How to Be Ready For QAPI Home Care

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QAPI / QI is NOT just Busy Work!

- Important component of an agency
- Many Administrators and Managers put it on the back burner, thinking that it is busy work!
- A well designed Quality Improvement program can increase your quality AND help you run an efficient organization with less risk.
- You need to identify what you should monitor, along with how to compile, analyze, and trend.
- Most importantly, how to implement action plans.
- A great Quality Improvement program can be simple!

Objectives

- Review the proposed COPs for QAPI standards
- Learn to do a Simple But Important QI Program
- Focus on High Risk, High Volume and Problem Prone Areas
- Incorporate into everyday operations
- Include field and office staff in reviews
- Take Action!

Why QAPI and not QI?

- Proposed COPs for homecare have language similar to Hospice COPs- Using the term:
  - Quality Assessment and Performance Improvement

    or QAPI
- Comprehensive Quality Improvement Programs are basis to the COPs QAPI standards
- Accredited agencies already must do this!
- Incorporates many facets of your agency

Proposed COPs- QAPI

§ 484.65 Quality assessment and performance improvement

Proposed COPs - QAPI

- The HHA must develop, implement, evaluate, and maintain an effective, **ongoing, HHA-wide, data-driven QAPI** program.
- The program reflects the complexity of the organization and its services;
- Involves all HHA services (including those under contract);
- Focuses on indicators related to improved outcomes;
- Takes actions that address performance across the spectrum of care, including the prevention and reduction of medical errors.
- The HHA must maintain documentary evidence of its QAPI program and be able to demonstrate its operation to CMS

Proposed COPs- QAPI

- The program must be capable of showing measurable improvement in indicators that reflect improved
  - Health outcomes,
  - patient safety,
  - and quality of care.
- The HHA must measure, analyze, and track quality indicators, including adverse patient events, and other aspects of performance in order to assess processes of care, HHA services, and operations.

Proposed COPs - QAPI

- The program must utilize quality indicator data, including measures from OASIS, and other relevant data, in the design of its program.
- The HHA must use the data collected to—
  - Monitor the effectiveness and safety of services and quality of care; and
  - Identify opportunities for improvement.
- The frequency and detail of the data collection must be approved by the HHA's governing body.

Proposed COPs - QAPI

- The HHA's performance improvement activities must—
  - Focus on high risk, high volume, or problem prone areas.
  - Consider incidence, prevalence, and severity of problems in those areas.
  - Lead to an immediate correction of any identified problem that directly or potentially threaten the health and safety of patients.

Proposed COPs- QAPI

- The number and scope of distinct improvement projects conducted annually must reflect the scope, complexity, and past performance of the HHA's services and operations.
- The HHA must document the quality improvement projects undertaken, the reasons for conducting these projects, and the measurable progress achieved on these projects.

Proposed COPs- QAPI

- The governing body ensures that:
  - An ongoing program for QI and patient safety is defined, implemented and maintained.
  - QAPI efforts address quality of care and patient safety, and all improvement actions are evaluated for effectiveness.
  - Clear expectations for patient safety are established, implemented, and maintained.
  - Any findings of fraud or waste are appropriately addressed

Where to Start With Your QAPI Program?

- Complete a Homecare Agency Assessment to Evaluate the agency in order to identify high volume, high risk and problem prone areas
- Incorporate Regulatory Compliance –

  State , COPs, Accrediting, OSHA, CDC, etc

  Customer Satisfaction – CAHPS

  Outcome Measurements – USE CASPER
- Perform a Mock Survey to do this:
  - Clinical Record Reviews
  - Home Visits with staff
  - HR File Reviews to include Competency, Orientation, Inservice Education
  - PAC/ GB Minutes

Regulatory Compliance Assessment

Previous Regulatory Surveys – State/Medicare/Accreditation

- Review the results of your last survey
- If deficiency, be sure your plan of correction is still working
- Sanctions for repeat deficiencies and Conditions
- Make the deficiency part of your QAPI plan
- Continue to monitor

Mock Survey- Home Visits

Do Home Visits with ALL staff

Quarterly is best practice – Bi-annually if not

- Review the Clinical Record prior to Visit
- Interview patient and/or Caregiver
- Locate and review Home Folder
- Observe the Visit- Don't intervene
- Check what was done to Physician Orders and Notes

Customer Satisfaction

- Review the CAHPS reports
- Choose indicators to focus on that are low to benchmarks AND that cross over
- Such as pain management . If this is also low in outcomes then you know you have a problem area.
- Develop an indicator and add criteria that is from the poor scores in the CHAPS survey

Outcome Measurements

CASPER REPORTS

- Critical to review these each time they are updated
- Determine which outcome indicators your agency should be working on - add to criteria in your QI program
- Potentially Avoidable Events
  - Be proactive in identifying adverse events
  - Audit patient records when identified – admissions for falls, hypo/hyperglycemia, wounds, meds, etc
  - Outcomes –
    - Choose those that affect all disciplines – ADL's, IADL's, Ambulation, Pain
    - Choose clinically significant ones – dyspnea, pain, meds, etc.

Mandatory Areas

- Incorporate those mandatory areas into QI
  - Fall reduction tracking
  - Incident Reports
  - Complaints
  - Med Errors / Adverse Med
  - Infections
- Trend/ Analyze and develop specific indicators for those deficient areas

Areas to develop Indicators

- Analyze Assessment Results and Trends
- Identify all of your high volume, high risk and problem prone areas
  - Examples:
    - Wound care
    - infection control
    - IV
    - Protimes
    - Falls
    - Pain
    - Ambulation

QI Team- Get Everyone Invested!

- Choose clinicians and office staff
  - As Large a number as possible
- All assigned indicator they are responsible for
- Minimum of 2 emp for each indicator
- QI Coordinator set up list of pt records for staff to review.
- Assign staff once a week or bi-weekly for half day

Analyze Results and Trends of Above

- The key to a successful QI program is to take the information from the assessment and then to Analyze It, Trend It, and Do Something with it!
- Many agencies collect a lot of data, but don't know what to do with it. . .

Analyze Results

- What did you find from your assessment?
- Where are your trouble areas?
- Do any areas tie together?
  - Examples:
    - Low patient outcomes and poor customer satisfaction
    - High visits per episode, low outcomes
    - Low visits per episode, readmission to hospital

Action Plan

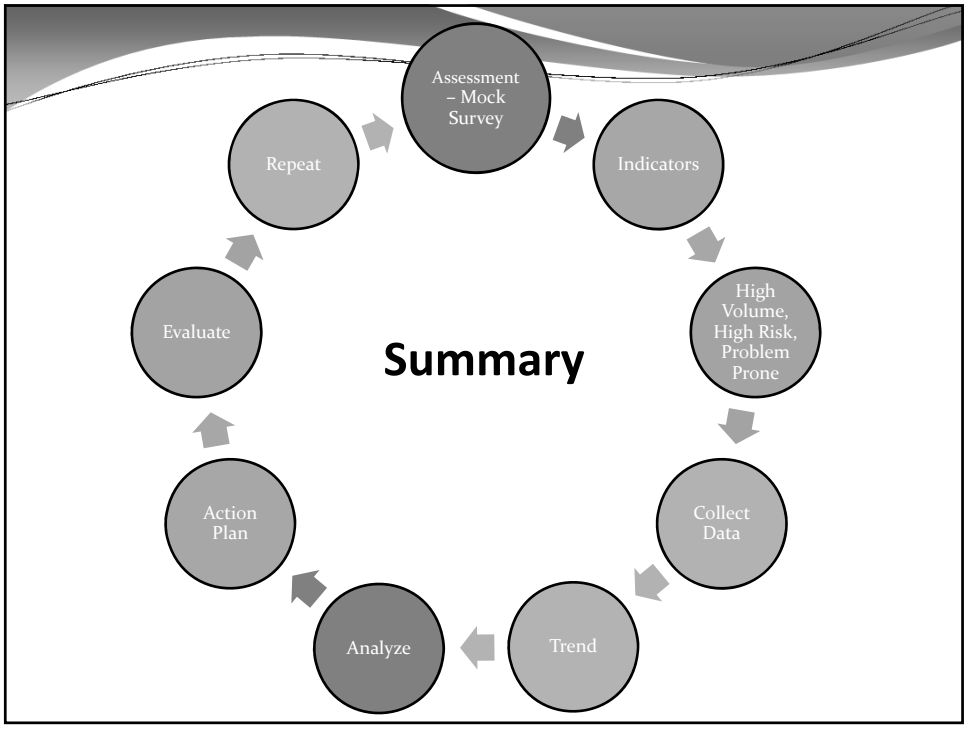
- Specifics found – ex: in 3 of 8 charts reviewed, physician orders were not followed. State for each chart what was not followed.
- Action items: Include monitoring – review 20 records a quarter to focus on following physician orders with a goal of 90% compliance
  - Have the audit tool designed for this particular deficiency – ex: wounds, meds, visit frequency

QI Program

- Use your QI program to help you!
  - Choose activities to monitor from your deficiencies and action plan
  - Focus activities to ensure that you have no vulnerabilities to getting a condition out!
  - Do chart audits with not only survey in mind, but also to prevent ADRs/ZPIC/RAC denials
  - Don't Just have a QI program that is Busy Work
  - Have ALL staff involved!

Analyze Results and Trends of QI

- The key to Continued Survey Readiness is to take the information from QI and the Mock Survey and Analyze It, Trend It, and do something with it!
- Many agencies collect a lot of data, but then let it pile up and don't improve their deficiencies. . .



Examples:

2015–Consents

As result of deficiencies seen in clinical record reviews, agency is doing a QI project to ensure consents are complete, thorough and accurate.

- Started 4th quarter of 2014 and will continue for minimum of 2 qtrs of 2015. An evaluation will be completed after 2nd qtr of 2015 to ascertain if this indicator will continue. If compliance is met, it will be discontinued at that time.
- 2014 actions: After review, of consent, a new consent form was instituted that is more user friendly and has all components required. All staff admitting pts were inserviced to the form.
- In addition, because of errors found in 'filing' in the EMR, a new process was instituted to keep hard copy files on all consents given to DPCS.
- Audit -quarterly review of 50% pt consents to ensure accurate and complete consents are done by admitting clinician - 100% threshold. To be done by QI Coordinator or designee.

Consent audit tool- 100% threshold Qtr: #/% of consents reviewed : _____

Criteria	pt	pt	pt	pt	pt	pt	pt	pt	pt	pt	Total compliance
All areas to be filled out are complete											
Insurance card verified by staff & # recorded											
Pts insurance checked, ie mc,mcd,private											
Verification of Medicare as Primary or Secondary Payor Source completed											
FINANCIAL RESPONSIBILITY completed											
Pt signs and dates											
If another person signs, documentation of POA etc											
Staff signs and dates											
Original consent in hard copy record in agency											
Consent scanned into EMR											
Total % Compliance											

Reason for Emergent Care- Audit Tool

Outcome Reports (CASPER):

- Other respiratory – 38% / 25% prior / 11% ntl
- Uncontrolled pain – 25% / 0 prior/ 5.5% national

Indicator: QI coordinator or designee will review 100% of pt OASIS - reason for emergent care quarterly.

If 'other respiratory' or 'uncontrolled pain' is the reason for emergent care, then a clinical record review will be completed to identify if the agency could have done anything to prevent these occurrences.

- Goal: CASPER data: other respiratory reason- 15%, uncontrolled pain reason- 10%
- Audit criteria met on clinical record review when reason respiratory or pain – Goal: 90%

Criteria	Pt-	Pt	Pt	Pt	Pt
Respiratory:					
Not scored – does pt have resp diagnosis?					
Did the respiratory assessment correlate with the M item for dyspnea?					
Was physician notified for all resp signs and symptoms?					
Was resp education documented ?					
Was understanding of education by pt/cg documented?					
Not Scored- Did the patient /cg contact the HHA prior to going to the ER?					
If yes, did the nurse call the physician and / or make a visit?					
Was there anything the HHA could have done to prevent emergent care for respiratory reasons?					
Total per pt:					
Total compliance : _____					

Criteria	Pt-	Pt
Pain		
Did the pain assessment correlate with the M item for pain on OASIS?		
Was physician notified for all pain signs and symptoms?		
Were all pain assessments complete and thorough?		
Was pain education documented ?		
Was understanding of education by pt/cg documented?		
Not Scored- Did the patient /cg contact the HHA prior to going to the ER?		
If yes, did the nurse call the physician and / or make a visit?		
Was there anything the HHA could have done to prevent emergent care for uncontrolled pain ?		
Total per pt:		
Total compliance : _____		

Homecare Agency QI Calendar		Quality Improvement Results			
Indicator	**Freq**	**Goal**	**Jan**	**Feb**	**Mar**
Clinical Record Review	q	90%			x
Home Visits	q	90%			x
Infection surveillance	q	<2%			x
Fall reduction program- audit	q	90%			x
Fall reduction program- % patient falls	q	<10%			x
Consents	q	100%			x
Human Resoure File - Audit	bi-ann	90%	82%		
Customer satisfaction- CAHPS overall	q	90%			x
Medication errors	q	<2%			x
Adverse drug reactions	q	<1%			x
ER- Respiratory-CASPER	q	15%			x
ER- Respiratory- audit	q	90%			x
ER- Uncontrolled Pain-CASPER	q	10%			x
ER- Uncontrolled Pain-audit	q	90%			x
Pressure Ulcer items - audit	q	90%			
x denotes when compilation data is due; replace with % result when done					

THANK YOU!

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