Model Quality Improvement (QI) Plan

The Model QI Plan was drafted as a guide to facilities as they develop their own plan. This plan outlines the basic components to include. Examples of language used in QI plans, provided by members of the Committee, are also included.

Purpose/Introduction:

The mission of Our Hospital is to provide quality health care which recognizes the inherent human worth and dignity of all persons, and to make our programs and services available to all without restriction; to create a healing environment where physicians, allied health professionals and staff work together to provide personalized care; to be a leader in advocating high quality health care programs and developing resources to satisfy the primary health care needs of the citizens of our service area; and to operate in an ethically and fiscally responsible manner without compromising the patient and patient care needs.

Consistent with this mission, our goal is to provide care that is:

> **Safe** – avoiding injuries to patients from the care that is intended to help them;
> **Effective** – providing services based on scientific knowledge to those who would benefit, and refraining from providing services to those not likely to benefit;
> **Patient centered** – providing care that is respectful of, and responsive to, individual patient preferences, needs, and values and ensuring that patient values guide all clinical decisions;
> **Timely** – reducing waits and potentially harmful delays;
> **Efficient** – avoiding waste, including waste of equipment, supplies, ideas and energy;
> **Equitable** – providing care that does not vary in quality because of personal characteristics such as gender, ethnicity, geographic location, and socioeconomic status.

To achieve this goal, all employees of Our Hospital will participate in ongoing and systematic quality improvement efforts. Our quality improvement efforts will focus on direct patient care delivery processes and support processes that promote optimal patient outcomes and effective business practices. This is accomplished through peer review, clinical outcomes review, variance analysis, performance appraisals, and other appropriate quality improvement techniques.

Our Quality Improvement Plan demonstrates our hospital's commitment to improve the quality of care we deliver. The QI Plan outlines the goals and strategies for ensuring patient safety, delivering optimal care, and achieving high patient satisfaction.

Authority:

The Board of Directors of Our Hospital is ultimately responsible for assuring that high quality care is provided to our patients. The Board delegates the responsibility for

implementing this plan to the medical staff, through its Medical Staff/Utilization Management Committee, the Quality Improvement Committee, and to the hospital's Leadership Team.

Scope:

To achieve the goal of delivering high quality care, all employees are given the responsibility and authority to participate in the quality improvement program.

The Quality Improvement Program includes the following activities:

- All direct patient care services and indirect services affecting patient health and safety
- Medication therapy (includes medication errors)
- Utilization management/PEPP (Hospital Payment Monitoring Program)
- Nosocomial infections
- Patient/staff/physician satisfaction surveys
- Professional staff credentialing
- Surgical case review
- Blood usage review
- Medical record review (includes active and closed record reviews)
- Risk management activities
- Patient/Staff/Physician satisfaction surveys
- Morbidity/Mortality Review
- JCAHO's 2003 National Patient Safety Goals
- (List other activities as appropriate to your facility, such as the QIO Surgical Site Infection project)

Quality Improvement Committee:

The Quality Improvement Committee consists of the following individuals: The CEO, Chief of Staff/designee, the Director of Nursing, the QI Manager, Pharmacist, Infection Control Nurse, Utilization Management Manager, representative from the Hospital Board of Directors. (Specify other Department Managers/Directors, Ancillary Services Mangers/Directors, Nursing Managers/Directors and Physicians as appropriate for your facility.)

The members of the QI Committee are responsible for

- Assuring that the review functions outlined in this plan are completed;
- Prioritizing issues referred to the QI Committee for review;
- Assuring that the data obtained through QI activities are analyzed, recommendations made, and appropriate follow up of problem resolution is done;

- Incorporating internal and external sources of benchmarking data, utilizing the Clinical Outcomes Measurement System (COMS) data and Project-in-a-Box data (CART data), and JCAHO's 2003 National Patient Safety Goals;
- Identifying other sources, such as the JCAHO's 2003 National Patient Safety Goals, for incorporation into the hospitals overall quality improvement efforts;
- Reporting on ongoing findings, studies, recommendations, and trends to the Governing Board quarterly and annually; reporting to the QI Committee and Medical Staff monthly; and reporting to hospital staff as appropriate;
- Identifying educational needs and assuring that staff education for quality improvement takes place;
- Appointing sub committees or teams to work on specific issues, as necessary;
- Assuring that the necessary resources are available;
- Coordinating activities with the CAH Network Hospital.

Medical Staff Responsibility:

The medical staff at Our Hospital participates in surgical case review; blood usage review; medical record review; infection control; pharmacy and therapeutics review; mortality review; utilization management, including PEPP and all denials issued by payers; review of transfers to other facilities; credentialing; and will serve, from time to time, as liaisons to the Quality Improvement Committee and any subcommittees it causes to be created. The ultimate goal is to improve the quality of care that is routinely provided to the patients of Our Hospital

Department Staff Responsibility:

Every department within Our Hospital is responsible for implementing quality improvement activities. All quality improvement initiatives must be conducted as a part of the hospital wide Quality Improvement Committee activities. Each department manager is responsible for identifying quality indicators, collecting and analyzing data, developing and implementing changes to improve service delivery, and monitoring to assure that improvement is made and sustained. The ultimate goal is to improve the quality of care that is routinely provided to the patients of Our Hospital.

Network Hospital Responsibility:

Our Hospital is a member of the XYZ Critical Access Hospital Network. ABC Hospital, as our network hospital, is responsible for providing support to Our Hospital for implementing this Quality Improvement Plan. The CAH Network allows us to work with other Critical Access Hospitals to identify appropriate measures of quality for CAHs, provides a mechanism to meet licensure and certification requirements for outside quality

review, and to establish best practices to implement in Our Hospital. (May already have language in contracts with network hospitals.)

Confidentiality:

As the hospital's medical staff committee, the information created or caused to be created by this Quality Improvement Plan is protected by Neb.Rev.Stat. Section 71-2046 to 71-2048.

The interviews, reports, statements, other data, proceedings and records of the Quality Improvement Committee shall be privileged and confidential and shall not be subject to discovery either by subpoena or other means of legal compulsion for release to any person or entity for any reason, including use in any judicial or administrative proceeding.

No member, consultant, advisor or person supplying information to the Quality Improvement Committee or sub-committee(s) shall disclose information concerning matters submitted to, considered by, or issuing from the Quality Improvement Committee or sub-committee(s). Unauthorized disclosure shall be grounds for disciplinary action, including termination of employment or termination of medical staff privileges. No disclosure of any such interview materials, reports, records, statements, memoranda, proceedings, findings, or data shall be made without the authorization of the Quality Improvement Manager or his/her designee.

Comparative Databases, Benchmarks and Professional Practice Standards/Best Practices:

Our Hospital will use comparative databases to incorporate a process for continuous assessment with similar organizations, standards and best practices. This assessment then leads to action for improvement as necessary. Databases that Our Hospital utilizes on an ongoing, routine basis are listed in Appendix "A".

Scope of Review:

Define the review to be done for each of the activities listed under "Scope". For each activity specify the type of review to be done. Include frequency, who is responsible, and how the results are reported. The definition may be written in this QI plan, may be written in departmental plans and referenced in this QI plan, or may be defined by policies and procedures which are referenced in this QI plan. (See tool kit for sample documentation)

Quality Improvement Processes and Methodology:

The Quality Improvement plan is a framework for the organized, ongoing and systematic measurement, assessment and performance improvement activities. The components of this plan include:

A quick fix process will be used for problems that do not need a comprehensive approach to problem solving and solution implementation.

Quality assessment activities, such as patient and staff satisfaction surveys, blood use, medication therapy, infection control surveillance, utilization management, and medical record review. These activities help assure that standards are met and maintained, and identify areas for review by quality improvement teams.

Quality improvement teams, which may be inter or intradepartmental, and which look at particular issues to identify opportunities to improve processes and outcomes.

Dashboard report, which provides summary data about selected indicators, prepared for the Board, Quality Improvement Committee and Medical Staff.

Outside sources/comparative databases, such as CART, COMS, professional practice standards, JCAHO, etc., will be used to compare our outcomes and processes with others, identifying areas to focus quality improvement efforts.

The quality improvement methodology we will use is the (select one.)

- ❑ PDSA
- ❑ Six Sigma

PDSA

PLAN the improvement. Identify the opportunity for improvement; define your objective. Ask why are we doing this and how can we do it differently to make it better. Develop a multidisciplinary team; identify what you will measure.

DO the improvement process. Collect and analyze data. Implement your change strategies. Do small changes.

CHECK/STUDY the result. Understand the source of errors. Review the re-measurement data. Were the results of the change better, worse or a lateral change?

ACT to hold the gain and continue to improve the process. Follow up with documentation and report to the people involved.

SIX SIGMA

DEFINE the problem and set the goal; focus not simply on the outcomes, but on the process. Write a problem statement. Develop a charter; identify who is the customer and what are their requirements. Map the process as it occurs now, to identify areas for improvement. Identify the benefits of making improvements.

MEASURE the defects or process operation. Develop a tool to collect the necessary data. Look to existing sources that you may already be collecting to help measure the problem.

ANALYZE the data and discover the causes of the problem. Use brainstorming techniques, bar graphs, etc., to help analyze. Identify the process that needs improving (identify the root cause).

IMPROVE the process to remove causes of defects. Test solutions on a small scale to see if they work. If it doesn't work, try another process. Fail small, fail often.

CONTROL the process to make sure defects don't recur. Establish standard measures to maintain performance.

Communication:

The Quality Improvement Committee provides oversight and functions as the central clearing house for quality data and information collected throughout the facility. The QI Committee tracks, trends and aggregates data from all sources to prepare reports for the governing board and the medical staff.

As the hospital's medical staff committee, this information is protected by Neb.Rev.Stat. Section 71-2046 to 71-2048.

Education:

All staff are given the responsibility and authority to participate in Our Hospital's Quality Improvement Plan. To fully accomplish this, all staff will be provided education regarding the QI Plan during their initial orientation, and on an annual basis thereafter. This education will include a description of the QI Plan and how they fit into the plan, based on their particular job responsibilities. It will also include education regarding the QI methodology (Specify methodology) utilized by Our Hospital.

Annual Evaluation:

Our QI Plan will be evaluated on an annual basis for effectiveness in achieving the goal of assuring that the most appropriate quality of care was provided to our patients. A summary of activities, improvements made, care delivery processes modified, projects in progress, and recommendations for changes to this QI Plan, will be compiled and forwarded to the Board for action.