CHARTIS | CLINICAL QUALITY SOLUTIONS

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Webinar Questions and Answers

The Quality Assessment and Performance Improvement Condition of Participation

Analyzing the March 9, 2023 CMS Interpretive Guidelines

May 23, 2023

Introduction

Chartis Clinical Quality Solutions ("CCQS") was delighted to host a recent webinar reviewing the updated QAPI interpretive guidelines recently published by CMS. This well-attended and lively discussion prompted a number of questions.

Disclaimer: *Chartis Clinical Quality Solutions does not give legal advice. These comments should be interpreted as our view of successful approaches to meeting QAPI requirements gained through decades of real-world experience helping clients across the country. Chartis Clinical Quality Solutions (formerly The Greeley Company) is the nation's leading consulting firm helping hospitals through CMS adverse actions, Systems Improvement Agreements and state-directed plans of correction.*

Question 1

How do I obtain a copy of webinar slides and handouts?

Response 1

Handouts for the March 18, 2023 webinar included:

- a PDF "notes" version of the slides (4 slides per page),
- the complete QAPI interpretive guidelines published by CMS on March 9, 2023, and
- "*Adverse Events in Hospital: A Quarter of Medicare Patients Experienced Harm in October 2018*" published by the Office of Inspector General, U.S. Department of Health and Human Services in May 2022

These materials were distributed in the "chat" function of the Webinar platform, Zoom Webinars, during the session.

To access and download these materials after the conclusion of the live event, visit the webinar's web page by clicking this link: https://www.chartisquality.com/insights/cms-updates-its-qapi-interpretive-guidelines. Each of these handouts is available by clicking their respective buttons near the bottom of the web page.

To stream the webinar, go to https://www.chartisquality.com/insights/cms-updates-its-qapi-interpretive-guidelines and download or play a recording of the live session.

To request a PowerPoint version of the slides email ***Bud Pate, Vice President for Content and Development, at bpate@chartis.com***. Chartis will make a copy of the slides available for the internal-only use of hospitals and health systems at no charge. Requests from other entities will be judged on a case-by-case basis.

Question 2

Can we get a copy of the templates used in your presentation for the indicator inventory and scope of service analyses shown during the presentation?

Response 2

As CCQS prepares its ***QAPI White Paper*** for distribution, we have attached samples of an indicator library and scope of service analysis at the end of this document.

Coming Soon: QAPI White Paper

CCQS is in the process of developing a comprehensive white paper addressing the subjects covered in the webinar and related QAPI and governance issues. This thought-leadership document will be made available to all webinar registrants in the near future.

Question 3

Can the QAPI program be developed at a system level?

Response 3

Yes. However, the program must meet the specific needs, cover the specific services, and evaluate the performance of each hospital (organizations with a separate CCN) within the system. Most hospital systems develop uniform indicator definitions and reporting formats to enable comparisons between sites of service. However, the governing board of the hospital, whether local or "corporate," must approve and oversee each hospital's performance through it's QAPI program.

This issue was addressed when the QAPI regulations were amended on February 21, 2020. Here's an excerpt from the 2020 regulation (which remains in effect):

> *"42 CFR §482.21(f) Standard: Unified and integrated QAPI program for multi-hospital systems.*
>
> *"If a hospital is part of a hospital system consisting of multiple separately certified hospitals using a system governing body that is legally responsible for the conduct of two or more hospitals, the system governing body can elect to have a unified and integrated QAPI program for all of its member hospitals after determining that such a decision is in accordance with all applicable State and local laws. The system governing body is responsible and accountable for ensuring that each of its separately certified hospitals meets all of the requirements of this section. Each separately certified hospital subject to the system governing body must demonstrate that: (1) The unified and integrated QAPI program is established in a manner that takes into account each member*

hospital's unique circumstances and any significant differences in patient populations and services offered in each hospital; and (2) The unified and integrated QAPI program establishes and implements policies and procedures to ensure that the needs and concerns of each of its separately certified hospitals, regardless of practice or location, are given due consideration, and that the unified and integrated QAPI program has mechanisms in place to ensure that issues localized to particular hospitals are duly considered and addressed."

Question 4

Are human resources, housekeeping, maintenance, staff education, etc., typically part of the QAPI program? If so, what types of QAPI measures do these departments have?

Response 4

This is an excellent question that unfortunately has a nuanced answer.

In this response we make a fine distinction between *quality assessment* and *quality control*. *Quality control* measures are supervisory tools that ensure minimal performance of a task and would not normally be considered part of the QAPI program. *Quality assessment* measures, on the other hand, are used to evaluate the overall effectiveness of a hospital service or function. Immediate corrective actions are typically taken for poor performance on supervisory quality control measures whereas performance for quality assessment measures should be measured over time, analyzed, and, when necessary, improved. It is important that the QAPI program make a clear (and sometimes arbitrary) distinction between the two.

The performance of operational departments such as housekeeping and maintenance should, indeed, be part of the QAPI program. However, measures for such departments may be reported to committees that are often not appreciated as part of the QAPI process (which they nevertheless are). Here are two examples:

Housekeeping departments typically measure performance in three ways:

- **Department-specific indicators**: Things like *Cleaning Effectiveness* is reported to and overseen by the Infection Prevention program and *Turn-Around Time for Discharged Patients* may be measured as part of an organization's patient flow improvement effort.
- **Hospital-wide Indicators**: Housekeeping's performance is also usually included in hospital-wide indicators such as use of personal protective equipment (PPE), hand hygiene, role identification (e.g., name badges), etc.
- **Patient Safety**: Like all departments, performance is monitored through the organization's adverse events (incident reporting) system. One would expect all hospital departments to report and respond to adverse events and be included in any hospital efforts to promote Culture of Safety.

All such indicators would be considered part of the hospital's QAPI program. The Board-approved list of quality-assessment indicators should include all of these measures.

Housekeeping's performance with respect to such indicators would be evaluated through the organization's broadly-defined QAPI program. This does not mean, however, that the a QAPI Committee must directly oversee performance of housekeeping (or any other department or service). Instead, performance may be reported and overseen by other committees or mechanisms as long as performance is ultimately reported to and

overseen by the governing body. Infection Prevention, Patient Flow, or Patient Safety may report separately to the Board rather than through a QAPI Committee.

Quality control measures that are used solely for supervision need not be considered part of the QAPI program. An example of such a quality control measure is the immediate feedback given to the front-line housekeeper based on a pre-defined look-behind supervisory check list.

Maintenance:

The Environment of Care Committee (or equivalent) usually tracks metrics for various maintenance functions, such as the timeliness of equipment maintenance, turn-around times for work orders, etc. Performance on such indicators should be considered part of the QAPI program and reported to the Board. Quality control indicators used for day-to-day supervision can remain within the department and need not be part of the QAPI program.

Reporting on such quality assessment indicators should not end at the Environment of Care Committee. Performance with respect to maintenance, engineering, security, or other operational departments should ultimately matriculate to and be overseen by the Board.

Support departments such as human resources and education typically collect the data to measure the performance of ***operational*** departments. For example, human resources may report on the timeliness of performance evaluations or education may report on the degree to which staff members have completed core or specialty “competencies” but these support departments are truly measuring the performance of the various operational departments. Such indicators (proportion of timely completion of performance evaluations, vacancy rates, use of contract staff members, competency completion rates, etc.) may indeed be important to the organization and included in the QAPI program. However, quality control measures for operational support departments need not be included. Likewise, there is often confusion between financial measures and quality measures. We find that some QAPI measures are included in the program due to their financial impact (e.g., use of contract staff members), but are nevertheless important for quality or safety reasons, and should be included in the inventory of QAPI measures tracked by the Board.

At the end of the day the Board has the discretion to choose which metrics are and are not included in the QAPI program. This judgement will satisfy the regulation as long as the hospital can demonstrate that the breadth of data collected and monitored is consistent with the scope and complexity of the services provided.

Presenting to a Survey Team

We sometimes see individual evaluators, who may not have a deep background in QAPI, confuse ***quality control*** and ***quality assessment*** metrics. Remember not to get sidetracked. As long as you can demonstrate that there are meaningful measures covering the entire scope of services provided by the hospital, including off site locations and services provided via contract, you are in fundamental compliance with the requirement. Then go on to explain that supervisors and managers are encouraged to use metrics in the executing of the supervisory/managerial duties. However, unless these metrics are part of the Board-approved inventory of indicators, we do not consider them part of the hospital’s QAPI program. Although we may measure how many days en employee is late for work, we do not consider that a quality metric.

Balancing Quality, Safety, and Efficiency

It remains more important than ever to implement meaningful and actionable quality metrics. According to the HHS Inspector General HAC (Hospital-Acquired Condition) penalties address only 5% or so of the harm/adverse events found in the May 2021 study. To sustain quality and safety over time, the measures you select must be relevant and meaningful. In our experience, if indicators are developed solely to show a surveyor on an upcoming survey, reporting of and performance on these indicators will languish to the detriment of the organization (not to mention CMS compliance).

Question 5

What should be reflected in the minutes of the QAPI Committee? Do you have samples?

Response 5

Please take a few minutes to review our recent (February 2023) webinar "Better Meetings, Better Results: Effective Oversight in Less Meeting Time," which is available for streaming at this link: https://www.chartisquality.com/insights/better-meetings-better-results and shares a number of samples.

Here are a few a few concepts covered in that earlier webinar, that address your question.

The QAPI Committee should be an oversight committee. It should not be used for problem solving or education: there are better mechanisms for these functions.

Like all oversight committees (e.g., Infection Prevention, Environment of Care, Medical Executive Committee, Board Quality Committee), the minutes should (but often do not) reflect a conclusion and actions for each item presented. Each item presented to the committee must address the question "so what?". Each item should also be clear about *Who* does *What* by *When*. There are really only two actions an oversight committee can take or recommend: "stay the course" or "change course." Here are a few examples of actions available to oversight committees:

Stay the course:

> *"Improvement noted: continue to improve. The presenter ('who') is requested to report back to the committee ('what') next month ('when')."*
>
> *"Target performance noted: continue to monitor to validate continued target performance. The presenter ('who') is requested to report back to the committee ('what') next quarter ('when')."*

Change course:

> "*The department should develop an action plan with respect to suboptimal performance next month's meeting;"* or
>
> "*The department should evaluate whether this indicator is meaningful and recommend replacement or retirement of this indicator at next month's meeting*;" or

The [position title] should recommend a sustainable solution to this less-than optimal performance and report on progress at next month's meeting.

All accountabilities ("who" does "what" by "when") should then be tracked and reported at every meeting by simply indicating which accountabilities are "delinquent" or "off track."

All presentations should be data/fact based and have a very (very) brief summary of the **Situation** (why is this on the agenda? Routine Report? New Issues? Etc.), **Background** and **Analysis** (bottom line only … the data to support the analysis should be attached), and **Recommendation** (including a proposed who does what by when).

If the presenter is not ready to make a recommendation they are not ready to present.

The recommendation becomes an action by being adopted, adopted and enhanced, or replaced with another action by the committee. These actions then becomes accountabilities to be tracked.

The Board Quality Committee (or equivalent) should have minutes that reflect at least the following functions with conclusions and actions:

- Approval of a Quality and Safety Plan that covers all quality and safety monitoring activities considered part of the QAPI program (clinical quality, patient safety, infection prevention, medication safety, environment of care, etc.);
- Approval of the specific indicators that are considered part of this plan and that address the scope of services provided by the institution (we recommend a separate "scope of services analysis" in addition to an inventory of indicators);
- An overview of performance with respect to metrics-based indicators that highlights performance requiring a "change in course" as discussed above;
- An overview of individual sentinel events, including the conclusions from any associated root cause analysis and evidence of sustainable process improvements associated with the event when applicable;
- A summary of the frequency of harm events (defined by the OIG as Category I, H, G, F and E on the modified MERP scale … events that resulted in death, resuscitation, permanent harm, prolonged hospitalization, or an intervention to prevent adverse consequences), including underlying systems or process issues; and
- An annual report of the degree to which CMS-required hospital services provided by contractors (rather than a hospital employees) complies with the Conditions of Participation and other contract requirements. Actions taken as a result of unacceptable performance should be included in the report.

Question 6

What about infection control?

Answer 6

Although infection prevention and control and antimicrobial stewardship has a number of its own requirements, performance on infection prevention metrics should also be considered part of the hospital's QAPI program. This does not mean that all performance measures must be reported *through* a QAPI committee to the Board. Indeed, it is best for the Infection Prevention committee to report separately to oversight and governing bodies. However, the separately-required Infection Prevention Plan should be referenced (NOT reiterated) in the Board-approved description of the QAPI program and infection-related metrics should be included in the inventory or board-approved QAPI indicators.

Question 7

How do we incorporate everything in the report to the Board? Is there anything other than meeting minutes and annual plans?

Answer 7

All reports to all levels of the oversight hierarchy should be "pre-chewed" by the presenter (refer to the February Webinar: better meetings, better results referenced above).

Let's look at a performance issue with **Falls** as an example scenario.

Report to Nursing Quality: The rate of patient falls is reported to the Nursing Quality Committee. The presenter does not just present the data, they also communicate a conclusion (e.g., performing at target, improving toward target performance, not performing at target) and a recommendation for the Nursing Quality Committee (stay to course, change course). Let's say the data suggests an unexplained cluster of falls with injury and nursing is in the process of analyzing the cases individually to identify potential system/process issues.

Report to QAPI: All Nursing Quality/Satisfaction Indicators, including Falls and other metrics, are reported to the QAPI Committee. The presenter summarizes the data analysis for all nursing quality metrics in an "SBAR" summary sheet. The actual data and analysis is attached to the SBAR. The SBAR presented to QAPI indicates:

> "The following indicators remained at or returned to target performance: *Satisfaction, Skin Integrity, Medication Administration Errors, Use of PPE* … etc.
>
> "While not at target performance, the following indicators reflected substantial, progress toward target performance: *Hand Hygiene* … etc.
>
> "The following indicators reflected less than target performance without signs of improvement: Falls … etc.

> "**Recommendation**: Nursing will present an analysis of the reason for less-than-target performance at the next meeting of the QAPI Committee."

Report to the Board Quality Committee: Data displays should be attached to the report summary (SBAR) for reference but discussed or explained only should questions arise.

> In the QAPI Committee's report to the Board the presenter's SBAR indicates:
>
> > "Except as otherwise noted, all quality data suggest performance at or returning to target performance."
> >
> > "Persistent, Non-Target Performance: Falls: Cluster of falls with injury."
> >
> > "**Actions approved by the QAPI committee and recommended for Board ratification**: Nursing will present an analysis of the reason for less-than-target performance at the next meeting of the QAPI Committee."
>
> The Board then either affirmatively accepts the recommendation of the QAPI Committee as it's "action," or substitutes it's own action specifying a new "who," "what," and "when."

In this example a dozen or more nursing indicators can be summarized into 1 or 2 issues for the QAPI Committee and the Board. The "Who" (nursing), "What" (present an analysis of the reasons for less than target performance), and "When" (next meeting of QAPI and next meeting of the Board Quality Committee) should be tracked in a separate tool and "off track" or "delinquent" accountabilities addressed during subsequent meetings.

Question 8

What frequency do you recommend reporting sentinel events to the board? They are consistently reported through our QAPI Committee and those minutes go to the board, but a written report on the sentinel events goes only annually for review to the board.

Response 8

The regulations and standards are not prescriptive. However, patient safety / adverse events are by far the most frequent cause of termination threats from CMS (not to mention "first do no harm" and risk management concerns). We therefore strongly encourage our clients to evolve their program along the following lines:

> The progress of each root cause analysis conducted for a sentinel event should be reported at every board meeting until the analysis and countermeasures are complete. There should be a brief summary in an SBAR that describes the event that can be easily updated with progress notes (e.g., "RCA in progress," "Countermeasures Identified," "Countermeasures Implemented,"). The Board does not need fishbone diagrams, timelines, or other details of the analysis.
>
> Care should be taken to only report on countermeasures that are likely to prevent a recurrence of the event. We sometimes get distracted by reporting on

“collateral” issues discovered during the RCA. We are so busy chasing relatively inconsequential matters that we never have time or attention to truly discover and solve the underlying vulnerability. Many real-world RCA’s we deal with every day never get to the true root cause. Finding 100 “collateral” issues is no substitute for identifying one true root cause.

Also be sure to conduct the appropriate level of causal analysis for true “near misses” where pure luck, rather than a pre-designed countermeasure, intervened to avoid a harm event. Near miss sentinel events should be analyzed and reported as if the patient had actually suffered the nearly-missed harm.

A fully mature safety program will perform presumptive cause analysis for a sample of actual and near miss harm events (MERP “E” or higher) and an analysis of underlying causes and contributing factors common to these harm events.

An annual summary of sentinel events is fine, but they are not always helpful. Better would be a simple tool (e.g., spreadsheet) that tracks sentinel events, near miss sentinel events, and the common causes of harm events. This tool can be regularly updated and available to the Board and others as new events or issues are tracked.

A better focus for an **annual report** to the Board might be the frequency of event reporting (up is better), the frequency of harm events (down is better), and the fraction of the various harm levels. (Note: we strongly recommend the use of a modified MERP scale because it’s specific severity score definitions promote inter-rater reliability, which is essential for meaningful trend analysis.) Consistently collected culture of safety metrics and improvement efforts should also be reported.

SAMPLE TEMPLATE: Library of Quality Assessment and Performance Improvement Indicators

Note: Organizations are to select indicators from this list and/or model organization specific indicators from this list. All indicators are not meant to be monitored at all times

No	Name	Definition	Target*	Accountability	Prioritization Criteria**	Reporting	Comment
	Self-Explanatory	*This may be event-related or a metric. When the indicators is a metric, the definition should include a numerator, a denominator, and a sample size/method*	*The target may be absolute or relative*	*Which department or service is responsible for collecting, analyzing and reporting the data*	*See Footnote for Definition of the reason the indicator is being collected*	*Who receives the report and how often*	*The source of indicator and other relevant information should be captured here.*
We recommend that all required and possible indicators be captured in the inventory. However, not all indicators may be "active." Some will time out or no longer be relevant. Others may be for future planning or collection. Inactive or retired indicators should be indicated either in a separate column or in the title of the indicator. We also recommend that the indicators be separated into major domains or clusters. In our opinion, the best practice is to capture these indicators in an interactive on-line tool that allows the attachment of documents to each row and nesting of rows under one another. SmartSheet.com is one such tool to consider.							
Medical Error Reduction and Risk Avoidance							
Significant Adverse Occurrences							
1	Sentinel Event	Event leading to death or significant impairment (per Sentinel Event Policy) includes Near Misses (reported under significant events on scorecard)	N/A	Risk Manager	R, P, C	QC, MEC, BOARD [Monthly]	Each sentinel event is reported. The root cause analysis and prevention interventions are also reported.
2	Event Reporting Frequency (RCA)	Number of events reported of the following types: Medication-Related; Other significant/Mandated Reporting	N/A	Risk Manager	R, P	QC, MEC, BOARD [Monthly]	The focus will be to increase reporting of issues
Compliance Issues							
3	TJC Vulnerabilities	List TJC MOS	N/A	Quality Director	P	QC, MEC, BOARD [Monthly]	Quality Council oversee the effectiveness of corrective actions
4	CMS Vulnerabilities	List of any significant vulnerabilities related to the CMS conditions of participation, or other federal statute or regulation Readiness Score	N/A	Quality Director	P	QC, MEC, BOARD [Monthly]	Quality Council will oversee the effectiveness of corrective actions
5	Other compliance vulnerabilities	Any issues related to compliance with state or local statute or regulation	N/A	Quality Director	P	QC, MEC, BOARD [Monthly]	Quality Council will oversee the effectiveness of corrective actions
Complaints/Grievances							
6	Patient Grievance Rate	**Numerator:** # of patient grievances **Denominator:** 100 patient days	1.5	Patient Advocate	R, P, S	QC, MEC, BOARD [Monthly]	Quality Council will oversee the effectiveness of corrective actions
7	Clinically Related Patient Grievance	**Numerator:** # of grievances related to clinical care/skill **Denominator:** # of grievances	0.7	Patient Advocate	R, P, C, S	QC, MEC, BOARD [Monthly]	Quality Council will oversee the effectiveness of corrective actions

* Target: N/A = Not Applicable to This Indicator; TBD = Applicable but the target has not been determined ("To Be Determined")

** Prioritization Criteria: XX = Required by External Authorities; R = High Risk; V = High Volume; P = Problem Prone; C = Clinical Excellence; E = Operational Efficiency; S = Patient, Employee and Physician Satisfaction; H = Employee Retention / Recruitment

Shaded Indicator Descriptions = performance measures under consideration for future use

Monthly statistical calculations unless otherwise stated

Sample Scope of Services / QAPI Program Spreadsheet

Services

Indicators

Contract?

	Support Departments													Nursing Departments								
Indicator Name	Admissions	Cardio-pulmonary*	Case Mgmt**	Central Distribution	Health Info Mgmt	Housekeeping	Human Resources	Laboratory*	Nutritional Svcs	Pharmacy	Plant Services	Radiology*	Rehabilitation*	Breast Cancer Unit	Emergency*	ICU	Perinatal*	Medical Surgical	NICU	Newborn Nursery	Surgical Svcs***	al Staff
Direct (D) or Contract ©	D	D	D	D	D	C	D	D	C	D	D	D	D	D	D	D	D	D	D	D	D	
Sentinel Event (actual and near miss)	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	
Other Adverse Event	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Event Reporting Frequency	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Compliance Action Plans	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
CMS Vulnerabilities	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓									
Other compliance vulnerabilities	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓										
Rate of Appropriate Patient Identification	✓	✓						✓	✓	✓		✓										
Rate of Compliance with the Universal Protocol		✓										✓										
Outcomes from Compliance with Universal Protocol		✓																				✓
Rate of Compliance CDC Hand Hygiene Requirements		✓		✓		✓		✓	✓	✓	✓											✓
Rate of telephone / verbal order read-back		✓						✓	✓	✓	✓	✓		✓	✓	✓	✓	✓	✓	✓	✓	✓
Errors resulting from lack of TOVO process	✗							✗	✗	✗	✗	✗	✗	✗	✗	✗	✗	✗	✗	✗	✗	✗

A check means the indicator referenced (which corresponds to the indicator definition in the separate indicator library) applies to the listed department, service, or function at the top.