

Eli's Hospice Insider

QAPI: Develop a QAPI Plan that will Demonstrate Hospice Value

If you're not accurately capturing the data, you can't be sure you're effectively treating and controlling pain.

The Conditions of Participation (CoPs) require you to show evidence of the quality of care you provide. Do you know how to best harness data to show the Centers for Medicare & Medicaid (CMS) that your hospice is continually working to improve performance?

Develop a QAPI Plan

When it comes to creating a quality assessment and performance improvement (QAPI) process, CMS wants you to include all pertinent indicators, says **Lynda Laff** of Laff associates in Hilton Head, SC. That includes:

- How and why you chose specific quality measures
- How you ensure consistent data collection
- How you use data in patient care planning
- How you aggregate and analyze data
- How you use the data analysis to select performance improvement projects
- How you implement performance improvement projects
- How you use data to evaluate the effectiveness of those projects

With that in mind, Laff advises considering the following as you develop a QAPI process:

- Which staff members will be responsible for the QAPI program
- What services and processes will be assessed
- What data will be documented and aggregated
- When high volume, problemprone care services are provided
- How often data will be collected and analyzed and how the findings will be used
- How you will use findings for ongoing care plan development
- What method(s) you will use to evaluate improvement
- How often you will report on performance

See How QAPI Impacts Outcomes and More

Working with Laff, Tidewater Hospice in Bluffton, SC decided to review their performance improvement program in 2008. Among other findings, the initial review pointed out that Tidewater's symptom assessment measurement was limited to pain control and that the data collection for this symptom was not ongoing or reliably measurable.

Tidewater staff decided to broaden their scope of symptom assessment measurement to include shortness of breath and constipation as well as pain, says Tidewater administrator **Susan Saxon**. The next step was to come up with consistent, quantifiable measures for these symptoms, Saxon and Laff revealed in their presentation at the National Association for Home Care and Hospice annual meeting.

The QI team decided to model their measurements on the Edmonton Assessment Tool using a 10 point scale to assess pain and shortness of breath. A patient was considered constipated if she hadn't had a bowel movement in four days.

All three symptoms were to be assessed at least once every eight days. If pain or shortness of breath was scored a four or higher, the patient would receive an intervention within four hours. And a constipated patient would also receive an intervention within four hours of this fact being made known.

After intervention, patients rating their pain or shortness of breath a four or higher would be re-assessed every 24 hours until resolution. Constipated patients would receive follow-up assessments until the patient or family was satisfied with the results.

Action plan: Tidewater recognized the need to clarify "accepted" level of pain and "normal" bowel movements with their patients and families, says Saxon. "We needed to talk about why a score of four or greater might be ok, or why no bowel movements in four days might be ok." These discussions often resulted in the nurse providing additional education to the patient and family about ways to better manage symptoms.

Assessment changes: Tidewater made the following changes to their visit assessments:

- Added patient/family acceptable level of pain
- Added patient's normal bowel movement frequency (number of days)
- Added patient/family satisfied: Yes/No for each symptom assessment
- Changed the Wong-Baker FACES scale from a 1-5 scale to a 1-10 scale

Monitor Data Frequently

The work didn't stop once Tidewater made these changes, Saxon says. "We looked at these items monthly so we could make rapid changes to forms and processes."

As a result, the PI team discovered that both clinicians and patients were having difficulty with the 1-10 scale. So they clarified the scale by adding descriptors: 1-3 was a mild symptom, 4-6 was moderate symptom, and 7-10 was a severe symptom with 10 being "worst symptom gets."

Some nurses found that turning the question around by asking if the symptom was mild, moderate, or severe and then asking the respondent to choose from the appropriate numbers worked better, Saxon says. PI staff also clarified the difference in the FACES scale used for non-verbal patients and the 1-10 scale used with patients who are able to communicate their pain level.

Caution: If you're not accurately capturing this data, it's hard to make sure you're effectively treating and controlling pain and other symptoms, Saxon says.

PI staff also reviewed how nurses were actually assessing pain and found that they were more intuitive than scale oriented, Saxon says. PI staff then focused on teaching the nurses to attach a number to that "intuitiveness." They also added "worst pain in 24 hours" to the assessment to help determine the actual overall level of pain control instead of simply capturing pain levels at the time of assessment.

Improve Care with Data

After fine-tuning their data collection efforts, Tidewater used the information gathered to refine their care delivery, Saxon

says. The data provides visuals that made it easy to identify and quantify levels of symptom control. For patients with inadequate symptom control, the data provides a jumping-off point for further care delivery improvement.

Gathering this data through the QAPI program doesn't just allow us to measure specific patient care outcomes, Saxon says. "It has also provided us with a venue to talk about and fine tune our assessment and treatment protocols."

Note: Check out the Edmonton Assessment Tool here: www.palliative.org/PC/ClinicalInfo/AssessmentTools/esas.pdf