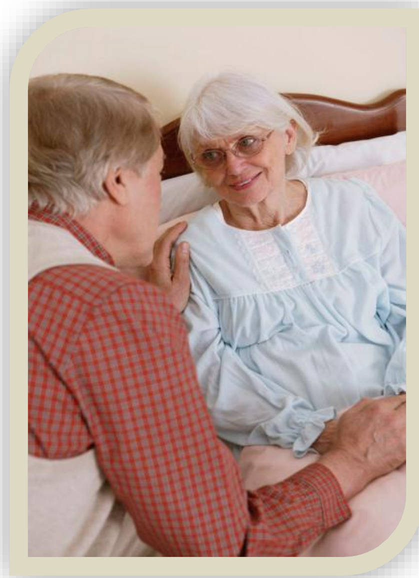
QUALITY ASSESSMENT AND PERFORMANCE IMPROVEMENT

2016 PLAN



PATIENT CENTERED HOSPICE CARE

EMPHASIZING PERFORMANCE IMPROVEMENT AND OUTCOMES

SAFE, EFFECTIVE,

EFFICIENT. TIMELY

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OVERVIEW AND PURPOSE

The purpose of Performance Improvement is to provide a comprehensive data based program to continually assess and improve the quality of the processes that affect patient outcomes. From Board to Bedside, the aim is providing patient centered care. The end effect will be the highest quality of care and a high level of patient perception of care and services.

Defining patient and family needs, designing well defined processes to meet those needs and achieving outcomes that patients and families have identified as having value to them are the keys to Amedisys Hospice's ability to achieve and maintain the best patient outcomes and financial viability.

QUALITY STATEMENT

The hospice program is an on-going, comprehensive, integrated, self-assessment program of the quality and appropriateness of care provided, including services provided under contract. The QAPI program is a critical component of the company wide planning process and provides the framework for the fulfillment of the company mission.

- It ensures the provision of uniform quality of care and services throughout the company as reflected in philosophy and service statement.
- Ensures that established policies, procedures, and guidelines are followed in the provision of hospice care (state, federal, accreditation and professional standards)
- Identify opportunities to improve in patient and family satisfaction and/or experience of hospice care

MISSION STATEMENT

Our mission is to provide cost - efficient, quality healthcare services to the patients entrusted to our care. As a community based care center, Amedisys Hospice is committed to providing proper care of the dying patient and his/her family as well as educating the community about Hospice.

To carry out this mission, Amedisys Hospice provides:

- Safe and effective care for the dying patient and family, caring for the physical, psychological and spiritual concerns
- Patient centered care that is respectful of and responsive to individual patient preferences, needs and values, and ensure that patient values guide all clinical decisions
- Timely relief of pain and other symptoms on a 24/7 time frame
- Bereavement services for patient and families, by anticipating grief before the patient's death, and after the death for the patient's loved ones

- Service that is efficient by avoiding waste, including that of equipment, supplies, and energy
- Education to families, caregivers, referral sources and the community in the areas of end of life care, death and dying, grief and hospice care.
- Care that is equitable by providing care that does not vary in quality because of personal characteristics such as gender, ethnicity, geographic location, and socioeconomic status

OBJECTIVES

- To assess the quality and appropriateness of all care, including general inpatient care, home care, continuous care, respite care and care provided under arrangements.
- To show measureable improvement in indicators that demonstrate an improvement in palliative outcomes and end-of-life support systems
- To evaluate the adequacy of clinical documentation utilizing UR audit and/or specific eligibility audit tools.
- To measure, analyze and track quality indicators, including adverse events, hospice acquired pressures ulcers and infections.
- To collect data to monitor and benchmark, the effectiveness and safety of services and quality of care, as well as identify opportunities for improvement, and best practices
- To utilize patient/caregiver perception of care and satisfaction and develop hospice services that are perceived to be of high quality and value
- To utilize standard processes to provide effective, efficient and safe delivery of hospice care services by continually assessing processes of care, hospice services and operations
- Educate and involve the care center staff in the Quality Assessment and Performance Improvement process
- Monitor and evaluate compliance with ACHC standards, COPs, policies and procedures
- To conduct Performance Improvement Projects (PIP) when gaps are identified between current and desired status.
- To conduct quarterly QAPI meetings and document activities and findings, including status of Performance Improvement Projects
- To evaluate on an annual basis

GOALS

Amedisys Hospice strives to design well-defined processes and to consistently implement those processes to achieve the best patient outcomes. Our goal is to have a healthcare system that is safe, efficient, patient-centered, timely and equitable.

- Patient centered, offering relief of pain and other distressing symptoms
- Safe & Comfortable Dying
- Self- Determined Life Closure
- Effective Grieving

METHODOLOGY

Performance measurement encompasses three different kinds of measures: process, structure, and outcomes. These measures come from one of the most common frameworks, known as Donabedian's Triad (or Framework). Donabedian's Triad defines

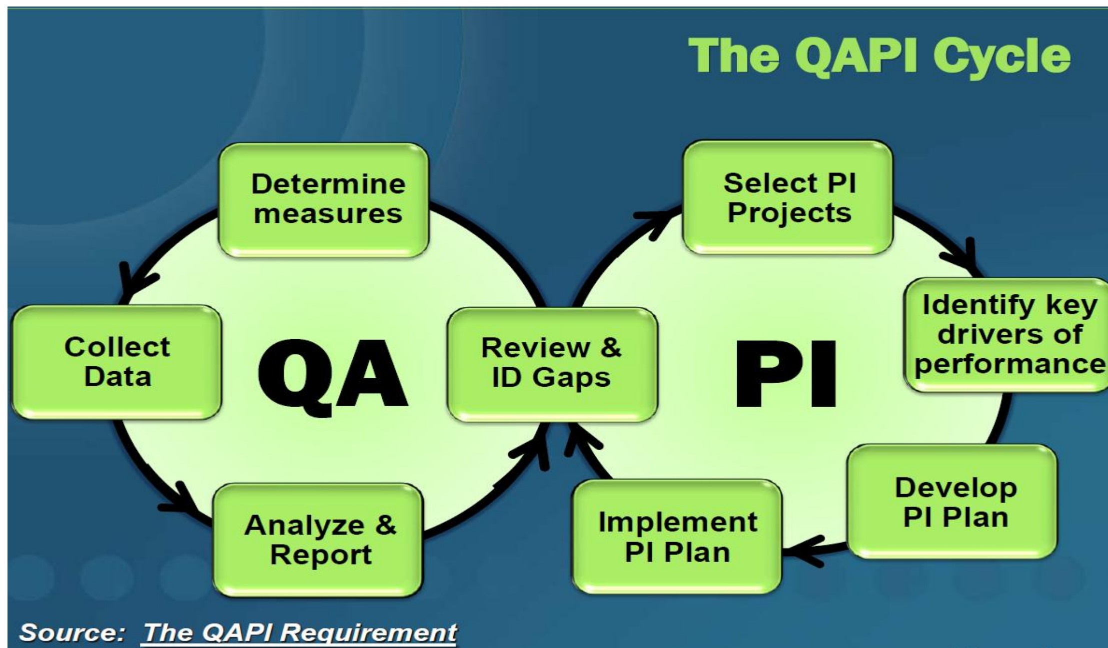
- ***Structure*** as the attributes of a setting where care is delivered,
- ***Process*** as whether or not sound practices were followed,
- ***Outcomes*** as the impact of the care on health status.

According to the framework, the three dimensions are interrelated. For example, if the structure is poor, it could affect process and/or outcomes. Outcomes, according to Donabedian, indicate the combined effects of structure and process. This framework can be applied specifically to hospice and palliative care and suggested performance measures described below can lead to improvements in care and business practices.
Doing the right thing with efficacy and appropriateness relating to the degree to which Care and services will achieve the desired or projected outcomes and meet relevant clinical needs of the patient, and by doing the right thing well.

The process is systematic, organization-wide implementation of quality assessment and performance improvement activities. The indicators for each aspect of care are measurable at the patient level and in aggregate. Data for measuring these Indicators are collected from clinical documentation, patient/caregiver satisfaction surveys, and administrative indicators.

Each Indicator will have a Level of Performance established as a benchmark or threshold for evaluating care, quality, and appropriateness. The threshold for the chart audits of clinical documentation is 85% compliance. When an Indicator shows that Improvement is needed, an Action Plan will be developed to evaluate the scope and effectiveness of the PI Program ensuring that actions taken are within the goals of the Hospice Care Center.

Results are achieved through a process that considers the institutional context, describes desired performance, identifies gaps between desired and actual performance, identifies root causes, selects interventions to close the gaps and measures changes in performance.

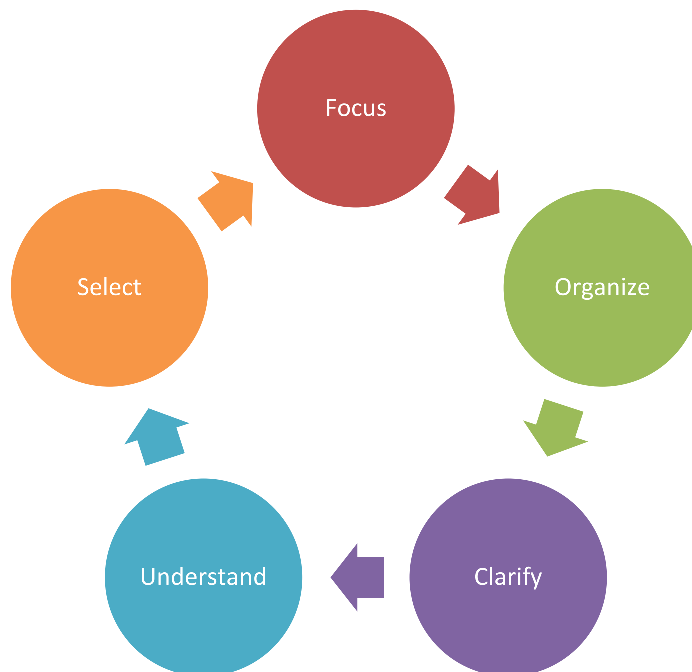


Data Analysis

The QAPI snapshots, (Quality reports including the Hospice Item Set (HIS) quality measures) and the Consumer Analysis of Healthcare Programs and Systems (CAHPs) reports are to be reviewed at the PI meeting, along with the action plans, trends and opportunities for improvement generated from the clinical chart audits. Both the CAHPS and Quality snapshots should be posted within the care center for all staff access.

The methodology selected to support and facilitate improvement activities is based on the Performance Improvement Model - FOCUS- PDCA. Performance Improvement Projects (PIP) are developed at the care center level to address any process for improvement. The PIP form is used for documentation of the project.

The FOCUS-PDCA model was developed by W. Edwards Deming and provides a model for improving processes. The model's name is an acronym that describes the basic components of the improvement process. PDCA is an acronym for Plan, Do, Check and Act. The PDCA cycle is a way of continuously checking progress in each step of the FOCUS process. The key steps of FOCUS-PDCA are as follows:



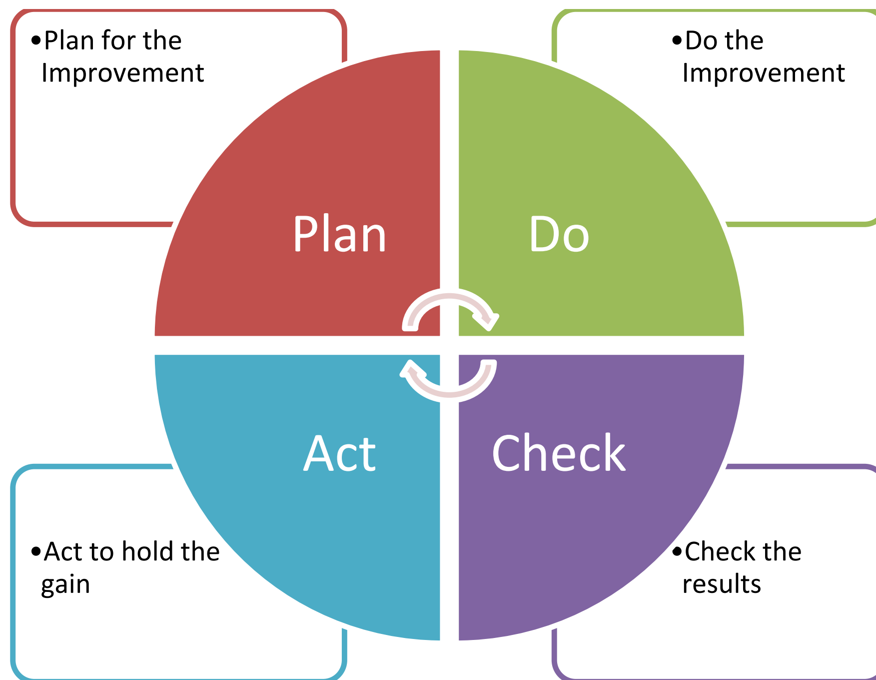
Find an opportunity to improve. In this stage, you identify a process to be improved. For example, you have identified a process may not be effective. Ask yourself if the current process is tied to the hospital's mission and priorities? Question the productivity of the process. Ask yourself if it can be improved and who will benefit from improvement.

Organize a team who understands the process. Here, you gather a team of employees who are closest to, or have ownership in the process.

Clarifying the current knowledge of the process is the next step. In this stage, you are gathering the "who, what, when, and where" information you need in examining the issue chosen.

Understanding the cause of process variation. Here, you ask yourself the "why" question. In other words, now you know the process by clarifying the elements, why is not it working effectively.

Select the process improvement. The team selects the most appropriate solution keeping in mind the cost and difficulty of implementation. Again, your selection is based on successfully completing the two previous steps. Rushing to selection will not improve the outcomes, so before you select an intervention, make sure you have done the groundwork.



Plan the improvement. This next step involves deciding how the improvement will be made. Action plans are developed for how the process will be implemented within the targeted area. A plan for data collection to monitor the effects of the change is also addressed at this stage.

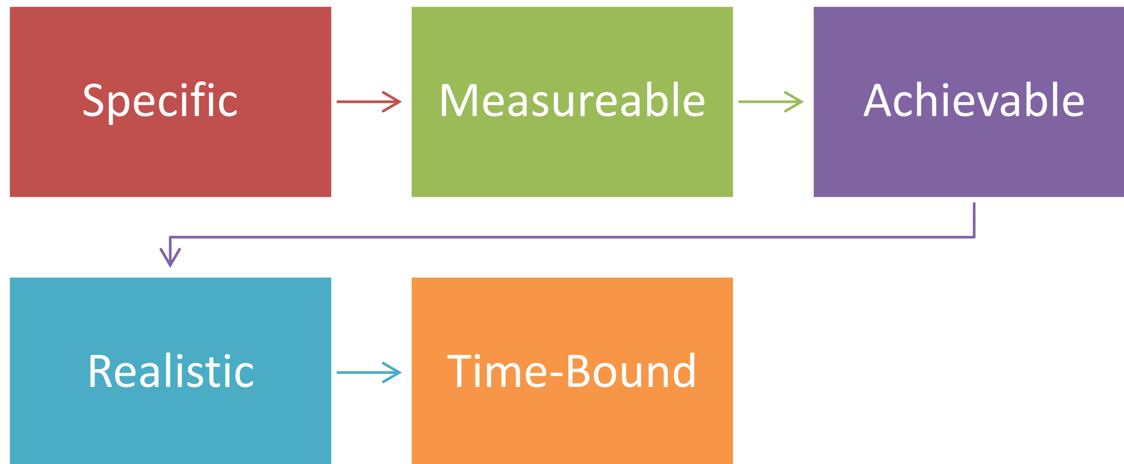
Do the improvement is the next step. Here, the focus is on collection of baseline data and information that will determine how the process performs prior to, and following any improvement efforts. In this stage, monitor the process closely. Are there any surprises? If so, why did they occur, and what can the team do about it?

Check the results is the next to last step. Here, you are evaluating to see if the process changes were actually implemented as planned. The team monitors the effects of the change, and most importantly, a comparison of predicated results versus actual changes is analyzed. If results are not as the team hoped, a review of the prior steps is in order. If everything checks out, you have successfully modified or changed an existing process for the better, and are at the last step.

Act to hold the gain. Here, the team creates a strategy for holding improvements and working toward further Improvements.

Develop AIM Statements: For example; By April 2016, 85% of patient family/care givers will respond that they were always informed of when the hospice team would arrive.

Be Smart!!



Amedisys collaborates with:

- Vendors such as Outcomes Systems (OCS) and or SHP who develops quality reports based on data elements found within the electronic medical record, and adjusts the report for benchmarking with other hospices across the country. The clinical data elements for the Hospice Item Set (HIS) are embedded in the nursing admission assessment. The data can be retrieved and reviewed at the patient level and in the aggregate.

- DEYTA – Imports data of patients of have died, and sends surveys to ask the responses of family experience of care. Data can be reviewed at the patient level and in the aggregate. Any negative comment/complaint reported on the survey is immediately sent to the Director of Operations. .

ADVERSE &SENTINEL EVENTS

Sentinel Events and "near misses" will be evaluated through an intensive investigation and root cause analysis. Hospice identifies and evaluates sentinel events and near misses to discover the causes and to redesign processes as necessary to prevent recurrence.

"**Sentinel Event"**:

- An unexpected occurrence involving death or serious physical or psychological injury, or the risk thereof.

- Suicide of a patient in a setting where the patient receives around the clock care (hospital, ALF, Nursing Home)
- Any patient death, paralysis, coma, or other major permanent loss of function associated with a medication error
- A patient fall that results in death or major permanent loss of function as a direct result of the injuries sustained in the fall
- Hospice acquired pressure ulcers

Examples of a sentinel event: A patient fall or patient infection that results in death or permanent disability.

"Near Misses": includes any process variation for which a recurrence would carry a significant chance of a serious adverse outcome Care center staff identifies potential sentinel events/near misses through review of incident reports, performance improvement activities, patient satisfaction surveys, and various other reports.

All sentinel events are reported to the Director of Operations immediately. The DOO reports to the AVP and Hospice Clinical Operations. A root cause analysis will be required. Decisions whether a sentinel event is reportable or reviewable will be made by the AVP and/or the Quality Manager, in conjunction with Hospice Director of Clinical Services, the Risk Management and Legal Departments:

A root cause analysis contains the following characteristics:

- Primarily focuses on systems and processes - not individuals
- Progresses from special cause process focus to common cause, system and/or organizational focus;
- Consistently focuses on basic, core rationale for causative factor(s);
- Identifies necessary redesign efforts and/or revisions in systems and processes,
- Intended to improve performance levels and reduce the risk of event recurrence.
- The analysis is thorough and credible.

FAILURE MODE ANALYSIS

High-risk processes are analyzed at least annually by studying the effects that failure would produce for a process that influences the safety of the patient.

The following guidelines are followed in the selection of the process:

1. The high-risk process should be based upon published safety issues relevant to patient care in a home care setting.
2. The analysis should include an accurate in-depth process depicting each step and who is involved.

3. The PIP team should identify the various ways in which the process could break down or fail to perform its desire function.
4. The effects that a breakdown or failure of the process and the seriousness of the possible effects should be analyzed.
5. The potential process for breakdowns or failures should be prioritized.

Please note that although an adverse event (something harmful) may have happened to your patient, not all adverse events are TRUE adverse events.

An investigation of adverse events is required, but if the care center followed their policies, made the proper assessments and referrals and did everything they possibly could to PREVENT the adverse event, then it is not a TRUE adverse event.

Please note that falls and infections that directly result in death or permanent disability are sentinel events!

Patient Falls:

A review of all patients with falls is documented on an occurrence form, and follow up completed by the Director of Operations. It is suggested that these charts be monitored on an ongoing basis in order to implement measures to mitigate patient risk for more falls. Falls resulting in death or loss of function as a direct result of the fall will be treated as a sentinel event.

Tracking & Trending Reports

- ✓ Infection Reports
- ✓ Complaint/Concern Reports
- ✓ Hospice Occurrence Reports
- ✓ Employee Occurrence

Reports should be logged each month in the “Tracking and Trending Section” of the PI Web Site. Data can be entered and saved on an ongoing basis and then “locked” or “completed” at the end of the quarter. The PI committee will identify any trends in infections, incidents or complaints/concerns and develop action plans when appropriate indicate what actions will be taken on the PI Committee Meeting Minutes

Data sources and collection will include but will not be limited to the following:

- Hospice Item Set (HIS)
- CAHPS (Consumer Assessment of Healthcare Programs and Systems)
- Retrospective and concurrent clinical record review
- Tracer Audits
- Eligibility Audits for LLOS and GIP level of care
- Infection Control data
- Complaints logs and Negative comments (Deyta)

- Occurrence reports
- Results of regulatory/accreditation surveys
- Information obtained during home visits, supervisory visits, etc.
- Hospice QAPI Data Elements and Collection Crosswalk
- Weekly Operational Indicators

PI required forms and documentation includes tracking logs, satisfaction surveys, chart audits, PIP forms, Hospice occurrence forms, etc. PI data is gathered both on a monthly and on a quarterly basis.

Monitoring and Evaluating Activities

1. Experience of Care

    - Satisfaction Survey
    - % of Caregivers kept informed of when hospice team would arrive (Always)
    - % of Caregivers received help afterhours, weekend or holidays (Always)
    - % of Caregivers who stated patient got as much help with pain as needed (Yes, Definitely)

A written **CAHPs Survey** form is mailed to each patient designee following the death of the patient. The survey reflects the level of satisfaction and experience with major clinical care activities and support functions. Surveys are evaluated by the care center and an immediate action plan is implemented when necessary. A quarterly summary of the results will be distributed to the appropriate care center leaders for incorporation into the Performance Improvement Plan. The survey response goal to meet or exceed the benchmark.

A **Complaint Report** is used to report any situation in which the organization's performance was compromised. It also documents the investigation process and follow-up action. The report is completed by any person observing or informed of an incident in which the organization's performance was jeopardized or has the potential to be jeopardized. The report becomes an integral part of the PI process. The goal is satisfactory resolution of the issue and actions that prevent reoccurrence. Each report will be recorded on the **Complaint Log**. The log will be used to identify trends and opportunities for improvement and is maintained quarterly per provider. The Customer Complaint Report and Log will be maintained by the Director of Operations in a confidential file. Service Recovery process and audit tool complete on the PI website.

Clinical Record Review

The sample size for Clinical record review is equal to 10% of the average daily census or 10 records, whichever is greater. If the active census for a care center is below 10, clinical record review will be performed on 100% of the records. The sample size will include, but not limited

to, a selection of active and non-active patients, admissions, recertification, LLOS (Facility, Home, ALF), and GIP. The Quality Management team or the DOO/CM will select the patients, based on the need of the care center. When completing the audit tool on the PI website, the sample size will default to 10% of your care center's average daily census for that quarter. If less than 10 populates, it may be necessary to change the sample size.

The **Clinical Record Review** is used to tally the percentage of compliance of each item to aid in identification of trends. Records will be reviewed using the "Clinical Record Audit Tool" located on the corporate server. The review must consist of both active and discharged records and an adequate sample in order to represent a statistically significant sample. The sample should represent all disciplines that provided care during the quarter.

ACTION PLANS

Action Plans are critical to the improvement of processes. It provides a mechanism to outline what needs to be done, who is responsible for it, a target date for completion and a date to follow up and make sure the action is complete.

Action plans are only generated for completed audits that have questions whose aggregate score is less than 85%. Action plans are generated separately by audit. **NOTE:** An 85% threshold of compliance is required for ALL Audits. An action plan should be developed when a threshold is less than 85.

Care center Specific Outcomes

QAPI and CAHPs reports are reviewed and gaps are identified in actual versus national benchmark and develop action plans to improve. These are reviewed and documented in the PI Summary of Act ivies/Minutes each quarter.

Risk/Safety Management

- Patient accident/injury
- Employee accident/injury
- Medication error
- Prevention and treatment of pressure ulcers
- Patient/Employee infection
- Sentinel Events
- Environmental controls

Amedisys PI process is composed of the following elements/activities:

- Reporting of Infections, Incidents, Complaints
- Fall Reduction Program
- Pressure Ulcer Prevention & Reduction

- Patient/Caregiver Satisfaction/Experience of Care Surveys (CAHPs)
- Clinical Record Review Audit Tool
- GIP Review Audit Tool
- Eligibility Review Audit Tool
- LOS > 180 days – PEPPER Report analyzed to determine high-risk areas for focused reviews by the Quality Managers.
- Adverse patient events
- Root Cause Analysis
- Care center Specific Indicator (s)
- Hospice Annual Care center Evaluation (Professional Advisory Group meeting)
- Emergency Preparedness Plan
- Appropriateness and effectiveness of pain management (Comfort within 48 hours of admission)
- Infection Control
- Patient/Caregiver Complaints
- Medication administration and errors
- HIS Quality Process Measures

ASSIGNMENT OF RESPONSIBILITY

Resources are made available to employees to assist them in gaining a basic understand of QAPI principles. Learning modules are available on the Academy Learn Center, and in-services are provided periodically to reinforce knowledge base. Each employee is responsible for the quality of care and services provided. The following summary of responsibilities provides a framework for the process of quality assessment and performance improvement.

Governing Body

- Ultimate responsibility for the PI Plan and the care that is provided
- Oversees the development, implementation and assessment of the PI Plan
- Allocates resources
- Evaluates the effectiveness of the plan
- Meets at least annually

Hospice Clinical Operations Quality Team

- Oversight of on-going organization wide Quality Assessment & Performance Improvement Program
- Development and implementation educational plan regarding quality principles
- Prepares annual comprehensive report describing QAPI activities and Performance Improvement Projects

Director of Operations – Care Center

- Ensures that all components on the Amedisys PI website are complete, as well as data entry as required by OCS
- Ensures development of appropriate focus groups to address problem areas (PIP)
- Assists with implementation of improvement activities
- Evaluates the effectiveness of implemented actions
- Reports significant findings to appropriate staff

QAPI Committee

- Consists of multi-disciplinary members representative of scope of services
- Under the leadership of the care center Director/Administrator
- Responsible for evaluating performance improvement activities based on the analysis of collected data
- May issue recommendations for further study or action
- Meets quarterly

Clinical Manager

- Identifies opportunities for improvement through daily functions
- Ensures data is collected and turned in timely
- Participates in performance improvement activities when requested
- Provides leadership to ensure coordination of performance improvement activities
- Process the Hospice Item Set (HIS) for export to CMS

Clinical and Support Staff

- Identifies opportunities for improvement through daily functions and contact with internal and external customers
- Participates in performance improvement activities when requested

Professional Advisory Committee (PAG)

- Review and evaluate individual care center's performance activities as presented by the Director of Operations
- Meets at least annually

Quality Management Team – Hospice Clinical Operations

- Ensures the collection of accurate and reliable data
- Participates in cross-organizational activities to assess and improve overall organizational quality and performance
- Assists in the implementation of corrective actions as appropriate

- Encourages staff participation in Performance Improvement Projects by mentoring; advancing education by acting as a resource to all staff
- Aggregate, trend and analyze data company-wide using appropriate statistical techniques
- Evaluate the effectiveness of planned and implemented actions of the care centers
- Support care center staff to help them understand, explain, and continuously improve their care centers to allow them to deliver quality and safe patient care, promote quality patient and organizational outcomes and improve hospice education in their communities.

RESPONSIBILITIES OF THE QAPI COMMITTEE

The QAPI committee is responsible for evaluating and prioritizing QAPI activities based on the aggregation of analysis of data collected. The QAPI committee has the authority to issue recommendations for action or further study. Under the direction of the Director of Operations, the committee issues a quarterly report summarizing QAPI activities and results of actions taken. The report is submitted to the Governing Body through the minutes of the Amedisys Performance Improvement website.

The committee members include:

- Director of Operations
- Clinical Manager
- Business Office Manager
- RN Case Manager
- Medical Director, or designee
- Spiritual Care
- Volunteer Services
- Medical Social Services
- Hospice Aide

Clinical and office staff is responsible for participating in identifying opportunities for improvement through their daily contact with patients, physicians, and other employees. All staff are invited to participate in the QAPI committee. Individual staff members are required to participate in specific PIPs (Performance Improvement Projects) that pertain the process for which the staff member is involved.

- The Performance Improvement Committee 's responsibilities include analysis and review of the following:
    - Results of the Utilization Review Audit
    - Results of Potential Avoidable Event Investigation
    - Analysis and trends of Complaints
    - Analysis and trends of Occurrences (falls, hospice acquired pressure ulcers, etc.)
    - Analysis and trends of Infection Control Reports
    - Patient and Family Satisfaction Surveys
    - Results of Hospice Item Set & Quality Report
    - Risk Management / Safety - Emergency Preparedness activities, fire safety
    - Review of root cause analysis performed
    - Ethical issues

- The Performance Improvement Committee will conduct a Performance Improvement Meeting at least once a quarter.
- The Performance Improvement Committee must document the meeting minutes which include a summary of the quarterly performance improvement activities to include at a minimum:
  - Members in Attendance
  - Date of meeting
  - Clinical Record Summary- Utilization Review/ Potential Avoidable Events
  - Summary of all activities related to Performance Improvement to include office operations
  - Analysis of Infection Reports/ Action Items
  - Analysis of Tracer Audits/Action Items
  - Analysis of Complaints/ Action Items
  - Analysis of Occurrences/Action Items
  - Care Center Specific Activities, QAPI, CAHPS/ Follow-up
  - Follow- up and review of Action Plans

Performance Improvement Activities must be completed in its entirety no later than the 5th days of the month, following end of month closure:

Complete audit activities includes performing all audits, home visits, action plans, and quarterly Performance Improvement meeting.

Guidelines for PI Reporting for Multi-Branch care centers

Performance Improvement activities should "flow" from branches to the parent care center. The following guidelines should be followed for a Medicare Provider Number with one or more branches:

Meetings: Quarterly PI Committee meeting may be held separately at each branch for the entire provider number OR A joint meeting may be held at the parent or other designated branch with representatives from all branches of the provider number.

Separate Meetings:

- Each branch will have to do a COMPLETE set of meeting minutes addressing all areas including the section of the PI Committee Meeting Minutes on the PI Web Site titled "Summary of PI Activities for a Medicare Parent Provider Number"
- "Summary of PI Activities for a Medicare Parent Provider Number" must reflect that the PI information has been submitted to the parent care center for review. The data must be submitted to the parent care center before the care center's scheduled meeting.
- The minutes of the parent care center must reflect that the branch QAPI data was reviewed. Please note this under "Summary of QAPI Activities for a Medicare Patient Provider Number."

Joint Meetings:

- All care centers must complete their own PI in the web site. This will include action plans for each branch
- For reporting summary of audits, trends and analysis: the review of each branch's data should be noted under the appropriate section of the meeting minutes, noting the branch name and any trends noted for this branch. Action plans developed for a branch should also be summarized.
- The list of attendees should show who attended from what branch.
- Copies of the completed minutes should be distributed to all branches upon completion.
- Each care center stands alone with the requirement to complete QAPI activities, and delivery of service.

If the deadline is missed for completing the meeting and minutes, a note should be made in the Meeting Minutes. Open the minutes that are not complete, and enter "Discussion of PI activities for this quarter, audits, action plans, tracking/trending will be reviewed in next QTR" Or state the QTR to be reviewed.

EVALUATION OF THE QAPI PLAN

A formal evaluation of the program will be completed annually as part of the Care center's annual evaluation, for the Professional Advisory Group. The report will summarize the care center's performance activities. The annual program evaluation is an evaluation of the entire care center including the parent and branches. All information should be gathered by individual care center locations, then aggregated, and reported as an overall care center evaluation when indicated.

Complete during the first quarter following the end of the year, and present the Annual Program Evaluation at the Professional Advisory Group Meeting, scheduled for the 1st quarter of the year, and then presented to the Board of Directors.

CONFIDENTIALITY

The Director of Operations maintains all QAPI – related records in a secure area. To protect individual identity, numbers/codes are assigned to employees and clinical records for data collection purposes. For company –wide review, each care center is designated with a number. Any requests for results of or data from the QAPI Plan will be forwarded to the designated corporate representative, who will respond only according to the Amedisys policy and procedure. All information will be protected by HIPAA regulations.

DATA ELEMENTS & RESOURCES

NHPCO Ten Components of Quality

1. **Patient and Family Centered Care** - Providing care and services responsive to the needs and exceed the expectations of those we serve.

2. **Ethics and Consumer Rights** - Upholding high standards of ethical conduct and advocating for the rights of patients and their family caregivers.

3. **Clinical Excellence and Safety** - Ensuring clinical excellence and promoting safety through standards of practice.

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

5. **Organizational Excellence** – Building a culture of quality and accountability within our organization that values collaboration and communication and ensures ethical business practices.

6. **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.

7. **Standards** – Adopting the NHPCO Standards of Practice for Hospice Programs and/or the National Consensus Project's Clinical Practice Guidelines for Quality Palliative Care as the foundation for our organization.

8. **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.

9. **Stewardship and Accountability** – Developing a qualified and diverse governance structure and senior leadership who share the responsibilities of fiscal and managerial oversight.

10. **Percent of all measures reported** – Collecting, analyzing, and actively using performance measurement data to foster quality assessment and performance improvement in all areas of care and services.

QAPI BINDER CONTENTS

QAPI Binder Contents:

- PI Website:
  - Blank Clinical Record Review Audit Tool (as an example for surveyor)
  - Quarterly Patient Tracer Audits
  - Quarterly Eligibility Audits (if applicable)
  - Quarterly Trended Reports for Complaints/Concerns
  - Quarterly Trended Reports for Incidents
  - Quarterly Trended Reports for Infection Control (Patient)
  - Quarterly Meeting Minutes (Include Agenda and Sign-In Sheet)
  - Action Plans for scores below 85% on any audit
- PIP Projects (Any Care Center specific PDCA's)
- Quarterly Quality Report includes the HIS quality process measures
  - HSP Comfort Measure Report from
  - Live Discharge Report for your Care Center
- Deyta – Consumer Assessment of Healthcare Programs and Systems(CAHPs) reports
  - Overview for each QTR
- PEPPER Reports (Annual cap year)
- QAPI Plan for the current year
- Hospice Key Quality Metrics current year

Print the QI Event Report in HCHB and attach to PI minutes/Summary.

The logs are maintained in HCHB:

- Patient Infection Log
  - (Employee Infection reports & log should be kept in a separate binder and locked up in the DOO's office)
- Complaint-Concern Log (Negative Comments from Deyta Attached to Complaint Reports)
- Occurrence Log
- PAG Annual Evaluation (Keep on hand/available for survey)

References

Centers for Medicare/Medicaid Services - Conditions of Participation (CFR 418.58)

Clinical Practice Guidelines for Quality Palliative Care

Accreditation Commission for Healthcare, Inc. – Section 6: Quality Outcomes Performance Improvement

Quality Partners: National Hospice and Palliative Care Organization. (NHPCO)

Standards of Practice for Hospice Programs – NHPCO

Amedisys Policies and Procedures

ATTACHMENT A - DATA ELEMENTS AND DEFINITIONS OCS

ATTACHMENT B – FEHC TO CAHPS CROSSWALK

ATTACHMENT C - QUALITY OUTCOMES – QAPI SNAPSHOT (HIS)

ATTACHMENT D – HOSPICE ITEM SET (HIS) PROCEDURE FOR CMS HOSPICE QUALITY REPORTING

The Amedisys Point of Care (POC) laptop computer and the POC software used to document hospice care visits is used to electronically capture the data for the Hospice Item Set, and transmitted to CMS routinely. Two (2) HIS records, ADMISSION AND DISCHARGE for each patient are submitted;

The HIS is a set of data elements that can be used to calculate seven quality measures

- NQF #1641 – Treatment Preferences
- Modified NQF #1647 – Beliefs/Values Addressed
- NQF #1634 & NQF #1637 – Pain Screening and Pain Assessment
- NQF #1639 & NQF #1638 – Dyspnea Screening and Dyspnea Treatment
- NQF #1617 – Patients treated with an Opioid who are Given a Bowel Regimen

ATTACHMENT E – HOSPICE KEY QUALITY METRICS ANALYSIS OF QAPI AND CAHPS DATA

ATTACHMENT F – OCCURRENCE REPORT FORM

ATTACHMENT G – PRESSURE ULCER MANAGEMENT & PREVENTION

ATTACHMENT H – PERFORMANCE IMPROVEMENT PROJECT FORM

ATTACHMENT I - COMPLAINT/CONCERN REPORT/SERVICE RECOVERY

ATTACHMENT J – AUDIT INTEGRITY MANUAL & TOOL

ATTACHMENT K - NHPCO STANDARDS & NATIONAL QUALITY FORUM PREFERRED PRACTICE

ATTACHMENT L - EDUCATION QAPI PRINCIPLES (AMEDISYS ACADEMY)

ATTACHMENT M- ANNUAL PROGRAM EVALUATION (PAG)