1. **PURPOSE**

The facility recognizes the need to develop, implement, and maintain an effective, ongoing, CAH-wide, data-driven Quality Assessment and Performance Improvement Program (“QAPI Program”) to improve patient outcomes and the safety and quality of care, treatment, and services provided by the facility. The facility also recognizes the need to maintain and demonstrate evidence of the effectiveness of its QAPI Program that the importance of data collection practices for that purpose. The purpose of this Policy is:

1. To establish the standards for a QAPI Program and the data collection and analysis activities necessary to implement the QAPI Program.
2. To establish leadership and responsibility for the implementation and development of this Policy.
3. To fulfill Critical Access Hospital conditions of participation in the Medicare program and Joint Commission accreditation standards.
4. **POLICY/SCOPE**
5. The facility and its governing body or responsible individual is ultimately responsible for the facility’s QAPI Program and is responsible and accountable for ensuring that the QAPI Program meets the criteria set forth in this Policy.
6. The standards captured in this Policy shall apply to all clinical and non-clinical staff, independent contractors, departments, and service-lines of the facility, including those furnished under contract or arrangement.
7. The [designee] shall be responsible for developing and implementing the QAPI Program, developing and implementing any written policies and documents necessary to implement the QAPI Program, reporting to the governing body or responsible individual, overseeing data collection, compilation, and analysis necessary to implement the QAPI Program, and coordinating facility-wide activities under the QAPI Program.
8. All departments and department leaders shall be responsible for participating in performance improvement activities pursuant to the QAPI Program.
9. All clinical and nonclinical staff shall be responsible for participating in performance improvement activities pursuant to the QAPI Program.
10. **DEFINITIONS**
11. ***“QAPI Program”*** means the Quality Assessment and Performance Improvement Program which encompasses all performance improvement priorities and activities, including data collection and analysis.
12. ***“Adverse Event”*** means an untoward, undesirable, and usually unanticipated event that causes death or serious injury or the risk thereof.
13. ***“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;
14. “***HAIs***” means Healthcare Associated Infections
15. ***“Medical Error”*** means an error that occurs in the delivery of healthcare services.
16. **PROCEDURES**
17. Governing Body or Responsible Individual Responsibilities. The governing body, or responsible individual, shall:
    1. Appoint a designee to develop and implement the QAPI Program in accordance with the criteria in this Policy and applicable laws and accreditation standards. The designee will make reports to the governing body or responsible individual.
       1. [PLACEHOLDER – provide adetailed description of the designee and processes for reporting to the governing board or responsible individual. Use titles, and not individual names, or describe the process for appointment if designee not tied to a particular title/position/committee within the organization]
       2. [PLACEHOLDER – if applicable include any education, training, experience, or certification that your organization shall require for these advisers]
       3. [PLACEHOLDER – if applicable, populate with any organization-specific selection, appointment, or election procedures]
    2. Through its designee, ensure that the QAPI Program fulfills the criteria set forth in this Policy.
    3. Through its designee, ensure that all issues identified pursuant to the Antimicrobial and Antibiotic Stewardship Policy, Infection Prevention and Control Policy, and Adverse Drug Reactions and Medication Administration Errors Policy (and programs administered pursuant to those policies) are addressed in coordination with the facility’s QAPI Program and this Policy.
    4. Ensure the QAPI Program an organizational priority. For example, governing body, or responsible individual may demonstrate prioritization of the QAPI Program through budget plans, strategic plans, or oversight over the Program or other relevant organization activities, such as infection prevention and control and quality improvement.
    5. Dedicate the necessary human, financial, and information technology resources to the QAPI Program.
    6. Set performance improvement priorities considering either high-volume, high-risk services, or problem-prone areas and the type and frequency of data collected under the QAPI Program.
    7. [PLACEHOLDER – include processes for ensuring the governing body or responsible individual addresses the above-mentioned activities. *For example, indicate whether such activities will be addressed in annual meetings of the governing body, joint meetings of the QAPI leadership and Leader(s), or whether the Leader(s) is responsible for presenting reports or annual findings to the governing body and responsible individuals on a dedicated or ad hoc basis.*]
18. QAPI Program Design and Scope. The designee will ensure that the QAPI Program:
    1. Is appropriate for the scope and complexity of the facility’s organization and services provided.
    2. Is ongoing and comprehensive.
    3. Uses objective measures to evaluate its organizational processes, functions, and services.
    4. Addresses outcome indicators related to improved health outcomes and the prevention and reduction of:
       1. Medical Errors;
       2. Adverse Events;
       3. HAIs; and
       4. Transitions of care, including readmissions.
    5. [PLACEHOLDER – if applicable, include organization-specific processes and protocols related to this Section and its implementation. Specifically, identify any departments, service-lines, or leaders involved with or responsible for the identified activities.]
19. QAPI Program Activities. The designee and the clinical and non-clinical staff and departments that participate in performance improvement activities will ensure that the facility and QAPI Program:
    1. Focuses on measures related to improved health outcomes that are shown to be predictive of desired patient outcomes.
    2. Uses objective measures to analyze and track the facility’s performance.
    3. Takes action on the performance improvement priorities set by the governing body or responsible individual.
    4. Takes action when the facility does not achieve or sustain planned improvements;
    5. Takes action on Primary Care Medical Home Data to improve its performance.
    6. [PLACEHOLDER – if applicable, include organization-specific processes and protocols related to this Section and its implementation. Specifically, identify any departments, service-lines, or leaders involved with or responsible for the identified activities.]
20. QAPI Program Data Collection and Analysis.
    1. *Generally*. The designee will ensure that the QAPI Program collects and analyzes quality indicator data including patient care data, and other relevant data, in order to achieve the goals of the QAPI Program, including addressing outcome indicators related to improved health outcomes and the prevention and reduction of:
       1. Medical Errors;
       2. Adverse Events;
       3. HAIs; and
       4. Transitions of care, including readmissions.
    2. *Data Collection*. The facility shall collect data particular to the facility’s needs including at least the following:
       1. The performance improvement priorities identified by the governing body or responsible individual;
       2. Operative or other procedures that place patients at risk of disability or death.
       3. All significant discrepancies between preoperative and postoperative diagnoses, including pathologic diagnoses.
       4. Adverse events related to using moderate or deep sedation or anesthesia.
       5. The use of blood and blood components.
       6. All report and confirmed transfusion reactions.
       7. The use of restraints.
       8. The use of seclusion.
       9. The results of resuscitation.
       10. Significant medication errors.
       11. Significant adverse drug reactions.
       12. Patient perception of the safety and quality of care, treatment, or services.
       13. Patient thermal injuries that occur during magnetic resonance imaging exams
       14. Incidents where ferromagnetic objects unintentionally entered the MRI scanner room
       15. Injuries resulting from the presence of ferromagnetic objects in the MRI scanner room.
       16. Pain assessment and pain management including types of interventions and effectiveness
       17. Events or information identified in the Adverse Drug Reactions and Drug Administration Errors Policy, Infection Prevention and Control Policy, or the Antimicrobial and Antibiotic Stewardship Policy that must be incorporated into the QAPI Program.
       18. Primary Care Medical Home data including:
           1. Disease management outcomes.
           2. Patient experience and satisfaction related to access to care, treatment, or services, and communication.
           3. Patient perception of the comprehensiveness of care, treatment, or services.
           4. Patient perception of the coordination of care, treatment, or services.
           5. Patient perception of the continuity of care, treatment, or services.
       19. [PLACEHOLDER – Insert any additional categories of data collection that are relevant to your specific organization and needs]
    3. *Data Sources*.
       1. [PLACEHOLDER – if applicable, include organization-specific processes and protocols related to this Section and its implementation. Specifically, identify any departments, service-lines, or leaders involved with or responsible for the identified activities.]
       2. The designee shall identify data sources and the persons responsible for collecting, tracking, and analyzing data from those sources.
       3. Data will be collected from all relevant sources, which may include:
          1. Staff;
          2. Patients;
          3. Records, including medical records;
          4. Observations;
          5. Quality control activities;
          6. Risk management activities;
          7. Research studies;
          8. Regulators;
          9. Insurers; and
          10. The community.
       4. Data will be collected and analyzed as follows: [PLACEHOLDER – Indicate whether any specific software, programs, or processes used by the facility for data collection or analysis purposes]
    4. *Data Analysis*.
       1. [PLACEHOLDER – if applicable, include organization-specific processes and protocols related to this Section and its implementation. Specifically, identify any departments, service-lines, or leaders involved with or responsible for the identified activities.]
       2. The facility will analyze data from internal sources over time to identify patterns and trends and to monitor the facility’s performance related to its performance improvement priorities. The facility may also access external databases that allow it to compare its performance with other organizations on a specific topic, such as procedures or outcomes.
       3. The designee will work with the facility’s information management department and staff and any other relevant clinical or non-clinical departments or staff necessary to ensure that the facility and QAPI Program:
          1. Use statistical tools and techniques to analyze and display data.
             1. [PLACEHOLDER – Indicate whether any specific software, programs, or processes used by the facility for data collection or analysis purposes]
          2. Analyzes and compares internal data over time to identify levels of performance, patterns, trends, and variations.
          3. Reviews and analyzes incidents where the radiation dose index (computed tomography dose index [CTDIvol], dose length product [DLP], or size-specific dose estimate [SSDE]) from diagnostic CT examinations exceeded expected dose index ranges identified in imaging protocols. These incidents are then compared to external benchmarks.
          4. Analyzes its organ procurement conversion rate data as provided by the organ procurement organization (OPO). The conversion rate is calculated as the number of actual organ donors over the number of eligible donors defined by the OPO, expressed as a percentage.
          5. Uses the results of data analysis to identify improvement opportunities.
          6. Analyzes data collected on pain assessment and pain management to identify areas that need change to increase safety and quality for patients.
          7. Monitors the use of opioids to determine if they are being used safely (for example, the tracking of adverse events such as respiratory depression, naloxone use, and the duration and dose of opioid prescriptions).
          8. Reviews and analyzes instances where the radiation exposure and skin dose threshold levels identified by the organization are exceeded.
          9. Provides incidence data to key stakeholders, including leaders, licensed practitioners, nursing staff, and other clinicians consistent with the Infection Prevention and Control Policy on the following:
             1. Multidrug-resistant organisms (MDRO)
             2. Central line–associated bloodstream infections (CLABSI)
             3. Surgical site infections (SSI)
21. **KEY SEARCH WORDS / CROSS-REFERENCING**

Adverse Drug Reactions and Drug Administration Errors Policies and Guidance: [PLACEHOLDER: Policy #] Problems identified pursuant to the Adverse Drug Reactions and Drug Administration Errors Policy must be addressed in coordination with the facility-wide QAPI Program.

Antimicrobial and Antibiotic Stewardship Policy [PLACEHOLDER: Policy #]: Problems identified pursuant to the Antimicrobial and Antibiotic Stewardship Policy must be addressed in coordination with the facility-wide QAPI Program.

Infection Prevention and Control Policy: [PLACEHOLDER: Policy #] Problems identified pursuant to the Infection Prevention and Control Policy must be addressed in coordination with the facility-wide QAPI Program.

IT / Information Management Policy and Procedures: [PLACEHOLDER: Policy # – If applicable, cross-reference any relevant policies, procedures, or requirements that address or overlap with the data collection and gathering requirements referenced in this policy]

Medical Staff / Nursing Services Policy: [PLACEHOLDER: Policy # – Cross-reference any policies that address periodic review of clinical privileges and performance (including diagnosis and treatment) of medical and nursing staff, or any other policies that evaluate the quality of care provided by NPs, CNSs, CNMs, PAs, MDs, and DOs]

Medical Records Policy and Procedures: [PLACEHOLDER: Policy # – If applicable, cross-reference any relevant policies, procedures, or requirements that address or overlap with the data collection and gathering requirements referenced in this policy]

Organ Procurement and Transplant Policy and Procedures: [PLACEHOLDER: Policy # – If applicable, cross-reference any relevant policies, procedures, or requirements that address or overlap with the data collection and gathering requirements referenced in this policy]

Radiology / Diagnostic Imaging Policy and Procedures: [PLACEHOLDER: Policy # – If applicable, cross-reference any relevant policies, procedures, or requirements that address or overlap with the data collection and gathering requirements referenced in this policy]

Training and Education Policy and Procedures: [PLACEHOLDER: Policy # – If applicable, cross-reference any relevant policies, procedures, or requirements that address or overlap with the training, education, and competency requirements referenced in this policy]

1. **RELATED DOCUMENTATION AND FORMS**

Related Adverse Drug Reactions and Drug Administration Errors Documents: [Include specific adverse drug reactions and drug administration errors documentation, clinical guidelines, standards or forms that are that are relevant to implementation of this Policy *if not addressed in separate policies* captured in **Section V. CROSS-REFERENCED POLICIES** above. ]

Related Antimicrobial and Antibiotic Stewardship Documents: [Include antimicrobial and antibiotic documentation, clinical guidelines, standards or forms that are relevant to implementation of this Policy *if not addressed in separate policies* captured in **Section V. CROSS-REFERENCED POLICIES** above. ].

Related Infection Prevention and Control Documents: [Include specific infection prevention and ctonrol documentation, clinical guidelines, standards or forms that are that are relevant to implementation of this Policy *if not addressed in separate policies* captured in **Section V. CROSS-REFERENCED POLICIES** above. ]

1. **SOURCES / REFERENCES**
2. 42 C.F.R. § 485.641 (2019).
3. 84 Fed. Reg. 51732, 51785 – 51788 (September 30, 2019).
4. The [State Operations Manual, Appendix W](https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/som107ap_w_cah.pdf) includes Survey Procedures and Interpretive Guidelines for this condition of participation. As of July 2021, the State Operations Manual has not yet been updated to address changes to the condition of participation effective in September 2019. In future revisions to this Policy, the State Operations Manual should be reviewed for updated sub-regulatory guidance related to this condition of participation.
5. The Joint Commission, Critical Access Hospital – Performance Improvement Chapter, PI.01.01.01 *et seq*.