Regularly Scheduled Report Documentation

Issue: missed deadlines or inconsistent results on regularly scheduled reports.

Background: between 130 and 150 reports run monthly by Quality/Data Analytics. Organically grown department, growing pains and confusion around deadlines and specifications. Occasional missed deadlines and customer complaints. During an FMLA emergency, IT and Informatics staff reported difficulty in taking on the workload of replicating reports.

Regularly Scheduled Report Documentation

Goals:

- Timeliness
- Consistency
- Repeatability

Regularly Scheduled Report Documentation

Analysis:

Issue: Missed deadlines or inconsistent results, especially during staffing shortages

Why? Staff could not locate list of required reports.

Why? No shared list of reports and deadlines.

Why? Staff could not locate report specifications.

Why? No standardized tool exists for communicating expected results of reports.

Regularly Scheduled Report Documentation

Plan:
Phase 1: create a centralized repository of reports containing the fundamental information needed to access the report information. Reach a high level of reliability for process operating under normal circumstances.

Phase 2: create specifications documents standardizing the process of handling the data. Reach a high level of repeatability through training of staff from other departments to understand documents and use them.

Regularly Scheduled Report Documentation

Test: create a procedural document for one report and add all requisite information in a centralized location.

Implementation: Fall 2020 – list all regularly scheduled reports, frequency, start and due dates, and report source information in a centralized location.

Measurement: complete >95% of scheduled reports on time during October and November 2020. Perform RCA on any failures and adapt solution based on findings before moving into Phase 2.

Regularly Scheduled Report Documentation

Results: 131/131 in October. 129/132 in November. Failures due to taking vacation during due date. Considering a Phase 3 - creation of a tool to provide a worklist integrated with tools such as MS Office that would provide reminders for this kind of situation before it happens. This would give a heads up to alert support staff to run reports in my absence.

Report Name	Frequency	Begin Date
ED Long Stays	Daily	Daily
Transfer Rollup	Daily	Daily
COVID State Reporting	7 Days Per Week	Daily
COVID Federal Reporting	7 Days Per Week	Daily
Rolling 12 Month Incident Response Rollup	Monthly	1
12 Month Incident Response Run Chart	Monthly	1
365 Day Discharge Reports	Monthly	1
Influenza Immunization Report	Monthly	1
Pnuemococcal Immunization Report	Monthly	1
BCMA Reports	Monthly	1
Auna Low Braden Scores	Monthly	1
Kirsten ED Registrations	Biweekly	Payday Monday
Kirsten EKG report	Biweekly	Payday Monday
Kirsten Nebulizer Treatments	Biweekly	Payday Monday
NHSN Patient Upload	Monthly	1
NHSN Foley Days	Monthly	Janet's spread
NHSN Central Line Days	Monthly	Janet's spread
NHSN Ventilator Days/Episodes	Monthly	Janet's spread
HH Feedback Reports	Monthly	18
Hospice Feedback Reports	Monthly	18
Sheryl Patient Days	Monthly	1
Quarterly IP Discharges	Quarterly	IP Coding Done
ICD-10 Data for Merge Into Above	PRN	PRN
PIN Benchmarking Sepsis Pts	Quarterly, 2nd mo	1st of Month
PIN Benchmarking 1,2,8, 53	Quarterly, 2nd mo	1st of Month
PIN Benchmarking 27	Quarterly, 2nd mo	1st of Month
PIN Benchmarking 48	Quarterly, 2nd mo	1st of Month
PIN Benchmarking 19, 22, 23, 24, 25, 26	Quarterly, 2nd mo	1st of Month
NPSG/CMS Measures	Quarterly	2nd of month
Promoting Interoperability Updates to Caravan	Semiannual	July 1st
Market Share	Quarterly	Data Release
ED Dwell Time Graphs	Monthly	2nd of month
Behavioral Health Volumes	Annually	PRN
Behavioral Health Patient List	Monthly	2nd of month
Behavioral Health SI Charge Report	Monthly	2nd of month
Behavioral Health SI Diagnosis Text Report	Monthly	2nd of month
MSSP Beneficiary Report	Monthly	1st of month
Medici Uploads	Monthly	5th of month

Due Date	
Daily	
Daily	
noon	
noon	
	1
	1
	3
	15
	15
1st Monday COB	
First Week	
Tuesday Noon	
Tuesday Noon	
Tuesday Noon	
	14
2 weeks	
2 weeks	
2 weeks	
1 week	
1 week	
1 week	
1 week	
PRN	
Deadline	
Deadline	
Deadline	
Deadline	
Deadline	
15th of month	
Email Stu Symonds	
7 Days	
ED Coding Done (15th?)	
PRN	
4th of month	
4th of month	
4th of month	
7th of month	
1 week	

Notes

See tutorial
See tutorial
Juvare deadline noon, otherwise enter into both systems manually
Juvare deadline noon, otherwise enter into both systems manually
Update data on "status graphs" tab and screenshot. Unshare if you need to make changes to the graph structure or ranges
Update data on "run charts" tab and screenshot. Unshare if you need to make changes to the graph structure or ranges
RWB Report "Victoria Monthly Report"
Workbench report "Influenza Immunization for IP" (run for Oct-Mar)
Workbench report "Pneumococcal Immunization for IP"
Complex; need to create tutorial
RWB Report "Auna Low Braden Scores"
Clarity report "ED Arrival Times By Hours of Day"
RWB Report "Kirsten EKG Productivity Charges"
Clarity report "MAR Barcode Compliance Go-Live Stats - Detail"
csv requirements available in data analysis\nhsn
Clarity report Urinary Catheter Days
Clarity report Central Line Days
Clarity report Ventilator Days
https://iqies.cms.gov/
https://qtso.cms.gov/providers/cmsnet-submission-access
Janet spreadsheet
RWB report Clarissa Report IP & NB DC Final
Pull table of ICD-10 codes with diagnosis text to merge with Clarissa's or other spreadsheets
Sepsis worksheet
Janet monthly stats spreadsheet
ED xfer data sent to MHA quarterly
Email to fiscal staff
Epic reports
SPLIT OUT TO REFLECT VARIOUS SOURCES
ssymonds@caravanhealth.com
COMPdata tip sheet link here
Discharged pts, provider specific as well
Custom Clarity code on local drive
C:\Users\bpower.BARRETTHOSPITAL\Desktop\SQL Scripts\Practice\BHI Annual Patient Totals.sql
RWB Report Behavioral Health Charges
Generic ED encounter report, filter on SI/attempt code
J:\Quality Coordinator - Data Analysis\SQL Production Scripts\mssp.sql
S:\Medici Uploads

Oct Num	Oct Den	Nov Num	Nov Den	Dec Num	Dec Den
22	22	16	16	3	3
22	22	16	16	3	3
31	31	30	30	3	3
31	31	30	30	3	3
1	1	1	1	1	1
1	1	1	1	1	1
1	1	1	1	1	1
		1	1		
		1	1		
1	1	1	1	1	1
1	1	1	1	1	1
2	2	3	3		
2	2	3	3		
2	2	3	3		
1	1	1	1		
1	1	0	1		
1	1	0	1		
1	1	0	1		
1	1	4	4		
		2	2		
1	1	1	1		
1	1	1	1		
		1	1		
		1	1		
		1	1		
		1	1		
		1	1		
1	1				
1	1				
1	1	1	1		
				1	1
1	1	1	1		
1	1	1	1		
1	1	1	1		
1	1	1	1		
1	1	1	1		
131	**131**	**130**	**133**	**18**	**18**
On Time:	**100%**	**On Time:**	**98%**	**On Time:**	**100%**

From QI to QAPI

Central Montana Medical Center

Lexie Jelinek, MHA, BSN, RN, CPHQ

The Mission of Central Montana Medical Center is to be the leader in assuring community-based, quality **healthcare.**

First COVID-19, now QAPI 2021

- Federal Register / Vol. 84, No. 189 / Monday, September 30, 2019

- The regulations at §485.641 regarding Quality Assessment and Performance Improvement Programs (QAPI) in critical access hospitals (CAHs) must be implemented by March 30, 2021

- SOM Appendix W has not been updated to incorporate the QAPI requirements.

St. Charles, C. – HealthTechS3. (2020).

Why the Change? *(According to CMS)*

1. CoPs have not been updated to reflect current industry standards that utilize the QAPI model to assess and improve patient care.

2. The existing annual evaluation and quality assurance review requirements at §485.641 are reactive; that is, once a problem has been identified, the health care facility takes action to correct it. The focus of a QAPI program is to proactively maximize quality improvement activities and programs, even in areas where no specific deficiencies are noted.

3. An effective QAPI program that is engaged in continuous improvement efforts is essential to a provider's ability to provide high quality and safe care to its patients, while reducing the incidence of medical errors and adverse events.

4. A QAPI program would enable a CAH to systematically review its operating systems and processes of care to identify and implement opportunities for improvement.

5. We also believe that the leadership or governing body or responsible individual of a CAH must be responsible and accountable for patient safety, including the reduction of medical errors in the facility.

St. Charles, C. – HealthTechS3. (2020).

Appendix W NOW *(Not all inclusive)*

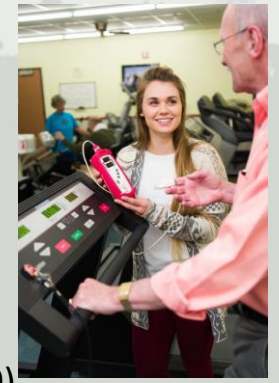
C-0336 §485.641(b) Standard: Quality Assurance
The CAH has an effective quality assurance program to evaluate the quality and appropriateness of the diagnosis and treatment furnished in the CAH and of the treatment outcomes. The program requires that–

Interpretive Guidelines §485.641(b) There is nothing in this requirement to preclude a CAH from obtaining QA through arrangement. Whether the CAH has a freestanding QA program or QA by arrangement, all of the requirements for QA must be met.

If a CAH chooses to have a freestanding QA program, the QA program should be facility wide, including all departments and all services provided under contact.

For services provided to the CAH under contract, there should be established channels of communication between the contractor and CAH staff.

"An effective quality assurance program" means a QA program that includes:
- Ongoing monitoring and data collection;
- Problem prevention, identification and data analysis;
- Identification of corrective actions;
- Implementation of corrective actions;
- Evaluation of corrective actions; and
- Measures to improve quality on a continuous basis.



St. Charles, C. – HealthTechS3. (2020).

New CAH CoPs (Federal Register)

C-1300 (Rev. – Effective March 30, 2021)
§485.641 Quality assessment and performance improvement program.

The CAH must develop, implement, and maintain an
- Effective,
- Ongoing,
- CAH-wide,
- Data-driven,

quality assessment and performance improvement (QAPI) program.

The CAH must maintain and demonstrate evidence of the effectiveness of its QAPI program.

St. Charles, C. – HealthTechS3. (2020).

New CAH CoPs (Federal Register) Definitions:

- **§485.641** Quality assessment and performance improvement program.

(a) Definitions

- Adverse event means an untoward, undesirable, and usually unanticipated event that causes death or serious injury or the risk thereof.

- Error means the failure of a planned action to be completed as intended or the use of a wrong plan to achieve an aim. Errors can include problems in practice, products, procedures, and systems; and

- Medical error means an error that occurs in the delivery of healthcare services.

St. Charles, C. – HealthTechS3. (2020).

New CAH CoPs (Federal Register) Program Design and Scope:

§485.641 Quality assessment and performance improvement program.

(b) The QAPI program must:

(1) Be appropriate for the complexity of the CAH's organization and services provided.

(2) Be ongoing and comprehensive.

(3) Involve all departments of the CAH and services (including those services furnished under contract or arrangement).

(4) Use objective measures to evaluate its organizational processes, functions and services.

(5) Address outcome indicators related to improved health outcomes and the prevention and reduction of medical errors, adverse events, CAH-acquired conditions, and transitions of care, including readmissions.

St. Charles, C. – HealthTechS3. (2020).

New CAH CoPs (Federal Register) Governance and Leadership:

§485.641 Quality assessment and performance improvement program.

(c) The CAH's governing body or responsible individual is ultimately responsible for the CAH's QAPI program and is responsible and accountable for ensuring that the QAPI program meets the requirements of paragraph (b) of this section.

New CAH CoPs (Federal Register) Program and Activities:

§485.641 Quality assessment and performance improvement program.

(d) For each of the areas listed in paragraph (b) of this section, the CAH must

(b)(1) Be appropriate for the complexity of the CAH's organization and services provided.
(b)(2) Be ongoing and comprehensive.
(b)(3)Involve all departments of the CAH and services (including those services furnished under contract or arrangement).
(b)(4)Use objective measures to evaluate its organizational processes, functions and services.
(b)(5)Address outcome indicators related to improved health outcomes and the prevention and reduction of medical errors, adverse events, CAH-acquired conditions, and transitions of care, including readmissions.

(1) Focus on measures related to improved health outcomes that are shown to be predictive of desired patient outcomes.

(2) Use the measures to analyze and track its performance.

(3) Set priorities for performance improvement, considering either high volume, high-risk services, or problem prone areas.

St. Charles, C. – HealthTechS3. (2020).

New CAH CoPs (Federal Register) Data Collection and Analysis:

- **§485.641** Quality assessment and performance improvement program.

- (e) The program must incorporate quality indicator data including patient care data, and other relevant data, in order to achieve the goals of the QAPI program.

St. Charles, C. – HealthTechS3. (2020).

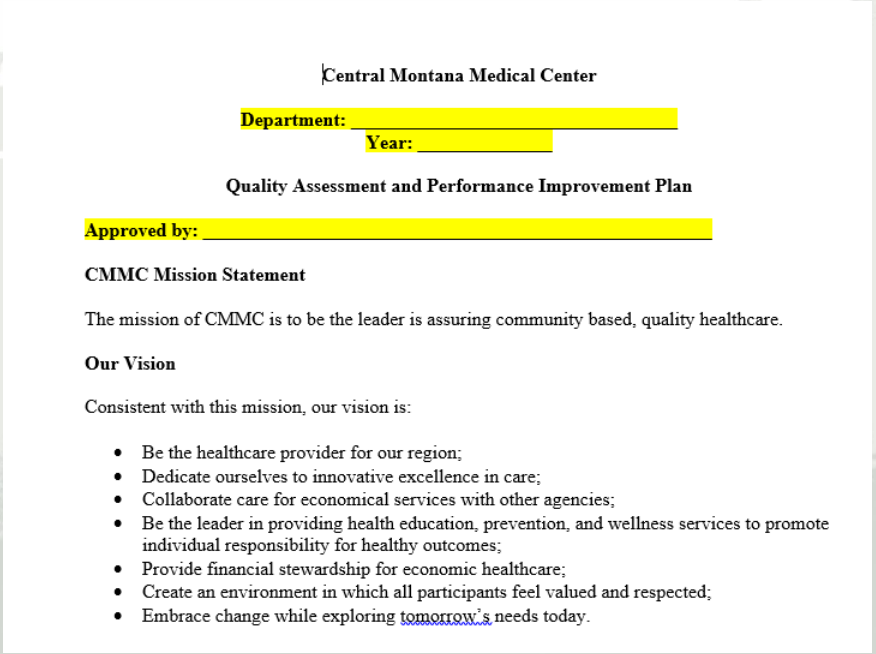
The Good and the Bad

- **Good News:** CMMC has components of a QAPI program already in place!
- **Not So Good News:** Our QAPI program is not as comprehensive and data driven as it needs to be to meet the new regulatory requirements.
- **Good News:** We still have three months! We can make changes now in order to be in compliance in 2021.
- **Important News: Your QI Plans will now be called "QAPI Plans." Templates are in place for each document you are required to complete. We will now go over each.**

1. The Department QAPI Plan

Department QAPI Plan 2021 Template

- **Complete this document FIRST – You only need to fill in the highlighted portions.**
- As you will find, you only need to list your quality control indicators in this document.



Central Montana Medical Center

Department: _____

Year: _____

Quality Assessment and Performance Improvement Plan

Approved by: _____

CMMC Mission Statement

The mission of CMMC is to be the leader is assuring community based, quality healthcare.

Our Vision

Consistent with this mission, our vision is:

- Be the healthcare provider for our region;
- Dedicate ourselves to innovative excellence in care;
- Collaborate care for economical services with other agencies;
- Be the leader in providing health education, prevention, and wellness services to promote individual responsibility for healthy outcomes;
- Provide financial stewardship for economic healthcare;
- Create an environment in which all participants feel valued and respected;
- Embrace change while exploring tomorrow's needs today.

What are quality control indicators you ask? Next Slide!

Quality Definitions

Quality Control – product oriented – focuses on defect identification
"An aggregate of activities (such as design analysis and inspection for defects) designed to ensure adequate quality especially in manufactured products" (Merriam-Webster)

Quality Assurance – process oriented – focuses on doing the right things the right way
"*The maintenance of a desired level of quality in a service or product, especially by means of attention to every stage of the process of delivery or production" (kwäl(ə)dē əˈSHoorəns)*

"QA is the specification of standards for quality of service and outcomes, and a process throughout the organization for assuring that care is maintained at acceptable levels in relation to those standards. QA is on-going, both anticipatory and retrospective in its efforts to identify how the organization is performing, including where and why facility performance is at risk or has failed to meet standards." (CMS)

Performance Improvement – focuses on improvement of current processes and identification of new approaches
"PI (also called Quality Improvement - QI) is the continuous study and improvement of processes with the intent to better services or outcomes, and prevent or decrease the likelihood of problems, by identifying areas of opportunity and testing new approaches to fix underlying causes of persistent/systemic problems or barriers to improvement. PI aims to improve processes involved in health care delivery and quality of life." (CMS)

Quality Assurance / Performance Improvement (QAPI) – coordination of QA and PI
QAPI is the coordinated application of two mutually-reinforcing aspects of a quality management system: Quality Assurance (QA) and Performance Improvement (PI). QAPI takes a systematic, comprehensive, and data-driven approach to maintaining and improving safety and quality while involving all caregivers in practical and creative problem solving. (CMS)

The focus of a QAPI program is to proactively maximize quality improvement activities and programs, even in areas where no specific deficiencies are noted. **(CMS)**

Quality Definitions Examples:

Quality Control – product oriented – focuses on defect identification - monitoring

- Temperature checks
- Code cart checks
- Documentation audits

QC may become a QA project if not meeting targets

Quality Assurance – process oriented – focuses on doing the right things the right way - reactive

- Ventilator Acquired Pneumonia (VAP)
- Readmissions
- Urinary Tract Infections

QA focused on meeting established targets

Performance Improvement – focuses on improvement of current processes and identification of new approaches - proactive

- Antibiotic Stewardship
- Opioid reduction
- SEPSIS
- Post-Partum Hemorrhage

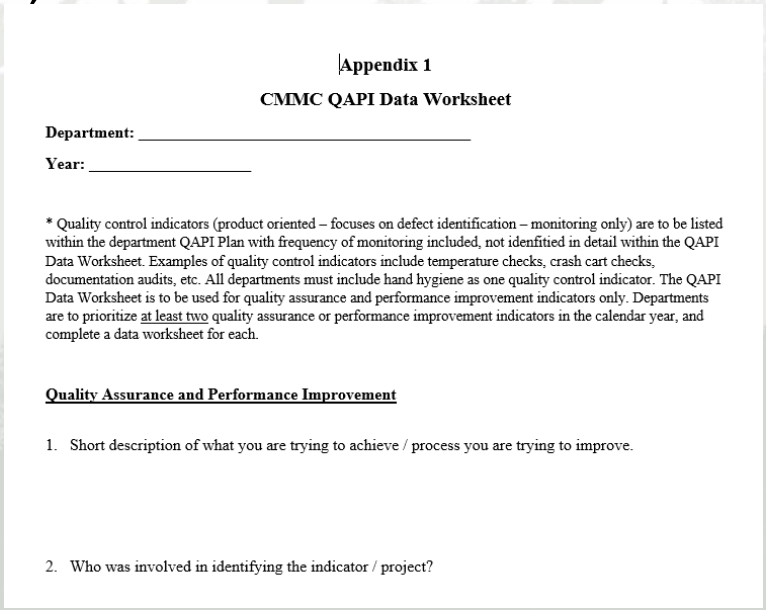
PI focused on improvement even when meeting targets – how do we do better? – or new initiatives

St. Charles, C. – HealthTechS3. (2020).

2. The QAPI Data Worksheet

The QAPI Data Worksheet – Appendix 1

- **Complete this document SECOND for <u>each</u> of your prioritized indicators– You need to have at least <u>two</u>, prioritized indicators so you will need to complete at least <u>two</u> data worksheets.**
- The worksheet is detailed, but it needs to be in order to meet regulatory requirements.



Appendix 1

CMMC QAPI Data Worksheet

Department: _____

Year: _____

* Quality control indicators (product oriented – focuses on defect identification – monitoring only) are to be listed within the department QAPI Plan with frequency of monitoring included, not idenfitied in detail within the QAPI Data Worksheet. Examples of quality control indicators include temperature checks, crash cart checks, documentation audits, etc. All departments must include hand hygiene as one quality control indicator. The QAPI Data Worksheet is to be used for quality assurance and performance improvement indicators only. Departments are to prioritize <u>at least two</u> quality assurance or performance improvement indicators in the calendar year, and complete a data worksheet for each.

<u>Quality Assurance and Performance Improvement</u>

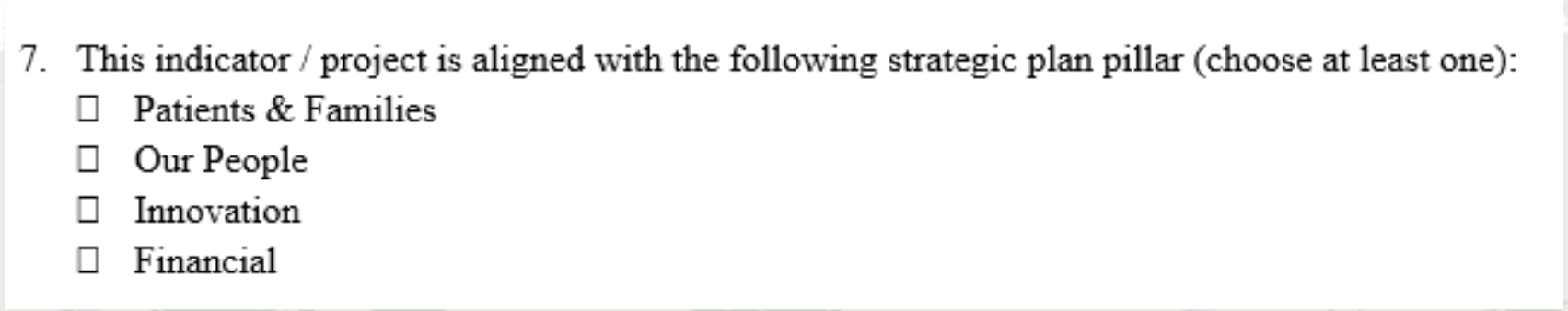
1. Short description of what you are trying to achieve / process you are trying to improve.

2. Who was involved in identifying the indicator / project?

- As you will find, this document is for <u>quality assurance and performance improvement indicators only</u> – remember that quality control indicators are to be listed in your QAPI plan.

The QAPI Data Worksheet – Cont.

- The QAPI Data Worksheet contains a question that asks which Strategic Plan pillar(s) the indicator aligns with(#7 shown in screenshot below).



7. This indicator / project is aligned with the following strategic plan pillar (choose at least one):
   - ☐ Patients & Families
   - ☐ Our People
   - ☐ Innovation
   - ☐ Financial

- Therefore, your two or more indicators for your QAPI plan will be the same indicators you will keep track of for the Strategic Plan.

The Prioritization Matrix *(Optional)*

QAPI Prioritization Matrix– Appendix 2

- **Complete this document IF NEEDED to prioritize your top <u>two</u> (or more) indicators that you complete a data worksheet for.**
- If your department has many potential indicators for the year, this matrix describes how those indicators should be prioritized according to the regulatory requirements.

Appendix 2 - QAPI Prioritization Matrix Identify Potential Areas of Improvement. For each category score from 1 (low) to 5 (high)							
Potential Area for Improvement	***High Volume** High volume population or service	***High Risk** The level to which this issue poses a risk to patients, providers, visitors, staff	***Problem Prone** The level to which this issue has the potential to prevent or reduce medical errors, adverse patient outcomes, or CAH-acquired conditions	***Transitions of Care** Potential to improve transitions of care, including readmissions	**Cost** The cost incurred each time this issue occurs	**Responsiveness** The likelihood an initiative on this issue would address a need expressed by patients, family and/or staff/medical staff	**Continuity** The level to which an initiative on this issue would support organizational goals and priorities
* Required by CAH CoPs: §485.641							

- If completed, please turn into QI department with other required documents.

3. The QAPI Reporting Scorecard

QAPI Reporting Scorecard – Appendix 4

- **Complete this document LAST, but CONTINUOUSLY for <u>each</u> of your prioritized indicators– You need to have at least <u>two</u>, prioritized indicators so you will need to complete at least <u>two</u> scorecards and update them at least quarterly.**
- Complete ALL sections of the scorecard. As you fill in the table, the data automatically populates to the graph.

QAPI Reporting Scorecard - Appendix 4

Department Name

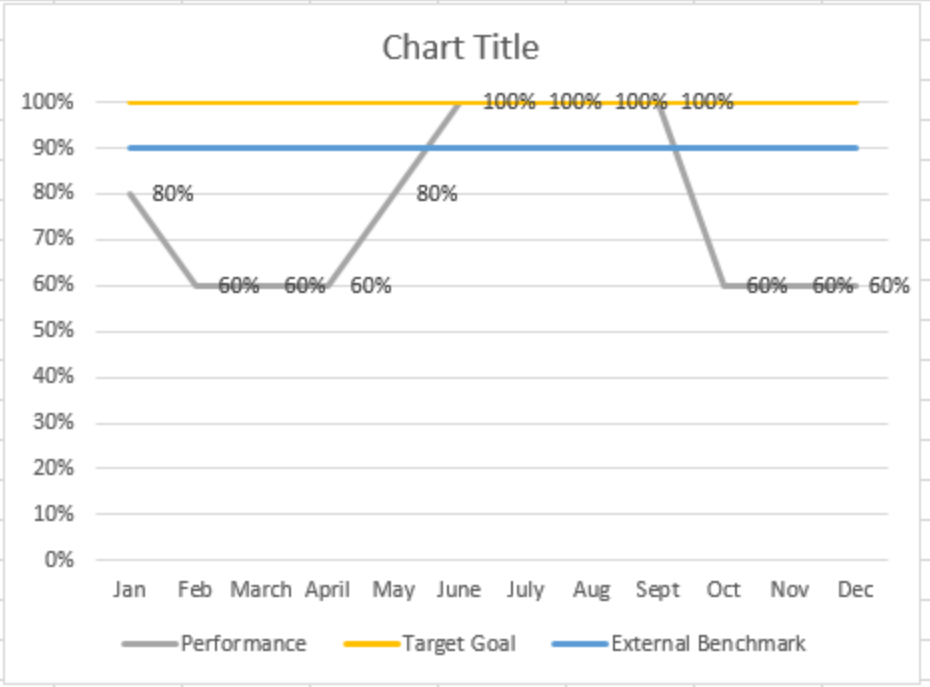
Manager's Name

Quality Assurance/Performance Improvement Goal

Improvement Opportunity

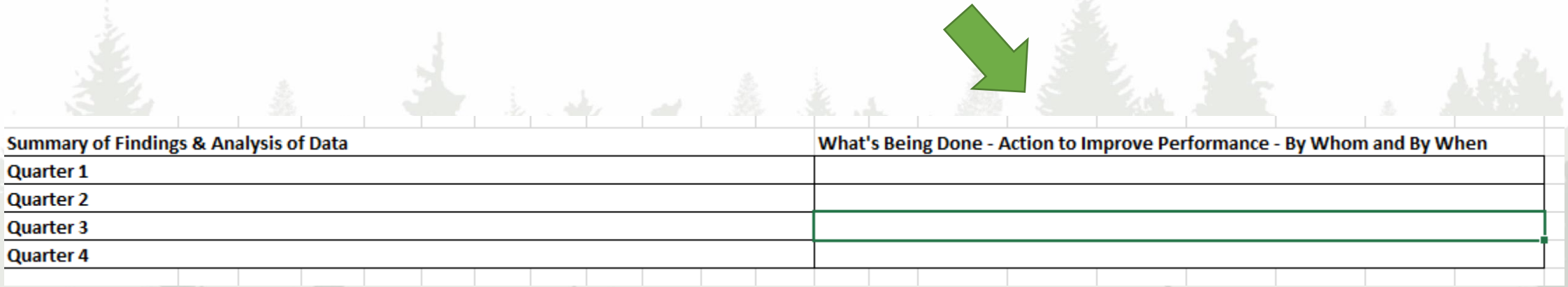
Data Collection Methodology

	Jan	Feb	March	April	May	June	July	Aug	Sept	Oct	Nov	Dec
Denominator	4	3	3	3	4	5	5	5	5	3	3	3
Numerator	5	5	5	5	5	5	5	5	5	5	5	5
Performance	80%	60%	60%	60%	80%	100%	100%	100%	100%	60%	60%	60%
Target Goal	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
External Benchmark	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%



The QAPI Reporting Scorecard – Cont.

- **NOTE: If you did not meet your target for the quarter, you must describe your action plan to improve performance before turning in the scorecard to QI. (See screenshot below).**



Summary of Findings & Analysis of Data	What's Being Done - Action to Improve Performance - By Whom and By When
Quarter 1	
Quarter 2	
Quarter 3	
Quarter 4	

- Each department uses these same, standardized scorecards for quality assurance and performance improvement indicators.
- Your scorecards are to be submitted to QI (Lexie J. & Lexie G.) at least quarterly.

Summary of Requirements

- **In this order:**

1. Complete your department QAPI plan using the ***Department QAPI Plan 2021 Template.*** *You only need to fill in the highlighted portions.*
2. Complete ***the QAPI Data Worksheet – Appendix 1*** for each of your prioritized indicators– You need to have at least two, prioritized indicators so you will need to complete at least two data worksheets.
   - *Complete the* ***QAPI Prioritization Matrix– Appendix 2*** if needed to prioritize your indicators.
3. Complete the ***QAPI Reporting Scorecard – Appendix 4*** for each of your prioritized indicators– You need to have at least two, prioritized indicators so you will need to complete at least two scorecards and update them at least quarterly.

Summary of Reporting Requirements

- **In this order:**

1. Turn in your QAPI Plan, QAPI Data Worksheets, Prioritization Matrix (optional), and Reporting Scorecards to both Lexie J. and Lexie G. by _____.
2. Continuously turn in your reporting scorecards to both Lexie J. and Lexie G. at least quarterly.
3. Report annually on your reporting scorecards and your quality control indicators to the QAPI Committee (2021 schedule attached). Each department uses their reporting scorecards for presenting on quality assurance and performance improvement indicators. You may present your quality control indicators however you wish for the QAPI Committee.
    - At the time of your scheduled presentation, you will report on the data you have thus far for 2021. If you are scheduled early in 2021, you will still need to report on 2020 data if you have not done so already.

QUESTIONS?

Resources

- St. Charles, C. – HealthTechS3. (2020). *QAPI is Coming March 2021: What You Need To Know* [PowerPoint presentation]. Montana Healthcare Conference.

Resources

- Centers for Medicare and Medicaid. Burden Reduction and Discharge Planning Final Rules Guidance and Process, December 20, 2019, Ref; QSO-20-07- ALL retrieved 1/3/20

- Centers for Medicare and Medicare. Medicare and Medicaid Programs; Revisions to Requirements for Discharge Planning for Hospitals, Critical Access Hospitals, and Home Health Agencies, and Hospital and Critical Access Hospital Changes to Promote Innovation, Flexibility, and Improvement in Patient Care, Effective 11/29/19 retrieved 10/1/19

- Centers for Medicare and Medicare. Medicare and Medicaid Programs; Regulatory Provisions To Promote Program Efficiency, Transparency, and Burden Reduction; Fire Safety Requirements for Certain Dialysis Facilities; Hospital and Critical Access Hospital (CAH) Changes To Promote Innovation, Flexibility, and Improvement in Patient Care, Effective 11/29/19 retrieved 10/1/19

- Institute of Healthcare Improvement. Improvement Stories/Improvement Tips: “Quality” is Not a Department retrieved 2/15/17.

Resources

- Revised Regulations for Various Certified Providers and Supplier Types
  - https://www.federalregister.gov/documents/2019/09/30/2019-20736/medicare-and-medicaid-programs-regulatory-provisions-to-promote-program-efficiency-transparency-and
- Discharge Planning for Hospitals, CAHs and HHAs
  - https://www.federalregister.gov/documents/2019/09/30/2019-20732/medicare-and-medicaid-programs-revisions-to-requirements-for-discharge-planning-for-hospitals
- CMS Final Guidance Memo Published
  - https://www.cms.gov/files/document/burden-reduction-discharge-planning-som-package.pdf
- Medicare State Operations Manuals
  - https://www.cms.gov/files/document/appendices-table-content.pdf
- CMS Measure/Indicator Development Worksheet (QAPI)
  - https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/QAPI/downloads/MeasIndicatDevWksdebedits.pdf
- CMS Prioritization Worksheet Example
  - https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/QAPI/downloads/PIPPriorWkshtdebedits.pdf
- CMS Worksheet to Create a Performance Improvement Project Charter (QAPI)
  - https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/QAPI/downloads/PIPCharterWkshtdebedits.pdf