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CHARTIS

Don’t fall into the QAPI trap

Avoid significant CMS sanctions while improving performance and safety

February 20, 2025

The webinar will start at the top of the hour.

2

Navigating the Zoom interface

Handouts:

Check the chat function for copies of the slides for note taking and any other handouts.

Questions and comments:

Please participate in the discussion by asking question through the Q&A function during the webinar.

There will also be a survey you will receive immediately after the webinar that will give you an opportunity to ask additional questions or make comments.

Any questions not answered during the webinar will be addressed in a follow-up email or posting.

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Healthcare challenges are not siloed. *Neither are we.*

Chartis has **six lines of business** that together craft **singular solutions**.

- 1000+ Professionals
- Mission: to materially improve healthcare
- Ranked Best Overall Management Consulting Firm by KLAS
- Chartis acquires Greeley in 2019
- Greeley brand brought back in 2024 to cover Medical Staff Services Related Offerings and now part of Clinical Transformation

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High Reliability Care

UNPARALLELED BREADTH AND DEPTH

Our clients are all striving toward the same goal of providing safe, high-quality care—something that's becoming even more important with the many distractions and disruptions in healthcare today. We help clients achieve their organizational reliability, quality, and safety goals, leading to results in areas that matter most—improved care outcomes, staff engagement, operational stability, and total cost of care, enhanced reputation, and better patient experience.

High Reliability Organization (HRO)

- High reliability organizational design and infrastructure
- Quality, Value, and Performance Improvement
- Quality ratings and rankings optimization
- Patient safety / harm reduction / safety and reliability culture
- Adverse event response and remediation / RCA
- High fidelity measurement / Clinical Documentation Integrity (CDI)
- Care facilitation

Clinical Compliance, Regulatory, and Physical Environment Solutions

- Adverse event response
- Adverse action regulatory response and remediation
- Accrediting body readiness assessment
- Regulatory readiness rehearsal / mock surveys
- Life safety and environment of care assessment
- Policy simplification
- Infection prevention program

Bylaws, Rules and Regulations, and Peer Review

- Bylaws and rules and regulations assessment and redesign
- Peer review assessment and redesign
- Medical staff / medical director structure and governance
- Credentialing, OPPE

External Peer Review

- Physician/advanced practice professional external peer review
- Focused Professional Practice Evaluation (FPPE)
- Ongoing case review in support of OPPE/FPPE
- Medical necessity reviews
- Patient safety/carequality case reviews

MEMBERSHIP AND PROFESSIONAL EDUCATION SERVICES

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Greeley

A CHARTIS COMPANY

We are a partner to healthcare organizations nationwide, helping to advance patient safety and clinical quality for the past 30+ years. We help healthcare providers achieve top-tier clinical performance through:

- Medical Staff Services Optimization
- Education Solutions
- Chartis Workforce Solutions

Integration with other best-in-class consulting services offered by Chartis

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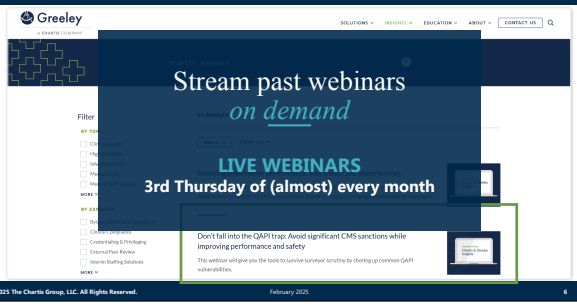
Past webinars available for streaming

GREELEY.COM



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BONUS Webinar: CMS PSSM Reporting

Register Now For This Important Webinar

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Today's *discussion*

This is a continuation of our QAPI series. Our panel will discuss common failure points and practical approaches to implement a comprehensive and effective quality and safety program.

Joshua Cartwright, DHA, MHL, CPHQ, FACHDM
Associate Partner,
High Reliability Care & Compliance

Kelsey McGinty DNP, FNP-C, RN, CPHQ, CPPS, CIC, HACP-CMS
Senior Consultant,
Compliance & High Reliability Care

Bud Pate RHES
Consultant Emeritus,
Compliance & High Reliability Care

"Following the path to High Reliability

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Objectives

Attendees will be able to:

- Gain a deep understanding of basic requirements and other information from **previous webinars**
- Learn from the **mistakes of others** and avoid serious consequences to Medicare and Medicaid fundings
- Implement successful and practical approaches to ensuring your program touches the **scope** of care and services; monitor **contract** services without engaging in overkill; resolve persistent **poor performance**; **unify** and simplify various elements of the quality and safety program; obtain meaningful involvement of and oversight by hospital **executives** and the governing body
- Leverage **adverse event reporting** to obtain meaningful information about departmental performance

Program slides, CMS interpretive guidelines, the OIG report, and other materials are shared as a PDF in the Chat function for live attendees.
Handouts will be linked to the Chartis Website for post-webinar streamers.

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Today's *agenda*

Context

Beyond root cause analysis

Connecting with executive leadership

Recognizing and avoiding myth

Questions should be posted in the webinar interface throughout the presentation.
We will respond to any unanswered questions in writing following the webinar.

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Context

The continuing series of webinars

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- The fundamental tactic for providing oversight and getting things done
- Do more with less meeting time
- Cut turn-around time in half

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- An introduction to the QAPI Interpretive Guidelines
- CMS expectations for
  - Program Scope
  - Involvement of the Board
  - Patient Safety

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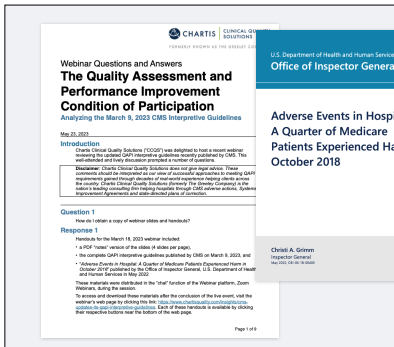

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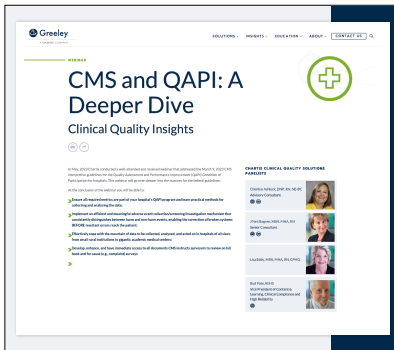

- Addressing common questions and challenges
- Getting real

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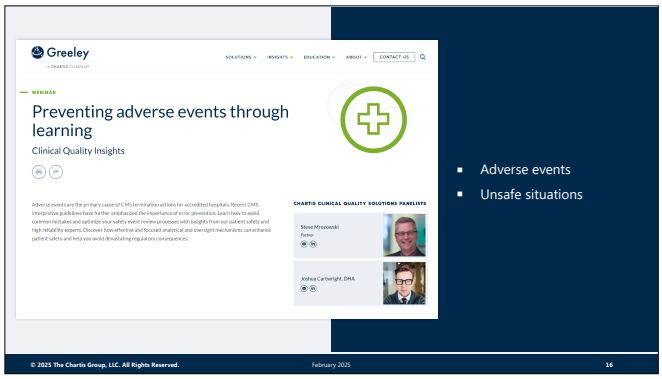

- Adverse events
- Unsafe situations

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Transforming available data into actionable information by executives and the Board

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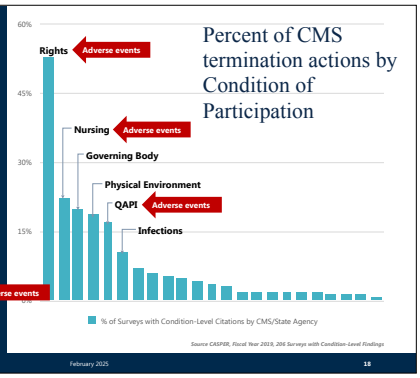
Frequency of CMS termination actions for accredited hospitals

The most highly cited regulation leading to CMS termination actions for accredited hospitals is **EMTALA**.

There are no routine EMTALA surveys, only "for cause" investigations, typically due to adverse events.



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Beyond Root Cause Analysis

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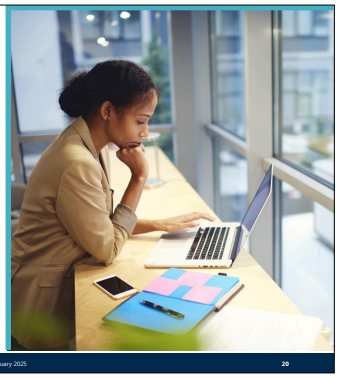
Hospital executives

WHAT THEY KNOW IMMEDIATELY

- Revenue
- Budget
- Vacancies
- Capital projects
- Strategic alliances
- Star rating
- Satisfaction

WHERE THEY ARE VAGUE

- Departmental performance
- At-risk processes
- QAPI
- Patient safety



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Zero harm *does not mean* zero incident reports

- To approach zero harm one must increase the reporting of all events and unsafe conditions.
- Many hospitals fail to accurately message this concept.

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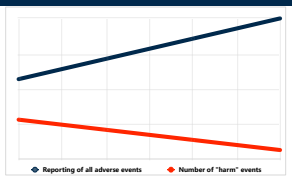
About adverse events



To optimize the value of incident reports as a credible monitor of quality and safety there MUST BE high inter-rater reliability (consistency) in the designation of incident categories and level of harm/analysis.

Sifting Through Adverse Events

Score at the highest reproducible level

ESS	Description	Infrastructure	Harm?	Analysis
Zero (0)	**No Variance**: No known or suspected error or adverse state. Includes recommendation for improvement.	✔	No Harm	Fact Finding
A	**Unsafe**: There was in increased capacity for error, even though no error was identified.	✔	No Harm	Fact Finding
B	**Captured**: An error occurred but it did not reach a person or infrastructure.	✔	No Harm	Fact Finding
C	**No Monitoring**: An error occurred that reached a person or the infrastructure, but there was no need for monitoring or intervention.	✔	No Harm	Fact Finding
D	**Monitoring** was necessary to look for potential signs of harm or damage. Monitoring includes non-invasive diagnostic testing.	✔	No Harm	Fact Finding
E	An **Intervention** was necessary to avoid further harm to the patient or infrastructure.	✔	Harm	ACA* (Sample)
F	The error lead to an initial or prolonged **hospitalization**.		Harm	ACA (Sample)
G	The error contributed to **permanent harm** to a person or the infrastructure.	✔	Harm	RCA*
H	**Resuscitation**: Intervention necessary to sustain life that involved advanced life support protocols.		Harm	RCA
I	**Death**		Harm	RCA
S	Defined **Sentinel Event**		Harm	RCA

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Connecting with executive leadership

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Compliance as a byproduct of quality, safety, and efficiency

Simply implementing a process to meet a requirement does not always result in quality, safety, or efficiency. However, implementing systems that support and sustain all three - quality, safety, and efficiency - leads to sustained compliance.

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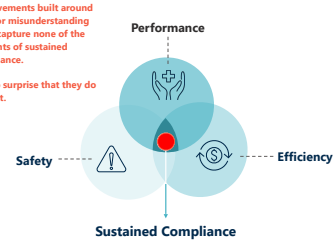
Improvements built around myth or misunderstanding often capture none of the elements of sustained compliance.

It is no surprise that they do not last.



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Avoiding myth

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Common QAPI failure points

- **Scope:** Lack of attention to the performance of all parts of the organization, not just those with public benchmarks.
- **Contract monitoring:** Due to pervasive misunderstandings of the actual requirement, contracted services are not monitored correctly.
- **Poor performance:** Tolerance for persistently poor performance on departmental or service indicators.
- **Fragmentation:** Lack of integration of non-clinical services (e.g., environment of care) and functions with specific monitoring requirements (e.g., medication safety, antibiotic stewardship, workplace violence, maternal safety) within the QAPI structure.
- **Executive and board focus:** Absence of an effective mechanism for hospital executive and the governing body to oversee all aspects of the QAPI program.
- **Oversight:** Ineffective oversight meetings without a credible process for data analysis (conclusions), accountability for actions, and follow-up to make sure actions taken were effective.

Modern QAPI programs tend to focus on Hospital-Acquired Conditions (HAC penalties) and other Hospital Compare and Pay for Performance indicators rather than the entire scope of services.

Medical error reduction (patient safety) programs often suffer due to a priority on analyzing significant harm events rather than permanently fixing the underlying process flaws that caused them.

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Contract monitoring

- Participation in the QAPI program is required for contracted services (NOT purchase agreements).
- Contracted services must be provided in compliance with federal regulations, including the Medicare Conditions of Participation.
- The Board must oversee the degree to which individual contractors meet regulatory and internal expectations.
  - Inventory of contracted services.
  - Very brief annual review of each contract:
    - Meets expectations in the contract.
    - Does not meet expectations (Explain)

    Actions taken when expectations not met
- **DO NOT** make indicators part of the contracting process. Leave that to the quality and safety program. Instead, require that contractors fully participate in QAPI, including the collection and reporting of indicators and other information required by the approved QAPI plan.

MYTH:

the contract or an attachment to the contract must include indicators.

REALITY:

the contract must include the scope of services provided and performance expectations (NOT indicators).

EXAMPLES:

"participate in the QAPI program"

"provide services in compliance with the Conditions of Participation"

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Poor performance

- Don't measure it if you don't intend to improve sub-threshold performance.
- Better to have one concurrent and overarching monitor than 10 retrospective chart review indicators that do not get to the actual safety issue.

Example: Monitoring of Restraint

- **Documentation of Monitoring** (retrospective chart review)
  April: 75%, May 80%, June 70%, July 75% … etc.
- **Face to Face Evaluation within 1 hour of initiation / application / Violent Restraint** (retrospective chart review)
  April: 75%, May 80%, June 70%, July 75% … etc.

- **Appropriateness of Restraint** (concurrent care facilitation)
  "Yes" plus "No-Corrected"
  April: 97%, May 95%, June 98%, July 100% … etc.
- **Safety of Restraint Method** (concurrent care facilitation)
  "Yes" plus "No-Corrected"
  April: 100%, May 100%, June 100%, July 100% … etc.

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Fragmentation

All performance related issues should be part of the overarching quality and safety plan

- Board Quality Ctte
- Medical Executive Ctte
- Quality and Safety Ctte
- Environment Ctte
- Emergency Mgmt Ctte
- Health Equity Ctte
- VTE Reduction TF
- Medication Safety Ctte
- Nursing Quality Ctte
- Risk Management Ctte
- Antibiotic Stewardship Ctte
- Etc …

Maternal Safety
Surgery
Anesthesia
Restraint
Satisfaction
Pain Opioid
Falls
PFP
Safety and Security
Resuscitation
Blood
Ambulatory Care
Resuscitation

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Reducing Fragmentation

All performance related issues should be part of the overarching quality and safety plan

- Board
  - Board Quality Ctte
  - Medical Executive Ctte
  - Quality and Safety Ctte
    - Emergency Mgmt Ctte
    - Nursing Quality Ctte
    - Health Equity Ctte
    - VTE Reduction TF
    - Medication Safety Ctte
    - Risk Management Ctte
    - Environment Ctte
    - Antibiotic Stewardship Ctte
    - Etc …

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Involvement of the governing body

The Board must expand its focus beyond benchmark Indicators

Board

Board Quality Ctte

Quality and Safety Ctte

Scope of services

Indicator Inventory

Contracts for Services

PI Projects

Sentinel Events
Near Misses
Common Cause Analysis

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Involvement of the governing body

The Board must expand its focus beyond benchmark Indicators

Board

Board Quality Ctte

Quality and Safety OVERSIGHT Ctte

~~Quality and Safety Ctte~~

Data-based Analysis of Performance

Conclusion/ Recommendation:

Stay the Course

Change Course

Change Indicator

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Oversight

The size and number of committees renders them ineffective for the purpose of performance oversight.

We recommend an executive team to oversee performance before issues go to the Board.

Quality and Safety Oversight Committee

- Executive level – a quality and safety focused "A Team"
- Assign Accountabilities
- Prioritize
- Allocate Resources
- React Quickly to Threats and Opportunities

All agenda items are "action ready."

- If there is no recommended action, the issue is not ready to go to the committee.
- This is not a problem-solving group.
- QSOC acts on recommendations and ensures accountabilities are realized.

Tools:

- Each agenda item with
  - Objective: why is this on the agenda
  - Analysis-based recommendation
- Accountability tracking tool with follow-up
- Agenda becomes minutes at the end of the meeting

Twice as much accomplished in half the meeting time.

Issue TAT decreased by 70%

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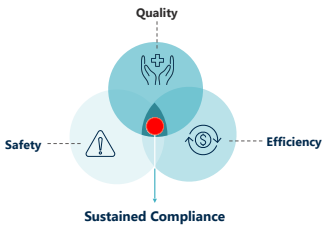

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Questions/discussion

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Thank *you*

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