Texas Association for Home Care & Hospice
Leading ★ Advancing ★ Advocating

57th Annual Meeting

Wednesday, September 2, 2026
Republic ABC Room
2:45pm-3:45pm

3a. Quality Isn't a Checkbox—It's a Strategy: Using QAPI to Improve Outcomes

Presented by:

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Quality Isn't a Checkbox—It's a Strategy: Using QAPI to Improve Outcomes

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MAC LEGACY

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CMS: Quality Improvement

- **Areas of focus:**
  - Address high impact measure areas that safeguard public health
  - Adopt measures that are patient-centered and meaningful to patients
  - Adopt outcome-based measures
  - Fulfill legislative requirements
  - Minimize burden for providers
  - Identify significant opportunities for improvement
  - Address measure needs for population-based payment through alternative payment models
  - Align across programs and payers (e.g., Medicare, Medicaid, and commercial payers)

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Understand the Why

CMS Quality Vision:

- Using incentives to improve care
- Tying payment to value through payment models
- Changing how care is given through:
  - Better teamwork
  - Better coordination across healthcare settings
  - More attention to population health
  - Putting the power of healthcare information to work

CMS Quality Strategy Goals:

- Safer care by reducing harm
- Promote effective communication/coordination of care
- Effective prevention and treatment of chronic disease
- Involving patients and families as partners
- Work with communities to promote healthy living
- Making care affordable

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What is "Quality"?

- Quality healthcare is:
  - The right care
  - At the right time
  - At the right place

The degree to which health services increase the likelihood of desired health outcomes for individuals and populations

Delivering all and only the care that the patient and family needs

Achieving positive patient experiences

Consistency with evidence-based professional knowledge

Meeting the needs and exceeding the expectations of those we serve

Chart reviews, improving functional, less SOB, medication management, staying out of the hospital/ED, remaining in the home, less pain.

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Why a Culture of Quality?

Remember -QAPI is not something you check off your to-do list – it is how the agency thinks, acts, learns, and improves every day

- Quality is everyone's job – QAPI is the structure/framework, but culture determines the quality of the agency
- Data turned into action – quality has to be a part of operations and drive how care is delivered, measured, and improved upon
- Learning opportunities – quality is not reporting data after the fact, it is using data patterns, adverse event, complaints, OASIS outcomes, hospitalizations. Emergency department use, and other issues to identify risks and improve the quality of care delivered
- Sustaining quality improvement – when quality is engrained in the culture, agencies are better positioned to prevent harm, improve outcomes, mitigate risk, and provide safe, equitable, and high-value care

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What is Required?

CMS §484.65 QAPI :

- Develop, implement, evaluate, and maintain an effective, ongoing, HHA-wide, data-driven ***QAPI program*** *with documentation to demonstrate the operation to CMS*
- Governing body oversight
- Measurable improvement to improve outcomes, patient safety, and quality of care
- Include adverse events, processes of care, services, operations
  - Infection control
  - Emergency preparedness
  - OASIS and/or other measurable data
- Select indicators to monitor based on analysis and tracking of negative patient outcomes, or agency processes
  - Each indicator must be measurable, monitor safety and effectiveness of services, identify opportunities for improvement, and include frequency of measurement and analysis

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What is Required?

CMS §484.65 QAPI :

- Conduct performance improvement projects (PIPs)
  - Number and scope of PIPs must reflect the scope, complexity, and past performance of the HHA's services and operations
  - Document the PIPs undertaken, the reasons for conducting these PIPs, and the measurable progress achieved
- At least one PIP in development, on-going, or completed each calendar year
- The HHA decides what PIPs are indicated and the priority
- PIPs must:
  - Focus on high risk, high volume, or problem-prone areas;
  - Consider incidence, prevalence, and severity of problems in those areas; and
  - Lead to an immediate correction of any identified problem that directly or potentially threaten the health and safety of patients

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Roadblocks to a Culture of Quality

QAPI failures are not caused by lack of effort—they occur when quality improvement becomes disconnected from everyday operations

- QAPI is seen as a "department"
  - One person or committee responsible
  - Frontline staff not involved
  - Improvement efforts in isolation
- Data without direction
  - Reports/dashboards overload
  - Data delayed or outdated
  - No connection between data and patient care
- Reactive firefighting
  - Always fixing yesterday's problems
  - Retroactive analysis of data/issues
  - Lack of continued education/survey readiness

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Where Do I Start?

Stop fighting fires and start preventing them – reactive vs. proactive

Firefighter - Reactive	Engrained QAPI Culture - Proactive
Responds and analyzes data after hospitalization	Identifies risks and prevents hospitalization
Corrects documentation errors in review or when ADR received	Prevents documentation breakdowns with education and monitoring
Reacts to survey deficiencies and creates plan of correction	Remains survey ready - mock surveys, ongoing regulatory compliance, and self-identified plans of correction
Conducts education and training after mistakes or adverse events	Uses data trends and risk assessments to anticipate learning needs and best-practice implementation
Investigates falls after they occur	Uses fall risk assessments and other assessment data to deploy fall reduction strategies to prevent falls

The goal should be to prevent fires; NOT to train firefighters.

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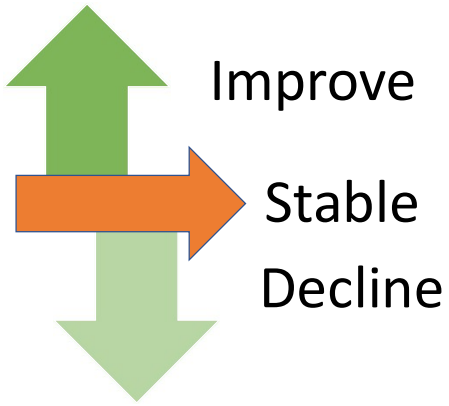

- Care Compare
  - Quality of Patient Care (QoPC) Star Rating
  - Consumer Assessment of Healthcare Providers and Systems (CAHPS)
- Home Health Value-based Purchasing (HHVBP)
- Quality Reporting
  - Outcome and process measure reports
  - Potentially avoidable event reports
- Patient-driven Groupings Model (PDGM) - Functional impairment level

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Measure	Star Rating	PDGM	HHVBP
Timely Initiation of Care (Multiple OASIS items)	Yes		
Risk for Hospitalization (M1033)		Yes	
Dyspnea (M1400)	Yes		Yes
Grooming (M1800)		Yes	
Dressing Upper Body (M1810)		Yes	Yes
Dressing Lower Body (M1820)		Yes	Yes
Bathing (M1830)	Yes	Yes	Yes
Toilet Transferring (M1840)		Yes	
Transferring (M1850)	Yes	Yes	
Ambulation (M1860)	Yes	Yes	
Oral Medications (M2020)	Yes		Yes
DC Function Score (10 GG items)			Yes
Home Health Within-Stay - Potentially Preventable Hospitalization (PPH) (claims)	Yes		Yes
Discharge to Community – Post-acute Care (DTC-PAC) (claims)			Yes
Medicare Spending Per Beneficiary (MSPB) (claims)			Yes
Overall Rating of Home Health Care (HHCAHPS)			Yes
Willingness to Recommend the Agency (HHCAHPS)			Yes

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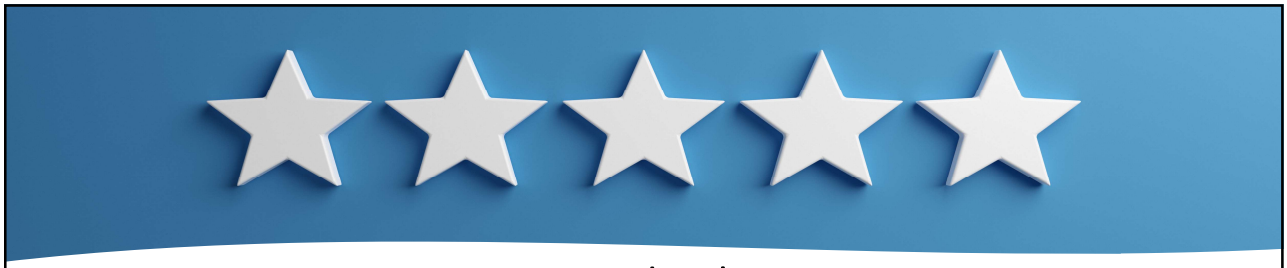

QAPI and Culture

- **Star Ratings**: Clinical outcomes + patient experience
- **HHCAHPS Survey**: Communication, care, and responsiveness
- **HHVBP**: Aligning quality with payment
- **PDGM:** Functional impairment level, progress to goals
- **QAPI Program**: The structure for improvement

Create a culture of quality to carry out the common theme; delivering safe, efficient, effective, patient-centered care that improves outcomes, enhances the patient experience, and ensures organizational sustainability.

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How To Move From Reactive to Proactive?

Stop training firefighters….start building fire prevention teams

Reactive Culture	Quality Culture - Proactive
Reviews data after performance/quality decreases	Monitors trends to identify problems before they occur
Prepares "crams" before surveys	Prepares every day – stays survey-ready
Reacts to events as they happen, "always putting out fires"	Improves processes and systems to prevent problems from happening again
Redirects based on individual failures and problems instead of looking at the big picture	Focuses on root causes and course-correcting procedures to ensure organizational excellence
Tears down teams by blaming and finger-pointing	Builds up teams with collaboration and input. Fosters a culture of success .

A Culture of Quality is achieved when every employee is involved, understands their role, has the tools to succeed, and uses data to drive continuous improvement.

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Achieving Quality Culture: A Balanced Approach

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Performance Management: The Continuous Improvement Cycle

Plan – Identify Opportunities & Set Goals

- Analyze data
- Prioritize improvement opportunities
- Establish measurable goals

Do – Implement Improvements

- Educate staff
- Deploy action plans
- Provide resources and support

Check – Monitor Performance

- Monitor Key Performance Indicators (KPIs)
- Review dashboards
- Evaluate effectiveness

Act – Sustain or Adjust

- Standardize successful practices
- Address barriers
- Launch next improvement cycle

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Performance Management

Plan: Identify Opportunities & Set Goals

- Leadership commitment and accountability
- Review data and establish baseline performance
- Identify performance gaps and root causes
- Prioritize opportunities based on impact, risk, and feasibility
- Focus on one or two high-impact improvement initiatives
- Establish measurable goals and target outcomes
- Identify champions and interdisciplinary team members
- Develop action steps, timelines, and responsibilities
- Communicate goals and expectations organization-wide

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Performance Management

Do: Execute the Improvement Plan

- Engage all staff, not just clinicians
- Communicate the purpose and "why" behind the initiative
- Focus improvement efforts on patient outcomes and experience
- Share baseline data, goals, and expectations
- Assign roles, responsibilities, and accountability
- Provide education, tools, and resources
  - OASIS and compliance education
  - Standardized workflows and processes
  - Patient education tools and resources
- Remove barriers, address resistance, and support staff success
- Monitor implementation, provide feedback, and reinforce progress

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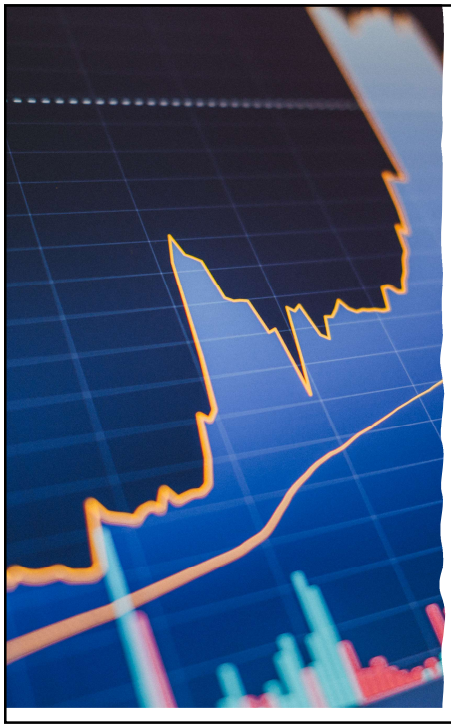

Performance Management

Check: Measure and Evaluate Performance

- Track performance using dashboards and current agency data
- Compare results to baseline performance and target goals
- Evaluate outcome, process, and patient experience measures
- Monitor compliance with new workflows and interventions
- Identify areas of success and opportunities for improvement
- Analyze trends, barriers, and unexpected results
- Share progress with leadership, staff, and QAPI committees
- Determine what should be sustained, modified, standardized, or improved

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Performance Management

Act: Sustain, Standardize, and Improve

- Determine what changes should be sustained, standardized, modified, or abandoned
- Standardize successful practices and workflows
- Integrate improvements into policies, procedures, and training
- Continue monitoring for sustained performance
- Adjust interventions based on performance data and feedback
- Address ongoing barriers and opportunities for improvement
- Recognize successes and celebrate achievements
- Establish new goals and begin the next improvement cycle

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Turning Data Into Improvement Opportunities

Compliance and Clinical Risk
- Survey Findings
- OASIS Audits
- Clinical Record Reviews
- Infection Control Data
- Adverse Events
- Medication Errors
- Incident Reports
- Emergency Preparedness

Outcome and Performance Data
- iQIES Reports
- HHVBP Reports
- Star Ratings
- OASIS Outcome Measures
- Hospitalization Data
- Emergency Department Use
- Functional Outcomes
- Discharge to Community

Performance Improvement Opportunities

Patient Experience and Satisfaction
- HHCAHPS
- Complaints
- Grievances
- Patient/family feedback
- Referral Source Feedback

Operational and Workforce Insights
- Employee Feedback
- Staff Turnover
- Vacancy Rates
- Missed Visits
- Orders Management
- Utilization Trends
- Referral Conversion Data

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From HHVBP Report to Performance Improvement Project

Measure Scorecard

Measure (Agency #1)	Your HHA's Care Points	Maximum Possible Points	Measure Weight [a]	Your HHA's Weighted Measure Points [b]
OASIS-based Measures				
Discharge Function Score (DC Function)	10.000	10.000	28.571	28.571
Improvement in Dyspnea	8.798	10.000	8.571	7.541
Improvement in Management of Oral Medications	8.682	10.000	12.857	11.163
Sum of OASIS-based Measures	**27.480**	**30.000**	**50.000**	**47.275**
Claims-based Measures				
Discharge to Community – Post Acute Care (DTC-PAC)	0.000	10.000	12.857	0.000
Potentially Preventable Hospitalizations (PPH)	0.000	10.000	37.143	0.000
Sum of Claims-based Measures	**0.000**	**20.000**	**50.000**	**0.000**

Agency #1

Potential PIP Focus:

Claims-based measures

Measure Scorecard

Measure (Agency #2)	Your HHA's Care Points	Maximum Possible Points	Measure Weight [a]	Your HHA's Weighted Measure Points [b]
OASIS-based Measures				
Discharge Function Score (DC Function)	10.000	10.000	20.000	20.000
Improvement in Dyspnea	6.068	10.000	6.000	3.641
Improvement in Management of Oral Medications	3.476	10.000	9.000	3.128
Sum of OASIS-based Measures	**19.544**	**30.000**	**35.000**	**26.769**
Claims-based Measures				
Discharge to Community – Post Acute Care (DTC-PAC)	10.000	10.000	9.000	9.000
Potentially Preventable Hospitalizations (PPH)	8.409	10.000	26.000	21.863
Sum of Claims-based Measures	**18.409**	**20.000**	**35.000**	**30.863**

Agency #2

Potential PIP Focus:

OASIS-based measures

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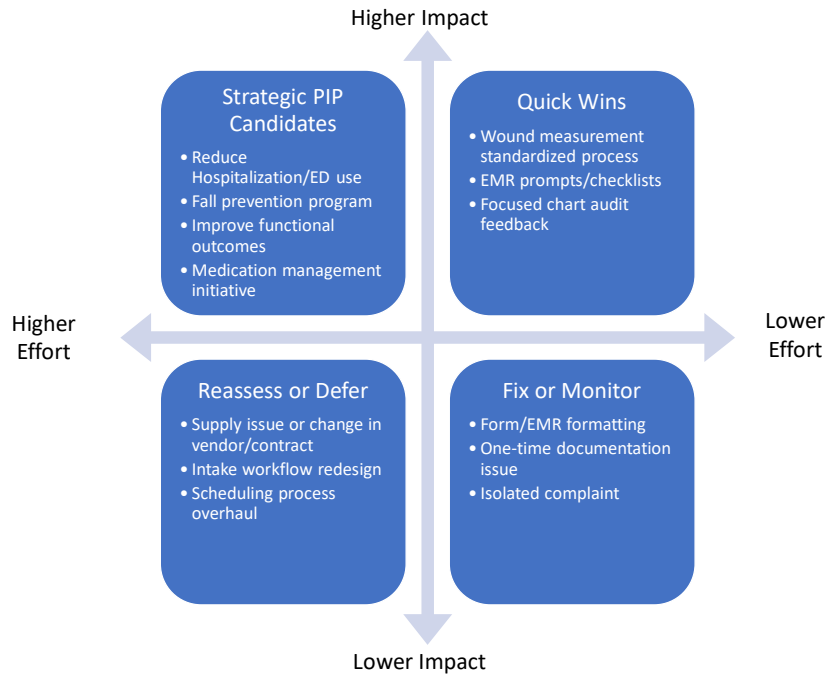
Prioritize Before You PIP

Prioritize opportunities based on impact, risk, and feasibility



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Anatomy of an Effective PIP

From Opportunity Identification to Sustainable Improvement

Identify the Opportunity	• DC Function, bathing, and upper/lower body dressing below HHVBP thresholds • Ambulation, bathing, and transferring below state and national average in Care Compare
Analyze Root Causes	• Inconsistent assessment and OASIS scoring • Lack of patient-specific interventions and goals • Limited interdisciplinary focus on functional improvement
Set a Goal	• Increase functional outcome performance by 8% within 6 months
Implement Interventions	• Improve assessment and OASIS accuracy • Outcome-focused care planning • Functional outcomes case conference • Strengthen interdisciplinary collaboration
Monitor Results	• Monthly outcome reviews • Targeted chart audits
Sustain Improvements	• Embed best practices into onboarding and education

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What Success Looks Like

Month 1

Staff educated

New processes implemented

Baseline expectations communicated

Month 2

Documentation consistency improves

Care planning more outcome-focused

Collaboration more intentional

Month 3

Outcome measures begin improving

Clinical practices align with quality goals

Month 4

Audit results demonstrate improved consistency

Case conferences focused on outcomes

Month 5

Falls and hospitalizations may begin decreasing

Patient experience may improve

Month 6

Goals achieved

Practices standardized

Improvements sustained

Sustainable improvement occurs when quality becomes part of daily practice, not a quarterly report.

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What Success Looks Like

Measure	Baseline	Goal – 8% Improved	Month 1	Month 2	Month 3
DC Function	58%	66%	59%	61%	60%
Bathing	84%	94%	85%	83%	85%
Upper Body Dressing	81%	91%	84%	82%	85%
Lower Body Dressing	83%	93%	82%	83%	84%
Ambulation	84%	94%	85%	86%	87%
Transferring	85%	95%	86%	84%	86%

Key Takeaway:
- Early results may fluctuate
- Look for trends, not perfection
- Use data to adjust interventions
- Continue the improvement cycle

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Performance Improvement Project Example

- **High incidence of falls with injury**
  - Set goal – reduce number of falls with injury by 20% by end of Q1 2027
  - Develop fall prevention program and educate staff by 9/15/26
  - Implement fall prevention program week of 9/18/26
  - Monitor for falls with injury weekly by branch and team. Root cause analysis for each fall with recommendations.
  - Analyze data and report results to team first week of each month beginning October 2026 to monitor progress
  - Act on results:
    - Progress to goal - continue with adjustments as needed
    - No progress or increase in falls- make adjustments to the plan and educate – set new goals as needed
  - Repeat process until goal is reached, making adjustments as needed
  - Document all actions and results
  - Continue to monitor quarterly and report to QAPI Committee

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How is Quality Impacted?

Therapy, HEP, HHA, DME	• Improved function and independence in ADLs/IADLs (M1800, GG0130, GG0170) – HHVBP, Care Compare, PDGM, Star Rating
Medications	• Medication improvement, reconciliation – HHVBP, Care Compare, Star Rating, HHCAHPS
Pain, Home safety	• Pain management, setting up your home for safety - HHCAHPS
Patient/caregiver involvement	• Keep up to date, discharge planning, coordination of care – HHVBP, HHCAHPS
Chronic Disease management, Prevention of falls	• Reduce hospitalizations/OBS and ED visits, Improved quality of life, less dyspnea – HHVBP, Care Compare, Star Rating

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Quality Isn't a Checkbox. It's a Strategy.

Quality Data
↓
QAPI Structure
↓
Performance Management
↓
PIPs
↓
Better Outcomes
↓
Better Patient Experience
↓
Stronger Financial Performance

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Resources

- CMS expanded HHVBP model: Expanded Home Health Value-Based Purchasing Model | CMS
- Provider Data catalog: Home health services data archive | Provider Data Catalog
- 2026 Home Health Final Rule: https://www.federalregister.gov/documents/2025/12/02/2025-21767/medicare-and-medicaid-programs-calendar-year-2026-home-health-prospective-payment-system-hh-pps-rate
- Home Health Quality Reporting Program: Home Health Quality Reporting Program | CMS
- OASIS Manual/Q&As: home-health-agency-hha-providers Reference & Manuals | QIES Technical Support Office

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Questions?

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