ALASKA NATIVE MEDICAL CENTER

ANMC Quality Assessment Performance Improvement (QAPI) Plan

FY 2022

Created/Approved Feb 2018; Revised Oct 2021; Approved at CQC Oct 2021, EMT Oct 2021, JOB Oct 2021

I. Design and Scope

Purpose

The Alaska Native Medical Center (ANMC)[1] demonstrates a systematic, organization-wide approach to provide comprehensive quality care and services to patients through its Quality Assessment Performance Improvement (QAPI) Plan. This plan identifies the structure and processes that ANMC utilizes to systematically monitor quality of care, identify opportunities for performance improvement, and prioritize initiatives to improve patient outcomes and delivery of services.

Our Mission:

The Alaska Native Medical Center fulfills the mission and vision of the Alaska Native Tribal Health Consortium (ANTHC) and Southcentral Foundation (SCF) by working together with the Native community to achieve wellness by providing the highest quality health services for all Alaska Natives.

Guiding Principles

QAPI principles drive the decision-making within our organization. The QAPI Plan utilizes a systematic, coordinated, continuous approach to process design, performance measure analysis and improvements focused on:

- Appropriateness of care (evidence-based/right care)
- Effectiveness of care (clinical outcomes)
- Patient safety
- Patient and customer satisfaction
- Flow (wait times, cycle times and throughput)
- Community/Population Health (health status)
- Financial (margin/operating indicators)

Scope

QAPI activities are integrated across all care and service areas at ANMC. The ANMC QAPI Plan involves providers, nurses, allied health disciplines, community service agencies, leadership, managers, and staff that provide care to the individuals of our community. The plan focuses on improving key patient care and organizational functions within the services offered on the accredited campus.

II. Governance and Leadership

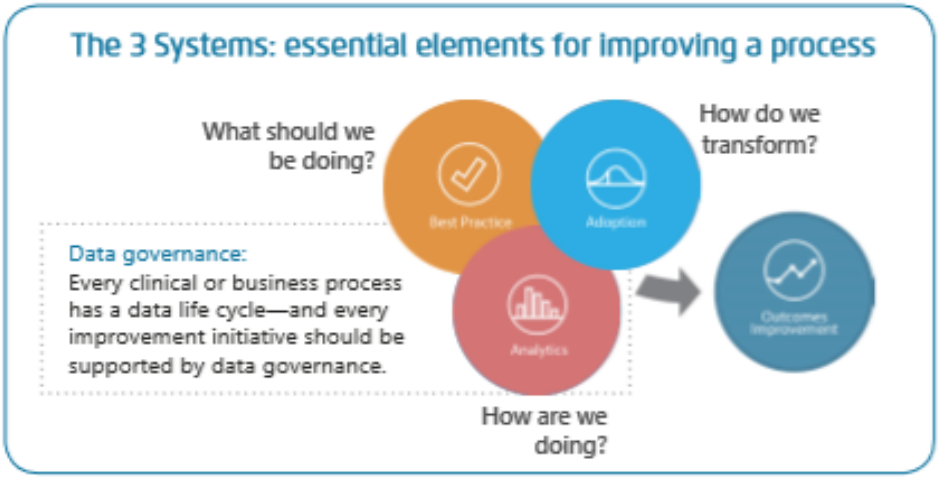
QAPI Plan Structure

The ANMC Joint Operating Board (JOB) has ultimate authority, responsibility and accountability for the quality of care and performance of the organization, managed jointly by ANTHC and SCF. These parent organizations have established a JOB to ensure unified operation of health services provided by the Medical Center. The JOB oversees quality at ANMC, working with their respective boards for strategy development and deployment.

[1] The Alaska Native Tribal Health Consortium and Southcentral Foundation jointly own and manage the Alaska Native Medical Center under the terms of Public Law 105-83. These parent organizations have established a Joint Operating Board to ensure unified operation of health services provided by the Medical Center.

The JOB delegates authority and responsibility for all matters relative to the QAPI to the Executive Management Team (EMT) and the Medical Executive Committee (MEC). EMT has assigned primary responsibility for the operations of the QAPI to the Clinical Quality Council (CQC). CQC, in collaboration with EMT and MEC, set priorities for performance improvements and coordinate with the appropriate oversight group on the frequency of data collection. Multiple committees, including the Clinical Core Business Groups (CCBGs) monitor and improve performance and report to the CQC. These committees enable ANMC to improve quality of care, and processes in order to produce results consistent with the mission. ANMC uses a three system framework that is essential for improving processes. This system outlines questions geared towards identifying areas of improvement. The questions are:

- What should we be doing?
- How do we transform?
- How are we doing?



Committee Structure for Clinical Quality at ANMC (See Attachment A)

Joint Operating Board (JOB)

- Provides leadership, guidance, authority, and accountability for the QAPI Plan.
- Ensures that resources (funding and personnel) are dedicated to the QAPI Plan.
- Reviews QAPI Plan indicators, results of data collection and analysis, and QAPI projects.
- Makes policy decisions and reviews and evaluates the annual results of the QAPI activities.
- Approves the QAPI Policies and Procedures and the Annual QAPI Plan.

JOB meetings are held at least quarterly. Discussions and decisions at the JOB are peer-review protected and not subject to disclosure to any individual or group within or outside ANMC without the permission of the Board Chairman.

Joint Conference Committee (JCC)

Interdisciplinary committee of the JOB that reviews ANMC quality and accreditation information. The JCC serves as the principal committee for dialogue and action planning between the ANMC JOB, the Medical Staff and ANMC Administration regarding the philosophy, nature and scope of services to be provided by and throughout ANMC. This committee convenes at least quarterly.

Executive Management Team (EMT)

Executive team responsible for the coordination of activities across the ANMC campus. This group meets at least monthly and promotes organizational values, sets high-performance expectations, and promotes the organization-wide focus on patients, customers, employee empowerment, learning and innovation. Some of the EMT duties related to QAPI include:

- Communicate and reinforce clear values and performance expectations.
- Review organizational performance and capabilities, competitiveness, progress relative to goals and setting priorities for improvement.
- Ensure regulatory and other legal requirements in areas such as safety, environmental protection, and waste management; anticipating public concerns and addressing risks to the public; and ensuring ethical business practices.
- Monitor the ongoing performance of the organization and the results of operations.
- Review all reports destined for the JOB and respective subcommittees, with the exception of the medical staff and nursing shared governance reports.

Medical Executive Committee (MEC)

Cohesive body comprised of qualified providers who deliver services at ANMC. The MEC's purpose is to further the mission of ANMC, promote wellness, provide the highest quality care for the patients of ANMC and carry out the responsibilities delegated to it by the JOB. In keeping with this purpose, the medical staff is responsible to the JOB to recommend procedures, rules and regulations necessary to assure the adequacy and quality of the medical care rendered to the patients of ANMC, and to this end offer advice, recommendations, and input to the Administration and EMT as defined in the ANMC Policy on Committees, JCC, and the JOB.

MEC duties related to QAPI include:

- Receive and, as appropriate, act upon reports and recommendations concerning patient care quality and appropriateness of reviews, evaluation and monitoring functions; discharge of any delegated administrative responsibilities; and recommend to the JOB specific plans and systems to implement quality and credentialing functions performed by the medical staff.
- Be accountable to the JOB and to the medical staff for the overall quality and efficiency of care at ANMC and participate in ANMC performance improvement activities.
- Take reasonable steps to encourage professionally ethical conduct and competent clinical performance on the part of Medical Staff members, including conducting investigations under the Medical Staff Bylaws and associated manuals where corrective action is warranted.

The MEC meets once a month or at the discretion of the committee chair and membership. Minutes of all meetings will be recorded and available in the ANMC Medical Staff Office.

Clinical Quality Council (CQC)

Interdisciplinary committee that provides a forum for coordination and alignment of all ANMC clinical quality activities. It reports to the EMT, JCC and JOB. CQC collaborates with MEC and jointly reviews quality data or processes that are relevant to both committees. The CQC is co-chaired by the Chief Medical Officer and the Medical Director of Quality Assurance. The CQC includes campus-wide representation, provides for the coordination and alignment of clinical quality activities and receives reports from all Clinical Core

Business Groups (CCBGs), as well as other designated workgroups. The CQC identifies performance gaps and has the authority to charter interdisciplinary teams to address system-wide improvements.

Meetings occur monthly or at the discretion of the committee co-chairs and membership. The CQC minutes are peer-review protected and not subject to disclosure to any individual or group within or outside ANMC without the permission of the ANMC Hospital Administrator.

Clinical Core Business Groups (CCBGs)

Interdisciplinary quality improvement is addressed through Clinical Core Business Groups (CCBGs). The primary focus of the CCBGs is to identify opportunities for improvement in patient care and process, organize efforts to improve and receive reports on the progress of improvement projects, and lead clinical improvement initiatives that involve more than one department or service line. The majority of the meeting agenda is devoted to reviewing reports on progress and discussing strategies to accelerate improvement projects and improve overall performance indicators.

Other Resources

Vice President (VP) of Quality and Director of Quality Assurance
The VP of Quality reports to the Chief Medical Officer. The Director of Quality Assurance reports to the VP of Organizational Development and Innovation. The operational responsibilities include but are not be limited to:

- Identification of opportunities for improvement in the delivery of care and service to ANMC patients.
- Provide direction to staff on quality issues.
- Review of all quality-of-care complaints.
- Responsibility for the monitoring and evaluation activities associated with the quality focus areas.
- Provide guidance regarding performance improvement projects.
- Communicate the organization's QAPI activities to EMT and JOB through regular reporting, as illustrated on the Committee Structure for Clinical Quality (Attachment A)
- Serve as a liaison for accreditation or regulatory organizations.

III. Feedback, Data Systems and Monitoring

ANMC has several systems in place to monitor care and services and provide feedback, drawing data from multiple sources. Data collection and reporting is crucial to the monitoring and evaluation of the quality of care and services delivered throughout ANMC. The source for the majority of data used for QAPI is the Electronic Health Record (EHR). Other data collection and reporting tools are also used. The ability to design statistically valid and reliable quality outcome measures is provided through the analytical support of Quality staff and other support resources as deemed necessary.

ANMC uses evidence-based data to benchmark, establish goals and define measurements for improvement. When establishing goals, defining measurements and choosing interventions, evidence-based practices and guidelines are used to drive decision-making.

Fair and Just Culture

ANMC is a learning environment. We believe in the practices and principles of a fair and just culture. Staff are encouraged to bring concerns, issues and opportunities for improvement to any

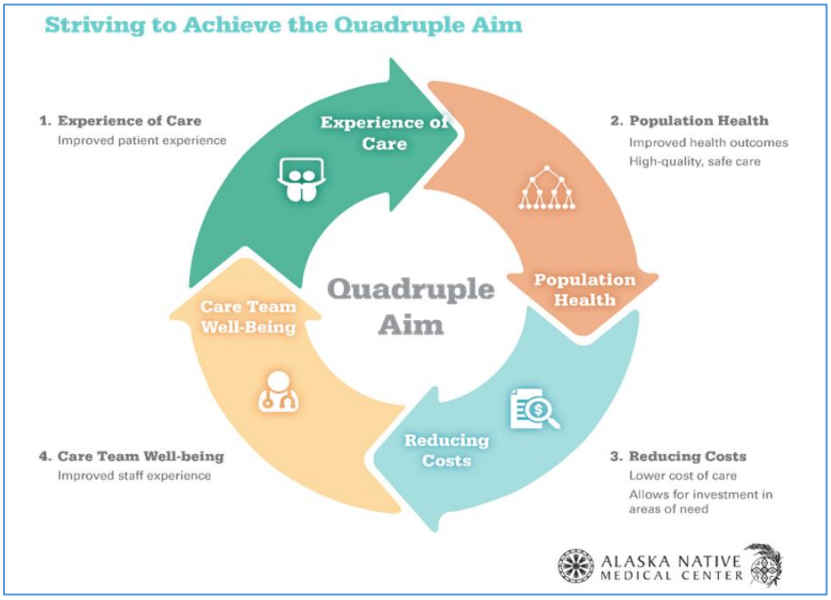
supervisor/manager. Managers create an environment that encourages staff to bring forward opportunities for improvement. Staff are encouraged to report errors and near misses to allow the organization to learn from those occurrences and make systemic changes to prevent recurrences. Staff are also encouraged to use tools to support rapid cycle improvements when needs are identified.

IV. Performance Improvement Projects

A performance improvement project is a concentrated effort on a particular problem; it involves defining performance indicators, collecting, aggregating and analyzing data and implementing the steps of continuous quality/process improvement. Performance improvement projects are developed or redesigned based on the mission and guiding principles of ANMC, combined with input from the community, patients, providers, staff and others. The initiatives are developed, or redesigned, using scientific and professional resources, available guidelines and practice parameters, external benchmarks, adverse occurrence alerts, internal quality management, and sound business practices. Those directly involved in delivering care and services or participating in the processes are closely involved in the planning and implementation phases. ANMC identifies all PI projects annually, which are addressed by the appropriate sub-committee. The committee structure referenced in Attachment A displays sub committees and oversight committees. Sub-committees report at a standardized frequency to the oversight committee.

In spring 2021, ANMC adopted the Quadruple Aim as a strategic framework for ANMC, as well as governance principles that support the success of outcomes improvement within this strategic framework (refer to Attachment B).

The four key elements of these strategic goals include experience of care, population health, reducing costs, and care team well-being. Experience of care focuses on the patient and their family experiences. Population health focuses health outcomes, high quality, and safe care. Reducing costs focuses on lower the cost of health care services and allows for investment in areas of greatest need. Care team well-being focuses on the staff experience.



Performance Indicators

As performance improvement initiatives are developed or redesigned, mechanisms to evaluate them are planned and implemented. Factors considered when selecting performance indicators may include but are not limited to high-risk, high-volume or problem prone areas that affect outcomes, quality of care and services, accreditation, regulatory and certification requirements, strategic planning, incident/accident reporting, and areas that affect staff. The focus on quality measures that are clinically relevant, or publicly reported or other appropriate performance indicators are based on the following criteria:

- The indicator identifies processes or outcomes that can be improved
- The indicator has defined and documented data elements
- The indicator can detect changes in performance and allows for comparison over time
- The data intended for collection is available for ongoing measurement
- Results can be reported in a way that is useful to ANMC and other stakeholders and can be compared to pre-determined thresholds.

Aggregation and Analysis of Data

There is a systematic process to aggregate and analyze collected data. Data is assessed to:

- Set priorities and determine actions for improvement
- Ensure completion and monitor results of improvements
- Ensure performance and stability of important existing processes

This assessment process includes using statistical quality process control techniques, as appropriate, and comparing data outcomes over time. Performance is also compared to relevant scientific, clinical and management literature, and to relevant practice guidelines and benchmarks, as appropriate.

Results of performance improvement projects are communicated via dashboards, board meetings, bulletin boards, department meetings and in other ways, as appropriate. Information regarding the QAPI Plan is available to a patient or provider upon request and available on the ANMC intranet site.

V. Systematic Analysis and Systemic Action

ANMC uses a systematic approach to determine when an in-depth analysis is needed to fully understand the problem, the causes and the implications of a change. ANMC uses the results of data analysis to identify improvement opportunities and interventions. When improvement opportunities are identified ANMC takes action to improve. ANMC also takes action when improvements goals are not achieved or sustained. To get at the underlying cause(s) of undesirable patterns, trends, or variations in performance related to safety and quality of care (this includes adequate staffing, skill mix and competency of staff), key teams/stakeholders are brought together to identify the root cause and contributing factors. When analysis reveals a problem with the adequacy of staffing, the leaders responsible for the hospital-wide patient safety program are informed to include the results of the analysis and the actions taken to resolve the identified issues.

A variety of analytic tools may be utilized at ANMC, dependent on the situation or need, and may include but are not limited to the following: Root Cause Analysis (RCA); Failure Mode and Effects Analysis (FMEA); Plan, Do, Study, Act (PDSA) (Attachment C); and the Five Whys.

When staff become aware of a potential sentinel event, near miss or adverse outcome, they take steps

to ensure the patient's safety, and then immediately notify the patient's provider, report the event through the established chain of command and submit the event to the Quality department in the Incident/Accident Reporting System.

The ANMC Quality Department is actively engaged in reviewing reported events and assisting in determining appropriate investigative follow-up, with established analytic tools and reviews. Examples of reviews may include but not limited to the following: Peer Review; Quality Review; Morbidity & Mortality Review; and other comprehensive analyses.

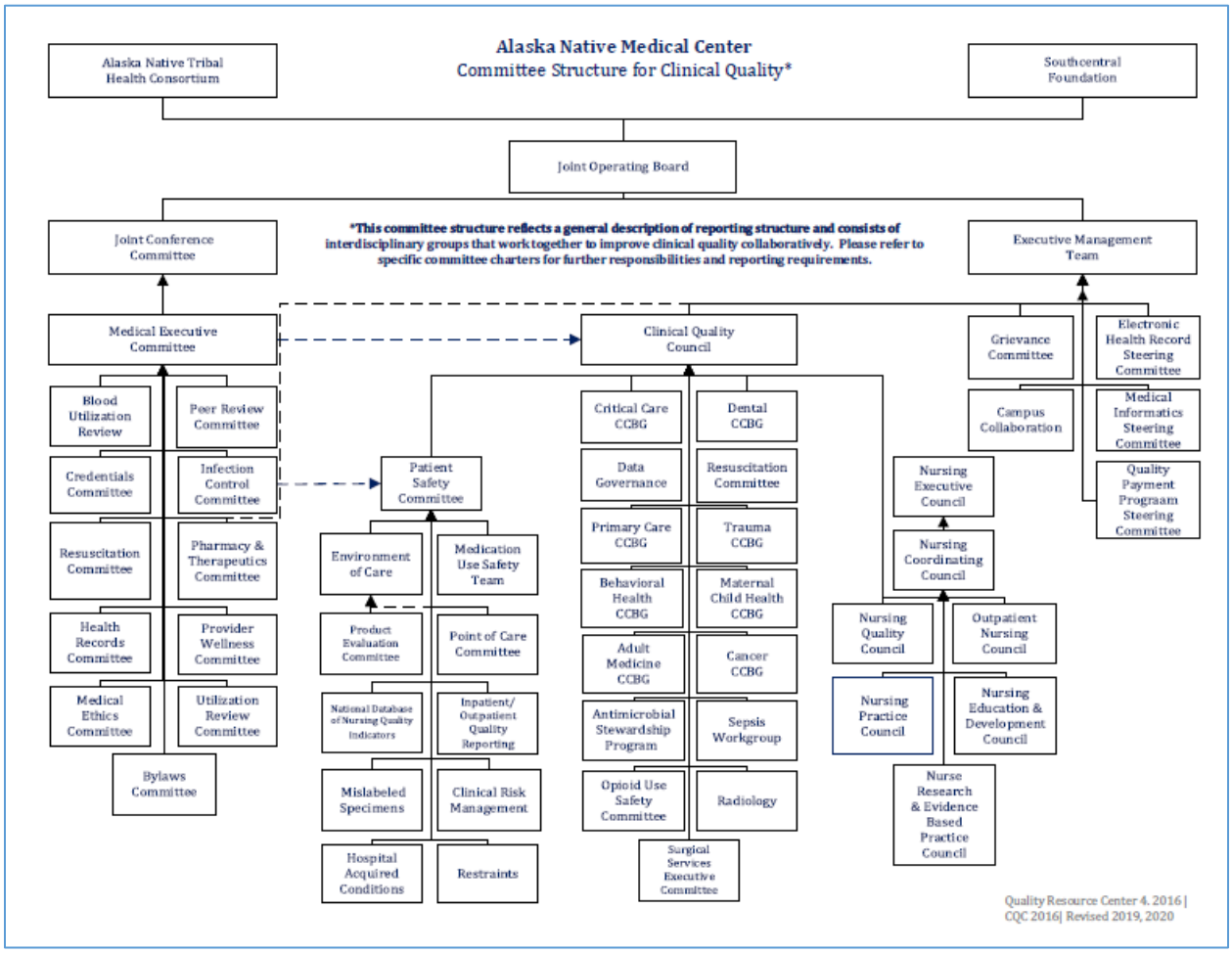
To prevent future events and promote sustained improvement, ANMC develops actions, as appropriate, to address identified causes and/or contributing factors of an issue/event that will affect change at the systems level. The action items, any plans for future audits, and follow up reports are assigned to responsible individuals and/or departments. Individuals and/or departments assigned these action items are responsible to provide regular updates on progress to the Quality Department until the action items are completed, and a stable process has been implemented. System changes are monitored to ensure changes are effective and sustainable.

VI. Annual Review, Plan Evaluation and Effectiveness

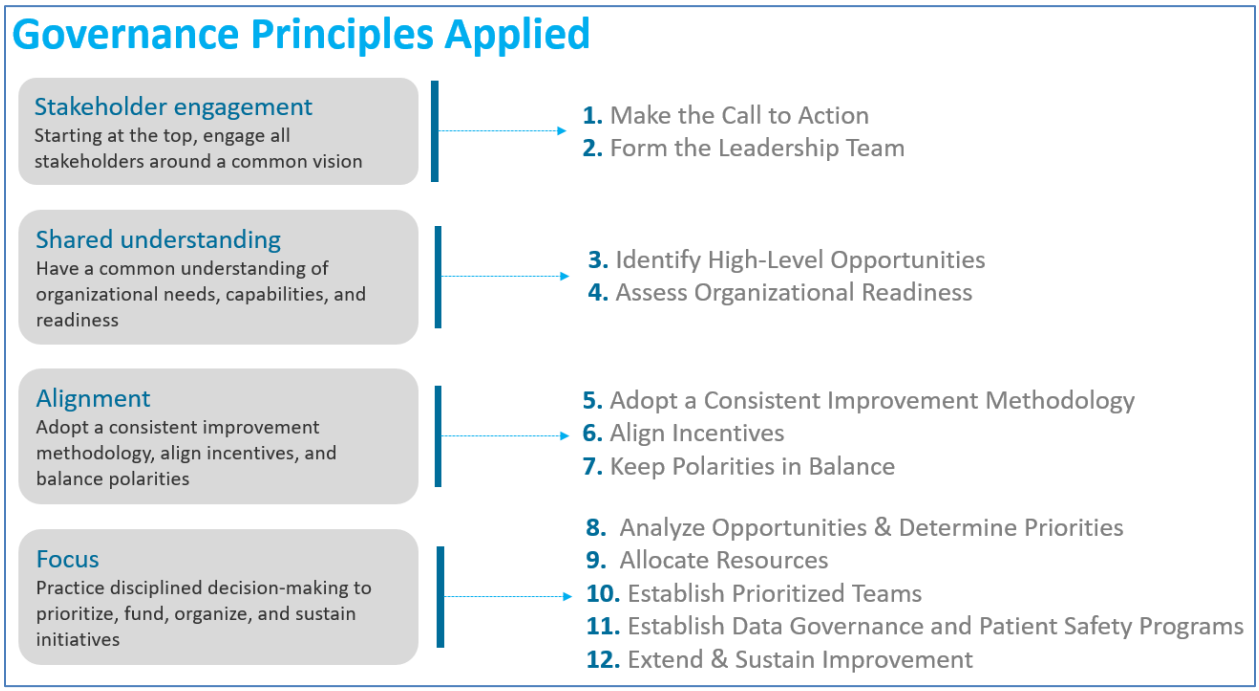
The VP of Quality, in collaboration with the Director of Quality Assurance and the Medical Director of Quality Assurance, are responsible for updating the annual QAPI Plan and completing an evaluation of its effectiveness. The QAPI Plan is reviewed annually and approved by the CQC, EMT and the JOB.

VII: Attachments

Attachment A: Committee Structure for Clinical Quality



Attachment B: Outcomes Improvement Governance Principles

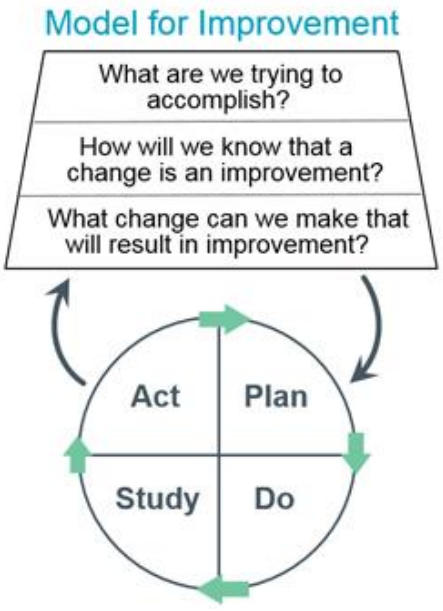


Attachment C: Example of an Analytical Tool

Plan, Do, Study, Act (PDSA): developed by Associates in Process Improvement (API)

PLAN:

Opportunity/problem identification and desired outcomes – The opportunity or problem statement is a brief, clear statement of the issue to be studied. Ideally this will be identified through previously collected data. The opportunity statement must be specific, and describe an observable, measurable, and manageable issue. The scope should be clearly defined and addressable in a short time frame. The desired outcome is the specific, measurable objective of the project.



Identify most likely cause(s) through data – The cause(s) of a problem may be identified by reviewing existing data, collecting baseline data on several items thought to be most likely causes of the problem, and/or by best guesses of those individuals with the most knowledge of the issue.

Identify potential solution(s) and the data needed for evaluation – Utilizing the most likely causes identified in step 2, list the potential solutions that may result in the desired outcome(s). Such solutions may be based on experience of other, published reports, and/or best guesses with knowledge of the issue. Following this, choose one or more solutions that can be reasonably instituted. For each solution to be acted upon identify those data elements required to determine whether the change(s) produced the improvement desired. Data collected should be the absolute minimum and of relevance to the desired solution. Once the required data elements have been specified, the source of these data must be

identified or developed.

DO:
Implement solution(s) and collect data needed for evaluation – The solution(s) most likely to be successful should be implemented. It is often preferable to do this on a small scale to see if the change(s) will work. Make the data collection easy enough and the time frames short enough so that data collection can be repeated frequently to allow for trending of changes over time. If not already available, build in baseline measures before implementing change so that it will be possible to measure whether an improvement has been produced.

STUDY:
Analyze the data and develop conclusions – The objective of data analysis is to measure a theory regarding whether the change(s) made has led to the desired outcome. It is essential that both the data elements and the anticipated analysis be planned before changes are implemented. This will often require analytical support.

ACT:
Recommendation for further study/action – Action in this step depends upon the results of the data analysis. If the tested solution was shown to produce the desired change, one may wish to more broadly implement if the initial test was done on a small scale. Effectively communicating the results of the measure is important. Finally, a decision should be made regarding the continuance of data collection to monitor whether the observed improvement is sustained over time. If the tested action did not achieve the desired outcome, a return to step 2 is necessary.