QAPI on a Shoestring
or
How to Survive QAPI Hysteria

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Remember this one key phrase

“The QAPI Program reflects the complexity of its organization and services”
What Will Complexity Mean?
We don’t have the revised SOM with Interpretive Guidelines yet, but an educated guess might be…

• Less Complex
  – Core services only
  – Paper documentation
  – Fewer employees wearing many hats

• More Complex
  – Alternative therapies
  – Electronic records
  – One or more individuals specifically assigned to QAPI
  – Serves pediatric patients
  – Inpatient facilities

You are already ahead of the game and moving in the right direction -

If your hospice program is accredited

- Joint Commission
- CHAP
- ACHC

If you meet similar regs for a home health care program

If you track adverse events

- Falls requiring intervention
- Medication errors
- Complaints
- Infection surveillance
- Incidence and prevalence
- DME events

If you industry (NHPCO) benchmarking

- FEHC/FEBS/soon to be released PEHC
- EROMS
- NDS
- STAR
- Quality Partner’s Self Assessments for the 10 Components of Quality

If you proprietary benchmarking

Some examples

- Outcome Concept Systems products
- PeerForum – QAPI Snapshot
- Joint venture with IHO
- Hospice Quality Resources products
  (Weatherbee, Deyta, Multiview)
- QAPI Navigator
- Deyta, Factual Foresight
QAPI Program Must

BE
- Developed, implemented, maintained
  Statement in the form of program description or policy describing program’s existence, structure and operation
- Effective, ongoing, hospice-wide
  Must demonstrate effectiveness and sustainment of improvements and take a 360 degree view of hospice operations – that is both clinical and non-clinical indicators of quality to be measured
- Data driven
  Must utilize quantitative measures

DO
- Involve all hospice services, including those under contract or arrangement
- Focus on indicators R/T improved palliative outcomes*
- Prove that “priorities” were identified and chosen for PI activities
- Take actions to demonstrate improvement and sustainment
- Maintain documentary evidence of it’s operation and be able to demonstrate this to CMS

How are we to do all of this?

Clues in the Preamble

Federal Register/
Vol. 73, No. 109/
Thursday June 5, 2008/
Rules and Regulations
Pages 32095, 32101, 32105, 32109, 32110, 32117-32123
Key Concepts

• Measures sometimes classified into three general types

  *Examples*
  • Structure — number or percentage of HPNA certified (CHPN) staff
  • Process — number of times or percentages of comprehensive assessments and/or ongoing assessments completed within time frames required by regulations
  • Outcome — average pain severity score during last week of life

  Structure and Process Measures should get us to Outcome Measures

Key Concepts

• Palliative outcomes are the results of care provided
• Data element examples for results of care provided (palliative outcomes) are in the clinical record and included in the comprehensive assessments—preamble 32117
• Patient outcome measure examples—preamble 32118 & 32119
• PEACE Project – tools with data elements for measures for various patient outcome domains that are being looked at by CMS as possible requirements for hospice programs in the future
Data Elements-Patient Outcome Measures-Quality Indicators

- Data elements collected the same way for each patient/family – questions asked in the same way and documented in a manner which allows data to be retrieved and analyzed
- Data elements for palliative outcome measures are part of the comprehensive assessment
- Data elements are part of individual care plans and used in the aggregate for identifying organizational priorities for performance improvement

Proving the QAPI Loop is Essential

Hospices are being called on to Prove it! at Patient Level and Aggregate Level Organizationally

- Pt/family needs we put in assessment
- Goes in care plan
- Goes into our actions
- Reflected in our discipline notes
- Goals met in care plan or interventions/goals changed
- We prove it by chart reviews and data collection or electronic queries
Standard (a) Program Scope

• Preamble 32118

Using standards and current literature to “select indicators…measure, analyze, track quality indicators…including adverse events and other aspects of performance

• Aspects/Areas
• Domains
• Indicators/Measures
• Data Elements

Area and Domain Examples

<table>
<thead>
<tr>
<th>Palliative Outcomes</th>
<th>Processes of Care</th>
<th>Hospice Services</th>
<th>Non –Clinical Operations</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient comfort</td>
<td>Staffing</td>
<td>After hours care/support</td>
<td>Job Satisfaction</td>
</tr>
<tr>
<td>Patient safety</td>
<td>Adherence to care plan</td>
<td>Volunteer Services</td>
<td>Technical ADRs as a % of all claims</td>
</tr>
<tr>
<td>Effective grieving</td>
<td>Time frames for assessments</td>
<td>Supplies</td>
<td>Fundraising % of total revenue</td>
</tr>
<tr>
<td>Self determined life closure (SLDC)</td>
<td>Transitions of care</td>
<td>Pharmacy</td>
<td>Overall profit margin</td>
</tr>
<tr>
<td>Patient/Family Satisfaction/ Evaluation of Care</td>
<td>Referral Conversion Rates</td>
<td>DME</td>
<td>Turnover or vacancy rates</td>
</tr>
</tbody>
</table>
Data-Measures-Indicators-Domains-Areas

<table>
<thead>
<tr>
<th>Data Elements</th>
<th>Measures/Indicators</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pain Severity Scores – self identified – actual and goal (from initial, comprehensive, and ongoing assessments)</td>
<td>% Patients uncomfortable because of pain upon admission made comfortable w/in 48 hours*</td>
</tr>
<tr>
<td>Desire to avoid hospitalization</td>
<td>% Patients with unwanted hospitalizations (or % avoided unwanted hospitalizations)*</td>
</tr>
<tr>
<td>Family Satisfaction Data – FEHC Questions</td>
<td>% of families who would recommend hospice</td>
</tr>
<tr>
<td>Admit and discharge dates</td>
<td>% Patients with short LOS</td>
</tr>
<tr>
<td>Employee start and end dates</td>
<td>Turnover or vacancy rates</td>
</tr>
</tbody>
</table>

Standard (b) Program Data

Preamble 32117

“Did not propose to require use of any particular process or outcome measures…however a hospice that would choose to use available quality measures would be able to expect an enhanced degree of insight into its quality of services and patient satisfaction.”

- Free tools from industry organizations and available within public domain to measure outcomes with some degree of validity and reliability
Standard (b) Program Data

Preamble 32118
“Patient care outcome data must be included in patient’s clinical record…all documentation must be in accordance with data collection policies and procedures established by the hospice…to ensure consistency and reliability.”

Preamble 32119
“…aggregation of data must be in accordance with policies and procedures developed by the hospice

Data elements are included in the comprehensive assessment

PEACE Project – mentioned at least 3 times in the preamble to the new hospice regulations www.qualitynet.org/dcs

PEACE Project – Conducted by CCME
Carolinas Center for Medical Excellence
www2.thecarolinascenter.org/ccme
Prepare-Embrace-Attend-Communicate-Empower
Standard (c) Program Activities

Preamble 32118

*Adverse Events*

- “may choose to use your own definition or use one developed by an accrediting body or industry organization”
- Introductions to Root Cause Analysis (RCA) and Failure Modes Effect Analysis (FMEA) and tools for how to conduct these analyses available in public domain- at no cost on several websites

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Standard (c) Program Activities

- Not just identifying opportunities – but also establishing priorities
- Focus – high risk, high volume, problem prone areas - prevalence and severity of identified problems
- Prioritize PI activities that are about palliative outcomes, patient safety, and quality of care
- Track adverse events – analyze their causes, implement preventive actions, etc.
Standard (c) Program Activities

Overlap with CoP 418.60 Infection Control

- Standard (b) “Control"
- Infection Control “will be an integral part of the QAPI Program”
- Infection Surveillance
- Incidence and Prevalence
- Not just for GIP and routine (residential) level patients in inpatient facilities, but also for home based patients

Standard (d) Performance Improvement Projects

- Number and scope of Performance Improvement Projects: “reflects scope, complexity, past performance of services and operations”
- Requirement to document
  - Projects being conducted
  - Reasons for conducting
  - Measurable progress achieved
Standard (d) PIPs

- “No specific model for PI required” – what does this mean?
- Low complexity hospice programs – utilize what is available in the public domain: [www.ihi.org](http://www.ihi.org)
  MFI – Model for Improvement – PDSA
  taught in the NHPCO Quality Collaboratives
- High complexity hospice programs – may likely be expected to have a wider variety of PI methods and tools within their QAPI programs

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Standard (d) PIPs

- Lower complexity tools for PI
  1. MFI/PDSA tests of change
  2. Root Cause Analysis
  3. FMEA – Failure Mode Effect Analysis

- Higher complexity tools for PI
  1. LEAN Process Mapping
  2. Adaptive Design (health care variant of TPS)
PDSA Method – Model for Improvement

• Plan
  • What ideas do those closest to the problem have about improving the process
  • Involves teams
  • Utilizes facilitator
  • AIM statements
  • Process/Outcome Measures

• Do

• Study

• Act

PDSA Test of Change

• Aim: Overall goal you wish to achieve, with time frames and objective measure(s)
  What Who When Where

• Plan: List out the tasks needed to set up this test of change
  What Who When Where

• Do: Describe what actually happened when you ran the test of change, both predicted and unpredicted

• Study: Describe the measured results and what actually happened compared to the predictions

• Act: 1) accept and implement 2) modify for next cycle 3) abandon the idea
Standard (d) PIPs

• Actionable Reporting

  Graphic reports
  Trends over time
  Relative to a benchmark or target

Graphic Displays

• Run charts or trend charts are graphic displays of data points over time

• User is looking for trends in the data but resists the tendency to see variation in the data as significant until an adequate number of data points have been plotted

• Use to observe the effects of a process improvement (to observe effects of test(s) of change in PDSA cycles)

How to Construct a Run Chart

1. Draw vertical and horizontal axes
2. Label the vertical axis with the indicator or the variable, and determine the scale
3. Label the horizontal axis with the unit of time or sequence for which the data was collected
4. Plot the data points
5. Connect the data points
6. Determine the mean of the plotted numbers and draw a mean line on the graph
7. Label the chart and name the source of the data, date and the author

Benchmarks and Targets

• Benchmarks represent the best possible performance

• Targets are acceptable and/or desirable levels of performance – what makes sense for your own hospice program

• National averages are often called “benchmarks” and sometimes used as “targets”
## IHO-specific Performance Measures

### 2007 Annual Report

<table>
<thead>
<tr>
<th>IHO-specific Performance Measures</th>
<th>Nat'l</th>
<th>IA</th>
<th>Peer Count</th>
</tr>
</thead>
<tbody>
<tr>
<td>Family Evaluation of Hospice Care Measures</td>
<td>94%</td>
<td>95%</td>
<td>8</td>
</tr>
<tr>
<td>Sufficiency of Pain Medication</td>
<td>68%</td>
<td>75%</td>
<td>9</td>
</tr>
<tr>
<td>Confidence in Knowledge of Medicines</td>
<td>6%</td>
<td>1%</td>
<td>9</td>
</tr>
<tr>
<td>Wanting More Info About Pain Medications</td>
<td>92%</td>
<td>9%</td>
<td>1</td>
</tr>
<tr>
<td>Comfort Within 48 Hours of Onset of Pain</td>
<td>31%</td>
<td>33%</td>
<td>7</td>
</tr>
<tr>
<td>% Patients in Pain on Admission</td>
<td>50%</td>
<td>44%</td>
<td>5</td>
</tr>
<tr>
<td>Responsive Patients in Pain</td>
<td>40%</td>
<td>38%</td>
<td>4</td>
</tr>
<tr>
<td>% Patients with Traced Pain</td>
<td>20%</td>
<td>19%</td>
<td>5</td>
</tr>
<tr>
<td>% Hospitalizations - Uncontrolled Pain</td>
<td>12%</td>
<td>3%</td>
<td>3</td>
</tr>
<tr>
<td>% Hospitalizations - Uncontrolled Dyspnea</td>
<td>61%</td>
<td>4%</td>
<td>4</td>
</tr>
<tr>
<td>% Patients Served with Alternative Therapies</td>
<td>46%</td>
<td>3%</td>
<td>3</td>
</tr>
<tr>
<td>Speech</td>
<td>42%</td>
<td>2%</td>
<td>2</td>
</tr>
<tr>
<td>Other</td>
<td>15%</td>
<td></td>
<td></td>
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<tr>
<td></td>
<td></td>
<td></td>
<td></td>
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</tbody>
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<th>IA</th>
<th>Peer Count</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient Volume and Mix</td>
<td>77%</td>
<td>90%</td>
<td>9</td>
</tr>
<tr>
<td>Conversion Rate</td>
<td>27%</td>
<td>22%</td>
<td>12</td>
</tr>
<tr>
<td>% Died or Discharged in &lt; 7 Days</td>
<td>8%</td>
<td>6%</td>
<td>13</td>
</tr>
<tr>
<td>% Died or Discharged in &gt; 180 Days</td>
<td>3%</td>
<td>0%</td>
<td>7</td>
</tr>
<tr>
<td>Inpatient Days as a % of Total Days</td>
<td>42%</td>
<td>41%</td>
<td>14</td>
</tr>
<tr>
<td>% of Total Admissions by Diagnosis</td>
<td>13%</td>
<td>13%</td>
<td>13</td>
</tr>
<tr>
<td>Cancer</td>
<td>10%</td>
<td>7%</td>
<td>13</td>
</tr>
<tr>
<td>Dementia</td>
<td>8%</td>
<td>8%</td>
<td>13</td>
</tr>
<tr>
<td>Lung Disease</td>
<td>3%</td>
<td>3%</td>
<td>13</td>
</tr>
<tr>
<td>Liver Disease</td>
<td>2%</td>
<td>1%</td>
<td>13</td>
</tr>
<tr>
<td>HIV</td>
<td>0%</td>
<td>0%</td>
<td>11</td>
</tr>
<tr>
<td>Stroke/Coma</td>
<td>3%</td>
<td>4%</td>
<td>12</td>
</tr>
<tr>
<td>AIDS</td>
<td>0%</td>
<td>0%</td>
<td>12</td>
</tr>
<tr>
<td>Other Motor Neuron</td>
<td>11%</td>
<td>11%</td>
<td>13</td>
</tr>
<tr>
<td>Other Diagnosis</td>
<td>1%</td>
<td>4%</td>
<td>13</td>
</tr>
</tbody>
</table>
Standard (e) Executive Responsibilities

Preamble 32117

Governing Body is responsible and accountable

• On going QAPI Program is defined, implemented, and maintained

• Ensures QAPI Program addresses priorities for patient care and safety

• Approves frequency and detail of data collection

• Ensures all QI activities are evaluated for effectiveness
Standard (e) Executive Responsibilities

• Documentary Evidence of a QAPI Program
• QAPI Program Description and/or QI Policy Statement and Procedures
• Governing body’s commitment
  – Statement – resolution – pledges www.nhpco.org
• Data collection, reporting and calculation procedures for measures
• Data aggregation
• How staff and governing body are educated about QAPI

More Documentary Evidence

• Minutes of meetings
• Manual or files containing program Description/policy/procedures
  Manual or files containing aggregate data with policy and procedure for calculations
• Run charts with targets or benchmarks
Quality Truism

All improvement involves change

but

Not all change = improvement

Resources

- Appendix M to State Operations Manual
  www.cms.hhs.gov/manuals/downloads/som107ap_m_hospice
- Center to Advance Palliative Care www.capc.org
- Hospice Quality Resources, LLC
  www.hospicequality.com
- Institute for Healthcare Improvement www.ihi.org
- Iowa Hospice Organization www.iowahospice.org
- Joint Commission www.jointcommission.org
- National Quality Forum Voluntary Consensus Standards for Symptom Management and EOL Care in Cancer Patients
  www.qualityforum.org/publications/reports/palliative
Resources (continued)

- NHPCO Quality Partners  www.nhpco.org
- Outcome Concept Systems www.ocs.org
- PEACE Project www.qualitynet.org/dcs
- Toolkit of Instrument for Measuring End of Life Care
  www.chcr.brown.edu/pcoc/toolkit.htm
- VA National Center for Patient Safety
  www.va.gov/ncps

Questions?

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