Quality Assessment, Performance Improvement, and Patient Safety Plan FY2026

Quality Assessment, Performance Improvement, and Patient Safety Plan

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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

Overall

UTMC implemented EPIC, UTMC achieved 3 -Stars in the CMS Star Rating, the COVID-19 public health emergency ended and UToledo approved the creation of UTHealth, which brings UTMC and UTP into greater alignment. UTMC continues to optimize the EPIC platform for quality and patient safety. New state directed payments have called for value based care

Magnet® Journey

UTMC is pursuing Magnet® certification to demonstrate its commitment to nursing excellence and high-quality, patient-centered care. It enhances clinical outcomes, supports professional development, and attracts top talent. By fostering a culture of safety, innovation, and collaboration, Magnet recognition strengthens staff engagement, elevates organizational reputation, and drives continuous improvement across all areas of patient care.

Health Equity

UTMC gets guidance on serving the community for adverse social determinants of health for its patient population from the Centers of Medicare and Medicaid Services.

EMTALA

The Emergency Medical Treatment and Labor Act (EMTALA) provides rights to any individual who comes to a hospital emergency department and requests examination or treatment. If such a request is made, hospitals must provide an appropriate medical screening examination to determine whether an emergency medical condition exists or whether the person is in labor. If an emergency medical condition is found to exist, the hospital must provide available stabilizing treatment or an appropriate transfer to another hospital that has the capabilities to provide stabilizing treatment.

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 Strategic (multi-year) Quality Objectives

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

i. Improve the *Hospital Compare* Overall Quality Rating
ii. Maintain UTMC's Hospital-acquired condition (HAC) reduction program current performance and neutralize Value-Based Purchasing related penalties
iii. Optimize EPIC platform for quality and patient safety
iv. Maintain enrollment and regulatory readiness in the value-based care programs e.g., Ohio invests in Priority Populations (OIPP)
v. Maintain accreditation and certification readiness.

f. Fiscal Year 2026 QAPI and Patient Safety Plan Priority Objectives

We have outlined our FY 2026 objectives to support the UTMC strategic objectives organized 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 (detailed metrics are defined in the Addendum)
    a. Optimize implementation of Epic Electronic Health Record
    b. Patient safety indicators (PSIs)
        i. Maintain pressure ulcers (PSI03) to below Vizient comparison
        ii. Maintain postoperative respiratory failure (PSI11) to below Vizient comparison
        iii. Maintain perioperative pulmonary embolism and deep vein thrombosis rate (PSI12) to below Vizient comparison
        iv. Maintain postoperative sepsis rate (PSI13) to below Vizient comparison
    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.
h. Improving diagnostic performance to reduce harm and improve health outcomes (specifically in Radiology and Pathology)

2. Access
    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.
    b. Reduce total Medicare spending per beneficiary spent index to below national and state average
    c. Collect patient reported outcomes performance measures for Hip and knee replacement – Track patient reported data for Inpatient total hip and knee replacement procedures for all payors including Medicare population (at least 50% of the population).

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 2023
    d. Reduce risk adjusted Geometric mean Length of Stay index to or below 1.2

5. Equitable
    a. Meet Health Care Equity Standards (and NPSG) set out by the joint commission.

6. Patient-centeredness- improve to 50th percentile in the following domains: Ambulatory Surgery, Emergency Department, Inpatient service, and Outpatient Medical Practice.

7. Maintain accreditation and certification readiness (See addendum). Maintain Regulatory compliance and meet performance standards for all Ohio dept of Medicaid Value Based Programs.

II. Structure and Leadership

a. The UTMC executive team, informed by the Quality Steering Committee, 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 (refer to addendum). 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. Refer to the perpetual calendar of reporting in the addendum for details on which department leadership is responsible for reporting and monitoring quality for what, frequency of reporting. Metrics with detailed definitions and targets are tracked within the quality department. 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 (See Addendum)
e. Scope of the Quality Plan: The Quality assessment, performance improvement, and patient and staff safety process and activities are endorsed in the entire organization and covers all service areas, departments, divisions, and staff members of UTMC. The services at all locations of the hospital are taken into consideration while developing, defining, implementing, and maintaining the Quality plan.

III. Quality Assessment and Performance Improvement Process

a. Setting Priorities

Quality priorities align with UTMC objectives and meet regulatory requirements. The CMO outlines, priorities, but obtains input from other hospital leaders, service chiefs, and the Quality Steering Committee. The governing body approves the priorities. 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 (Refer to Addendum).

b. Model for Quality Assessment and Performance Improvement

UTMC uses the Institute for Healthcare Improvement (IHI) model and tools from Total Quality improvement model which encompasses Lean and Six Sigma concepts.

i. The IHI model of improvement or the PDSA cycle is comprised of the following questions/steps:

1. What is the aim (what is trying to be accomplished)?
2. What will be measured (how will we know a change is an improvement)?
3. What change/intervention will be made?
4. Following these three questions, we execute the PDSA cycle (Plan-Do-Study-Act) (see addendum)

ii. Six Sigma improvement tools such as DMAIC (Define, Measure, Analyze, Improve and Control) are used as needed by the nature of the improvement project. Whereas PDSA is iterative short cycle improvement that is continuous; is ideal for incremental improvement, can be deployed quickly and is particularly effective for small to medium sized problems, DMAIC is a data driven problem solving approach ideal for large or complex problems, especially those that require cross-functional collaboration. For projects that expand over the Rapid cycle improvement phase will utilize DMAIC methodology

iii. 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 (Refer to Addendum).

iv. List of Quality improvement Tools:

♦ PDSA / worksheet ♦ DMAIC ♦ Driver Diagram ♦ Flowcharts ♦ Cause and Effect Diagrams ♦ Run, Pareto, Control charts ♦ Histogram ♦ Scatter Diagram ♦ Control charts and run charts	♦ Lean/Six Sigma- Value stream mapping ♦ Root Cause Analysis^2 (RCA Squared) ♦ Case Investigation ♦ Evidence Based/Best Practice Review ♦ Failure Mode and Effects Analysis (FMEA) ♦ Surveys ♦ Audits ♦ Voice of customer

The Quality and Patient Safety Plan is flexible to accommodate change.

c. Developing Measure Specifications

Committees and working groups provide input for developing quality measures and metrics. UTMC relies on Vizient, CMS, and organic resources for actionable data. These organic sources include patient safety, near miss, or high-risk events. 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 the findings to the Quality Management Department. The Quality Management Department is responsible for disseminating important information throughout the organization. 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 in form of scorecards and dashboards
iv. Display of quality data on individual hospital units (Visual management boards and tiered huddles)
v. EPIC dashboards visible to all who have the correct level of access for more real-time and concurrent reporting.

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

v. 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.

vi. 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.

ii. Each department and/or service is responsible to review what resources the contractor has allocated to QAPI activities, how the contractor actively participates in QAPI activities, such as providing the QPSC (and, governing body, through the QPSC) with periodic quality reports/data, attending QAPI planning meetings, and, when appropriate, conducting performance improvement projects. Any non-compliance with contractor affecting quality and safety must be reported to QPSC by the local leadership in addition to respective leadership reporting channels.

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. Safety Behaviors: The governing body sets expectation of the safety culture. Below listed are safety behaviors that are incorporated in the new hire orientation and continuous trainings of the clinical staff.

Safety Behaviors

i. Attention to detail
ii. Communicate clearly
iii. Handoff effectively
iv. Speak up for safety
v. Got your back!

c. Tools to Prevent Errors: Tools that go along with safety behaviors are also taught in these orientation/ training by Quality management Staff.
   i. STAR: Stop Think Act Review
   ii. 3 Way Repeat Back and Read Back

iii. SBAR – Situation Background Assessment Recommendation
iv. Question and Confirm
v. ARCC – Ask a question; Make a request; Voice a concern; Use chain of command
vi. Stop the line when there is immediate threat
vii. Peer checking and Peer coaching

d. The Quality Management department proactively institutes action plans based on findings from various sources such as the Joint Commission (Sentinel Event Alert), Agency for healthcare research and Quality, National Patient Safety Foundation, Institute for Safe Medication Practices (reviewed and managed by Pharmacy) etc.

e. 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 through the event reporting software, this component integrates all departments into the safety program.

f. The Quality Management department facilitates execution of action plans derived from Root Cause Analysis activities, including those from Sentinel Events. Local leaders actively participate in ongoing monitoring.

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

h. The quality management department also maintains continuous staff education program on "Patient safety, Error reduction, and Just Culture" by conducting workshops for the UTMC staff. This training is now a part of employee trainings through the "safety test bank"

i. The quality management department also maintains organizational learning program on quality and performance improvement science by establishing a Quality improvement course for clinical and operational leaders. Leaders are expected to complete systematic projects aligned with overall mission, vision, values, and the Quality objectives.

j. In accordance with 42 CFR 482.12(e)(1), the UTMC's governing body ensures that services performed under contract are provided in a safe and effective manner. Periodic assessment of contracted services will be compiled at the organizational level by the Contract Compliance Officer and submitted to QPSC for review, each department and/or service is responsible to review what resources the contractor has allocated to QAPI activities, how the contractor actively participates in QAPI activities, such as providing the QPSC (and, governing body, through the QPSC) with periodic quality reports/data, attending QAPI planning meetings, and, when appropriate, conducting performance improvement projects.

k. Senior governing board prioritizes safety as a core value, holds hospital leadership accountable for patient safety, and includes patient safety metrics to inform annual leadership evaluation.

l. The quality department conducts a hospital-wide culture of safety survey using a validated instrument (AHRQ SOPS) every two years with pulse surveys on target units during non-survey years. Results are shared with the governing board and hospital staff and used to inform unit-based interventions to reduce harm.

m. Quality has a dedicated team that conducts event analysis of serious safety events using an evidence-based approach, such as the National Patient Safety Foundation's Root Cause Analysis and Action (RCA^2)

n. UTMC has a patient safety metrics dashboard and uses external benchmarks (such as CMS and Vizient academic medical centers) to monitor performance and inform improvement activities on safety events (such as: falls, pressure injuries, and healthcare-associated infections).

o. UTMC implements following high reliability practices:

    i. Hospital leaders including C Suite rounding (at-least monthly) for safety on all units, with a focus on follow-up on issues identified.

    ii. A data infrastructure to measure safety, based on patient safety evidence (e.g., systematic reviews, national guidelines) and data from the EMR that enables identification and tracking of serious safety events and precursor events. These data are shared with C-suite executives at least monthly, and the governing board at every regularly scheduled meeting.

    iii. Technologies, including a CPOE system and BCMA system, that promote safety and standardization of care using evidence-based programs.

    iv. The use of a defined improvement method (or hybrid of proven methods), such as Lean, Six Sigma, PDSA, and/or high reliability framework.

    v. Team communication and collaboration training of all staff.

p. Patients have comprehensive access to and are encouraged to view their own medical records and clinician notes via patient portals and other options, and the hospital provides support to help patients interpret information that is culturally-and linguistically appropriate as well as submit comments for potential correction to their record. UTMC supports the presence of family and other designated people (as defined by the patient) as essential members of a safe care team, and encourages engagement in activities such as bedside rounding and shift reporting, discharge planning, and visitation 24 hours a day, as feasible.

Age Friendly Hospital

As the U.S. population ages and lives longer, we continue to see increasing morbidity and healthcare costs. Patients are more complex and often live with multiple chronic conditions. To assist in addressing delivery of care to the aging population in the community UTMC deployed age friendly practices that are based on evidence and provide goal centers, clinically effective care for older patients.

- Established protocols are in place to ensure patient goals related to healthcare (health goals, treatment goals, living wills, identification of healthcare proxies, advance care planning) are obtained/reviewed and documented in the medical record.
- Medications are reviewed for the purpose of identifying potentially inappropriate medications (PIMs) for older adults as defined by standard evidence-based guidelines, criteria, or protocols. Review should be undertaken upon admission, before major procedures, and/or upon significant changes in clinical status. Once identified, PIMS are considered for discontinuation, and/ or dose adjustment as indicated.
- Patients are screened for risks regarding mentation, mobility, and malnutrition using validated instruments (ideally upon admission, before major procedures, and/or upon significant changes in clinical status)
- Positive screens result in management plans including but not limited to minimizing delirium risks, encouraging early mobility, and implementing nutrition plans where appropriate. The plans should be included in discharge instructions and communicated to post-discharge facilities.
- Older adults are screened for geriatric specific social vulnerability including social isolation, economic insecurity, limited access to healthcare, caregiver stress, and elder abuse to identify those who may benefit from care plan modification. The assessments are performed on admission and again prior to discharge. Positive screens for social vulnerability (including those that identify patients at risk of mistreatment) are addressed through intervention strategies. These strategies include appropriate referrals and resources for patients upon discharge.
- UTMC compiles quality data related to the Age-Friendly Hospital measure. These data are stratified by demographic and/or social factors and should be used to drive improvement cycles.

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. Every quarter, the Quality Steering committee shall meet to provide review progress towards strategic objectives as outlined earlier and to provide guidance for overall Quality and patient safety activities. This committee can request more information, charter projects, and provide feedback to individual department. This

committee shall operate as an extension of the QPSC and work closely in conjunction with the QPSC membership.

b. UTMC's governing body is responsible for the oversight of the QAPI program through its periodic review of the program, including, the development of a plan to implement and maintain the QAPI program, the review of the progress of QAPI projects, the determination of annual QAPI projects, and the evaluation of the effectiveness of improvement actions that the hospital has implemented. The governing body works with the senior managers and leaders of the organized medical staff to annually evaluate the hospital's performance in relation to its mission, vision, and goals. This group of leaders is also responsible for ensuring that clear expectations for safety are established and communicated hospital-wide, as well as allocating adequate resources to carry out the functions of the QAPI program requirements.

c. The various duties of these oversight committees are further defined below:

i. The Board of Trustees of the University of Toledo: 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. The Clinical Affairs Committee of the Board of Trustees: 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. 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. Quality Data Structure and Oversight:

UTMC aims to create a framework that will facilitate the achievement of organizational goals using EPIC E.M.R. Dashboards are a type of health information technology (HIT) that use data visualization techniques to support clinicians and managers in viewing and exploring data on processes and outcome of care. Local and senior leadership will assess need and charter EPIC reports and dashboards to provide feedback to clinical teams and managers, to monitor care quality, and stimulate quality improvement.

VIII. Resources

a. The Quality Management Department supports and facilitates ongoing organizational quality assessment, performance improvement, and patient safety activities.

b. The Quality Management Department assists physicians and hospital staff with developing and executing quality improvement projects.

c. The resources dedicated to the QAPI program are commensurate with the overall scope and complexity of the services provided by UTMC.

d. 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.
xvii. Quality management conducts a Performance improvement training for managers and directors.
xviii. Quality Management department conducts training on error reduction and safety regularly

IX. 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."

Signature Page

Quality Plan must be approved by the Quality patient safety Council, Medical Executive Committee, and the University of Toledo Board of Trustees

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
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Performance Improvement Plan 12/04
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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
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Quality Assessment, Performance Improvement and Patient Safety Plan, 7/2015
Quality Assessment, Performance Improvement and Patient Safety Plan, 8/2016
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Quality Assessment, Performance Improvement and Patient Safety Plan, 6/2024
Quality Assessment, Performance Improvement and Patient Safety Plan, 6/2025

/s/
_____
Dan Barbee
Chief Executive Officer

/s/
_____

Michael Ellis, M.D.
Chief Medical Officer

/s/
_____
Puneet Sindhwani MD.
Chief of Staff

ADDENDUM

TRACKED AND REPORTED QUALITY MEASURES WITH TARGETS AND FREQUENCY OF REPORTING TO QPSC

GOAL	Target for Dan reporting	Stretch Performance	High Achievers	Reporting Frequency
SAFETY				
Reduce postoperative respiratory failure	Below Vizient Comparison	Top 25%tile - Vizient	Top 10 rank Vizient	Bi-annual
Reduce pressure ulcers.	Below Vizient Comparison	Top 25%tile - Vizient	Top 10 rank Vizient	Bi-annual
Perioperative pulmonary embolism and deep vein thrombosis rate	Below Vizient Comparison	Top 25%tile - Vizient	Top 10 rank Vizient	Bi-annual
Postoperative sepsis rate	Below Vizient Comparison	Top 25%tile - Vizient	Top 10 rank Vizient	Bi-annual
Composite PSI 90 score	Below Vizient Comparison	Top 25%tile - Vizient	Top 10 rank Vizient	Bi-annual
Mortality: Reduce Risk Adjusted Mortality Index	Below Vizient Comparison	Top 25%tile - Vizient	Top 10 rank Vizient	Quarterly
Sepsis Risk Adjusted Mortality Index	Below Vizient Comparison	Top 25%tile - Vizient	Top 10 rank Vizient	Yearly
Sepsis Core Measure Compliance	Better than CMS national rate	NA		Yearly
CMS Diseases specific mortality rates	Better than CMS national rate	Top 25%tile	Top 10 rank Vizient	Yearly
Universal Protocol- Compliance	100%	100%	100%	Quarterly
Pre op and OR Time Out Compliance.	100%	100%	100%	Quarterly
Improve Accuracy of Patient Identification- Audits	100%	100%	100%	Quarterly
Accurately & Completely Reconcile Medications	100%	100%	100%	Quarterly
Medication Administration Safety audits	100%	100%	100%	Quarterly
Compliance with communication of critical results	100%	100%	100%	Quarterly
Infection prevention				
Hospital Acquired Central Line Bloodstream Infection (CLABI)	Below CDC NHSN SIR	Top 25%tile - Vizient	Top 10 rank Vizient	Quarterly
Hospital Acquired Catheter Associated Urinary Tract	Below CDC NHSN SIR	Top 25%tile Vizient	Top 10 rank Vizient	Quarterly
Infection (CAUTI)	Below CDC NHSN SIR	Top 25%tile Vizient	Top 10 rank Vizient	Quarterly
Surgical Site Infection within 30 Days – Colon Surgery	Below CDC NHSN SIR	Top 25%tile Vizient	Top 10 rank Vizient	Quarterly
Surgical Site Infection within 30 Days – Hysterectomy	Below CDC NHSN SIR	Top 25%tile Vizient	Top 10 rank Vizient	Quarterly
Hospital Acquired MRSA Bacteremia	Below CDC NHSN SIR	Top 25%tile Vizient	Top 10 rank Vizient	Quarterly
Hospital Acquired Clostridium Difficile	Below CDC NHSN SIR	Top 25%tile Vizient	Top 10 rank Vizient	Quarterly
Hand Hygiene Compliance overall (hospital)	90%	95%	98%	Quarterly

Access				
Median time in the ED before leaving from the visit	Meet CMS benchmark	NA	NA	Yearly
Compliance with EMTALA	100%	NA	NA	Yearly
Effective and efficient care				
30-day readmission rate	Below Vizient median	Top 25%tile	Top 10 rank Vizient	Quarterly
Risk Adjusted Length of Stay	Below Vizient median	Top 25%tile	Top 10 rank	Quarterly
Improve OR on-time start percentage to above 85% for first start cases	Below Vizient median	Top 25%tile	Top 10 rank Vizient	Monthly
Improve annual OR turnaround time of less than 30 minutes	Below Vizient median	Top 25%tile	Top 10 rank Vizient	Monthly
Improve overall UTMC clinical documentation	Meet Vizient median	Top 25%tile	Top 10 rank Vizient	Yearly
Improve and maintain rank in the top 25 best performers for Vizient equity score (for gender and race in Sepsis, STEMI)	Meet Vizient median	Top 25%tile	Top 10 rank Vizient	Yearly
Patient Experience				
Ambulatory Surgery	50th Percentile			Quarterly
Emergency Department	50th Percentile			Quarterly
Inpatient	50th Percentile			Quarterly
Outpatient Medical Practice	50th Percentile			
Other Goals				
Maintain accreditation and certification readiness	NA			
Participate in effective implementation of Epic Electronic Health Record	NA			
Improve Leadership/management Promoting Patient Safety Measured via AHRQ Culture of Safety Survey question.	improve 1% on domains from previous	improve 2% on domains from previous	Achieve AHRQ Benchmarks	Yearly

List of Clinical Data Registries

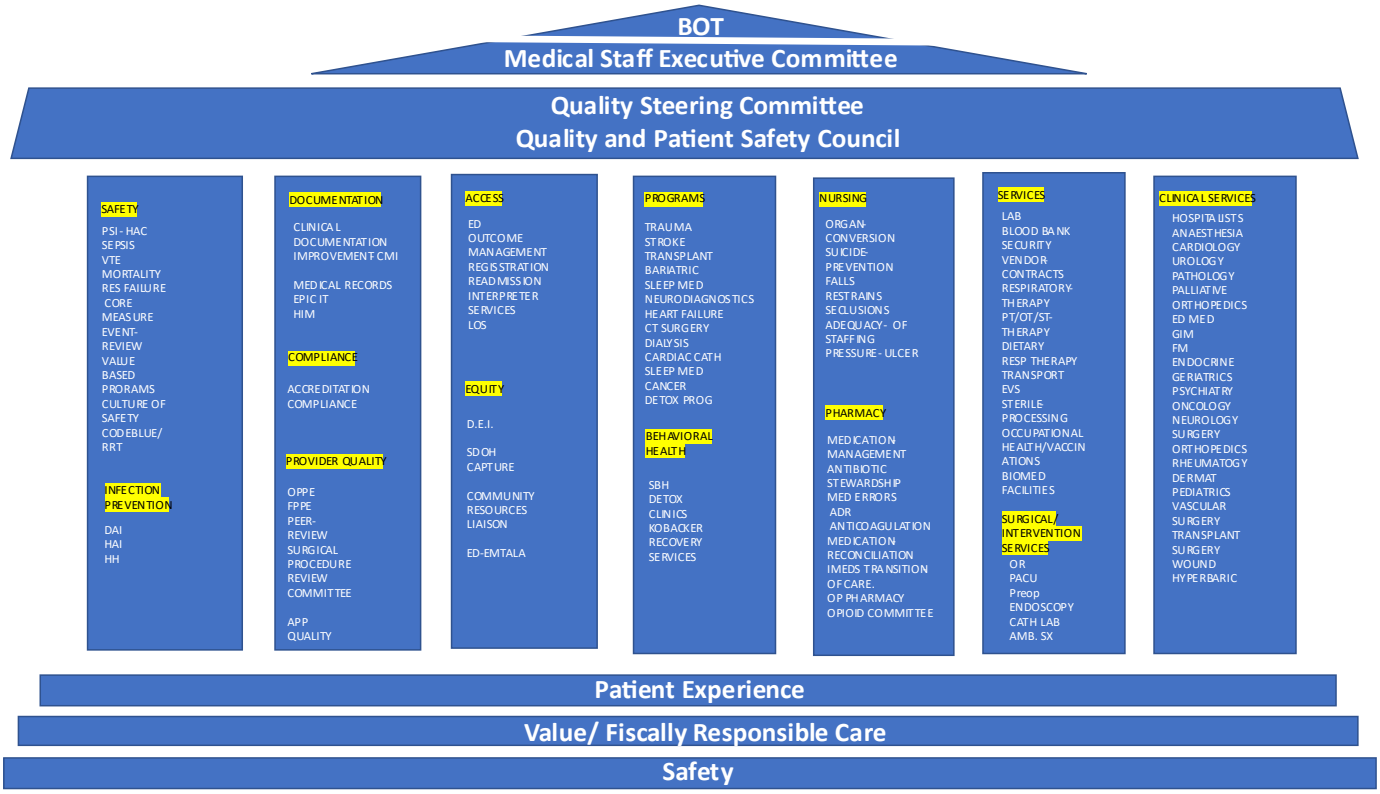
Name of Data Registry	Measures Associated with Registry	Clinical Department
STS Adult Cardiac	NQF measures	Cardiac Surgery
NCDR PCI RR & SMH	STEMI Core Measures	Cardiac Intervention
NCDR-TVT	CMS mandatory registry for valve replacement	Cardiac Intervention
MBASQIP	Bariatric peri-op and postop	General Surgery
Outcome-GWTG Heart Failure	JC and GWTG measures	Cardiology
NCDR Chest Pain- AMI	JC and GWTG measures	Cardiology
Outcome-GWTG Stroke	JC and GWTG measures	Neurology
NCDR LAAO (Left Atrial Appendage Occlusion Registry	Watchman device implantation for atrial fibrillation/ stroke prevention	Cardiac Intervention
UNOS-Kidney Transplant	Mandatory donor registry for pts in kidney waiting list	Kidney Transplant Program
SRTR-Kidney Transplant Recipients	Graft survival rates of kidney transplant recipients	Kidney Transplant Program
CCSP - Cancer Surveillance	Cancer cases abstracted & survivor follow up	Oncology
National Trauma Data Bank- ACS	Outcomes of trauma patients	Trauma program

Performance Improvement projects (Ongoing and Iterative)

PI Project	Department
Reduce HbA1C poor control in diabetes patient population	Family Medicine, Quality
Follow-up after ED visit for alcohol or other drug abuse.	Behavioral Health- ED- Quality
30-day Readmission reduction	Outcomes management, Quality
Follow-up After Hospitalization for Mental Illness	Behavioral Health, Quality

Table: STRUCTURE OF REPORTING UTMC

QUALITY – CLINICAL AND NONCLINICAL



PRIORITIZATION MATRIX –FY 2026

Quality and Patient Safety Focus Areas

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	✓			✓	✓			✓	✓	✓

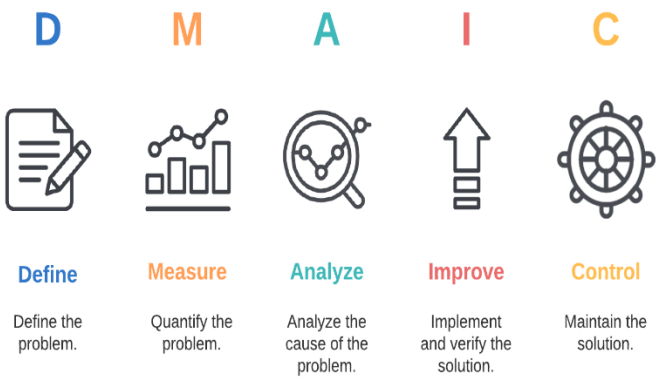
Monitor External Regulatory Compliance Indicators

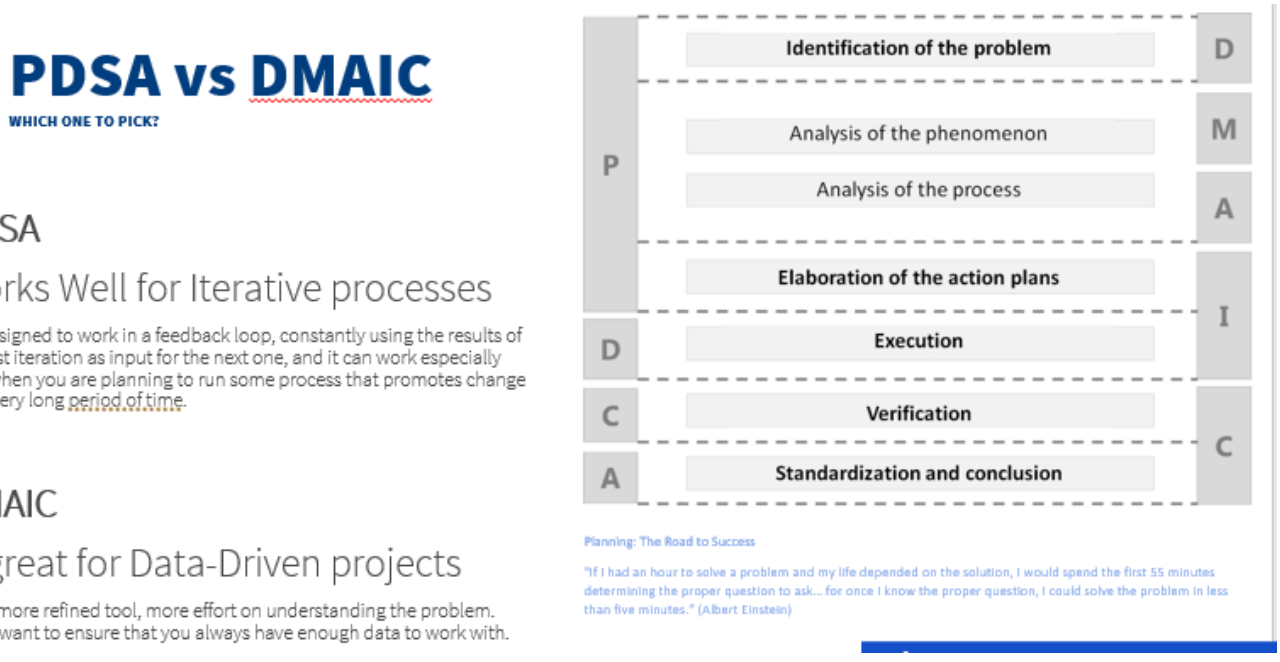
Opportunity	High Risk	High Volume	Problem Prone	Important to Mission	Customer Satisfaction	Staff Satisfaction	Physician Satisfaction	Clinical Outcome	Safety	Regulatory Requirement
Resuscitation	✓							✓	✓	✓
Sedation/Analgesia	✓							✓	✓	✓
Pain	✓	✓	✓		✓			✓	✓	✓
Resource Utilization				✓						✓
CORE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

Opportunity	High Risk	High Volume	Problem Prone	Important to Mission	Customer Satisfaction	Staff Satisfaction	Physician Satisfaction	Clinical Outcome	Safety	Regulatory Requirement
Adverse Drug Reaction	✓		✓	✓				✓	✓	✓
Organ Conversion				✓						✓
Restraints	✓			✓	✓			✓	✓	✓
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	✓		✓	✓	✓			✓	✓	✓

EVIDENCE BASED METHODOLOGIES FOR QUALITY IMPROVEMENT

Plan-Do-Study-Act
Define Measure Improve Analyze and Control





QUALITY PERFORMANCE IMPROVEMENT QUARTERLY REPORT

Team/Disciplines: _____

USE PDSA or DMAIC (WHICHEVER FITS PROJECT NEEDS)

THE PDSA CYCLE

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?)

DMAIC

Define: What problem would you like to fix? Define is the first phase of the Lean Six Sigma improvement process. During this phase the project team can create a Project Charter, plot a high-level process map of the and clarify the needs of the process customers. Observation exercises such as “Gemba walks” or “Go-see” can be used to collect information.

Measure: How does this process currently perform? What is the magnitude of the problem? Measurement is critical throughout the life of the project since it provides key indicators of process health and clues to where process issues are happening.

Analyze: What is causing the problem? Without proper analysis, implemented solutions may not resolve the issue—this wastes time, consumes resources, increases variation and risks causing new problems. The crux of this phase is to verify hypotheses before implementing solutions.

Improve: How will the team fix the root causes of the problem? The Improve Phase is where the team refines their countermeasure ideas, pilots process changes, implements solutions and lastly, collects data to confirm there is measurable improvement.

Control: How do you sustain the improvement? With improvements in place and the process problem fixed, the team must work to maintain the gains and make it easy to update best practices. In the Control Phase, the team develops a Monitoring Plan to track the success of the updated process and crafts a Response Plan in case there is a dip in performance. Once in place, the Process Owner monitors and continually updates the current best method.

Contact Person Completing Form: _____Dept._____

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

Quality and patient Safety Council Calendar of reporting – Perpetual

QPSC Months	S	O	N	D	J	F	M	A	M	J	J	A
QEC/Board Report Reviews/Approvals												
Measures - To Board (including measures publicly reported)												
30 day readmission rate		AA, BP			AA, BP			AA, BP			AA, BP	
In pt. Mortality Review Index		AH				AH			AH			AH
Length of Stay Index					AA				HF			
Cases with HAC/PSIs						CC			CC			
Quality plan approval: Annual review of targets,measures and goals/projects									ME, PY, RS			
Quality Plan metrics review "Pulse Check" and Appraisal		Appraisal				PY, CC						
Value Based Care							BP					PY
Health Equity Sub Committee	PY											
Policy Review and updates								PY				
Equity Standards									RS, PY			
Standing Reports												
Utilization / Outcome Management (Pt. Flow)		AA, DK, WM										
Serious safety event update	PY	PY	PY		PY	PY	PY	PY	PY	PY	PY	PY
PSN Trends and SAC Matrix	JF,	JF, J	PY, JF, JC		JF,	JF, J	JF,	JF,	JF,	JF,	JF,	JF,
Patient satisfaction: grievance/complaints/compliments							TP, CP*					
Culture of Safety							,R					
Service Excellence Statistics and Trends-Quarterly		TP, CSR			TP, CSR			TP, CSR *			TP, CSF	
Regulatory update						CC						
NPSG goals	PY											
Projects												
VTE Task force	AH, JS											
Skin Care – PSI 03 Pressure Ulcers								PV, KB, KK				
Falls												JW
Sepsis										FS, PV		
Sedation											KF, KK	
PSI 11 Update/Respiratory Failure						PV, FS						
HIT-CPOE/Barcode/Smart pump performance(Pharmacy/biomed)					LE, SC, SH							
Service lines/ departments/ committee reporting												
Pharmacy												
Medication Management – P&T		RS,										
Antibiotic Stewardship		LE, CG, MR?										
Errors , ADR, Anticoagulation		MS										
iMeds transition of care						HS (postponed)						
Inpatient Pharmacy Annual Summary						LE						
Opioid Committee		KR										
Hemodialysis			AM, DM									
Endoscopy and Amb Surgery	AN, MM											
Dana Cancer Center											CA	
Emergency Department (EMTALA, Times, Transfers)			WS, JB									
Organ Conversion			KC									
[illegible]												
Radiology												AI
Anesthesiology –			KJ, AC									
Heart failure Program + TAVR + Watchman for LAAO						GM, BY, LB, MT, CM						
Behavioral Health Update - SBH, Kobacker, Detox					SC, TC, DK, RS							
H & V Services					TK							
Cath Lab -						EE, LB						
Environment of Care						HL						
Haz. Material & Safety - Heather Lorenz						HL						
Emergency Prep – Nicole Meagher						NM						
Nursing –												
· Restraints						PM, KK- CNO						
· Code Blue/ Failure to rescue						MK, AH						
· Adequacy of Staffing							KK, KF					
Surgical services – Tim Etue/Ryan Plymale, Michelle Mallet			MM, TE, RP, SP, AR									
Sterile Processing							CL, MG, MM					
Sedation							KK, KF					
Suicide prevention							KK, KF					
Transplant Quality Data										JH, MR		
Diet/Nutrition PI Update							ML, DO					
Orthopedics								AF, MS				
Cardiac Surgery – STS								SG, LA, LB				
Infection Prevention								AK, ME				
Respiratory Therapy								MK (PFT and R				
Sleep Disorder Center/Neurodiagnostic-EEG			MT, AA, IA, MK									
PT/OT								SF, JM, AM				
Trauma -												K(
Pathology/Procedural Case Review									CG, CF			
Blood Utilization & Transfusion									DW, LS			
Stroke											RB, K	
BioMed		SH										
Facilities Management	MN									MN		
Hospital Security										BS		
Legal Affairs Contract Compliance -		CM			CM			CM			CM	
Medical Records		BH*										
Clinical Documentnation Imrpovement CMI	?				AA							
Pathology:Specimen Tracking / Lost Specimens, Utilization of Labs, TAT											G	
Time out PDSA Surgical safety			MM									
Environmental Services	EVS											
Ad Hoc Topics												
- PI Collaboratives (OHA/Vizient/Ect)										…		
PI Specific Initiatives: Process for recalls from manufacturers.										U		
- Medication Updates – Shortages, Exchanges, etc												
- Culture of Safety Survey Results												
- IT Updates (documentation)												
Emergency Disaster Info												
TJC/ISMP Sentinel Event Alert and Quick Safety updates												
CMS Value Program Results / Leapfrog as they are reported					RS							
Med Staff Updates												
OPPE (only report numbers of completed %)	Dir	Dir	Dir-MS		Di	Dir-	Dii	Di	Dii	Di	Dii	Di
Peer review case log(only report numbers of completed %) proposed in future	Dir	Dir	Dir-MS		Di	Dir-	Dii	Di	Dii	Di	Dii	Di
Feedback From Med Exec/ Board of Trustees	ME	ME	ME		M	ME	MI	M	MI	M	MI	M
Trauma Quality Committee minutes	AC	AC	AC		A	AC	AC	A(	AC	A(	AC	A
Surgical Services Committee	MI	MI	MM		M	MN	MI	M	MI	M	MI	M
HIM Comittees Annual Plan and findings	PE											
Pharmacy and Therapeutics Committee Annual Plan and Findings	LE											
Pressure Ulcer - Early mobility A3			KF, BP									

REGULATORY READINESS

Program Area	Accreditation Organization	Cycle
340B Drug Program	Health Services Resources Administration Office of Pharmacy Affairs	No cycle for HRSA, 2 years for independent.
Pharmacy	Board of Pharmacy	
Ryan White Program/Grant	Site Visit for Ryan White funding, HHS	No set cycle, the program doesn't require site visits.
Lab	American Society for Histocompatibility and Immunogenetics	2 year
Food and Nutrition Services	Ohio Department of Health / License (all three HSC locations)	1 year
Bariatric Accreditation	MBSAQIP	New certification
Food and Nutrition Services Hospital	Ohio Department of Health / Site Evaluation	6 months
Food and Nutrition Services BHC	Ohio Department of Health / Site Evaluation Inpatient Behavioral Health/Kobacker Center	6 months
Thrombectomy Capable Stroke Program	The Joint Commission	2 year
Radiology/Mammography DCC	Ohio Department of Health / FDA / MQSA	1 year
Cardiac Cath	Ohio Department of Health	5 year
Open Heart	Ohio Department of Health	5 year
Solid Organ Transplant	Ohio Department of Health	5 year
Infection Control/COVID Vaccine Mandate	Ohio Department of Health	Varies
Emergency Preparedness	Ohio Department of Health	Varies
Hemodialysis	ODH on behalf of CMS	2 year
Heart Station / Echocardiography	Intersocietal Commission for the Accreditation of Echocardiography Laboratories ("ICEAL")	3 year
Radiology/MRI 1.5T , 3T scanner, MRI Breast.	American College of Radiology Magnetic Resonance Imaging, submit images and reports.	3 year
Transplant	UNOS/OPTN / Deceased and Living Donor Program	3 year
Eleanor N. Dana Cancer Center	Commission on Cancer	3 year
Radiology/Mammography	American College of Radiology Mammography/Online, send reports, etc.	3 Year
Advanced Heart Failure Certification	The Joint Commission	2 year
Lab	College of American Pathologists ("CAP")	2 year
Radiology/CT 64 Slice, CT 320 Slice	American College of Radiology Mammography/Online, send reports	3 Year
Trauma Level II	American College of Surgeons / Trauma	2 year
Kobacker	Ohio Department of Mental Health	3 year
Regency Radiation Generating Equipment Inspection CCC	Ohio Department of Health RGE CCC	3 year
Radiology/Nuclear Medicine & Radioactive Materials	Ohio Department of Health RAM both HSC and MC	2 year

HSC Radiation Generating Equipment Inspection (Includes Cath Lab, Diagnostic, CT, Rad Oncology).	Ohio Department of Health RGE	2 year
Radiology/PET	American College of Radiology Mammography/Online, send reports	3 Year
Sleep Lab Accreditation		2 year
Vascular Ultrasound	Intersocietal Commission for the Accreditation of Vascular Laboratories (IAC) All online/report submissions.	3 Year
Nuclear Medicine	American College of Radiology / No onsite visit / online application	3 year
Behavioral Health Services	The Joint Commission	3 year
Home Care (DME for DCC Renee's Survivor Shop)	The Joint Commission	3 year
Transplant	ODH on behalf of CMS	5 year