Madera Community Hospital

QUALITY ASSESSMENT
PERFORMANCE IMPROVEMENT PLAN
FYE 2021

AUTHORITY AND RESPONSIBILITY
The Board of Trustees has the authority and responsibility to require and support a Quality Assurance and Performance Improvement Program (QAPI) at Madera Community Hospital. The Board of Trustees has delegated the responsibility of implementing an organization-wide QAPI program to the Chief Executive Officer (CEO), the Medical Staff and the Leadership Council.

BOARD OF TRUSTEES
The Board of Trustees receives QAPI reports from the Leadership Council. The Board of Trustees also receives other quality related reports and recommendations, as necessary, from the Medical Executive Committee (MEC).

LEADERSHIP COUNCIL
CEO, VP's, Administrative Staff, Chief of Staff, and appointed Medical Staff and Board members serve as the Leadership Council. The CEO and Chief of Staff also serve on the Board of Trustees. The council is responsible to approve and oversee the organization-wide QAPI Program.

The Leadership Council shall:

- Annually approve the organizational wide QAPI Plan including individualized department or service specific indicators to improve quality care utilizing evidence based practices.
- Prioritize and appoint organizational wide QAPI Teams to improve quality outcomes.
- Receive and act on reports of QAPI outcomes and communicate findings and actions to the MEC and Board of Trustees.
- Assure QAPI monitoring outcomes are communicated to hospital and medical staff members.
- Assure the effectiveness of sentinel event corrective action through QAPI monitoring.
- Facilitate integration of risk reduction strategies into the QAPI program to reduce medical errors.

CEO
The CEO oversees the development and implementation of the QAPI activities to assure the integration and coordination of service-specific activities into the organization- program. Educational resources shall be allocated by Administration for employee education and participation in QAPI activities. The CEO delegates authority to the Director of Quality Management and the Vice President Chief Nursing Officer for coordinating and implementing the program.

MEDICAL STAFF
Medical Staff Members are assigned by the MEC to serve on the Quality Improvement Committee (QIC). QIC monitors the approved QAPI Plan indicators and reports actions and findings to the MEC and Leadership Council. The Departments of Medicine and Surgery will also be informed of the QAPI outcomes and actions.

PLAN

The organization-wide QAPI Plan encompasses major important aspects of care provided by the hospital and Medical Staff in support of the achievement of MCH's mission and strategic goals. This includes continual quality data measurement, assessment and process improvement activities. The Plan describes the overall process for Departments and Services to collaboratively perform QAPI activities in a systematic manner, including the communication of activities and outcomes directed towards improving quality care and services.

"Department" refers to the Medical Staff departments and "Service" refers to the clinical and non-clinical hospital support services, including those provided under contract. Each Service Director develops a unit specific plan, consistent with the mission and scope of services provided in their unit which describes the goals, standards of practice, standards of care and measurements to be utilized in performance improvement.

NURSING SERVICES

The Chief Nursing Officer is responsible for the integration, development and coordination of the nursing QAPI into the organization-wide performance improvement program through participation and representation of nursing on organizational performance improvement teams in conjunction with the Director of Quality Management. The nursing department also maintains quality control programs as required for safe patient care delivery. The substantive results of nursing QAPI monitors are reported to the assigned Medical Staff Committees, MEC and Leadership Council.

QUALITY CONTROL

Each Service and Department maintains quality control measures and programs as appropriate. The substantive results of quality control programs will be regularly reported to the assigned Medical Staff Teams, MEC and the Leadership Council and Governing Body.

EDUCATION

QAPI education will be provided to the QAPI Teams, Medical Staff, hospital employees and contract employees, MEC, Leadership Council and Board of Trustees. QAPI education will be provided to the Medical Staff members at the time of appointment and reappointment and to hospital employees at the time of hire. Ongoing QAPI education and reports will be provided to all involved employees and Medical Staff members, which is an important component of QAPI activities.

PATIENT SAFETY AND MEDICAL ERROR REDUCTION INTEGRATION

Reduction of medical errors and the delivery of safe patient care is a priority. Occurrences are reported through the electronic event management system and overseen by Risk Management and the department Directors. Individual and trended reports are provided to Administration, Medical Staff and Services for information and follow up. Information related to adverse events, unusual occurrences, medical errors, sentinel events and error reduction is also provided to appropriate Root Cause Analysis committees, QAPI committees and other organizational teams for implementation of risk reduction strategies and monitoring. Aggregate information related to patient safety and the risk management program is reported to the Leadership Committee, MEC and Board of Trustees on a regular basis by Risk Management. Additionally, aggregated event data is reported to CHPSO, the California Hospital Patient Safety Organization, to facilitate state-wide review and learning about safety issues impacting patients in California.

INTERDISCIPLINARY QAPI TEAMS

QAPI teams, appointed by the Leadership Council, are interdisciplinary department and service groups organized to collaboratively measure, assess and improve important functions and processes within the organization. In selecting members for process improvement teams, the organization will select providers who are most closely associated with the processes being studied.

PLAN * DO * CHECK * ACT

Process improvement activities are carried out on an ongoing basis, as described in this plan utilizing the rapid cycle Plan*Do*Check*Act (PDCA) model to improve the timeliness of transforming information into activities and improve the care delivery and outcomes. PDCA tests a change in the real work setting by planning it, trying it, observing the results, and acting on what is learned. This is the scientific method used for action-oriented learning. When actions are taken to improve a process, the following elements should occur, if appropriate:

- Plan specific process changes.
- Collect baseline data of performance.
- Implement process changes on a pilot / trial basis.
- Measure and assess the effectiveness of the actions taken.
- If initiated actions do not achieve desired outcomes, then redesign process changes.
- If implemented process changes meet desired outcomes, then implement changes on an organization- wide basis.
- Continue measurement to ensure that the process improvement is maintained.

MONITORING

Process Design

When MCH is designing or redesigning a process or system, they will be based upon;

- MCH's mission and vision.
- The health care needs of the community and input from community leaders.
- The needs and expectations of patients, staff and other customers.
- Department goals and services provided.
- Quality and performance indicators designed to improve quality care delivery and outcomes.
- Up-to-date information including evidence based practice guidelines.
- Performance dimensions (PD) shall include- (A) Efficacy (B) Appropriateness (C) Availability (D), Timeliness (E) Continuity of services with respect to other services/practitioners/organization (F) Safety (G) Efficiency (H) Respect and Caring (I) Effectiveness.
- Quality Indicators (QC codes) may include (R) Required by accreditation or regulatory agency; (S) Standard monitor used in the profession/industry (but not mandated by accreditation or regulatory agency); (M) Monitored to assure the stability of an important process (historically not a problem); (T) Targeted for improvement.

Measurement

MCH has systematic process in place to collect QAPI data.

- Key indicators selected for review shall be prioritized according to high volume, high risk or specific identified problem prone areas.
- Data sources measured may be internal and/or include from external comparative data bases.
- Data is collected monthly and reported quarterly.
- Measures related to quality control activities will also be carried out on an ongoing basis as determined to be necessary by each Department or Service.
- Other indicators identified for focused improvement must be measured until expected outcomes are met and sustained for a minimum of six to nine months.
- Some key indicators may be measured indefinitely.
- Thresholds for Evaluation/Benchmark (TFE/B) shall be based upon targeted performance goals and/or published standards. If no published data is available, measures from past performance may be used.
- Measurement outcomes shall be reliable with high inter-rater reliability. Source data must be verifiable from MCH medical records or from observed data. Statistical measurements must include adequate data sampling, as follows:
    - For a population size of fewer than 30 cases, sample 100% of cases.

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

Assessment and Reporting

- Utilize assessment tools and techniques including data aggregation, analyzing performance over time, statistical process control, comparative data, comparison to clinical practice guidelines and other techniques that may be appropriate to evaluate the outcome data.
- Reports shall be submitted quarterly per the annual reporting schedule and include verifiably correct numerators and denominators.
- Display results with dashboards, run charts, control charts and other statistical methods. Graphs should include a title, data points, color for distinction of columns or graphs, labeled vertical axis with the key element or process measures, labeled horizontal axis in "time" or specific data points, add targeted benchmarks whenever possible. Added desired direction symbols, chart interpretation text may be added to the chart. Other options include average data points, average centerlines, standard deviations etc. Outcomes below expected thresholds require an analysis and action summarized on the Report.
- Intensified assessments related to a sentinel event will include a thorough and credible root cause analysis.
- Clinical contracted patient care services will be assessed annually by the **Quality Improvement Committee,** Medical Executive Committee and recommendations made to the Leadership Council and Board of Trustees to ensure services meet contractual, patient safety, timeliness and quality requirements.

PRIORITIES FOR 2020-2021

The priorities for hospital-wide improvement projects for this year include:

1. **Severe Sepsis/Septic Shock (SEP-1) – adherence to CMS core measure related to early identification and treatment of severe sepsis and septic shock.**
2. **Hospital-acquired condition prevention – prevention of CAUTI (Catheter associated urinary tract infections), CLBSI (Central-line associated blood stream infection), MRSA, C-diff and VRE prevention, pressure ulcer prevention and other post-surgical complications.**
3. **Medication Error Prevention Program – all titratable medication infusions will be administered per MD orders that include parameters, with appropriate documentation of RASS goals as applicable.**
4. **Patient Experience improvement – using Press Ganey as our vendor, Madera Community Hospital will address the patient experience by review of HCAHPS surveys with identification of best practices and implementation of action plans to improve scores. All grievances shall be investigated and resolved within the 30 days rule per MCH policy.**
5. **Expansion of Culture of Safety Program – implementation of Just Culture principles and AHRQ's Culture of Safety survey. Service specific results will be analyzed with action plans designed and implemented at the service unit level to ensure the service unit staff will be able to address their own unique needs.**

ANNUAL EVALUATION

An annual report, summarizing outcomes of the QAPI program will be submitted to the Leadership Council for approval at the end of the plan year. The report will contain information regarding opportunities identified to improve care through the QAPI process, the effectiveness of actions taken**.** Council recommendations regarding reported outcomes will be sent to the QIC and MEC. This annual report serves as the basis for development of the subsequent annual QAPI Plan. The Leadership Council shall forward the annual summary to the Medical Executive Committee and Board of Trustees.

MCH PERFORMANCE IMPROVEMENT MODEL

RAPID FOCUS P*D*C*A

- Find a process that needs improvement.
- Organize a team that knows the process.
- Clarify the current knowledge of the process.
- Understand the process and learn the cause of variation.
- Plan objectives, make a prediction regarding expected outcomes, identify actions to be taken, define responsibilities and timeframes. Define methods and frequency of measurement. Plan a small test of change to test approach.
- Do small tests of change; make modifications to policies, procedures and systems.
- Check and evaluate data, compare results to anticipated results, summarize findings.
- Act based upon the results of the study. Change the approach as indicated by the data and begin another cycle. Implement change in a broader setting.