Implementing an Effective Quality Assurance Performance Improvement Program (QAPI): A Cheerleader’s Guide

March 6, 2020

Presented By: Armella (Mella) Grainger
Currently provides hospital management, consulting services and technology to:

- Serving community, district, non-profit and Critical Access hospitals
  Example Managed Hospital Client: Barrett Hospital and Healthcare in Dillon, MT, Ranked as a Top 100 Critical Access Hospital for 8 years in a row

Example technology and AR services client includes two-hospital NFP system in southeast GA with numerous associated physician practices

Preferred vendor to:
- California Critical Access Hospital Network
- Western Healthcare Alliance Partner with Illinois Critical Access Hospital Network
- Vizient Group Purchasing Organization
## Areas of Expertise

*Strategy - Solutions - Support*

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The Right Executive – our experience and understanding of your hospital is the key to placing the right executive

Immediate Response – Interim needs are typically immediate. Our bench strength allows us to find the right executive quickly to provide a seamless transition

Experience – over 49 years of supporting executives & teams in hospitals and healthcare companies of all sizes

Support Services – our business is managing hospitals more efficiently. We provide comprehensive support services to all our Interim Executives

Our Depth:
We support all positions from middle management and up including clinical managers, HR up to CEO, CFO, CNO, CIO & Clinic Administration

Interim Executive Placement Services:
“Blue Mountain Hospital District has benefited from the interim executive placement services HealthTech S3 provides. Our current CFO started as an interim placement for BMHD, prior to joining our organization in a permanent capacity. The success with this placement has motivated us to consult Health Tech with two subsequent interim executive needs.” Derek Daly, CEO BMHD

HealthTechS3
Design.Build.Optimize High Performance Teams

Retained Contingency Interim Contract
Mentoring/Support Team

Every Interim Executive is backed by a support team and mentor who help ensure that the team gets the right results.

HealthTechS3
Design. Build. Optimize → High Performance Teams

Operations
- Neil Todhunter, President
- Mike Lieb, VP - Interim Placement
- Derek Morkel, CEO

Clinical
- Carolyn St. Charles, Regional Chief Clinical Officer
- Faith Jones, Director of Care Coordination and Lean Consulting
- John Coldsmith, Clinical Consultant

Financial/RCM
- John Freeman, AVP Finance
- Kevin Stringer, AVP Finance
- Joy Smith, Senior Patient Financial Consultant

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What's New In The 2020: Physician Fee Schedule That May Impact Your Care Coordination Program?

Date: January 23, 2020 Time: 12pm CST
Presenter: Faith M Jones, MSN, RN, NEA-BC – Director of Care Coordination and Lean Consulting, HealthTechS3

Swing Bed Regulatory Requirements Revised – Again!

Date: January 24, 2020 Time: 12pm CST
Presenter: Carolyn St.Charles, RN, BSN, MBA, Regional Chief Clinical Officer

New Discharge Planning Requirements – What You Need To Know

Date: February 7, 2020 Time: 12:00 pm CST
Presenter: Carolyn St.Charles, RN, BSN, MBA, Regional Chief Clinical Officer
https://bit.ly/3oLDCz2

Health Promotion Is The Goal Of An Effective Care Coordination Program – Are You Reaching Your Goal?

Date: February 20, 2020 Time: 12pm CST
Presenter: Faith M Jones, MSN, RN, NEA-BC – Director of Care Coordination and Lean Consulting, HealthTechS3

Implementing An Effective Quality Assurance/Performance Improvement Program – A Cheerleader's Guide

Date: March 6, 2020 Time: 12pm CST
Presenter: Carolyn St.Charles, RN, BSN, MBA, Regional Chief Clinical Officer

The Art And Science Of Interim Placement: Speed Dating

Date: March 11, 2020 Time: 12pm CST
Presenter: Mike Lieb, Vice President – Interim Services, HealthTechS3
https://bit.ly/3avl6Qt

Recruiting A Difference Maker For Your Rural Hospital

Date: March 19, 2020 Time: 12pm CST
Presenter: Peter Goodspeed – VP of Executive Search, HTS3 Executive Recruiting

Managing Behavioral Health Patients In Your Primary Care Practice With Collaborative Care Management

Date: March 26, 2020 Time: 12pm CST
Presenters: Faith M Jones, MSN, RN, NEA-BC, Director of Care Coordination and Lean Consulting, HealthTechS3
https://bit.ly/36mmL7j
Instructions for today's Webinar

- You may type a question in the text box if you have a question during the presentation.
- We will try to cover all of your questions – but if we don’t get to them during the webinar we will follow-up with you by e-mail.
- You may also send questions after the webinar to our team (contact information is included at the end of the presentation).
- The webinar will be recorded and the recording will be available on the HealthTechS3 web site: www.healthtechs3.com.

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Mella is the Vice President of Healthcare Strategies and has over 25 years of experience in healthcare providing regulatory compliance and quality services for healthcare organizations. She has provided consulting services for over 50 healthcare facilities, including acute care and CAHs, throughout the United States.

Healthcare Strategies collaborates with HealthTechS3 to provide mock surveys for HTS3 clients.

Armella (Mella) Grainger
MSN, MBA, MT, RN, CNL, HACP
Vice President, Healthcare Strategies, Inc.
Agenda

1. Objectives
2. Note/Disclaimers
3. Format
4. Why a Cheerleaders Approach?
5. Introduction to Structure, Process, Outcomes (SPO) Considerations for QAPI
6. CMS QAPI Timeline & Basics
7. Highlights of CMS QAPI Changes & Suggested Strategies for Compliance
8. Questions
Objectives

Upon completion of the webinar participants will be able to identify at least one strategy for:

1. Developing and implementing prioritization strategies for a QAPI program; and

2. Implementing and sustaining an organization wide program focused on reducing harm and improving safety.
1. **Objective Evidence**

2. This presentation is not a detailed review of all recent CMS changes, including CMS QAPI requirements.

3. Although QAPI improvement strategies may be applied to any facility type, only Hospital and CAH CoPs are referenced.

4. All applicable CMS Tags are not referenced; only most pertinent Tags are referenced.
Topics Covered ➔ Based Upon CMS QAPI Conditions of Participation
  ❑ Leadership – Responsibility and Oversight
  ❑ Integration/Scope
  ❑ Priorities/Prioritization
  ❑ Measurement & Data Collection
  ❑ Analysis & Tracking / Reporting & Action
  ❑ Outcome
  ❑ Additional Hospital Requirements

Can you provide Objective Evidence of Each Requirement?

➢ Review of QAPI Requirements by Topic Followed by Strategies

Leadership & Integration / Scope: Requirements

Leadership & Integration / Scope: Suggested Strategies
Why a Cheerleader’s Approach?

• “Quality is not a Department..... The Quality Director is basically the coach, facilitator and cheerleader. His or her job is to instill principles of quality at all levels, helping everyone in your organization---every employee, executive, caregiver, and consultant--- feel driven to exceed.” (1)

• Responsibility and Accountability

• Culture

(1) Institute for Healthcare Improvement, Improvement Tip: “Quality” is not a Department, retrieved 2/15/17
Does Your QAPI Program Look/Feel Like This?

Structure

Process

Outcome
Or This?

Structure → Process → Outcome
Structure, Process, Outcome (SPO) Model

• **SPO Quality Framework**
  ➢ Framework for assessing quality of care
  ➢ Flexible/Multiple Uses

• **Use in Development and Assessment of QAPI Program**

  - **Structure**
    • What are the structures that support your QAPI program?

  - **Process**
    • What are the processes that support your QAPI program?
    • Are they efficient and effective?

  - **Outcome**
    • What are the outcomes of your QAPI program?
    • How do you know your QAPI program is efficient and effective?
CMS QAPI Timeline & Basics
Timeline of Recent CMS Revisions

- **Sept 30, 2019**
  - CMS Published Final Rules:
    1. Revised Regulations for Various Certified Providers and Supplier Types (includes QAPI, IC, H&P, Nursing and other revisions)
    2. Discharge Planning for Hospitals, CAHs and HHAs

- **Nov 29, 2019**
  - All Revisions Effective Except:
    1. Antibiotic Stewardship
    2. CAH QAPI

- **Dec 20, 2019**
  - CMS Final Guidance Memo Published which describes:
    1. Effective Dates
    2. Training Development for Surveyors
    3. Deemed Status AO Requirements
    4. SOM Appendix Revisions

  **Important!** Some IGs pending

- **Dec 2019 - Jan 2020**
  - Surveyor Training
    1. CMS to Initiate Release of Surveyor Training

- **Mar 30, 2020**
  - Hospital & CAH
    1. Antibiotic Stewardship Effective

- **Mar 30, 2021**
  - CAH
    1. QAPI Effective *

  * Current Tags Effective Until Mar 30, 2021

**Be on lookout for when your accrediting body(ies) updates their standards (e.g. DNV, TJC, HFAP, CIHQ, etc.)**
CAH Example:

C-1300
(Rev. - Effective March 30, 2021)

§485.641 Condition of Participation: Quality Assessment and Performance Improvement Program

The CAH must develop, implement, and maintain an effective, ongoing, CAH-wide, data-driven quality assessment and performance improvement (QAPI) program. The CAH must maintain and demonstrate evidence of the effectiveness of its QAPI program.

(a) Definitions. For the purposes of this section—

Adverse event means an untoward, undesirable, and usually unanticipated event that causes death or serious injury or the risk thereof. Error means the failure of a planned action to be completed as intended or the use of a wrong plan to achieve an aim. Errors can include problems in practice, products, procedures, and systems; and Medical error means an error that occurs in the delivery of healthcare services.

Interpretive Guidelines §485.641(a)

Guidance is pending and will be updated in future release.

Survey Procedures §485.641(a)

Survey Procedures are pending and will be updated in future release.

C-1302
(Rev. - Effective March 30, 2021)

§485.641(b) Standard: QAPI Program Design and scope. The CAH’s QAPI program must:

(1) Be appropriate for the complexity of the CAH’s organization and services provided.
Medicare State Operations Manual

**Important:** Not yet updated with recent CMS revisions

### Appendix

- Each Appendix is a separate file that can be accessed directly from the SOM Appendix Table of Contents, as applicable.
- The appendices are in PDF format, which is the format generally used in the SOM to display files. Click on the corresponding letter in the Appendix Letter column to view any available file in PDF.
- To return to this page after opening a PDF file on your desktop, use the browser “back” button. This is because closing the file usually will also close most browsers.

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Highlights of CMS QAPI Changes (Hospital/CAH) & Suggested Strategies for Compliance
Leadership & Integration/Scope - Requirements

Leadership - Responsibility and Oversight

➢ Governing body ultimately responsible (A-0083, C-1313)
  “Responsible Individual”
➢ Must develop, implement and maintain an ongoing effective program (A-0263, C-0336, C-1300, C-1306)
➢ Must be organization-wide and appropriate for complexity of services provided (A-0083, A-0263, C-1302, C-1306)

Integration/Scope

➢ All department and services must be involved (including those under contract or arrangement) (A-0083, A-0263, C-1306)
Leadership & Integration/Scope – Suggested Strategies

- **Identify leadership group to conduct a GAP Analysis of New Requirements**
  - Consider including Board member(s) and medical staff leader(s)

- **Educate Board, Medical Staff Leadership, Administrative Team**

- **Review current organizational chart**
  - Does it include the Board, Medical Staff and **ALL** departments and services provided by the organization (including NS, Contractors, IP, OP, etc.)?
  - Current? Evidence of Review and Approval?
Leadership & Integration/Scope – Suggested Strategies

- Review the QAPI communication/reporting structure, including feedback loops
  - Does it include:
    - The Board, including any applicable Board subcommittees?
    - Medical Staff?
  - Is there an assigned mechanism/committee for each department and service to report to the Quality Oversight Committee and ultimately the MEC & Board?
    - Reporting Structure → MAP IT!!
    - Are feedback loops identified?
    - Are data collection requirements & responsibilities clearly defined → MAP IT!!
Leadership & Integration/Scope – Suggested Strategies

❑ **Committee leadership and members**
  o Assess
    ▪ Are they the right people? Are they advocates of the QAPI program?
    ▪ What support do they need to achieve goals of the quality program?
  o Clearly define Committee Responsibilities, Accountabilities & Expectations
  o When structure is completed/revised, educate committee leaders (official and unofficial) and members

❑ **PI/QAPI Plan**
  o Review and update PI/QAPI Plan to reflect integrated structure & revised standards → **Attach MAP**
  o When finalized → Approve the Plan

❑ **CMS Worksheet(s)**
  o QAPI
  o Infection Control
  o Discharge Planning
Priorities/Prioritization

➢ Must be identified (A-0283, C-1321)

➢ Must address/consider the following criteria:
  - **High Volume (HV), High Risk (HR) or Problem Prone (PP) areas** (A-0283, C-1321)
  - **Incidence, prevalence and severity** of problems (A-0283)
  - Affect on health **outcomes, patient safety**, and **quality of care** (A-0283)
Priorities/Prioritization – Suggested Strategies

1. What is a Priority?

2. If you have a prioritization grid/document:
   a. Do you use it??
   b. When was last time it was reviewed??

- Review/develop criteria-based prioritization process.....and USE IT!
  - Criteria must include requirements noted on previous slide; and
  - Criteria should include:
    - Issues key to achieving strategic plan priorities/goals
    - Anything CMS, State or your AO indicates should be a priority

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<th>POTENTIAL AREAS FOR IMPROVEMENT</th>
<th>PREVALENCE</th>
<th>RISK</th>
<th>COST</th>
<th>RELEVANCE</th>
<th>RESPONSIVENESS</th>
<th>FEASIBILITY</th>
<th>CONTINUITY</th>
<th>TOTAL SCORE</th>
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<td>Consider areas identified through Dashboard(s), Feedback from staff, families, patients, other Incidents, near misses, unsafe conditions, Survey deficiencies</td>
<td>The frequency at which this issue arises in our organization.</td>
<td>The level to which this issue poses a risk to the well-being of our patients.</td>
<td>The cost incurred by our organization each time this issue occurs.</td>
<td>The extent to which addressing this issue would affect quality of life and/or quality of care.</td>
<td>The likelihood an initiative on this issue would address a need expressed by patients, family and/or staff/medical staff</td>
<td>The level to which an initiative on this issue would support our organizational goals and priorities.</td>
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CMS Prioritization Worksheet Example

Important Note
Priorities identified should:

1. Be consistent with any priorities specified by CMS, State or your AO
2. Support organization’s strategic plan initiatives
3. Be identified based upon CMS criteria and any State or AO required criteria
Priorities/Prioritization – Suggested Strategies

- Identify Priorities at least annually
  - When documenting identified priorities make certain link to rationale for selection (HR, Problem Prone, etc.)

- Review/update QAPI Plan to describe
  - How priorities are identified and how/when priorities may be adjusted throughout the course of the year (e.g. unusual or urgent events)
Priorities/Prioritization – Suggested Strategies

- **Required Priorities**
  - Anything **CMS, State or your AO** indicates should be a priority (e.g., JC identifies several required priorities (e.g., antimicrobial stewardship, clinical alarm safety, opioid safety)
    - COVID-19 Response (3/4/20 - FAQs, Triage, Placement, Discharge Planning, etc.)
      - Memo to State Survey Agency Directors
    - Review your AO priority requirements and CMS, State requirements

- **Highly Recommended Priorities**
  - Antimicrobial Stewardship (JC required)
  - Opioid Safety (JC required)
  - HLD & Sterilization
  - Culture of Safety
  - IV Compounding (Pharmacy and Non-Pharmacy compounding)
  - Ligature Risk and Suicide Prevention
  - Water Management
  - Publicly Reported Measures
Priorities/Prioritization – Suggested Strategies

- **Identify specific measurements and goals for priorities identified**
  - E.g. if HLD/Sterilization is identified as a priority, what are the specific measures to be achieved?
  - SMART?
    - Specific, Measurable, Achievable, Relevant, Time-bound

- **QAPI Annual Report**
  - Include summary of PI Priorities for year
  - Identify the PI Priorities for the coming year using data for current year and prioritization grid
    (may also be included in next years QAPI Plan)
Measurement & Data Collection - Requirements

Objective measures are used to analyze and track performance (C-1309, C-1319)

Measures must be “predictive of desired patient outcomes” (C – 1315)

Must include relevant data, including but not limited to: (A-0273, C-1311, C-1315, C-1325)

- Measures to improve health outcomes (outcomes indicators) and prevent/reduce errors and adverse events
- Data submitted to or received from Medicare quality reporting and quality performance programs, including but not limited to:
  - Hospital/CAH acquired conditions
  - Transitions in care, including readmission

IMPORTANT - SPECIFIC NEW DISCHARGE (DC) PLANNING REQUIREMENT!!

- Assessment of DC Planning Process on a regular basis, including representative sample of DC Plans, including patients who were readmitted within 30 days of previous admission (A-0803, C-1422)
Measurement & Data Collection - Requirements

**Measurement & Data Collection (continued)**

➢ Infection Control → Additional updates found in Infection Control CoPs.
  
  o **Tracking and surveillance** systems for IP&C and antibiotic use demonstrate implementation, success and sustainability of activities (C-1225)
  
  o **IP&C and Antibiotic Use** must be communicated and addressed in collaboration with the organization-wide QAPI program (A-0747, C-1200, C-1229, C-1237, C-1248)
  
  o **HAIs**, including **auditing of adherence** to infection prevention and control policies and procedures by hospital personnel must be conducted (A-0776, C-1240)

➢ Multiple other specific requirements, including **but not limited** to:
  
  o **Medication Therapy**
  
  o **Discharge Planning** (A-0803, C-1422)
Measurement & Data Collection – Suggested Strategies

- Conduct a GAP Analysis against current CMS, State and Accrediting Organization (AO) measurement and data collection requirements
  o DO NOT focus only on AO’s QAPI chapter!!!
  o Include appropriate leaders in review, for example:
    - New CMS Discharge Planning CoPs → Case Management Leadership
    - New CMS Infection Control and Abx Stewardship → Pharmacy and IP&C Leadership
  o Is there anything currently being collected that could be dropped, no longer relevant, required, etc.?

- Report results of GAP Analysis and corrective action plan to quality oversight committee

- Verify measures are clearly defined:
  o Rate based when applicable (e.g., restraint usage data)
  o Definition is consistent with nationally recognized metrics when available
  o Have established benchmarks
    • Use nationally recognized benchmarks, if available
    • If benchmarking against self, clarify this and how the benchmark was established.
Measurement & Data Collection – Suggested Strategies

❑ Develop a standardized form/format for defining indicators
  o Indicator Definition (Numerator, Denominator, Exclusion Criteria)
  o Source of Indicator Definition (CMS, JC, Press-Ganey, etc. etc.)
  o Rationale for Selection (e.g., Priority, Required by ____, Low Volume/High Risk, etc.) Important Note
  o “Pillar” of Strategic Plan indicator supports
  o Indicator Type → Outcome, Process, Structural, etc.
  o Benchmark/Goal
  o Benchmark/Goal Source (e.g., CMS, internal, etc.)
  o Responsibility for Data Collection
  o Responsibility of Oversight of Corrective Actions and Sustaining Compliance
  o Oversight Committee
  o Report Format (e.g., is it a specifically titled dashboard, such as the HLD/Sterilization Dashboard or P&T Committee Dashboard?)
  o Data Collection Frequency
  o Reporting Frequency
  o Data Source, Sample Size Methodology, Duration

❑ Complete above for each indicator → Where to Start?
Measurement & Data Collection – Suggested Strategies

- Helpful Tool
  - CMS Measure/Indicator Development Worksheet (QAPI) [Important Note]

- Have each department/service identify a minimum of 2 indicators, one of which is an outcome indicator

- Add the indicator specifics to Dashboard(s) or Presentation Materials for easy access and reference

- MAP assignment of oversight responsibilities!
Measurement & Data Collection – Suggested Strategies

❑ Review How Data Is Collected & Aggregated
  o Obtain Data Collector’s Feedback and Identify Opportunities for Improvement (OFIs) Include
    • Audit Tools (Manual)
    • Electronic
    • Data Entry/Aggregation
    • Training Needs
  o IT Opportunities?

❑ Review How Data is Validated and Identify OFIs
  o Inter-Rater Reliability – How do you validate the data?
Analysis & Tracking/Reporting & Action - Requirements

Analysis & Tracking
➢ Measures are used to track and analyze (A-0273, C-1319)
➢ Measurable improvements and goal achievement (A-0273, C-1325)

Reporting & Taking Action
➢ Periodic Evaluation and Review (C-0330)
  o AOs for Hospitals
➢ IMPORTANT !!! If it’s not documented, it didn’t happen!
  o What Objective Evidence of the following:
    ▪ Leadership oversight and accountability
    ▪ Integration
    ▪ Analysis
    ▪ Action
    ▪ Etc.
Analysis & Tracking/Reporting & Action –
Suggested Strategies

- **Reporting Schedule**
  - Develop a **reporting schedule** that includes all required measures & dept/services to the QAPI Oversight Committee
  - Develop a **reporting schedule** to the Board
  - Define **when flexibility/variation is allowed** and **who is authorized** to allow the variation

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<td>Utilization Review (QM.7 SR.9)</td>
<td>John Doe, CM Director</td>
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<td>Compliance with Discharge Planning Processes</td>
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<td>Staff and physician satisfaction with Discharge Planning Process</td>
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<td>Patient Satisfaction – Readiness for Discharge</td>
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<td>Compliance with IMM</td>
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<td>Pain Management (QM.7 SR.7)</td>
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<td>Patient Satisfaction with Pain Management</td>
<td>Bob White, PharmD, Pain Management Team Leader</td>
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<td>Compliance with Assessment and Reassessments by Individual Department</td>
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<td>Opioid Safety Report</td>
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Analysis & Tracking/Reporting & Action –
Suggested Strategies

❑ Minutes
  o Educate Recorder/Individual responsible for taking minutes
  o Consider “Real Time” DRAFT Minutes if possible
  o Educate Proofer
  o Legal/Risk

❑ Standardized Minutes Template
  o TOPIC
  o DISCUSSION (includes discussion of data or reference to attached data, etc.)
    ▪ POINT IN TIME DATA REPORTS ➔ Should be minimal and only to indicate/confirm “Hey, we
      might have a problem here”
  o ANALYSIS ➔ WHY
    ▪ IMPORTANT
      • “WHY” IS NOT a restatement of the data (i.e., statement of data is in Discussion)
      • “WHY” IS the barriers to/root causes of suboptimal performance
    ▪ Use SPC when appropriate (at a minimum identify those indicators which will include SPC)
  o ACTION ➔ WHO, WHAT, WHEN, FOLLOW-UP
If ISO, include clarity on INPUTS and OUTPUTS

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<tr>
<th>INPUTS</th>
<th>OUTPUTS</th>
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<tbody>
<tr>
<td><strong>Topic</strong></td>
<td><strong>Findings / Discussion/Analysis (WHY)</strong></td>
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<td>Findings/Discussion:</td>
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<td>Analysis (WHY?):</td>
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Check all that apply and provide details below:
- Opportunities for Improvement
- Preventive Action Required
- Corrective Action Plan Required
- Change to QMS needed
- Resources needed
- No action/output required

Details (must be provided unless no action required):
Analysis & Tracking/Reporting & Action – Suggested Strategies

❑ Develop a Standardized Reporting Template - INCLUDE ANALYSIS & ACTION, etc.
  o Dashboard?
  o PowerPoint?
  o Other?

❑ Consent Agenda
  o Consider using, BUT only when appropriate and not otherwise conflicting with law/reg
  o Define in QAPI Plan:
    • When consent agenda may be used
    • Criteria used to determine an item may be on a consent agenda
    • How consent agenda items are submitted to committee
    • Approval process of consent agenda items
Outcome - Requirements

➢ QAPI Program Evaluation
  o CAH (C-0331 – C-0343 Effective until 3/30/21)
    ▪ Periodic/at least annually
    ▪ Details required elements to be evaluated
  o Hospital
    ▪ Less specific (CMS)
    ▪ AO’s more specific

How do you know your QAPI Program is effective & efficient? Is sustainable?
QAPI Report

- At least annually
- In addition to evaluating progress on Priorities and other metrics:
  - Summarize assessment of effectiveness and efficiency of QAPI Program -
    - Meeting established goals met (General)
    - Qualitative Data (Specific to QAPI program)
      - Interviews or surveys of staff, committee members/chairs, etc.
        Communication, Audit Tools, Aggregation of Data, Presentation Templates, etc.
    - Quantitative Data (Specific to QAPI) - Examples ONLY!!!
      - % of established goals met
      - % of time reports are submitted on time by department and services
      - % of time agendas must be revised due to reports not available
      - % of time corrective action plans are completed within required timeframe
  - Address Resources Needed to Improve QAPI Program
  - Follow outline of CMS QAPI Stds and your AO QAPI/PI Chapter and any Patient Safety requirements
  - Policy and Procedure Summary – Evidenced-Based Practice
  - Summarize QAPI for each department/service
  - Identify Priorities for coming year
  - Identify the distinct number of improvement projects for coming year (Hospital ONLY)

Other Considerations

- Manager/Director/VP evaluation process as related to QAPI
Additional Hospital QAPI Requirements & Suggested Strategies

➢ **Improvement Projects (A-0297)**
  - Distinct number conducted annually **must be proportional** to scope and complexity of services and operations of hospital & documentation requirements (A-0297)
  - Improvement project **must be documented**
  - **Strategies**
    - Identify the PI Projects to be conducted in the coming year in the annual PI report (noting that may be added as identified/needed)
    - Develop **team “charters” and standardized report templates** that address all requirements of A-0237 (Reasons for conducting, goal(s) and measurable progress)
      - Charter Example: CMS [Worksheet to Create a Performance Improvement Project Charter](#)
    - Include PI Project **summaries in annual PI Report**

➢ **Frequency and detail of data collection specified by the Board (A-0273)**
  - **Strategies**
    - Define in QAPI Plan how the Board specified the frequency and detail of data collection.
Additional Hospital QAPI Requirements & Suggested Strategies

Additional Hospital Requirements

- **Multihospital System QAPI** (A-0320 – A-0322; NEW = OPTIONAL)
  - Optional for all system member hospital with separate CCNs and system governing body if in accordance with applicable State and local laws.
  - **Suggested Strategies**:
    - **Review** full requirement with Legal and Governing Body
    - **Document** Governing Bodies determination in minutes
    - If option taken, **update** applicable documents (e.g., QAPI Plan, etc.)
    - **QAPI Oversight Committee and Board Minutes** – Make certain reflect reports from separately certified hospitals
    - Watch for final CMS **Interpretive Guidelines**

**NOTE:** Similar new option exists of Infection Control and Antimicrobial Stewardship
QAPI Program

Structure → Process → Outcome
Summary

1. Why a Cheerleaders Approach?

2. Introduction to Structure, Process, Outcomes (SPO) Considerations for QAPI

3. CMS QAPI Timeline & Basics

4. Highlights of CMS QAPI Changes & Suggested Strategies for Compliance
   - Leadership – Responsibility and Oversight
   - Integration/Scope
   - Priorities/Prioritization
   - Measurement & Data Collection
   - Analysis & Tracking / Reporting & Action
   - Outcome
   - Additional Hospital Requirements
Resources


Centers for Medicare and Medicaid. Hospital Discharge Planning Worksheet released 11/26/14
Centers for Medicare and Medicaid. Medicare and Medicaid Programs; Revisions to Requirements for Discharge Planning for Hospitals, Critical Access Hospitals, and Home Health Agencies, and Hospital and Critical Access Hospital Changes to Promote Innovation, Flexibility, and Improvement in Patient Care, Effective 11/29/19 retrieved 10/1/19

Centers for Medicare and Medicaid. Medicare and Medicaid Programs; Regulatory Provisions To Promote Program Efficiency, Transparency, and Burden Reduction; Fire Safety Requirements for Certain Dialysis Facilities; Hospital and Critical Access Hospital (CAH) Changes To Promote Innovation, Flexibility, and Improvement in Patient Care, Effective 11/29/19 retrieved 10/1/19

Institute of Healthcare Improvement. Improvement Stories/Improvement Tips: “Quality” is Not a Department retrieved 2/15/17
Revised Regulations for Various Certified Providers and Supplier Types

Discharge Planning for Hospitals, CAHs and HHAs

★CMS Final Guidance Memo Published★

Medicare State Operations Manuals

CMS QAPI Worksheet

CMS Measure/Indicator Development Worksheet (QAPI)

CMS Prioritization Worksheet Example

CMS Worksheet to Create a Performance Improvement Project Charter (QAPI)

CMS COVID-19 Response Memo 3/4/20 (FAQs, Triage, Placement, Discharge Planning, etc.) - Hospitals★

Questions for Mella
Thank You

I hope this information has been helpful

If you are interested in a review of your Quality Program – or a Mock Survey – please contact Carolyn St.Charles

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Cell: 206-605-3748