WellSky

Home Health QAPI
Self-Assessment Tool

DIRECTIONS: Use this tool* as you begin work on QAPI and as an annual or semiannual evaluation of your agency's program. Complete the assessment with input from your entire QAPI team and agency leadership. Make it an honest reflection of your progress. The results will guide you toward areas that need your attention. Be sure to add notes under each item about **why** you rated yourself a certain way.

Date of review: _____ **Next review scheduled for:** _____

Rate how closely each statement applies to your agency	*Not Started*	*Just Starting*	*On Our Way*	*Almost There*	*Doing Great*
Our agency has developed principles guiding how QAPI will be incorporated into our culture and how we work. For example, we consider QAPI to be an integrated method for decision making and problem solving rather than a separate program. **NOTES:**					
Our agency has identified how all service lines and departments will utilize and be engaged in QAPI to plan and do their work. For example, we can say that all service lines and departments use data to make decisions and drive improvements, and that we measure to evaluate the success of our improvement efforts. **NOTES:**					
Our agency has developed a written QAPI plan that includes the steps that we take to identify, implement, and improve continuously across all departments, and our plan is revised on an ongoing basis. For example, we understand that even a beautifully written plan designed purely for compliance will not meet the intent of QAPI if the plan is not actively followed and revised when needed. **NOTES:**					

* Adapted from the **QAPI Self-Assessment Tool** developed by the Centers for Medicare & Medicaid Services (CMS). The original version is available at https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/QAPI/downloads/QAPISelfAssessment.pdf

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Our governing board is engaged in and supportive of the performance improvement work being done in our agency. For example, it is evident from board meeting minutes and other leadership meetings that board members are informed of insights gained from QAPI data, and that the board provides input on proposed initiatives. Board members may also work on performance improvement projects or teams. **NOTES:**					
QAPI is considered a priority in our agency. For example, there is a process for covering caregivers who serve on improvement teams. **NOTES:**					
QAPI is an integral component of new staff orientation and training. For example, new staff understand and can describe their role in identifying opportunities for improvement. Another example is that new staff expect to be active participants on improvement teams. **NOTES:**					
Training on performance improvement strategies and tools is available to all employees, both direct and contract. **NOTES:**					
Our agency makes continuous improvement in incremental, measureable steps in our performance improvement projects. For example, we make a small change and measure the effect of that change before boader implementation. An example of a small change would be pilot testing and measuring with one nurse and one patient on one day before expanding or adjusting based on test results. **NOTES:**					

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When addressing performance improvement, our agency focuses on changes to systems and processes rather the behavior of individuals. For example, we avoid assuming that an individual's lack of education or training is the problem. Instead, we examine the sequence of events that allowed a problem to occur and look for opportunities to change the process and reduce the chances of the problem happening again. **NOTES:**					
Our organization has established a culture in which employees are held accountable for their performance, but not punished for errors and do not fear retaliation for reporting quality concerns. For example, we have a process in place to clearly distinguish between unintentional errors and intentional reckless behavior. **NOTES:**					
Leadership can clearly describe our agency's approach to QAPI, and give accurate and up-to-date examples of how we are using QAPI to improve the quality and safety of patient care. For example, our administrator can clearly explain our current performance improvement projects and describe in detail how our QAPI work is guided by staff and incorporates input from patients and families. **NOTES:**					
Our agency has identified all the data sources that are available and relevant to our QAPI program. This includes data that reflects measures of clinical care; input from staff, patients, families, and stakeholders; and other data that reflects our agency's services. For example, we have listed all available measures, indicators, and sources of data. We have carefully selected the information used for decision making. Likewise, we have excluded measures not currently relevant in our decision making process. **NOTES:**					

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Our agency sets goals for desired performance, as well as thresholds for minimum performance. For example, our *goal* for patients recommending our agency to family and friends is 100% and our *threshold* is 85%. This means we will revise the strategies we are using to reach our goal if we fall below this threshold. **NOTES:**					
Our agency has a system to effectively collect, analyze, and display our data to identify opportunities to make improvements. This includes comparing our results to benchmarks or to our internal performance targets or goals. For example, our performance improvement projects are selected based on facility performance as compared to national benchmarks, best practices, or applicable clinical guidelines. **NOTES:**					
Our agency already has employees with skills in data analysis and interpretation, or we support our employees in developing those skills to assess our performance and support our improvement initiatives. For example, our agency provides opportunities for training and education on data collection and measurement methodology to staff involved in QAPI. **NOTES:**					
Our agency has a systematic and objective way to prioritize and determine our opportunities for improvement. This process considers input from multiple disciplines, teams, and patients. This process identifies problems that are high risk, frequent, or could otherwise impact the safety and quality of life for our patients. **NOTES:**					

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When a performance improvement priority is identified, our agency has a process in place to establish a charter for a performance improvement project (PIP). This charter describes the scope and objectives of the project so the team working on it has a clear understanding of what they are being asked to accomplish. **NOTES:**					
We have a process in place for documenting what we have done in our performance improvement projects, including highlights, progress, and lessons learned. For example, we have project documentation templates that are used consistently and filed electronically in a standardized way for future access and reference. **NOTES:**					
We measure to determine if changes to systems and processes have been effective in each performance improvement project. We use process measures and outcome measures to assess the impact of our projects on patient care and quality of life. For example, we measure if change has actually occurred and whether it had the desired impact on our patients. **NOTES:**					
Our agency has a clear and well-understood process to identify the initiating cause or causes of problems, such as root cause analysis. **NOTES:**					
When investigating a problem and analyzing its causes, our agency identifies system and process breakdowns and avoids focusing on individual performance. For example, if an error occurs, we focus on the process that allowed the error to occur. We then change the process to prevent the same situation from happening again. **NOTES:**					

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When system and process breakdowns are identified, we link corrective actions with the specific system and process breakdown. We focus on improving processes rather than blaming staff, asking staff to be more careful, or using staff training as a default response. We also look for ways to assure that change can be sustained. For example, if a policy or procedure was not followed due to distraction or lack of staff, our corrective action focuses on eliminating distraction or changing staff levels. **NOTES:**					
Once corrective actions have been identified, our agency puts process and outcome measures in place to see if change is happening and if patient care is improving as expected. For example, if we were to make a change to care practices related to fall prevention, we would determine whether the change is being carried out and measure the impact on fall rate. **NOTES:**					
When an intervention has been put in place and determined to be successful, our agency measures whether the change has been sustained. For example, if a change is made in medication administration, we would determine whether the change is in place and measure if it is having the desired impact. This would be done at six and 12 months. **NOTES:**					