CHAPTER 9: TARGET QAPI

Another frequent issue cited from surveyors: QAPI. CMS expects agencies to carry out an ongoing quality assessment — "incorporating data-driven goals, and an evidence-based performance improvement program of its own design to affect continuing improvement in the quality of care furnished to its patients."

CMS does not intend to require agencies to incorporate any specific clinical practice guidelines. It is the expectation that every agency would identify its specific performance problems and address them. For example, an agency may choose to adopt current guidelines found in the ANA Scope and Standards of Practice for Home Health Nurses.

QAPI requires every agency to implement an ongoing quality assessment that would incorporate data-driven goals and evidence-based performance improvement that would be uniquely designed by the individual agency.

CMS expects that non-accredited agencies will have extra expenses related to identifying quality measures to improve, training the board and training clinicians on the QAPI program, and gathering and aggregating related data.

This condition is organized into five standards: Program scope, program data, program activities, performance improvement projects and executive responsibilities.

How to track QAPI data

Be sure to track OASIS data, quality indicators and adverse events to assess processes, services and operations. That includes monitoring high-priority safety and health conditions including high risk, high volume or problem-prone areas. Conduct performance improvement projects at least annually.

Data collection and review must include:

- Indicators showing improvement
- Documented measurable improvement
- Establishment of the patient's ability to sustain the individual goals

The board of directors is responsible for the overall success of the QAPI program and for approving its frequency as well as the level of detail used in data collection. At §484.65(e), CMS proposes "executive responsibilities." According to current information, this will be part of the survey process and agencies will need clear documentation on just how they have achieved compliance.

The agency can rely on outside resources for assistance and also may contract with physicians for completion of this task.

The QAPI program is expected to focus on high-risk, high-volume problem areas and consider incidence, prevalence and severity of problems in those areas.

After looking at which patients are high-risk and which diagnoses occur frequently, QAPI staff will need to start with a baseline to measure improvements and a one-year goal for improvement. For example, if your agency's baseline re-hospitalization rate is above the national rate, make it a goal to match the national rate within a year.

Don't forget to meet regularly with clinical staff. At this meeting, review QAPI data and let people know what's working well. This will help employees feel more connected to the QAPI project.

Address this frequent survey target

Quality assessment and performance improvement was one of the most common

condition-level deficiency reported by CMS in FY2021, the most recent data available.

Here are some of the things the CoPs say:

- Analyze and track quality indicators such as OASIS data and adverse events.
- Closely monitor high-priority safety and health conditions the agency identifies.

  Your governing body is responsible for approving the frequency of and level of detail to be used in data collection.
- Conduct performance improvement projects (PIPs) at least annually. They should include the scope, complexity and past performance of the agency's services that have proven problematic. Document the reasons for undertaking the projects and measurable progress achieved. Agencies should have "at least" one PIP either in development, ongoing or completed each calendar year, according to the final interpretive guidelines [§484.65(d); G658]. The agency would decide "based on the QAPI program activities and data" what projects are necessary and should be prioritized.
- Task your governing body with responsibility for the QAPI program and for the agency's overall patient safety.

QAPI CoPs are organized into five standards

1. **Program scope.** Agencies need a data-driven QAPI program capable of showing measurable improvement in outcomes such as reduced hospitalizations and admissions, safety and quality of care for patients. Agencies are required to measure, analyze and track quality indicators, including adverse patient events, as well as other indicators of performance so that processes, services and operations can be adequately assessed [§484.65(a); G642].
2. **Program data.** The QAPI program will utilize quality indicator data, including measures derived from the OASIS and other relevant data, to assess the quality of care provided and identify and prioritize opportunities for improvement. The governing body will be responsible for approving the frequency of and the level of detail to be considered in the data collection [§484.65(b); G644].

3. **Program activities.** The agency's QAPI activities will focus on high-risk, high-volume or problem-prone areas of service, and consider the incidence, prevalence and severity of problems in those areas [§484.65(c); G646].
4. **PIPs.** The agency's PIPs, conducted at least annually, should reflect the scope, complexity and past performance of the agency's services and operations. High-risk and high-volume areas are unique to each agency. Agencies must document the QAPI projects, the reasons for selecting the projects and the measurable outcomes achieved [§484.65(d); G658].
5. **Executive responsibilities.** The governing body is responsible for the QAPI program. CMS believes the QAPI program provides agencies with enough flexibility to implement a QAPI program without a sizable expense of capital or of human resources. The CoP relies on a problem-oriented approach; this will be a more proactive monitoring system through an ongoing agency-wide, data-driven program under the agency's governing board [§484.65(e); G660].

QAPI programs must be ongoing, driven by data

Agencies "must measure, analyze and track quality indicators, including adverse patient events, and other aspects of performance" that enable them to assess processes of care, services and operations, CMS says.

Agencies would select these indicators "based upon identified adverse or negative patient outcomes or agency processes" the agency wants to measure and monitor, according to the final interpretive guidelines [§484.65(a)(2); G642]. The indicators must be measurable through data so changes in procedure, policy or intervention can be evaluated.

The guidelines also state that all skilled professional staff members from an agency "must provide input into and participate in" the implementation of the QAPI program in order for the program to be effective [§484.75(b)(8); G720]. Every skilled professional — regardless of whether the person is a direct employee or contractor from the agency — is expected to contribute to all phases of the QAPI program.

Contributions of skilled staff might include identifying problem areas, offering recommendations to address problem areas, collecting data, attending periodic QAPI meetings or participating in PIPs.

What do agencies need to track?

The quality improvement person at your agency should track outcomes measured by:

- OASIS assessments;
- patient characteristics reports within the Certification And Survey Provider Enhanced Reports (CASPER);
- PEPPER reports;
- star ratings;
- survey results;
- discharge summaries; and
- potentially avoidable events.

Quality staff will need to drill down into the data to see if a particular clinician, referral source or a diagnosis or combination of diagnoses is causing a problem leading to increased readmissions. This type of data and the related quality improvement projects can be taken from outcomes reported in Home Health Compare or within agencies' CASPER reports.

Then, agencies will propose ways to reverse undesirable outcomes like a high readmission rate, educate clinicians on how to do so and document not just improvements but that an agency sustains such improvements.

When quality improvements aren't realized, agencies will have to show through documentation why this didn't happen and what plan they put in place to remedy the issue.

Get ideas for where to focus your QAPI efforts

The first step any agency should undertake when choosing a QAPI project is to identify issues that most impact the care and safety of patients or nurses and/or impose significant costs to the agency.

This should be done by making data-driven decisions at the executive level, and should include having quality and clinical managers, as well as billing managers and others gather historical outcomes data, billing reports, internal quality improvement audits and patient satisfaction surveys so administrators can decide on a project.

One New York-based agency decided to have a QAPI project after suffering about $300,000 in lost expenses after payment from Medicaid for a decade's worth of care for just one patient. These costs were associated with treating multiple pressure ulcers, a non-healing surgical wound, diabetes, paraplegia and renal disease.

Delving further into its process of care coordination with its parent hospital system, the agency identified other areas to improve processes, such as making certain wound supplies ordered initially by a hospitalist, for example, can be obtained by the agency. The agency couldn't order some supplies because it didn't have contracts with suppliers of those products.

Most agencies have some sort of surveillance process, so they're aware of some of their improvement opportunities. They also can get ideas of what they need to focus on to develop a comprehensive quality program through:

- Utilization review committees. This group captures trends through chart review.
- Department of health certification surveys. These find deficiencies and provide recommendations.
- CASPER reports. The reports can identify process and outcome issues.
- Staff and patient complaints. Such complaints can reflect issues needing process improvement.
- Root cause analysis of a near miss or a poor outcome. This is another way to identify holes in a process.

Three steps to set up a sound program

1. Assess your risks. Conduct a thorough risk assessment to determine what focus your program should have.

A small committee should be formed to accomplish this task. One agency's committee at different times has included the vice president of continuing care, the director of patient services, the director of quality management, community health nurse supervisors, field nurses and physical therapists (PTs).

The agency combines a risk assessment with a hazard vulnerability and infection control assessment.

This comprehensive document calculates risks such as natural or manmade disasters, community outbreaks of transmissible infections, probability of staffing shortages, high-risk patient population, home care acquired infections, epidemiologically significant organisms (such as C. difficile or MRSA), employee-related risks (such as noncompliance with immunization policies or weak understanding of the chain of infection), high-risk

procedures, staff communication, adequate and appropriate equipment, emergency preparation and environmental issues.

These are classified in categories and rated on the probability of occurrence, expected patient effect, intensity of organization's response needed, and the organization's preparedness to address such a risk at the present time.

From there, a risk level is calculated. Any item that has maximum negative patient effect increases the risk score. Risks are stratified so those scoring the highest are targeted for improvement first.

The risk assessment is a great triage tool.

When it comes to setting up improvement projects, look and see which would involve patient care and safety. It all needs to be data-driven so you need to have something in place that shows why you picked this project. If you are falling particularly low in a score, consider picking that project.

2. Create a written plan. This should look at the scope of services the agency offers, address areas of risk and identify the methodology for surveillance.

The plan should determine which benchmarks to use and set goals for each initiative addressed. One agency's goals included: Fall rate of less than 1%, overall infection rate of less than 2% and a rehospitalization rate of 15%.

Your written plan also should include the structure of Performance Improvement and Utilization Review committees.

A Performance Improvement Committee meets to discuss measures needing improvement. Great ideas come from including supervisors, field staff and clerical employees. Note that social workers and PTs often look at a problem using different skill sets than nurses, so their participation would be valuable.

A Utilization Review Committee reviews charts of cases from the prior quarter. Charts are examined for appropriateness of services provided. This committee can have any combination of clinicians reviewing charts, but it's a good idea to have PTs look at charts of patients who had physical therapy and a wound care nurse look at complicated wound care charts. Regulation dictates 10% of the census should undergo review.

Costs for the committees are included in the cost of running any agency. If field staff members are pulled in, they must be paid for time they put into chart reviews. These employees should not look at the charts of patients for whom they personally cared.

3. Report your results. One agency reports to the overall hospital Quality Excellence Council monthly. The report presented addresses each issue and offers an analysis of the issue, prevention and control activities and the numerical outcome or results of each issue.

It previously reported out on: falls rate, falls with injury rate, home care acquired infection rates for urinary tract infections for urinary catheter patients, wound infections and catheter infections in intravenous medication administration.

The agency also reports out rehospitalizations, documentation compliance with diabetic management, documentation compliance with wound care, supervision rate of home health aides, whether or not it met its budgeted admissions and targeted areas in the HHCAHPS.

Reporting continues until the agency hits the targeted goal for at least three months in a row. If the item is a regulatory one (such as signed doctor's order back by 30 days), the agency continues to follow it even if it does not necessarily report out the results to the council. If an item does not improve in three months, the Performance Improvement Committee must devise a more robust plan of action.

Key reports to analyze

Before building a QAPI program, examine the following information in CASPER:

- **Agency patient-related characteristics.** This includes many items that will be used to calculate your agency's risk adjustment for the outcomes. In health care terms, it can denote your agency's acuity in items on the OASIS. This report includes items such as: demographics, payment sources, therapy days, length of stay, diagnoses and results of many M items (including activities of daily living (ADLs), ambulation, medications, dyspnea, pain and confusion).
- **Risk-adjusted outcome report.** For example: XYZ agency's improvement in patient's pain is 62.5%. The agency in the prior period was 58.0%. Note: the national average on the pain measure in July 2018 was 77.2%.
- **Potentially avoidable events**. This report is what was historically called "adverse events." Print off the patient tally listing for this report as well, since it is important to audit the patient's record to try to prevent any adverse event from occurring in the future. Among the potentially avoidable events: emergent care for improper medication administration or medication side effects; emergent care for hypo/hyperglycemia, development of urinary tract infection; increase in the number of pressure ulcers; substantial decline of three or more activities of daily living; substantial decline in management of oral medications; and discharged to community needing wound care or medication assistance, needing toileting assistance, with behavioral problems or with an unhealed Stage 2 pressure ulcer.
- **Process-based quality improvement**. This report indicates standards for best practices. Some of these are included in 5-star ratings as well. Once you have identified and developed the QAPI indicators to monitor from the CASPER outcome reports, it is important to ascertain through the monitoring if the deficiency is from lack of understanding the OASIS M item intent and guidance from the OASIS manual and/or if it is a care issue. The QAPI monitoring should be set up to be able to determine this. The earlier you share this CASPER outcome deficiency and QAPI indicator with the field clinicians the better, as this is information directly from the OASIS documentation. Involving the frontline staff will help you achieve relatively rapid and sustained improvement.

More tips to comply with the QAPI CoP

Examine CMS' guidance about what constitutes high-risk, high-volume and problem-prone areas. CMS previously said performance improvement activities needed to focus on these three categories, and the final interpretive guidelines provide some additional detail.

For high-risk areas, consider "global" concerns, "geographic" concerns and "specific patient care services" [§484.65(c)(3); G656].

Global concerns are areas where you provide a specific type of service to many patients, such as if you're a pediatric agency. The risk potential increases because you have such a large volume.

Geographic concerns would be, for example, the safety of a neighborhood served, the final guidelines state. It's unclear how an agency would conduct a PIP based on a neighborhood's safety.

Specific patient care services would include, for example, administration of intravenous medications or tracheostomy care.

These areas might be high-risk based upon the nature of care provided.

For high-volume areas, CMS explains it means care or services often provided to a large patient population.