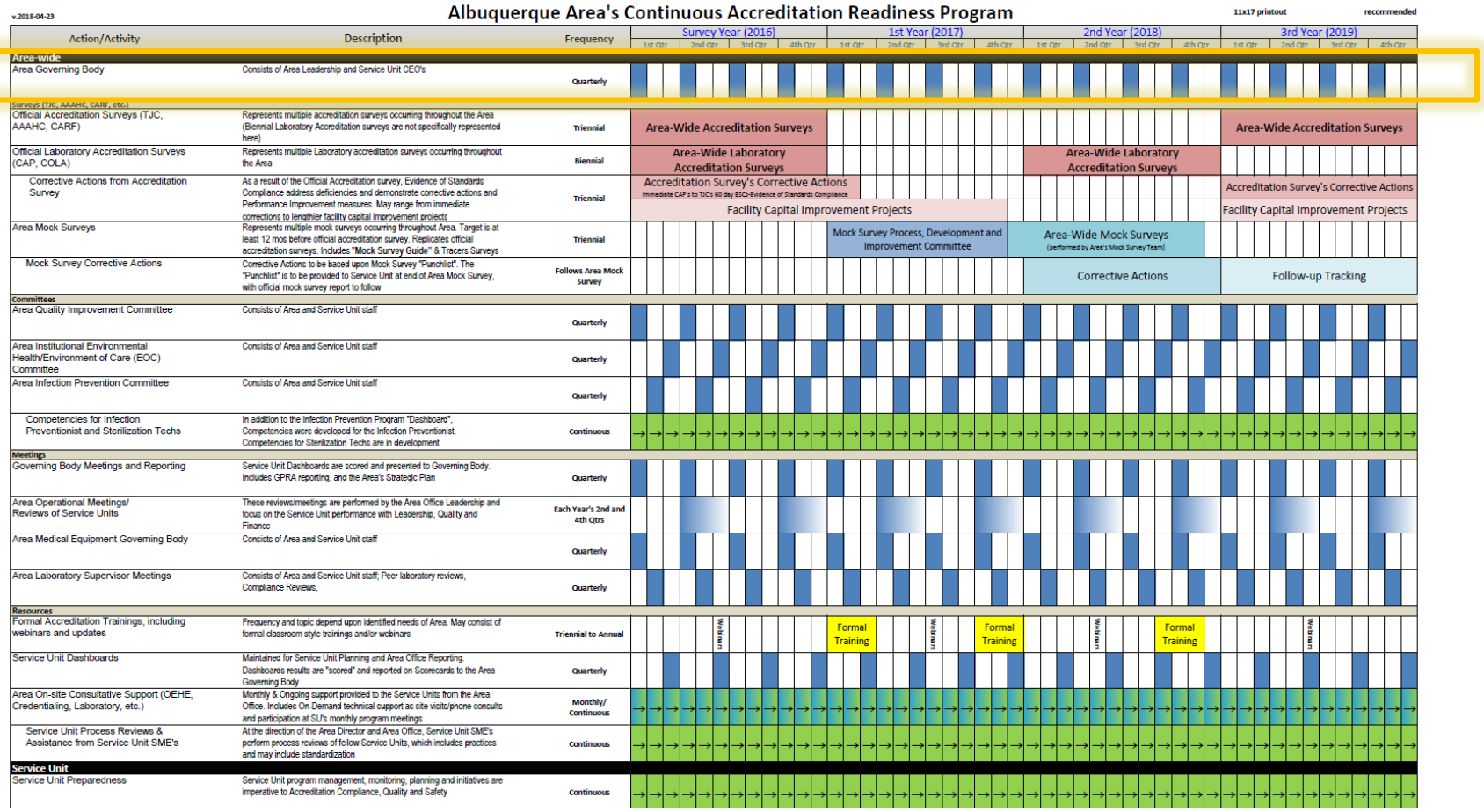
How it works - continued

Oversight from the **Area's Governing Body**



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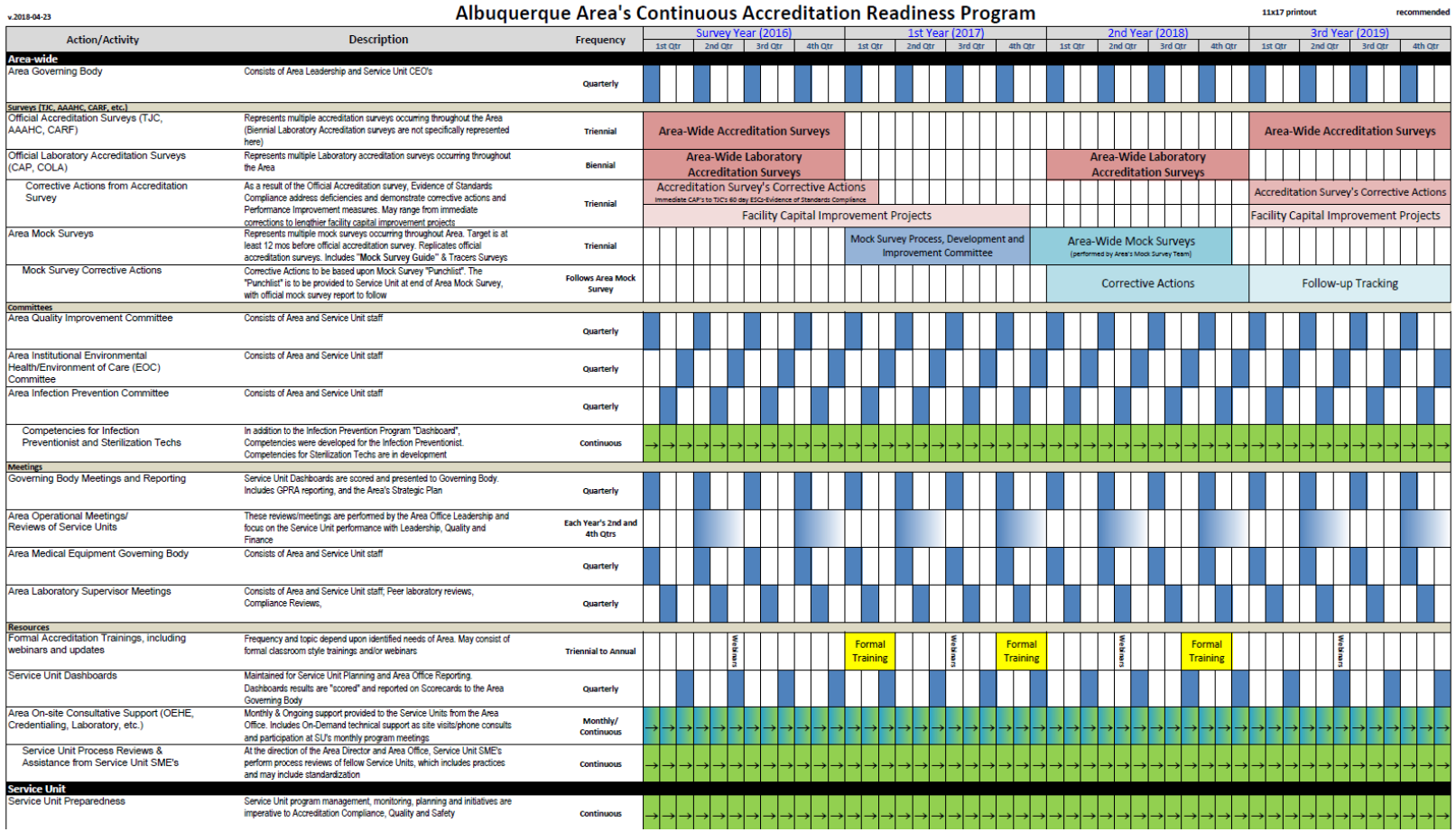
How it works - continued

Categorized into **Surveys**, **Committees**, **Meetings**, and **Resources**



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Official Accreditation Surveys

- Representation of multiple accreditation surveys occurring throughout the Area for a four year period.
  - Health Care Facilities are on a 3 year accreditation cycle
  - Laboratories are on a 2 year accreditation cycle

- Corrective Actions are addressed:
  - Immediately to 60 days
  - Facility Capital Improvements may require greater time

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Area Mock Surveys

- Representation of recurring mock surveys throughout the Area over the accreditation cycle.

- Seeks to replicate official accreditation surveys and includes a “Mock Survey Guide” and Tracers
  - Previous target was at least 12 months before the (anticipated) official accreditation survey.
  - After comments through the “Mock Survey Process, Development and Improvement Committee” we revised the target to at least 18 months before the anticipated accreditation survey.

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			1st Qtr	2nd Qtr	3rd Qtr	4th Qtr	1st Qtr	2nd Qtr	3rd Qtr	4th Qtr	1st Qtr	2nd Qtr	3rd Qtr	4th Qtr	1st Qtr	2nd Qtr	3rd Qtr	4th Qtr
Service Unit																		
Service Unit Preparedness	Service Unit program management, monitoring, planning and initiatives are imperative to Accreditation Compliance, Quality and Safety	Continuous	→	→	→	→	→	→	→	→	→	→	→	→	→	→	→	→
Intracycle Monitoring	Includes Focused Standards Assessment (FSA)	Continuous	→	→	→	→	→	→	→	→	→	→	→	→	→	→	→	→
WebCident, Patient/EOC/IC Tracers, Risk Assessments, Electronic Statement of Conditions (eSOC)	Ongoing processes and activities to assess and monitor conditions for quality and environment of care	Continuous	→	→	→	→	→	→	→	→	→	→	→	→	→	→	→	→
SU Programs and Meetings-QAPI/PDSA/GPRA/ Infection Prevention/EOC	Monthly/Quarterly meetings for SU Implementation of Area's Strategic Plan, QAPI, GPRA, Infection Prevention, EoC, PDSA, "AAAHC 10-Step", Improving Patient Care Home Model	Monthly																
Management Plan Evaluations & Policy Reviews/Revisions	Annual Evaluations of Managements Plans	Annual																
Environmental Rounds	Biannually for Patient Care Areas, Annually for Non-Patient Care Areas. Includes Infection Control, Environment of Care, Life Safety, Emergency Management	Bi-Annual																
Corrective Actions from Environmental Rounds	Various options for implementation exist which may be performed independently or may be performed in conjunction with Environmental Rounds	Bi-Annual Varies																

Service Units

- Service Unit program management, monitoring, planning and initiatives are imperative to Accreditation Compliance, Quality and Safety.
  - Joint Commission's Intracycle Monitoring, including Focused Standards Assessment (FSA)
  - WebCident, Patient/EOC/IC Tracers, Risk Assessments, Electronic Statement of Conditions (eSOC)
  - SU Programs and Meetings-QAPI/PDSA/GPRA/ Infection Prevention/EOC
  - Management Plan Evaluations & Policy Reviews/Revisions
  - Environmental Rounds and Corrective Actions

Albuquerque Area's Governing Body Environment of Care Dashboard and Scorecard

CAPT Richard Turner[1], CAPT Brian Hroch[2], CDR Gary Carter[2], Mr. Spencer Weaver[3], Ms. Ann Buchanan[4]

[1]Environmental Health Support Center; [2]Albuquerque Area Office; [3]Acoma Canoncito Laguna Service Unit; [4]Mescalero Service Unit

Introduction

The Albuquerque Area developed a Dashboard and Scorecard for monitoring and reporting the status of the Area's Health Care Facilities (HCF's) for compliance and proper management of the Environment of Care's Safety Management, Life Safety and Emergency Management programs. The status of these programs are critical for: 1) protecting patients, staff and visitors 2) monitoring and improving the Environment of Care and 3) maintaining compliance with accreditation and regulatory requirements. These management tools were developed through a multi-disciplinary process with staff from the Area Office Leadership, OEHE and the Service Unit Health Care Facilities.

Individual Facility Specific EOC Dashboard

Requirement	Responsibility	Weekly	Monthly	Quarterly	Semi-Annual	Annual	JAN	FEB	MAR	APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC	ANNUAL REVIEW
EOC/Safety Committee Meeting	Safety Officer		(X)	(X)			C	C	X	C	C	C	X	C	C	S	S	S	N/A
Management Plans and Annual Evaluations																			
Safety Management	Safety Officer					RE	C												S
Security	Safety Officer					RE			C										S
Hazardous Material & Waste	Safety Officer					RE					C								S
Fire Safety	Safety Officer					RE							X	C					S
Utility	Facility Management					RE											S		S
Medical Equipment	Biomed					RE									C				S
Emergency Operations Plan	Safety Officer/Emergency Mgr					RE						C							S
Risk Assessments																			
Safety Management Risk Assessment	Safety Officer					X		C											N/A
Security Risk Assessment	Security					X		C											N/A
Mock Surveys																			Current or Prior Year?
Performed	Area Office					every 3yrs				C									2015
Corrective Actions	Multi-Disciplinary					every 3yrs					C	C	C	C	C	C	C	C	2014
Environmental Rounds																			
Clinical Environment	Safety Officer				X				C						S				N/A
Non-Clinical Environment	Safety Officer					X			C										N/A
Consultant Reports																			Current or Prior Year?
Ventilation Testing (Isolation, OR)	Facility Mgt/Safety/IEH		rel pressure			X=ACH	C			C			C			S			2015
Ventilation Testing (CSR, Soiled Utility Rms	Facility Mgt/Safety/IEH		rel pressure			X=ACH	C			C			C			S			2015
Ventilation Testing (Lab: Gen, Bact, Path...)	Facility Mgt/Safety/IEH		rel pressure			X=ACH		C											2015
Rad Protection Surveys-Med	IEH					every 2yrs										S			2014
Rad Protection Surveys-Dental	IEH					every 3yrs									C				2014
Nitrous Oxide Monitoring (Dental, Cryo)	IEH					every 2yrs							C						2015
Other Routine IEH Consultant Surveys	IEH					RE							C						2015
Emergency Management																			
Exercises	EOC Committee				X					C						S			S
EOP	EOC Committee					RE													S
Hazard Vulnerability Assessment (HVA)	EOC Committee					X													S
96-Hour Evaluation and EM Inventory	EOC Committee					RE									C				C
COOP	EOC Committee					RE													S
Life Safety/Fire Safety																			
Fire Drills																			
Day Shift	Safety Officer			X			C		C				C			C			N/A
Evening Shift	Safety Officer			X			C		C				C			S			N/A
Night Shift	Facility Management			X			C		X				C			S			N/A
Health Centers: Name	Facility Management					X		C			C			C			C		N/A

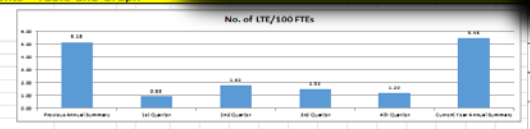
Safety Management

All Occupational Incidents - Table and Graph

ALL OCCUPATIONAL INCIDENTS		No. of Incidents	No. of FTEs	No. of Incidents/100 FTEs
Current Year Data	Previous Annual Summary	16	328	4.88
	1st Quarter	2	323	0.62
	2nd Quarter	4	326	1.23
	3rd Quarter	4	330	1.21
	4th Quarter	5	329	1.52
	Current Year Annual Summary	15	327	4.59

Lost Time Occupational Incidents - Table and Graph

Lost Time Occupational Incidents		No. of LTE	No. of FTEs	No. of LTE/100 FTEs
Current Year Data	Previous Annual Summary	17	328	5.18
	1st Quarter	3	323	0.93
	2nd Quarter	6	329	1.82
	3rd Quarter	5	330	1.52
	4th Quarter	4	332	1.20
	Current Year Annual Summary	18	329	5.48



Methods

After developing the EOC Dashboard and Scorecard templates, pilot testing was performed with two of the Area's Hospitals (Acoma Canoncito Laguna (ACL) and Mescalero). After this testing, this process was implemented Area-wide for the first Governing Body meeting of 2016. This process is as follows: 1) The Service Unit staff will complete and update the individual EOC Dashboards and return to the IEH program. 2) The IEH program will then review, analyze, summarize and score (Green, Yellow, Red) the updated Dashboards and enter into the Area-wide EOC Scorecard. 3) These results will be provided to the Area's Governing Body. 4) The Governing Body will address noteworthy deficiencies identified from EOC Dashboard 5) The EOC Dashboard should also be used by the Service Unit's Safety and Facility Management staff for planning and monitoring EOC activities.

Results

This reporting process was successfully utilized for the Area's first Governing Body meeting of 2016. This allowed the Governing Body members, OEHE and IEH staff to review the Area-wide EOC Scorecard, a summarized status of the Area's health care facility EOC programs. Additionally, health care facilities have also reported their satisfaction with the EOC Dashboard and have voluntarily begun using it as a planning and tracking tool.

Discussion

With the numerous participants, components and requirements for managing an EOC program, the Dashboard and Scorecard, provide a structured approach to planning, documenting and reporting these numerous activities. These management tools allow for local program management and planning. At the Area level, it also assists with accreditation compliance and preparation. Additionally, it allows for proper prioritization and focus of support to the Service Unit healthcare facilities.

Aggregated Area-wide EOC Scorecard

Area Governing Body

Conclusions/Recommendations

Recommendations for additional actions, include: 1) continuing the use of the EOC Dashboard/Scorecard by the Area's Governing Body 2) advocating for the health care facilities to use the Dashboard as a management tool 3) refining and improving the Dashboard with suggestions for improvement from the health care facilities 4) sharing this process as a resource with other Area's and through the IHS Quality Consortium.

CARP's Critical Components

- **Support**
  - Leadership
  - Service Unit
- **Commitment**
  - Quality of Care
  - Continual improvement
- **Involvement**
  - Integral aspect to CARP
- **Communication**
  - Fundamental bases for the success of CARP

CARP's Fundamentals

- Continually evolving and improving over time
- Maintains the focus on continual improvement and proactive approaches
- Establishes a working relationship between Area and Service Units
  - Team-based approach
- Provides structure and guidance to assist with the high turnover rate often seen within our sites.

CARP's Challenges

- Personnel
- Resources
- Time
  - Coordinating/scheduling
- Prioritization and Focus

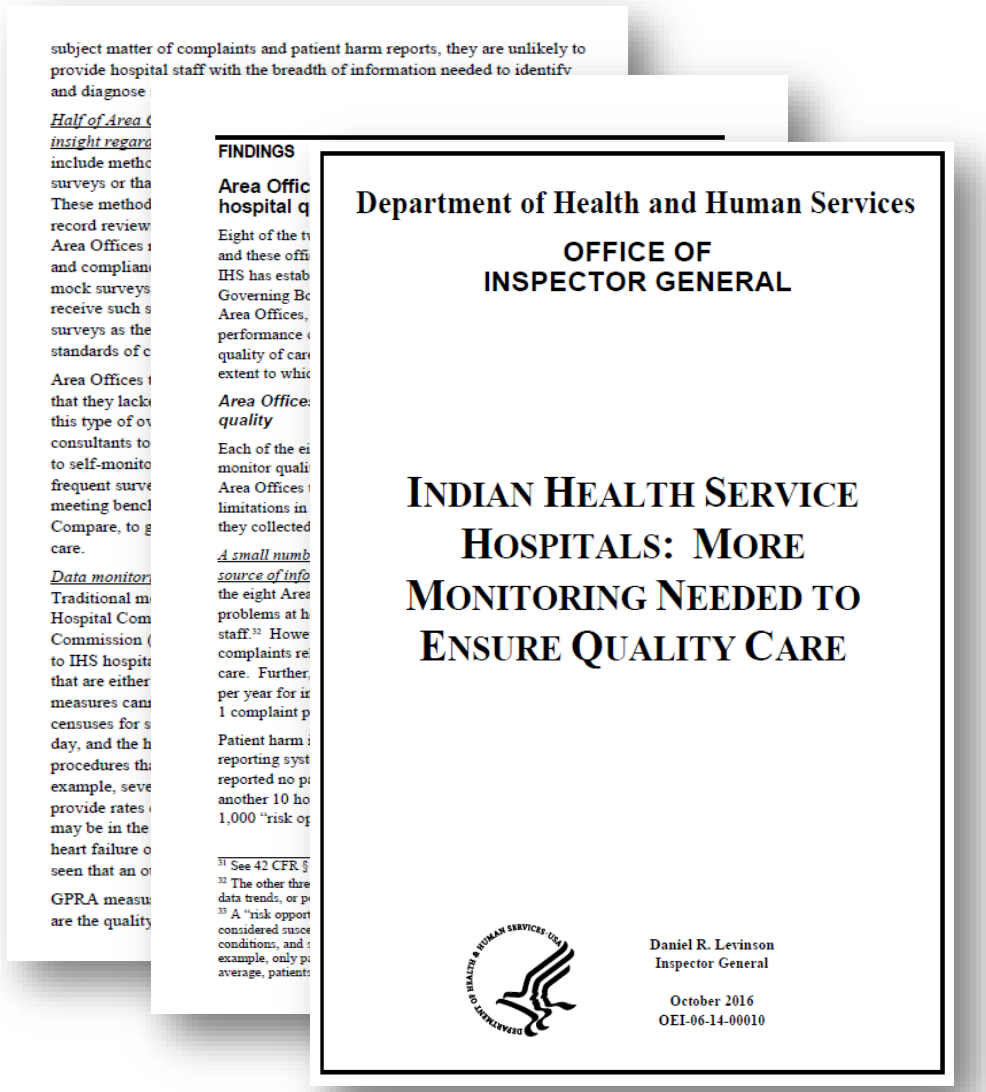
The IHS Quality Framework

Goals

- Improve Health Outcomes for Patients Receiving Care
- Provide a Care Delivery Service All Patients Trust

Priorities

1. Strengthen Organizational Capacity to Improve Quality of Care & Systems
2. Meet & Maintain Accreditation for IHS Direct Service Facilities
3. Align Service Delivery Processes to Improve Patient Experience
4. Ensure Patient Safety
5. Improve Processes & Strengthen Communications for Early Identification of Risks



Department of Health and Human Services

OFFICE OF INSPECTOR GENERAL

INDIAN HEALTH SERVICE HOSPITALS: MORE MONITORING NEEDED TO ENSURE QUALITY CARE

Daniel R. Levinson
Inspector General

October 2016
OEI-06-14-00010

https://oig.hhs.gov/oei/reports/oei-06-14-00011.asp

GAO Highlights

Highlights of GAO-17-181, a report to congressional requesters.

January 2017

INDIAN HEALTH SERVICE

Actions Needed to Improve Oversight of Quality of Care

Why GAO Did This Study

IHS is charged with providing health care to American Indian/Alaska Native (AI/AN) people who are members or descendants of 567 tribes. AI/AN people born today have a life expectancy that is 4.4 years lower than all races in the United States, and they continue to die at higher rates than other Americans from preventable causes. Concerns about the quality of care provided to AI/ANs in IHS facilities have been identified recently by federal officials and tribal members. GAO was asked to review how IHS oversees the quality of care provided in its facilities.

This report examines IHS's oversight of the quality of care provided in its federally operated facilities. GAO reviewed policies and guidance related to quality of care in federally operated facilities and interviewed IHS officials at the headquarters level and all nine area offices with federally operated facilities. GAO also examined documents from governance meetings between area office and facility staff.

What GAO Recommends

GAO recommends that the Secretary of the Department of Health and Human Services direct the Director of IHS to (1) as it implements its quality framework, ensure that agency-wide standards for the quality of care provided in its federally operated facilities are developed, that facility performance in meeting these standards is monitored over time, and that enhancements are made to its adverse event reporting system, and (2) develop contingency and succession plans for the replacement of key personnel.

HHS concurred with GAO's recommendations.

View GAO-17-181. For more information, contact Kathy King at (202) 512-7114 or kingk@gao.gov.

What GAO Found

The Indian Health Service's (IHS) oversight of the quality of care provided in its federally operated facilities has been limited and inconsistent. While some oversight functions are performed at the headquarters level, the agency has delegated primary responsibility for the oversight of care to nine area offices. Area officials stated that the oversight they provide has included, for example, holding periodic meetings with facility staff, reviewing available quality performance data and reviewing adverse events. However, GAO found that this oversight was limited and inconsistent across IHS facilities, due in part to a lack of agency-wide quality of care standards. Specifically, GAO found:

- variation in the frequency of governing board meetings and the extent to which quality was a standing agenda item at these meetings;
- limited and inconsistent reporting of quality data across IHS areas and facilities; and
- inconsistent reporting of adverse events at federally operated facilities.

These inconsistencies are also exacerbated by significant turnover in area leadership. Officials from four of the nine area offices in our review reported that they each had at least three area directors in the past five years. According to IHS officials, the agency has not defined contingency or succession plans for the replacement of key personnel, including area directors. IHS's lack of agency-wide quality of care standards and lack of contingency and succession plans for key personnel are inconsistent with federal internal control standards. These standards suggest that agencies should establish and review performance standards and then monitor data to assess the quality of performance over time, and define contingency and succession plans for the replacement of key personnel to help IHS continue achieving its objectives. As a result, IHS officials cannot ensure that facilities are providing quality health care.

Recognizing the challenges it faces with overseeing and providing quality health care in its facilities, IHS finalized the development of a quality framework in November 2016 that outlines, at a high level, IHS's plan to develop, implement, and sustain a quality program intended to improve patient experience and ensure the delivery of reliably high quality health care. For example, the framework directs IHS to develop a quality office that will be responsible for identifying resource needs, structures, processes, and supports for an effective and sustainable quality assessment and performance improvement system. More specifically, the framework directs IHS to develop a process for monitoring select performance measures, such as measures of clinical care, patient access, and financial performance, for periodic review by leadership. The framework also explains that IHS will enhance its current patient safety reporting systems to encourage consistent use by staff. If effectively implemented, the quality framework could address the limited and inconsistent oversight of the quality of care provided in federally operated IHS facilities. As of November 2016, IHS officials stated that the agency has not yet selected quality performance measures but has plans to do so.

United States Government Accountability Office

http://www.gao.gov/products/GAO-17-181

Looking ahead…

- Continue to monitor, assess, and address areas of improvement in our health care facilities
  - Requirements from the Agency, Department, Accrediting Bodies and the applicable multiple disciplines and subject areas.
- Improvement with Mock Survey process (based upon customer feedback)
  - More comprehensive involving additional subject areas
  - Additional “Surveyor days”
- Improvement in Quality Reporting
  - Modification of EOC/IC reporting templates
  - Development of Quality reporting templates

Thank you for your time!

Questions??

Albuquerque Area's Continuous Accreditation Readiness Program

v.2019-04-23 — 11x17 printout recommended

Action/Activity	Description	Frequency	Survey Year (2016)	1st Year (2017)	2nd Year (2018)	3rd Year (2019)
Area-wide						
Area Governing Body	Consists of Area Leadership and Service Unit CEO's	Quarterly				
Survey (TJC, AAAHC, CARF, etc.)						
Official Accreditation Surveys (TJC, AAAHC, CARF)	Represents multiple accreditation surveys occurring throughout the Area (Biennial Laboratory Accreditation surveys are not specifically represented here)	Triennial	Area-Wide Accreditation Surveys			Area-Wide Accreditation Surveys
Official Laboratory Accreditation Surveys (CAP, COLA)	Represents multiple Laboratory accreditation surveys occurring throughout the Area	Biennial	Area-Wide Laboratory Accreditation Surveys		Area-Wide Laboratory Accreditation Surveys	
Corrective Actions from Accreditation Survey	As a result of the Official Accreditation survey, Evidence of Standards Compliance address deficiencies and demonstrate corrective actions and Performance Improvement measures. May range from immediate corrections to lengthier facility capital improvement projects	Triennial	Accreditation Survey's Corrective Actions; Facility Capital Improvement Projects			Accreditation Survey's Corrective Actions; Facility Capital Improvement Projects
Area Mock Surveys	Represents multiple mock surveys occurring throughout Area. Target is at least 12 mos before official accreditation survey. Replicates official accreditation surveys. Includes "Mock Survey Guide" & Tracers (Surveys	Triennial		Mock Survey Process, Development and Improvement Committee	Area-Wide Mock Surveys (performed by Area's Mock Survey Team)	
Mock Survey Corrective Actions	Corrective Actions to be based upon Mock Survey "Punchlist". The "Punchlist" is to be provided to Service Unit at end of Area Mock Survey, with official mock survey report to follow	Follows Area Mock Survey			Corrective Actions	Follow-up Tracking
Committees						
Area Quality Improvement Committee	Consists of Area and Service Unit staff	Quarterly				
Area Institutional Environmental Health/Environment of Care (EOC) Committee	Consists of Area and Service Unit staff	Quarterly				
Area Infection Prevention Committee	Consists of Area and Service Unit staff	Quarterly				
Competencies for Infection Preventionist and Sterilization Techs	In addition to the Infection Prevention Program "Dashboard", Competencies were developed for the Infection Preventionist. Competencies for Sterilization Techs are in development	Continuous				
Meetings						
Governing Body Meetings and Reporting	Service Unit Dashboards are scored and presented to Governing Body. Includes GPRA reporting, and the Area's Strategic Plan	Quarterly				
Area Operational Meetings/ Reviews of Service Units	These reviews/meetings are performed by the Area Office Leadership and focus on the Service Unit performance with Leadership, Quality and Finance	Each Year's 2nd and 4th Qtrs				
Area Medical Equipment Governing Body	Consists of Area and Service Unit staff	Quarterly				
Area Laboratory Supervisor Meetings	Consists of Area and Service Unit staff, Peer laboratory reviews, Compliance Reviews,	Quarterly				
Resources						
Formal Accreditation Trainings, including webinars and updates	Frequency and topic depend upon identified needs of Area. May consist of formal classroom style trainings and/or webinars	Triennial to Annual	Pre-Survey	Formal Training; Pre-Survey; Formal Training; Pre-Survey	Formal Training; Pre-Survey	Pre-Survey
Service Unit Dashboards	Maintained for Service Unit Planning and Area Office Reporting. Dashboards results are "scored" and reported on Scorecards to the Area Governing Body	Quarterly				
Area On-site Consultative Support (OEHE, Credentialing, Laboratory, etc.)	Monthly & Ongoing support provided to the Service Units from the Area Office. Includes On-Demand technical support as site visits/phone consults and participation at SU's monthly program meetings	Monthly/ continuous				
Service Unit Process Reviews & Assistance from Service Unit SME's	At the direction of the Area Director and Area Office, Service Unit SME's perform process reviews of fellow Service Units, which includes practices and may include standardization	Continuous				
Service Unit						
Service Unit Preparedness	Service Unit program management, monitoring, planning and initiatives are imperative to Accreditation Compliance, Quality and Safety	Continuous				
Intracycle Monitoring	Includes Focused Standards Assessment (FSA)	Continuous				
WebCident, Patient/EOC/IC Tracers, Risk Assessments, Electronic Statement of Conditions (eSOC)	Ongoing processes and activities to assess and monitor conditions for quality and environment of care	Continuous				
SU Programs and Meetings- QAPI/PDSA/GPRA/ Infection Prevention/EOC	Monthly/Quarterly meetings for SU implementation of Area's Strategic Plan, QAPI, GPRA, Infection Prevention, EoC, PDSA, "AAAHC 1-Step", Improving Patient Care Home Model	Monthly				
Management Plan Evaluations & Policy Reviews/Revisions	Annual Evaluations of Management Plans	Annual				
Environmental Rounds	Biannually for Patient Care Areas, Annually for Non-Patient Care Areas. Includes Infection Control, Environment of Care, Life Safety, Emergency Management	Bi-Annual				
Corrective Actions from Environmental Rounds	Various options for implementation exist which may be performed independently or may be performed in conjunction with Environmental Rounds	Bi-Annual varies				