2A. Building a Successful Home Heath
QAPI Program

Presented by:

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Healthcare Provider Solutions
Objectives

- Understand the Home Health QAPI Condition of Participation (CoP)
- Identify the steps involved in an agency self-assessment
- Describe the key components of a QAPI program
- Explain the benefits of having an effective QAPI plan
- Describe elements of a good tracking & trending report
- Identify the critical components of a performance improvement project (PIP)
Benefits of an Effective QAPI Program

- Minimize Risks
- Improves patient outcomes
- Improves home health agency performance
- Prevents future problems!
- Increase your agency’s quality and efficiency
- A Quality Program is a key component of a well-ran organization!

Building a Successful QAPI Program

Ensure that program is designed to help you!
- Choose activities to monitor based on your deficiencies and action plan
- Focus on the Program activities to ensure that you have no vulnerabilities
- Focus on high risk, high volume, and problem prone areas
  - Consider incidence, prevalence and severity
- Have an immediate correction of any identified problem(s) that directly OR potentially threaten the health and safety of patients
- Involve all agency staff
Quality Assessment & Performance Improvement

QAPI: What Does it Mean?

✓ A data-driven, proactive approach to ensuring high quality of care.
✓ Involves all levels of the organization;
✓ Identifies opportunities for improvement;
✓ Addresses gaps in systems or processes;
✓ Develops and implements improvement plans;
✓ Continuously monitors effectiveness of interventions

§484.65 Condition of participation: Quality Assessment & Performance Improvement

All Medicare Certified Home Health Agencies Must:

Develop ➔ Implement ➔ Evaluate ➔ Maintain an Effective, Ongoing, HHA-wide, Data-Driven program for Quality Improvement.

- **Ongoing** means that there is a continuous & periodic collection and assessment of data. Assessment of such data enables areas of potential problems to be identified and indicates additional data that should be collected & assessed in order to identify whether a problem exists.
- The HHA Governing Body Must ensure that the program reflects the complexity of its organization covering all services provided, including contracted staff with focus on improving outcomes.
Quality Assessment & Performance Improvement

The QAPI Condition of Participation:

- Involves all HHA services including contracted services
- Focuses on indicators related to improved outcomes, including the use of emergent care services, hospital admissions, and re-admissions
- Takes actions that address the HHA’s performance across the spectrum of care, including the prevention of medical errors
- Maintains documentary evidence of its QAPI program and be able to demonstrate its operation to CMS.

Quality Assessment & Performance Improvement

The Home Health QAPI program should demonstrate, using objective data, that improvements have taken place in:

- Actual Care Outcomes
- Patient Safety & Processes of Care
- Patient and Family Satisfaction Levels
- Home Health Operations or
- Other Performance Indicators Identified

Surveyors will review the impact of the program by looking at data gathered and compared at different points in time, and actions taken based on that comparison.
Key Points to Remember

▪ Develop a QAPI Plan that reflects the complexity of your organization and all services provided that includes the data that will be collected & the frequency in which the data will be collected.

▪ The Focus on indicators (reviews) needs to be related to improved outcomes and Must include the use of emergency care services and re-hospitalizations.

▪ The program must show the HHAs actions taken to address the agency’s performance that includes the prevention and reduction of medical errors.

▪ Determine who will review the data and how often the data will be reviewed. Some areas will warrant continuous evaluation while others may warrant only once a quarter or annual evaluation.

Key Points to Remember

▪ The Governing Body is responsible for the oversight of the QAPI program and should approve the QAPI plan that includes the data to be collected and the frequency of the data collection.

▪ You must keep documentary evidence of the program and be able to demonstrate and measure its operations to CMS including the involvement and updates to the Governing Body.

▪ Educate ALL Staff on the QAPI Plan and include that the focus of QAPI is to identify gaps in systems & processes to identify potential problem prone areas to improve patient outcomes.
Quality Assessment & Performance Improvement

5 Standards

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

QAPI CONDITION...KNOW THE RULES!

QAPI - allows agencies to be flexible in development of their programs

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 rehospitalizations
- 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
§484.65(a) Standard: 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, services, and operations.

- The HHA selects the indicators based upon identified adverse or negative patient outcomes or agency processes that the HHA wishes to monitor.

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**Key Points to Remember**

- The HHA selects the indicators based upon identified adverse or negative patient outcomes or agency processes that the HHA wishes to monitor.
- Each indicator must be **measurable** through data in order to evaluate any HHA change in procedure, policy or intervention.
- The HHA must maintain a coordinated agency-wide infection control program for the surveillance, identification, prevention, control and investigation of **infectious and communicable diseases**.
- The program must include procedures for measurement and analysis of indicators and address the frequency with which such measurement and analysis will occur.
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 do the following:
- Monitor the effectiveness and safety of services and quality of care
- Identify opportunities and priorities for improvement

The frequency and detail of the data collection must be approved by the HHA’s governing body.

You must be able to show the governing body’s approval of the QAPI program and their ongoing involvement and updates with the program.
Program Activities

\textbf{§484.65 (c)(1)} The HHA QAPI Performance Improvement Activities Must:

- Focus on Areas of
  - High Risk
  - High Volume
  - Problem Prone

- Consider incidence, prevalence and severity of problems in those areas; And

- Lead to an immediate correction of any identified problem that directly or potentially threatens the health and safety of patients. (immediate jeopardy)
Program Activities

- §484.65 (c)(2) Performance Improvement Activities must track Adverse patient events, analyze their causes, and implement preventive actions. “Adverse patient events” are those patient events that are negative and unexpected, impact the patient’s home health plan of care, and have the potential to cause a decline in a patient’s condition or serious injury and/or death.

- §484.65 (c)(3) 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(d)(1) 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.

Performance Improvement Project (PIP)

§484.65(d)(2) The HHA must document the quality improvement projects undertaken, the reasons for conducting these projects, and the measurable progress achieved on these projects.

- A minimum of one PIP either in development, on-going or completed each calendar year.
  - Based on the QAPI program activities and data determine what projects are indicated and the priority of the projects.

- Utilize data collection and analysis to select focus areas:
  - Previous problematic performance issues
  - Clear evidence of poor patient outcomes
  - High-risk and High-volume
Executive Responsibilities

Executive Responsibilities for the Home Health QAPI Program

The HHA’s Governing Body must assume responsibility for the QAPI program and ensure:

- An ongoing program for quality improvement and patient safety is defined, implemented, and maintained.

- 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.

- Clear expectations for patient safety are established, implemented, and maintained; and

- Any findings of fraud or waste are appropriately addressed.

Where do you start to build your QAPI program?
Clinical Record Reviews

- The purpose of clinical record reviews is to audit documentation that was non-compliant to physician orders, medications, aide care plan, patient rights, etc.
- Complete clinical record reviews on a routine frequency such as monthly or quarterly.
- Ensure the audit tool is appropriate to capture all regulations.
- Ensure auditor understands what to look for in a clinical record review based on regulatory requirements.
- Include and train staff to help with clinical record reviews.
Clinical Record Reviews

Look for commonly seen deficiencies, such as:

- **Plan of Care**
  - ✓ Not updated when problems or changes occur
  - ✓ Goals/interventions not specific or measurable with timeframes for achievement

- **HHA Care Plan**
  - ✓ Not following aide care plans, and untimely supervisory visits
  - ✓ Untimely supervisory visits which are required every 14 days

- **Incomplete comprehensive drug assessment review**
  - ✓ Missing over the counter or herbal medications

- **Physician orders:**
  - ✓ Visit frequencies, interventions, medications, treatments

<table>
<thead>
<tr>
<th>Criteria</th>
<th>Mickey Mouse</th>
<th>Spider Man</th>
<th>Batman</th>
<th>Total YES</th>
<th>Total No</th>
<th>Total NA</th>
<th>Total Charts</th>
<th>Compliance by Indicator %</th>
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<tbody>
<tr>
<td>Signed Consent Forms including documentation of patient rights requirements</td>
<td>N</td>
<td>Y</td>
<td>Y</td>
<td>No</td>
<td>2</td>
<td>1</td>
<td>0</td>
<td>3</td>
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<tr>
<td>Review of current 485 indicates accurate &amp; complete plan of care (based on diagnosis, medications, risk for ED visits, risk for hospitalization, etc.)</td>
<td>N</td>
<td>N</td>
<td>N</td>
<td>No</td>
<td>0</td>
<td>3</td>
<td>0</td>
<td>3</td>
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<td>Emergency Preparedness</td>
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<td>Y</td>
<td>Y</td>
<td>yes</td>
<td>3</td>
<td>0</td>
<td>0</td>
<td>3</td>
</tr>
<tr>
<td>Review of most recent OASIS comprehensive assessment correlates with plan of care/485.</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
<td>yes</td>
<td>3</td>
<td>0</td>
<td>3</td>
<td>3</td>
</tr>
<tr>
<td>Documentation supports patient's primary caregiver(s) / appointed representative, as applicable</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
<td>yes</td>
<td>3</td>
<td>0</td>
<td>3</td>
<td>3</td>
</tr>
</tbody>
</table>

**Total Criteria Points**: 5 5 5

**YES's/Blanks**: 3 4 4

**No's**: 2 1 1

**NA's**: 0 0 0

**Total Chart Points**: 5 5 5

**Chart Compliance %**: 60% 80% 80% Average 73%
iQIES Reports

- Establish a process to review reports monthly
- Analyze data focusing on the statistically significant areas (**)
- Develop an action plan for variances
- Develop Quality indicators and audit tools for objective monitoring
- Identify what complex areas and choose at PIP
- Share with all staff! That is quickest, simplest way to get improvement!
- Plan the episode of care for the patient in order to focus on improving outcomes as a team!

This information primarily comes from what your clinicians document in OASIS!!!
iQIES Reports

**Process Measures**
- Timely Initiation of Care-Star Rating
- Flu vaccine, drug regimen reviews

**Potentially Avoidable Events**
- UTI, Emergent Care, Pressure Ulcers

**Agency Patient Related Characteristics**
- Information used for daily management and educational opportunities for the home health agency.

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**Home Health Quality Measures**

**3 Categories of HHQRP**

1. **Outcome measures**
   - Data is collected from the OASIS and Medicare Claims
2. **Process measures**
   - Data is collected from the OASIS
3. **Patient reported outcome measures**
   - Data is collected from the HHCAHPS 34-question survey.
Outcome Measures

**Outcome measures** assess the results of health care that are experienced by patients.

- Data collected from the OASIS and Medicare Claims
- Improvement measures (patient’s ability to get around, perform ADLS and general health)
- Potentially Avoidable Events (potential problems in care)
- Utilization of care measures (how often patients access other health care resources during their home health episodes or after discharge)
- Cost/Resource Measures

Process Measures

**Process measures** evaluate the rate of home health agency use of specific evidence-based processes of care. The HH process measures focus on high-risk, high-volume, problem-prone areas.

- Derived from data collected in the OASIS submitted by home health agencies.
- Not Risk-Adjusted
- Measures include
  - Timely initiation of care
  - Percent of patients with an admission and discharge functional assessment and a care plan that addresses function.
  - Flu immunizations
  - Drug regimen review
Patient Reported Outcome Measures

- The HHCAHPS measures are derived from a 34-question survey.
- Collects feedback from current or recently discharged home health patients about their experiences with a home health agency.
- Determines the home health agencies Patient Survey Star Rating on Care Compare.
  - Care of Patients
  - Communication between providers and patients
  - Specific care issues
  - Overall rating of care provided by the home health agency

Care Compare Reports

- Quality Rating
  - Managing daily activities-Ambulation, transfers and bathing-All star rating
- Treating symptoms
  - Improved dyspnea-star rating
  - Percentage of patients with new or worsened pressure ulcers/injuries
- Preventing Harm
  - Timely initiation of care*
  - Medication education*/improvement in patient’s condition *
  - Medication reconciliation to prevent adverse drug events and Flu vaccine
- Preventing unplanned hospital care
- Payment and value of care
- Patient Survey Star Rating
Choosing Indicators

When choosing indicators to develop from iQIES reports consider:

- 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.
- Identify if there is an OASIS knowledge deficit, or if an actual care issue.
- Continue OASIS Education on specific M, GG, J items identified in knowledge deficit.
- Educate task force on clinical record reviews to read assessments associated with M, GG, J items to improve.

Self-Assessment/Mock Survey

- Another valuable tool to help select areas to monitor in your QAPI program.
- Best way to ensure that you are in a state of continued survey readiness.
- Must assign qualified employees (often managers or QAPI 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.
- Engage your staff to participate in a mock survey to create a sense of ownership and value to your agency’s quality program.
Self-Assessment/Mock Survey

Reports to review:

Previous regulatory survey reports & the agency’s approved plan of correction
- Are previous deficiencies included as a QAPI indicator?
- Important to avoid repeat deficiencies.
  - A standard level deficiency, if repeated, is vulnerable to escalating to a condition level deficiency.
- Ongoing monitoring in the QAPI program can help your agency to avoid repeat deficiencies and Conditions!

Self-Assessment/Mock Survey

Additional reports and programs to review:
- Complaints, incidents including falls, and infection surveillance
  - Ensure that there is resolution documented for all complaints.
  - Trend reports to see red flags early. Trends may become QAPI indicators.
    ✓ Ex: increasing falls for patients without therapy services, complaints regarding staff competency, and increasing numbers of UTI’s
- In-service, Orientation and Competency programs, Human Resource files
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

- Low patient outcomes and poor customer satisfaction
- High therapy visits per episode, low outcomes
- Low medication outcomes, HHCAHPS indicate patients are reporting they did not receive an explanation of their medication
- Low visits, High Re-Admissions
- Low ADL outcomes, Low aide and OT utilization

### Data Analysis/Run Charts

A Run or Trend Chart are graphic displays of data points over time. Trends generally indicate a statistically important event that needs further analysis.

<table>
<thead>
<tr>
<th>Date</th>
<th>Compliance</th>
<th>Goal</th>
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<tbody>
<tr>
<td>Jan-21</td>
<td>85%</td>
<td>90%</td>
</tr>
<tr>
<td>Feb-21</td>
<td>89%</td>
<td>90%</td>
</tr>
<tr>
<td>Mar-21</td>
<td>91%</td>
<td>90%</td>
</tr>
<tr>
<td>Apr-21</td>
<td>92%</td>
<td>90%</td>
</tr>
<tr>
<td>May-21</td>
<td>90%</td>
<td>90%</td>
</tr>
<tr>
<td>Jun-21</td>
<td>84%</td>
<td>90%</td>
</tr>
<tr>
<td>Jul-21</td>
<td>82%</td>
<td>90%</td>
</tr>
<tr>
<td>Aug-21</td>
<td>79%</td>
<td>90%</td>
</tr>
<tr>
<td>Sep-21</td>
<td>84%</td>
<td>90%</td>
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<tr>
<td>Oct-21</td>
<td>89%</td>
<td>90%</td>
</tr>
<tr>
<td>Nov-21</td>
<td>92%</td>
<td>90%</td>
</tr>
<tr>
<td>Dec-21</td>
<td>94%</td>
<td>90%</td>
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</table>
Clinical Record Reviews

Compliance —— Goal


Trend

Further Analysis

✓ What are your top 4-5 lowest scoring indicators?
✓ Drill down to root causes to determine possible reasons for variances.
✓ Do you need to do additional focus reviews?
✓ Does a PIP need to be implemented? Yes, if it is a widespread issue.
✓ Is there a need for additional staff education?

Compliance Rate

<table>
<thead>
<tr>
<th>Compliance Indicator</th>
<th>Rate</th>
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<tbody>
<tr>
<td>Transfer summary faxed within 2 days</td>
<td>79%</td>
</tr>
<tr>
<td>Therapy evaluations occur within 5 days of SOC</td>
<td>85%</td>
</tr>
<tr>
<td>SN interventions follow physician orders</td>
<td>70%</td>
</tr>
<tr>
<td>HHA supervisory visits occur at least every 30 days</td>
<td>50%</td>
</tr>
<tr>
<td>Aide Care Plan was complete with specific instructions</td>
<td>10%</td>
</tr>
</tbody>
</table>
Analyze Data Using Graphs

Bar Graphs are used to summarize groups of data.

- What are your top 1-2 highest number of infections?
- Drill down to root causes to determine possible reasons for variances.
- Do you need to do additional focus reviews?
- Does a PIP need to be implemented? Yes, if it is a widespread issue.
- Is there a need for additional staff education?

Methodology

**PLAN**
- What changes need to be made to the next cycle?
- If no changes, roll out the improvement

**DO**
- Set improvement goals
- Predict what will happen
- Plan the cycle (who, where, what, and how)
- Decide what data to gather

**STUDY**
- Fully analyze data
- Compare data to predictions
- Examine learning

**ACT**
- Carry out the plan
- Document any problems encountered and observations
- Gather data
PDSA Methodology

**PLAN** – Write the Plan - Determine **what** data you are going to analyze, **how** you are going to analyze it, **who** is going to collect and review the data and **when or how** often the data will be analyzed.

**DO** – Implement the Plan – Test and gather data: **Implement** the plan, **educate** the entire home health team on the PIP and any new processes or procedures you are implementing. **Document** the data and begin analyzing.

**STUDY** – **Analyze** the data collected - Did you meet target/benchmark or goal? If not are your actions effective? Compared to anticipated result, are you moving in the right direction?

**ACT** – **Respond** to the results - Does the plan or interventions need to be altered? Will new processes/procedures be implemented? Will the project continue?

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**Action Plans**

Ensure that your Action Plans are specific with findings

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 Changes
- Policy Changes
- 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.
The QAPI regulation requires a written plan that will guide your organization’s performance improvement efforts.

The QAPI plan is a framework for an effective, comprehensive, data driven program that focuses on the indicators that reflect outcomes and quality of life.

The QAPI plan is intended to be a living document that your organization will continue to review and revise.
Home Health QAPI Plan

The following elements should be considered within the QAPI plan however it is structured:

- Program Objectives
- All patient care disciplines
- Description of how the program will be administered and coordinated
- Methodology for monitoring and evaluating the quality of care
- Priorities for resolution of problems
- Monitoring to determine the effectiveness of actions for improvement
- Oversight responsibility reports to the Governing Body
- Documentation to support the HHAs review of its own QAPI program

Development of the QAPI Plan

Remember as you develop your QAPI plan:

- Prioritize topics that you found from the iQIES Quality Measure Reports, Self-Assessment/Mock Survey Deficiencies, Clinical Record Reviews, Infection Control Reports, Adverse Event Reports, etc.

- Separate into items that can be addressed and resolved immediately and those that require more time for review and auditing.

- Focus on high volume, high risk, problem prone areas.
Development of the QAPI Plan

Audit tools must be developed for each indicator
- There are many variations to audit tools and tracking forms
- Make certain that the criteria area objective in order to ensure accurate results.
- Measure compliance for each criteria/indicator
- Drill down to identify and determine if issues are related to
  ✓ Documentation
  ✓ Knowledge deficit of policies, processes and regulatory requirements
  ✓ Care issue

Home Health QAPI Plan

- **Step 1** – Identify indicators to improve: Clinical Record Reviews
- **Step 2** – Document the what you are trying to improve: Compliance to the CoPs
- **Step 3** – Document who is responsible for the audit: QAPI coordinator or DON
- **Step 4** – Document the process for data collection: Review 10% of patient records
- **Step 5** – Document the frequency of the data collection: Quarterly
- **Step 6** – Set goal: 90% to audit criteria
1. Clinical Record Reviews (CRR)

The QAPI Coordinator or designee will review 10% of patient records per quarter to ensure compliance to CoPs and State regulations.

**Goal:**
- 90% to audit criteria.

9. Medication Errors/Adverse Drug Reactions

QAPI Coordinator or designee will review 20% of discharge clinical records per quarter to review medication management for the following:

**Goals:**
- Less than 2% of unduplicated patients will have Medication error
- Less than 2% of unduplicated patients will have Adverse Drug reactions.

**Determining Performance Improvement Project(s) (PIPs)**

Number and scope is determined by the Home Health agency annually based on
- Scope
- Complexity
- Past Performance

HHA Must Document
- Quality projects undertaken
- Reason for conducting the projects
- Measurable progress achieved
Performance Improvement Project (PIP)

Step #1: Identify Indicators to Improve

- **Review Data**: List all indicators currently being collected through routine monitoring & current projects
- **Determine Priorities**
  - ✓ What is the greatest concern to patient care and/or safety?
  - ✓ Which indicators will help to improve care with measurable outcomes?
  - ✓ What changes can be made that will result in improvement?
- **Organizational Strategic Plans and Goals**
  - ✓ Are the performance improvement projects in line with the organization’s strategic plan and goals?
  - ✓ What is the process for demonstrating the leadership (including the governing body authority) reviews and approves the performance improvement priorities?

Performance Improvement Project (PIP)

Step #2: Selecting a Performance Improvement Project (PIP)

- Does the data warrant the development of a PIP or does continue monitoring need to occur first to collect more data?
- Do you need to provide staff education and monitor future data before implementing a new PIP?

**Consider when selecting a PIP**

- ✓ What is the importance of the problem?
- ✓ Is it a high risk, high volume or problem prone process?
- ✓ Is the impact critical to patient care or safety such as medication management, Implementation of EMR, reducing unplanned hospitalizations/emergent care?
- ✓ Is there an internal support for responding to the problem?
- ✓ Is the deficiency widespread, with multiple services affected that may include both office and field staff?
Performance Improvement Project (PIP)

Step #3 - Implement a Performance Improvement Project (PIP)

- Choose indicators and develop audit tool
- Document the reason for the PIP and what your ending goal will be.
- Document the education and processes you will implement to meet the desired goal.
- The PIP must be measurable through data collected so you can show measurable progress.

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Performance Improvement Project (PIP)

PIP Example

Specifics Findings

- In 5 of 8 patient records, the physician was not notified for changes in patient status and/or areas outside of the physician parameters.
  - For each chart state specifically, what date & what physician notifications were omitted

Examples:

- **MR#0789** - 02/03/20 Physical Therapy visit note - physician was not notified of patient pain level of 8 when the physician parameters for pain notification were 7 or greater.
- **MR#0345** - 02/05/20 Skilled Nursing visit note - physician was not notified of increased drainage and redness noted with the left heel pressure ulcer.
Performance Improvement Project (PIP)

PIP Example continued...

PIP is warranted - Develop a Quality Indicator for QAPI monitoring and a written plan for improved outcomes.

- **Improvement in Physician Notification** - On a quarterly basis, the QAPI coordinator or designee will review 50% of patient records to identify if the physician was notified for changes in patient status and/or areas outside of physician parameters, including but not limited to high blood pressure, edema, pain, wound changes, falls, and vital signs, with a goal of 95% compliance;
  - ✓ If, after 3 months the Goal is achieved, then the review will decrease to 20% of patient records to be review every quarter with a goal of 95% compliance
  - ✓ Have the audit tool designed for this specific deficiency – Physician Notification

Performance Improvement Project (PIP)

**PIP Example: Improve Physician Notification**

- **Education** – The Clinical Director will educate **ALL** clinical staff regarding appropriate physician notification for changes in the patient status and/or areas outside of physician parameters.
- **Education** – The Clinical Director will educate **ALL** clinical staff regarding new or updated processes implemented to improve physician notification.
- Collect data and monitor for effectiveness of interventions
- Analyze data to determine if interventions need to be updated or changed
Sample Worksheet – MD Notification

Indicator: Improvement in Physician Notification

Improvement in Physician Notification: On a quarterly basis, The DPS or designee will review 20% patient records to identify if the physician was notified for changes in patient status and/or areas outside of physician parameters, including but not limited to high blood pressure, edema, pain, wound changes, falls, and Pulse Ox.

Goal: ≥90% to audit criteria.
- 90% to audit criteria.

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<tr>
<th>CRITERIA</th>
<th>Patient</th>
<th>Patient</th>
<th>Patient</th>
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</thead>
<tbody>
<tr>
<td>Physician notified for:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>BP outside of parameters</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Worsening edema</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pain - severe and/or unacceptable to patient after ordered interventions</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Wound changes - ex more drainage, pain</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Falls</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pulse Ox outside of parameters</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Any other patient status changes (list specific reasons below)</td>
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</table>

3. PIP-Intravenous Therapy

The DPS or designee will review a percentage of patient records monthly to ensure that agency follows standards, policies, procedures, and regulations and to the audit tool. Documentation within the plan of care and nursing visits will be reviewed for care related to IV therapy which includes but not limited to physician’s orders, dressing changes, medication profile management, patient education and care coordination. Action items to include are:

- Staff education regarding the IV therapy policy with required documentation to support the skilled intervention followed the plan of care orders.
- Clinical Manager or designee to perform audits monthly on 20% of charts starting January 1st until 90% of compliance is achieved to the audit tool. After 3 consecutive months of 90% compliance is achieved, audit will be converted to monthly audits of 10% of charts with goal of 90% compliance to the audit tool.
- Clinical Manager or designee will monitor the infection control report to identify trends with infections related to infusion therapy.
- Action plans will be implemented to include education, competency, process development or revision, policy, and procedure revisions.
- This project will continue for at least one year beginning in January 2022.

Goal:

- 90% compliance to the audit tool.
Is it time for your survey? Are you ready?

Survey Readiness

Clear Documentation to Support:

- The HHA Governing Body’s oversight of the QAPI program.
- The QAPI Program is Data Driven.
- Must be able to show that you are utilizing the data collected to identify opportunities for improvement.
- Documentation supports the data collected is at the frequency according to the QAPI plan.
- Review of the QAPI meeting minutes to determine if the HHA documented appropriate action and its outcomes for any issues or problems identified from the data analysis.
- QAPI meeting minutes should reflect measurable data for monitoring effectiveness of interventions implemented.
- Evidence for continued monitoring to ensure improvements achieved are sustained.
Survey Readiness

Be prepared to answer the questions:

- How the HHA uses the data analysis to select performance improvement projects?
- How are performance improvement projects implemented?
- How does the HHA use the data to evaluate the effectiveness of each PIP?
- What are your agency’s current PIPs?
- What is your role in your agency’s QAPI?

Evidence that the QAPI program has been implemented & is functioning effectively with:

- Regular meetings
- Investigation/analysis of sentinel and adverse events
- Recommendations for systemic changes to prevent recurrence of sentinel or adverse events
- Identified performance measures that are tracked and analyzed
- Regular review and use of the QAPI analyses by HHA and the governing body to make sure systemic improvements.
Home Health QAPI Checklist:

- Ensure the iQIES outcome reports are reviewed
- Perform an agency self-assessment (mock survey)
- Create an Action plan from reports/survey findings
- Develop a QAPI Plan
- Develop QAPI indicators and/or PIPs with audit tools
- Collect the data
- Review, Analyze and Trend the Data Collected
- Revise Action Plans for improvement when indicated
- Involve all your agency staff for improved performance!

QAPI Never Stops!

Indicators may be able to be discontinued once you find sustainment and complete improvement. . .but the evaluation must continue!
Successful QAPI Program

- A successful QAPI program takes dedication and teamwork!
- A successful QAPI program is led by a dedicated QAPI team and organizational leadership.
- Staff participation in clinical record reviews and mock surveys.
- Improved patient outcomes, patient/family satisfaction scores
- Improved patient safety and processes of care
- Consistent survey readiness

Don’t forget to celebrate all victories big and small!

Small Steps are the Keys to Success!
References


National Association for Home Care and Hospice (NAHC): https://www.nahc.org/

National Hospice and Palliative Care Organization (NHPCO): https://www.nhpco.org/
Thank You For Participating!

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