CRITICAL ACCESS HOSPITAL QUALITY MANUAL AND RESOURCES 101

This Critical Access Hospital Quality Manual and Resource was constructed by Tracy Smith MSN, RN-BC, CPHQ in conjunction with the Illinois Critical Access Hospital Network (ICAHN) as a partial fulfillment of the requirements for the degree of Doctor of Nursing Practice.

Disclaimer- The manual is not all inclusive and include the update process. If you find an area in this manual that needs updating. Please email ICAHN utilizing the form on page 59.

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Purpose of the Manual

The purpose of the manual is to provide a quality management resource for Critical Access Hospitals (CAHs) that are served by the Illinois Critical Access Hospital Network (ICAHN). The quality management resource manual was designed based on the findings of the gap analysis encompassing CAH quality managers' needs and evidence-based quality practices. The central purpose of the quality management resource manual involves empowering CAH quality managers with a simple and concise manual of basic information and provides evidence-based resources to effectively administer quality programming; thus: elevating the quality of care delivery, improving outcomes for patients and populations served, and securing financial viability within their respective organizations. Throughout each section there is an overview and resources available.

Critical Access Hospital Overview

If this is your first time in a CAH or you are moving into a leadership role, it is imperative that you understand that CAHs are different from other acute care hospitals. CAHs have a vital role in rural health care. The US government created the Medicare Rural Hospital Flexibility Program (Flex Program) in 1997; whereby, hospitals receive cost-based reimbursement if they are licensed as a CAH. The cost-based reimbursement is what keeps CAHs viable. CAHs had to be certified as such before January 1, 2006 or they must be located more than 35 miles from another hospital (or 15 miles in areas with mountainous terrain or secondary roads). CAHs must have 24-hour emergency care services available. A maximum of twenty-five acute care and swing beds (a bed used for either acute or skilled nursing facility care depending on need), and they should maintain an acute care average length of stay of 96 hours or less (Crawford, Schumock, Ursan, Walton, & Donnelly, 2013). Watch for ICAHN's swing bed manaul coming soon.

A CAH is subject to the diversity of the population the CAH serves. Reimbursement stems from insurance companies, state Medicaid programs, and self-private pay individuals who are not covered by insurance and who do not meet guidelines for governmental coverage. Of all the payor sources, Medicare is the primary source of reimbursement for CAHs. Medicare pays for the same services from CAHs as is paid to all acute care hospitals (e.g., inpatient stays, outpatient visits, laboratory tests and post-acute skilled nursing days). CAH payments are based on each CAH's costs and the share of costs that are allocated to Medicare patients. Cost-based reimbursement provides significant financial incentive by allowing the CAH to be paid at 101% of costs for all Medicare covered services (Rural Health Information Hub, 2018). CAHs are not subject to the Inpatient Prospective Payment Systems (IPPS) or Outpatient Prospective Payment Systems (OPPS). Under the Medicare ambulance benefit, if a CAH or an entity that is

owned and operated by the CAH is the only provider or supplier of ambulance service located within a 35-mile drive of the CAH or entity, then the CAH is paid at 101% based on reasonable cost for the ambulance services.

CAHs are held to the same accountability as other acute care hospitals and must meet the same applicable or similar conditions of participation sanctioned by Centers for Medicare and Medicaid Services (CMS). CAHs are obligated to have and maintain quality assurance activities with at least one of the following criteria being met: one other CAH or hospital that is part of the hospital's network, a quality improvement organization (QIO) or equivalent entity, and/or another qualified entity, such as accreditation by an accrediting body. Unique to the CAH is the Medicare Beneficiary Quality Improvement Project (MBQIP), a grant project under the Flex Program. The aim of the MBQIP program is to improve quality of care in CAHs by encouraging self-reported quality data that is analyzed and used to drive quality activities at the facility.

Critical Access Hospital Fact Sheet

https://icahn.org/wp-content/uploads/2018/10/CAH_Factsheet.pdf

Medicare Learning Network Booklet

https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/critaccesshospfctsht.pdf

Small Rural Hospital and Clinic Finance 101 Manual

https://www.ruralcenter.org/resource-library/finance-101-manual

Quality Manager Role in a CAH

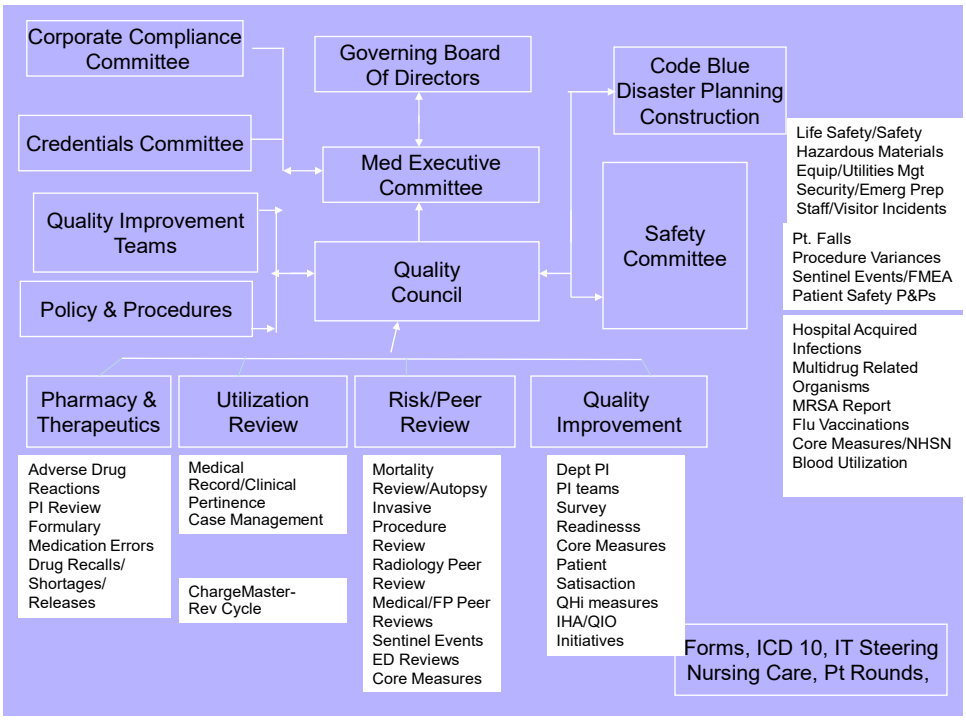
As a performance improvement and patient safety expert, you must develop a Quality Assessment and Performance Improvement (QAPI) plan that ensures that your hospital delivers the correct services, and that services are delivered safely. Quality is not the sole responsibility of the quality department; the entire hospital must prioritize a culture of safety and continual improvement. Your role as the quality manager is to guide the management team to emphasize objective data, utilize feedback from frontline staff members, and focus on process improvement.

Regardless of the size of the organization, the Chief Quality Officer (CQO)/Quality Director/Quality Manager's primary responsibilities rest with the task of collecting data that is highly accurate, can demonstrate the organization's standard of quality, and that demonstrates high-quality outcomes through patient centered care, which translates to high HCAHPS scores.

Some of the key responsibilities associated with the CQO/Quality Director/Quality Manager role include:

- Coordinating hospital wide data collection, analysis, reporting and improvement
- Overseeing the abstraction process and submission for Medicare Beneficiary Quality Improvement Project (MBQIP) data (also known as core measure data).
- Medical Staff Ongoing Professional Practice Evaluation (OPPE), Focused Professional Practice Evaluation (FPPE), and Peer Review Process
- Maintaining and supervision of continual survey readiness

Many quality leaders report directly to the hospital governing board. It is important to understand the structure of the reporting process and how the board oversees the organization. The board is held legally responsible for the oversight of the CMS conditions of participation (CoP). The board has the responsibility of establishing and /or adhering to organizational vision mission, and values and develop strategies to achieve or work toward the driving forces of the organization while positioning the organization to assure ongoing viability of the organization. These set the overall direction for the hospital. The board must appoint the Chief Executive Officer (CEO) to manage the hospital. The management team has the responsibility in deciding the correct way to achieve those outcomes. An open communication approach is a necessity between hospital leaders and the board members. Below is a sample reporting grid for how the quality information may be communicated to the board.



Quality/Performance Improvement Overview

A commonly used definition of quality is the one published by the Institute of Medicine (2001) and explains that health services for individuals and populations increase the likelihood of desired health outcomes, that services are consistent with current professional knowledge, as well as stating health care should be safe, effective, patient-centered, timely, efficient and equitable.

The U.S. Agency for Healthcare Research and Quality (AHRQ, para 1) defines quality health care as “doing the right thing, at the right time, in the right way, for the right person---and having the best possible results.” Although there are many systematic frameworks for healthcare quality, one of the most significant is the framework put forth by the Institute of Medicine (IOM, 2001), which includes six aims for any health care system. These include that the healthcare organization be:

- Safe: Avoiding harm to patients from the care that is intended to help them.
- Effective: Providing services based on scientific knowledge to all who could benefit and refraining from providing services to those not likely to benefit (avoiding underuse and misuse, respectively).
- Patient-centered: Providing care that is respectful of and responsive to individual patient preferences, needs, and values and ensuring that patient values guide all clinical decisions.

- Timely: Reducing waits and sometimes harmful delays for both those who receive and those who give care.
- Efficient: Avoiding waste, including waste of equipment, supplies, ideas, and energy.
- Equitable: Providing care that does not vary in quality because of personal characteristics such as gender, ethnicity, geographic location, and socioeconomic status

High Reliability Organizations

As part of health care quality, organizations are also desired to be considered high reliability organizations (HRO). HROs use systems-based thinking. They must evaluate processes and design processes for safety of patients and staff. HROs are aware that safety is not static and must be evaluated on an ongoing basis. Therefore, HROs work to create and maintain an environment that potential problems are anticipated and can be avoided. Variances and work arounds are detected early so that the process may be revised. The goal is to respond early enough to prevent adverse events. HROs are supported by five characteristic ways of thinking: preoccupation with failure; reluctance to simplify explanations for operations, successes, and failures; sensitivity to operations (situational awareness); deference to frontline expertise; and commitment to resilience. HROs mitigate issues that may negatively impact outcomes associated with quality, cost, and patients. Required public disclosure of quality, cost, and patient outcomes allow the public to utilize this information to select a provider and/or organization. Consumer-driven healthcare is a reality and the quality manager is required to be acquainted with data reflecting your organization's quality on websites available to the public. Take the time to access the websites in the resources section and search for your organization (websites in the resources).

Characteristic	Description
Preoccupation With Failure	Everyone is aware of and thinking about the potential for failure. People understand that new threats emerge regularly from situations that no one imagined could occur, so all personnel actively think about what could go wrong and are alert to small signs of potential problems. The absence of errors or accidents leads not to complacency but to a heightened sense of vigilance for the next possible failure. Near misses are viewed as opportunities to learn about systems issues and potential improvements, rather than as evidence of safety.
Reluctance to Simplify	People resist simplifying their understanding of work processes and how and why things succeed or fail in their environment. People in HROs* understand that the work is complex and dynamic. They seek underlying rather than surface explanations. While HROs recognize the value of standardization of workflows to reduce variation, they also appreciate the complexity inherent in the number of teams, processes, and relationships involved in conducting daily operations.
Sensitivity to Operations	Based on their understanding of operational complexity, people in HROs strive to maintain a high awareness of operational conditions. This sensitivity is often referred to as "big picture understanding" or "situation awareness." It means that people cultivate an understanding of the context of the current state of their work in relation to the unit or organizational state—i.e., what is going on around them—and how the current state might support or threaten safety.
Deference to Expertise	People in HROs appreciate that the people closest to the work are the most knowledgeable about the work. Thus, people in HROs know that in a crisis or emergency the person with greatest knowledge of the situation might not be the person with the highest status and seniority. Deference to local and situation expertise results in a spirit of inquiry and de-emphasis on hierarchy in favor of learning as much as possible about potential safety threats. In an HRO, everyone is expected to share concerns with others and the organizational climate is such that all staff members are comfortable speaking up about potential safety problems.
Commitment to Resilience	Commitment to resilience is rooted in the fundamental understanding of the frequently unpredictable nature of system failures. People in HROs assume the system is at risk for failure, and they practice performing rapid assessments of and responses to challenging situations. Teams cultivate situation assessment and cross monitoring so they may identify potential safety threats quickly and either respond before safety problems cause harm or mitigate the seriousness of the safety event.
*HROs: High reliability organizations Sources: Weick et al 2007; Hines et al 2008; Chassin et al 2013; Rochlin 1999.	

As a quality manager in a CAH you will be expected to be the expert on performance improvement (PI). There is a vast amount of knowledge to gain when it comes to PI. Others in this position have found it beneficial to request education on:

- How to lead a team https://www.franklincovey.com/Solutions/6-Critical-Practices.html
- Microsoft training at a local college
- Six Sigma, Lean, or CQI training https://www.6sigma.us/six-sigma-training.php

- National Association for Healthcare Quality (NAHQ) training for the Certified Professional in Healthcare Quality (CPHQ) including the Q Solutions books https://nahq.org/certification/cphq-preparation
- Institute of Healthcare Improvement (IHI) open school modules http://app.ihi.org/lmsspa/#/certificates/6cb1c614-884b-43ef-9abd-d90849f183d4
- Vendor training (The Joint Commission, Press Ganey, etc.)
- Formalized healthcare quality training such as Quality Bootcamp 101 by QHR https://qhr.com/learning-institute/

If finances are limited it may be beneficial to visit another CAH nearby and spend time with their quality manager.

Getting Started: Quality and/or Performance Improvement Plan

When beginning quality and/or performance improvement plan, you need to start with the organization's mission, vision, values, and strategic plan. Ask for the most up to date strategic plan and review the plan. Reflect on and identify the priorities for the organization that are modifiable by action and change. Does the organization have dashboards or other specific indicators that they monitor on a regular basis? Assess these in conjunction with the strategic plan to narrow the focus and define where quality/performance improvement efforts are best spent.

Interview leaders from hospital departments. Ask the following key questions:

• What is the quality manager's role in facilitating the strategic plan?

• How do the quality manager's job activities fit with the organization's overall mission and strategic direction?

• How does quality improvement and regulatory readiness fit in with role as quality manager/your department?

• How does the leader perceive your role as quality manager working with the department/leader to achieve the organization's overall mission and strategic direction, especially with regards to quality and patient safety?

Learn about how to effectively lead a meeting and a team, this will take practice so do not be discouraged. Key points to remember include that leaders guide team members by example, encourage trust and respect, get the right people on the team (make sure to include front line staff), measurable objectives for any meeting should be set at the beginning to help guide team members, time is important and a schedule should be kept, make sure that assignments are clearly defined at the end of the meeting, hold yourself and others accountable to those assignments at the next meeting. While your team is working on a process, as well as after improvement has been made it is important to

integrate the front-line staff and establish effective communication methods to all involved in the quality/performance initiatives.

The IHI provides free modules that may be beneficial, a basic certification may be attained if all modules are completed. These courses may also be taken for continuing education credits http://app.ihi.org/lmsspa/#/certificates/6cb1c614-884b-43ef-9abd-d90849f183d4 . Throughout these resources you will find recommendations and guidelines to further your understanding of healthcare quality.

Basic Certificate in Quality & Safety

Earning the Basic Certificate in Quality and Safety boosts your knowledge and skills — and proves to employers you're serious about changing health care for the better. To receive the Certificate, you must complete the following 13 Open School courses: *QI 101–Q105*, *PS 101–105*, *TA 101*, *PFC 101*, and *L 101*. When you enter the courses, the required modules are indicated with an *asterisk.

Improvement Capability	Patient Safety
QI 101: Introduction to Health Care Improvement	**PS 101:** Introduction to Patient Safety
QI 102: How to Improve with the Model for Improvement	**PS 102:** From Error to Harm
QI 103: Testing and Measuring Changes with PDSA Cycles	**PS 103:** Human Factors and Safety
QI 104: Interpreting Data: Run Charts, Control Charts, and Other Measurement Tools	**PS 104:** Teamwork and Communication in a Culture of Safety
QI 105: Leading Quality Improvement	**PS 105:** Responding to Adverse Events
Triple Aim for Populations	**Person- and Family-Centered Care**
TA 101: Introduction to the Triple Aim for Populations	**PFC 101:** Introduction to Person- and Family-Centered Care
Leadership	
L 101: Introduction to Health Care Leadership	

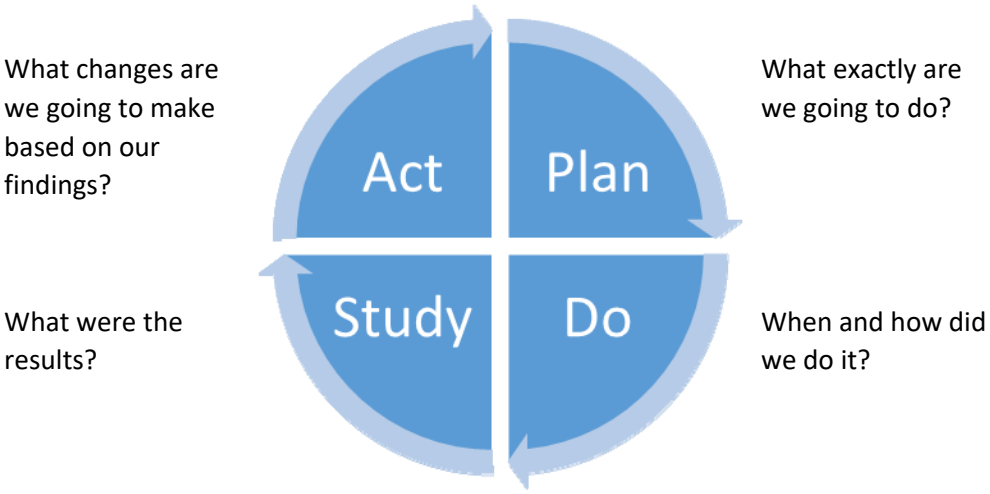
Getting Started Checklist

	Received/ Scheduled	Completed	Additional Follow Up Needed
Review strategic plan			
Review annual QAPI plan			
Review patient satisfaction surveys			
Review staff satisfaction surveys			
Review past surveys such as IDPH, TJC, CAPS, CLIA, Nuclear Med, etc.			
Review prior claims from insurance (loss/run reports)			
Review event reporting trends			
Review any publicly reported data			
Review current quality indicators measured for each department			
Meet with and utilize questions above (some people may hold multiple titles):			
CEO/CFO			
CNO			
Risk manager			
Patient Safety Officer			
Life Safety Leader			
Process/Quality Improvement staff			
Workers Compensation manager			
Individual departmental managers			
Informatics			
Other:			
Analyze trends and conduct a gap analysis			
Contact your QIO https://qioprogram.org/locate-your-qio?map=qin			
Attain access to Q Net https://www.qualitynet.org/			

Once you identify trends and opportunities, it is time to conduct a gap analysis. Simply put a gap analysis is knowing where you are now in your measures, knowing where you want to be, identifying the gap between the two, and then figuring out how to close that gap. Utilize resources for developing a plan IHI open school module QI 102.

For your first PI project you may want to choose a simple process, that has staff buy in and can be a quicker turn around so that it can be a positive experience.

This is where PI can get complicated, to keep it simple there are easy to use tools that are free and that all staff can understand. Below is are template links for the most commonly used PI framework for those surveyed. The Plan, Do, Study, Act (PDSA) cycle walks you through the steps of writing down and focusing on what we want to change. By working through the tool, it guides thinking into breaking down the process into steps and then evaluating the outcome, improving on it, and testing again.



Institute of Healthcare Improvement (IHI) based PDSA links

http://www.ihi.org/resources/Pages/Tools/PlanDoStudyActWorksheet.aspx

https://www.integration.samhsa.gov/pbhci-learning-community/PDSA_Worksheet.pdf

This just a brief introduction into the quality arena. In 2016 ICAHN partnered with Medicare Rural Hospital Flexibility Grant program (CFDA # 93.241) through Health Resources and Services Administration and the Illinois Department of Public Health to develop a resource called the BASIC FIELD GUIDE TO HEALTHCARE QUALITY. You may find this free resource at https://www.healthtechs3.com/2016-basic-field-guide-to-healthcare-quality/ . This resource is a great example of broad information that you need to be familiar with. Take the time to access and utilize this information.

MBQIP measures

The Medicare Beneficiary Quality Improvement Project (MBQIP) is a quality improvement activity under the Medicare Rural Hospital Flexibility (Flex) grant program of the Health Resources and Services Administration's Federal Office of Rural Health Policy (FORHP). The goal of MBQIP is to improve the quality of care provided in CAHs, by increasing quality data reporting by CAHs and then driving quality improvement activities based on the data. MBQIP provides an opportunity for individual hospitals to look at their own data, measure their outcomes against other CAHs and partner with other hospitals in the state around quality improvement initiatives to improve outcomes and provide the highest quality care to every one of their patients. This and more information can be located at https://www.ruralcenter.org/tasc/mbqip and ICAHN.

Current Medicare Beneficiary Quality Improvement Project (MBQIP) Measures

	Patient Safety/Inpatient	*Patient Engagement*	*Care Transitions*	*Outpatient*
Core MBQIP Measures	**HCP (formerly OP-27):** Influenza Vaccination Coverage Among Healthcare Personnel (HCP) **IMM-2*:** Influenza Immunization for inpatients **Antibiotic Stewardship:** Measured via Center for Disease Control National Healthcare Safety Network (CDC NHSN) Annual Facility Survey **Inpatient ED Measures:** • **ED-1***: Median Time from ED Arrival to ED Departure for *Admitted* ED Patients • **ED-2:** Admit Decision Time to ED Departure Time for *Admitted* Patients	**Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS)** *The HCAHPS survey contains 21 patient perspectives on care and patient rating items that encompass nine key topics:* • Communication with Doctors • Communication with Nurses • Responsiveness of Hospital Staff • Pain Management† • Communication about Medicines • Discharge Information • Cleanliness of the Hospital Environment • Quietness of the Hospital Environment • Transition of Care *The survey also includes four screener questions and seven demographic items. The survey is 32 questions in length.*	**Emergency Department Transfer Communication (EDTC)** *7 sub-measures; 27 data elements; 1 composite* • EDTC-1: Administrative Communication (2 data elements) • EDTC-2: Patient Information (6 data elements) • EDTC-3: Vital Signs (6 data elements) • EDTC-4: Medication Information (3 data elements) • EDTC-5: Physician or Practitioner Generated Information (2 data elements) • EDTC-6: Nurse Generated Information (6 data elements) • EDTC-7: Procedures and Tests (2 data elements) • **All-EDTC:** Composite of All 27 data elements	**Chest Pain/AMI:** • **OP-2:** Fibrinolytic Therapy Received within 30 minutes • **OP-3:** Median Time to Transfer to another Facility for Acute Coronary Intervention • **OP-5‡:** Median Time to ECG **ED Throughput** • **OP-18:** Median Time from ED Arrival to ED Departure for *Discharged* ED Patients • **OP-22:** Patient Left Without Being Seen

*Inpatient measures IMM-2 and ED-1 are being removed by the Centers for Medicare & Medicaid Services (CMS) following submission of Quarter 4 2018 data. State Flex programs may continue to support hospitals with these as additional measures after this

†Pain Management HCAHPS questions are being removed by CMS beginning with Quarter 3 2019 surveys.

‡Outpatient measure OP-5 is being removed by CMS following submission of Quarter 1 2019 data.

Revised on 01/15/2019

National Rural Health Resource Center (2019)

Current Medicare Beneficiary Quality Improvement Project (MBQIP) Measures

	Patient Safety/Inpatient	*Patient Engagement*	*Care Transitions*	*Outpatient*
Additional MBQIP Measures	**Healthcare Acquired Infections (HAI)** • **CLABSI:** Central Line-Associated Bloodstream Infection • **CAUTI:** Catheter-Associated Urinary Tract Infection • **CDI:** *Clostridium difficile* (C. Diff) Infection • **MRSA:** Methicillin-resistant *Staphylococcus aureus* • **SSIs:** Surgical Site Infections Colon or Hysterectomy **Perinatal Care** • **PC-01:** Elective Delivery **Falls**§ Potential measurement around: • Falls with Injury • Patient Fall Rate • Screening for Future Fall Risk **Adverse Drug Events (ADE)**§ Potential measurement around: • Falls with Injury • Opioids • Glycemic Control • Anticoagulant Therapy	**Emergency Department Patient Experience Survey**§	**Discharge Planning**§ **Medication Reconciliation**§ **Swing Bed Care**§ **Claims-Based Measures** *Measures are automatically calculated for hospitals using Medicare Administrative Claims Data* • **Reducing Readmissions** • **Complications** • **Hospital Return Days**	**Chest Pain/AMI** • **Aspirin at Arrival**§ (formerly OP-4) **ED Throughput** • **Door to Diagnostic Evaluation by a Qualified Medical Professional**§ (formerly OP-20)

§No nationally standardized or standardly reported measure currently available, however, Flex programs can propose work on these measures if there is a data collection mechanism in place.

Revised on 01/15/2019

National Rural Health Resource Center (2019)

The current MBQIP measures may be found at https://www.ruralcenter.org/resource-library/mbqip-measures .

In 2018 the Oregon Office of Rural Health partnered with the Rural Hospital Flexibility Grant Program (H54RH00049) to provide a resource called the CRITICAL ACCESS HOSPITAL QUALITY REPORTING OVERVIEW GUIDE. You may find this resource at https://www.ohsu.edu/xd/outreach/oregon-rural-health/hospitals/upload/2018-Critical-Access-Hospital-Quality-Reporting-Guide.pdf . This is an excellent resource to understand the program details, reporting methods, resources, directions on how to report using the cart tool and how to analyze and share the data. One should note that this resource was provided to the CAHs in Oregon, however it contains minimal information specific to Oregon. **ICAHN provides the Care Transitions: Emergency Department Transfer Communication (EDTC) reporting tool for you.

Care Transitions (EDTC) toolkit, abstraction tools, and resources
http://www.stratishealth.org/providers/ED_Transfer_Resources.html

OPPE/FPPE and Peer Review

Initial Focused Professional Practice Evaluation (FPPE [also known as IPPE])– Requires organizations to review performance data for all practitioners with privileges initially upon credentialing. What does this entail?

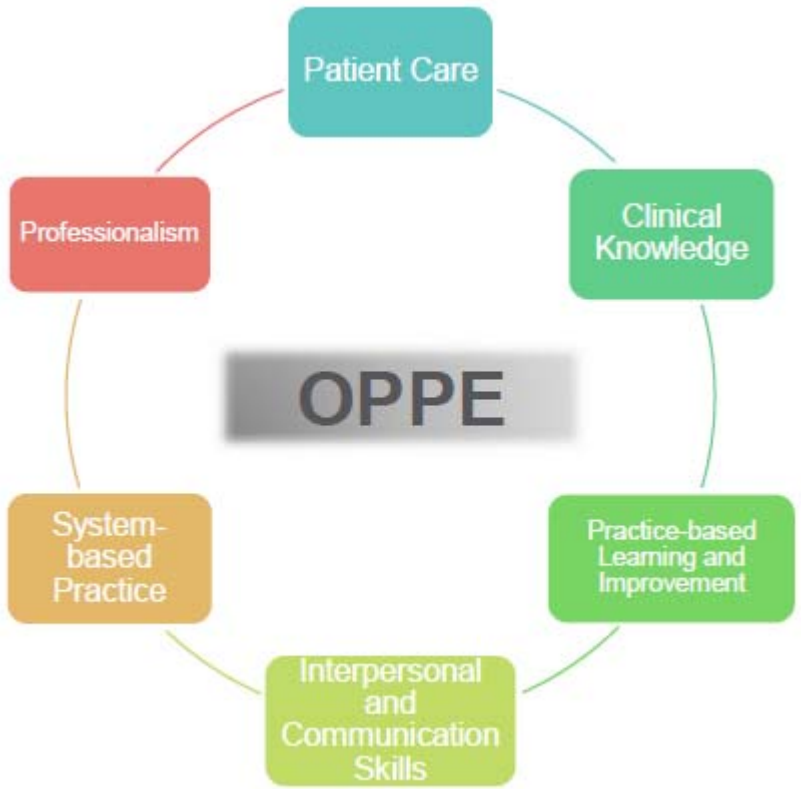
Ongoing Professional Practice Evaluation (OPPE)– Requires organizations to review performance data for all practitioners with privileges on an ongoing basis rather than with the two-year reappointment process and, thus; allow them to take the appropriate steps to improve performance on a timelier basis.

Focused Professional Practice Evaluation (FPPE)– Requires organizations to follow up on any 'trigger' indicators to determine the validity, and if any additional follow up is needed. This process is applied to all practitioners, however only a small number of practitioners will trigger an FPPE process.

This process is often given to the quality department to support the medical staff in achieving a thorough review. A process must be defined and approved by the medical staff and board. Measures should be clearly defined and contain competencies from all six categories defined by the Accreditation Council for Graduate Medical Education (ACGME) and the American Board of Medical Specialties (ABMS). They include:

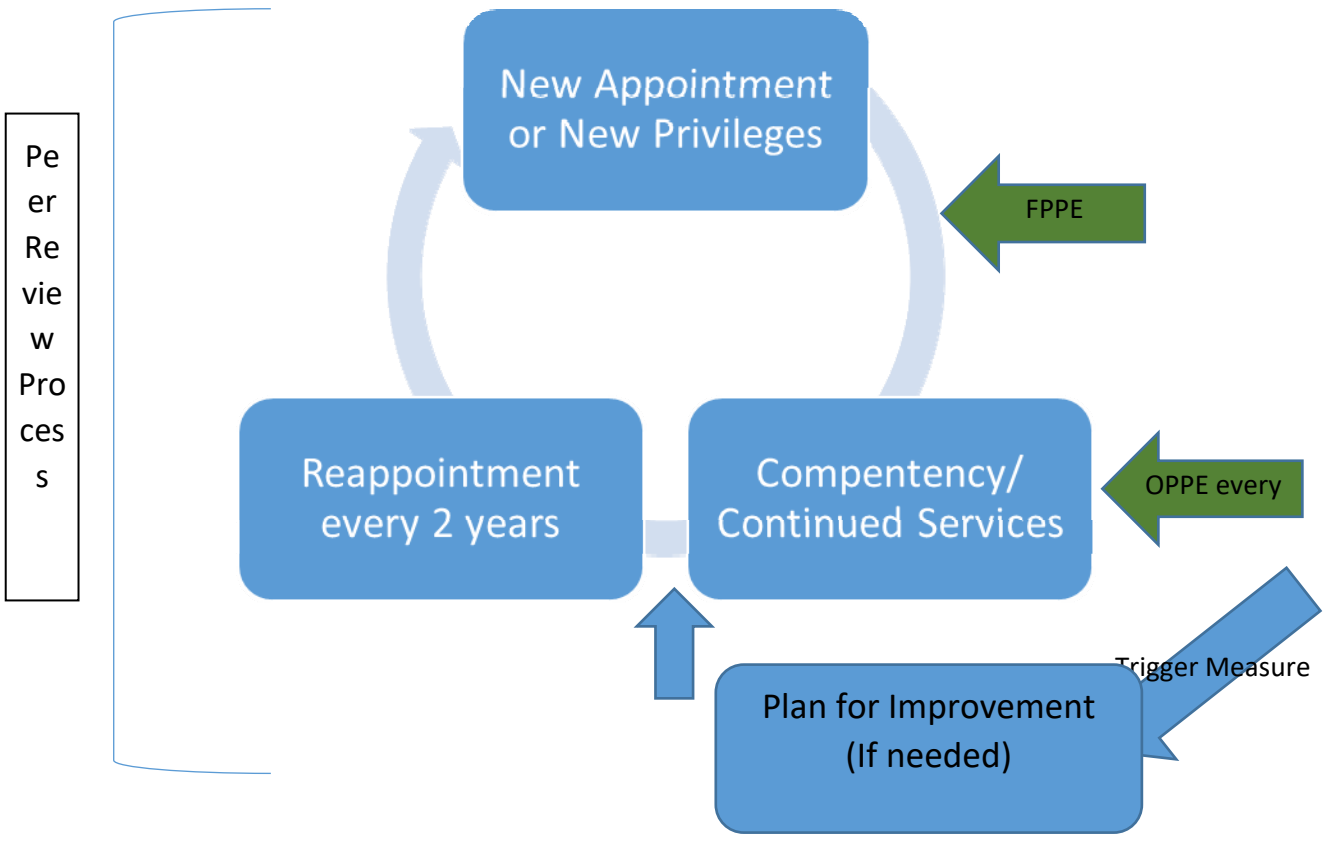
1. **Practice-based Learning and Improvement:** The practitioner must show an ability to investigate and evaluate patient care practices, appraise and assimilate scientific evidence, and improve the practice of medicine.
2. **Patient Care and Procedural Skills:** The practitioner must provide care that is compassionate, appropriate, and effective treatment for health problems and to promote health.

3. **Systems-based Practice:** The practitioner must demonstrate awareness of and responsibility to the larger context and systems of health care. Be able to call on system resources to provide optimal care (e.g. coordinating care across sites or serving as the primary case manager when care involves multiple specialties, professions or sites).
4. **Medical Knowledge:** The practitioner must demonstrate knowledge about established and evolving biomedical, clinical, and cognate sciences and their application in patient care.
5. **Interpersonal and Communication Skills:** The practitioner must demonstrate skills that result in effective information exchange and teaming with patients, their families and professional associates (e.g. fostering a therapeutic relationship that is ethically sound, uses effective listening skills with non-verbal and verbal communication; working as both a team member and at times as a leader).
6. **Professionalism:** The practitioner must demonstrate a commitment to carrying out professional responsibilities, adherence to ethical principles and sensitivity to diverse patient populations.



Sample OPPE and FPPE indicators to show how a practitioner moves through the process.

Department	FPPE Initially Granted privileges when first credentialed	OPPE Indicators These are monitored on a regular basis	FPPE (Focused Review) These are trigger indicators that may be found during the OPPE monitoring that require further review
General Medicine	-Review of X number of charts and complete review form for each AND/OR -Review of X number of charts for adequacy of H&Ps and consultations reports in specific DRGs/diagnosis	-Length of Stay -MBQIP Core measures - Unplanned transfer to special care unit -Mortality rates	-Adverse Events unrelated to natural disease process -Patient/Staff concerns or complaints



Sample OPPE form

Provider Name / ID #:			**Department:**		
Review Period: Q1 Q2 Q3 Q4			**Section:**		
Activity Data (each line item if applicable)			**Data Collected by:**		
Total Inpatient Admissions			**Date of Completion:**		
Total Inpatient Discharges					
Total Patient Consults					
Total Patient Days					
Average LOS (all patients by this provider)					
PERFORMANCE DATA (5-10 reviews per quarter)	**Current Physician Performance (Data)**	**Peer Range (If applicable)**	**Expected Performance (Range)**	**Previous Performance**	
PATIENT CARE					
Delinquent Charts / Medical Records			< 50% of D/Cs		
"Do Not Use" Abbreviations			100%		
Timed Entry Compliance			100%		
Sentinel Events			0		
Prescribed Medication Errors			0		
Blood Utilization Criteria met			number met /		
MEDICAL CLINICAL KNOWLEDGE					
Peer Review Results: Level 2 and >			0		
Acute Out Transfer			≤ 10%		
PRACTICE BASED LEARNING & IMPROVEMENT					
Progress Notes Complete			100%		
Authentication of Orders: Date, Sign and Time			100%		
Time Out Performed (Pre-Procedure)			100%		
INTERPERSONAL / COMMUNICATION SKILLS /					
Patient Satisfaction			>95%		
Physician Behavior Incidents			0		
Employee Complaints			0		
Patient / Family Complaints			0		
SYSTEM-BASED PRACTICE					
Hand Hygiene			100%		
Number of Days on Medical Record Suspension List (12 Month Period)			0		

Method of Evaluation (Please Circle All Applicable)						**Expected Target Met** / **Follow / Up, Continue Monitoring** / **Below Expected Performance, Monitor Need for Focused Review**
Record Review	**Direct Observation**	**Patient/ Family Feedback**	**Monitoring of Diagnostic & Treatment Techniques**	**Other**		
Document Reviewed / Approved by Medical Director					**Signature:**	
Comments:						

FACTOR	EVALUATION C – Comments on pg 2			DATA SOURCE Check all applicable.
Professionalism	YES	NO	C	☐ Interdisciplinary team
10. Responsive, accountable, and committed to patients, the hospital, and the healthcare team.				☐ Chart review
11. Timely response to pages and/or phone messages from members of the healthcare team.				☐ Comments on file
12. Demonstrates ethical principles: provision/withholding of clinical care, confidentiality, informed consent, and clinical practices.				☐ Staff Verbalization
13. Issues regarding the practitioner's physical/mental ability to safely render care.				☐ Observation
				☐ Other:

14. Patient Satisfaction ☐ No comments on file ☐ Comments on file: Positive #_____ Negative # _____* ☐ Complaints* ☐ Trends*

15. Approximate Volume _____ Number of Mortalities _____ Average LOS _____ (days)

COMMENTS (Include factor #, as appropriate):_____

Assessment completed by: _____
Printed Name/Signature Title Date

Review performed when received by Medical Staff Services
Assessment reviewed by: _____
Department Chair/Division Chief Date

CMS Condition of Participation §482.22 Medical Staff

https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/som107ap_a_hospitals.pdf

Regulatory Compliance

Survey readiness may at first seem to be a daunting and unattainable quest. It is important to remember that no matter what accrediting agency you may work with, CMS has oversight and must sanction that agency. Multiple CAHs choose not to utilize an accrediting agency and utilize IDPH to achieve certification. Accrediting agencies are deemed by CMS to survey the organization; however, the state will conduct random validation surveys to conclude that the agency is effective. One of the benefits of utilizing an accrediting agency is that they offer resources, thus assisting in regulatory readiness.

Regulatory readiness is achieved by continual focus on maintaining the Conditions of Participation (CoPs) and other requirements of the accrediting agencies. Adherence to all CoP and regulations cannot be achieved by one department, nor can it be achieved quickly. Determine the organization's current survey readiness program and clarify the quality manager's role in the program.

Identify the regulatory bodies associated with the organization. Review and become familiar with the mandates of the regulatory bodies and CMS CoPs (link below). If the organization engages an accrediting agency, seek out their resources to assist in continual readiness.

In conclusion, it is our hope that this provides you with a brief overview of hospital quality. Below are other quality organizations and resources that may be beneficial to you. Do not forget to reach out to your peers and utilize the list serve as questions arise.

Resource Directory

State of Illinois Quality Resources				
Agency	Website	Who they are	What they do	Importance to CAHs
Illinois Critical Access Hospital Network (ICAHN)	https://icahn.org/	ICAHN is a non-profit organization that provides services to member organizations through partnership.	ICAHN strives to strengthen critical access and small, rural hospitals through collaboration.	ICAHN provides a vast amount of resources, collaboration, services, and education to CAHs.
Illinois Hospital Report Care, State of Illinois	http://www.healthcarereportcard.illinois.gov/	Illinois compiles this data for consumers to make informed choices and improve their healthcare selections.	Publish Illinois hospital data for consumer usage to determine cost and quality comparisons of health care provided in Illinois.	Publicly reported data on Illinois hospitals including volume and cost of services in hospitals and ambulatory surgery treatment centers, quality and safety data, nurse staffing data, patient satisfaction surveys, summaries and links to Illinois laws that ensure consumer protection.
National Quality Resources				
Centers for Medicare and Medicaid Services (CMS), Quality Initiatives	www.cms.hhs.gov	CMS plays a key role in the overall direction of the health care system.	CMS provides Conditions of Participation (COP) to all hospitals receiving Medicare and Medicaid reimbursement for services will receive reduced or no payment for hospital-acquired infections, conditions not present on admission, and never events (e.g. wrong side surgery).	Revenue. Hospitals submit CMS core measures quality data to receive payment based on performance of these measures. It's important to understand the criteria for CoP. The website contains an abundance of information to use as a resource and to answer questions regarding CoP.
Agency for Healthcare Research and Quality (AHRQ)	www.ahrq.org	AHRQ is part of the U.S. Department of Health and Human Services. AHRQ is charged with providing research on the nation's health care delivery system. AHRQ creates materials for teaching and training purposes to improve the quality of healthcare, reduce health expenditures, and reduce disparities.	AHRQ provides information for consumers, clinicians, payers, researchers, and policymakers. AHRQ publishes evidence-based clinical practice guidelines and the newest research findings. The agency is also a source for grants for research and information technology projects.	The website has comprehensive information and a helpful section on medical errors and patient safety. The evidence-based clinical guidelines are particularly useful when conducting process improvement.

		AHRQ generates and maintains data including the Consumer Assessment of Health Plans (CAHPS).		
Institute for Healthcare improvement	www.ihi.org	The Institute for Healthcare Improvement (IHI) is an independent, not-for-profit organization helping to lead the improvement of health care throughout the world.	IHI works with other quality organizations around the world to collaborate on initiatives and best practices.	Hospitals from around the world can participate in the collaboratives IHI has available. IHI Open School for Health Professions is another valuable IHI resource. This interprofessional educational community provides students the skills and knowledge to become change agents in health care improvement via online courses, case studies, and campus-based networks. IHI.org IHI's online resource contains a wealth of improvement knowledge and tools – available free of charge to anyone, anywhere whose aim is to improve health care.
National Association for Healthcare Quality (NAHQ)	www.nahq.org	NAHQ is the nation's leading organization for healthcare quality professionals.	NAHQ publishes the Journal for Healthcare Quality (JHQ), that is a professional forum that advances quality. It also provides various publications and products related to CQI, but with an emphasis on building continuous quality improvement in healthcare teams. NAHQ is the parent professional association of the Healthcare Quality Certification Board (HQCB) that administers the Certified Professional in Healthcare Quality (CPHQ) certification exam.	Quality improvement educational resources, quality foundation grants, and state quality associations.
National Committee for	www.ncqa.org	NCQA is an	This site identifies	Included in this site are reports

Quality Assurance (NCQA)		independent, non-profit organization who assesses and reports on the quality of managed care plans.	and explains the processes of accreditation and performance measurement, including the Health Plan Employer Data and Information Set (HEDIS) report card. HEDIS is the most widely used set of performance measures for analyzing the quality of managed care plans.	on quality, descriptions of quality measures, a list of NCQA-accredited managed care organizations, and separate sections with information dedicated to consumer, employer, provider, and government issues.
Institute of Medicine (IOM)	www.iom.org	IOM is part of the National Academy of Sciences that was created by the federal government to be an adviser on scientific and technological matters.	The IOM reports on quality in health care and are written by the Committee on Quality of Health Care in America, composed of representatives from every segment of the nation's health care industry. Some familiar reports include, *Crossing the quality chasm: A new health system for the 21st century* and *To err is human: Building a safer health system*	The IOM is considered a credible and reliable national resource for healthcare information. The IOM definition of quality is regarded as the gold standard, addressing six dimensions of care: safe, timely, effective, efficient, equitable and patient centered.
American Hospital Association Quality and Patient Safety	www.aha.org Need exact address for AHA Quality Center	AHA is the national organization that represents and serves all types of hospitals, health care networks, and their patients and communities.	AHA provides representation and advocacy activities, ensuring that members' perspectives and needs are heard and addressed in national health policy development, legislative and regulatory debates, and judicial matters.	The AHA Quality Center is a resource of the AHA to help hospitals accelerate their quality and performance improvement processes. It features tools, articles and other resources to support hospitals to achieve better patient outcomes, enhanced safety, increased satisfaction, as well as improved operational and financial performance.
Hospital Quality Alliance (HQA)	www.hospitalqualityalliance.org	The HQA is a national public-private collaboration. The organizations representing America's hospitals	HQA makes easily understood information about hospital performance accessible to the public through the	Hospital performance data can influence a patient's decision on where to receive care.

		joined with consumer representatives, physician and nursing organizations, employers, and payers, oversight organizations and government agencies to form the HQA.	Hospital Compare website www.hospitalcompare.hhs.gov. Hospital Compare contains performance information about more than 4,000 hospitals and data are updated quarterly. The HQA will continue to expand Hospital Compare to include additional measures that will help consumers assess hospital quality and value and make informed decisions about their care.	
National Patient Safety Foundation (NPSF)	www.npsf.org	The NPSF site is dedicated to all things "patient safety." Current patient safety research, forums, conferences, resources, and the Lucian Leape Institute are available on this site.	NPSF provides patient safety education resources, such as publications, yearly conferences, and forums. The site has resources for patients, as well as clinicians.	Patient safety list-serve, forums, resource library are all valuable education resources.
National Quality Forum (NQF)	www.qualityforum.org	NQF is an organization that sets national priorities and goals for performance improvement; endorses national consensus standards for measuring and publicly reporting on performance; and promotes attaining national goals through education and outreach programs.	The National Priorities Partnership is a collection of 32 organizations that have significant influence over healthcare. The Partnership has identified six priorities to target for the greatest impact on healthcare: patient and family engagement; population health; safety; care coordination; palliative and end-of-life care; and overuse.	Information on national healthcare quality efforts.

American Society for Quality (ASQ)	www.asq.org	ASQ is a global community of experts and the leading authority on quality in all fields, organizations, and industries.	ASQ provides resources, training, certification and networking opportunities to professionals in healthcare.	This site contains many valuable tools, definitions of quality, measurement and other resources.
Program for Evaluating Payment Patterns Electronic Report (PEPPER)	https://pepper.cbrpepper.org/Training-Resources/Critical-Access-Hospitals	Contracted with The Centers for Medicare & Medicaid Services to provide comparative data reports to providers and to Medicare Administrative Contractors in support of efforts to reduce Medicare fee-for-service improper payments.	PEPPER provides provider-specific Medicare data statistics for discharges/services vulnerable to improper payments. PEPPER can support a hospital or facility's compliance efforts by identifying where it is an outlier for these risk areas. This data can help identify both potential overpayments, as well as potential underpayments.	Resources to review and analyze your PEPPER reports.

Regulatory Body Resources				
Agency	Website	Who they are	What they do	Importance to CAHs
Centers for Medicare and Medicaid Services (CMS)	www.cms.hhs.gov	CMS plays a key role in the overall direction of the health care system.	CMS provides Conditions of Participation (CoP) to all hospitals receiving Medicare and Medicaid reimbursement for services.	The regulations and interpretive guidelines for hospitals manual above lists all CoPs for the hospital. These must be met as a minimum to maintain payment from CMS.
Illinois Department of Public Health (IDPH)	http://dph.illinois.gov/topics-services/health-care-regulation Hospital Administrative Code and Licensing Requirements http://www.ilga.gov	State oversite for the Office of Health Care Regulation.	Ensures Illinois facilities provide health care services in a clean and safe environment through licensing, inspection, and certification.	Illinois hospitals must be licensed and meet guidelines to receive payment for state Medicaid.

	/commission/jcar/admincode/077/07700250sections.html			
Joint Commission (TJC)	www.jointcommission.org	The Joint Commission is a nationally recognized accreditation agency for hospitals and other types of healthcare facilities.	Joint Commission develops evidence-based standards that are the basis of an objective evaluation process that can help health care organizations measure, assess, and improve performance. The standards focus on important patient, individual, or resident care and organization functions that are essential to providing safe, high quality care. The Joint standards set expectations for organization performance that are what they deem reasonable, achievable and surveyable. Joint Commission uses outcome and other performance measures to compile reports that are available to the public.	Hospitals may choose TJC as their accrediting agency.
Det Norke Veritas (DNV)	www.dnvaccreditation.com	A CMS-approved accreditation service that surveys annually and integrates ISO 9001 quality methods with Medicare CoPs. As a business entity, DNV Healthcare is a global, independent foundation whose purpose is safeguarding life, property, and the environment. DNV was established in	DNV's NIAHOSM hospital accreditation program provides hospitals with a survey process that integrates accreditation to standards that conforms to the COPs with ISO 9001 certification, the universally accepted international standard for a quality management	Hospitals may choose DNV as their accrediting agency.

		1864 in Oslo, Norway, and has been operating in the United States since 1898.	system. Surveys are annually, rather than every three years.	
Healthcare Facilities Accreditation Program (HFAP)	www.hfap.org	HFAP is authorized by CMS to survey all hospitals for compliance with the Medicare CoPs. They pride themselves on being user friendly, being educationally focused, and cost-effective.	HFAP's CAH program incorporates CMS Conditions of Participation for CAH's in its standards and surveys.	Hospitals may choose HFAP as their accrediting agency.

Sample Agendas

Board of Directors
Quality Committee Agenda

Friday, May 31, 2013
12:00 pm – Lower Level Conference Room

Lunch tickets will be distributed to go through the cafeteria line.

I. Call to order
* A. Approval of Minutes: May 15, 2013
* B. Enclosed: Hospital Quality Minutes – April 25, May 29, & June 21, 2013

II. Follow Up Business:
* A. Readmission Data – Summary
* 1. COMPDATA Preventable Readmission Report Set (PMH)

III. New Business:
* A. Prevention of Readmission Plan
* B. Comparative Quality "Core" Measure Rates *(2009-2012)*
* C. HQA Comparative Data *(4Q11-3Q12)*

IV. Other Business
A.

Next Committee Meeting: November 15, 2013
12:00 Noon – Lower Level Conference Room

INFECTION CONTROL COMMITTEE AGENDA

Friday, October 18, 2013– 8:00 a.m.

~~ 4th Floor Multipurpose Room ~~

I. Call to Order

* II. Approval of Minutes – August 16, 2013

III. Follow-up Business

A.

IV. New Business

* A. Surveillance Reports - (July/August) – Dr. [ ]

* B. Infection Control Activities - (July/August) – Ms. [ ]

1. CRE (Carbapenem Resistant Enterobacteriaceae) reporting
2. Pt Safety Goals—Update
3. West Nile Virus
4. Tdap shortage (Adacel, Boostrix—Tetanus/Diphtheria/Pertussis Vaccine)
5. * Influenza Vaccinations
6. Government shutdown—CDC, OSHA
7. Education

C. Hand Hygiene Report –

D. Sterilizer Monitoring Report – Ms. [ ]

E. Other Monitoring Activities – Ms. [ ]

E. Quality Improvement Tours – Ms. [ ]
(Purchasing, Dietary, Linen, OR, PACU, Anesthesia, SPD)

@ G. Policies – Ms. [ ]

1. Construction and Renovation
2. Surgical Wound Class
3. Glossary

H. Safety Committee / Incident Report – Ms. [ ]

I. New Products and Services

J. Other Business

V. Adjournment

Next meeting: December 16, 2013 – White Oak Classroom
(Note date and location change)

* Included in packet @ e-mailed # distributed at the meeting

SURGICAL & MEDICAL DEPARTMENTS MEETING AGENDA
Monday, July 15, 201X
7:30 am – WHITE OAK CLASSROOM – 3RD FLOOR

I. Call to Order – Dr. [ ], Chief of Staff
* A. Approval of Minutes – April 22, 2013

II. DEPARTMENT OF SURGERY – Dr. [ ], Chief of Surgery
* A. Surgical Indications Monitoring – Dr. [ ]
B. Morbidity & Mortality – Dr. [ ]
* C. OB/GYN – Dr. [ ]
D. Laboratory/Pathology Report – Dr. [ ]
* 1. Blood Usage Report
* 2. Hand Hygiene Report (1st Quarter 2013)
* E. Anesthesia Report –Dr. [ ]

III DEPARTMENT OF MEDICINE – Dr. Patel, Chief of Medicine
A. Morbidity & Mortality –Dr. [ ]
B. Medical Records Review - Dr. [ ]
* C. Emergency Department Report – Dr. [ ]
* D. Pharmacy & Therapeutics Report– Dr. [ ]
* E. Medical Rehabilitation Report – Dr. [ ]
* F. Radiology QA Report (1st Quarter 2013) – Dr. [ ]
* G. Utilization Review Report – [ ]
* H. Critical Care Minutes – Dr. [ ]

IV. FOLLOW-UP BUSINESS

V. NEW / OTHER BUSINESS
* A. Physician Scorecard – Ms. [ ]
B. Clinical Report – Ms. [ ]
C. President / CEO Report – Mr. [ ]
D. Other Business

VI. Adjournment/Next Meeting – **Monday, October 28, 2013**

201X Meeting Dates:

Quarterly Reports	Dept	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
Blood Utilization	Surg		X			X			X			X	
Respiratory Care	Surg		PRN			PRN			PRN			PRN	
Utilization Review	Med		X			X			X			X	
Physical Therapy	Med	X			X			X			X		
Pharm & Therapeutics	Med	X			X			X			X		
Radiology QA	Med	X			X			X			X		
Critical Care Report	Med	X						X					

* included in meeting packet # distributed at meeting

PHARMACY & THERAPEUTICS COMMITTEE AGENDA

Thursday, October 10, 2013 – 7:30 AM
Private Dining Room

I. Call to Meeting

* II. Approval of the Minutes – July 11, 2013

III. Follow-Up Business
- A.
- B.

IV. Quality Review (May - August 2013)
- * A. Pharmacist Interventions/Statistics
- * B. Medication Incidents
- * C. Adverse Drug Reactions
- D. Drug Formulary
  1. Delete:
  2. Addition:
- E. Drug Recalls

May (14) – 0 in stock
June (21) – 0 in stock
July (4) – 0 in stock
August (25) – 0 in stock

V. New Business
- * A. DUE:
- * B. ISMP Safety Alerts

VI. Other Business

VII. Adjournment/Next Meeting – **December 12, 2013** at 7:30 AM

* Enclosure # Will be brought to the meeting

Annual Review Schedule
- 1st Qtr: Medication Formulary; Therapeutic Interchange List
- 2nd Qtr: Floor Stock/Pyxis/Emergency Med List
- 4th Qtr: Policy & Procedure Manual (annual); Performance Improvement Plan

Sample Annual Reports to the Board

Table of Contents
(For further information contact the name in parenthesis)

I. INTRODUCTION

Group Health Generic Hospital utilizes a systematic, hospital wide, interdisciplinary approach for providing uncompromising, safe, quality care and services to patients through the implementation of the Hospital's Quality Management Plan. The primary objectives of this plan are to measure, monitor, analyze and continually improve health outcomes, while reducing risks to patients and ensure that corrective and preventative actions are taken.

The Quality Committee of the Group Health Board of Trustees delegates responsibility for quality and safety of care to the Hospital Administrator and Chief of Hospital Medical Staff. The Hospital Quality Committee oversees and directs the quality and safety of care provided.

This report provides a summary of performance and outcomes in 201X and plans for 201X.

Heading	Display/Data Collection	Responsible Person
Significant Events & Economic Factors		
• Admission growth/decline • Swing bed growth/decline • Outpatient registrations • Clinic growth • Any financing changes/loans/etc. • Any enhancements to Complex • Medicare patient make-up and volume • Charity write-off's • Commercial insurance growth/decline • Board Stressors	• Such as bad debt reduction	
Hospital Activity Analysis		
• Medicare/Medicaid/Ins/Prvt Pay/Admissions • Acute Care Avg Dly Census & LOS • Swing bed activity & Medicare Mix • ER Visits & Admissions	• Graph with trend line • Graph with trend line • Graph with trend line • Graph with trend line	
ER Activity by Acuity		
• Trend by Level 1-5 incl. % change • Observation & O/P Surgery Activity • Outpatient Activity* • Charge master report • Stats report IP/OP/Swing/HH/Aquatics • Top 10 surgeries IP/OP with volume • Any returns to surgery • Any new surgeons/physicians added/removed • Radiology • IP/Retail Pharmacy • Specialty Clinics • Family Practice Clinics	• Chart and paragraph description • Bar graph includes observation stays • Chart of year after year comparison • May consider adding concussion treatment program or school outreach • include dollars associated • Paragraph explaining trends/% growth/decline/any new testing • Paragraph description and chart comparison/additions/deletions to services • Paragraph description and chart comparison/new or deleted practitioners • Trend by physician/loss of #'s or $'s from satelitte offices/revenue by zip code/	

	year over year	
Revenue & Expense Analysis		
• Gross IP & OP Revenues by Payer	• Bar graph: Medicare,Medicaid, Insurance, Prvt Pay and % change • Chart comparing year over year IP & Swing Gross Revenue and by payer • Paragraph description of any net operating revenue changes and relations	
• Operating Expenses Trended % Change • Salaries & Benefits • Total Operating Expenses	• As per monthly report and year over year comparison • Incl. narrative description of changes	
• Grant Funding • Technology and Capital Improvements • Trended Audited Operating and Net Income Results	• Grant, amount, brief description • Line item dollars and short narrative if necessary • Would only look at few years of comparison unless relevant information	
• Chart Reviews • EMTALA • Transfer/Delays in Transfer	• From Quality/Risk: brief narrative and any findings of significance (one year summary) • # patients admitted to ED and transferred • Need to begin tracking stats of transfer for detail/narrative description • Have not started to trend	
Closed Chart Reviews		
• Timeliness of Records • Closed inpatient record review • Closed Swing Bed Record Review	Percent compliant for all	
Medication Errors		
• Current data collection (QHi/Compdata etc.) • CLABSI and CAUTI data • Skin Breakdown • IHA Project Participation • Discharge Planning • QI specific team projects • Quality Council	• May include a narrative for any/all graphs • Project participation and outcomes • Who attends council, structure, PI compliance by dept.	
• Patient Satisfaction • Hospital • NH • Daycare	Graphs and narrative	

• Clinics • By Dept		
• Policy & Procedure • Staff Education	Annual narrative summary from P&P Committee Mandatory versus non-mandatory Any vendors present to staff Annual education Overview of offerings throughout the year/clubs associated with/$ contributed Any community scholarships	
• Community Education/Giving	• Any community scholarships • Community giving events • Organization sponsorship	
HR		
• Employee Celebrations • Employee of the Month celebrations • Wellness accomplishments • New Hires • Turnover rates • Culture Changes • Employee Health • Diabetic Educator	• Trends of completion of new hires/any employees turned away? • Any trends/# clients IP/OP/Revenue?	
• Commons • Cafeteria	• Any trends/contribution to net income of operations/census • Meals at discounted rates	
Other		
• Daycare • Wellness • Nursing Home • Pain clinic	• Operation rev/loss; service to employees versus public • Rev/loss; number employees versus public; • Rev/loss; stats of residents/significant trends;	

Sample QAPI Plan

ANYWHERE Community Hospital

Organization-wide Quality Assessment and Performance Improvement Program

2019

Approved By:

<<Insert Facility Specific Committees>>

Medical Executive Committee

Board of Trustees

Formulated By:

Chief Quality Officer

Revision Dates

ANYWHERE Community Hospital

Organization-wide Quality Assessment and Improvement Program

2019

Table of Contents ***Page***

I. Mission and Vision

ANYWHERE Community Hospital
Mission Statement
EXAMPLE

ANYWHERE Community Hospital is dedicated to providing safe, quality, personalized, caring, and efficient service to its patients, with total satisfaction as top priority.

Vision Statement
EXAMPLE

Our vision is:

- To be seen by the community as the provider of choice for the services we provide;
- To expand our scope of services to meet the needs of the community and to provide for a culture of quality improvement and patient safety;
- To involve our employees, medical staff, and the community in decision-making and the direction of the hospital;
- That customer service and customer satisfaction is a top priority.

Values Statement
EXAMPLE

- We recognize the value of each employee in providing high quality, personalized care to our patients.
- We encourage employee involvement in quality improvement to improve processes on an ongoing basis. We advocate participation in community activities.
- We are committed to involving physicians in partnership, both as consumers of services and as providers in ensuring safe, quality care.
- We are devoted through services, quality, and innovation to providing continued health care leadership in the communities we serve. We are dedicated to compliance with all federal, state, and local laws, rules and regulations, including confidentiality of patient information.

II. INTRODUCTION:

A. Purpose

ANYWHERE Community Hospital is dedicated to meeting the needs of our patients in a manner which is consistent with our mission, vision and belief statements. The Organizational Quality Assessment and Performance Improvement plan is designed to provide a systematic and organized program for the promotion of safe, quality patient care and services. The plan outlines improvement principles, organizational structure and approach to continually strive toward our purpose of (1) doing the right things, (2) doing the right things well, and (3) continually improving. Activities are interdisciplinary and collaborative in order to respond to the needs of the customer, patient, physician, employee and community.

Through an interdisciplinary and integrated process, patient care and processes that affect patient care outcomes shall be continuously monitored and evaluated to promote optimal achievements, with appropriate accountability assumed by the Governing Board, Medical Staff, Administration, and support personnel.

B. Quality Definition

<<Insert Facility Specific >>

C. Quality Values

<<Insert Facility Specific >>

Our Quality Assumptions:

(1) The quality of a service or product is determined by a careful understanding of the needs & expectations of our customers.
(2) The improvement of the quality of a product or service is continuous.
(3) Quality Improvement involves every staff member in the organization.

D. GOALS

Goals of the Quality Improvement Program are as follows:

- To improve the quality, safety and reliability of patient care processes and outcomes.
- To promote patient safety by prevention and reduction of medical errors.
- To integrate the principles of high reliability into our quality structure and culture.

- Shift the primary focus from the performance of individuals to the performance of the organization's systems and processes, while continuing to recognize the importance of the individual competence of credentialed staff and other staff.

- To utilize internal and external customer feedback to improve the services necessary to excel in a competitive health care environment.

- To organize data into useful information, including comparison to internal and external data sources.

- To utilize external information sources representing "Best Practices" in the design of systems to improve patient outcomes and processes.

- To promote a culture of continual survey readiness.

- To enhance communication between the Medical Staff, Hospital Department/Services, and the Governing Body regarding the conclusions and recommendations resulting from data analysis and the actions taken to address the findings and recommendations.

E. Scope of Activities

The scope of the Organizational Quality Assessment and Performance Improvement Program encompasses measurement and assessment activities of the Medical Staff, Nursing and Ancillary or support services and includes every department and service of the hospital. Processes and outcomes of care are designed, measured and analyzed.

Quality Improvement activities will address both clinical and organizational functions. These activities are designed to assess key functions of patient care and to identify, study, and correct problems and improvement opportunities found in the processes of care delivery.

The Board of Trustees, Administration, Department Leaders and leaders of the organized Medical Staff regularly communicate with each other on issues of safety and quality.

III. Organization and Responsibilities of Leaders

A. Responsibilities

Participation in Quality Improvement activities are the responsibility of everyone employed by, on the medical staff of, or contracted with ANYWHERE Community Hospital. The organizational Plan for Quality is reviewed and approved annually by the <<Insert Facility Specific Committee(s)>>, MEC, and Governing Body.

Governing Board

The Governing Board shall be responsible to ensure the provision of optimal quality care, safety, and organization-wide performance. The Board is ultimately accountable for the safety and quality of patient care provided in every department and service of the hospital, and has legal responsibility and operational authority for hospital performance. While maintaining overall responsibility, the Board delegates operational responsibility to the Medical Staff and Administration. The Board shall facilitate Quality Improvement by:

1) The Governing Board authorizes the establishment of a committee structure to implement the QAPI Program. Attachment One: Committee Structure **<<Specific to your hospital>>**
2) Providing direction in setting performance improvement priorities based on our mission, vision, and strategic goals;
3) Establishing an organizational culture that supports a commitment to quality and patient safety;
4) Ensuring the quality program reflects the complexity of the hospital's organization and services;
5) Ensures the quality program is focused on metrics related to improved health outcomes and the prevention and reduction of medical errors;
6) Approve the QAPI Plan;
7) Providing adequate resources, both material and manpower, to accomplish the QAPI function;
8) Receives reports of QAPI data from all departments and services of the hospital including those provided through contracts;
9) Reviewing, accepting or rejecting periodic action plans based on findings, actions, and results of program activities regarding the effectiveness of organization-wide quality and safety activities;
10) Evaluating on an annual basis, the effectiveness of the quality program, and if necessary, require modification to organizational structure and systems to improve outcomes;
11) Require a process designed to assure that all individuals responsible for the treatment and/or care of patients, whether provided through internal mechanisms or contracted services, are competent.
12) Specifies the detail and frequency of data collection;
13) Annually, reviews a written report on the results of any analyses related to the adequacy of staffing and any actions taken to resolve identified problems.
14) To provide a mechanism in which the Chief of the Medical Staff (the individual assigned the responsibility for the organization and conduct of the hospital's medical staff) / designee to consult no less than twice per calendar year with the Board of Trustees regarding the quality of care provided to the patients of the hospital.

Medical Executive Committee (MEC) and the Organized Medical Staff

The Medical Executive Committee, accountable to the Board, has the primary authority for activities related to self-governance of the medical staff and for performance improvement of the professional services provided by licensed independent practitioners and other practitioners privileged through the medical staff process. The MEC makes recommendations directly to the governing body based on the conclusions of the MEC's review of QAPI reports from medical staff committees, departments, and other assigned activity groups.

The organized medical staff provides leadership for measuring, assessing, and improving processes that primarily depend on the activities of one or more licensed independent practitioners, and other practitioners credentialed and privileged through the medical staff process. The MEC is responsible for review of findings of the assessment process that are relevant to an individual's performance; Focused Professional Practice Evaluation (FPPE) and Ongoing Professional Practice Evaluation (OPPE). The medical staff is actively involved in the measurement, assessment, and improvement of the following:

Data on individual practitioners as well as aggregated data for:

The quality of Histories and Physicals
Medical assessment and treatment of patients
Appropriateness of clinical practice patterns including significant departures from established patterns of clinical practice
Unexpected Complications Review
Medication Use Monitoring
Accurate, timely, and legible completion of patient's medical records
Blood / Blood Component Usage Review
Mortality / Autopsy Review
The use of developed criteria for autopsies
Operative / Invasive Procedure and Anesthesia Review
Risk Management / FMEA
Sentinel/ Serious Safety Event
Patient Safety including safe opioid prescribing

Infection Control

Utilization Management
Publicly reported metrics/data

The organized medical staff:

- Participates in developing specific indicators to systematically evaluate practitioner care. This may be accomplished by individual medical staff departments or medical staff committees and are approved by the MEC.

- Identifies and analyzes problems and opportunities, recommends actions to the MEC and monitors the effect of the actions taken to determine that problems have been resolved.

- Monitors the appropriateness of clinical practice patterns and significant departures from established patterns of clinical practice;

- Reports Medical Staff QAPI results through the QAPI Committee structure to the MEC and Board by way of written reports and summaries.

Senior Leadership

Senior leadership supports the maintenance of the QAPI process through allocation of staff and resources necessary to fulfill the requirements of the program. Leaders also:

- Analyze data and information in decision-making that supports the safety and quality of care;

- Perform evaluations of clinically contracted services in collaboration with the respective department director and reporting the results of the evaluation through the QAPI Committee structure to the Medical Executive Committee and the Board;

- Regularly evaluate the culture of safety and quality using valid and reliable tools.

- Ensures the participation of appropriate staff members and all departments and services in the program through collaborative monitoring and evaluation of patient outcomes and important functions through the QAPI Committee structure.

Quality and Regulatory Compliance

The Quality and Regulatory Compliance department shall be responsible to support the organization's Quality Improvement principles, strategies, priorities, approach, and methodologies, which includes but is not limited to the following tasks:

1) Working with the Medical Staff, and all hospital departments/services, and teams to effectively measure, assess, analyze, and improve the quality and safety of care and services.
2) Coordinate Quality Improvement orientation, education and training.
3) Facilitate and support Quality Improvement teams.
4) Coordinate survey preparations and facilitate a culture of continual survey readiness.
5) Maintain the database for all QAPI activities including quality improvement teams, departmental quality measures, medical staff quality and peer review activities.
6) Works with the Medical Staff Leadership and hospital leadership to prepare an annual organization-wide evaluation of the Quality Program.
7) Facilitates communication of quality improvement activities throughout the organization and the QAPI committee structure to the MEC, Medical Staff and Board at the frequency specified by the Governing Board.
8) Works closely with Risk Management to monitor/analyze serious safety events and/or sentinel events and promote patient safety.
9) Works with the Medical Staff and hospital leadership to select meaningful quality measures that address the needs of the patients it serves.
10) Provides reports using statistical tools & techniques to analyze and display data.
11) Compares internal data over time to identify patterns, trends and variations.
12) Compares data with external sources.

Hospital Departments

The Department Leaders are accountable for the quality and safety of care/services and performance of their staff and departments. Department Directors and Managers are responsible for the systematic monitoring and analysis of the quality and safety of care provided in their departments. Directors will:

- ❑ Communicate opportunities for improvement for prioritization.
- ❑ Promote the development of standards of care and criteria to objectively measure the quality and safety of care/services rendered in their departments.
- ❑ Monitor, analyze and report the processes in their areas that affect patient care, safety, outcomes and satisfaction.
- ❑ Design and redesign work processes to improve safety and quality.
- ❑ Participate in the evaluation of the performance of contracted services.
- ❑ Participate in quality improvement teams.
- ❑ Report QAPI data and actions taken as appropriate.
- ❑ Communicate the status of departmental quality, patient safety, and survey readiness initiatives regularly to departmental staff members.

<< Insert Facility Specific Committee, e.g. Quality Improvement Council>>

<<Insert Facility Specific>> is the hospital-based multidisciplinary body or senior leadership committee>> that serves to coordinate organizational quality improvement activities. Membership includes <<Insert Facility Specific>> e.g. *but is not limited to representatives from both clinical and non-clinical areas including the Medical Staff, Senior leadership (CEO, CNO, CQO, CFO), Quality Coordinator, Risk Management/Patient Safety Officer and other clinical and non-clinical staff as appropriate on an ad hoc basis.* Council meetings are scheduled <<Insert Facility Specific>>. Activities include but are not limited to:

1) Assist the Governing Board and MEC with development and evaluations of the Quality Improvement Plan
2) Considers the setting, scope and services provided and selects meaningful measures addressing the needs of the patients served
3) Assist the Governing Board and MEC with setting priorities for ongoing measurement of important processes
4) Evaluating the need to reprioritize improvement activities in response to unusual or urgent events identified through measurement and/or changes in the environment of care or community
5) Receive and review reports regarding the effectiveness of organization-wide QAPI activities
6) Review new service proposals ensuring appropriate quality measures are established
7) Analyze and identify trends or patterns that might suggest an improvement opportunity
8) Compare data with external sources when available
9) Review and act upon Opportunity/Process Improvement Referrals
10) Support quality improvement teams, acting upon their recommendations
11) Convening multidisciplinary QI teams for specific improvement efforts, some of which may be triggered by the results of ongoing measurement and/or customer feedback
12) Communicating relevant activities, as necessary, throughout the organization
13) Review Customer Service Surveys, QI Teams, Risk Management, Hospital Committees, Resource Management reports and other executive level data/information impacting organization quality and safety
14) Assist the Governing Board and MEC with evaluating the effectiveness of the QAPI activities of the hospital departments / services and teams
15) Integrate findings and outcomes of reviews conducted by the Medical Staff that identify systems process issues
16) Determine the education and training needs of the organization related to Quality Improvement
17) Assist the Governing Board and MEC with evaluating and validating corrective action has resulted in improvement
18) Reporting to the Medical Staff and Board of Trustees
19) Maintain a permanent record of council proceedings

Quality and Patient Safety Integration

It is essential the Patient Safety Program and Quality Assessment and Performance Improvement Program are integrated to assure the flow of information to the appropriate areas for review, action, and/or follow-up. The Quality and Risk Management programs seek to reduce the frequency and severity of adverse events, thus minimizing loss and contributing to Quality Improvement through risk identification, evaluation, control and education. The Chief Quality Officer and << Insert Facility Specific; e.g. Risk Manager and/or Patient Safety Officer>> both identify conditions/significant events which could or have caused injury or loss; will monitor resolution of risk-related problems; plan/provide appropriate education to employees, Medical Staff, Governing Body and interact with the Medical Staff Administration; Nursing and Clinical Services.

Risk Management analysis of Safety Events includes the adequacy of staffing, including nurse staffing. The adequacy of staffing includes the number, skill mix and competency of staff.

Annually provides a written report to the Governing Board on the results of any analyses related to the adequacy of staffing and any actions taken to resolve identified problems.

The << Insert Facility Specific; e.g. Risk Manager and/or Patient Safety Officer>> attend(s) the <<Insert Facility Specific; e.g. Quality Improvement Council >> and provide reports Risk Management reports as specified by the Governing Board.

B. Establishing Priorities for Quality Improvement

Priorities for Quality Improvement shall be established collaboratively by the Board, Senior Leadership and Medical Staff Leadership. The following criteria will be considered in establishing priorities:

- ❑ Mission, Vision and Values
- ❑ Strategic Plan, Community needs
- ❑ Needs and expectations of patients and families and other customers
- ❑ Input from Medical Staff and Employees
- ❑ High Volume diagnoses/procedures/processes
- ❑ High Risk diagnoses/procedures/processes
- ❑ High cost diagnoses/procedures/processes
- ❑ Problem prone procedures/processes
- ❑ Input from external sources (licensing, regulatory agencies)
- ❑ Clinical competency and training needs
- ❑ Resources required to make the improvement, both human and material
- ❑ Priority Scoring Grid Tool (Attachment Two)

Prioritization

The << Insert Facility Specific; e.g. Quality Improvement Council>> will oversee the setting of priorities for quality improvement activities. Items/topics will be evaluated by the Committee utilizing the priority scoring grid. (Attachment Two). The committee will evaluate the combined scores of each opportunity prioritized and take appropriate actions using the following guide:

Score	Potential Council Decisions
0 – 10	Trend data
11 – 24	Refer to Department Chairperson or Manager for action
25-34	Refer to Administration
35-45	Possible Improvement Team or other single action
Over 45	Required Quality Improvement Team

Reprioritization

Quality Improvement activities may be re-prioritized by the committee based on needs and resources. Issues may be reprioritized in response to sentinel/serious safety events identified, through quality indicators tracking and trending, unanticipated adverse occurrences affecting patients, changes in regulatory requirement, changes in patient population, in the environment of care, and/or changes in the expectations or needs of patients, staff or the community.

Reporting

The << Insert Facility Specific; e.g. Quality Council>> reports the results of monitoring activities and the improvement action plans as appropriate to the Medical Executive Committee and Governing Board at the frequency specified by the Governing Board.

C. QUALITY IMPROVEMENT TEAMS

Composition:

Teams are made up of individuals with expertise relating to the processes of care being evaluated. *(Refer to "Guidelines for Quality Improvement Teams" manual).*

Activating a Team

Any employee or Medical Staff member may forward a request for a team to the << Insert Facility Specific; e.g. Quality Improvement Council>>. Each referral will be evaluated and prioritized by the committee or a sub-committee as assigned. If the problem/process involves more than one department, the committee may authorize the formation of the Team, and assign a Team Leader. If the problem/process affects a single department, the committee will forward the referral to a single department for intra-departmental team development. It is imperative that departmental leadership allow staff member(s) time to participate in order for the team to be successful.

IV. Design – Quality Methodology

A. Methodology

The <<Insert Facility Specific>> model/process for performance improvement is utilized as the methodical approach to Quality Assessment and Performance Improvement initiatives.

B. Measure

The monitoring and analysis process will include at least the following activities:

- Core Measures and other Value-Based Purchasing (VBP) metrics
- The use of blood and blood components
- All reported and confirmed transfusion reactions
- Medication Management System
- Significant medication errors
- Significant adverse drug reactions
- Antimicrobial Stewardship data
- Processes related to the National Patient Safety Goals
- Organ Procurement conversion rate data as provided by the OPO
- Morbidity and Mortality
- Operative and Invasive Procedures
- Anesthesia Use
- Significant discrepancies between preoperative and postoperative diagnoses, including pathologic diagnoses

- Medical Record Completion & Timeliness
- Quality of H&Ps
- Infection Control Data (including Surveillance and goals)
- Utilization Review
- Patient perception of the safety & quality of care, treatment or services
- Use of the medical staff approved criteria for autopsy and autopsy review
- Risk Management/Patient Safety data and reports, including the effectiveness of fall reduction activities
- Restraint Use
- Comparison of hospital performance through reference databases
- Analyzing and responding to reports of surveys, assessments, licensing, regulatory, and reimbursement authorities
- Evaluation of the needs, expectations, and satisfaction of patients, physicians, employees
- Staff willingness to report adverse events and suggestions for improving patient safety & quality of care
- The results of resuscitation and Rapid Response Processes
- Grievances and Complaints
- Evaluation of processes in response to Patient Safety Alerts from internal or external sources
- Evaluation of processes in response to The Joint Commission Sentinel Event Alerts
- The results of any analyses related to the adequacy of staffing and any actions taken to resolve identified problems.
- Evaluation & improvement of the Environment of Care
- Infection Prevention
- Review and analysis of incidents where the radiation dose index (Computed Tomography Dose Index), dose length product, or size-specific dose estimate from diagnostic CT exams exceeded expected dose index ranges identified in imaging protocols. These incidents are then compared to external benchmarks.
- Patient thermal injuries that occur during magnetic resonance imaging exams. - Incidents where ferromagnetic objects unintentionally entered the magnetic resonance imaging (MRI) scanning Room
- Injuries resulting from the presence of ferromagnetic objects in the MRI scanner room
- fluoroscopic instances where the radiation exposure and skin dose threshold levels identified
- Pain management including safe opioid prescribing
- Quality Control monitoring
- Processes related to ongoing professional practice evaluation and focused professional practice evaluation
- Departmental / Service QAPI from all departments and services of the hospital

The hospital will conduct a root cause analysis, and other investigations as appropriate, in response to a sentinel event, serious safety event or significant near miss. The root cause analysis involves an internal investigation and assessment of the sentinel event to reduce variations and prevent the event from recurring in the future.

Design of New Processes

When it is established that there is a need or opportunity to initiate a new service, extend product lines, occupy a new facility, or significantly change existing functions or processes, the design will be based upon the organization's mission, vision and plans. The needs of the patients, staff, and all who use this service will be considered and up-to-date sources of information shall be used to design the process or service.

Quality Measures

Measures for periodic assessment and improvement arise from Employees, Leadership Group, Medical Staff and other sources. Important functions and processes of care are selected on the basis of which most significantly impact patient care. These may be included, but not limited to the following:

- ❑ Problem Prone/High Risk/Volume Processes
- ❑ Utilization Review and Risk management findings
- ❑ Results of ongoing activities designed to control and prevent infections
- ❑ Patient Safety and the reduction of medical errors
- ❑ Importance to patient/customer

Data Collection

The staff collects, organizes and analyzes data necessary to determine root causes, track performance, benchmarking, etc. Data is organized in such a manner as to facilitate comparison and trends. The data collection is conducted in a timely and efficient manner. Statistical techniques and data displaying "tools" will be utilized. Tools may include but are not limited to: charts and graphs, Run Charts, Histograms, Pareto Charts, Flow Charts, Cause and Effect diagrams (Fishbone Diagrams), Control Charts, etc.

Frequency of Data Collection

The frequency of data collection and measurement is related to:

1) The frequency of the event (affect a large percentage of patients)
2) Problem prone processes
3) The significance of the event or process monitored:

    a) What the leaders view as most important
    b) The extent to which the important aspect of care, processes, and outcomes monitored has been demonstrated to meet expectation or be problem free
    c) Customer satisfaction responses to measure the extent that the organization meets the needs and expectation of patients/families
    d) Priority issues and adverse/significant events may require more detail and frequency of measurement activities.

The Governing Body specifies the frequency and detail of data collection.

Sample Size

When sampling is appropriate, the representative sample number is determined by the situation or process under review, i.e. intensive review vs. random review. The below illustration is also recommended as a guide for sample size:

- For a population size of fewer than 30 cases, sample 100% of available cases.
- For a population size of 30 to 100 cases, sample 30 cases.
- For a population size of 101 to 500 cases, sample 50 cases.
- For a population size greater than 500 cases, sample 70 cases.

A *case* refers to a single instance in which a situation related to a survey finding occurs.

Population size totals may be interpreted as "annually" unless otherwise specified.

C. IMPROVE

Improvement opportunities are identified by departmental and organizational QI activities, customer satisfaction surveys, sentinel/serious safety events, hospital/medical staff committees, opportunity for improvement forms and through formal and informal networking of all Employees.

Appropriate action will be recommended and implemented to eliminate or reduce variations identified or to improve quality of care. Multidisciplinary QI Teams will be initiated at the direction of the <<Insert Facility Specific, e.g. Quality Improvement Council>> to address identified opportunities.

Re-design/Design of Improvement Initiatives (Re-Assessment Process)

The effectiveness of any action taken is assessed and documented. Periodic monitoring of the results of correction action, including re-design of processes, will be conducted to make sure that any problems identified have been alleviated or eliminated and the improvement sustained. Any design/re-design initiative(s) will be evaluated for their effectiveness. If the specific area does not show improvement, new actions/design will be taken and, once again, the effectiveness will be assessed.

Communication and Reporting

To coordinate the quality improvement activities throughout the organization, the Chief Quality Officer/Quality Director will receive and have access to all QI information. Department leaders will communicate their quality activities and performance to their Employees, to the Senior Leader to whom they report, and/or to the Quality Coordinator using the approved reporting forms and format. Measurement and assessment activities are reported to the <<Insert Facility Specific Committee, e.g. Quality Improvement Council>>, Medical Executive Committee, and to the Governing Board at the frequency specified by the Board
Feedback from organizational QAPI activities is provided at Leadership group meetings, in departmental staff meetings, hospital newsletters and between the Medical Executive Committee and Board as appropriate.

VI. Staff Development/Education

Staff will be introduced to Quality Assessment and Performance Improvement concepts and objectives during new Employee orientation, department staff meetings, hospital publications and in-services as needed. Employees are encouraged to participate in the team process which provides additional "just in time" training.

VII. Annual Program Evaluation

The effectiveness of the Quality Assessment and Performance Improvement Program is evaluated annually and revised as necessary by department leaders, <<Insert Hospital Specific Committees the MEC, and Board of Trustees.

VIII. Conflict of Interest

The Hospital manages conflict between leadership groups to protect the quality and safety of care.

IX. Confidentiality

Confidentiality shall be maintained, based on full respect of the patient's right to privacy and in keeping with Hospital Policy and State and Federal Regulations governing the confidentiality of quality improvement work products.

X. Retention of Records

All minutes of meetings are maintained as defined in the Record Retention policy either in their original form or electronically. Cumulative quality improvement activity reports are maintained for three years either in their original form, or electronically.

APPROVAL:

Chief Quality Officer	Date
Chair, <<Insert Facility Specific, e.g. Quality Improvement Council >>	Date
CEO	Date
Chief of Staff	Date
Chairman, Board of Trustees	Date

XII. APPENDICES

A. QAPI Model (i.e. PDCA, IDEA Cycle or other Performance Improvement Model)
B. Opportunity Referral System
   Opportunity Referral Form
C. Committee Structure
   Flow of Information
D. Priority Scoring Grid
   Team Assignment Form, Charter Team Form, Interim Team Report, Team Final Report

OTHER:

Peer Review Appendix D to the Medical Staff Bylaws
External Peer Review
Pathology Peer Review
Radiology Peer Review
Medical Record Review
    Sample Medical Record Review Form
Medication Use Review (Includes Antimicrobial Stewardship)
    Sample MUE Report
Operative/Invasive Procedure Review
    Sample Review Calendar
    Sample Review Tool
Mortality / Autopsy Review
    Sample Review Tool
Blood Usage Review
    Sample Blood Products Review Form
    Sample Monitoring Tool

Sample IDEA performance improvement tool

IDEA Performance Improvement Report - 2014

(DEPARTMENT NAME)

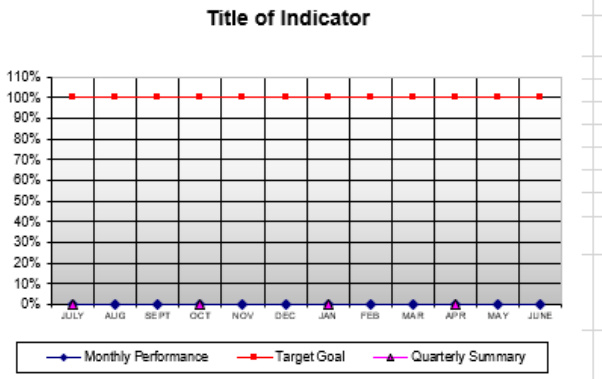
Director/Manager Name

I - Identify Opportunity for Improvement - What is the Performance Improvement Goal:

Performance Improvement Goal

Improvement Opportunity: The focus is on: *explain what you are monitoring*

Data Collection Methodology: *Describe the method you are using to collect your data.*



		JULY	AUG	SEPT	OCT	NOV	DEC	JAN	FEB	MAR	APR	MAY	JUNE
Denominator	Number of (fill in denominator)												
Numerator	Number of (fill in numerator)												
Percentage	Percent of (fill in numerator)												
Target Goal	(Change target goal if needed)	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
Quarter Summary		Qtr 1			Qtr 2			Qtr 3			Qtr 4		

	D - Determine Causes **Summary of Findings - Analysis of Data**	*E - Explore Solutions A - Activate Action Plan for Improvement* **What's Being Done - Action to Improve Performance By Whom and By When**
Quarter 1:	Explain your findings of the quarterly data collection for the 1st quarter.	Now you've identified an issue in the 1st quarter data what action are you taking to address this problem; who will be responsible to address the action and when is the action due to
Quarter 2:	Explain your findings of the quarterly data collection for the 2nd quarter.	Again, now you've identified an issue in the 2nd quarter data what action are you taking to address this problem; who will be responsible to address the action and when is the action due to
Quarter 3:	Explain your findings of the quarterly data collection for the 3rd quarter.	Again, now you've identified an issue in the 3rd quarter data what action are you taking to address this problem; who will be responsible to address the action and when is the action due to
Quarter 4:	Explain your findings of the quarterly data collection for the 4th quarter.	Again, now you've identified an issue in the 4th quarter data what action are you taking to address this problem; who will be responsible to address the action and when is the action due to

Director's Annual Performance Summary: *(Describe the PI indicator you were monitoring, a summary analysis of how well you performed in meeting your goals, activities you implemented to make improvements, follow up activities you will continue to implement and the PI indicators you will be working on next year)*

CRITICAL ACCESS HOSPITAL QUALITY MANUAL AND RESOURCES REQUEST FOR UPDATE

Instructions

Please complete this form and email it to acharlet@icahn.org

Update/Additional information Request

Section to update:	
Page Number:	
Update requested:	
Supporting information:	

Name/email of requester	

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