



EDUCATIONAL RESOURCES

QAPI — SUCCESSFUL COMPLIANCE WITH THE NEW COPS

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**“If you think
compliance is
expensive –
try non-compliance.”**

Former U.S. Deputy Attorney General Paul McNulty

484.65 — Condition of Participation

Q

• Quality

A

• Assessment

P

• Performance

I

• Improvement

QUALITY OVER THE DECADES

- QA ... QI ... CQI ... TQC ... PI ... CASPER ... OBQI ... OUTCOMES ... and so on ...
- For Years our home health industry, as the rest of the healthcare industry, has done some form or another of quality improvement
- Therefore, the New CoP for Quality Assessment and Performance Improvement Program (QAPI) should not be brand new for most agencies!
- In fact, in any accredited agency, the AO standards are very similar to the Condition!

QAPI

- Many HHAs feel that QAPI, or any kind of quality improvement program, is just busy work, and they are just too busy to deal with it, or don't have the staff resources ... but ...
- A Quality Program it is a **key component of a well-run** organization
- It not only assists in being compliant to laws and regulations, but it:
 - Minimizes risk
 - Improves patient AND agency outcomes...and five-star ratings!
 - Lessens your crises "du jour"
 - Prevents future problems!
 - Increase your agency's quality and efficiency
- A good QAPI program should be incorporated into everyday operations and involve ALL staff!

CONDITION 484.65 — QAPI

- Standards:

- Program Scope
- Program Data
- Program Activities
- Performance Improvement Projects
- Executive Responsibilities



484.65 — QAPI STANDARD — (A) PROGRAM SCOPE

- The program must at least be capable of showing **measurable improvement** in indicators for which there is evidence that improvement in those indicators will improve health outcomes, patient safety, and quality of care
- The HHA must measure, **analyze**, and track **quality indicators**, including adverse patient events, and **other aspects of performance** that enable the HHA to assess processes of care, HHA services, and operations

484.65 — QAPI STANDARD — (B) PROGRAM DATA

- The program must utilize quality indicator data, including measures derived from OASIS, where applicable, and other relevant data, in the design of its program
- The HHA must use the data collected to:
 - Monitor the effectiveness and safety of services and quality of care
 - Identify opportunities for improvement
- The frequency and detail of the data collection must be approved by the HHA's governing body

484.65 — QAPI STANDARD — (C) PROGRAM ACTIVITIES

- The HHA's performance improvement activities must:
 - Focus on **high-risk, high-volume, or problem-prone** areas
 - Consider incidence, prevalence, and severity of problems in those areas
 - **Lead to an immediate correction** of any identified problem that directly or potentially threaten the health and safety of patients
- Performance improvement activities must **track adverse patient events, analyze** their causes, and implement preventive actions
- The HHA must take actions aimed at performance improvement, and, after implementing those actions, the HHA must measure its success and track performance to ensure that **improvements are sustained**

484.65 — QAPI STANDARD — (D) PI PROJECTS

- Beginning July 13, 2018 HHAs must conduct performance improvement projects!
 - The number and scope of distinct improvement projects conducted annually must reflect the scope, complexity, and past performance of the HHA's services and operations
 - The HHA must document the quality improvement projects undertaken, the reasons for conducting these projects, and the measurable progress achieved on these projects

484.65 — QAPI STANDARD — (E) EXECUTIVE RESPONSIBILITIES

- The HHA's governing body is responsible for ensuring the following:
 - That an ongoing program for quality improvement and patient safety is defined, implemented, and maintained
 - That the HHA-wide quality assessment and performance improvement efforts address priorities for improved quality of care and patient safety, and that all improvement actions are evaluated for effectiveness
 - That clear expectations for patient safety are established, implemented, and maintained
 - That **any findings of fraud or waste** are appropriately addressed

HHA'S QAPI BEING PART OF A SYSTEM

CoP Final Rule Response:

- Participation in a larger, system-based improvement program may or may not satisfy the requirements of this rule, depending on whether the program addresses the specific areas of concern or weakness within the HHA component of the system
- HHAs are required to include, at a minimum, those areas that are high-risk, high-volume, or problem-prone, and that reflect the scope, complexity, and past performance of the HHA's services and operations
- If, for example, a system-based program focused on infection prevention and control, while the HHA's historical area of weakness is the effectiveness of occupational therapy in achieving desired outcomes, then participation in the larger, system-based improvement program would not be considered sufficient to meet the requirements of this rule



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QAPI CONDITION

QAPI — ALLOWING AGENEINCIES FLEXIBILITY

- But there are Some Rules:
 - Must include contracted services
 - Must focus on indicators related to improved outcomes
 - Must focus on the use of emergent care services, and re-admissions
 - Must focus on high-risk, high-volume, problem-prone areas
 - Must address performance across the spectrum of care, including the prevention and reduction of medical errors
 - Must be capable of showing measurable improvement in indicators and sustain the improvement



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BUILDING A SUCCESSFUL QAPI PROGRAM

WHERE DO WE START?

- CASPER reports
- Home Health Compare:
 - Five-star ratings
 - Value-based purchasing outcomes in nine pilot states
- Self-assessment of agency
- How to select the outcome measures to focus on
- What to do with the selected outcomes:
 - How to develop indicators and audit tools
- How to write action plans
- What if we aren't improving?

OASIS (AND CLAIMS) OUTCOME REPORTS

- CASPER OASIS Outcomes started in 2003, but many managers do not know about them, how to access them, and /or how to utilize them!
- Information compares your agency to national:
 - State information is on Home Health Compare but not on CASPER
- CASPER is the computer system that compiles the OASIS data of every certified HHA at two time points
 - SOC to Tx/DC, or ROC to Tx/DC and gives the outcome reports



CASPER OUTCOME REPORTS — KEY REPORTS

- Agency patient-related characteristics
- Risk-adjusted outcome report
 - Includes claims-based emergent care and hospitalization
- Potentially avoidable events
- Process-based quality improvement
- Three-bar is most meaningful — agency current observed %, agency prior period % (some outcomes now have agency risk-adjusted %), and national current observed %
- KEY: Asterisks mean statistically significant data



AGENCY PATIENT RELATED CHARACTERISTICS REPORT

- Information on your agency for use for management, education, as well as QAPI, including:
 - Demographics
 - Payment sources
 - Therapy days
 - Length of stay
 - Diagnoses
 - Results of many M items
- Contribute to your RISK ADJUSTMENT
- Useful information regarding differences in your agency to others

RISK-ADJUSTED OUTCOME REPORT

Outcomes compared on a three-bar report give information on the percentage of patients you have improved in various M items, current, prior and nation (and some risk-adjusted).

- ADLs, IADLs, ambulation:
 - Includes GG items — data just being updated
- Clinical — medications, dyspnea, pain, UTIs
- Confusion, anxiety
- Emergency Department and re-hospitalizations:
 - Claims-based now — no longer reports OASIS utilization for these important outcomes

POTENTIALLY AVOIDABLE EVENTS (PAE)

- Adverse Events

- Important to audit the patient's records on these in order to prevent from occurring in the future
- Emergent care for: improper medication administration or medication side effects and hypo/hyperglycemia
- Development of UTI, increase in number of pressure ulcers, decline in management of oral medications
- Decline of three or more ADLs
- Discharged to community needing wound care, med assistance, toileting assistance, behavior problems or unhealed stage 2 pressure ulcer

PROCESS BASED QUALITY IMPROVEMENT (PBQI)

Process Measures — Standards for Best Practices

- Updated recently:
 - Timely initiation of care
 - Risk assessments — falls and depression
 - Diabetic foot care and patient/caregiver education implemented
 - Drug education on all medications provided to patient/caregiver
 - Influenza immunization received for current flu season, offered/refused, contraindicated
 - Pneumococcal vaccine ever received, offered/refused, contraindicated
 - Drug regimen review conducted with follow-up for identified issues

CASPER REPORTS

- Need to assign someone to look in system monthly to see if reports have been updated
- When updated, do an analysis of the data, focusing on the statistically significant areas
- Write an action plan for needed areas
- Incorporate into your QAPI plan — have a QAPI indicator for formal monitoring
- Shared with all staff! This is how you get improvement!
- Plan the episode of care for the patient in order to focus on improving outcomes as a team!
- This information comes from what your clinicians document in OASIS!!!

HOME HEALTH COMPARE

- Some of the outcomes from CASPER reports are on this public website
- Variances to CASPER — agency compared to state and nation and can be compared to other agencies
- Purpose for the public to choose quality HHAs
- [www.https://Medicare.gov/homehealthcompare/search.aspx](https://www.Medicare.gov/homehealthcompare/search.aspx)
- Can use this information for marketing your agency when your outcomes are better for patients than other agencies

FROM CASPER AND HH COMPARE REPORTS FOCUS ON THE FOLLOWING

- Statistically significant outcomes
- Star rating outcomes
- VBP outcomes
- Outcomes are below national/state benchmarks
- Clinical, multidisciplinary, each discipline significant:
 - Example: dyspnea-clinical, pain-multi, improve in ambulation-therapy, improvement in bathing-aide and OT
 - IV services — high-risk and problem-prone
- Identify if there is an OASIS understanding deficit, or an actual care issue

WHEN CHOOSING INDICATORS TO DEVELOP

- Task force of stakeholders to brainstorm areas to improve care to increase outcomes
- Target high-volume/ high-risk/problem-prone areas
- Develop Audit Tools for each and include in QAPI program
- Continue OASIS education on specific M items identified in knowledge deficit
- Educate task force on clinical record reviews to read assessments associated with M items to improve



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OASIS ACCURACY

OASIS ACCURACY

- **If this is lacking, your work on improving outcomes will not be successful!**
- Steps:
 - OASIS audit of all of your clinicians completing OASIS time points
 - Trend results — identify if common problem or individuals
 - Develop Education Plan — tailored education:
 - Example: if common problem with three outcomes, educate all OASIS clinicians on those; example: if individuals that don't understand OASIS — do full education
 - However, a FULL OASIS training class needs to be done at least annually!
 - To update on CMS Q&As , etc.
 - To Review CMS OASIS MANUAL Chapter 3 INTENT and Guidelines — since many clinicians forget all of the caveats that can assist in increasing outcomes!
 - Audit again! Drop frequency and amount of best performers

OASIS CONSISTENCY

- Are all clinicians performing the comprehensive OASIS assessment in the same manner?
- If not, your outcomes WILL be skewed! And your work to improve outcomes will not succeed!
- Mock assessment in-services with all work wonderfully to engage staff!
- Clinicians must walk with patient around the house to “SEE” how the patient does and have patient SHOW you activities:
 - Examples:
 - Transfer to toilet
 - Go down two steps to go outside
 - Take off shoes and socks and put back on
 - Read meds to you and describe them
- MUST do Assessments in this manner on DISCHARGE OASIS VISIT AS WELL!

QUESTION



- Where else other than CASPER OASIS outcomes do we find high-volume/high-risk/problem-prone indicators to monitor?

SELF-ASSESSMENT



- Self-assessment or mock survey
- This is another valuable tool to help select areas to monitor in your QAPI program. It is also the best way to ensure that you are in a state of continued survey readiness
- Assign qualified employees (often managers or QI staff) from your agency or another location if multi-site
- If no one is qualified to be able to “survey” your agency internally, consider engaging a consultant with appropriate survey expertise
- Even if your own staff is performing the mock survey, do it formally as a surveyor would

SELF-ASSESSMENT — ITEMS TO REVIEW



- Previous regulatory survey reports and the agency's approved plan of correction:
 - The previous deficiencies and the plan of correction may be included as a QAPI indicator
 - This is extremely important as you need to avoid repeat deficiencies
 - A standard level deficiency, if repeated, is vulnerable to escalating to a condition level deficiency
 - Ongoing, formal monitoring in the QAPI program can help your agency to avoid repeat deficiencies and conditions!
- Complaints, incidents including falls, and infection surveillance:
 - Ensure that there is resolution documented for all complaints
 - Trend complaints to see red flags early. Trends may become QAPI indicators
 - Example: increasing falls for patients without therapy services, complaints regarding staff competency, and increasing numbers of UTIs
- In-service, orientation and competency programs, human resource files

HOME VISITS SHOULD BE DONE AS A SURVEYOR WOULD PERFORM

Choose all disciplines with various care needs of patients such as wound care, multidisciplinary, therapy only, IVs, and aide services.

- Review the Clinical Record prior to visit so that the plan of care and subsequent physician orders, medications, and goals are known during the visit.
- Interview the patient and/or caregiver. Ask questions that a Surveyor asks. Examples include:
 - Have you had any complaints?
 - Can you reach the agency after-hours?
 - Have the clinicians told you when they are coming?
 - Were you taught infection control?
 - Were you told about the hot line numbers, etc.?
- Locate and review the Home Folder, which should include copies of signed consents, a medication list, education materials, etc.
- Observe the visit. Don't intervene unless a safety issue is seen

CLINICAL RECORD REVIEWS

- From home visits now note what was non-compliant to physician orders, medications, patient rights, infection control, aide care plan, etc.
 - Ensure the audit tool is appropriate to capture all regulations
 - Ensure that the auditor understands what to look for on both clinical record reviews and home visits
 - It is very possible that you may have to train staff on how to perform these key areas of a mock survey
- Look for commonly seen deficiencies, such as:
 - Lack of coordination of care and communication between disciplines and/or physicians
 - Not following physician orders — visits and treatments
 - Aides not following aide care plans, and untimely supervisory visits

DEVELOPMENT OF THE QAPI PLAN

- List and prioritize the topics that you have found from the CASPER outcome analysis and the mock survey deficiencies
- Describe each indicator with the methodology, threshold (goal %), frequency, and responsible party
 - Example: Development of UTI: QAPI coordinator or designee will review 100% of patients who develop a UTI during the homecare episode of care to ensure appropriate interventions, education and infection control were performed. Frequency — quarterly, goal: 90% compliance to audit criteria.
- Audit Tools must be developed for each indicator.
 - There are many variations to audit tools and tracking
 - Make certain that they are objective in order to ensure accurate results
 - Drill down — Identify if documentation issue, knowledge deficit or care issue



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ANALYZING, TRENDING AND DEVELOPING ACTION PLANS

- Many agencies perform a lot of audits, gather a lot of data, but then don't do the most important steps in a QAPI program

ANALYZE RESULTS



What did you find from your assessment?



Where are your vulnerable areas?



Do any areas tie together?

ACTION PLANS

- Ensure that your action plans are specific with findings
- Be more specific than simply stating to continue monitoring.
- Drill down to the items that you will perform during this time period in order to improve and sustain
- Action items may include:
 - Staff education
 - Process change
 - Policy change
 - QAPI monitoring
 - PIP project
- Whenever an indicator is lower than the goal or has significantly varied over the time periods of collection, it is important to revise the action plan

ACTION PLAN — BE SPECIFIC — WOUND CARE EXAMPLE

Specifics Findings

■ Example:

- In six of eight patients with a wound, clinical records indicated physician orders for wound care were not followed
 - (State for each chart specifically what was not followed)

■ Example:

- MR#1234 — wound care was not performed to physician orders from 1/10 to 1/12 — physician order 1/9:
 - “Discontinue wound care with hydrogel to left lower leg. Cleanse wound with NS and apply Aquacel to wound bed daily.”
 - SN documented, “Cleansed wound left lower leg with NS, followed by hydrogen peroxide, and applied Aquacel.”

ACTION PLAN — BE SPECIFIC — WOUND CARE EXAMPLE (CONT.)

- QAPI monitoring — Indicator: DPS to review 100% wound care patient records a quarter to focus on following physician orders with a goal of 90% compliance
 - If after three months Goal is achieved, then review will decrease to 20% records a quarter with a goal of 90% compliance
 - Have the audit tool designed for this particular deficiency – example: wound care
- Education — In-service to ALL skilled nursing will be done
 - 2-15 by DPS — regarding following physician orders for wound care
 - 3-1 by Wound Care Consultant — regarding wound care types
 - Home Visits with Wound Certified nurse and all nurses on wound patients by end of May

ACTION PLAN- BE SPECIFIC — WOUND CARE EXAMPLE (CONT.)

- Process Change — On patients orders from “567 Wound Care Clinic,” the DPS will contact SN on patient same day with changes
- Coordination of Care — All wound care patients will have communication notes in EHR by clinician receiving new wound care orders same day

QAPI — RESULTS

- It is important to improve results in an indicator being monitored and then sustain that improvement
- An annual QAPI calendar is an easy way to track results over a year

Indicator	Freq	Goal	Jan	Feb	Mar
Clinical Record Review	q	90%	78%		82%
Home Visits	q	90%	85%		90%
Infection Surveillance	q	<10%	2%		8%
Fall Reduction	q	<10%	15%		9%
Human Resource File — Audit	annual	90%			95%
Medication Errors	q	<2%	0%		1%

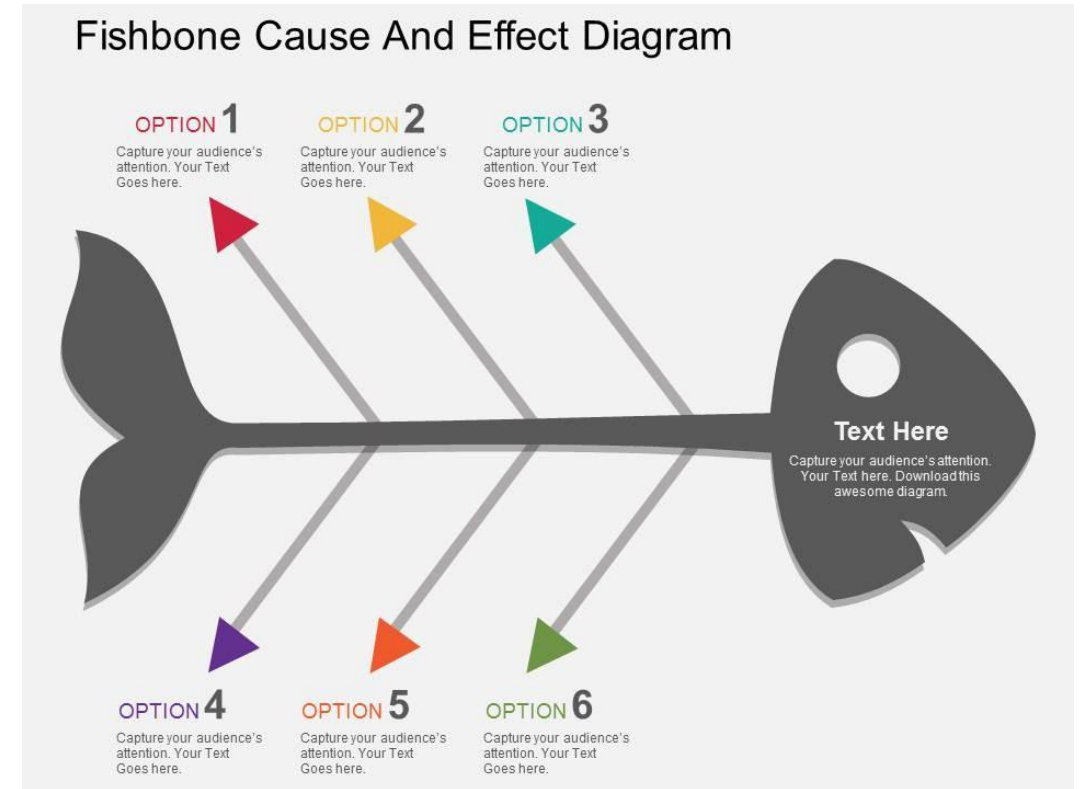
PROCESS IMPROVEMENT PROJECTS

- You may find that a deficiency is widespread, effecting many services as well as office and field staff. This would become then a PI project!
- Remember PIP — Performance Improvement Projects?
 - Most of us in healthcare have done many PIPs!
 - That is what the QAPI condition is requiring, but not until July 2018
 - Don't wait until then if you find a deficiency and/or problem area that is critical to patient care, safety and/or outcomes

PROCESS IMPROVEMENT PROJECTS

The projects will often involve performing a root cause analysis or Fish Bone Analysis, where a task force of stakeholders reviews the deficient area, and then drills down to all the various facets that are involved.

- Often communication is key — between clinicians, office staff, physicians and patients / caregivers
- Very often processes and policies need to be revised
- Several ongoing QAPI indicators may need to be developed as a result as well

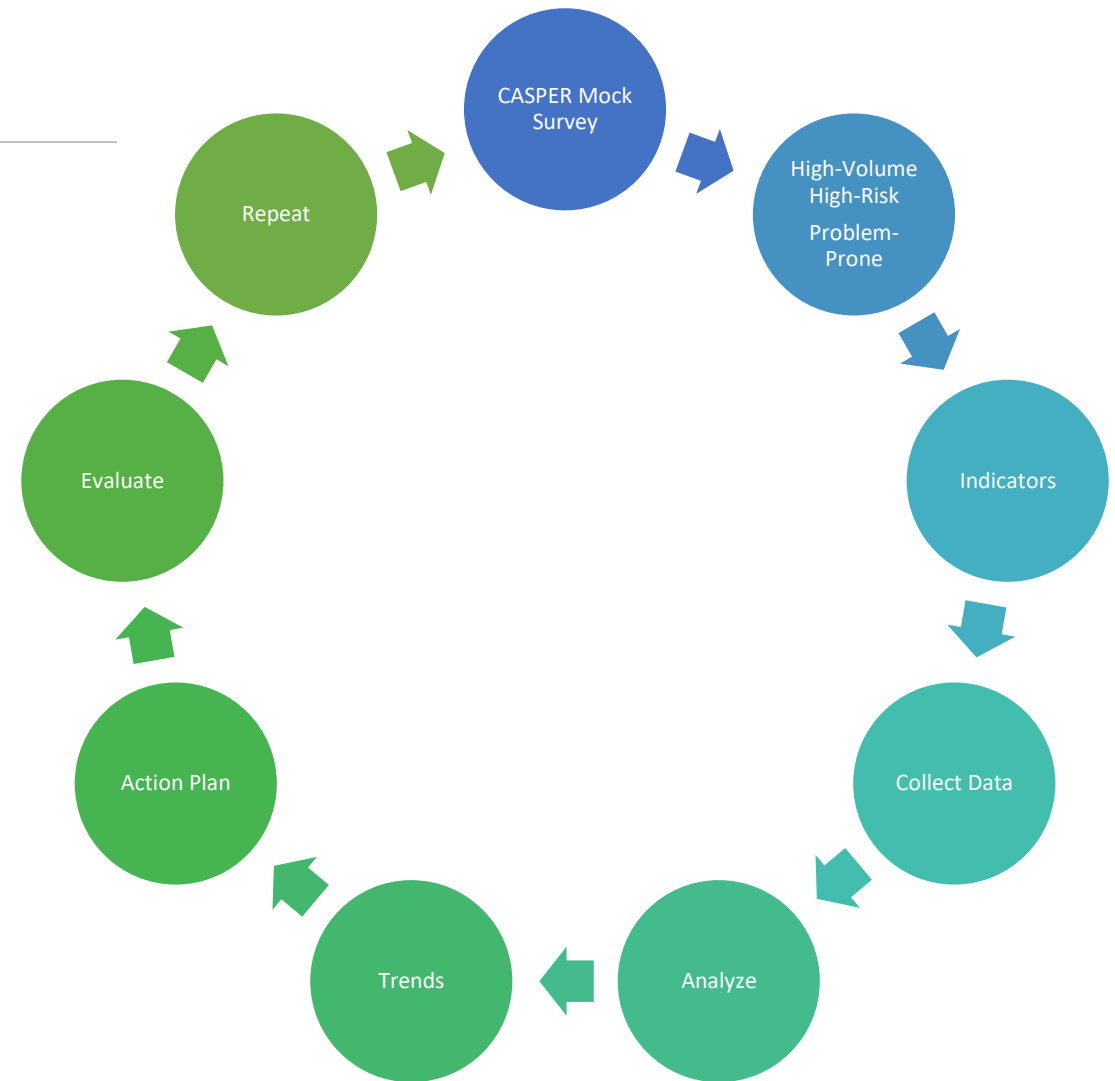


QAPI SUCCESS

- Get Everyone in your Agency Involved!
- Having a large QAPI team and rotating them every six months to a year is a great way to get all staff involved
 - The team will brain storm on action plans, indicators, audit tools, etc.
 - Assign team members to parts of the action plan, examples include clinical record reviews, education, and process development
- Your agency will improve in many ways when your staff is involved in QAPI!

QAPI NEVER STOPS!

- Indicators may be able to be discontinued once you find sustained and complete improvement...
- But the evaluation must continue





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QAPI INDICATOR AND AUDIT TOOL EXAMPLES

Wound Audit Tool

Review Date:

Pt Name:

SOC/Recert Date:

Type of Wound: PU Stasis Surgical Other: _____

Number of Wounds:

Criteria:

Y

N

NA

Comments

Wound Care Orders specific and appropriate by physician

Nursing visits document wound care to physician orders

Every Nursing Visit complete wound assessment

Weekly Wound Measurements

Nursing notifies physician for changes in wound

Nursing documents education to patient and caregiver

Nursing documents return demonstration by patient or caregiver

Total Compliance %

Action Plan:

FALL AUDIT

- **The QAPI coordinator or designee will audit 25% of clinical records of patients with falls per quarter to criteria with expected threshold 90%**
- Falls will be <10% of patient population
 - Was fall assessment complete on SOC?
 - Was fall assessment completed on ROC and Recert?
 - Were interventions documented if risk was medium or high?
 - Were interventions appropriate for the patient?
 - Was there documentation of patient/ caregiver education?
 - Was the physician notified of the fall?
 - Emergent care for fall? If yes, was there anything the Agency could have done to prevent the fall?

ER VISIT FOR FALLS WITH INJURY

- The QAPI coordinator or designee will audit 100% records of patients with ER visits for falls with injury per quarter to criteria with expected threshold 90%.
- Potentially Avoidable Event — ER for Falls with injury will be below _% (CASPER Benchmark)
- Criteria for Audit Tool
 - Was fall assessment complete on SOC?
 - Was fall assessment completed on ROC and Recert?
 - Were interventions documented if risk was medium or high?
 - Were interventions appropriate for the patient?
 - Was there documentation of patient/ caregiver education?
 - Was the physician notified of the fall?
 - Was there anything the Agency could have done to prevent the fall?

ER WITHOUT HOSPITALIZATION

The QAPI Coordinator or designee will review 100% patients going to the ER without hospitalization quarterly to ascertain if there was anything the HHA could have done to prevent the ER visit.

Goal: 90% to audit criteria

Goal to Outcome: __%

ER WITHOUT HOSPITALIZATION

Criteria	Pt
Was assessment on SOC complete?	
Were appropriate disciplines ordered based on OASIS?	
Was frequency and duration appropriate?	
Were visits front-loaded?	
Was MD notified of any changes in patient condition?	
Was visit frequency increased, if necessary, after change in condition?	
Did disciplines communicate with each other re: patient change?	
If patient/caregiver called RN after-hours; did on-call RN make visit?	
If patient was non-compliant with orders, was MD called?	
Was appropriate patient/cg teaching documented re when to call 911, go to ER, call HHA RN, or call MD?	
Was response to patient teaching documented?	
TOTAL COMPLIANCE: _____	
NOT SCORED: Was there anything the agency could have done to prevent hospitalization?	

REASON FOR EMERGENT CARE AUDIT TOOL

- Outcome Reports (CASPER):
 - Other respiratory — 38%/25% prior/11% national
 - Uncontrolled pain — 25%/0 prior/5.5% national
- Indicator:
 - QI coordinator or designee will review 100% of patient OASIS — reason for emergent care quarterly
 - If “other respiratory” or “uncontrolled pain” is the reason for emergent care, then a clinical record review will be completed to identify if the agency could have done anything to prevent these occurrences. Goal: CASPER data: other respiratory reason — 15%, uncontrolled pain reason — 10%
 - Audit criteria met on clinical record review when reason respiratory or pain — Goal: 90%

DYSPNEA AUDIT TOOL

Criteria	Pt	Pt	Pt	Pt	Pt
Respiratory:					
Not scored – does patient have respiratory diagnosis?					
Did the respiratory assessment correlate with the M item for dyspnea?					
Was physician notified for all respiratory signs and symptoms?					
Was respiratory education documented?					
Was understanding of education by patient/caregiver documented?					
Not Scored- Did the patient /cg contact the HHA prior to going to the ER?					
If yes, did the nurse call the physician and / or make a visit?					
Was there anything the HHA could have done to prevent emergent care for respiratory reasons?					
Total per patient:					
Total compliance: _____					

PAIN AUDIT TOOL

Criteria	Pt	Pt
Pain		
Did the pain assessment correlate with the M item for pain on OASIS?		
Was physician notified for all pain signs and symptoms?		
Were all pain assessments complete and thorough?		
Was pain education documented?		
Was understanding of education by patient/caregiver documented?		
Not Scored- Did the patient /cg contact the HHA prior to going to the ER?		
If yes, did the nurse call the physician and / or make a visit?		
Was there anything the HHA could have done to prevent emergent care for uncontrolled pain ?		
Total per patient:		
Total compliance : _____		

QAPI INDICATOR RE-HOSPITALIZATIONS

- A primary goal of having a patient receive homecare services is to keep that patient in the home, and to prevent hospitalizations
- Agency goal is to have less than __% (based on Agency VBP report as well as CASPER outcomes) of our patients be hospitalized during an episode of care
- The QAPI coordinator or designee will review 100% of patient records that are hospitalized during an episode of care every quarter. The goal is for a 90% compliance to the audit criteria

CONCLUSION: QAPI — NEW COP

- QAPI CoP may be new but Quality Management has been done for decades for most HHAs!
- Review your current QAPI program — plan, indicators, audit tools, action plans, improvement
- Review CASPER outcomes quarterly
- Identify vulnerabilities to the conditions /standards through mock survey/self-assessment
- EDUCATION ... ongoing!
- Task forces to include field staff are excellent ways to improve both programs!
- Involve ALL staff
- Don't wait till the last minute!



EDUCATIONAL RESOURCES

THANK YOU

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