An Orientation Guide for the New

Quality Improvement Professional

Developed by:
Nebraska Rural Quality Improvement Steering Committee
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Getting Started in Your New QI Position

This document was prepared to help you get started in your position as a quality improvement (QI) professional. It is meant to serve as an educational (not legal) resource to identify people and resources that are available to help you be successful.

The quest for quality is nothing new to the health care industry. The nation's first hospital, the Pennsylvania Hospital, was established in the mid 1700s by Dr. Thomas Bond, who with the help of Benjamin Franklin, persuaded the Pennsylvania legislature to undertake the organization and development of a hospital for the community. Over the next 150 years, the Pennsylvania Hospital became a model for the development of hospitals in other communities. It even attempted to standardize its care processes by publishing rules and regulations for its physicians and staff. These regulations represent early attempts at quality and health care improvement.

The American Medical Association was established in 1840 to represent the interests of physicians across the United States. In 1876, the Association of American Medical Colleges was established. Its purpose was to standardize the curriculum of US medical schools and to develop the public' s appreciation of the need for medical licensure. In the early 1900s, nurses began to organize state nursing associations to advocate for the registration of nurses. Their goal was to increase the level of competence among nurses nationwide. The hospital standardization and accreditation movement also began in the early 1900s. In 1912, Dr. Edward Martin, at the Third Clinical Congress of Surgeons of North America, made proposals that eventually led to the formation of the American College of Surgeons. The American College of Surgeons developed a minimum set of standards that US hospitals would have to meet if they wanted approval from the American College of Surgeons. In December of 1917, they formally established the Hospital Standardization Program and published a formal set of hospital standards, which they called The Minimum Standard. Over the next thirty years, the American College of Surgeons continued to examine and approve hospitals. Due to the growing number of hospitals being surveyed each year, the American College of Physicians, the American Medical Association, the American Hospital Association and the Canadian Medical Association joined the American College of Surgeons and formed the accrediting agency we now call the Joint Commission on Accreditation of Healthcare Organizations. The standards developed by the JCAHO covered every aspect of hospital care. Their intent was to ensure that the care provided to patients in accredited hospitals would be of the highest quality.

As an individual working in health care today, you will hear many terms reflecting the development of the quality improvement philosophy: quality assurance, quality improvement, quality management and performance improvement. They are all focused on one thing – providing quality health care, and doing so by the most efficient and effective means possible. The achievement of quality is an evolving quest, and one that is always seeking a better way. There are many ongoing national and Nebraska quality initiatives, which are discussed later in this guide.

Nebraska Association of Healthcare Quality, Risk & Safety (NAHQRS)

The Nebraska Association of Healthcare Quality, Risk and Safety (NAHQRS) is a voluntary association of individuals devoted to quality improvement. The Mission of NAHQRS is to develop and empower health care quality, risk and safety professionals to advocate for and improve patient care in Nebraska. The association meets six times a year offering educational programs with CEs, and a chance to network with your peers. A telehealth option is available for five of these meetings. During 2015, Nebraska hosted a national educational program for those who want to sit for the CPHQ exam.

For more information about NAHQRS or to complete an application for membership, go to www.nahqrs.org.

The Health Care Quality Professional Role

The quality professional is relied upon to navigate and understand the healthcare system which can often be complex and confusing. Below are some of the essential responsibilities that can assist in ensuring a successful quality program. These responsibilities can be adapted to your organization. This list is not intended to be all inclusive but to give direction to the new quality professional.

- **Evaluate organizational culture and develop a quality program that supports and strengthens culture**
  - Conduct employee engagement survey
  - Conduct culture of safety survey
- Establish goals and action plans that support organizational strategic plan, vision and mission.
  - If your organization does not have a current /effective strategic plan, vision or mission discuss strategic planning options at administrative level.
- **Establish priorities and strategic alignment for goals and objectives**
- **Select process and outcome measures to evaluate results**
- **Utilize established improvement methodology**
  - PDCA/PDSA
  - LEAN
  - DMAIC
  - Etc.
- **Understand quality terms and utilize quality tools**
  - Root cause analysis
  - Standard work checklist
  - Continuous data
  - Etc.
- **Communicate quality goals and outcomes at all levels in the organization**
  - What does transparency look like in your organization? For frontline? For your board?
- **Facilitate and develop quality and performance improvement teams**
- **Facilitate and lead change**
  - System/process redesign based upon results and outcomes
  - Data collection and analysis for established priority projects
- **Provide training and orientation on the organizations quality program**
- **Provide oversight, involvement in or have knowledge of the following processes and/or areas in your organization**
  - Credentialing
  - Privileging
  - Peer review
  - Survey preparation and readiness
  - Concurrent and retrospective chart audits and reviews
  - Voluntary/Mandatory reporting measures
    - Core measures
    - MBQIP (Medicare Beneficiary Quality Improvement Program)
    - PQRS (Physician Quality Reporting System)
    - Readmissions
    - Hospital-acquired conditions (HAI)
    - Etc.
  - Service excellence
    - Patient satisfaction
    - Employee engagement
    - Service strategies
    - Patient Advisory Council
    - Etc.
  - Infection prevention and control practices
  - Risk Management and Safety
    - Identification of risk
    - Risk prevention

As health care continues to move towards a performance-based system, the quality professional's role is key to ensuring accountability for the quality and safety of the care our organization is delivering. An effective quality program is vital to an organization's overall performance.

QA Resource Listing - July 2015

The following may be helpful resources for information to have or to know where to find:

Your Hospital Information

Most recent survey results. Always know where these are kept and make sure you have resolved any issues from past surveys. Has there been ongoing monitoring of the action plan to make sure past issues haven't surfaced again?

Network Agreements/Arrangements. These may be for quality or credentialing services or other patient care agreements. CEO usually keeps as is usually the case with contracts.

Organizational Chart. Keep current.

Medical Staff Bylaws/Rules and Regs. Be knowledgeable of content and where these are kept.

Facility QI Plan/Infection Control Plan.

Annual or Periodic Evaluation. This is a total "snapshot" of the CAH year, (volumes, services, QA practices, etc.).

Become familiar with: Grievances, Complaints, Advanced Directives, Informed Consents, EMTALA policies…

State of Nebraska Information

Nebraska Hospital Association: http://www.nebraskahospitals.org/

Nebraska Rural Health Association: http://nebraskaruralhealth.org/

State Operations Manual for Critical Access Hospitals (Appendix W): http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/som107ap_w_cah.pdf

State Operations Manual for Hospitals (Appendix A): http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/som107ap_a_hospitals.pdf

Other Appendix's to keep handy: Q = Immediate Jeopardy; V = EMTALA; B = Home Health – if you have this department, I = Life Safety Codes.

National Website Information

The Joint Commission: http://www.jointcommission.org/default.aspx

The American Hospital Association: Current Events, Newsletters, Hospital Listings in US…: http://www.aha.org/

CMS: http://cms.gov/; Has a website for resources such as the State Operations Manuals, Program transmittals, Guidance for laws and regulations, Medicare Learning Network, etc….

Centers for Medicare and Medicaid (CMS) Hospital Compare
http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/HospitalQualityInits/HospitalCompare.html

Rural Assistance Center: www.raconline.org

The Federal Register: www.gpoaccess.gov/fr/index.html

Great Plains Quality Innovations Network: (formerly CIMRO of NE): http://greatplainsqin.org/

gpTRAC – Great Plains Telehealth Resource and Assistance Center: http://www.gptrac.org/

Institute for Healthcare Improvement (IHI): http://www.ihi.org

National Rural Health Association: http://www.ruralhealthweb.org

National Association for Healthcare Quality (NAHQ): www.nahq.org

Association for Professionals in Infection Control and Epidemiology (APIC): http://www.apic.org

National Healthcare Safety Network: www.cdc.gov/nhsn

Agency for Healthcare Research and Quality (AHRQ): www.ahrq.gov

QualityNet: https://qualitynet.org

"The Janet A. Brown Healthcare Quality Handbook: A Professional Resource and Study Guide 28th Edition, 2015."
JB Quality Solutions: www.jbqs.org

"Journal for Healthcare Quality": http://journals.lww/jhqonline

Common QA Terminology

ADE – Adverse Drug Event
AHRQ – Agency for Healthcare Research and Quality
Balanced Scorecard – Typically measures Financial, Customer, Learning and Growth and Internal Business Processes
CAUTI – Catheter-Associated Urinary Tract Infection
CDI – Clinical Documentation Improvement
CLABSI – Central Line-Associated Blood Stream Infection
CUSS – I'm Concerned, I'm Uncomfortable (about a Safety issue), please STOP.
DMAIC – Define, Measure, Analyze, Improve, Control
EED – Early Elective Delivery
HCAHPS – Hospital Consumer Assessment of Healthcare Providers and Systems
HEN – Hospital Engagement Network
Hospital Compare – CART Tool – for data abstraction
ICD-10-CM/PCS – International Classification of Disease (Coding), 10th revision, Clinical Modifications/Procedures
Lean/Six Sigma – Efficiencies of resources
MBQIP – Medicare Beneficiary Quality Improvement Project
MRSA – Methicillin-Resistant Staphylococcus Aureus
NAHQRS – Nebraska Association for Healthcare Quality, Risk & Safety
NCPS – Nebraska Coalition for Patient Safety
PDCA – Plan, Do, Check, Act
PNA /PN – Pneumonia
PQRS – Physician Quality Reporting System
QIO – Quality Improvement Organization – Each state should have one.
RCA – Root Cause Analysis
SBAR – Situation, Background, Assessment, Recommendation
SSI – Surgical Site Infection
SSE – Serious Safety Event
STEMI – S.T. Elevated Myocardial Infarction
TeamSTEPPS – Team Strategies and Tools to Enhance Performance and Patient Safety
VAE – Ventilator-Associated Event
VTE – Venous Thromboembolism

Nebraska Statutes Related to Quality

71-3401. Information, statements, and data; furnish without liability.
Any person, hospital, sanitarium, nursing home, rest home, or other organization may provide information, interviews, reports, statements, memoranda, or other data relating to the condition and treatment of any person to the Department of Health and Human Services, the Nebraska Medical Association or any of its allied medical societies, the Nebraska Association of Hospitals and Health Systems, any in-hospital staff committee, or any joint venture of such entities to be used in the course of any study for the purpose of reducing morbidity or mortality, and no liability of any kind or character for damages or other relief shall arise or be enforced against any person or organization by reason of having provided such information or material, by reason of having released or published the findings and conclusions of such groups to advance medical research and medical education, or by reason of having released or published generally a summary of such studies.
Source: Laws 1961, c. 347, § 1, p. 1105; Laws 1992, LB 860, § 4; Laws 1994, LB 1223, § 44; Laws 1996, LB 1044, § 646; Laws 2007, LB296, § 561.

71-3402. Publication of material; purpose; identity of person confidential.
The Department of Health and Human Services, the Nebraska Medical Association or any of its allied medical societies, the Nebraska Association of Hospitals and Health Systems, any in-hospital staff committee, or any joint venture of such entities shall use or publish the material specified in section 71-3401 only for the purpose of advancing medical research or medical education in the interest of reducing morbidity or mortality, except that a summary of such studies may be released by any such group for general publication. In all events the identity of any person whose condition or treatment has been studied shall be confidential and shall not be revealed under any circumstances.
Source: Laws 1961, c. 347, § 2, p. 1106; Laws 1992, LB 860, § 5; Laws 1994, LB 1223, § 45; Laws 1996, LB 1044, § 647; Laws 2007, LB296, § 562.

71-3403. Information, interviews, reports, statements, data; privileged communications; not received in evidence.
All information, interviews, reports, statements, memoranda, or other data furnished by reason of sections 71-3401 to 71-3403 and any findings or conclusions resulting from such studies are declared to be privileged communications which may not be used or offered or received in evidence in any legal proceeding of any kind or character, and any attempt to use or offer any such information, interviews, reports, statements, memoranda or other data, findings or conclusions or any part thereof, unless waived by the interested parties, shall constitute prejudicial error resulting in a mistrial in any such proceeding.
Source: Laws 1961, c. 347, § 3, p. 1106.
Source: Laws 1961, c. 347, § 3, p. 1106.

71-7905. Purposes of act.
The purposes of the Health Care Quality Improvement Act are to provide protection for those individuals who participate in peer review activities which evaluate the quality and efficiency of health care providers and to protect the confidentiality of peer review records.
Source: Laws 2011, LB431, § 2.

71-7906. Definitions, where found.
For purposes of the Health Care Quality Improvement Act, the definitions found in sections 71-7907 to 71-7910 apply.
Source: Laws 2011, LB431, § 3.
71-7907. Health care provider, defined.
Health care provider means:
(1) A facility licensed under the Health Care Facility Licensure Act;
(2) A health care professional licensed under the Uniform Credentialing Act; and
(3) An organization or association of health care professionals licensed under the Uniform Credentialing Act.
Source: Laws 2011, LB431, § 4.
Cross References
- Health Care Facility Licensure Act, see section 71-401.
- Uniform Credentialing Act, see section 38-101.

71-7908. Incident report, defined.
Incident report or risk management report means a report of an incident involving injury or potential injury to a patient as a result of patient care provided by a health care provider, including both an individual who provides health care and an entity that provides health care, that is created specifically for and collected and maintained for exclusive use by a peer review committee of a health care entity and that is within the scope of the functions of that committee.
Source: Laws 2011, LB431, § 5.

71-7909. Peer review, defined.
Peer review means the procedure by which health care providers evaluate the quality and efficiency of services ordered or performed by other health care providers, including practice analysis, inpatient hospital and extended care facility utilization review, medical audit, ambulatory care review, root cause analysis, claims review, underwriting assistance, and the compliance of a hospital, nursing home, or other health care facility operated by a health care provider with the standards set by an association of health care providers and with applicable laws, rules, and regulations.
Source: Laws 2011, LB431, § 6.

71-7910. Peer review committee, defined.
Peer review committee means a utilization review committee, quality assessment committee, performance improvement committee, tissue committee, credentialing committee, or other committee established by the governing board of a facility which is a health care provider that does either of the following:
(1) Conducts professional credentialing or quality review activities involving the competence of, professional conduct of, or quality of care provided by a health care provider, including both an individual who provides health care and an entity that provides health care; or
(2) Conducts any other attendant hearing process initiated as a result of a peer review committee's recommendations or actions.
Source: Laws 2011, LB431, § 7.

71-7911. Liability for activities relating to peer review.
(1) A health care provider or an individual (a) serving as a member or employee of a peer review committee, working on behalf of a peer review committee, furnishing counsel or services to a peer review committee, or participating in a peer review activity as an officer, director, employee, or member of the governing board of a facility which is a health care provider and (b) acting without malice shall not be held liable in damages to any person for any acts, omissions, decisions, or other conduct within the scope of the functions of a peer review committee.
(2) A person who makes a report or provides information to a peer review committee shall not be subject to suit as a result of providing such information if such person acts without malice.
Source: Laws 2011, LB431, § 8.

71-7912. Confidentiality; discovery; availability of medical records, documents, or information; limitation.
(1) The proceedings, records, minutes, and reports of a peer review committee shall be held in confidence and shall not be subject to discovery or introduction into evidence in any civil action. No person who attends a meeting of a peer review committee, works for or on behalf of a peer review committee, provides information to a peer review committee, or participates in a peer review activity as an officer, director, employee, or member of the governing board of a facility which is a health care provider shall be permitted or required to testify in any such civil action as to any evidence or other matters produced or presented during the proceedings or activities of the peer review committee or as to any findings, recommendations, evaluations, opinions, or other actions of the peer review committee or any members thereof.

(2) Nothing in this section shall be construed to prevent discovery or use in any civil action of medical records, documents, or information otherwise available from original sources and kept with respect to any patient in the ordinary course of business, but the records, documents, or information shall be available only from the original sources and cannot be obtained from the peer review committee's proceedings or records.
Source: Laws 2011, LB431, § 9.

71-7913. Incident report or risk management report; how treated.
An incident report or risk management report and the contents of an incident report or risk management report are not subject to discovery in, and are not admissible in evidence in the trial of, a civil action for damages for injury, death, or loss to a patient of a health care provider. A person who prepares or has knowledge of the contents of an incident report or risk management report shall not testify and shall not be required to testify in any civil action as to the contents of the report.
Source: Laws 2011, LB431, § 10.

National Quality Initiatives

The Joint Commission (JC)

http://www.jointcommission.org

The Joint Commission is an independent, not-for-profit organization with the mission "to continuously improve health care for the public, in collaboration with other stakeholders, by evaluating health care organizations and inspiring them to excel in providing safe and effective care of the highest quality and value." As the nation's oldest and largest standards-setting and accrediting body in healthcare, the Joint Commission accredits over 20,500 health care organizations and programs in the United States are certified by the Joint Commission. Organizations that are not certified by the JC can benefit by measuring performance according to same set of standardized core performance measures required by the JC.

Performance measurement in health care represents what is done and how well it is done. Performance measurement is used internally by health care facilities to support performance improvement, and externally, to demonstrate accountability to the public and other interested stakeholders. Performance measurement benefits the health care facility by providing statistically valid, data driven mechanisms that provide performance information. This allows the health care facility to understand how well their facility is doing over time and have access to objective data to support claims of quality. The use of standardized core performance measures permits comparison of the actual results of care across hospitals. CMS has separate quality initiatives for hospital inpatients and outpatients, Critical Access Hospitals (CAHs), home health and nursing facilities.

Hospital Quality Reporting Program

http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/HospitalQualityInits/HospitalRHQDAPU.html

The purpose of the Hospital Quality Initiative is to provide data about quality for use by consumers and to provide hospitals with comparable information to use for their internal quality improvement efforts. The program, originally mandated by Section 501(b) of the Medicare Prescription Drug, Improvement, and Modernization Act (MMA) of 2003, authorized CMS to pay hospitals that successfully report designated quality measures a higher annual update to their payment rates. This incentive only applies to hospitals that are paid under the prospective payment system and therefore does not include CAHs. A list of current inpatient and outpatient hospital quality of care measures can be found here.

The reporting program requires hospitals to conduct the Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) Survey. Developed by CMS, the HCAHPS provides a standardized measure of patients' perceptions of their hospital experience. The survey contains a standard set of questions that hospitals ask of their patients. The survey can be completed by paper or by phone.

In addition to giving hospitals a financial incentive to report the quality of their services, the hospital reporting program provides CMS with data to help consumers make more informed decisions about their health care. Most of the hospital quality of care information gathered through the program is available to consumers on the Hospital Compare website. Hospitals that are paid on the prospective payment system method are required to participate in Hospital Compare or risk reduction in payment; critical access hospitals are encouraged, but not required by federal law or regulation, to participate in Hospital Compare. In Nebraska, almost all critical access hospitals participate in Hospital Compare. CMS uses inpatient data to determine an incentive or reduction of payment for perspective payment system hospitals for the readmission reduction and value-based purchasing programs.

Critical Access Hospital Quality Initiatives

Reporting Critical Access Hospital Quality Data for Annual FLEX grant funds: The Nebraska Office of Rural health provides funds to all of the critical access hospital networks from the Medicare Rural Hospital Flexibility grant program. The amount of funding is based on the number of CAHs in the network and must be used to fund activities and programs that improve the quality and performance of the CAHs in the network. In order to receive these funds, each network must submit a work plan and demonstrate that all of the CAHs in the network are submitting data for at least one measure into the CMS Hospital Compare Project. If one or more hospitals decide not to submit the data, the network will lose that amount of funding.

Nursing Home Quality Initiative

http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/NursingHomeQualityInits/index.html

One of the goals of the CMS Nursing Home Quality Initiative is to publicly report on the quality of care given at every Medicare- and Medicaid-certified nursing home. The measures for long-term care that are being monitored are loss of ability in performing daily tasks, pressure sores, pain, physical restraints and infections. The measures for short-term residents are delirium, pain and walking as well or better than upon admission.

The nursing home quality measures come from a nursing home's minimum data set, which is information collected by all nursing homes on their residents' physical and clinical conditions and abilities, as well as their preferences and life care wishes. CMS uses a process called risk adjustment before publishing this data. Risk adjustment takes into account the differences in nursing homes. For example, facilities vary in the level of overall health and functional impairment displayed by individual residents and also in admission and discharge practices.

CMS offers a Nursing Home Compare tool that contains demographic information about the nursing home; data on quality measures such as percent of residents with pressure (bed) sores, and percent of residents with physical restraints; results of surveys conducted by the Nebraska Department of Health & Human Services; and information about staffing.

Home Health Quality Initiatives

http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/HomeHealthQualityInits/index.html

The Centers for Medicare and Medicaid Services (CMS) has established a national Home Health Outcomes-Based Quality Improvement (OBQI) System. The goal of the OBQI System is to use OASIS-derived outcome information to improve patient care processes and specific clinical outcomes. OASIS data is data that is routinely collected on a home health patient and reported to CMS. Home Health agencies are required to submit an OBQI Outcome Report that includes 37 risk-adjust outcome measures that track changes in a patient's health status between two or more time points. These include improvement in ability to ambulate, bathe, and manage home medicines. CMS publishes data about home health services on Home Health Compare. These quality measures are an additional resource to help consumers compare the quality of care provided by home health agencies. The quality measures are also intended to motivate home health agencies to improve care and to inform discussions about quality between consumers and clinicians.

Agency for Healthcare Research and Quality (AHRQ)

http://www.ahrq.gov

AHRQ, a part of the U.S. Department of Health and Human Services, is the lead agency charged with supporting research designed to improve the quality of health care, reduce its cost, improve patient safety, decrease medical errors, and broaden access to essential services. AHRQ sponsors and conducts research that provides evidence-based information on healthcare outcomes; quality; and cost, use, and access. The information helps healthcare decision makers—patients and clinicians, health system leaders, and policymakers—make more informed decisions and improve the quality of healthcare services. The AHRQ website contains valuable information about evidence-based practices and clinical practice guidelines. Nebraska participates in AHRQ's HCUP project.

Surveys on Patient Safety Culture

http://www.ahrq.gov/professionals/quality-patient-safety/patientsafetyculture/

As part of its goal to support a culture of patient safety and quality improvement in the Nation's health care system, the Agency for Healthcare Research and Quality (AHRQ) sponsored the development of patient safety culture assessment tools for hospitals, nursing homes, ambulatory outpatient medical offices, community pharmacies, and ambulatory surgery centers.

Association for Professionals in Infection Control and Epidemiology (APIC)

http://apic.org

The Association for Practitioners in Infection Control was organized in 1972 for the Infection Control Professional (ICP) and changed its name in 1993 to the Association for Professionals in Infection Control and Epidemiology, Inc. (APIC). APIC currently represents more than 11,000 ICPs in the US and overseas.

Quality of care and improving quality of care, along with reducing costs, has become a focal point in the national health care agenda. Continuous quality improvement (CQI) refers to improving quality through continuous evaluation of performance and identifying opportunities to improve the product or outcome. Because the collection of data is an essential element of the CQI evaluation process, surveillance of health care-associated infections can make an important contribution to CQI in the health care facility. As a result, health care- associated infection rates have received attention as a basis for measuring quality of care. Tracking infection rates is necessary to compare the hospital's infection experience with that of other hospitals (and to itself) over time. When risk-adjusted infection rates are compared, significant variations in the rates may suggest the need for further investigation to identify possible infection control problems.

Institute for Healthcare Improvement (IHI)

http://www.ihi.org/Pages/default.aspx

The Institute for Healthcare Improvement (IHI) is an independent not-for-profit organization helping to lead the improvement of health care throughout the world. Founded in 1991 and based in Cambridge, Massachusetts, IHI works to accelerate improvement by building the will for change, cultivating promising concepts for improving patient care, and helping health care systems put those ideas into action. Nebraska hospitals have participated in a variety of IHI programs such as the 100,000 Lives Campaign, the Saving 5 Million Lives from Harm Campaign, and the World Health Organizations Surgical Safety Checklist. The IHI's Improvement Map is an online tool which lets you select a measure for improvement and provides you with links to important information about that measure and tips on how to revise your policies and practices to achieve higher quality care in that particular measure.
Go to www.ihi.org to learn more about the resources available.

Nebraska Quality Initiatives

CIMRO of Nebraska

As the Medicare Quality Improvement Organization for the State of Nebraska, CIMRO has initiated many quality initiatives. CIMRO has quality initiatives for hospitals, nursing homes and home health agencies, physician offices and the rural and underserved populations. See page 13 for more information about quality improvement organizations (QIO).

In 2014, CIMRO of Nebraska joined forces with agencies from Kansas, North Dakota and South Dakota to form a new not-for-profit organization called the Great Plains Quality Innovation Network (QIN). CIMRO has just release a new QIN website where improvement tools and resources can be obtained. http://greatplainsqin.org.

CIMRO of Nebraska began a new Medicare Quality Improvement Organization Program. The three goals follow the National Quality Strategy 1) better care 2) better health and 3) affordable care. They will work with health care providers on evidence-based care, technical assistance, educational sessions, tools and resources. Efforts align with other National Health Initiative, such as:

- Advancing Excellence in America's Nursing Homes Campaign
- Partnership for Patients
- Patient Safety and Clinical Pharmacy Collaborative
- Medicare Beneficiary Quality Improvement Program

CIMRO of Nebraska also assists and guides health care providers through their Learning and Action Networks (LANs). The LANs improve collaboration and reduce duplication of efforts.

For more information on Quality Initiatives or to learn more about CIMRO of Nebraska, LANs, or the Great Plains Quality Innovation Network go to www.cimronebraska.org.

Hospital Engagement Network (HEN)

Multiple agencies including the American Hospital Association and the Nebraska Hospital Association joined forces in early 2012 to create a pool of 1500+ hospitals across the country in an effort to reduce patient harm and increase patient safety. To date, approximately 92,000 harm events were prevented with an estimated $988 million savings. These efforts, funded by a government grant, have been revised slightly over the last couple years but continue today.

Areas of focus include:

- VTE (Venous Thromboembolism)
- Falls
- CAUTI (Catheter-Associated Urinary Tract Infections)
- Readmissions
- ADE (Adverse Drug Events)
- Pressure Ulcers
- EED (Early Elective Deliveries)
- SSI (Surgical Site Infections)
- CLABSI (Central Line-Associated Blood Stream Infections)
- VAP (Ventilator-Associated Pneumonia)
- OB Harm

Additional information and educational resources can be found at www.hret-hen.org

Nebraska Coalition for Patient Safety (NCPS)

Is both a state and federally designated Patient Safety Organization (PSO). The Coalition shares information and encourages a culture of safety and quality. The PSO provides a legal protection of information reported to them. The Coalition focuses on education – helping health care providers learn from others so that they may reduce the risk of patient safety events and near misses occurring in their facilities. Educational activities lately have focused on TeamSTEPPS, Root Cause Analysis and Just Culture. For more information go to www.nepatientsafety.org.

Quest for Excellence Award

The Quest for Excellence Award recognizes outstanding efforts to improve hospital quality and patient care for Nebraskans. The goal of the award is to encourage improvement in quality performance practices, facilitate communication and sharing of best practices among Nebraska's hospitals, serve as a working tool for developing organizational performance improvement with a focus on building innovative quality improvement programs, and to provide opportunities for learning methods, strategies and systems to help achieve excellence in health care. Additional quality information can be found on the Nebraska Hospital Association (NHA) website at www.nebraskahospitals.org.

Rural Quality Improvement Steering Committee

This working committee was formed in 2002 to provide the framework for developing a model QI plan that is comprehensive, integrated and holistic in its approach to quality management. The Rural Quality Improvement Steering Committee makes recommendations regarding forms, reports and education that are needed to implement the model QI plan and process in hospitals across Nebraska. Committee members include representatives of Critical Access Hospitals, Network Hospitals, CIMRO of Nebraska, the Nebraska Hospital Association, the Nebraska Health and Human Services System Office of Rural Health and the Credentialing Division, and the Nebraska Center for Rural Health Research. To view additional patient safety and quality improvement links, go to www.nebraskahospitals.org and select the 'Quality & Safety' tab.

University of Nebraska Medical Center:

TeamSTEPPS™

TeamSTEPPS™ (Team Strategies & Tools to Enhance Performance & Patient Safety) is an evidence-based teamwork system developed by the Department of Defense Safety Patient Program and the Agency for Healthcare Research and Quality. TeamSTEPPS™ is being implemented by healthcare professionals throughout the United States and internationally to: improve patient safety, improve health care professionals' teamwork skills, and eliminate barriers to quality and safety (http://teamstepps.ahrq.gov/). In Nebraska, the University of Nebraska Medical Center (UNMC), with support from the Nebraska Department of Health and Human Services of Office of Rural Health, has trained over 350 health care professionals in 65 organizations to be TeamSTEPPS™ Master Trainers. These Master Trainers are part of a collaborative that actively spreads the use of team strategies and tools to improve quality and safety throughout their facilities and across the state. For more information on the UNMC initiative and upcoming training sessions click http://www.unmc.edu/patient-safety/teamstepps/index.html.

CAPTURE Falls

Collaboration And Proactive Teamwork Used to Reduce (CAPTURE) Falls is an inter-professional team-based approach to fall risk reduction that engages front-line workers in quality improvement and patient safety work. Originally developed by the Patient Safety Team at the University of Nebraska Medical Center, led by Katherine Jones PT, PhD, through a grant from the Agency for Healthcare Research and Quality, this approach is transferable to other quality and safety initiatives. Current information regarding CAPTURE Falls is available at http://www.unmc.edu/patient-safety/capturefalls/.

Contacts

Medicare Quality Improvement Organization/Quality Improvement Network (QIO/QIN)

CMS contracts with an organization in each state to perform services for Medicare beneficiaries. These organizations are called Quality Improvement Organizations (QIOs). The QIOs work with consumers, physicians, hospitals, and other caregivers to refine care delivery systems to make sure patients get the right care at the right time, particularly among underserved populations. The program also safeguards the integrity of the Medicare trust fund by ensuring payment is made only for medically necessary services, and investigates beneficiary complaints about quality of care.

The work plan that directs the activities of the QIO is defined by the 'Statement of Work' (SOW). The responsibilities of the QIO are to (1) Improve quality of care for beneficiaries by ensuring that beneficiary care meets professionally recognized standards of health care; (2) Protect the integrity of the Medicare Trust Fund by ensuring that Medicare only pays for services and items that are reasonable and medically necessary and that are provided in the most appropriate (e.g., economical) setting; and (3) Protect beneficiaries by expeditiously addressing individual cases such as beneficiary complaints, provider-issued notices of non-coverage (HINNs), EMTALA violations (dumping), and other statutory responsibilities. More information about the QIOs can be obtained at the CMS website http://www.cms.hhs.gov.

CIMRO of Nebraska (CIMRO-NE) is the Medicare Quality Improvement Organization (QIO) for the state of Nebraska. The goal of CIMRO-NE is to improve the delivery of quality health care by collaborating with medical professionals, Medicare beneficiaries and community organizations. www.cimronebraska.org.

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The Joint Commission (JC)

The Joint Commission (JC) is an independent, not-for-profit organization, established over 50 years ago. The Joint Commission is governed by a board that includes physicians, nurses, and consumers and sets the standards by which health care quality is measured in America and around the world. The JC evaluates the quality and safety of care for more than 16,000 health care organizations. The purpose of the review is to evaluate the organization's performance in areas that affect your care. Accreditation may then be awarded based on how well the organizations met JCAHO standards. www.jointcommission.org.

National Association for Healthcare Quality (NAHQ)

The National Association for Healthcare Quality is the nation's leading organization for health care quality professionals. Founded in 1976, NAHQ currently comprises more than 6,000 individual members and 100 institutional members. Its goal is to promote the continuous improvement of quality in health care by providing educational and development opportunities for professionals at all management levels and within all health care settings. www.nahq.org

Nebraska Association for Healthcare Quality, Risk & Safety (NAHQRS)

The Nebraska Association for Healthcare Quality, Risk & Safety is an affiliate of the National Association for Healthcare Quality and the American Society for Healthcare Risk Management. The Nebraska Association for Healthcare Quality, Risk & Safety is the state's recognized organization for health care quality professionals and risk managers. Formerly called the Nebraska Association of Healthcare Quality, it merged with the Heartland Risk Management Society in 2007 and the NAHQRS was formed. Its goal is to promote the continuous improvement in health care by providing educational and development opportunities for professionals within Nebraska's health care settings. NAHQRS also sponsors a mentoring program, matching individuals new to quality improvement with experienced individuals. The mentoring may include an occasional phone call or more in depth sharing of ideas, policies and procedures. Refer to www.nahqrs.org for a list of current board members and key contacts.

American Hospital Association (AHA)

The American Hospital Association is the national organization that represents and serves all types of hospitals, health care networks, and their patients and communities. Close to 5,000 hospitals, health care systems, networks, other providers of care and 37,000 individual members come together to form the AHA. Visit their website at www.aha.org.

Nebraska Hospital Association (NHA)

The Nebraska Hospital Association has been representing and supporting the needs of Nebraska's rural and urban hospitals since 1927. Today, NHA supports and encourages its members in developing various health care delivery systems geared toward improving the health and well-being of Nebraska's communities. Hospitals are the stewards of good health. Through partnerships with representatives in the health care industry, legislators, government and citizens, the NHA is able to assist in the development of strong, healthy communities. Visit their website at www.nebraskahospitals.org.

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Nebraska Health Care Association (NHCA)

The Nebraska Health Care Association is a non-profit trade association representing long-term health care facilities in Nebraska. Its affiliate, the Nebraska Assisted Living Association (NALA), represents assisted living facilities. The activities of the Licensed Practical Nurses Association of Nebraska (LPNAN) are managed by NHCA staff. The Nebraska Health Care Foundation is a non-profit charitable organization serving the needs of Nebraska's nursing home residents by providing scholarship and educational opportunities for long-term care personnel. Visit their website at www.nehca.org.

State of Nebraska, Department of Health and Human Services, Public Health Division

The Department of HHS licenses health-related professionals such as nurses, doctors, and psychologists, as well as facilities and services. Included with the health related professions are occupations such as cosmetologists, asbestos workers, massage therapists, physical therapists, etc. The agency is also responsible for regulations for the Health and Human Services System. The Credentialing Division licenses health related professions and occupations, as well as health care facilities and services, and child care programs. Visit their website at www.dhhs.ne.gov.

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Nebraska Association Medical Staff Services (NeAMSS)

The Nebraska Association Medical Staff Services is a professional association that provides an opportunity to improve professional knowledge in the field of medical health care provider activities. It is comprised of members who are experienced in the field of health care provider credentialing, appointment, reappointment, privileging, development of bylaws, policies and procedures for medical staffs and other health care provider organizations. For more information, go to http://www.namss.org/StateAssociations/StateWebsites/Nebraska/tabid/216/Default.aspx

American Society for Healthcare Risk Management (ASHRM)

The American Society for Healthcare Risk Management is a personal membership group of the American Hospital Association with more than 4,300 members representing health care, insurance, law and other related professions. ASHRM promotes effective and innovative risk management strategies and professional leadership through education, recognition, advocacy, publications, networking and interactions with leading health care organizations and government agencies. ASHRM initiatives focus on developing and implementing safe and effective patient care practices, the preservation of financial resources and the maintenance of safe working environments. The Nebraska chapter merged with the Nebraska Association for Healthcare Quality and is now known as the Nebraska Association of Healthcare Quality, Risk & Safety.

Glossary of Terms

Accountable Care Organization (ACO): A group of health care providers (e.g., primary care physicians, specialists, and hospitals) that have entered into a formal arrangement to assume collective responsibility for the cost and quality of care of a specific group of patients and that receive financial incentives to improve the quality and efficiency of health care.

Acute care: Short-term, medical treatment most often in a hospital, for people who have a severe illness or injury, or are recovering from surgery.

Ambulatory care: Medical care provided on an outpatient basis.

Adverse drug reaction: A bad or harmful reaction to a drug that is used to treat or prevent a disease.

Adverse effect: Anything that a person might feel is a negative or harmful result of a treatment or test.

Adverse event: Any negative or unwanted effect from any drug, device or medical test.

Adverse reaction: Any negative or unwanted effect from a drug, device or medical test.

Benchmark/benchmarking: A way for hospitals and doctors to analyze quality data, both internally and against data from other hospitals and doctors, to identify best practices of care and improve quality.

Black Box Warning: An advisory from the US Food and Drug Administration (FDA) that tells health care professionals and consumers that a drug might be dangerous.

Balanced scorecard: Tool to categorize measures into four significant areas: finance, process, people and innovation.

Best practices: The most up-to-date patient care interventions, which results in the best patient outcomes and minimize patient risk of death or complications.

Bundled payments: A set, single payment for all health care services for an episode of care or a health condition.

Clinical practice guidelines: A set of systematically developed statements, usually based on scientific evidence, that help physicians and their patients make decisions about appropriate health care for specific medical conditions.

Clinical quality measures: Criteria to evaluate the care provided to a patient, based on the treatments and tests the patient received compared to care that is proven to be helpful to most patients with a certain condition.

Consumer Assessment of Healthcare Providers and Systems (CAHPS): Standardized surveys that ask consumers and patients to report on and evaluate their experiences with health care.

Core measures: Specific clinical measures that, when viewed together, permit a robust assessment of the quality of care provided in a given focus area, such as acute myocardial infarction.

Disease management: An approach designed to improve the health and quality of life for people with chronic illnesses by working to keep the conditions under control and prevent them from getting worse.

Evidence-based medicine: The use of the current, best available scientific research and practices with proven effectiveness in daily medical decision making.

Federally Qualified Health Center (FQHC): A health organization that offers primary care and preventive health services to all patients regardless of their ability to pay for care.

Fee schedule: A complete listing of fees used by health plans to pay physicians and other providers.

Health care-acquired infection (hospital-acquired infection) (HAI): Illnesses that patients get while receiving medical or surgical treatment.

Health Plan Employer Data and Information Set (HEDIS) Measures: A set of health care quality measures designed to help purchases and consumers determine how well health plans follow accepted care standards for prevention and treatment.

Informed consent: An agreement to receive a treatment or medical procedure; the person understands the treatment planned and agrees to receive the treatment.

Inpatient care: The delivery of health care services to a person who has been admitted to a hospital or another health facility for a period of at least 24 hours.

Medical error: An event that harms a patient; adverse drug events, hospital acquired infections and wrong site surgeries are examples of preventable medical errors.

Medical home: A health care model that provides structured, proactive and coordinated care for patients rather than episodic treatments for illnesses. The physician operates as a "home base" for patients, overseeing all aspects of a patient's health and coordinates care with any specialists involved in the patient's care.

Outpatient care: Medical or surgical care that does not include an overnight hospital stay.

Patient-Centered Care: Care that considers a patient's cultural traditions, personal preferences and values, family situation and lifestyle. Patient-centered care ensures that transitions between different health care providers, and care settings are coordinated and efficient.

Pay for Performance: A method of paying hospitals and physicians based on demonstrated achievements in meeting specific health care quality objectives.

Performance measures: Sets of established standards against which health care performance is measured.

Plan-Do-Study-Act (PDSA) or Plan-Do-Check-Act (PDCA): A basic model or set of steps in the continuous improvement process; also referred to as the "Shewhart Cycle" or "Deming Cycle."

Physician quality reporting initiative (PQRI): Authorized by the Medicare, Medicaid and SCHIP Extension Act of 2007, it is a financial incentive for health care professionals to improve the quality of care they provide.

Preventive Care: Health care services that prevent disease or its consequences, secondary prevention to detect early disease and tertiary prevention to keep ill people or those at high risk of disease from getting sicker.

Price transparency: Ability of consumers to know what it will cost to receive a given health care service at a variety of settings.

Process improvement: Techniques and strategies used to make the processes implemented to solve health care problems better.

Quality (of care): A measure of the ability of a doctor, hospital or health plan to provide services for individuals and populations that increase the likelihood or desired health outcomes and that are consistent with current professional knowledge.

Quality (of life): The amount of happiness and balance in an individual's life.

Quality assurance (QA): A formal process of reviewing the quality of medical services provided by a physician, hospital or other health care entity and addressing problems through corrective actions.

Quality council: Leadership group guiding the implementation of quality activities within an organization.

Quality improvement (QI): Typically, quality improvement efforts are strongly rooted in evidence based procedures and rely extensively on data collected about processes and outcomes.

Quality indicator: An agreed upon process or outcome measure that is used to determine the level of quality achieved.

Quality measure: Mechanisms used to assign a quantity to quality of care by comparison to a criterion.

Rapid cycle change: A quality improvement method that identifies, implements and measures changes made to improve a process or a system. Improvement occurs through small rapid DSA cycles to advance practice change. This model requires targeting a specific area to change, planning changes on the basis of sound science, theory and evidence; piloting several changes with small patient groups, measuring the effects of change, and acting according to the data.

Report card: an assessment of the quality of care delivered by health plans.

Return on investment (ROI): The amount of improvement in care brought about by a certain investment.

Risk/benefit ratio: A method for comparing a treatment's benefits and risks.

Sentinel event: Any unexpected event in a health care setting that causes death or serious injury to a patient and is not related to the natural course of the patient's illness.

Standard of care: The expected level and type of care provided by the average caregiver under a certain set of circumstances. These circumstances are supported through findings from expert consensus and based on specific research and/or documentation in scientific literature.

Transparency: The process of collecting and reporting health care cost performance and quality data in a format that can be accessed by the public and is intended to improve the delivery of services and ultimately improve the health care system as a whole.

To help keep you connected . . .

Join the Nebraska Association for Healthcare Quality, Risk & Safety (NAHQRS). You will meet others who work in the same position as you do. It's a good opportunity to network with your peers. Visit www.NAHQRS.org for more information about the Association.

Obtain your CPHQ certification (Certified Professional in Healthcare Quality). Designation as a CPHQ lets everyone know you are committed to learning and applying your new knowledge to help your facility deliver high quality patient care

Become a member of the National Association for Healthcare Quality. Network with peers from around the nation. Several educational opportunities are available through the NAHQ. Visit their website at www.nahq.org

Participate on committees like the Rural Quality Improvement Steering Committee; it's a good way to learn from your peers and, to share your knowledge with others!

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