Connecting the Dots for a Successful Quality Assessment/Performance Improvement (QAPI) Program

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Today’s Program

• Describe the state and federal regulatory requirements for Quality Assessment/Performance Improvement (QAPI) programs to ensure survey readiness/compliance for hospice leadership.
• Identify the components of a comprehensive QAPI program including key performance indicators to be utilized by hospice leadership for monitoring, management and prioritization of agency-wide QAPI efforts.
• Utilize examples, group discussion and industry best practices to demonstrate successful integration of key performance indicators into a comprehensive QAPI program which efficiently measure outcomes, ensures regulatory compliance/survey readiness, and reduces risk of financial penalties due to non-compliance with quality reporting requirements.
• Q&A’s.
Why Do We Need These New Requirements?

- Affordable Care Act requires CMS to:
  - Collect data from claims and cost reports.
  - Revise the payment system and rates for hospice services.

- Better Data:
  - Measure quality, safety and efficacy of care.
  - Design payment systems and process claims for reimbursement.
  - Prevent and detect healthcare fraud and abuse.
  - Performance monitoring - P4P.
  - Monitoring resource utilization.

Part 1: Regulatory Compliance
### Quality Measures - Regulatory Background

- **Regulatory Background:**
  - Medicare Conditions of Participation for Hospice:
    - § 418.58 Quality Assessment/Performance Improvement.
  - Section 3004 of the Patient Protection and Affordable Care Act (ACA) authorizes the Health and Human Services Secretary to establish a quality reporting program for hospices.

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### Quality Measures - Regulatory Background

- **Regulatory Background:**
  - The Centers for Medicare & Medicaid Services (CMS):
    - FY 2012 Hospice Wage Index Final Rule:
      - Implemented the Hospice Quality Reporting Program (HQRP) in the FY 2012 Hospice Wage Index final rule.
      - National Quality Forum (NQF) Endorsed Measures:
        - NQF #0209-Comfortable Dying
        - Structural Measure
    - 2% reduction in Market Basket for the following year if a hospice does not participate in Quality Reporting.
Quality Measures - Regulatory Background

- Regulatory Background:
  - The Centers for Medicare & Medicaid Services (CMS):
    - FY 2014 Hospice Wage Index Final Rule
      - QAPI Quality Reporting Measures Introduced:
        » Hospice Item Set
        » CAHPS Hospice Survey
    - FY 2015 Hospice Wage Index Final Rule
      - Codification of Hospice Quality Reporting Items.
      - 2% reduction in Market Basket for the following year if a hospice does not participate in Quality Reporting.
    - IMPACT Act.
    - PEPPER Reports.

CMS FY 2016 Hospice Wage Index Final Rule

- Published in the Federal Register 8/6/15:
### CMS FY 2016 Hospice Wage Index Final Rule

- **Key Components Impacting Operations:**
  - Hospice Payment Update.
  - Two Level Routine Home Care Rate:
    - Effective 1/1/16
  - Service Intensity Add On (SIA):
    - Effective 1/1/16
  - Diagnoses on the Claim Form:
    - Effective 10/1/15
  - Assessment of Conditions and Comorbidities Required by Regulation.

### CMS FY 2016 Hospice Wage Index Final Rule

- **Key Areas Impacting Quality Reporting:**
  - Implementation of compliance goals for timely HIS submission of admissions and discharges.
  - 2% market basket reduction if not compliant:
    - 2016-70% threshold must be met effective 1/1/16.
    - 2017-80% threshold must be met.
    - 2018 and thereafter - 90% threshold must be met.
  - 30 day submission deadline for HIS admission and discharge assessment.
  - Submission deadlines will be used to assess further penalties.
  - Reminder to download/print validation reports and address all errors timely to avoid 2% penalties.
CMS FY 2016 Hospice Wage Index Final Rule

• Retention of HQRP Measures:
  → Beginning with FY 2018, once a quality measure is adopted it is retained for use in the subsequent FY wage index payment update unless otherwise stated by CMS.
  → CMS reserves the right to change measures.
    • Criteria established to change measures.

• No new measures in 2017.

CMS FY 2016 Hospice Wage Index Final Rule

• Public Reporting:
  → CMS will publicly report CAHPS Hospice data when at least 12 months of data are available.
• Hospice Compare and STAR rating in process - no date yet.
  → HIS Data: Q1-Q3 CY 2015 data will be analyzed to determine public reporting.
• New Hospices will be responsible for HQRP reporting upon Medicare Certification (CCN).
• CMS will continue to grant extensions/exceptions in extraordinary circumstances.
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CMS FY 2016 Hospice Wage Index Final Rule

- High Priority Concept Areas for Future Measure Development:
  - Pain outcome measure that incorporates patient and/or proxy report regarding pain management.
  - Claims-based measures focused on care practice patterns:
    - Skilled visits in the last days of life.
    - Transitions of care in and out of the hospice benefit.
    - Live discharge rates.
  - Responsiveness of hospice to patient/family needs.
  - Hospice team communication/coordination.

CMS FY 2016 Hospice Wage Index Final Rule

- Program Integrity Efforts
  - PEPPER reports.
  - Medical Review/MAC/ZPIC/RAC.
  - Suspension of provider billing privileges.

- Reporting of compliance notifications through QIES/CASPER system:
  - Communication through memos, MLN matters and CMS website notices.
  - Publish a list of hospices who successfully meet reporting requirements.
IMPACT Act

  - Effective October, 2014.
  - Mandatory surveys every 36 months through 2025.
    - Surveys conducted by state survey agency or accrediting body with deemed status (JC, CHAP, ACHC)
  - Increased medical review for hospices with higher percentage of patients with LOS greater than 180 days.
    - Discussing 40-60% threshold but not finalized yet
  - Aligns hospice aggregate cap with reimbursement (beginning with cap year FY 2017).

Initial Results from the IMPACT Act

- Many agencies now having their first survey under the updated Medicare Hospice CoPs (2008).
- New surveyors, with updated CMS training.
- CMS Central Office supporting increased scrutiny.
- Many surveyors need to revisit the State Operations Manual Appendix M to ensure thorough review of all areas.
- Result:
  - Increased Scrutiny=Increased Survey Findings.
### Top Survey Deficiencies (CMS 2014)

<table>
<thead>
<tr>
<th>CoP/Standard</th>
<th>L-Tag</th>
<th>Tag Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>418.56(b)</td>
<td>L543</td>
<td>Standard: Plan of Care</td>
</tr>
<tr>
<td>418.56 (c)</td>
<td>L545</td>
<td>Standard: Content of the Plan of Care</td>
</tr>
<tr>
<td>418.54 (c)(6)</td>
<td>L530</td>
<td>Standard: Drug Profile</td>
</tr>
<tr>
<td>418.76(h)</td>
<td>L629</td>
<td>Standard: Supervision of Hospice Aides</td>
</tr>
<tr>
<td>418.54 (d)</td>
<td>L533</td>
<td>Standard: Update of the Comprehensive Assessment</td>
</tr>
<tr>
<td>418.56 (e)(2)</td>
<td>L555</td>
<td>Standard: Coordination of Services</td>
</tr>
<tr>
<td>418.56 (c)(2)</td>
<td>L547</td>
<td>Standard: Scope and Frequency of Services</td>
</tr>
<tr>
<td>418.56(d)</td>
<td>L552</td>
<td>Standard: Review of the Plan of Care</td>
</tr>
<tr>
<td>418.54(b)</td>
<td>L523</td>
<td>Standard: Timeframe for Completion of the Comprehensive Assessment</td>
</tr>
<tr>
<td>418.58</td>
<td>L560</td>
<td>Standard: Quality Assessment &amp; Performance Improvement</td>
</tr>
</tbody>
</table>

Source: NHPCO and CMS

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### Top 5 CoPs Cited in Nation FFY 2015 (10/1/14-9/30/15)

1. **418.58 Quality Assessment and Performance Improvement**
2. **418.56 Interdisciplinary Group, Care Planning and Coordination of Services**
3. **418.78 Volunteers**
4. **418.52 Patient Rights**
5. **418.60 Infection Control**

NOTE: Findings can cross over into Governing Authority as well as other CoPs/Standards:

→ **418.00 Organization and Administration of Services**
State Hospice Agency Regulations

• Hospices must also meet any state-specific regulations for Quality Assessment/Performance Improvement:
  → TX DADS: 97.287 Quality Assessment/Performance Improvement:
    • QAPI Program
    • QAPI Committee
    • Measurable Data
    • Annual Evaluation
  → TX DADS 97.813 Hospice Client Outcome Measures.
  → 7NMAC 12.2.24 Annual Review.

Part 2: QAPI Program Components
Connecting the Dots for a Successful QAPI Program

QAPI Program Status?

- **Smooth Sailing:**
  - Fully implemented, including governing authority responsibilities clearly delineated

- **Rough Seas:**
  - Not fully implemented or put on “back burner”

- **Shipwreck:**
  - Program is non-existent for hospice

CMS’ Purpose for QAPI Condition of Participation

- To set a clear expectation that hospices must take proactive approaches to improve their performance.

- Focus on improvement patient/family care and activities that improve their health and safety.

- Focus on improving system which ultimately improves processes and patient outcomes.
§ 418.58 Condition: Quality Assessment and Performance Improvement

§ 418.58 - The hospice must develop, implement, and maintain an effective, ongoing, hospice-wide data-driven quality assessment and performance improvement program. The hospice’s governing body must ensure that the program:

- reflects the complexity of its organization and services;
- involves all hospice services (including those services furnished under contract or arrangement);
- focuses on indicators related to improved palliative outcomes;
- and takes actions to demonstrate improvement in hospice performance.

The hospice must maintain documentary evidence of its quality assessment and performance improvement program and be able to demonstrate its operation to CMS.

QAPI Program Elements (State Operations Appendix M)

- 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 effectiveness of action;
  - Oversight responsibility reports to governing body; and
  - Documentation of the review of its own QAPI program.
Connecting the Dots for a Successful QAPI Program

Five Components of QAPI Program as indicated in the Medicare Hospice Conditions of Participation

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

QAPI Programs Overview of Requirements

- QAPI Programs Should:
  - Encourage hospices to look at systems and processes.
  - Help agencies steer clear of just focusing on a single problem at a time.
  - Involve all patient care disciplines, all services (even contracted), entire business operations, as well as any adverse events.
QAPI Program Overview of Requirements

- QAPI Programs Should:
  - Consist of continual assessments of the entire hospice organization (collecting, identifying, and prioritizing data).
  - Focus on activities that are high risk, high volume and problem prone areas for YOUR Hospice.
  - Foster an environment to implement solutions that fix the problem.
  - Ensure there is a written plan to assess effectiveness of solutions.
  - Re-evaluate using standard methodology (i.e IHI, PDCA, OBQI).

§ 418.58(a) Standard: Program Scope

- § 418.58(a)(1): The program must at least be capable of showing measurable improvement in indicators related to improved palliative outcomes and hospice services.
- § 418.58(a)(2): The hospice must measure, analyze, and track quality indicators, including adverse patient events, and other aspects of performance that enable the hospice to assess processes of care, hospice services, and operations.
§ 418.58(b) Standard: Program data

• § 418.58(b)(1): The program must use quality indicator data, including patient care, and other relevant data, in the design of its program.

• § 418.58(b)(2): The hospice must use the data collected to do the following:
  →(i) Monitor the effectiveness and safety of services and quality of care.
  →(ii) Identify opportunities and priorities for improvement.

• § 418.58(b)(3) - The frequency and detail of the data collection must be approved by the hospice’s governing body.

§ 418.58(c) Standard: Program activities

§ 418.58(c)(1): The hospice’s performance improvement activities must:
  →(i) Focus on high risk, high volume, or problem-prone areas.
  →(ii) Consider incidence, prevalence, and severity of problems in those areas.
  →(iii) Affect palliative outcomes, patient safety, and quality of care.
§ 418.58(c) Standard: Program activities

- § 418.58(c)(2): Performance improvement activities must track adverse patient events, analyze their causes, and implement preventive actions and mechanisms that include feedback and learning throughout the hospice.

- § 418.58(c)(3): The hospice must take actions aimed at performance improvement and, after implementing those actions, the hospice must measure its success and track performance to ensure that improvements are sustained.

§ 418.58(d) Standard: Performance Improvement Projects

- § 418.58(d)(1): The number and scope of distinct performance improvement projects conducted annually, based on the needs of the hospice’s population and internal organizational needs, must reflect the scope, complexity, and past performance of the hospice's services and operations.

- § 418.58(d)(2): The hospice must document what performance improvement projects are being conducted, the reasons for conducting these projects, and the measurable progress achieved on these projects.
§ 418.58(e) Standard: Executive Responsibilities

§ 418.58(e): The hospice’s governing body is responsible for ensuring the following:

→(1) That an ongoing program for quality improvement and patient safety is defined, implemented, and maintained, and is evaluated annually.

→(2) That the hospice-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.

→(3) That one or more individual(s) who are responsible for operating the quality assessment and performance improvement program are designated.

Survey Activities related to QAPI

• Surveyors will request the following:
  → Aggregated data and analysis.
  → QAPI Plan:
    • What PIPs are being conducted;
    • The reason why they are being conducted;
    • What is the measurable progress achieved.

→ Names and titles of individuals responsible.
→ Evidence the QAPI plan has been implemented and is functioning effectively.
### Survey Activities related to QAPI

- Surveyors will assess the following to determine compliance:
  - Regular meetings;
  - Investigation and analysis of sentinel and adverse events;
  - Recommendations or options for systemic change to prevent recurrence of sentinel or adverse events;
  - Identified performance measures that are tracked and analyzed; and
  - Regular review and use of the QAPI analyses by hospice management and the governing body to make systemic improvements.
  - Any other necessary resources needed to assess a hospice’s compliance.

### Examples of Survey Deficiencies-QAPI

- The QAPI program is not agency wide in scope.
- There is no evidence of the governing authority responsibility for QAPI program oversight and decision making.
- There is not a person designated to oversee the QAPI program.
- The QAPI program does not have all of the components specified in the CoPs.
- The agency does not address issues identified in the QAPI program.
Sample Hospice QAPI CoPs Compliance Checklists

- www.NHPCO.org/regulatory
## Hospice QUALITY ASSESSMENT / PERFORMANCE IMPROVEMENT – TOOL 1

<table>
<thead>
<tr>
<th>Tag #</th>
<th>Regulatory focus</th>
<th>Guidance</th>
<th>Comments</th>
<th>Met</th>
<th>Not Met</th>
</tr>
</thead>
<tbody>
<tr>
<td>567</td>
<td>Pw activities include problems considered for incidence, prevalence, severity</td>
<td>No guidance to surveyors. If a problem occurs frequently, or is prevalent due to types of common diagnoses seen, or has more severe negative effects, the hospital should consider some of these problems to track and address.</td>
<td>Review QAPI data collected. Performance improvement projects for problems identified that are prevalent at this hospital, and could cause serious negative outcomes.</td>
<td></td>
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</tr>
<tr>
<td>568</td>
<td>Pw activities affect palliative outcomes, quality care outcomes, patient safety</td>
<td>Outcomes are the results of care processes.</td>
<td>In patient satisfaction data. Ensure that QAPI data collected. Performance improvement projects for problems identified that are prevalent at this hospital, and could cause serious negative outcomes.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>569</td>
<td>Pw activities track adverse events, analyze causes, implement preventative actions—learn from results</td>
<td>Hospitals may define “adverse events” or use a national/industry organization definition. In general, an adverse event is harm to a patient from hospital action or inaction. Most hospitals analyze these events and try to prevent.</td>
<td>Review this hospital’s QAPI plan and ask to see what adverse events they named, tracked and whether they implemented preventative actions based on findings.</td>
<td></td>
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<tr>
<td>570</td>
<td>Hospice not only tracks problems, but implements actions to sustain improvements</td>
<td>If hospital must ensure new procedures are implemented hospital-wide, and are effective to reduce adverse events.</td>
<td>Review QAPI meeting minutes and reports to see if adverse events were reduced by measures implemented.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>571</td>
<td>Hospitals must develop, implement, and evaluate performance improvement plans</td>
<td>No guidance to surveyors, but ask if they have PIPs teams and who are on those teams.</td>
<td>Interview two or three staff (registered nurse case manager, social worker, volunteer coordinator) to see if they are involved in any PIP work. Ask how long have they met and what focus?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>572</td>
<td>Number and scope of PIPs: based on needs of hospice patients, organizational needs, agency past performance</td>
<td>No guidance to surveyors except at LTCH: No regulatory requirement for a specific number of PIPs, but they must select number and topic based on results of their quality monitoring or state survey results.</td>
<td>Do the PIPs reflect needs based on their results from quality monitoring of patient outcomes, internal organizational processes, past performance (such as survey results)?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>573</td>
<td>Must document PIPs: reasons for projects, measure progress toward goal</td>
<td>Performance improvement projects must be documented as written, include elements outlined in standards and have data to show measurable improvement toward goals.</td>
<td>Review PIP reports to see if they regularly measure progress toward goals, follow the best performance standards developed.</td>
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<tbody>
<tr>
<td>574</td>
<td>Governing body responsible to ensure QAPI program for quality assurance, pt safety is implemented, maintained and annually evaluated</td>
<td>No guidance to surveyors here. Ask for copy of governing body minutes for past two years. See if they received QAPI plan for each year, and had regular reports of QAPI progress toward goals, ensure evaluation of success/progress from implementation of plan.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>575</td>
<td>Governing body (GB) to assure QAPI program is hospital-wide and addressed priorities for quality care, patient safety and improvement actions are evaluated for effectiveness</td>
<td>QAPI program approved by GB. Should be focused on one service (e.g. nursing). It should include patient satisfaction measures, and effectiveness of actions implemented should be evaluated for any further need for the planned actions. Do they decide to continue to monitor for improvement, or change to new problem focus/review corrective actions needed?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>576</td>
<td>Governing body ensures that one or more persons are appointed to operate the QAPI program</td>
<td>GB is responsible to make sure the QAPI program actively addresses problem areas in patient care, and other hospital operations. GB must assign at least one person responsible to lead the QAPI program.</td>
<td>Review GB minutes for the past two to three years to see if they appointed, or received reports from, the person responsible for QAPI program leadership. GB regularly receives reports and gives approval of QAPI measures chosen, and providing oversight of QAPI implementation and evaluation process.</td>
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******************  ******************
For any deficiencies identified: See notes of findings for QAPI deficiencies on Surveyor Notes Worksheets and attached copies.
**Part 3: Implement QAPI Program**

- **Regulatory Compliance**
- **Quality Assessment/Performance Improvement**
- **QAPI Components**

**Recommendations for Implementation**

- Conduct a hospice-wide (360 degree) assessment to identify QAPI program priorities and include all departments.
- Conduct an annual update of the QAPI Plan (based on the hospice-wide assessment).
- Designate in writing the person or persons responsible for the QAPI program.
- Ensure that the QAPI program is data driven and contains all required elements.
- Ensure there is evidence of Governing Body involvement in the development/approval of QAPI plan including frequency and detail of data collection.
- Utilize a standard methodology for Performance Improvement Projects (PIPs) such as OBQI, PDCA, IHI, etc.
Example Performance Improvement Project Methodology (Deming)

QAPI Program Data-Routine Monitoring

- Clinical Record Review Results
- Look at Timeliness of Documentation
- Use of LCDs - Compliance with Documentation
- CAHPS Hospice Survey
- Hospice Item Set
- QAPI Measures and benchmarking
- PEPPER Reports
- Plans of Correction
- GIP Utilization
- SNF Coordination
- Pre Billing Audit Measures
- Compliance Audits
- Risk Management (falls, infection control, adverse events, complaints, etc.)
- Clinical Competency
- Human Resources/Personnel Manual
QAPI Program Data-Routine Monitoring

- Additional Process Measures:
  → What would your Agency like to look at?
    - Pain Measurement/Management
    - Fall Prevention
    - Symptom Management
    - Medication Reconciliation
    - Opioid/Bowel Management
    - Timeliness of Care
    - Other?

- Next Up: Sample Performance Improvement Plan (PIP)

A monitoring plan provides the scope of your program (what you are measuring/monitoring), the frequency of your analysis (monthly, quarterly, annually) and the desired outcomes for evaluating the effectiveness of your efforts (goals).
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PIP Example

• Problem statement
  → “HIS measure for pain assessment has aggregate score of 70% across the division through Q2 2015 – this is below the national benchmark of 76% and does not represent the actual work of pain assessment completion being documented by RNs.”
  → WHY?

PIP Example

• To answer the question, “Why?”
  → Conducted root cause analysis (RCA) identifying possible reasons for the missed goal of 80% or better.
  → Identified 2 potential primary causes:
    • Technical – mapping issue between EMR and SHP identified and corrected.
    • Comprehension and output – RNs were not completing a full comprehensive pain assessment for non-verbal patients as instructed in the HIS manual from CMS.
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PIP Example

• Actions
  → Worked with SHP and AS to correct the technical issues – minimal impact to overall outcome.
  → Conducted re-training with all clinical leaders and provided education and support tools for them to use with local staff in July (start of Q3).
    • Overview of HIS.
    • Workflow from EMR documentation to SHP report.
    • Walked through how to read and use the SHP HIS report at the local level to drill down to individual documentation.
    • Worked backwards from the report to the data from the assessment to the actual screens where data entry occurred.

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PIP Example

• Monitoring
  → Reviewed individual site scores and aggregate divisional scores monthly.
  → Conducted additional peer-to-peer training using clinical leaders who garnered immediate improvement to support clinical leaders who continued to struggle (top performer with underperformer = everyone wins!).
  → Checked results at end of Q4 – WIN! Aggregate scores for HIS Pain assessment measure now at 86% - 16% increase in 3 months.
## PIP Example

### 4. Pain Assessment

The percentage of hospice patients who screened positive for pain and who received a comprehensive assessment of pain within 1 day of screening.

<table>
<thead>
<tr>
<th>Patients</th>
<th>Measure Me</th>
<th>Measure Not Me</th>
<th>Your</th>
<th>SHP Multistate</th>
<th>SHP National</th>
<th>Your % Rank</th>
</tr>
</thead>
<tbody>
<tr>
<td>1,116</td>
<td>839</td>
<td>347</td>
<td>76.7</td>
<td>73.6</td>
<td>76.4</td>
<td>33</td>
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<tbody>
<tr>
<td>204</td>
<td>205</td>
<td>41</td>
<td>86.1</td>
<td>83.9</td>
<td>84.5</td>
<td>30</td>
</tr>
</tbody>
</table>

## HIS and CAHPS Hospice Survey - Connections

- Potential uses of Quality Reporting Data for Hospice agency strategic and operational decision making: Key crossover areas:
  - Pain
  - Breathing/Dyspnea.
  - Opioid Use/Bowel Regime.
- Note areas that non-direct care staff will have impact:
  - Timeliness of response to calls - including weekend/on-call.
  - Timeliness of visits - this includes admissions.
  - Dignity and Respect/Caring.
Quality Reporting Data: HIS and CAHPS Hospice Survey

- Objective measures - can begin to compare QUALITY, not only claims data.
- Must be collected in a consistent manner (“apples to apples”).
- Train staff in key quality measures-HIS and CAHPS Hospice Survey to increase awareness of how they address these areas with the patient/family.
  \( \rightarrow \) Identify how HIS and CAHPS Hospice outcome measures will impact hospice operations and reimbursement.
  \( \rightarrow \) Identify how daily clinical practice and operations can impact these responses and hospice outcomes.

PIP Example

- Problem statement
  \( \rightarrow \) “CAHPS questions 16, 22, 25 and 27 (all related to symptom management support and the provision of information to the PCG) are consistently below national benchmarks.”
  \( \rightarrow \) WHY?
To answer the question, “Why?”

- Conducted root cause analysis (RCA) identifying possible reasons for the missed goal of 80% or better.

- Multiple potential reasons identified:
  - Communications issues (language, verbiage, timing, etc).
  - Comprehension issues (overly technical, generality of terms, clinical expertise lacking).
  - Missed opportunities to conduct teaching/provide education.
  - Lack of process to support learner feedback (teach back or show back method).
**PIP Example**

- Can’t address them all so we picked the one we felt had the broadest impact – comprehension.
- Developed broad task force with nurses, social workers and leadership team members.
- Brainstormed methods to improve comprehension to include references for patients/caregivers, support tools for clinicians and materials for just-in-time teaching (JITT).

Developed a 35-page booklet to address expectations, including the specific language found in the survey questions.
There are 8 sections in the booklet.

Each section is divided into 2 parts. The first part provides a narrative with helpful information written specifically for patients/caregivers.

What is pain?
- It is what the individual says it is
- Hurting or discomfort
- A condition that can cause physical, emotional or spiritual distress and can contribute to financial stress
- An aching that can only be felt and described by the person with the pain
- Pain affects everyone involved
- Older adults may describe pain as aching, burning, growing, grabbing, being uncomfortable, or numbing
- Children may express pain in different ways, such as when they sleep, when they are crying, or when they are described using words like owie or boo-boo to describe pain
- Confused patients, those with cognitive impairment, or those that cannot speak for themselves may have behavior changes such as pacing, moaning, agitation, grinning, or furrowed brow that can indicate pain.

What to report to the hospice/palliative care team?
- How severe or intense the pain is. It can be reported on a number using 0 as no pain and 10 as the worst possible pain imaginable. Other ways of reporting pain are also available such as; mild to severe, using different types of pictures. Ask your nurse to tell you more about the options for reporting. There are also options for rating children’s pain.
- Where the pain is located
- If the pain keeps you from doing your usual activities
- What makes the pain worse
- What makes the pain better
- What does the pain feel like (burning, sharp, stabbing)
- Is the pain constant or does the pain come and go

Managing pain (cont’d)

<table>
<thead>
<tr>
<th>Drug Classification</th>
<th>Examples</th>
<th>Common Uses</th>
<th>Potential Warnings</th>
</tr>
</thead>
</table>
| Non-Narcotic Analgesics | Transdermally (Esky)
|                     |          | Relieves mild to moderate pain |
|                     | \* Morphone
|                     | \* Daranegrin
|                     | \* Ocydrenalin |

| Non-Steroidal Anti-Inflammatory Drugs (NSAIDS) | Aspirin
| Supplinary (Pristone, Advil)
| Metamizol (Browne, Ambrel)
| Trimecain |

| Non-Steroidal Anti-Inflammatory Drugs (NSAIDS) | Relieves inflammation or swelling that can cause pain and/or reduces fever |
| May cause stomach upset (nausea), constipation, diarrhea, or heartburn |
| Avoid alcohol |
| Avoid all NSAIDS |

| Non-Steroidal Anti-Inflammatory Drugs (NSAIDS) | Relieves soreness, helps initiate and maintain sleep |
| May cause dry mouth, constipation, diarrhea, or heartburn |
| Avoid alcohol |
| Do not stop taking this medication without first talking to it may affect your ability to focus or drive |

| Non-Steroidal Anti-Inflammatory Drugs (NSAIDS) | Helps regulate body function |
| May cause heartburn, higher blood pressure, constipation, diarrhea, or heartburn |
| Avoid alcohol |
| Do not stop taking this medication without first talking to it may affect your ability to focus or drive |

The second part contains a grid with common medications used to manage that particular symptom and potential side effects common to that medication.
Connecting the Dots for a Successful QAPI Program

**PIP Example**

- **Actions (continued)**
  - We vetted the book with our physicians and our PBM provided the medications grid.
  - Our marketing department put the whole thing together and we sent a box of 100 to each office location.
  - We conducted training with executive directors and clinical leaders – the booklets were inserted in the admission packets AND all nurses received 5 extra copies to carry with them for JITT.

**PIP Example**

- **Monitoring**
  - Checked CAHPS scores monthly and reached out to individual locations when requested for additional support.
  - Over 5 months (Aug – Dec 2015), scores steadily improved to either slightly below or at the national marks but certainly markedly better than our scores from Jan – July.
5. Getting Help for Symptoms

<table>
<thead>
<tr>
<th>Individual Questions</th>
<th>Jan – Jul</th>
<th>Aug - Dec</th>
</tr>
</thead>
<tbody>
<tr>
<td>16: Appropriate amount of help with pain was provided (% Yes, definitely)</td>
<td>77%</td>
<td>83%</td>
</tr>
<tr>
<td>22: Help provided for trouble breathing (% Always)</td>
<td>77%</td>
<td>83%</td>
</tr>
<tr>
<td>25: Help provided for trouble with constipation (% Always)</td>
<td>72%</td>
<td>73%</td>
</tr>
<tr>
<td>27: Help provided for feelings of anxiety or sadness (% Always)</td>
<td>58%</td>
<td>63%</td>
</tr>
</tbody>
</table>
### QAPI Program: Staff Involvement

- **Why is it important and/or useful?**
  - Compliance with CoPs.
  - Demonstrate quality of care.
  - Provide Feedback on performance.
  - ACCOUNTABILITY!
  - Possible incentive programs if benchmarks/goals are reached.
  - Track performance against budget (if applicable) and/or potential financial penalties if noncompliant with data submission requirements.

### Tips for Performance Improvement Teams (PIPs)

- **Accountability**
  - Identify who should be involved in the PIP.
  - Identify data that is needed.
  - Determine how the data can be collected.
  - Designate a PIP Lead to report to the QAPI Committee.
  - Make sure PIP updates occur according to schedule.
  - Develop a schedule to evaluate results.
  - Use a Team approach to reviewing QAPI findings.
  - Train staff and provide resources as necessary.
  - Ensure Governing Body involvement/oversight.
Culture of Compliance

- Developing a culture of compliance starts at the leadership of an organization and filters down to all staff.

- Compliance with regulatory requirements shapes policies, procedures, job descriptions, performance evaluations, code of conduct, and everyday interaction and behavior of staff within the hospice program.

- This is readily apparent in a comprehensive, agency wide QAPI program.

Involve, Engage, Empower Staff

- Clear definitions create more empowerment.
- Visibility of QAPI initiatives allows staff to work on same goals as management.
- Set targets which will engage all staff:
  → Monitor and share updates;
  → Share information – make it a part of vocabulary;
  → Engage staff in problem solving for indicators that aren’t performing.

- Hold staff and management accountable for managing to specific indicators:
  → Own the results!
Integrating Hospice-Wide QAPI Program Goals

- Foster Employee Engagement
  - At the agency level with identified issues
  - To the staff level
  - Where you want to be
  - Accountability

Group Discussion: Examples
Connecting the Dots for a Successful QAPI Program

Case Examples - Other?

- Focus on areas that are important to YOUR hospice based on data (high risk, problem prone).

Examples:

→ Complaint Logs
→ Plan of Correction L-Tags
→ Adverse Events
→ HIS
→ CAHPS Hospice Survey
→ PEPPER Reports
→ Clinical Record Review Results
→ Pre-Billing Audit Results (Revenue Cycle)
→ Personnel Record Review Results
Questions?

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