Harnessing Change:
The QAPI and Clinical Operations Collaborative

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Learning Outcomes

Upon completing this session, participants will be able to:

- Describe the current use of work force analytics data to enhance engagement.
- Discuss methodology which ties QAPI performance improvement projects to enhancing clinician productivity
- Describe the link between the time to document and the potential impact on optimal clinical outcome achievement.

Change is consistent within how we serve our purpose

We work to deliver care that is:

Compliant
Efficient
Effective
Compassionate
Patient-centered/engaging

Value based care design is:

Born of effective QAPI and Clinical Ops collaboration, guided by a unifying mission and fueled by integrated AI

"The conditions [man] tries to adjust to are going to change, and change so darned fast that he never will actually adjust to a given set of conditions. He'll have to adjust in a different way: he'll adjust to an environment of change."

— John W. Campbell

Silos easily separate us

The engagement challenge

Current State:
40% of home health organizations report difficulty retaining clinical staff
Key Factors:
Burnout
Documentation burden
Lack of meaningful feedback
Limited growth opportunities

Bottom Line:
Disengagement threatens quality of care and organizational sustainability

How are your clinical operations, QAPI and education personnel addressing this issue?

The challenge: the documentation cascade

- Variable assessment habits, documentation timing, and plain fatigue increase expense and leak quality/competence. This drives up reactive QAPI need.
- Example - Historic under-report of functional ability/clinical complexity on the OASIS, yielding suppressed quality outcome scores (and revenue/case mix weight).
- 2026 CMS Final Rule's behavioral adjustments eliminate past leniency — documentation precision is now a baseline requirement for financial survival and quality reporting accuracy.

~40%	#1	10–15%	$1M+
of clinician's day spent on administrative tasks	driver of clinician burnout and attrition	CMI suppression from under-coded OASIS items	estimated cost per lost clinician (recruitment + training)

The precision we need is no longer optional!

The pressure is on, across care at home.
Solid collaboration between QAPI and Clinical Operations is essential!

Payer pressure and scrutiny rising

Often within reduced rates (CMS)
Or
Rates subject to competitive pricing

Workforce Crisis

Growing demand cannot meet supply

Legacy habits of documentation unsustainable and undesired

Extreme Scrutiny

Advent of AI is also helping payers easily filter for missed elements – on the rise as bad actors are identified

Reality check for clinicians, managers & QAPI

01	**Variable OASIS Knowledge**	Coding skill varies widely — two clinicians can score the same patient very differently.
02	**Delayed Charting**	Documenting hours or days after a visit loses subtle, high-weight clinical detail.
03	**Fatigue-Driven Neutral Coding**	Tired clinicians default to safe, lower-acuity scores to sidestep QA questions.
04	**Missed Comorbidities**	Secondary diagnoses that add PDGM payment weight get overlooked in rushed visits.
05	**Reactive QA**	Often repetitive, iterative correction to clinician, absent expectation of resolution of competence.

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What underlies the work of both QAPI and Clinical Ops?

What actions can you take to systematically build method in support of serving that purpose-driven work and top-notch care delivery?

To answer that best, ask what matters most to each cohort?

- The patient/family we serve
- The clinicians who serve them
- The administrative and leadership teams who keep the work going
- QAPI and Education
- Clinical Operations

How can QAPI and Education best collaborate with Clinical Operations?

Hypothesis:

Through thoughtful collaboration we have the opportunity to thrive, survive, and adapt to changing circumstance, while fueling what matters most to us all.

This collaboration advocates for the unifying mission to serve by thoughtfully managing risk.

Careful risk management builds a strategic silo, by design….

QAPI and Clinical operations Silos by design

Collaboration by Design
QAPI, Education and Operations

Partners in Advocacy
Empowered with Data!

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Collaboration between Clinical Operations and QAPI

QAPI:
- Gathering data
- Identifying patterns of risk
- Conveying data aligned findings
- Communicating findings to Clinical Operations
- Collaborating on potential solutions to challenges identified
- Plan Do Check Act cycle…

Clinical Operations:
- Supporting QAPI fueled educational initiatives through aligned performance expectataions.
- Supervising key performance behaviors (KPBs) aligned with desired achievement of KPIs
- Leading individual teammate and department leadership to risk-informed accountability:
  - Clarify expectations
  - Provide skills/tools to meet expectations
  - Have a method to monitor adherence to expected actions
  - Hold accountable

Innovation building the link between data understanding and desired actions

Personal Care	Hospice	Home Health
Leveraging AI to see into risk of hospitalization	Leveraging AI to see into prognostication	Leveraging AI – predict risk of hospice suitability and ACH
Medicare Advantage	AI evolving as data evolves	Rising virtual care reality within value-based constructs
Growing telecommunications and associated RPM/AI	Optimizing continuum-based protocols	CMS initiating data-gathering, g-codes for virtual telecommunications and RPM
Caregiver insights	SFP/payer impacts	**Clinician insights**
	IDT insights	

Strategic planning for healthcare at home must ask and answer the question: How does your organization equip teams with tools for today's work?

AI is helping both QAPI and Operations find the suppressed OASIS elements

NLP and Agentic AI

Top 5 Commonly Under-Coded Items AI Captures

M1800 Grooming	Functional limitation often not coded due to brevity of observation window at SOC
M1033 Pain Interference	Patient verbal reports during visit frequently not mapped to OASIS; significant CMI weight
Diabetes + Neuropathy Secondary Dx	Adds 0.2–0.5 CMI points per 30-day period ($400–$1,000 per episode)
M1242 Frequency of Pain	Requires a specific question — clinicians under time pressure often skip or default to lowest response
M1700–M1745 Cognitive / Behavioral	Cognitive impairment items are frequently under-reported; AI flags inconsistency with hospital records

Harnessing change – as analytics evolve

The right change, at the right time can be harnessed to elevate measures of engagement, outcomes and success

- Today let's focus on how changes in our technology have driven insights which impact top collaboration between QAPI and Clinical Operations
  - A structured methodology for connecting quality initiatives with clinician engagement and productivity
  - A practical model for implementation
  - Real-world examples of leveraging workforce metrics
  - Step-by-step approach for applying top leadership approach and QAPI collaboration to positively impact your organization

AI: working to meet predictable challenges

Ambient Clinical Intelligence (ACI)
Records the patient assessment in real time and auto-maps data directly to OASIS-E2 M-items — eliminating delayed charting and manual entry errors. First-draft notes reduce admission documentation time by up to 50%, saving clinicians ~30 minutes per visit.

Agentic AI — NLP Comorbidity Discovery
Scans complex referral packets and hospital discharge summaries to surface high-weight secondary diagnoses clinicians miss during a time-pressured Start of Care. Captures the "hidden" case mix that adds real PDGM payment weight.

Human-in-the-Loop QA Workflow
AI pre-audits documentation for consistency before it reaches your QA team. Every OASIS score is cited back to a verbatim patient statement or clinical observation — creating an audit-proof trail that satisfies CMS surveyors under iQIES validation.

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AI real-time partner

AI records the assessment conversation
AI listens during the SOC visit and captures clinical detail in real time — including offhand patient statements about pain, falls, and function that might otherwise be forgotten

AI auto-maps to OASIS M elements
AI listens during the SOC visit and captures clinical detail in real time — including offhand patient statements about pain, falls, and function that might otherwise be forgotten

AI auto-drafts the initial document
AI listens during the SOC visit and captures clinical detail in real time — including offhand patient statements about pain, falls, and function that might otherwise be forgotten

Captures what delayed documentation often misses
Documenting hours or days later erodes accuracy. ACI locks in clinical detail at the moment of observation — before fatigue sets in.[19]

Impact at Scale

50%
reduction in documentation time

~30 min
saved per admission visit

<2%
OASIS entry error rate (vs. 15–20% manual)

75%
reduction in "pajama time" charting

Expect to continue to face increased demand & aligned workforce challenges

Workforce issues will grow with demographic rise in demand – we need to refine how we anticipate and manage into growth of compliant, high-quality care delivery

Empower Your Leadership - Stay up to date with evolving technology and best practice tools

Refine Your Method and Discipline – Retain and engage clinicians during onboarding and beyond:

- Get ahead of team-member performance preparation while addressing challenges before they get out of control
- Gain better understanding cause and effect – what expectations have you created? How will you best support their achievement?
- Provide different tools to get the job done

We have to see the pattern to change it

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Where we focus our attention matters

When we support and sustain *less than effective choices*, we erode top and bottom-line performance:

- delegation of blame, absent insight into cause
- front line leadership and field absent consistent approach to see and manage clinical risk
- sustaining variable clinician approach to patient assessment and documentation capture on datasets:
  - misinforming risk engines
  - suppressing revenue
  - generating erroneous/suppressed outcomes/aligned perception
- care planning absent data and risk informed utilization management

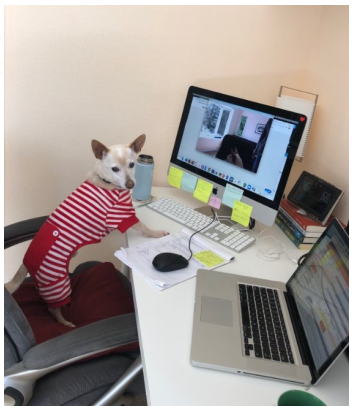
Often missed QAPI/PIP goals reflect our inability to 'see into' the clinical and operational risks we can unknowingly create

QAPI and worforce productivity
Making the connection

- Systematic approach to quality improvement
- Required by CMS for home health and hospice organizations
- Traditionally focused on patient-centered outcomes

Now consider one of the most common challenges impacting the clinical operations and QAPI members alike…

Can you say 'pajama-time'?



Documentation time – Hiding in plain sight

Reality check – eyes wide open!

- Home health clinicians spend 25-35% of their time on documentation
- Documentation time too often not factored into productivity expectations
- Rushed documentation leads to quality and compliance risks
- Often asynchronous – yielding delays in capture
- Hospice - new data set Oct.1, 2025 HOPE - now learning from Home Health's QAPI and Clinical Operations collaboration

Indirect effects of documentation patterns if not optimized:

- Clinician stress and burnout
- Increased error rates
- Reduced job satisfaction
- Higher turnover
- Frustrated growth

Calculating the Burnout ROI

"We don't have a staffing problem; we have a 'time-usage' problem"
AI and Aligned QAPI/Ops Collaborative Supports can Help to Mitigate

5–10 hrs	$50K–100K	10–15%	12%
returned to clinicians per week via AI charting relief	saved per retained clinician vs. replacing one	CMI improvement from capturing missed comorbidities	average CMI accuracy improvement in mid-size agency pilot

25 *Source: Industry estimates based on 2024–2025 home health workforce studies and agency-reported AI pilot data*

Alignment of purpose – walking a mile in the shoes of the field

Remember - If we lack confidence, motivation is inhibited

Leadership theory compels us to assure our teams have the tools to meet the expectations of the work

We cannot assume an advanced level of clinician teammate competence/ability and motivation, given:

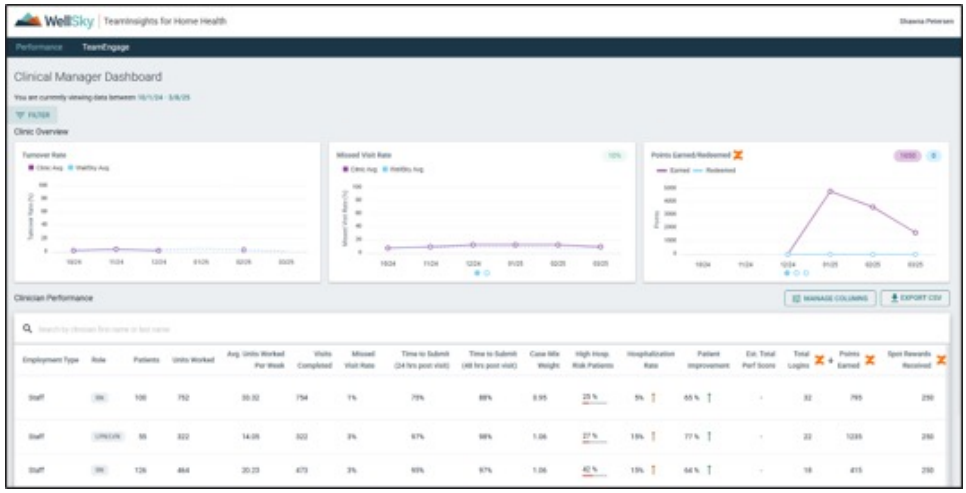
- patient acuity has increased post Covid-19
- outcome pressure is up
- productivity pressure is up
- technology has advanced
- training and ongoing preparation is variable/limited

Stacking skills to meet top performance is key to successful strategy

Build confidence and competence through iterative learning methodology

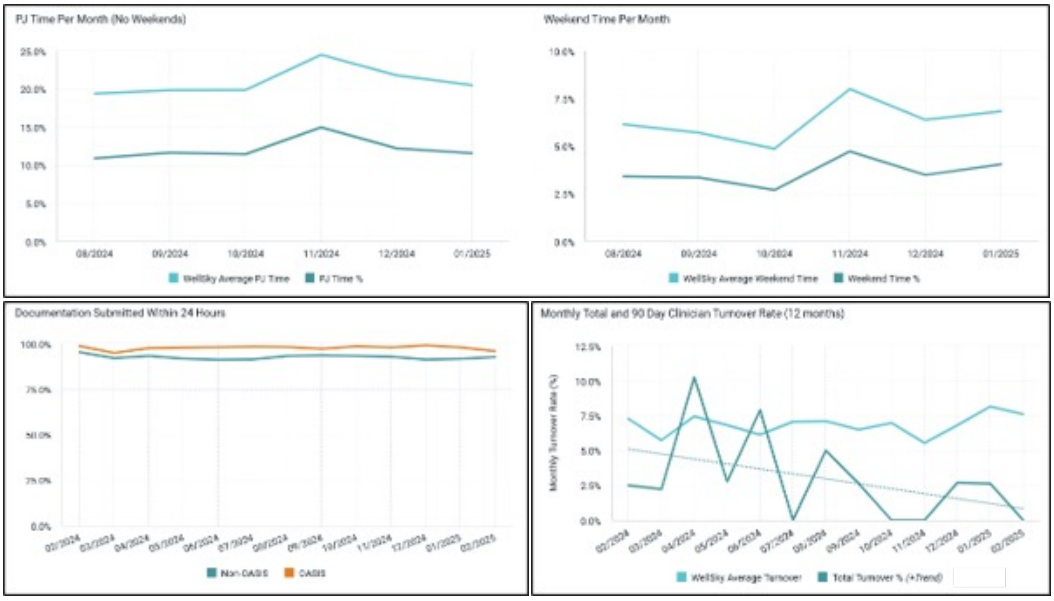
Where once we guessed, now we can see

- Competitive performance banks on competitive workforce culture
- You cannot build strong culture if you cannot see the impact of our choices
- Consider IDT's impact on agency outcomes and your aligned actions to *engage, support and lead them to success*



WellSky Average

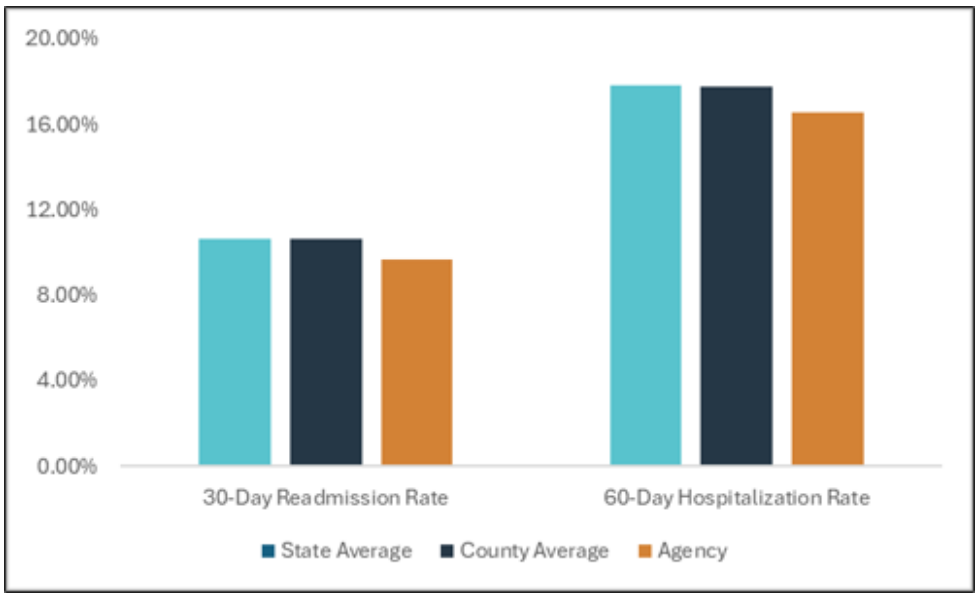
Example of an East Cost agency/ ~40 clinicians



Time to submit rates reflect risk

Average Caregivers	Average Turnover	Average Turnover 90 Days	Average 24 Hour Time to Submit	Average PJ Time Percentage
39	3%	2%	95%	12%
37	2%	0%	93%	8%
25	3%	0%	93%	8%
31	6%	40%	88%	10%
48	2%	9%	86%	9%
24	7%	4%	80%	17%
71	8%	14%	75%	4%
20	38%	0%	73%	4%
24	3%	15%	73%	15%
55	7%	23%	70%	25%
58	7%	22%	70%	9%
33	4%	0%	70%	2%
25	26%	50%	68%	16%
23	4%	8%	68%	8%
31	2%	0%	67%	4%

Results for an East Coast agency with ~40 clinicians



Workforce analytics: Bringing clarity

- Customizable dashboards for clinicians and leadership
- Predictive analytics to identify burnout risk factors
- Real-time data collection on workload, documentation time, and travel
- Benchmark comparisons against organizational and industry standards
- Engagement surveys linked to performance metrics

Analytics are helping top leaders see into risk and aligned actions

Top performers are proactive:

- Seeking greater insights
- Leveraging innovation
- Consistent leadership approach
  - Leveraging situational leadership theory
  - Clear method and discipline to track and manage achievement of key performance behaviors (KPBs)
- Do not rest on erroneous assumptions
  - *Leverage evolving data to tell the story of performance*
  - *Leverage data to also see where best-intended efforts within the office can unknowingly set up a clinician to fail*

QAPI – Data changing how to focus

Clinical and workforce analytic engines help QAPI focus how we should best spend precious time:

- in review of records
- in aligned education
- in direct supervision, one-on-one
- in team function

Remember: in any situation there is usually one course of action which yields the most substantial result

Take comfort in data (even if not comforting!) - it is not emotional!

Examples:

Hospice QAPI in era of heightened scrutiny
Home Health QAPI in an era of value-based-payment

Analytics fueled engagement strategies

- **Transparent Performance Metrics**: Shared visibility of workload distribution
- **Personalized Development Plans**: Using data to identify growth opportunities
- **Recognition Programs**: Data-driven achievement celebrations
- **Work-Life Balance**: Optimizing schedules based on efficiency patterns
- **Voice of the Clinician**: Regular feedback channels tied to metrics

Evolving analytics work to simplify the view – focusing the team

AGENCY

Value-Based Purchasing Quality Measure	Agency Performance (Improvement Threshold 2023)	All Agency Median (Achievement Threshold 2023)	All Agency Mean of the Top Decile (Benchmark 2023)	Current Value	Achievement Score (Compared to All Agencies, 0-10)	Improvement Score (Compared to Self, 0-9)	Performance Score (Unweighted, 0-10)	Performance Score National Percentile	Weight	Weighted Care Points
OASIS-based Measures										
Improvement in Oral Medications (Risk-adjusted)	84.6%	85.2%	98.7%	100.0%	10.000	9.000	10.000	87th	9.0%	9.000
Improvement in Dyspnea (Risk-adjusted)	83.9%	89.7%	99.4%	99.2%	9.802	8.906	9.802	81st	6.0%	5.881
Discharge Function Score (Risk-adjusted)	80.4%	62.4%	83.2%	100.0%	10.000	9.000	10.000	90th	20.0%	20.000
Sum of OASIS-based Measures	-	-	-	-	-	-	**29.802**	-	**35.0%**	**34.881**
Claims-based Measures										
Discharged to Community - PAC (Claims-based)	66.0%	80.5%	90.1%	74.5%	0.000	3.171	3.171	-	9.0%	2.854
Home Health Within-Stay Potentially Hospitalization (PPH) (Claims-based)	13.0%	9.8%	6.1%	3.1%	10.000	9.000	10.000	-	26.0%	26.000
Sum of Claims-based Measures	-	-	-	-	-	-	**13.171**	-	**35.0%**	**28.854**
HHCAHPS Survey-based Measures										
HHCAHPS Professional Care	92.0%	89.5%	94.6%	92.0%	4.909	0.000	4.909	73rd	6.0%	2.945
HHCAHPS Communication	83.2%	86.8%	93.2%	79.0%	0.000	0.000	0.000	0th	6.0%	0.000
HHCAHPS Team Discussion	100.0%	82.4%	91.3%	84.0%	1.823	0.000	1.823	55th	6.0%	1.094
HHCAHPS Willingness to Recommend	81.0%	80.2%	91.4%	73.0%	0.000	0.000	0.000	0th	6.0%	0.000
HHCAHPS Overall Rating	90.5%	86.3%	94.7%	100.0%	10.000	9.000	10.000	89th	6.0%	6.000
Sum of HHCAHPS Measures	-	-	-	-	-	-	**16.733**	-	**30.0%**	**10.039**

Evolving analytics work to simplify the view – saving time

Help clinicians build engaging habits

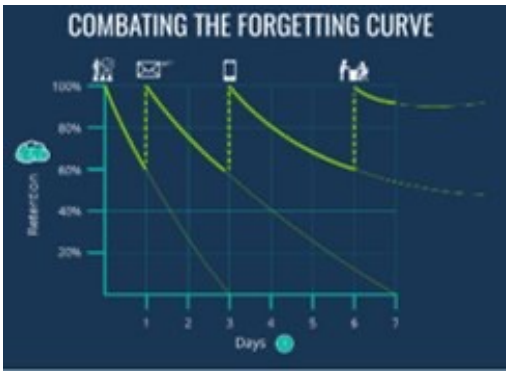
Understand how we learn, how we forget, and what we most love to hate...

Teach your staff to document at the point of care, or adjacent to the visit

Based on the Ebbinghaus' Forgetting Curve, learners will have forgotten an average of 90%percent of what they have learned within the first month.

Targeted iteration

- Lose the "one size fits all" trainings/learning
  - Reinforce training targeted to the individual
  - Utilize varied training methodologies
- Use micro-learning with spaced intervals – based on identified learning need!
- Emphasize learning where and how the work is done
- Encourage peer collaboration on case studies – iterating on themes of data and risk informed best practice cascade (HINT: use risk informed data to accompany IDT case discussion)
- Individual and agency-wide trainings should mirror quality initiatives



Alignment of engagement and outcomes

Clinician Best Practice Intro of assessment to patient

- **Cause and effect** Engaged clinicians yield more engaged patients
- **Teach clinicians** how to introduce their expected performance behaviors to their patients:
  - Point of care documentation - example of script with high value return:
    - ✓ "Hello Mrs. Johnson...Your doctor's orders and the work we do together is kept in your patient chart, and this is where we keep that (refer to device). I don't want there to be mistakes in your chart, because I care about you, so let me explain how I will be using it when I see you."
    - ✓ "We will do the work your doctor has ordered together (refer to 'work' e.g. exercises or wound care, etc.) and I will be speaking through my assessment, and asking some specific questions. With your permission, I will use my phone (device) to hear my description of your assessment and our discussion about how you are doing and capture it in your medical record.
    - ✓ Alternatively, I will be capturing the work we have done through my assessment in your medical record (refer to device) before I leave so I am sure to not forget anything. We care about you and don't want mistakes in your chart. You can relax while I quickly capture our work. Please think of any questions you may have for me."
    - ✓ CLINICIAN CAPTURES KEY DOCUMENTATION, followed by
    - ✓ *"Thank you, now, before I leave, is there anything more I can do for you? I have the time."*

Supervise and manage

Education without validation and reinforcement is **money down the drain!**

- How do **YOU** know **THEY** know?
- What checks are in place?
- How long does it take?
- Were the suggested corrections actually made?
- What "tools" do you use?
- Are there repeated errors? If so – WHY?
- Repeated errors cost money $$$
- Who validates that education and/or corrective action improved outcomes and behavior?
- Watch for adaptation to Generative AI advancements and how that will impact oversight of competence in the assessment process

Gemba 現場 impact on clinician engagement

- Gemba is the Japanese term for "the real place"
- The term Gemba is used for any place where **value-creating work actually occurs** (e.g. in manufacturing, the factory floor)
- When focusing on achieving excellence in value-based-purchasing performance, how do we leverage supervisory time best? As yourselves:
  - **Where does our high-impact value-creating work happen?**
  - **Do we get there very often?**
  - What tools help your front line clarify and prioritize the need for clinician attention?
  - What helps managers see the impact of their own choices on clinician performance?
  - Are you aligning authority with responsibility, empowering the front line in their leadership approach, training and tools?
- The market is competitive – go to the real place, empowered within sight and a consistent approach to leadership

The leader's challenge and opportunity

- Leverage foundational leadership theory:
  - Clear expectations of performance
  - Provide tools to meet the expectation
  - Have methodology to review adherence to desired process/behaviors
  - Hold folks accountable
- Now embrace the reality of change when evaluating and implementing the tools you need, and now have available, to get the job done
- Work to integrate innovative, data-fueled insight and supports into daily actions
- Our job to change the perception of QAPI as 'correctors':
  - They are collaborators in solving clinical, operational problems

Breathing life into QAPI in the field

QAPI identifies key trends in outcome performance – seeking actionable insights:

- By outcome measure
- By clinician
- By micro-learning element
- By overall trend

QAPI and Clinical Operations collaboratively set priorities based on risk – 'keeping it real' in how plans are made to execute and monitor for adherence to desired changes

Cascades of risk-related prioritization shift with regulatory/industry changes (examples: OASIS for all patient payer groups July, 2025, HOPE instrument for Hospice October, 2025)

QAPI in clinical operations is ongoing – as challenges rise, so does industry learning!

Help QAPI come to life in the field, reinforcing PIP themes

Example:

- **QAPI PIP – reduce potentially preventable hospitalization**
- Related field clinician-based actions:
  - ✓ Enhance assessment technique accuracy and aligned capture of documentation at the point of care or adjacent to the visit. Why?
    - Clinician increases accuracy in recalling what they have just seen- setting the stage for more accurate predictive analytic capture.
    - IDT better able to respond to risk/need – integrating visits/outreach when rising risk is noted
  - ✓ Integrate scripting at beginning of visit to reiterate patient centered goal, motivating higher patient engagement in participating in the plan of care
  - ✓ Front-load care and anticipate need, based on known chronic disease progression (e.g. get a predictive diuretic protocol of orders in the plan of care before the anticipated heart failure exacerbation)
- Share resultant impact of actions taken on outcomes achieved – building pride in ownership and improvement!

Iterative high value focus and top results

Daily virtual huddle:

- Quick touch: New admits, recerts, DC, afterhours call log
- Visual Triage guided by risk
  - Triage may initiate virtual or in person visit, small IDT prn

Weekly clinician 1:1 with clinical manager, 15 mins, virtual or in person (preferred):

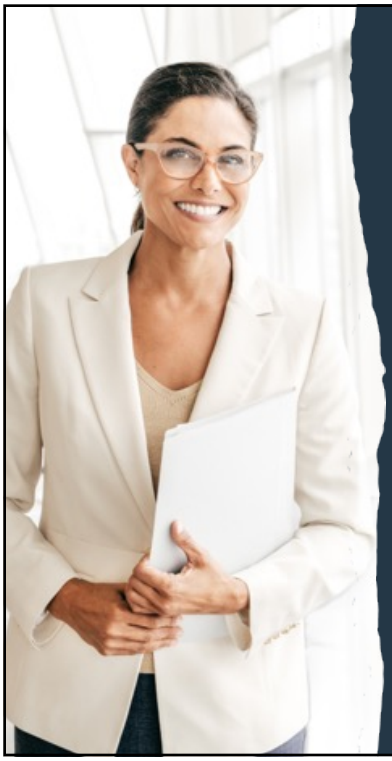
- Data driven performance view (workforce specific and clinical analytics)

Monthly Staff Grand Rounds (HH)/ Hospice IDT:

- Hospice IDT – data and risk informed/tying IDT discussion to actions aligned with PIP goals
- HH – Data and risk informed, targeted grand rounds education - stacking skills - QAPI aligned goals
- Quick highlight HHCAPs, comments and progress on outcome performance
- Build confidence/pride and deeper understanding of the impact of team's actions

Quarterly incentive plans:

- Collaborative Clin Ops/QAPI review with each clinician to review their impact/opportunity
- Report cards tying clinician performance, objective data with real time behaviors
- Incentive, reward and recognition – from MOST IMPROVED to G.O.A.T, data-fueled



Beware the arrogance of your own expertise

Experiential Arrogance

Often unintended and within humble intent, our own experience, as it grows, can create traps

- We may become dogmatic in opinion
- We may assume other colleagues' competence based on our own understanding of what is competent...
- We may be closed to identifying our own blind spots, or those of our teams
- We are afraid to innovate, given the pressure we feel
- We may inadvertently close off our learning and the learning of those relying on us

When stuck trying to shift into high gear with performance, have you heard this before?

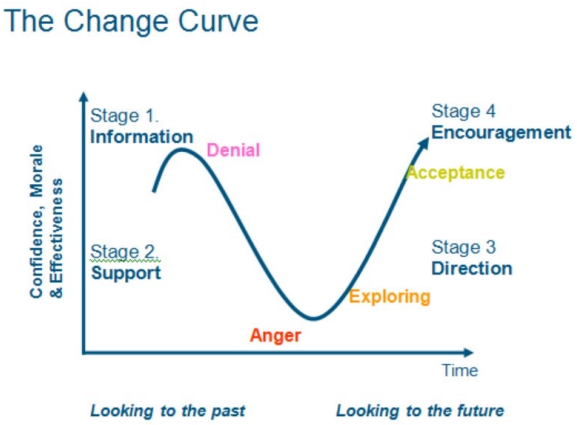
We could try that, but...

-we tried it once and it didn't work

-this is how it's done around here

-we've always done it that way

Anticipate and lead through change



- Change is inevitable in healthcare delivery
- Pro-active, informed leadership anticipates the U-curve of change and leads through it...
- Applying clear QAPI/Clinical Ops collaborative strategy builds a better place to:
  - Be a patient
  - Be a clinician
  - Be a continuum partner
  - Be a stakeholder in the business
- **Lead your performance into the future you create**

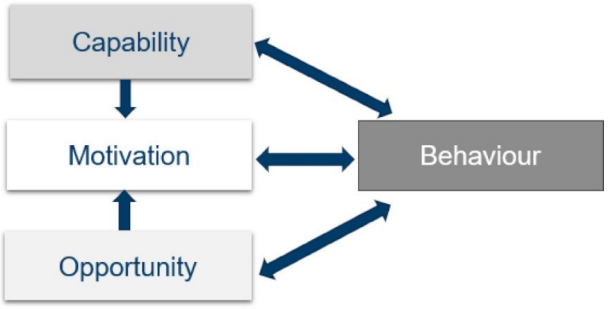
Never underestimate your data impact

Alignment across PAC settings will continue, as CMS ties together cause and effect – what is the story you are telling them?

- Have a clear strategy to educate your teams- for HHVBP/HOPE and beyond!
- QAPI and Clinical Operations design PIPs in support of strategy and collaboratively position goals and progress to key stakeholders:
  - ✓ Position clinician competence as advocacy for the patient
  - ✓ Bring clarity and simplicity
  - ✓ Organize around a consistent framework
  - ✓ Bring learning into the flow of the work
  - ✓ Drive competence objectively
  - ✓ Iterate on the targeted needs - learn within the quality cycle
  - ✓ Present expectations and hopes for the integration of advancing artificial intelligence

Think about this question:
how are you using data to serve?

We lead to top stakeholder engagment in QAPI initiatives



If teams and individuals are not engaged, they will not be very motivated to change their behavior

Lean into leadership of Key Performance Behaviors, building motivation – improving outcomes!

Reflect...

Though I may travel far I will meet only what I carry with me, for every man is a mirror.
We see only ourselves reflected in those around us. Their attitudes and actions are reflections of our own.
The whole world and its conditions has its counterpart within us all.
Turn the gaze inward… correct yourself and the world will change.

-Kristin Zambucka, Ano Ano: The Seed

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THANK YOU!

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