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CENTERS for MEDICARE & MEDICAID SERVICES

Center for Medicaid and State Operations

Ref: S&C-03-16

DATE: April 10, 2003

FROM: Director
Survey and Certification Group

SUBJECT: Interim Guidance for the Hospital Quality Assessment and Performance Improvement Condition of Participation

TO: Survey and Certification Regional Office Management (G-5)
State Survey Agency Directors

The new hospital Condition of Participation (CoP) at 42 CFR §482.21: Quality Assessment and Performance Improvement (QAPI) was published January 24, 2003, with an effective date of March 25, 2003. On March 25, 2003, QAPI will replace the hospital Condition of Participation: Quality Assurance (QA).

The fundamental purpose of the QAPI CoP is to set a clear expectation that hospitals must take a proactive approach to improve their performance and focus on improved patient care and patient safety, including the reduction and prevention of medical errors. We stress improvement in systems in order to improve processes and patient outcomes. Since hospitals are currently required to have an "effective, hospital-wide quality assurance program" in accordance with existing requirements at 42 CFR §482.21, we do not believe a transition period is necessary.

The hospital's QAPI Program will be evaluated for its hospital-wide effectiveness on the quality of care provided. The impact of the program will be assessed during a survey, as surveyors will look at data gathered by the hospital at different points in time, compared, and actions taken based on that comparison. Hospitals will analyze data and evaluate the effectiveness of their own programs continually.

Through our survey process, we intend to assess whether hospitals have all of the components of a QAPI program in place. The state agencies (SAs) will expect hospitals to demonstrate, with objective data, that improvements have taken place in actual care outcomes, processes of care, patient satisfaction levels, hospital operations, or other performance indicators.

Surveyors should have begun surveying for compliance with the QAPI (and discontinue the QA) CoP on March 25, 2003. The hospital QA requirements (tags) will be removed from the Automated Survey Process Environment (ASPEN) and replaced with the new QAPI tags. The QA CoP will be crosswalked to the QAPI CoP at the condition level (QA A-0050 crosswalks to QAPI A-0625).

Interpretive Guidelines for QAPI are being developed at this time. The attached interim guidance is provided to surveyors to use when assessing a hospital's compliance with QAPI.

Effective Date: March 25, 2003.

Training: The information contained in this announcement should be shared with all survey and certification staff, their managers and the state/RO training coordinator.

/s/
Steven A. Pelovitz

Attachment

INTERIM SURVEYOR GUIDANCE FOR QAPI CoP FOR HOSPITALS (42 CFR 482.21)

Probes

1. Is the hospital's QAPI program ongoing and hospital-wide (all departments, locations, and services) and includes all contracted services?

2. Determine if hospital leadership (governing body, medical staff and administrative staff) has assumed responsibility for QAPI activities as required by standard (e) of this CoP.

3. What evidence is there that hospital leadership has established clear expectations for safety?

4. Have adequate resources (people, money, time, equipment, space, etc.) been allocated for meeting the requirements of this CoP for performance improvement and the reduction of risks to patients?

5. Review the hospital's documentation of all of its activities to meet the QAPI CoP. Are all program components in place? Is there objective data demonstrating actual improvements in patient care, safety, and reduction of medical errors? Review other documentation that demonstrates the hospital's compliance activities.

6. Does the hospital have all the components of a QAPI program in place?

7. Evaluate whether the hospital can demonstrate with objective data that improvements have taken place.

8. Is the hospital tracking medical errors and adverse patient events? Is it analyzing their causes? Is it implementing preventive actions and mechanisms?

9. Has the hospital taken actions aimed at performance improvement? Has it measured its success? Does it track performance on its improvements?

10. Identify the hospital's performance improvement (PI) projects. Are the number and scope of projects conducted annually proportional to the scope and complexity of its services and operations?

11. Is the hospital using Quality Improvement Organization (QIO) projects, its own projects, or both? What are the hospital's reasons for conducting these projects?

12. Does the QAPI program collect data hospital-wide and from sources outside the hospital such as its QIO?

13. Does the hospital have measurable progress on its projects?

14. Does the hospital have a methodology or system for the prioritization of performance improvement, patient safety and medical error reduction activities? Does it set priorities as required (see A-0636 and A-0637) for health outcomes and quality of care, and patient safety?

15. Is the hospital's quality improvement program ongoing, defined, implemented and maintained? Does it address priorities for improved care? Are improvement actions measured and sustained?

16. Is the hospital's ongoing program for patient safety, including medical error reduction, defined, implemented and maintained? Does it address priorities for improved patient safety? Are improvements evaluated?