Quality Assessment, Performance Improvement, and Patient Safety Plan FY 2023

I. Introduction

a. Purpose

The purpose of the Quality Assessment, Performance Improvement (QAPI) and Patient Safety Plan is to support the University of Toledo Medical Center (UTMC) mission and strategic vision by outlining priorities, objectives and overall improvement strategies.

b. Mission

The mission of The University of Toledo Medical Center is to improve the human condition by providing patient-centered, university-quality care.

c. Situation

The landscape surrounding UTMC is dynamic owing to many factors. Most importantly, in response to the Coronavirus Disease 2019 (COVID-19) Pandemic, UTMC activated our Emergency Preparedness plan in January 2020. UTMC has concentrated on safety while adapting to altered clinical operations. While addressing the near-term public health emergency, UTMC remains focused on longer term objectives time. UTMC has adapted its Quality and Safety plan to this situation. In 2022 CMS preview report UTMC improved to 4 -Stars in the CMS Star Rating, but dipped to Leapfrog Safety grade of C, barely missing grade "B" by decimal points. To improve patient safety and quality of care, UTMC's primary goal is to implement Epic in Fiscal Year 2023

Participation in AHRQ listed Patient safety Organization (Vizient PSO).

As Patient Safety and Quality Improvement Act of 2005, outlines, UTMC is determined to collect and voluntarily report information to our PSO (Vizient PSO) on a privileged and confidential basis, as provided for under the Patient Safety and Quality Improvement Act, for analysis of patient safety events for the purpose of improving patient safety and quality of healthcare services. 42 U.S.C. sections 299b-21 to 299b-26

d. University of Toledo Goal for UTMC

Grow the reputation and visibility of health care in Toledo provided by UT physicians, health-care providers, residents and students.

e. UTMC COVID-19 Response

UTMC maintains a flexible posture anchored in evidence-based infection control and prevention measures. We have outlined a four-fold COVID-19 mission:

i. Keep our healthcare team safe
ii. Provide state-of-the-art care for COVID-19 patients
iii. Participate in the local, state, and national health response
iv. Minimize the negative impact on clinical operations

f. UTMC Strategic (multi-year) Quality Objectives

In order to support the overall mission, strategic vision, and goals for UTMC we have outlined the following objectives.

i. Achieve *Hospital Compare* Overall Quality Rating of 5 -Stars by December CY2023
ii. Maintain UTMC's Hospital-acquired condition (HAC) reduction program current performance and neutralize Value-Based Purchasing related penalties by CMS FY2022
iii. Improve clinical documentation by harnessing Epic features
iv. Improve health quality information management to meaningfully capture risk and opportunities.
v. Maintain enrollment and regulatory readiness in the value-based care programs e.g. Ohio invests in Priority Populations (OIPP)
vi. Maintain accreditation and certification readiness.

g. Fiscal Year 2021 QAPI and Patient Safety Plan Priority Objectives

We have outlined our FY 2023 objectives to support the UTMC strategic objectives. We have organized them according to the Institute of Medicine (IOM) six dimensions of quality: safe, timely, effective, efficient, equitable, and patient-centered. The most important objective is safety. We will employ CMS (the Centers for Medicare and Medicaid Services), Vizient, the Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS), and UTMC data sources to measure our progress toward meeting objectives.

1. Safety
    a. Participate in effective implementation of Epic Electronic Health Record
    b. Patient safety indicators (PSIs)
        i. Maintain pressure ulcers (PSI03) to below Vizient median
        ii. Maintain postoperative respiratory failure (PSI11) to below Vizient median
        iii. Maintain perioperative pulmonary embolism and deep vein thrombosis rate (PSI12) to below Vizient median
        iv. Maintain postoperative sepsis rate (PSI13) to below Vizient median
    c. Healthcare-associated infections
        i. Maintain the surgical site infection rate reported to the Center for Disease Control-National Healthcare Safety Network (CDC-NHSN) below the established standardized infection rate (SIR) threshold
        ii. Decrease the catheter-related blood stream infection rate below the CDC-NHSN SIR established threshold
        iii. Maintain the catheter-associated urinary tract infection rate below the CDC-NHSN SIR established threshold
        iv. Maintain the *Clostridium difficile* infection rate below the CDC-NHSN SIR established threshold
        v. Maintain methicillin-resistant *S. aureus* blood stream infections below CDC-NHSN SIR established threshold
    d. Improve hand-hygiene observations to achieve an overall average above 90%

e. Maintain service line specific mortality rates below Vizient index
f. Decrease UTMC overall mortality rate below Vizient Index
g. Improve Leadership/management Promoting Patient Safety Measured via AHRQ Culture of Safety Survey question.

2. Timeliness
    a. Maintain Emergency Department (ED) average (median) time patients spent in the emergency department before leaving from the visit below national rate as reported in the CMS Outpatient Quality reporting program (publicly reported on the CMS hospital compare reports)
3. Effectiveness
    a. Maintain UTMC overall 30-day readmission rate below Vizient average median and decrease it by 10% (Vizient) from FY2022.
4. Efficiency
    a. Improve annual OR on-time start percentage to above 85% for UTMC surgical services
    b. Improve annual OR turnaround time of less than 30 minutes.
    c. Improve overall UTMC clinical documentation capture of Medicare Severity Diagnosis Related Groups (MS-DRGs) complication or comorbidity (CC) or a major complication or comorbidity (MCC) (i.e., MS-DRG CC/MCC), improving CMI by 10% from FY 2022
5. Equitable
    a. Improve and maintain rank in the top 25 best performers int he benchmarking cohort for Vizient equity score (for gender and race in Sepsis, STEMI)
6. Patient-centeredness
    a. Achieve 27th HCAHPS percentile (overall hospital ratings)
    b. Achieve 30th HCAHPS percentile (overall score: Care provider)
    c. Achieve Vizient ranking of 25 for patient-centeredness domain
7. Maintain accreditation and certification readiness (Table 1).

II. Structure and Leadership

a. The UTMC executive team is responsible for developing the Quality Assessment, Performance Improvement and Patient Safety Plan. These leaders set priorities, provides leader emphasis, and allocates resources to support the plan.
b. Execution of the plan carried out by committees, working groups, departments, and services (Figure 1). These committees, working groups, departments, and services operationalize the plan, defining, refining, implementing, and monitoring. These bodies are comprised of physicians and appropriate hospital staff.
c. Designated clinical and non-clinical departments will develop performance improvement initiatives that align with the UTMC quality and safety plan.
d. The CMO oversees the plan as the Chair of the Quality and Patient Safety Council. This oversight ensures quality and safety activity alignment within the organization and allows for collaboration while avoiding redundancy. The Quality and Patient Safety Council reports to the Medical Staff Executive Committee, which in turn reports to the Clinical Affairs Committee of the Board of Trustees (Figure 2).

III. Quality Assessment and Performance Improvement Process

a. Setting Priorities

Quality priorities align with UTMC objectives and meet regulatory requirements. The CEO outlines, priorities, but obtains input from other hospital leaders and service chiefs. Other issues (e.g., external benchmark projects, analysis of patient safety event reports, sentinel event analysis, or standard of care findings) may also receive priority. UTMC uses decision matrices along with other modalities to aid in developing priorities (Table 2).

b. Model for Quality Assessment and Performance Improvement

UTMC uses the Institute for Healthcare Improvement (IHI) model. This model is comprised of the following questions/steps:

i. What is the aim (what is trying to be accomplished)?
ii. What will be measured (how will we know a change is an improvement)?
iii. What change/intervention will be made?
iv. Following these three questions, we execute the PDSA cycle (Plan-Do-Study-Act) (Figure 3).
v. Key resources will include IHI's QI Essentials Toolkit using the tools and templates needed to launch and manage a successful improvement project. These tools help PI teams follow a standardized approach to accomplish their goals. The Performance Improvement methods are designed to assist with implementing appropriate action plans for variances, selecting quality tools, and launching PI projects/initiatives. Example of tools (Figure 4 & 5).
vi. Tools:

♦ PDSA / worksheet ♦ DMAIC ♦ Driver Diagram ♦ Flowcharts ♦ Cause and Effect Diagrams ♦ Run, Pareto, Control charts ♦ Histogram ♦ Scatter Diagram	♦ Lean/Six Sigma, Value stream mapping ♦ Root Cause Analysis (RCA) ♦ Case Investigation ♦ Evidence Based/Best Practice review ♦ Failure Mode and Effects Analysis (FMEA) ♦ Surveys ♦ Audits

vii. For projects that expand over the Rapid cycle improvement phase will utilize DMAIC methodology (Define, Measure, Analyze, Improve, Control)
viii. The Quality and Patient Safety Plan is flexible in order to accommodate change.

c. Developing Measure Specifications

Committees and working groups outline quality measures and metrics. UTMC relies on Vizient, CMS, and organic resources for actionable data. Committees and working groups develop written measurement specifications along with data abstraction tools with assistance from Quality Management personnel.

d. Reporting and Implementation

Committees, working groups, departments, and services will report findings to the Quality Management Department. The Quality Management Department is responsible for disseminating important information throughout the organization, in such formats as the

Performance Improvement Quarterly report and/or other acceptable formats. Annually or more frequently as necessary, findings from committees, working groups, departments and services will be presented at the Quality and Patient Safety Council, with minutes from the council presented to the Medical Executive Committee. UTMC performance improvement activities may also be shared in the following modes:

i. Departmental in-services on special quality performance improvement topics
ii. Presentations to students, residents, staff and faculty
iii. Reports of clinical data distributed to the Clinical Affairs Committee of the Board of Trustees, Executive Committee of the Medical Staff, members of management and leadership teams
iv. Display of quality data on individual hospital units (Visual management boards and tiered huddles)

IV. Medical Staff and Clinical Department and Services Quality and Safety Responsibilities

a. Medical Staff Committees

All UTMC committees report their plans and activities to the Quality and Patient Safety Council at least annually. As medical staff committees, several key committees must also submit their activities (in the form of minutes) to the Medical Executive Committee. These committees and their activities include:

i. Blood and Laboratory Utilization Committee (BUC): The purpose of the committee is to ensure the safe, effective, and efficient use of blood products and appropriate use of the laboratory resources. The committee annually reports their plan and findings to the Quality & Patient Safety Council.

ii. Cancer Committee: The purpose of the committee is to ensure quality care in patients with cancer. Cancer Conference presentations occur monthly, which includes all major cancer sites treated at UTMC. The Cancer Committee plans and conducts a minimum of two outcome studies annually. The committee annually reports their plan and findings to the Quality & Patient Safety Council.

iii. Infection Control Committee: The purpose of the committee is to ensure safe care by instituting and overseeing evidence-based infection control practices. The committee also ensures integration and oversight of the antimicrobial stewardship program. The committee meets no less than quarterly to review and evaluate the hospital-wide infection control initiatives. The committee annually reports their plan and findings to the Quality & Patient Safety Council.

iv. Health Information Management Committee: The purpose of the committee is to ensure the timely completion and accuracy of medical documentation (e.g., history and physical). The committee monitors regulatory requirements for completion of required documentation. The committee annually reports their plan and findings to the Quality & Patient Safety Council.

v. Surgical Services Executive Committee: The purpose of the committee is to ensure the delivery of quality surgical care. .

vi. Pharmacy and Therapeutics Committee: The purpose of the committee is to oversee all aspects of quality related to the selection, ordering, transcribing,

preparing, dispensing, administering, and monitoring of medications throughout UTMC. In addition, they maintain and make recommendations to the drug formulary. The committee works closely with nursing, Infection Control, and other medical staff departments in developing policies and monitoring. Pharmacy is responsible for tracking and monitoring medication errors and adverse events and reporting findings to the Quality & Patient Safety Committee. The committee annually reports their plan and findings to the Quality & Patient Safety Council.

vii. Trauma Committee: The purpose of the committee is to provide quality oversight for the Trauma program. The committee annually reports their plan and findings to the Quality and Patient Safety Council.

b. Clinical Departments and Services

i. Each clinical department and service is responsible for establishing specific quality improvement indicators, which align with the hospital-wide plan. Clinical departments and services annually report their plans and findings to the Quality and Patient Safety Council.

V. Safety

a. Safety is the most important aspect of quality care. UTMC integrates the patient safety with all quality assessment and performance improvement activities. It encompasses risk assessment and avoidance tactics such as conducting a "Failure Mode Effect Analysis" (FMEA). FMEA is a proactive risk assessment, which examines a process in detail including sequencing of events, assessing actual and potential risk, failure, or points of vulnerability, and prioritizes areas for improvement based on the potential impact on patient care.

b. The Quality Management department proactively institutes action plans based on findings from the "Sentinel Event Alert" provided by the Joint Commission.

c. All patient safety events in the safety program track and trend or initiate activities that address process, system, protocol, or equipment events. This includes near miss occurrences and unsafe conditions, as well as findings from adverse events. As the entire organization reports patient safety events, this component integrates all departments into the safety program.

d. The Quality Management department facilitates execution of action plans derived from Root Cause Analysis activities, including those from Sentinel Events.

e. The plan endorses the Just Culture approach and policy to enhance patient and staff safety efforts at UTMC

f. The quality management department also maintains continuous staff education program on Patient safety, Error reduction, and Just Culture by conducting workshops and publishing quarterly patient safety newsletter for the UTMC staff.

VI. Oversight and Information Sharing

a. Committees, working groups, departments and services report quality assessment and performance improvement information to the Quality and Patient Safety Council. The Quality and Patient Safety Council submits minutes to the Medical Staff Executive Committee, which in turn reports to the Clinical Affairs Committee of the Board of Trustees. Additionally, the Clinical Affair Committee approves the annual Quality Assessment, Performance Improvement and Patient Safety Plan and monitors completion of the plan. The various duties of these oversight committees are further defined below:

   i. <u>The Board of Trustees of the University of Toledo:</u> establishes, maintains, supports, and exercises oversight of the quality monitoring and performance improvement function of UTMC. The Board of Trustees fulfills its responsibilities related to the quality assessment, performance improvement, and safety functions through its Clinical Affairs Committee.

   ii. <u>The Clinical Affairs Committee of the Board of Trustees:</u> reviews and provides feedback related to quality reports submitted to the committee and the Board of Trustees. The Clinical Affairs Committee approves the annual plan and annual

appraisal. They are also responsible for making recommendations to enhance the Quality Assessment, Performance Improvement and Patient Safety Plan.

iii. The Executive Committee of the Medical Staff: provides oversight for reporting quality initiatives from the medical staff committees and hospital initiatives.

VII. Resources

a. The Quality Management Department supports and facilitates ongoing organizational quality assessment, performance improvement, and patient safety activities. The Quality Management Department assists physicians and hospital staff with developing and executing quality improvement projects.
b. The duties of the Quality Management Department include:
    i. Promoting patient safety through evidence-based clinical programs and initiatives
    ii. Ensuring accreditation and certification readiness (e.g., Joint Commission)
    iii. Management of quality databases (e.g., Vizient, American College of Cardiology (ACC) national database, and Patient Safety Net event reporting.)
    iv. Collaboration with all departments and services to execute the quality and patient safety plan (e.g., assisting with performance improvement projects) and achieve hospital objectives
    v. Collaboration with Medical Staff Office/Central Verification Office (CVO) for physician assessments
    vi. Quality improvement training and education
    vii. Preparation of all salient quality and safety plans and reports
    viii. Collaboration with health information management to aid in accurate documentation
    ix. Dissemination of patient safety event reports to departments, Quality and Patient Safety Council, and other key groups in the organization
    x. Patient safety event and sentinel event report tracking and analysis
    xi. Coordinating and leading root cause analyses for sentinel events and other occurrences requiring intense analysis
    xii. Coordinating and ensuring completion of action plans related to sentinel events or failure mode effect analysis (FMEA) projects
    xiii. Organizing performance improvement projects for issues found in patient safety event reports
    xiv. Oversee submission of data to CMS, third party payers, and other collaboration efforts.
    xv. Support provider data aggregation, analysis, and validation.
    xvi. Provide clinical case reviews for adverse events, triggered reviews and support reviews for M&M and Peer Review processes.

VIII. Summary

The Quality Assessment, Performance Improvement, and Patient Safety Plan provides the objectives and framework for UTMC to implement quality assessment, performance improvement, and safety activities. These activities improve patient outcomes, patient experience, and patient safety in a comprehensive, methodical, and systematic manner and compliment the Hospital Plan for the Provision of Collaborative Patient Care Services.

IMMUNITY/CONFIDENTIALITY CLAUSES

The Quality and Patient Safety Council is a UTMC quality assurance committee as referenced in the Ohio Revised Code. Those sections of the Ohio Revised Code pertaining to immunity and confidentiality apply to the Quality and Patient Safety Council.

Ohio Revised Code §2305.24 (eff. 9/29/2009)

> "Any information, data, reports, or records made available to a quality assurance committee or utilization committee of a hospital or long-term care facility or of any not-for-profit health care corporation that is a member of the hospital or long-term care facility or of which the hospital or long-term care facility is a member are confidential and shall be used by the committee and the committee members only in the exercise of the proper functions of the committee.
>
> No physician, institution, hospital, or long-term care facility furnishing information, data, reports, or records to a committee with respect to any patient examined or treated by the physician or confined in the institution, hospital, or long-term care facility shall, by reason of the furnishing, be deemed liable in damages to any person, or be held to answer for betrayal of a professional confidence within the meaning and intent of section 4731.22 of the Revised Code."

Original Date: 9/87
Revised:
Utilization Management Plan 4/90
Quality Assessment Plan 6/90
Quality Assessment and Improvement Plan 7/92
Patient Care and Service Improvement Plan 1/93
Quality Improvement Plan 1/94
Quality Improvement Plan 1/95
Quality Improvement Plan 1/96
Quality Improvement Plan 1/97
Quality Improvement Plan 1/98
Quality Improvement Plan 1/99
Performance Improvement Plan 4/99
Performance Improvement Plan 6/99
Performance Improvement Plan 9/00
Performance Improvement Plan 3/02
Performance Improvement Plan 5/03
Performance Improvement Plan 12/04
Performance Improvement Plan 6/06
Performance Improvement Plan 11/07
Quality and Patient Safety Plan 12/08
Quality and Patient Safety Plan 2/2010
Quality and Patient Safety Plan 2/2012
Quality and Patient Safety Plan 12/2012
Quality Assessment, Performance Improvement and Patient Safety Plan, 11/2013
Quality Assessment, Performance Improvement and Patient Safety Plan, 1/2015
Quality Assessment, Performance Improvement and Patient Safety Plan, 7/2015
Quality Assessment, Performance Improvement and Patient Safety Plan, 8/2016
Quality Assessment, Performance Improvement and Patient Safety Plan, 8/2017
Quality Assessment, Performance Improvement and Patient Safety Plan, 8/2018
Quality Assessment, Performance Improvement and Patient Safety Plan, 8/2019
Quality Assessment, Performance Improvement and Patient Safety Plan, 5/2020
Quality Assessment, Performance Improvement and Patient Safety Plan, 5/2021
Quality Assessment, Performance Improvement and Patient Safety Plan, 6/2022

___/s/_____
Richard Swaine
Chief Executive Officer

___/s/_____
Michael Ellis, M.D.
Chief Medical Officer

___/s/_____
Andrew Casabianca MD.
Chief of Staff

Table 1

Regulatory Agencies - Continuous Readiness

Program Area	Accreditation Organization	Last Visit	Next Visit	Cycle
HSC Radiation Generating Equipment Inspection (Includes Cath Lab, Diagnostic, CT, Rad Onc).	Ohio Department of Health RGE	7/27/2020	7/2022	2 year
Kobacker	Ohio Department of Mental Health	8/15/2019	8/15/2022	3 year
Food and Nutrition Services	Ohio Department of Health / Site Evaluation	5/10/2022	11/10/2022	6 months
Food and Nutrition Services	Ohio Department of Health / License Inpatient Behavioral Health/Kobacker Center	5/10/2022	11/10/2022	6 months
Advanced Heart Failure Certification	The Joint Commission	8/13/2021	1/15/2023	2 year
Food and Nutrition Services	Ohio Department of Health / License (all three HSC locations)	3/15/2022	3/15/2023	1 year
Infection Control	Ohio Department of Health	4/14/2021	4/14/2023	Varies
Emergency Preparedness	Ohio Department of Health	4/14/2021	4/14/2023	Varies
Hemodialysis	Ohio Department of Health	4/14/2021	4/14/2023	2 year
340B Drug Program	HHS - Health Services Resources Administration Office of Pharmacy Affairs (OPA)	7/15/2021	4/28/2023	No cycle for HRSA, 2 years for independent.
Radiology/Mammography	Ohio Department of Health / FDA / MQSA	5/3/2022	5/3/2023	1 year
Trauma Level II	American College of Surgeons / Trauma	5/17/2021	5/17/2023	2 year
Ryan White Program/Grant	Site Visit for Ryan White funding	7/21/2021	7/21/2023	No set cycle, the program doesn't require site visits.
Radiology /MRI Breast	American College of Radiology / No onsite visit / online application	8/2020	8/2023	3 year
Nuclear Medicine	American College of Radiology / No onsite visit / online application	8/2020	8/2023	3 year
Behavioral Health Services	The Joint Commission	6/18/2021	10/20/2023	3 year
Home Care (DME for DCC Renee's Survivor Shop)	The Joint Commission	6/18/2021	10/20/2023	3 year
Hospital	The Joint Commission	6/18/2021	10/20/2023	3 year
Lab	College of American Pathologists ("CAP")	10/27/2021	10/27/2023	2 year
Lab	American Society for Histocompatibility and Immunogenetics	12/15/2021	12/15/2023	2 year
Radiology/Nuclear Medicine & Radioactive Materials	Ohio Department of Health RAM both HSC and MC	12/19/2021	12/19/2023	2 year
Stroke	The Joint Commission	12/14/2021	12/14/2023	2 year
Radiology/Mammography	American College of Radiology Mammography	3/16/2021	3/16/2024	3 Year
Regency Radiation Generating Equipment Inspection	Ohio Department of Health RGE Regency	11/1/2021	11/1/2024	3 year
Heart Station / Echocardiography	Intersocietal Commission for the Accreditation of Echocardiography Laboratories ("ICEAL")	11/22/2021	11/22/2024	3 year
Radiology/MRI 1.5T Scanner	American College of Radiology Magnetic Resonance Imaging	12/2021	12/1/2024	3 year
Transplant	UNOS/OPTN / Deceased and Living Donor Program	2/15/2022	2/15/2025	3 year

Figure 1
Quality & Patient Safety Initiative
Care and Safety Oversight

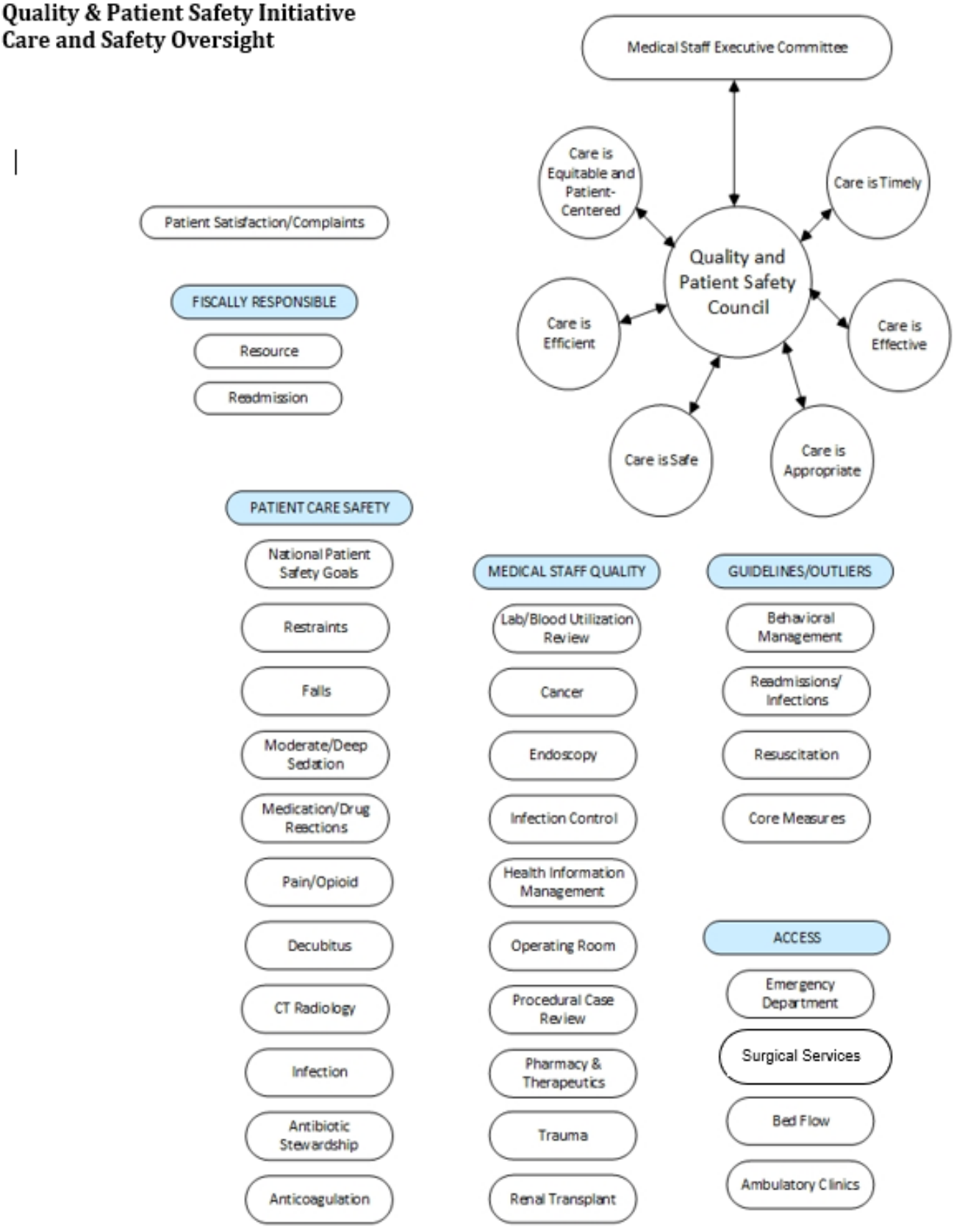

Table 2

PRIORITIZATION MATRIX –FY 2021
Quality and Patient Safety Goals

Improve Patient Safety & Quality

Opportunity	High Risk	High Volume	Problem Prone	Important to Mission	Customer Satisfaction	Staff Satisfaction	Physician Satisfaction	Clinical Outcome	Safety	Regulatory Requirement
Hospital Acquired Conditions	✓		✓	✓	✓			✓	✓	
Patient Safety Events	✓			✓	✓	✓	✓	✓	✓	
Pain Management – Safe opioid use	✓		✓	✓	✓	✓	✓	✓	✓	✓

Improve Resource Utilization

Opportunity	High Risk	High Volume	Problem Prone	Important to Mission	Customer Satisfaction	Staff Satisfaction	Physician Satisfaction	Clinical Outcome	Safety	Regulatory Requirement
Reduce Readmission	✓		✓	✓	✓			✓	✓	

Improve Satisfaction

Opportunity	High Risk	High Volume	Problem Prone	Important to Mission	Customer Satisfaction	Staff Satisfaction	Physician Satisfaction	Clinical Outcome	Safety	Regulatory Requirement
Patient Satisfaction	✓		✓	✓	✓	✓	✓	✓	✓	✓
Perception of Safety	✓		✓	✓	✓	✓	✓	✓	✓	✓
Complaint Management	✓		✓	✓	✓	✓	✓	✓	✓	✓

Reduce Infection Rates

Opportunity	High Risk	High Volume	Problem Prone	Important to Mission	Customer Satisfaction	Staff Satisfaction	Physician Satisfaction	Clinical Outcome	Safety	Regulatory Requirement
Clostridium Difficile	✓		✓	✓	✓	✓	✓	✓	✓	✓
Blood Stream Infections	✓		✓	✓	✓			✓	✓	✓
Hand Hygiene	✓		✓	✓	✓			✓	✓	✓
Surgical Site Infections	✓		✓	✓	✓			✓	✓	✓
UTI	✓		✓	✓	✓			✓	✓	✓

Monitor External Regulatory Compliance Indicators

Opportunity	High Risk	High Volume	Problem Prone	Important to Mission	Customer Satisfaction	Staff Satisfaction	Physician Satisfaction	Clinical Outcome	Safety	Regulatory Requirement
Resuscitation	✓							✓	✓	✓
Sedation/Analgesia	✓							✓	✓	✓
Pain		✓	✓	✓	✓	✓	✓	✓	✓	✓
Resource Utilization				✓						✓
CORE Measures			✓	✓				✓	✓	✓
Adverse Drug Reaction	✓		✓	✓				✓	✓	✓
Organ Conversion				✓						✓
Restraints				✓	✓			✓	✓	✓

Opportunity	High Risk	High Volume	Problem Prone	Important to Mission	Customer Satisfaction	Staff Satisfaction	Physician Satisfaction	Clinical Outcome	Safety	Regulatory Requirement
Lab/Blood Utilization	✓			✓				✓	✓	✓
Operative/Invasive procedures.	✓		✓	✓				✓	✓	✓
Seclusion	✓			✓				✓	✓	✓
Behavioral Management	✓			✓				✓	✓	✓
Mortality/Autopsy				✓						✓
Hazard Management				✓					✓	✓
Operative Diagnosis Concurrence	✓			✓				✓	✓	✓
NPSG	✓			✓					✓	
CT Radiology indicators	✓	✓		✓	✓			✓	✓	✓
Suicide Risk	✓		✓	✓				✓	✓	✓
Falls	✓		✓	✓	✓			✓	✓	✓
Medication Errors	✓			✓	✓	✓	✓	✓	✓	✓
Patient Throughput	✓			✓	✓	✓	✓			✓
Antimicrobial Stewardship	✓		✓	✓				✓	✓	✓
Contracted Services	✓			✓			✓	✓	✓	✓
ECT	✓		✓	✓	✓	✓	✓	✓	✓	✓
Detox	✓		✓	✓	✓			✓	✓	✓

Figure 3
Plan-Do-Study-Act
Quality & Patient Safety Cycle

Figure 4
QUALITY PERFORMANCE IMPROVEMENT QUARTERLY REPORT
THE PDSA QUALITY CYCLE

Team/Disciplines: _____

Plan (Aim): (Identify your problem using priorities from the Quality and Patient Safety Annual Plan or issues identified as affecting important outcomes of care, treatment or service.)

1. Describe the objective:
2. List questions and make predictions:
3. Specify how to carry out the cycle:
    a. Who
    b. What
    c. Where
    d. When
4. How will cycle results be measured:

Do (Intervention): (Carry out the plan, start with pilot or small scale. Observe impact, document problems, collect data and gather informal feedback. Share real-time results if possible to make just in time changes when able.

Study (Measures): (Study results—how did implementation go? Were results achieved? Show data via tables and graphs. Compare results to predictions. What did you learn? Summarize quantitative and qualitative analysis. Quantitative: Which way is the experience moving - up down or static over time? Is this desirable or undesirable? Is the process in control, or does it have a lot of variation? How does the experience compare to the Goal or Benchmark. Qualitative: Why is this happening? Consider all reasons. What are the contributing factors? What does this mean?)

Act (Analyses): (What did you conclude from this cycle review? Refine the change based on what was learned from the do/study. Did the implementation work or not? If it did not work, what can you do differently in next cycle to address this? If it did work, can you spread across entire practice? Should this continue to be measured? Should another indicator be introduced?)

Contact Person Completing Form: _____Dept._____

Return completed form to Quality and Patient Safety, Room 2240, Dowling Hall.

Figure 5 A3 Template