QAPI TOOLKIT

PROFESSIONAL DEVELOPMENT AND RESOURCE SERIES

National Hospice and Palliative Care Organization

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Table of Contents

Introduction

The National Hospice and Palliative Care Organization (NHPCO) understands the need for a quality assessment performance improvement (QAPI) resource that assists a hospice provider with implementation and maintenance of their quality improvement program and activities. The purpose of the NHPCO QAPI Toolkit is to furnish hospice providers with information and resources to support their QAPI program.

The revision of the federal hospice Conditions of Participation (CoP) in 2008 included the QAPI regulatory requirement which is a more robust approach to quality assessment and performance improvement than seen before in hospice regulations. The Centers for Medicare and Medicaid Services stated in the Preamble to the CoPs the following core requirements for hospice services[1]:

- Patient rights
- Comprehensive assessment
- Patient care planning and coordination of care by an interdisciplinary group

Encompassing these core requirements is the idea that a hospice provider's QAPI program uses its own quality management system to improve patient and family care performance.[2]

The Toolkit provides a framework for QAPI with review of § 418.58 of the Medicare Hospice Conditions of Participation (CoPs): Quality Assessment and Performance Improvement. It will also explore the detailed requirements of the CoP and lists the definition of 'quality' in hospice. In addition, the Toolkit will identify NHPCO's core quality components in the *Hospice Standards of Practice*. The toolkit also provides a review of the components of a quality program and tools and resources to support the development, implementation, and maintenance of a comprehensive and high functioning QAPI program.

It is important to make the distinction between QAPI and the Medicare Hospice Quality Reporting Program (HQRP). HQRP incorporates the compliance requirements related to quality improvement and can help to drive service excellence within a hospice program; however, the measures are standardized and should not be the only focus for quality assessment and performance improvement in a hospice program.

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[1]Centers for Medicare and Medicaid Services. (2008, June 5). Medicare and Medicaid Programs: Hospice Conditions of Participation, Preamble. Retrieved from: https://www.federalregister.gov/documents/2008/06/05/08-1305/medicare-and-medicaid-programs-hospice-conditions-of-participation

[2]Centers for Medicare and Medicaid Services. (2008, June 5). Medicare and Medicaid Programs: Hospice Conditions of Participation, Preamble. Retrieved from: https://www.federalregister.gov/documents/2008/06/05/08-1305/medicare-and-medicaid-programs-hospice-conditions-of-participation

Framework for Quality

1.§ 418.58 Condition of Participation: Quality Assessment and Performance Improvement

The federal hospice Conditions of Participation (CoPs) requires hospice providers to develop, implement and maintain a hospice wide quality assessment performance improvement (QAPI) program in their organization. The QAPI CoP sets a clear expectation that hospices are required to take a proactive approach in improving their performance and focus on improved patient/family care and activities that impact patient health and safety. The QAPI program must have a written plan of implementation and demonstrate continuous assessment of a performance with application of solutions, evaluation of the effectiveness of the solutions, and critical thinking related improvement strategies.[3]

The hospice program's governing body must ensure that the QAPI program is effective, ongoing, data driven, and reflects the complexity of the organizations and its services. The program must focus on indicators related to palliative outcomes and adopt actions to demonstrate improvement in performance. The hospice must maintain documentary evidence of its quality assessment and performance improvement program and be able to demonstrate its operation to CMS.[4]

A hospice QAPI program can be structured any way the hospice chooses, but the following elements should be considered within the QAPI program:

- 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
- Documentation of the review of its own QAPI program

The QAPI regulations contain several components that guide the development, implementation, and maintenance of a hospice provider's program. Each element of the program is outlined below with key requirements.[5]

[3, 4, 5] Code of Federal Regulations, 42 CFR 418.58, Condition of Participation: Quality Assessment and Performance Improvement, Retrieved from: https://www.ecfr.gov/cgi-bin/text-idx?SID=6b9820d5223ada558471f96fd3ab1b8d&mc=true&node=pt42.3.418&rgn=div5#se42.3.418_158

A. Program scope:

- The program must at least be capable of showing measurable improvement in indicators related to improved palliative outcomes and hospice services.
- 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.[6]

B. Program data:

- The program must use quality indicator data, including patient care, and other relevant data, in the design of its program.
- The hospice must use the data collected to do the following:
  - Monitor the effectiveness and safety of services and quality of care.
  - Identify opportunities and priorities for improvement.
- The frequency and detail of the data collection must be approved by the hospice's governing body.[7]

C. Program activities:

- The hospice'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
  - Affect palliative outcomes, patient safety, and quality of care
- 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.
- 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.[8]

D. Performance improvement projects (PIPs):

- 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.
- 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.[9]

[6, 7, 8, 9] Code of Federal Regulations, 42 CFR 418.58, Condition of Participation: Quality Assessment and Performance Improvement, Retrieved from: https://www.ecfr.gov/cgi-bin/text-idx?SID=6b9820d5223ada558471f96fd3ab1b8d&mc=true&node=pt42.3.418&rgn=div5#se42.3.418_158

E. Executive Responsibilities

The hospice's governing body is responsible for ensuring the following:

- That an ongoing program for quality improvement and patient safety is defined, implemented, and maintained, and is evaluated annually.
- 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.
- That one or more individual(s) who are responsible for operating the quality assessment and performance improvement program are designated.[10]

Compliance with QAPI:

Hospices must collect and analyze patient care and administrative quality data and use that data to identify, prioritize, implement, and evaluate performance improvement projects to improve the quality of services furnished to hospice patients.

A surveyor will request evidence of the following to assess compliance with the QAPI requirements and to assess the adequacy and appropriateness of a hospice's QAPI program:

- The hospice's aggregated data and its analysis of that data.
- The hospice's QAPI plan.
- The individuals responsible for the QAPI program.
- Evidence that the QAPI system has been implemented and is functioning effectively, including evidence of:
  - 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
  - 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.

[10] Code of Federal Regulations, 42 CFR 418.58, Condition of Participation: Quality Assessment and Performance Improvement, Retrieved from: https://www.ecfr.gov/cgi-bin/text-idx?SID=6b9820d5223ada558471f96fd3ab1b8d&mc=true&node=pt42.3.418&rgn=div5#se42.3.418_158

2. NHPCO Quality Components

NHPCO's *Standards of Practice for Hospice Programs (2018)* are organized around the following core quality components, which provide a framework for developing and implementing QAPI.

A. Patient and Family Centered Care

Providing care and services that are responsive to the needs and exceed the expectations of those we serve.

B. Ethical Behavior and Consumer Rights

Upholding high standards of ethical conduct and advocating for the rights of patients and their family caregivers.

C. Clinical Excellence and Safety

Ensuring clinical excellence and promoting safety through standards of practice.

D. Inclusion and Access

Promoting inclusiveness in our community by ensuring that all people — regardless of race, ethnicity, color, religion, gender, disability, sexual orientation, age or other characteristics — have access to our programs and services.

E. Organizational Excellence

Building a culture of quality and accountability within our organization that values collaboration and communication and ensures ethical business practices.

F. Workforce Excellence

Fostering a collaborative, interdisciplinary environment that promotes inclusion, individual accountability and workforce excellence, through professional development, training, and support to all staff and volunteers.

G. Standards

Adopting the NHPCO Standards of Practice for Hospice Programs and the National Consensus Project's Clinical Practice Guidelines for Quality Palliative Care as the foundation for an organization.

H. Compliance with Laws and Regulations

Ensuring compliance with all applicable laws, regulations, and professional standards of practice, and implementing systems and processes that prevent fraud and abuse.

I. Stewardship and Accountability

Developing a qualified and diverse governance structure and senior leadership who share the responsibilities of fiscal and managerial oversight.

J. Performance Measurement

Collecting, analyzing, and actively using performance measurement data to foster quality assessment and performance improvement in all areas of care and services.[11]

[11]NHPCO Standards of Practice for Hospice Programs, 2018. Retrieved from: https://www.nhpco.org/nhpco-standards-practice, 2018

Key Components for a Quality Program

Policies and Procedures

Policies and procedures provide documentation that define an agency's QAPI program, communicate clear guidelines for staff, facilitate consistent program replication, and establish a baseline for continuous improvement.

State and federal regulations, as well as accreditation standards (if applicable to the agency) and industry standards provide the basis of policies and procedures. It is the responsibility of each agency to determine what is needed based on regulations and accreditation requirements.

Policies and procedures facilitate the following "5 Cs":

- Compliance
- Care
- Consistency
- Communication
- Collaboration

Policies and procedures are a key component for defining the agency's QAPI program, but also as a key tool utilized when implementing performance improvement projects. State and accreditation surveyors will assess the agency's compliance with its own policies and procedures. For this reason, it is imperative that all staff and managers are knowledgeable about the agency's policies and procedures and that daily operations and practices are reflective of this.

1. Definitions/Clarifications

- **Policies** provide statements that outline the goals of your program and define what is acceptable to ensure program success.[12] They are typically expressed in broad terms, are non-negotiable and change infrequently.
    - Policies must be reviewed and approved by the designated interdisciplinary group and governing authority per Medicare hospice regulations. State regulations, accreditation standards, and agencies that belong to health care systems may have additional policy review and approval processes.

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[12] Merriam-Webster Dictionary. (2018). Protocol. Retrieved from: https://www.merriam-webster.com/dictionary/policy

- **Procedures** are brief statements or descriptions of step-by-step processes indicating *how* an operational function is to be implemented and managed within your agency. They are typically narrower in focus and are open to change. Procedures must be consistent with state and federal regulations, accreditation standards and industry best practices.[13]
    – Agencies may utilize an industry or health care system procedure manual as long as the procedures are reviewed and approved by the hospice and are reflective of the hospice's practices.
- **Protocols** involve a strict set of rules that address practical issues.[14]
- **Best Practices** are accepted, effective, and detailed steps to accomplish a given task.[15]

Protocols and best practices may be referenced in a policy and procedure but may be external to that document for immediate access and rapid changes when better processes are identified.

2. Assessment

A thorough evaluation of program policies and procedures is necessary to ensure there are established guidelines and protocols in areas required by regulation and specific to your agency. The following questions are meant to guide you in assessing the status of your agency's policies and procedures, with a focus on policies and procedures impacting your agency's QAPI program. The following areas of focus include questions for consideration to aide a provider in completing a comprehensive self assessment of their hospice operations.

A. Organizational Environment

- What is your agency's process for development, review and approval of policies and procedures?
- Does your agency policies and procedures reflect an emphasis on quality and relate directly to the mission of the agency and scope of service of your hospice program?
- Does your agency's policies and procedures and educational materials accurately reflect current accepted clinical practice and current professional standards of care?
- Do your agency's current processes reflect your policies and procedures?
- Does your clinical policies and procedures define the process for accessing, planning, delivering, evaluating, and improving hospice care and services?
- Are your policies and procedures readily available to staff and managers at all times?
- Can your staff tell you how they access your agency's policies and procedures?

B. Mission, Vision, Values

- Does your agency have a policy that states your mission, vision, and values and procedures that provide direction on how to fulfill these?

[13]Merriam-Webster Dictionary. (2018). Protocol. Retrieved from: https://www.merriam-webster.com/dictionary/procedure

[14]Merriam-Webster Dictionary. (2018). Protocol. Retrieved from: https://www.merriam-webster.com/dictionary/protocol

[15]Merriam-Webster Dictionary. (2018). Protocol. Retrieved from: https://www.merriam-webster.com/dictionary/best%20practice

- Does your written mission statement include that the patient and family guide their care and affirm the concept of hospice addressing the physical, social, psychological and spiritual dimensions of care as an integrated whole?
- Is your mission reflected in your agency's referral, admission, service policies and procedures?
- Is the mission statement supported through the interdisciplinary plan of care as well as the implementation and evaluation of hospice services?
- Does your vision include commitment to continuous improvement and quality outcomes?
- Does your agency have an agreed upon set of values, with behavioral expectations, to serve as a foundation for practice, service, and relationships with patients/families, other staff members and the community?
  - Are all staff and managers aware of these values and expectations and where to reference them?
- Does your agency include observation of staff knowledge and implementation of the agency's mission, vision and values in daily operations?

C. Strategic Planning

- Does your organization have a policy to briefly describe your strategic planning goals and procedures that outline who, when, and how strategic planning occurs?
- Does your strategic planning reflect your organizational mission and vision and include a comprehensive evaluation of both internal and external environments?
- Is your operational plan reviewed and revised on an ongoing basis?
- Do you integrate consumer and community needs into your planning process?

D. Organizational Quality & Safety

Comprehensive QAPI programs include routine monitoring of indicators to ensure compliance and identify opportunities for improvement. Using routine monitoring, hospices can demonstrate ongoing measurement, tracking, analysis and improvement of identified areas. Routine monitoring indicators and opportunities for improvement may be identified through a systematic, agency-wide 360-degree assessment.[16]

Examples of routine monitoring include, but are not limited to: occurrence reports, adverse events, equipment safety, complaints, personnel or clinical record audits, compliance audits, contract oversight, Hospice Quality Measure and Hospice CAHPS submission requirements and findings, survey or external audit results. More information on routine monitoring may be found in the "Choosing Quality Indicators" section.

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[16] Code of Federal Regulations, 42 CFR 418.58, Condition of Participation: Quality Assessment and Performance Improvement, Retrieved from: https://www.ecfr.gov/cgi-bin/text-idx?SID=6b9820d5223ada558471f96fd3ab1b8d&mc=true&node=pt42.3.418&rgn=div5#se42.3.418_158

Questions for Consideration:

- Do your agency policies include conducting a systematic, agency-wide assessment of your operations which includes all departments, to identify areas in need of ongoing monitoring and/or improvement?
  – Does your agency conduct this assessment annually as part of the QAPI program evaluation and plan development?
- Has your agency identified indicators for routine monitoring and are these outlined in agency policy?
- Does your agency have a consistent process for staff reporting of these indicators?
  – Is the process implemented throughout the hospice in accordance with your agency policies and procedures?
- Patient Safety:
  – Does your agency have policies and procedures that address patient safety goals, fall prevention, environmental safety assessment and planning, and disaster planning?
  – Are measures identified for monitoring, auditing, and improving patient safety?
- Adverse Events
  – How does your agency define an adverse event?
  – Does your agency adhere to the definition when tracking and analyzing these events and when implementing preventive actions?
- Does your agency outline a procedure for tracking the results of all monitoring priorities in an efficient manner, and utilizing technology and available reports as much as possible?
- Is there an individual or individual(s) identified in your policies and procedures who is responsible for receiving and analyzing QAPI routine monitoring data?
- Does your agency have a defined procedure for trending and reporting results of monitoring and performance improvement projects to the QAPI committee?
- Is there a defined procedure for approval and reporting of performance improvement projects and data collection by the Governing Authority?
  – Is there evidence of Governing Authority involvement in review and approval of performance improvement projects based on the results of routine monitoring?
- Does your agency have a defined procedure for prioritizing performance improvement projects based on the findings of routine monitoring and review/approval by the QAPI committee and Governing Authority?
- Do your agency policies outline a systematic process or model for performance improvement such as Plan-Do-Check/Study-Act, Lean Six Sigma, Institute for Healthcare Improvement (IHI) or other models?
  – Is there evidence of staff training and implementation of this consistent model in use for all identified performance improvement projects?

E. Infection Surveillance and Control

While infection surveillance and control are an integral part of an agency's routine monitoring processes, there are specific policies that are required to meet state and federal regulations, accreditation standards (if applicable) and industry best practice standards. It is important to note that hospices must reference the standards utilized in establishment of Infection Surveillance and Control Policies.

Questions for consideration:

- Does your agency have policies and procedures that outline an infection control program that protects patients, families, visitors and hospice personnel by preventing and controlling infections and communicable diseases?
- Are outcome measures that monitor and support quality improvement for infection control program outcomes addressed in your policies & procedures?
- Does your infection control program include a professional nurse(s) with training in infection surveillance and control?
- What are your agency's best practices and protocols for addressing patient care issues and prevention of infection related to high risk areas such as infusion therapy, urinary tract care, respiratory tract care, and wound care?
- What are your agency's guidelines on caring for patients with multi-drug resistant organisms?
- Do you have policies and procedures specific to a hospice residence or inpatient unit, if applicable?
- What are your protocols and tools for educating staff and families in standard precautions and the prevention and control of infection?
- Does your staff have ready access to personal protective equipment (PPE) as needed?
  – Does your staff utilize PPE appropriately when caring for patients?
- Does your organization teach, encourage, or provide influenza vaccines?
- How does your organization monitor staff for compliance with hospice policies and procedures related to infection control?
- Do you have evidence of annual OSHA and Infection Control training for your staff and contractors?

F. QAPI Program Implementation:

- Is your QAPI Program described in your policies and procedures and aligned with CoPs CFR 42.418.58?
- Do your organization's policies & procedures include a means to demonstrate, with objective data, how your performance improvement findings are used to resolve identified problems, improve quality of services and products, and incorporated into program planning?
- Is there evidence to support the implementation of your agency's QAPI program in accordance with the Medicare CoPs, applicable state regulations and accreditation requirements, and your agency policies and procedures?

3. Tools & Resources

There are many established tools available to assist hospice agencies in development of policies and procedures necessary to demonstrate compliance with QAPI program requirements. Hospice agencies are encouraged to utilize tools as a starting point for their programs. Note that all tools and resources are to be used as a resource for hospices, it is the responsibility of each agency to ensure that these tools, policies, procedures and resources are reflective of the agency's practices and that the QAPI program meets applicable state, federal and accreditation requirements and industry standards. See the Tools and Resources page for information.

4. Tips for Success

- If your organization has more than one interdisciplinary group, ensure one group is specifically designated to establish policies governing the day-to-day provision of hospice care and services (42 CFR 418.56(a)(2))
- Define in policies and procedures the process for policy development, updating, review and approval.
- Designate one individual position (with designated back up) to be responsible for facilitating policy and procedure review and approval.
- Determine how often your policies will be reviewed (once per year, once every 2 years, etc.) in accordance with applicable state regulations and accreditation standards and ensure this frequency is stated in your agency policy.
  - Ensure evidence of policy review in accordance with your agency policies and procedures.
- Ensure you have written policies and procedures for all areas required by the Conditions of Participation, applicable state regulations and accreditation standards as well as any areas unique to your agency.
- Meet with other leaders in your agency who have input and responsibility for policies and procedures. Discuss with these leaders how quality definition, measures, and performance improvement can be integrated into policies and procedures they are writing or reviewing.
- Ensure all staff and managers have ready access to policies and procedures via hard copy, electronic files, intranet, and/or internet.
- QAPI team may periodically highlight with staff a policy and procedure with a story that connects the purpose of that policy to the patient/family experience, team work, and success.
- Conduct periodic staff interviews and direct observation as part of your agency's survey readiness program to determine staff knowledge and implementation of agency policies and procedures. This includes but is not limited to QAPI program policies.

Organizational Structure

The structure of a QAPI Program provides guidance, consistency, and accountability which support achievement of quality experiences for the community served and staff. The structure needs to be clear, realistic, stable, and sustainable. It also needs to be flexible enough to be adjusted as regulations change, or to adapt when other significant organizational changes occur.

The Medicare Hospice Condition of Participation §418.58 outlines basic components of a QAPI Program.[17] These requirements can be enhanced based on the hospice agency's goals and culture. State licensure regulations and accreditation standards may also have additional requirements pertaining to the organizational structure of the agency's QAPI Program.

State and accreditation surveyors will assess the agency's compliance with its own QAPI Program. For this reason, it is imperative that all staff and managers are knowledgeable about the agency's QAPI Program and its organizational structure and that daily operations and practices are reflective of this.

1. Definitions/Clarifications

A. Structure: "The arrangement of and relations between the parts or elements of something complex".[18]

- Consider the structure of your agency's QAPI Program as the framework or building blocks. When placed securely in an organized manner a functional, durable and beautiful building (program) takes shape.

B. Data: Facts and statistics collected together for reference or analysis".[19]

- Data are measurable facts (e.g. number, yes or no) and the basic information used in calculating an indicator. Pain scores is an example of data used to determine the quality indicators that show the effectiveness of pain management.

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[17]Code of Federal Regulations, 42 CFR 418.58, Condition of Participation: Quality Assessment and Performance Improvement, Retrieved from: https://www.ecfr.gov/cgi-bin/text-idx?SID=6b9820d5223ada558471f96fd3ab1b8d&mc=true&node=pt42.3.418&rgn=div5#se42.3.418_158

[18]http://www.oxforddictionaries.com/us/definition/american_english/structure

[19]http://www.oxforddictionaries.com/us/definition/american_english/data

C. Indicators: "An indicator provides evidence that a certain condition exists, or certain results have or have not been achieved (Brizius & Campbell, p.A-15) .[20]

- Indicators enable decision-makers to assess progress towards the achievement of intended outputs, outcomes, goals, and objectives. As such, indicators are an integral part of a results-based accountability system.[21] A thing, especially a trend or fact that indicates the state or level of something.[22]
- Consider this example: "Pain dropped by one level within 48 hours" is used as an indicator of symptom management. Data points to calculate this indicator are the pain scores of multiple patients recorded in the medical record.
- The structures of an indicator include a numerator and a denominator:

= **Number of patients whose pain score did drop by 1 level within 48 hours**
_____
Total number of patients whose pain score was recorded on initial visit

2. Assessment

A thorough evaluation of the current QAPI Program identifies the strong components that can be continued and the areas that need improvement, replacement, or development.

- Begin by comparing the current program to the Conditions of Participation.
- Then look at the program considering the organization's mission, vision, values, and key goals and strategies, policies and procedures to individualize the QAPI Program to something robust, meaningful and successful.

The following questions are meant to guide you in assessing the status of your hospice QAPI program's organizational structure.

A. QAPI Program Structure related to CoP §418.58

- Is there involvement of the Governing Body in oversight of the QAPI Program and designation of persons responsible for the QAPI Program documented? (§418.58(b)(e)).
- Is one (or more) person(s) designated to be responsible for the QAPI Program? (§418.58(e)).
- Is the QAPI Program defined and planned with the following components?
  - Program objectives

[20]JA Brizius and MD Campbell, Getting results: A guide for government accountability (Washington, DC: Council of Governors Policy Advisors 1991)

[21]http://www.hfrp.org/publications-resources/browse-our-publications/indicators-definition-and-use-in-a-results-based-accountability-system

[22]http://www.oxforddictionaries.com/us/definition/american_english/indicator

– All patient care disciplines included

– Administration & coordination of program

– Methods for monitoring & evaluating quality data

– Methods to prioritize and resolve/improve data points of concern

– Performance Improvement Projects

– Oversight by & reporting to Governing Body

– Review and evaluations of QAPI Program

B. Details for Compliance:

• Is the QAPI Program evaluated for compliance and effectiveness at least annually?

• Do the quality indicators reflect the size and complexity of the organization?

• Are contracted services quality data included in the QAPI Program?

• Do quality indicators go beyond basic patient clinical assessments? (§418.58(b); See also QAPI Toolkit Choosing Quality Indicators Module)

• Are quality indicators and "adverse events" defined, identified, prioritized, measured, tracked, and monitored?

• Does the QAPI Program use measurable data to monitor effectiveness of processes and structures, safety outcomes, care outcomes, satisfaction (e.g., patient, family, staff, referral sources), and sustained improvements?

• Are there processes and resources (e.g. trained staff) in place to ensure reliability of data, analyze indicators and identify areas for improvement? (§418.58(b)).

• Are there processes and training to implement, sustain, monitor, evaluate, and document improvement of indicators? (§418.58(c); See also QAPI Toolkit Choosing Quality Indicators Module).

• Are there feedback loops for input and continuous improvement built into the QAPI Program?

3. Tools & Resources

There are many established tools available to assist hospice agencies in development of a QAPI Program that meets Medicare CoPs and other applicable regulations. Hospice agencies are encouraged to utilize tools as a starting point development of their QAPI Programs. Note that all tools and resources are to be used as a resource for hospices. It is the responsibility of each agency to ensure that these tools, policies, procedures and resources are reflective of the agency's practices and that the QAPI program meets applicable state, federal and accreditation requirements and industry standards.

Tools include:

• NHPCO's **Standards of Practice for Hospice Programs**

• Hospice program existing tools and reports to implement an efficient, data driven QAPI Program. Examples include, but are not limited to:

–   Electronic Health Records (EHRs);
–   Add on software analytical reports;
–   Data spreadsheets and scorecards to compile, organize, and display quality indicators.

4. Tips for Success

A. Considerations for Implementation of a Robust QAPI Program:

- Develop policies and procedures, processes and communication structures to teach correct data recording, collection and indicator analysis.
- Assure the medical record (paper or electronic) is set up to document and collect identified data.
- Combine or coordinate patient care indicators and other organizational indicators (e.g. staff satisfaction/engagement, finance, volunteer utilization, etc.) in the QAPI Program definitions and actions.
- If organizational quality indicators not directly related to patient care are distinct and not managed by the QAPI Program create structures for collaborative communication across departments, especially for the many quality indicators that interact and intersect.
- Consider which quality indicators are better suited to be tracked and presented at the patient level, the team level, the discipline level, the organization level.
- Define in your QAPI Program a way to test if quality indicators are measurable, meaningful, and manageable.
- Quality indicators have a numerator and denominator and may need inclusion or exclusion lists so the indicator is consistently measured over time.
- Provide opportunities for the person(s) responsible for the QAPI Program to receive applicable continuing education to improve their analytical, measurement, reporting, and leadership skills.
- Depending on the size and complexity of your organization engage other leaders, direct care interdisciplinary staff, volunteers, office staff, or board members in a QAPI team under the guidance of the designated QAPI Program leader.
- Benchmark quality indicators with other similar hospice organizations, NHPCO members, EHR or other software analytics vendor users, Hospice CAHPS and Hospice Item Set vendor users, Medicare Administrative Contractor (MAC), State hospice organizations, the Program for Evaluating Payment Patterns Electronic Report (PEPPER), etc…
  – Strengths and opportunities for improvement can be identified in benchmark comparisons.
- Present Quality Indicators routinely in a variety of formats and settings to leaders, staff, governing authority, CMS and the community.

B. Additional Considerations:

- The best clinicians do not always make the best leaders. Carefully consider the characteristics and skills you need for your QAPI Program leader.
- The QAPI Program leader does not have to be an RN.
- When selecting and prioritizing quality indicators know that everything can be measured, but not everything needs to be measured.
- Consider implementing brief reviews of data in IDG meetings, in organization's newsletter (paper and or electronic), use of intranet system bulletins, and request a brief "Quality Update" agenda item in as many standing meetings as possible.
- Communicate and collaborate with your EHR and other software/data analytics vendors for structures that support direct care staff in recording data points and the QAPI Program in retrieving the data.
- Include all disciplines of direct care staff in quality data design elements with your EHR vendor as possible. If staff help build it, they will more easily use it.
- Enlist qualified trainers to teach skills in data analysis, use of spreadsheets for data compilations and presentations, and leadership competencies for the QAPI Program leaders.

CMS Hospice Quality Reporting Program (HQRP)

The Patient Protection and Affordable Care Act (ACA) mandated the initiation of a quality reporting program for hospices – the Hospice Quality Reporting Program (HQRP). The Center for Medicare and Medicaid Services (CMS) determines the quality measures that hospices must utilize, and the processes hospices must use to submit data for those measures. Hospices that fail to comply with HQRP requirements will incur a 2-percentage point reduction to the market basket percentage increase for the corresponding fiscal year.[23]

HQRP is a "pay-for-reporting" program, meaning hospice providers must complete data and submit it timely to be compliant with HQRP requirements. The two HQRP program components that comprise the data sources for the measures include[24]:

- **Hospice Item Set (HIS)** HIS is a patient level data collection tool developed by CMS. Hospices are required to submit a HIS-¬Admission record and an HIS¬-Discharge record for each patient regardless of their payer source. CMS requires a 90% submission threshold for compliance.
- **CAHPS® Hospice Survey** CAHPS Hospice Survey is a post¬ death family caregiver survey developed by CMS for the assessment of patient and family experiences with hospice care.

HIS and Hospice CAHPS® data are used to calculated performance on specific quality measures. Hospice provider should use HIS and CAHPS® scores for performance improvement activity. Reporting compliance for a provider is determined by successfully fulfilling both the CAHPS® Survey requirements and the HIS data submission requirements.

HQRP and Compliance

HQRP is where QAPI and regulatory compliance come together. HQRP represents the compliance aspect of quality and can help to drive quality improvement within a hospice program. Required compliance with regulations not only targets compliance issues but provides assessment data for the QAPI process and performance improvement.

[23]Centers for Medicare and Medicaid Services. (2013, Aug 7). Medicare Program; FY 2014 Hospice Wage Index and Payment Rate Update; Hospice Quality Reporting Requirements; and Updates on Payment Reform; Final Rule. Retrieved from: https://www.gpo.gov/fdsys/pkg/FR-2013-08-07/pdf/2013-18838.pdf

[24]Centers for Medicare and Medicaid Services. (2018). Hospice quality reporting. Retrieved from: https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Hospice-Quality-Reporting/index.html
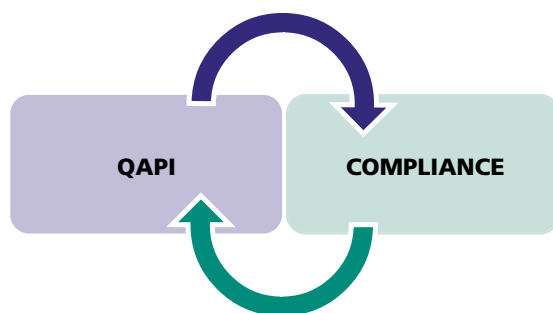
Learn about the CMS HQRP program at the following links:

- Hospice Quality Reporting - **https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Hospice-Quality-Reporting/index.html**
- CAHPS® Hospice Survey - **https://www.hospicecahpssurvey.org/en/general-information/**

NHPCO Performance Measures

NHPCO offers performance measures that yield useful, meaningful, and actionable data with ongoing refinement and enhancement of current performance measures.

For the following tools, we do not collect data nor provide reporting. We provide data workbooks for automatic visual analysis and results of a hospice's data: Family Evaluation of Hospice Care (FEHC), Family Evaluation of Palliative Care (FEPC), and the Comfortable Dying Measure (part of POM):

- **Family Evaluation of Hospice Care (FEHC)** – FEHC is a post-death survey that asks questions about the family's perception of the care provided to the patient, as well as their own hospice experience. Hospices that utilize FEHC must be exempt from CMS-required CAHPS Hospice Survey. For more information on FEHC, please visit **www.nhpco.org/fehc**
- **Family Evaluation of Palliative Care (FEPC)** – FEPC is a post-death survey that captures family members' perceptions about the quality of the palliative care their loved ones received whether that care was provided by a hospital-based consult service or by a hospice program offering palliative care. The questions on the FEPC survey are based on those in the Family Evaluation of Hospice Care (FEHC) survey, with wording modifications appropriate to palliative care service delivery. For more information on FEPC, please visit **www.nhpco.org/fepc**.
- **Patient Outcomes and Measures (POM)** – The POM includes two measures, 1) Comfortable Dying Measure (how well hospices achieve the goal of managing pain within 48 hours of admission) and 2) the Self-Determined Life Closure Measure (SDLC) (avoiding unwanted hospitalizations and avoiding unwanted CPR). For more information on NHPCO's about POM, please visit **www.nhpco.org/pom**.

We provide online data submission and reporting for the following:

- Evaluation of Grief Support Services (EGSS) – The EGSS survey is designed to evaluate bereavement services from the perspective of the recipients of the services. The survey takes a comprehensive approach by including questions on a wide range of services, many of them optional so that hospices may tailor the EGSS survey to reflect the specific services they offer. For more information on EGSS, please visit **www.nhpco.org/egss**.
- National Data Set (NDS) – The NDS is comprised of program level descriptive statistical information that provides a comprehensive picture of hospice operations and care delivery. NDS data are used to answer such key questions as who is providing hospice care, who are the patients receiving that care, and how much and what kind of services were provided. For more information on the National Data Set (NDS), please visit **www.nhpco.org/nds**.
- Survey of Team Attitudes and Relationships (STAR) – STAR is the only job satisfaction tool designed specifically for the hospice field. In addition to providing agency level reports, NHPCO creates an annual national level report available through NHPCO Marketplace. For more information on STAR, please visit **www.nhpco.org/star**

Support

NHPCO offers support and guidance for all performance measures. Each performance measure's web page includes detailed information and guidelines. For EGSS, NDS, POM, and STAR, please email their dedicated email addresses for any inquiries specific to those measures. For all other inquiries, please email research@nhpco.org.:

EGSS: **egss@nhpco.org**
NDS: **nds@nhpco.org**
POM: **pom@nhpco.org**
STAR: **star@nhpco.org**
Research: **research@nhpco.org**

Leader & Staff Training and Engagement

Initial and ongoing training is key to developing an overall culture focused on quality assessment and improvement and demonstrating leadership and staff engagement in QAPI activities. Agency leadership must ensure that staff and managers have access to training and resources to continually improve care for the patients and families. The implementation of comprehensive QAPI training and engagement efforts assists in demonstrating compliance with the Medicare Hospice CoPs related to Quality Assessment and Performance Improvement.

State and accreditation surveyors will assess the agency's compliance with its own QAPI Program efforts and staff knowledge and involvement in the agency's QAPI Program. For this reason, it is imperative that all staff and managers are knowledgeable about the agency's QAPI Program, identified performance improvement projects and their role in supporting the implementation of QAPI Program initiatives.

1. Definitions/Clarifications

- **Culture** is a way of thinking, behaving, or working that exists in the organization.
- **Organizational Culture** is defined as "The values and behaviors that contribute to the unique social and psychological environment of an organization…it's shown in… how committed employees are towards collective objectives. It affects the organization's productivity and performance, and provides guidelines on customer care and service, product quality and safety".[25]
- **Engagement** is the state of involvement/commitment or willingness to be involved.
- **Employee Engagement** is defined as "Emotional connection an employee feels toward his or her employment organization, which tends to influence his or her behaviors and level of effort in work related activities. The more engagement an employee has with his or her company, the more effort they put forth… ability of an employee to see how their own work contributes to the overall company performance…".[26]

2. Assessment

A thorough assessment of leader and staff abilities, resources, values, and engagement to promote and assure quality care and services will identify strengths and opportunities to improve training and engagement. Some areas of opportunity for improvement that may become clear with this assessment include, but are not limited to the following:

[25]Merriam-Webster Dictionary. (2018). https://www.merriam-webster.com/dictionary/culture

[26]Business Dictionary. (2018 http://www.businessdictionary.com/definition/employee-engagement.html

- Knowledge about the agency's QAPI Program and purpose.
- Levels of understanding and commitment to quality throughout the agency.
- Individuals with high engagement and interest that may be recruited for a QAPI team or specific projects.
- Leaders' ability to establish goals and accountability toward continuous quality improvement.

The following questions are meant to guide you in assessing your agency's leadership and staff training and engagement needs related to the QAPI Program.

- Can all leadership, staff and managers identify the individual(s) responsible for leading the QAPI Program?
  – How do staff members know who that person is and how to contact that person?
- What evidence exists that demonstrates governing body involvement with the QAPI Program?
  – Can staff, leaders, and surveyors access the evidence in governing body minutes or reports?
- Can agency leaders locate and summarize QAPI CoP regulations and purpose?
- Are agency leaders able to communicate to staff the agency-established measurable and meaningful goals for care and service outcomes and processes?
- Are leaders equipped and empowered to hold teams accountable to quality goals?
- Are quality goals included in performance evaluations for every staff level?
- Is QAPI training part of new staff orientation?
  – Is this training consistently provided for all staff and managers?
  – Is there a pre-test and post-test to gauge staff understanding of educational material?
- Are all staff and managers knowledgeable of the policies and procedures related to the QAPI Program, routine monitoring and implementation of performance improvement projects?
- Are quality indicators reviewed and discussed routinely, in staff meetings, newsletters, IDG meetings, coaching sessions, etc.?
- Are leaders able and willing to present and explain quality measures (e.g. organization's QAPI summary reports/dashboard), meaning, and analysis to their teams?
- Is staff trained to read your agency's QAPI Summary reports/dashboards and summarize the meanings?
- What levels of staff are currently involved in QAPI activities?
- Are QAPI activities only done by management or clinicians?
- Is support staff involved?
- Is front line staff involved?
- Can staff identify the agency's routine monitoring reporting requirements as they relate to individual job responsibility?
- Can staff identify the agency's priority performance improvement projects (PIPs) that have been approved by leadership and the governing authority?

- Can staff describe their individual involvement in agency QAPI Program activities?
- Do leaders &/or staff suggest or volunteer for Performance Improvement Projects (PIPs)?
- Have staff and managers received education related to Hospice Quality Reporting Measures and the Hospice CAHPS® Survey, including how each staff member can potentially impact these measures?
- Are quality outcomes documented in plans of care?

3. Tools

Hospice agencies are encouraged to utilize existing tools as a starting point development of their QAPI Program training. Note that all tools and resources are to be used as a resource for hospices, but it is the responsibility of each agency to ensure that these tools and resources are reflective of the agency's practices and that the QAPI program meets applicable state, federal and accreditation requirements and industry standards.

Hospice agencies should utilize their existing tools and reports to implement comprehensive training and ensure engagement in the QAPI Program. Examples include, but are not limited to:

- Staff Engagement Surveys:
  – Often used to identify overall engagement with the agency but may not have questions specific to engagement in the QAPI Program.
  – If the survey used by the agency is not specific to QAPI then caution is advised in extrapolating the engagement measure to QAPI.
- Clinical record audits:
- Include in clinical record audits a review item to track evidence of quality data in assessments (such as the presence of Hospice Item Set responses or implementation of pain assessments) and goals in plans of care.
- Industry Tools that may be used for standardized QAPI Program training:
  – National Association for Healthcare Quality Leadership Development Module: http://www.nahq.org/membership/leadership/devmodel.html
  – Training tools relevant to QAPI regulations and purpose such as written materials, webinar, video, and/or presentation
  – CMS training available for Hospice Quality Program Reporting requirements
  – CMS and Vendor training related to Hospice CAHPS survey requirements
  – Training tools relevant to basic quality improvement process selected by the organization such as Plan-Do-Check-Act (PDSA or PDCA[27]) or Define, Measure, Analyze, Improve, and Control (DMAIC[28]) (See also Choosing Quality Indicators Module)
  – Lean Six-sigma
  – Change management theory

[27]The W. Edwards Deming Institute. (2018). PDSA cycle. Retrieved from: https://deming.org/explore/p-d-s-a

[28]The Certified Quality Engineer Handbook, Third Edition, ed. Connie M. Borror, ASQ Quality Press, 2009, pp. 321–332.

4. Tips for Success

A. General Training & Engagement:

- Provide an overview orientation & periodic reviews to all staff of the QAPI program including purpose, structure, and individual role expectations. Consider having formal and informal leaders help present the information to demonstrate support and to strengthen their personal commitment via action.
- Consider starting with a topic that affects most of the staff to gain interest. Present case studies with results, incorporating use of quality processes and structures that will pique interest.
- Incorporate the QAPI program purpose, structure, and individual role expectations into orientation for all new hires.
- Ensure that all staff are aware of the agency process for governing authority responsibilities for the QAPI Program.
- Collaborate with leaders and Human Resources about including QAPI Program participation and expectations into position descriptions.
- Face-to-face contact with administration and leaders is required to validate staff understanding related to the QAPI program and its importance.
  - Listen to staff feedback to ensure that the QAPI program and training will be supported by management and is valued as an important component in day-to-day hospice operations.

B. Performance Improvement Project (PIP) Training & Engagement:

- Be creative in staff meetings, newsletters, and other means of communication to demonstrate value and purpose of PIPs, and to present current PIP needs based on quality indicators.
- Spend part of the first meeting on every PIP instructing on how to conduct a meeting including how to stay on track. Create an agenda for every meeting, be clear on the purpose, control the size of the group, and set the tone at the beginning of every meeting.
- Consider having frontline staff chair PIP groups to enhance engagement and learning skills. Allowing staff to volunteer for PIP teams can be more effective than assigning staff.
- Consider expectations for all to participate at varying levels of participation over specified periods of time.
- Encourage participation by personal invitation based on behaviors that indicate interest or ability. Interests often appear in very informal conversations and sometimes are subtle. Astute leaders can be on the lookout.
- Collaborate with leaders to allow time for regular duties to effectively participate in PIPs and other QAPI activities such as chart auditing.
- It is important to have resources, coaching, and leadership available for the PIP team to ensure they understand regulatory restrictions and/or other administrative boundaries.
- Utilize consistent tools for each PIP and provide QAPI leadership support and guidance in the use of these tools.

C. Policies and Procedures

Have QAPI policies available to make sure your staff is following agency policies and procedures and that and that they meet regulatory requirements (see Clinical Record Audit section):

- Provide auditing tools that include quality indicator related questions for staff and leaders to conduct audits. Ask those assigned to auditing to help develop user friendly tools and train staff on the audit items to ensure consistency in results.
  - Note that quality indicator-related questions can be modified from quarter to quarter based on current PIP projects.
- Provide place for feedback, comments, questions in the audit tool. Ensure those comments are reviewed & directed to the correct persons in a timely manner for immediate coaching and encouragement.
- Allow staff time to complete audits during their work day.
- Help staff relate to the value of chart audit processes:
  - Help identify areas that need improvement and/or the status of current PIP initiatives.
  - Show areas where staff excel and
  - Comply with regulations.
- Build chart review into new hire orientation or within the first year by having new staff participate in a record review of their documentation and coach them on opportunities for improvement.
- Compile audit results on a frequency determined by the PIP (weekly, monthly, quarterly) and provide trending of results between reporting periods.
- Teach staff the process for acting to improve on indicators that are not demonstrating improvement.

D. Quality Indicator Measures and Meaning Presentation & Review:

- Identify the meetings and opportunities to report & allow for discussion of quality indicators. As an example, a monthly staff meeting is a good opportunity for report of measures that have monthly results.
- Enlist IDG members to periodically present a quality indicator & facilitate discussion about meaning & improvement.
- Encourage ongoing training of leaders & staff to related to how identified quality indicators impact the patient-family experience.
- Recognize examples of high quality care and documentation in staff meetings for positive reinforcement.
- Elicit feedback from staff and managers regarding alternative strategies for indicators that are not improving.
- Hold staff and managers accountable for their responsibilities in improving specified QAPI indicators.

E. Validation of Learning Tools:

- Test learning tools that are developed or procured through other means on small groups to gain feedback.
- Utilize evidence-based (and preferably validated) tools for staff training.

F. Individual development plans with quality component:

- Incorporate quality efforts and results to performance evaluations.
- Promote individual goal setting at least annually that includes improved quality results. Frequent review of progress toward goals helps promote continued engagement and ultimate success.
- Equip & encourage leaders to guide staff to identify what they want/need to learn more about related to QAPI, such as reading graphs, how to incorporate quality indicators into assessments and care plans, etc.
- Trends that identify learning needs will be evident in quality measures, audit results & comments, discussions at meetings.
- Individual staff plans to develop skill and knowledge and attitude in the identified areas should be specific, realistic, and within a time frame.

Performance Improvement Projects (PIPs)

The goal of all efforts in a comprehensive QAPI Program is to improve patient and family care outcomes by establishing a data driven, quality assessment, and performance improvement program within the hospice agency. Performance Improvement projects must utilize quality indicator data (patient/family or administrative) to develop measurable, and sustainable goals.[29]

State and/or accreditation surveyors will assess the agency's compliance with its own QAPI Program efforts and staff implementation of identified Performance Improvement Projects (PIPs) as well as staff knowledge and involvement in PIPs. For this reason, it is imperative that all staff and managers are knowledgeable about the agency's QAPI Program, identified performance improvement projects and their role in supporting the implementation of QAPI Program initiatives

1. Definitions/Clarifications

A. Benchmark is a standard or point of reference against which things may be compared or assessed.[30]

- Benchmarks may be internal or external

B. Data Collection Tool is a standardized document used to collect data to demonstrate performance with selected quality indicators. This allows for collection of data in an objective manner.[31]

- Agencies should utilize research-based and validated tools whenever possible. An example of this is the Hospice Item Set or Hospice CAHPS Survey, research-based tools such as fall risk assessments, depression scales or skin assessments.

C. Data includes unevaluated facts, occurrences, or other information (data can be collected at any time).[32]

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[29]Code of Federal Regulations, 42 CFR 418.58, Condition of Participation: Quality Assessment and Performance Improvement, Retrieved from: https://www.ecfr.gov/cgi-bin/text-idx?SID=6b9820d5223ada558471f96fd3ab1b8d&mc=true&node=pt42.3.418&rgn=div5#se42.3.418_158

[30] American Society for Quality. (2018). Retrieved from: https://asq.org/quality-resources/quality-glossary/b

[31, 32] American Society for Quality. (2018). Retrieved from: https://asq.org/quality-resources/quality-glossary/d

D. Plan-Do-Check-Act (PDCA) or Plan-Do-Study-Act (PDSA) is an example of a research-based methodology for implementing Performance Improvement Projects.

- PDCA/PDSA is four-stage problem-solving model used for improving a process or implementing change.[33]
- May also be known as "Rapid Cycle Improvement."

E. PIP: Acronym for "Performance Improvement Project."[34]

F. Performance Improvement Matrix or Prioritization Grid:

- A visual method of assisting team members to choose between options out of several possibilities.
- A method used to help teams to reach agreement in a logical, objective manner.
- May be used to prioritize potential performance improvement projects based on specific criteria.

G. Project Planning Form is a useful tool for planning an entire improvement project which includes, but is not limited to:

- A listing of all the changes that the team is testing;
- All Plan-Do-Check-Act (PDCA) or Plan-Do-Study-Act (PDSA) cycles for each change;
- The person responsible for each test of change; and
- The timeframe for each test.

H. QAPI: Acronym for "Quality Assessment, Performance Improvement"

I. Root Cause Analysis is a structured facilitated team process used to identify possible causes of an event that resulted in an undesired outcome and to develop corrective actions.

2. Assessment

Identifying opportunities for improvement, and measuring outcomes, is an integral part of a QAPI program for hospice agencies. Developing an agency-wide, systematic approach to quality assessment and performance improvement, demonstrates that the hospice provider is committed to implementing

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[33]The W. Edwards Deming Institute. (2018). PDSA cycle. Retrieved from: https://deming.org/explore/p-d-s-a

[34]Code of Federal Regulations, 42 CFR 418.58, Condition of Participation: Quality Assessment and Performance Improvement, Retrieved from: https://www.ecfr.gov/cgi-bin/text-idx?SID=6b9820d5223ada558471f96fd3ab1b8d&mc=true&node=pt42.3.418&rgn=div5#se42.3.418_158

process change with measurable outcomes to improve performance (patient/family care or administrative). The following outline is meant to guide you in assessing the status of your agency's QAPI Program's process for implementing performance improvement projects (PIPs).

A. Step 1: Identifying Indicators to Improve

Reviewing the data:

- List all indicators currently being collected through routine monitoring and current projects.
- Identify reasons each of the indicators are being collected:
    - What are we trying to accomplish?
    - How does this indicator impact patient care?
- Determine priorities:
    - Which indicators are of the greatest concern to patient care and/or safety?
    - Which indicators will help us improve care with measurable outcomes?
    - What changes can we make that will result in improvement?
- Organizational strategic plans and goals:
    - Are the performance improvement projects in line with the organization's strategic plan and goals?
    - What is the process for demonstrating leadership (including the governing authority) review and approval of performance improvement priorities?

B. Step 2: Selecting A Performance Improvement Project (PIP)

Planning Steps and Tools

- Construct a performance improvement matrix to help prioritize potential PIPs from a list of options.
- List any obstacles for all problems identified on the list on the matrix
- Consider these factors when selecting a possible PIP:
    - What is the importance of the problem?
    - Is it a high risk, high volume, or problem prone process?
    - What is the impact on our customers?
    - Is there internal support for responding to the problem?
- It is very important to correlate the PIPs with the mission and values of the agency.
    - What are the mission and values of the agency?
    - Does our PIP selection support the mission and values of the agency?

C. Step 3: Establishing a Performance Improvement Team

- Including the right people on a performance improvement team is critical to a successful improvement effort.
- Teams vary in size and composition based on the PIP.

- – Each agency builds teams to suit its own needs.
- – Teams should include representatives for all stakeholders involved in the process being improved.
- – Consider the following:
  - - What is the goal for the team?
  - - Which departments or disciplines are involved in the process we want to improve?
  - - How many members should be on a team?
- • Each team needs to have a senior representative who takes responsibility for the success of the project and becomes the team leader. Examples of a senior representative may be the Chief Nursing Officer, Physician, Pharmacist, Director, Nurse Practitioner.
- • Establish a consistent process for Performance Improvement Teams to provide written and verbal updates to the agency QAPI Committee and to the QAPI leader.

D. Step 4: Setting Goals

- • Performance improvement requires setting goals, or outcome measures.
- • The goals, or outcome measures should be time specific and measurable, and should also define the specific patient population, or other system or process that will be impacted.
- • Tools that can be used to assist a team with breaking down a problem include:
  - – Storyboarding assists the team in recording information as they work through the PIP.
  - – Brainstorming is an effective way for a team to discuss a broad range of ideas. Brainstorming encourages creativity and the free flow of ideas. Rules for brainstorming include:
    - - Each person has a turn at expressing one idea at a time
    - - Quickly present your idea
    - - Be creative, think outside of the box
    - - Do not judge or criticize
    - - Do not stop to discuss ideas, this is strictly brainstorming
    - - It is okay for a team member to pass
    - - Quantity of idea counts: the more, the better
    - - Record all ideas in a place that everyone on the team can see. Flipcharts are wonderful for brainstorming.
- • Multi-voting is an effective way to select the most important ideas from a list:
  - – Using the list from the brainstorming session, group similar ideas together and create a new list.
  - – Number each item on the list
  - – Allow time for each team member to assign a pre-specified number of points to one or more ideas on the list. Team members may use their points by assigning them all to one item, or breaking them up in whatever manner they choose
  - – Tally the votes for each item on the list
  - – List the items from most to least points to determine areas to focus on.

- Root cause analysis is a structured facilitated team process used to identify root causes of an event that resulted in an undesired outcome and to develop corrective actions.
- Flow charts and other tools such as fishbone diagrams can be utilized by agencies to identify contributing factors that may require intervention as part of the PIP.

E. Step 5: Defining Goals and Outcome Measures

- Tips for assisting teams to define PIP goals and outcome measures
  - Establish a clear goal:
    - By working through the processes listed in step 4, the team will come to a consensus on the most appropriate goal or outcome measure.
    - Make sure that the goal or outcome measure captures the information from the process that you are trying to improve and includes the patient population that is impacted.
    - Sometimes the team leader may need to help focus the team on the process for determining the most appropriate goal or outcome measure.
    - Utilize SMART goal setting (see below).
  - Set numerical goals when possible:
    - Setting numerical goals clarifies the desired outcome for the team members. For example, "reducing falls in the inpatient setting" is a vague goal, and difficult to define the information needed to prove the process improvement was successful. "Reducing falls in the inpatient setting by 25% in the next 12 months" quantifies the expected impact of the PIP, defines what the goal or outcome measurement will be, and helps the team to consider how their measures of improvement will impact patient care.
- Encourage the team to set stretch goals:
  - Stretch goals are goals to reach within a specified time frame. By setting stretch goals, the team is clearly communicating that maintaining current practices and processes is not an option.
- Effective team leaders make it clear to the team the PIP goals must include changes in systems and processes, tweaking current systems and processes will not sustain long term permanent process changes.
- Avoid drifting away from the goal:
  - Repeat the goal continually, start every meeting with the goal statement.
  - Review progress toward the goal at each meeting.
  - Determine at the beginning of the project areas to be included and excluded. Defining what will be out of scope for this project helps keep the project focused on the originally intended goal.
- Be prepared to reset the goal:
  - Every team needs to recognize that sometimes the goal may not work within the timeframe chosen or the interventions may need to be revised.
  - When this occurs, do not become discouraged; allow the team to review their goal statement and their progress towards that goal. Sometimes the goal needs to be reset to a

smaller patient population, or a longer timeframe for completion, or a modification to the interventions to address contributing factors and demonstrate improvement.

- SMART Goal[35] setting
  - A SMART goal is a goal that is:
    - Specific
    - Measurable
    - Attainable
    - Relevant, and
    - Time based.
  - A SMART goal is a goal that is very clear and easily understood.
    - Specific:
      - The goal must clearly state what is to be achieved, by whom, where and when it is to be achieved.
      - The goal may state why it is important
      - These questions will not always apply to every goal, but it is important to ask all questions to assess how specific the goal is and make it as clear as possible.
    - Measurable:
      - Make the goal measurable.
      - Measurability applies to both the result and the milestones along the way to attaining a goal.
      - It answers the question of quantity – how much, how often, how many?
      - The milestones are signs along the way that will identify that the team is on the right track to achieving their goal.
      - It has been said that what cannot be measured cannot be managed. This is often true when it comes to goals. Sometimes it is difficult to measure a goal, but at such times, there is usually an indirect measure that can be applied.
    - Attainable:
      - Ensure that the goals the team sets are achievable and attainable.
      - Agreement and participation in the SMART goal setting process is important to ensure that most people are satisfied with the realistic attainment of the established goals.
    - Relevant:
      - The goals must be relevant to what the team wants to achieve in the short term and the long term.
      - Understanding the organizational vision, mission and purpose is critical in this respect.
    - Time-based:
      - This sometimes overlaps with the goal being specific, but it aims to ensure that there is a time frame put into place.
      - Deadlines reduce the risk of procrastination.

[35]Doran, G. T. (1981). "There's a S.M.A.R.T. way to write management's goals and objectives". Management Review. AMA FORUM. 70 (11): 35–

F. Step 6: Testing Change

- The next step is to test the change in the workflow setting
- The Plan-Do-Study-Act (PDSA) or Plan-Do-Check-Act (PDCA) cycle is a method for testing change:
  - First, plan the change
  - Second, implement, or try, the change
  - Third, study/check the results of the change
  - Last, act on the results of what was learned
  - Continue with the cycle to ensure interventions are effective to demonstrate improvement.
- Reasons to test change:
  - To determine which proposed change/intervention will lead to the most desired improvement.
  - To evaluate if the proposed change will work in the environment.
  - To determine if there are multiple changes, or combinations of changes that will have the desired effect on the quality outcome measures.
  - To evaluate the cost, impact and side effects from the process change.
  - Most importantly, to minimize the resistance to change when the process is implemented throughout the organization.
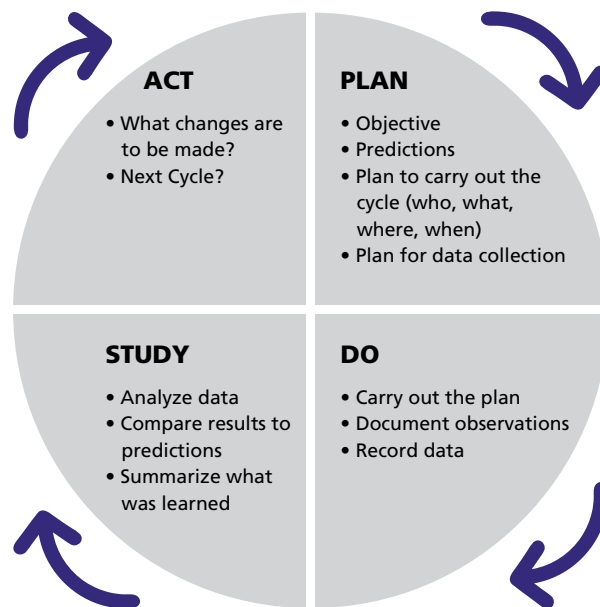
G. Step 7: Implementing Change

- Final steps for process improvement:
  - After the proposed change has been tested on a small scale and redefined after going through several PDCA cycles, the change is ready for implementation on a broader scale throughout the agency.
  - Consider how the change can be assimilated into daily operations.
  - Areas that may be impacted with the change include:
    - Documentation
    - Policies
    - Education and training
    - Hiring
    - Equipment
- Implementation also requires the use of the PDCA cycle and change management cycle.
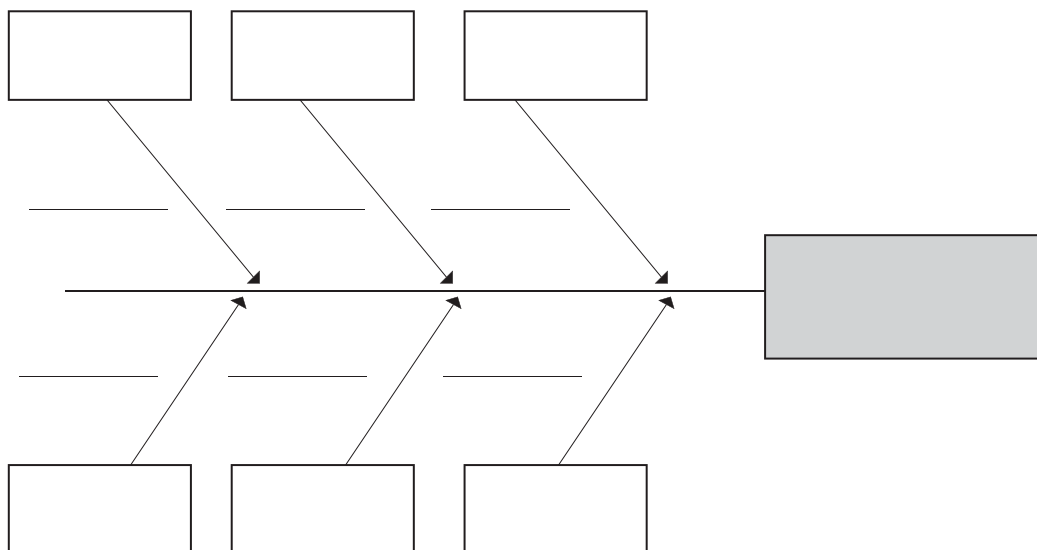
3. Tools

A. Industry Templates/Models

- Plan/Do/Study/Act Model

PDSA MODEL

Source: CMS QAPI at a Glance: A Step by Step Guide to Implementing Quality Assurance and Performance Improvement (QAPI) in Your Nursing Home 2012. **http://tiny.cc/QAPI**

- Lean Six Sigma
- Lean A-3 reports
- Change management cycle
- Sample Fishbone Diagram

CMS Resource - **How to Use the Fishbone Tool for Root Cause Analysis**

- PIP Documentation Template
  - Prioritization Matrix to select elements for focus
  - Root Cause Analysis Template (see Resource page at end of document)

4. Tips for Success

A. Selecting quantifiable data:

- Review all data elements/indicators currently being measured:
  - Incorporated into the clinical documentation
  - Observations, which will be subsequently recorded for reporting
  - Reported to a third party who will record the information and provide a report to the team.
  - Consider the development of additional data collection forms (recommended only if the data is not currently available).
  - Identify how the data will be retrieved for reporting.
- Identify all benchmarking opportunities to provide industry comparative data.
- Identify trends outside of the established standard or benchmark.
- Determine priorities.
- Ensure that the priorities support the agency's mission.
- Ensure that the leadership of the agency is supportive of all PIPs, and that continuous process improvement is valued within the leadership team.

B. Determining accountability for the performance improvement plan:

- Identify the person within the agency who is responsible for the agency's performance improvement plan and the person who is responsible for leading the specific PIP.
  - It is important to train and empowering all staff to participate in the PIP, including the identification of PIP opportunities.
- Identify who has responsibility for measuring each data element.
- Collaborate with the person responsible for the agency's performance improvement plan and determine the frequency that PIP progress reports and outcome measure should be reported.
- Goal statement for performance improvement project must be included on all reports to the QAPI committee.
- Continue to monitor and report out on all PIPs for at least 12 months after implementation to monitor improvement and ensure improvement achieved is sustained.

C. Achieving the performance goal: the action plan, testing and implementation using a consistent methodology such as the PDCA/PDSA Cycle:

Step 1: Plan: Develop an action plan for performance improvement based on the information collected through brainstorming sessions, flow charting, root cause analysis, storyboarding, performance improvement matrix and other tools.

- Plan the test or observation, including a plan for collecting data
- State the objective of the test.
- Make predictions about what will happen and why.
- Develop a plan to test the change (Who? What? When? Where? What data need to be collected?).

Step 2: Do

- Try out the test on a small scale.
- Carry out the test.
- Document problems and unexpected observations.
- Begin analysis of the data/

Step 3: Check: Analyze the data to determine if changes need to be made in the plan.

- Set aside time to analyze the data and study the results.
- Complete the analysis of the data.
- Compare the data to your predictions.
- Summarize and reflect on what was learned.

Step 4: Act: Improve the process after analyzing and retesting using the PDCA Cycle

- Refine the change, based on what was learned from the test.
- Determine what modifications should be made.
- Prepare a plan for the next test.

D. Sustaining improved performance

- Include representatives from all stakeholders involved in the process on the team.
- Ensure that all team members have a voice on the team.
- Assign a senior leader as the team leader to offer experience and guidance to the team and to ensure that the organization's leadership support the PIP.
- Use established tools and resources for process improvement throughout the process.
- Document all the work of the team on approved forms using process for reporting PIPs in accordance with agency policy.
- Implement change using the PDSA/PDCA process.
- Continue to use the PDSA/PDCA process as the change is implemented throughout the organization.
- Monitor the change outcome measure for a minimum of twelve months to ensure that the change is sustainable.
- Celebrate successes.

Program Evaluation

The purpose of QAPI program evaluation is to determine the overall effectiveness of the quality program to inform the update of the quality plan. Evaluating the results of individual PI projects occurs throughout the year as interventions are tested and either adopted or revised and retested. The annual evaluation is a higher-level self-assessment that allows an organization to share strengths and identify opportunities for ongoing improvement of care processes and to meet regulatory requirements. It includes reflection on the prior year and a determination of which elements of the quality program are on track and where changes are needed.

The Medicare CoPs for hospice specifies that the quality program is evaluated annually. In addition, the hospice may have specific state or accreditation requirements for quality program evaluation.

§ 418.58 Condition of participation: Quality assessment and performance improvement.

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.

(e) Standard: Executive responsibilities. 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.[36]

1. Definitions/Clarifications

A. Evaluation is a process to determine the significance, worth, or condition of something, usually by careful appraisal and study.[37]

[36]Code of Federal Regulations, 42 CFR 418.58, Condition of Participation: Quality Assessment and Performance Improvement, Retrieved from: https://www.ecfr.gov/cgi-bin/text-idx?SID=6b9820d5223ada558471f96fd3ab1b8d&mc=true&node=pt42.3.418&rgn=div5#se42.3.418_158

[37]Business Dictionary. (2018). Evaluation. Retrieved from: http://www.businessdictionary.com/definition/program-evaluation.html

B. Outcomes are defined as something that happens as the result of an activity or process.[38]

2. Assessment

Developing an agency-wide, systematic approach to quality assessment and performance improvement, demonstrates that the hospice provider is committed to quality at all levels of the organization, from operations to patient care. The annual QAPI program evaluation is a process by which the hospice agency can demonstrate the evidence of implementation of PI priorities and the QAPI program and evaluate the effectiveness of QAPI efforts and identify opportunities for improvement for the new year QAPI Plan. The following outline is meant to guide you in completion of an annual QAPI program evaluation.[39]

Important Components of QAPI program evaluation Include:

A. Annual QAPI Plan Review:

- The QAPI leader may ask:
  – Did the quality plan reflect the complexity of the agency and address all services provided including contracted services or by arrangement?

B. Summary of the Quality Indicators and Routine Monitoring:

- In this phase, the QAPI leader aggregates or summarizes outcome data on quality measures that were prioritized for inclusion in the quality plan.
  – This includes the aggregated results of all routine monitoring as well as specific indicators measured through PIPs.
  – Routine Monitoring may include, but is not limited to:
    - 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
    - General inpatient (GIP) utilization

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[38]Merriam-Webster Dictionary. (2018). Outcome. Retrieved from: https://www.merriam-webster.com/dictionary/outcome

[39]Code of Federal Regulations, 42 CFR 418.58, Condition of Participation: Quality Assessment and Performance Improvement, Retrieved from: https://www.ecfr.gov/cgi-bin/text-idx?SID=6b9820d5223ada558471f96fd3ab1b8d&mc=true&node=pt42.3.418&rgn=div5#se42.3.418_158

- Skilled nursing facility (SNF) coordination
- Pre-Billing audit measures
- Compliance audits
- Risk management (falls, infection control, medication errors, adverse events, complaints, etc.)
- Clinical competency
- Human resources/personnel record reviews
- Specific process measures related to patient care.

- The QAPI leader may ask: Did the outcomes for the quality indicators in the quality plan demonstrate improved palliation of symptoms or patient / family experience of care?

C. Performance Improvement Projects (PIPs) Including Achievement of Goals and Sustainability:

- In this phase, the QAPI leader reviews the documentation of individual PIPs to evaluate the status of the improvement interventions.
- The QAPI leader may ask:
  – Which projects were successful and why?
  – Which projects need more attention?
  – Are there additional opportunities for improvement?
- All leaders may want to ask whether the improvements tested in the PIP are "hardwired" to ensure future sustainability. That is, if an improvement included a staff education component, has that education been built into new hire orientation?

D. Staff Engagement in Quality:

- A thorough evaluation of the quality program includes consideration of staff engagement in quality. In this phase, the QAPI leader may review the PIP teams and evaluate the following:
  – Do the same employees always work on PI Projects?
  – What is the total number and percent of staff who participated in at least one PIP in the past year?
  – What are the communication methods and frequency used to keep staff informed of reason for and the progress of PIPs?
  – Are there opportunities to improve leadership/management/staff engagement?

E. Policies and Procedures:

- An evaluation of the quality program includes an assessment of the relationship between policies and procedures and the QAPI program.
  – This may include monitoring of staff adherence to key policies, especially those related to patient safety and regulatory requirements.

- The quality leader may review which policies need to be updated based on changes to federal or state requirements. Staff may be asked which policies are most problematic or no longer reflect current processes.
- Refer to the NHPCO QAPI Tool Kit "Policies and Procedures" section for further information.

3. Tools

There are several tools that hospice agencies can use to evaluate the overall effectiveness of the QAPI Program. Some examples include the following:

- Staff surveys related to knowledge of or participation in PIPs.
- Clinical Documentation formats to collect, quantify and aggregate quality indicators and routine monitoring results.
- Spreadsheets for calculations and graphs for trending quality indicators and routine monitoring results.
- Appreciative Inquiry for culture development.
- Six Sigma, Lean, PDSA/PDCA tools
- Accreditation or state required tools for mandated data submission (if applicable).
- Intranet or Internet systems to present quality outcomes to staff across settings.

4. Tips for Success

A.   Identify the Strengths and Positive Findings.:

- Often, the work of the QAPI leader is to identify gaps and help the organization make changes to close the gaps.
- Use a strengths-based approach to keep the momentum going for successes and to keep teams from getting discouraged.
- Improvement implies change, which can be very challenging.

B.   Ongoing Communication of QAPI Program Findings:

- Have PIP teams provide updates on improvement efforts at staff meetings or in staff newsletters.
- Have PIP teams create storyboards to showcase improvements.
    - Using the Data-Change-Data format, teams can start a storyboard with the background and reason the project was chartered and add to the storyboard as the PIP progresses by adding the improvement intervention and then later adding the outcomes and next steps.
- Provide quarterly updates on routine monitoring and identification of additional QAPI priorities throughout the year.
- Regular communication of QAPI Program activities and results will assist in agency-wide

competency and awareness of quality initiatives and provides a timely foundation for data collected for the annual QAPI program evaluation.

- The NHPCO self-assessment system can seem overwhelming at first, but it can be completed over time.
  - The QAPI leader can share the self-assessment sections with others in the organization and enlist assistance in scoring the sections.
  - Once the first self-assessment is completed, it is easier to update over time.

Resources

Center for Medicare and Medicaid Services

- **Conditions of Participation (42 CFR 418)**
- **State Operations Manual**
- **Hospice Quality Reporting Program (HQRP)**
- **Hospice Consumer Assessment of Healthcare Providers and Systems (CAHPS) Hospice Survey**
- **CMS tool: QAPI at a Glance** (created for nursing homes but Plan do Study Act Model is applicable to hospices.

NHPCO **Standards of Practice for Hospice Programs** (2018)

Performance Improvement Models:

- **Institute for Healthcare Improvement**
- **Lean Six Sigma**

Association of Professionals in Infection Control and Epidemiology

Additional Resources for staff training and engagement:

- **The Seven Imperatives to Keeping Meetings on Track**

Resources from the Institute for Healthcare Improvement

- **Transforming Care at the Bedside How to Guide: Engaging Front-Line Staff in Innovation and Quality Improvement**
- **Frontline Dyad Approach to Maximize Frontline Engagement in Improvement and Minimize Resource Use**

SMART Goal Worksheet

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