An Orientation Guide for the New

Quality Improvement Professional

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Rural QI Steering Committee

The purpose of the Rural Quality Improvement Steering Committee is to provide the framework for developing a QI plan that is comprehensive, integrated and holistic in its approach to quality management. The Committee was asked to make recommendations regarding forms, reports, and education that are needed to implement the model QI plan.

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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 and a chance to network with your peers. An interactive video option is available for five of these meetings. NAHQRS supports those quality professionals who want to sit for the Certified Professional in Healthcare Quality (CPHQ) Exam. NAHQRS will periodically host CPHQ national review courses in the state for those preparing to sit for the exam.

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

Find us on Facebook: https://www.facebook.com/groups/1178315565523872/

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
    - CMS
    - NHSN
    - HIIN
  - Service excellence
    - Patient satisfaction
    - Employee engagement
    - Service strategies
    - Patient Family Engagement
    - Etc.
  - Infection prevention and control practices
  - Risk Management and Safety
    - Identification of risk
    - Risk prevention
  - Population health
  - Emergency management
  - Corporate compliance
  - HIPAA security and privacy

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.

QI Resource Listing

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 survey. 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 and EMTALA policies.

State of Nebraska Information

- **Nebraska Hospital Association:** http://www.nebraskahospitals.org/
- **Nebraska Coalition for Patient Safety:** https://www.nepatientsafety.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
- **State Operations Manual for Rural Health Clinics:** https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/som107ap_g_rhc.pdf
- **State Operations Manual for Hospitals (Appendix Z) Emergency Preparedness:** https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/SurveyCertificationGenInfo/Downloads/Survey-and-Cert-Letter-17-29.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/
- **The American Hospital Association:** Current Events, Newsletters, Hospital Listings: https://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:** (GP QIN): 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 (NHSN):** www.cdc.gov/nhsn
- **Agency for Healthcare Research and Quality (AHRQ):** www.ahrq.gov
- **AHRQ PSO Program:** https://www.pso.ahrq.gov/
- **QualityNet:** https://qualitynet.org
- **"Journal for Healthcare Quality":** http://journals.lww/jhqonline
- **Health Care Compliance Association (HCCA):** https://www.hcca-info.org/
- **American Association for Quality (ASQ):** https://asq.org/; **Quality Tools:** https://asq.org/quality-resources/quality-tools
- **Det Norske Veritas (DNV) Accreditation:** https://www.dnvgl.us/assurance/healthcare
- **Quality Payment Program (QPP):** https://qpp.cms.gov/
- **American Society for Healthcare Risk Management (ASHRM):** http://www.ashrm.org
- **National Quality Forum (NQF):** http://www.qualityforum.org/Home.aspx
- **Quality Improvement Toolkit by the Institute for Helathcare Improvement (IHI):** http://www.ihi.org/resources/Pages/Tools/Quality-Improvement-Essentials-Toolkit.aspx
- **National Patient Safety Foundation by IHI:** https://www.npsf.org/

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.

PATIENT SAFETY IMPROVEMENT ACT

STATUTES PERTAINING TO THE PATIENT SAFETY IMPROVEMENT ACT

71-8701. Act, how cited. Sections 71-8701 to 71-8721 shall be known and may be cited as the Patient Safety Improvement Act.
Source: Laws 2005, LB 361, §1. Effective date April 28, 2005.

71-8702. Legislative findings and intent. (1) The Legislature finds that:

(a) In 1999, the Institute of Medicine released a report entitled "To Err is Human" that described medical errors as the eighth leading cause of death in the United States;

(b) To address these errors, the health care system must be able to create a learning environment in which health care providers and facilities will feel safe reporting adverse health events and near misses in order to improve patient safety;

(c) To facilitate the learning environment, health care providers and facilities must have legal protections that will allow them to review protected health information so that they may collaborate in the development and implementation of patient safety improvement strategies;

(d) To carry out a program to promote patient safety, a policy should be established which provides for and promotes patient safety organizations; and

(e) There are advantages to having private nonprofit corporations act as patient safety organizations rather than a state agency, including the enhanced ability to obtain grants and donations to carry out patient safety improvement programs.
(2) It is the intent of the Legislature to encourage the establishment of broad-based patient safety organizations. Source: Laws 2005, LB 361, §2. Effective date April 28, 2005.

71-8703. Purposes of act. The purposes of the Patient Safety Improvement Act are to (1) encourage a culture of safety and quality by providing for legal protection of information reported for the purposes of quality improvement and patient safety, (2) provide for the reporting of aggregate information about occurrences, and (3) provide for the reporting and sharing of information designed to improve health care delivery systems and reduce the incidence of adverse health events and near misses. The ultimate goal of the act is to ensure the safety of all individuals who seek health care in Nebraska's health care facilities or from Nebraska's health care professionals.
Source: Laws 2005, LB 361, §3. Effective date April 28, 2005.

71-8704. Definitions, where found. For purposes of the Patient Safety Improvement Act, unless the context otherwise requires, the definitions found in sections 71-8705 to 71-8709 apply.
Source: Laws 2005, LB 361, §4. Effective date April 28, 2005.

71-8705. Identifiable information, defined. Identifiable information means information that is presented in a form and manner that allows the identification of any provider, patient, or reporter of patient safety work product. With respect to patients, such

information includes any individually identifiable health information as that term is defined in the regulations promulgated pursuant to section 264(c) of the Health Insurance Portability and Accountability Act of 1996, Public Law 104- 191, as such regulations existed on April 28, 2005.
Source: Laws 2005, LB 361, §5. Effective date April 28, 2005.

71-8706. Nonidentifable information, defined. Nonidentifiable information means information presented in a form and manner that prevents the identification of any provider, patient, or reporter of patient safety work product. With respect to patients, such information must be de-identified consistent with the regulations promulgated pursuant to section 264(c) of the Health Insurance Portability and Accountability Act of 1996, Public Law 104-191, as such regulations existed on April 28, 2005.
Source: Laws 2005, LB 361, §6. Effective date April 28, 2005.

71-8707. Patient safety organization, defined. Patient safety organization means an organization described in section 71-8714 that contracts with one or more providers subject to the Patient Safety Improvement Act and that performs the following activities:

(1) The conduct, as the organization's primary activity, of efforts to improve patient safety and the quality of health care delivery;

(2) The collection and analysis of patient safety work product that is submitted by providers;

(3) The development and dissemination of evidence-based information to providers with respect to improving patient safety, such as recommendations, protocols, or information regarding best practices;

(4) The utilization of patient safety work product to carry out activities limited to those described under this section and for the purposes of encouraging a culture of safety and of providing direct feedback and assistance to providers to effectively minimize patient risk;

(5) The maintenance of confidentiality with respect to identifiable information;

(6) The provision of appropriate security measures with respect to patient safety work product; and

(7) The possible submission, if authorized by federal law, of nonidentifiable information to a national patient safety data base.

Source: Laws 2005, LB 361, §7. Effective date April 28, 2005.

71-8708. Patient safety work product, defined. (1) Patient safety work product means any data, reports, records, memoranda, analyses, deliberative work, statements, root cause analyses, or quality improvement processes that are:

(a) Created or developed by a provider solely for the purposes of reporting to a patient safety organization;

(b) Reported to a patient safety organization for patient safety or quality improvement processes;

(c) Requested by a patient safety organization, including the contents of such request;

(d) Reported to a provider by a patient safety organization;

(e) Created by a provider to evaluate corrective actions following a report by or to a patient safety organization;

(f) Created or developed by a patient safety organization; or

(g) Reported among patient safety organizations after obtaining authorization.

(2) Patient safety work product does not include information, documents, or records otherwise available from original sources merely because they were collected for or submitted to a patient safety organization. Patient safety work product also does not include documents, investigations, records, or reports otherwise required by law.

(3) Patient safety work product does not include reports and information disclosed pursuant to sections 71-8719 and 71- 8720.

Source: Laws 2005, LB 361, §8. Effective date April 28, 2005.

71-8709. Provider, defined. Provider means a person that is either:

(1) A facility licensed under the Health Care Facility Licensure Act; or

(2) A health care professional licensed under the Uniform Credentialing Act.

Source: Laws 2005, LB 361, § 9; Laws 2007, LB463, § 1307. Operative date December 1, 2008.

71-8710. Patient safety work product; confidentiality; use; restrictions. (1) Patient safety work product shall be privileged and confidential.

(2) Patient safety work product shall not be:

(a) Subject to a civil, criminal, or administrative subpoena or order;

(b) Subject to discovery in connection with a civil, criminal, or administrative proceeding;

(c) Subject to disclosure pursuant to the Freedom of Information Act, 5 U.S.C. 552, as such act existed on April 28, 2005, or any other similar federal or state law, including sections 84-712 to 84-712.09;

(d) Offered in the presence of the jury or other factfinder or received into evidence in any civil, criminal, or

administrative proceeding before any local, state, or federal tribunal; or

(e) If the patient safety work product is identifiable information and is received by a national accreditation organization in its capacity:

(i) Used by a national accreditation organization in an accreditation action against the provider that reported the information;

(ii) Shared by such organization with its survey team; or

(iii) Required as a condition of accreditation by a national accreditation organization. Source: Laws 2005, LB 361, §10. Effective date April 28, 2005.

71-8711. Patient safety organization; proceedings and records; restrictions on use; violation; penalty. No person shall disclose the actions, decisions, proceedings, discussions, or deliberations occurring at a meeting of a patient safety organization except to the extent necessary to carry out one or more of the purposes of a patient safety organization. The proceedings and records of a patient safety organization shall not be subject to discovery or introduction into evidence in any civil action against a provider arising out of the matter or matters that are the subject of consideration by a patient safety organization. Information, documents, or records otherwise available from original sources shall not be immune from discovery or use in any civil action merely because they were presented during proceedings of a patient safety organization. This section shall not be construed to prevent a person from testifying to or reporting information obtained independently of the activities of a patient safety organization or which is public information. A person who knowingly violates this section shall be guilty of a Class IV misdemeanor.
Source: Laws 2005, LB 361, §11. Effective date April 28, 2005.

71-8712. Patient safety work product; unlawful use; effect. Any reference to, or offer into evidence in the presence of the jury or other fact finder or admission into evidence of, patient safety work product during any proceeding contrary to the Patient Safety Improvement Act shall constitute grounds for a mistrial or a similar termination of the proceeding and reversible error on appeal from any judgment or order entered in favor of any party who discloses or offers into evidence patient safety work product in violation of the act.
Source: Laws 2005, LB 361, §12. Effective date April 28, 2005.

71-8713. Act; cumulative to other law. The prohibition in the Patient Safety Improvement Act against discovery, disclosure, or admission into evidence of patient safety work product is in addition to any other protections provided by law.
Source: Laws 2005, LB 361, §13. Effective date April 28, 2005.

71-8714. Patient safety organization; conditions. A patient safety organization shall meet the following conditions:

(1) It shall be a Nebraska nonprofit corporation described in section 501(c)(3) of the Internal Revenue Code as defined in section 49-801.01, contributions to which are deductible under section 170 of the code;

(2) The purposes of the organization shall include carrying out the activities of a patient safety organization as described in the Patient Safety Improvement Act; and

(3) It shall have a representative board of directors as described in section 71-8715. Source: Laws 2005, LB 361, §14. Effective date April 28, 2005.

71-8715. Patient safety organization; board of directors; membership. The board of directors of a patient safety organization shall include at least one representative each from a statewide association of Nebraska hospitals, Nebraska physicians and surgeons, Nebraska nurses, Nebraska pharmacists, and Nebraska physician assistants as recommended by such associations. At least one consumer shall be a member of the board. The board shall consist of at least twelve but no more than fifteen members as established at the discretion of the board.
Source: Laws 2005, LB 361, §15. Effective date April 28, 2005.

71-8716. Election to be subject to act; contract; requirements. (1) A patient safety organization shall contract with providers that elect to be subject to the Patient Safety Improvement Act. The patient safety organization shall establish a formula for determining fees and assessments uniformly within categories of providers.
(2) A provider may elect to be subject to the Patient Safety Improvement Act by contracting with a patient safety organization to make reports as described in the act.
Source: Laws 2005, LB 361, §16. Effective date April 28, 2005.

71-8717. Reportable patient safety events; provider; duties. (1) Every provider subject to the Patient Safety Improvement Act shall track and report pursuant to section 71-8718 the following occurrences of patient safety events:

(a) Surgery or procedures performed on the wrong patient or the wrong body part of a patient;

(b) Foreign object accidentally left in a patient during a procedure or surgery;

(c) Hemolytic transfusion reaction in a patient resulting from the administration of blood or blood products with major blood group incompatibilities;

(d) Sexual assault of a patient during treatment or while the patient was on the premises of a facility;

(e) Abduction of a newborn infant patient from the hospital or the discharge of a newborn infant patient from the hospital into the custody of an individual in circumstances in which the hospital knew, or in the exercise of ordinary care should have known, that the individual did not have legal custody of the infant;

(f) Suicide of a patient in a setting in which the patient received care twenty-four hours a day;

(g) Medication error resulting in a patient's unanticipated death or permanent or temporary loss of bodily function, including (i) treatment intervention, temporary harm, (ii) initial-prolonged hospitalization, temporary harm, (iii) permanent patient harm, and (iv) near death event in circumstances unrelated to the natural course of the illness or underlying condition of the patient, including, but not limited to, errors involving the wrong drug, the wrong dose, the wrong patient, the wrong time, the wrong rate, the wrong preparation, or the wrong route of administration, but excluding reasonable differences in clinical judgment on drug selection and dose;

(h) Patient death or serious disability associated with the use of adulterated drugs, devices, or biologics provided by the provider;

(i) Patient death or serious disability associated with the use or function of a device in patient care in which the device is used or functions other than as intended; and

(j) Unanticipated death or major permanent loss of function associated with health care associated nosocomial infection.

(2) A patient safety organization, based on a review of new indicators of patient safety events identified by the Joint Commission on Accreditation of Healthcare Organizations, shall recommend changes, additions, or deletions to the list of reportable patient safety events, which changes, additions, or deletions shall be binding on the providers. Providers may voluntarily report any other patient safety events not otherwise identified.

Source: Laws 2005, LB 361, §17. Effective date April 28, 2005.

71-8718. Reporting requirements. (1) Every provider subject to the Patient Safety Improvement Act shall report aggregate numbers of occurrences for each patient safety event category listed in section 71-8717 to a patient safety organization. Reporting shall be done on an annual basis by March 31 for the prior calendar year.

(2) For each occurrence listed in section 71-8717, a root cause analysis shall be completed and an action plan developed within forty-five days after such occurrence. The action plan shall (a) identify changes that can be implemented to reduce risk of the patient safety event occurring again or formulate a rationale for not implementing change and (b) if an improvement action is planned, identify who is responsible for implementation, when the action will be implemented, and how the effectiveness of the action will be evaluated. The provider shall, within thirty days after the development of an action plan, provide a summary report to a patient safety organization which includes a brief description of the patient safety event, a brief description of the root cause analysis, and a description of the action plan steps.

(3) The facility where a reportable event occurred shall be responsible for coordinating the reporting of information required under the Patient Safety Improvement Act and ensuring that the required reporting is completed, and such coordination satisfies the obligation of reporting imposed on each individual provider under the act.

Source: Laws 2005, LB 361, §18. Effective date April 28, 2005.

71-8719. Nonidentifiable information; disclosure. A patient safety organization may disclose nonidentifiable information, including nonidentifiable aggregate trend data and educational material developed as a result of the patient safety work product reported to it.

Source: Laws 2005, LB 361, §19. Effective date April 28, 2005.

71-8720. Public disclosure of data and information. A patient safety organization shall release to the public nonidentifiable aggregate trend data identifying the number and types of patient safety events that occur. A patient safety organization shall publish educational and evidenced-based information from the summary reports, which shall be available to the public, that can be used by all providers to improve the care they provide.

Source: Laws 2005, LB 361, §20. Effective date April 28, 2005.

71-8721. Immunity from liability. Any person who receives or releases information in the form and manner prescribed by the Patient Safety Improvement Act and the procedures established by a patient safety organization shall not be civilly or criminally liable for such receipt or release unless the receipt or release is done with actual malice, fraudulent intent, or bad faith. A patient safety organization shall not be liable civilly for the release of nonidentifiable aggregate trend data identifying the number and types of patient safety events that occur. Because the candid and conscientious evaluation of patient safety events is essential to the improvement of medical care and to encourage improvements in patient safety, any provider furnishing services to a patient safety organization shall not be liable for civil damages as a result of such acts, omissions, decisions, or other such conduct in connection with the duties on behalf of a patient safety organization if done pursuant to the Patient Safety Improvement Act except for acts done with actual malice, fraudulent intent, or bad faith.

Source: Laws 2005, LB 361, §21. Effective date April 28, 2005.

National Quality Initiatives

National Accrediting Bodies Used in Nebraska

The Joint Commission (JC)

http://www.jointcommission.org

An independent, not-for-profit organization, The Joint Commission accredits and certifies nearly 21,000 health care organizations and programs in the United States. Joint Commission accreditation and certification is recognized nationwide as a symbol of quality that reflects an organization's commitment to meeting certain performance standards.

Our 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.

Vision Statement: All people always experience the safest, highest quality, best-value health care across all settings.

Det Norske Veritas - DNV

https://www.dnvgl.us/assurance/healthcare

We received CMS Deeming Authority in 2008, and since then have accredited nearly 500 hospitals of all sizes and in every region of the United States. We are the first and only accreditation program to integrate the CMS Conditions of Participation with the ISO 9001 Quality Management Program. Our collaborative survey teams visit your hospital annually, not every three years, making each visit far less stressful and more of a routine check up on your success, not an epic investigation of your faults.

Our Philosophy
WHAT: Accreditation can -- and should -- enable a broader culture change toward high performance and continual improvement.
HOW: By combining the 'mandatory' CMS evaluation with a proven world class quality management system into 1 seamless program.
WHY: Because that's why you got into healthcare; to focus on people and their health, not checklists and rules from outsiders.

Hospital Quality Reporting Programs

The purpose of the Hospital Quality Reporting 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 at QualityNet.org.

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 (and outpatient) data to determine an incentive or reduction of payment for perspective payment system hospitals for the readmission reduction and value-based purchasing programs.

Although CAHs are encouraged, but not required, to participate in the Hospital Inpatient Quality Reporting (IQR) Program, CAHs are required to participate in the Medicare Promoting Interoperability Program. Review the Medicare Promoting Interoperability Program information on the CMS.gov website for more information. https://www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms/

Critical Access Hospital Quality Initiatives/MBQIP

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 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

https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment/Instruments/NursingHomeQuaitylnits/index.html
The Nursing Home Quality Initiative (NHQI) website provides consumer and provider information regarding the quality of care in nursing homes. NHQI discusses quality measures that are shown at the Nursing Home Compare website (medicare.gov), which allows consumers, providers, States and researchers to compare information on nursing homes. Many nursing homes have made significant improvements in the care being provided to residents by taking advantage of these materials and the support of the Quality Innovation Network - Quality Improvement Organization (QIN-QIO) staff, such as Great Plains QIN - Nebraska.

The nursing home quality measures come from resident assessment data that nursing homes routinely collect on the residents at specified intervals during their stay and are documented on the minimum data set (MDS). The data collected consists of the resident's physical and clinical conditions and abilities, as well as preferences and life care wishes. This assessment data is converted to develop quality measures that give consumers another source of information that show how well nursing homes are caring for their residents' physical and clinical needs. Currently there are 13 Short Stay Quality Measures and 17 Long Stay Quality Measures.

CMS created the Five-Star Quality Rating System to help consumers, their families, and caregivers compare nursing homes more easily and to help identify areas about which to ask questions. Nursing Home Compare features an overall quality rating system with a separate rating for health inspections conducted by the Nebraska Department of Health and Human Services, staffing, and quality measures. The quality measure rating has information on 16 different physical and clinical measures for nursing home residents.

Home Health Quality Reporting Program

Home Health Quality Reporting Program
https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment/Instruments/HomeHealthQualitylnits/index.html
The CMS Outcome Assessment Information Set (OASIS) data is used for the Home Health Quality Reporting Program (HHQRP). OASIS-D is the most current OASIS data set, implemented on January 1, 2019. Outcome and process measures as well as potentially avoidable events are used for the Home Health Quality Reporting Program (HHQRP).

Outcome measures include: functional measures (ability to perform ADLs) and health outcomes (such as dyspnea, pain, wounds, etc.). Claims-based utilization measures are a sub-set of outcome measures and include: Acute Care Hospitalization within the first 60 days of home health care; Emergency Department Use without hospitalization within first 60 days of home health care; Re-hospitalization within the first 30 days of home health care; and ED use without hospital readmission during the first 30 days of home health. Claims-based utilization measures also include, Potentially Preventable 30-day post-discharge readmission; discharge to the Community; and Medicare spending per Beneficiary - Post-acute Care (MSPB-PAC) Home Health.

Process measures evaluate the rate of home health agency use of specific evidence-based processes of care, and focus on high-risk, high-volume, problem-prone areas for home health care pertaining to most home care patients, such as timeliness of initiation of care, depression assessment, multi-factor fall risk assessment for falls. Also included are care plan implementation, medication education, immunizations, and drug regimen review.

Potentially Avoidable Events include: Emergent care for improper medication administration or medication side effects; Emergent care for hypo/hyperglycemia; Development of urinary tract infection; Increase in the number of pressure ulcers/injuries; Substantial decline in 3 or more activities of daily living; Substantial decline in management of oral medications; Discharged to the Community needing wound care or medication assistance; Discharged to the Community needing toileting assistance; Discharged to the Community with behavioral problems; and Discharged to the Community with an unhealed stage 2 pressure ulcer.

Medicare certified home health agencies are required to report both OASIS data and HHCAHPS measures.

Home Health Compare is a CMS tool that publicly reports data about home health agencies. Home Health Compare is a valuable tool for consumers to use when searching for a home health agency. Home Health Agency star ratings are also included in Home Health Compare, giving consumers another tool to help them make decisions about home health agencies. Home health agencies find Home Health Compare valuable when comparing one agency with another and gain knowledge about what the public and other agencies find on Home Health Compare.

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. **AHRQ PSO Program Information:** https://www.pso.ahrq.gov/

Working with a Patient Safety Organization gives providers many benefits, which are evidenced by stories from the field showing improved safety. When a provider works with a PSO, many of the long-recognized impediments to successful improvement projects can be overcome. The law provides confidentiality protections and privilege protections (inability to introduce the protected information in a legal proceeding), when certain requirements are met. Enables all licensed or certified health care facilities and clinicians to participate. Unlike state protections that often target hospitals or physicians, these protections are broad. Protections are nationwide and uniform. Each provider benefits from the insights that it can obtain from a PSO that aggregates higher volumes of event data from multiple providers. Moreover, your data remains protected even when the PSO is aggregating it with data from other providers. The law permits providers to undertake deliberations and analyses at their facilities that become protected as Patient Safety Work Product immediately as long as they are conducted in the provider's Patient Safety Evaluation System.

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). It is the leading professional association for infection preventionists (IPs) with over 15,000 members in 48 countries. With a vision of healthcare without infection and a mission to create a safer world through prevention of infection, APIC world wide provides education for consumers and those in professional practice, certification and advocacy through public policy. This includes evidence-based, scientific resources for IPs, healthcare professionals and patients. Local chapters are organized to provide ongoing member support and offer educational opportunities through chapter conferences and events. Greater Omaha APIC Chapter 064 works in collaboration with Nebraska Department of Health and Human Services to prevent and eliminate healthcare acquired infections throughout Nebraska and Southwest Iowa.

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. The Institute for Healthcare improvement takes a unique approach to working with health systems, countries and other organizations on improving quality, safety and value in health care. This approach is called the science of improvement. IHI uses the Model for improvement in all of its improvement efforts. There are many quality improvement and patient safety related initiatives, toolkits, manuals, educational programs and other resources available through IHI. Many are available at no cost through their website. There are other programs which require purchase. The IHI merged with the National Patient Safety Foundation in 2017. Go to www.ihi.org to learn more about available resources.

Quality Payment Program

https://qpp.cms.gov

CMS is required by law to implement a quality payment incentive program, referred to as the Quality Payment Program (QPP), which rewards value and outcomes in one of two ways: Merit-Based Incentive Payment System (MIPS) and Advanced Alternative Payment Models (APMs). Under MIPS, clinicians are included if they are an eligible clinician type and meet the low volume threshold, which is based on allowed charges for covered professional services under the Medicare Physician Fee Schedule (PFS) and the number of Medicare Part B patients who are furnished covered professional services under the Medicare Physician Fee Schedule. Performance is measured through the data clinicians report in four areas: Quality, Improvement Activities, Promoting Interoperability (formerly Advancing Care Information) and Cost. We designed MIPS to update and consolidate previous programs, including: Medicare Electronic Health Records (EHR) Incentive Program for Eligible Clinicians, Physician Quality Reporting System (PQRS) and the Value-Based Payment Modifier (VBM). An Alternative Payment Model (APM) is a payment approach that gives added incentive payments to provide high-quality and cost-efficient care. APMs can apply to a specific clinical condition, a care episode or a population.

Nebraska Quality Initiatives

Great Plains Quality Innovation Network

Great Plains Quality Innovation Network
Great Plains Quality Innovation Network works with healthcare providers and communities to implement data-driven quality initiatives to improve healthcare. They offer technical assistance, tailored education, best practices, tools and resources. Through these efforts, they strive to improve patient safety, reduce harm and improve clinical care at the local and regional levels.
The Great Plains Quality Innovation Network's mission is to leverage the state's collective knowledge and resources to achieve the aims of better health care, improved health, safer care and lower healthcare costs. By collaborating with providers and the community on multiple, data-driven quality initiatives to improve patient safety, reduce harm and improve clinical care, Great Plains QIN aspires to make health in our region the best in the nation.

Hospital Improvement Innovation Network (HIIN)

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. The Centers for Medicare & Medicaid services award the Health Research & Educational Trust (HRET) contracts to roll out evidenced based patient focused safety driven quality measures to reduce all patients harm and readmissions. To date HIIN participants have prevented more than 120,000 patient safety incidents and saved over $1 billion in associated health care costs.

As of 2018, in Nebraska, HIIN hospitals have:

- prevented 3,672 patient harm events,
- saved 310 lives and
- avoided $27.3 million dollars in costs

For the past decade the HIIN has been proactively preparing hospitals for quality updates, we have seen in Conditions of Participation, Joint Commission Standards, Patient Safety Organization (PSO) Requirements, Value Based Purchasing, MARCRA requirements, etc. The HIIN has provided the tools and the time to prepare you for the mandates that are now in place and will continue into the future.

- Areas of focus include:
- Adverse Drug Events
- CAUTI
- CLABSI
- Hospital Acquired Infections
- C-Diff
- Falls
- Pressure Ulcers
- MRSA
- Ventilator Assisted Pneumonia
- Surgical Site Infections
- Worker safety: Violence
- Patient Family Engagement
- Health Disparities

PEPPER Reports

The Program for Evaluating Payment Patterns Electronic Report (PEPPER) is a Microsoft Excel file summarizing provider-specific Medicare data statistics for target areas often associated with Medicare improper payments due to billing, DRG coding and/or admission necessity issues. Target areas are determined by the Centers for Medicare & Medicaid Services (CMS).
PEPPER facilitates the prioritization of areas on which a hospital or facility may want to focus auditing and monitoring efforts. Hospitals and facilities are encouraged to conduct regular audits to ensure that medical necessity for admission and treatment is documented and that bills submitted for Medicare services are correct.

PEPPER can be used to review three years of data statistics for each of the CMS target areas, comparing performance to that of other hospitals or facilities in the nation, specific Medicare :Administrative Contractor (MAC) jurisdiction and state. PEPPER can also be used to compare data statistics over time to identify changes in billing practices, pinpoint areas in need of auditing and monitoring, identify potential DRG under- or over-coding problems and identify target areas where length of stay is increasing. PEPPER can help hospitals and facilities achieve CMS' goal of reducing and preventing improper payments. For more information, see: https://pepper.cbrpepper.org/PEPPER.

NEHII

Nebraska Health Information Initiative (NEHII)
The Nebraska Health Information Initiative was founded in 2008 to support the secure transfer of information through the healthcare environment. Today, NEHII securely shares health information amongst healthcare providers, pharmacists, emergency rooms, urgent cares, essentially wherever healthcare is delivered.

By sharing this information, your healthcare providers have access to lab comprehensive health history, medication dispensed by a pharmacy, laboratory tests, allergies, immunizations, transcribed reports and many other elements of health information. The benefit of the health information-exchange is that information is shared where care is delivered, when it is needed, and is easily accessible to providers through a web browser.

NEHII ensures all data is securely managed and accessed through a number of procedures and policies that are governed by HIPPA and overseen by leading experts in health information privacy and security. NEHII complies with HIPAA rules, as do NEHII participants. Protecting the privacy and security of health information is the highest priority to NEHII and its participants. Health information is kept secure using many technical safeguards and administrative policies and procedures.

Patient health information is only available to a treating provider that has been granted access to NEHII. Patient health information accessed on the system is monitored and audited to ensure privacy controls are maintained. For more information, see: https://nehii.org/nebraska-health-information-exchange/.

Nebraska Prescription Drug Monitoring Program (PDMP)

Launched at the beginning of 2017, the new Nebraska Prescription Drug Monitoring Program (PDMP) is offered as a stand-alone medication query platform and integrated into the NEHII HIE. The PDMP was enhanced per legislation (LB471, 2016) to collect all controlled substance prescriptions which are dispensed from pharmacies and other dispensers on a daily basis. The PDMP allows prescribers and pharmacists to view those prescriptions to prevent the misuse of controlled substance prescriptions. Beginning January 1, 2018 Nebraska began collecting all dispensed prescriptions so that the clinicians can better monitor the care and treatment of their patients. The PDMP is integrated within the NEHII. Health Information Exchange to facilitate an improved workflow for providers. For more information, see: https://nehii.org/nebraska-prescription-drug-monitoring-program/

Medicare Quality Improvement Organizations

The Medicare Quality Improvement Organization (QIO) Program, one of the largest federal programs dedicated to improving health quality for Medicare beneficiaries, is an integral part of the U.S. Department of Health and Human (HHS) Services' National Quality Strategy for providing better care and better health at lower cost. By law, the mission of the QIO Program is to improve the effectiveness, efficiency, economy, and quality of services delivered to Medicare beneficiaries. Based on this statutory charge, and CMS' program experience, CMS identifies the core functions of the QIO Program as:

- Improving quality of care for beneficiaries;
- Protecting the integrity of the Medicare Trust Fund by ensuring that Medicare pays only for services and goods that are reasonable and necessary and that are provided in the most appropriate setting; and
- Protecting beneficiaries by expeditiously addressing individual complaints, such as beneficiary complaints; provider-based notice appeals; violations of the Emergency Medical Treatment and Labor Act (EMTALA); and other related responsibilities as articulated in QIO-related law.

What are QIOs?

A Quality Improvement Organization is a group of health quality experts, clinicians, and consumers organized to improve the quality of care delivered to people with Medicare. There are two types of QIOs that work under the direction of the Centers for Medicare & Medicaid Services in support of the QIO Program:

Beneficiary and Family Centered Care (BFCC)-QIOs

BFCC-QIOs help Medicare beneficiaries exercise their right to high-quality health care. They manage all beneficiary complaints and quality of care reviews to ensure consistency in the review process while taking into consideration local factors important to beneficiaries and their families. They also handle cases in which beneficiaries want to appeal a health care provider's decision to discharge them from the hospital or discontinue other types of services. The BFCC-QIO for the state of Nebraska is Livanta. https://www.livantaqio.com

Quality Innovation Network (QIN)-QIOs

The QIO Program's Quality Innovation Network-QIOs (QIN-QIOs) bring Medicare beneficiaries, providers, and communities together in data-driven initiatives that increase patient safety, make communities healthier, better coordinate post-hospital care, and improve clinical quality. By serving regions of two to six states each, QIN-QIOs are able to help best practices for better care spread more quickly, while still accommodating local conditions and cultural factors. The QIN-QIO for the state of Nebraska is Great Plains Quality Innovation Network- Nebraska, https://www.greatplainsqin.org, 402-476-1399.

Why does CMS have QIOs?

CMS relies on QIOs to improve the quality of health care for all Medicare beneficiaries. Furthermore, QIOs are required under Sections 1152-1154 of the Social Security Act. The QIO Program is an important resource in CMS' efforts to improve quality and efficiency of care for Medicare beneficiaries. Throughout its history, the Program has been instrumental in advancing national efforts to motivate providers in improving quality and in measuring and improving outcomes of quality.

The QIO structure maximizes learning and collaboration in improving care, enhances flexibility, supports the spread of effective new practices and models of care, helps achieve the priorities of the National Quality Strategy and the goals of the CMS Quality Strategy, and delivers program value to beneficiaries, patients, and taxpayers.

Nebraska State Immunization Information System (NESIIS)

The Nebraska State Immunization Information System (NESIIS) is a secure, statewide, web-based system that connects and shares immunization information among public clinics, private provider offices, local health departments, schools, hospitals, and other health care facilities that administer immunizations and provide medical care to Nebraska residents.

NESIIS maintains computerized immunization data for people of all ages in a confidential and secure manner.

NESIIS helps to service the public health goal of preventing the spread of vaccine preventable diseases. A major barrier to reaching this goal is continuing difficulty of keeping immunization records accurate and up-to-date. It's difficult for providers and parents to accurately assess the immunization status of their children and patients when records are scattered between medical provider offices and parent records. NESIIS can help eliminate missed opportunities and over immunization by providing one secure location to store complete immunization- records.

NESIIS helps ensure that children get only the vaccines they need, and at the same time, improves the efficiency of the office (private, public, state) by reducing the time needed to find, assess, and document a patient's immunization status.

Nebraska Coalition for Patient Safety (NCPS)

Is both a state designated and federally-listed Patient Safety Organization (PSO). NCPS provides confidentiality and privilege protection for certain patient safety information reported to them. A health care provider can only obtain the confidentiality and privilege protections of the Patient Safety Act by working wiah a federally-listed PSO. The Coalition shares learning from events and provides resources, education and training for patient safety improvement. Education, services and support are offered for patient safety culture development such as conducting Surveys on Patient Safety Culture™ (SOPS™) and training in Root Cause Analysis, Just Culture and TeamSTEPPS.

Surveys on Patient Safety Culture™ (SOPS™)

The Agency for Healthcare Research and Quality (AHRQ) sponsored development of the SOPS™ as part of its goal to support a culture of patient safety and quality improvement in the U.S. health care system. The AHRQ SOPS™ program allows health care organizations to assess the current status of their patient safety culture, raise staff awareness about patient safety, evaluate the impact of changes over time, and conduct benchmarking. NCPS offers SOPS™ survey administration, analysis, assistance in interpreting and f:)resenting results, and support with action planning for improvement. Surveys are available for hospitals, nursing homes, ambulatory outpatient medical offices, community pharmacies, and ambulatory surgery centers. Optional supplemental items related to Just Culture and TeamSTEPPS can be added to your SOPS™ survey.

Just Culture

A just culture is foundational to improving safety and managing organizational risk. A safe, reliable culture has four key components: reporting, just, flexible and learning. A just culture fosters an environment where employees feel free to report errors, problems and system vulnerabilities so that information can be used for learning and improvement. Just culture training provides tools for implementing a consistent, fair, transparent approach to managing human error and behaviors and investigating underlying system factors. The ultimate goal is improving outcomes. NCPS provides on-site leadership and manager training for health care organizations.

TeamSTEPPS™

Team Strategies & Tools to Enhance Performance and Patient Safety (TeamSTEPPS™) is an evidence-based framework and curriculum that is used to optimize team performance. It was developed by the Department of Defense and the Agency for Healthcare Research and Quality, stemming from 20 years of research and application of teamwork principles. The curriculum is based on team structure and four key skills that are teachable and learnable - leadership, situation monitoring, mutual support, and communication. TeamSTEPPS contributes to a flexible culture through use of tools and techniques that enhance communication and teamwork skills among healthcare professionals.

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.

Rocky Mountain Performance Excellence Award

Rocky Mountain Performance Excellence (RMPEx) Awards Program

The Rocky Mountain Performance Excellence (RMPEx) Awards Program (using the Baldrige criteria) recognizes organizations from education, health care, manufacturing, nonprofit/government, service, and small business in Colorado, Montana, Nebraska, and Wyoming for their achievements in performance excellence. Award applicants receive extensive feedback identifying the organization's positive attributes and opportunities for improvement.

Organizations or individuals seriously committed to reaping the many benefits of systematic performance improvement can benefit from joining the RMPEx community as an applicant, examiner, and/or volunteer. Get more information at: https://rmpex.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, GP-QIN 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.

Contacts

Great Plains Quality Innovation Network

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 under served populations. See page 13 for more information about quality improvement organizations (QIO).

Key contact:
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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 Coalition for Patient Safety

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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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Email: mwoeppel@nebraskahospitals.org

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.

Key contact:
Diana Meyer, Program Manager
Nebraska Department of Health and Human Services
Acute Care Facilities Section
PO Box 94986
Lincoln, NE 68509-4986
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Nebraska Association Medical Staff Services (NAMSS)

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/

Nebraska Chapter, HIMSS

The mission of Nebraska HIMSS is to lead change in the healthcare information management systems field through the knowledge sharing, advocacy, collaboration, innovation, education and community affiliations in Nebraska. The Nebraska HIMSS provides education, professional resources, newsletters and other publications related to healthcare information management, systems and technology.

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.

Common QI 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
HAPI - Hospital Acquired Pressure Injury
HCAHPS – Hospital Consumer Assessment of Healthcare Providers and Systems
HIIN – Hospital Improvement Innovation Network
Hospital Compare – CART Tool – for data abstraction
I**CD-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
NAHQRS – Nebraska Association for Healthcare Quality, Risk & Safety
NCPS – Nebraska Coalition for Patient Safety
PDCA – Plan, Do, Check, Act
PFE/PFAC – Patient and Family Engagement / Patient and Family Advisory Council
PSES – Patient Safety Evaluation System
PSO – Patient Safety Organization
PSWP – Patient Safety Work Product
QIN-QIO – Quality Innovation Network-Quality Improvement Organization
QPP – Quality Payment Program
RCA – Root Cause Analysis
SBAR – Situation, Background, Assessment, Recommendation
SRE – Serious Reportable Event
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

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 outcome: an event resulting in a negative impact, for example: injury; illness; fatality; social or psychological impacts; equipment/environmental damage; or financial loss.

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.

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/condition (HAI/HAC): 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.

High Reliability Organizations: an organization that operates in complex, high-hazard domains for extended periods without serious accidents or catastrophic failures. High reliability organizations cultivate resilience by relentlessly prioritizing safety over other performance pressures.

Human factors: an established science that strives to understand how people perf9rm under different circumstances. It studies the interrelationship between humans, the tools and equipment they use in the workplace, and the environment in which they work. Awareness of human factors is used in the design of systems and equipment to improve performance, effectiveness and safety.

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.

LEAN: The core idea is maximizing customer value while minimizing waste (resources, time energy and effort). A lean organization understand customer value and focuses it key processes to continuously increase it. This management philosophy is derived mostly from the Toyota Production System and has been adopted into healthcare over the past decade.

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.

Pathways to Success (CMS): A proposed rule that would overhaul the Medicare Shared Savings Program in which a majority of the Medicare's Accountable Care Organizations (ACOs) operate.

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.

Patient Safety Organization (PSO): An organization created as part of the Patient Safety and Quality Improvement Act of 2005 to encourage health care providers to voluntarily report-adverse events confidentially and without fear of discovery. PSOs collect, analyze, and aggregate clinical data (known as patient safety work product) to develop insights into the underlying causes of patient safety events. PSOs work with healthcare providers to help them improve quality and patient safety. A PSO that has submitted its certification submission and has had its submission accepted by AHRQ is deemed "listed" by AHRQ. The list of PSOs is available online at www.pso.ahrq.gov.

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.

Population Health: The health outcomes of a group of individuals, including the distributions of such outcomes within the group. It is an approved that aims to improve the health of an entire human population.

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.

Six Sigma: A set of techniques and tools for process improvement. First introduced in the engineering world, it has been adopted to healthcare. Six Sigma is a process improvement strategy that focuses on eliminating defects, i.e. anything that does not meet customer requirements.

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.

Value based care: The idea of improving quality and outcomes for patients. Reaching this goal is based on a set of changes in the ways a patient receives care. Value-based programs reward health care providers with financial incentive payments for the quality of care they give to people from payers such as CMS or private insurers.

To help keep you connected...

1. 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.
2. 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
3. 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.
4. 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!

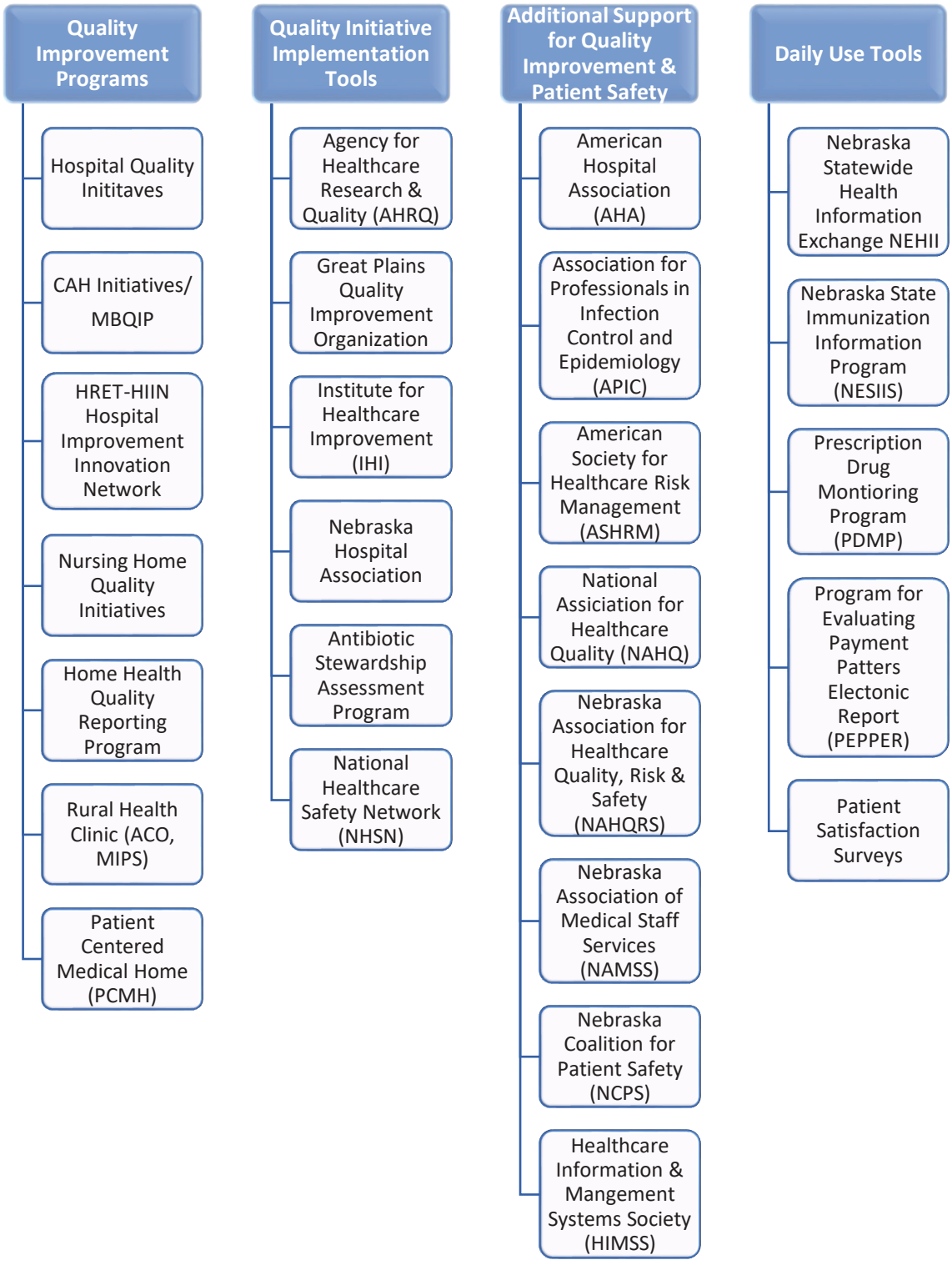
Listservs to be aware of...

CAH listserv
Statewide listserv for all CAH personnel; contact Great Plains QIO at (402) 476-1700 to join.
CAH Quality Improvement listserv
Maintained by the Office of Rural Health; contact Nancyjo.Hansen@nebraska.gov to join.

HIIN listserv
For all HIIN reporting information and monthly Quality Matters newsletter; contact mwoeppel@nebraskahospitals.org to join.

NHA Newslink
Weekly e-newsletter; contact mwoeppel@nebraskahospitals.org to join.

REGULATION DRIVEN—CMS, DHHS, JOINT COMMISSION, DNV—QUALITY NETWORK



Model Quality & Performance Improvement Plan

NHA Nebraska Hospital Association

Model Quality & Performance Improvement (QPI) Plan

The Model Quality Improvement (QPI) 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

"Organizations must define what they want to accomplish in the future. The mission is the organization's purpose or reason for existing. It answers questions such as, "Why are we here?" "Whom do we serve?" and "What do we do?" (White, 2012, p. 2).

"Goals and objectives are essential components of any planning process; they guide actions and serve as a yardstick for measuring the organization's progress and performance." "In general, goals are broad, general statements specifying a purpose or desired outcome and may be more abstract in nature than objectives (one goal can have several objectives)." "Goals need to be; observable, measurable, challenging, but attainable, controllable, visible and time limited." (White, 2012, p. 3).

Example #1

The mission of [Hospital name] 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 [modeled after IOM aims for health care quality]:

- **Safe:** Avoiding harm to patients from the care that is intended to help them.
- **Effective:** Providing services based on scientific knowledge to all who could benefit and refraining from providing services to those not likely to benefit (avoiding underuse and misuse, respectively).
- **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 sometimes harmful delays for both those who receive and those who give care.
- **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.

Example #2

The mission of the [Hospital name] is: To advance the health of the communities and the region we serve, through collaboration, prevention, innovation and exceptional care.

To achieve this goal, all employees of [Hospital name] and medical staff will participate in ongoing quality improvement efforts. Our quality and performance improvement plan will focus on direct patient care delivery 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 performance improvement techniques. our performance improvement plan demonstrates [Hospital name] commitment to improve the quality of care we deliver. The PI Plan outlines the goals and strategies for ensuring patient safety, delivering optimal care and achieving high patient satisfaction.

Authority

"The organization's governing body bears ultimate responsibility for setting policy, financial and strategic direction, and the quality of care and service provided by all of its practitioners and nonclinical staff. Together with the organization's management and medical staff leaders, the governing body sets priorities for QPI activities." (White, 2012, p. 8).

Example #1

The Board of Directors of [Hospital name] 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 Committee and Utilization Review Committee, and to committees working under the authorization of such Medical Staff Committee and Utilization Review Committee such as the Quality Improvement Committee, and to the hospital's Leadership Team.

Example #2

The Board of Directors of [Hospital name] is ultimately responsible for assuring that high quality care is provided to our patients. The board oversees and monitors outcomes that result from performance improvement activities. The CEO, senior leadership, managers and frontline staff are responsible for strategic, operational and tactical aspects of performance improvement.

Scope

"Everyone in the organization is responsible for quality and safety." (White, 2012, p. 79).

Example

To achieve the goal of delivering high quality care, all em-

ployees 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
- Healthcare acquired 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
- The Joint Commission's National Patient Safety Goals
- Readmission review
- Root cause analyses
- Core clinical measures
- Preventable error
- (List other activities as appropriate to your facility)

Quality Improvement Committee

"The role of the steering committee or quality council is to sustain, facilitate and expand the QPI initiative based on the strategic plan. It should comprise top leaders in the organization, including medical staff. That main responsibility of the quality council include: lending legitimacy to the QPI efforts; maintaining organization focus on identified goals and priorities; fostering teamwork for improvement; providing necessary resources (human, financial, etc.); and formulating QPI policies regarding quality and safety priorities, participation, annual self-assessments, and rewards and recognition systems" (White, 2012, p. 48).

Example

The Quality Improvement Committee consists of the following individuals: The CEO, chief of staff/designee, the director of nursing, the QI manager, pharmacist, infection preventionist, 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, Hospital Compare data, HCAHPs data.
- Identifying other sources, such as the Joint Commission's National Patient Safety Goals, for incorporation into the hospital's overall quality improvement efforts.
- Reporting on ongoing findings, studies, recommendations, and trends to the governing board quarterly; 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.

Leadership Responsibility

For practical purposes, day-to-day leadership is delegated to the CEO and senior management, elected or appointment members of the medical staff (e.g. chairs) and administrative and clinical staff (e.g. nursing and health care quality professionals). (Duquette, 2012, p. 11)

Example

CEO and senior leadership are to ensure that quality actions are based upon strategic plan therefore ensuring the future of quality health care for our patients and community. CEO and Senior leadership are responsible for monitoring outcomes of performance improvement and assisting with key processes when the need arises.

Medical Staff Responsibility

Example

The medical staff at [Hospital name] participates in surgical case review; blood usage review; medical record review; infection control; pharmacy and therapeutics review; mortality review; utilization management, including denials issued by payers; review of transfers to other facilities; credentialing and will serve, from time to time, as liaisons to quality and performance improvement activities. The ultimate goal is to improve the quality and safety of care that is provided to the patients of [Hospital name].

Manager/Department Staff Responsibility

Example

Every department within [Hospital name] is responsible for implementing quality and performance improvement activities. All quality improvement initiatives are conducted as a part of hospital wide and departmental quality and performance improvement. each department manager is responsible for setting goals that give direction for process improvement. Managers and department staff identify quality indicators, collect and analyze data, develop and implement changes to improve care and service delivery. Ongoing monitoring assures that improvement is made and sustained. The ultimate goal is to improve the quality and safety of care that is routinely provided to the patients of [Hospital name].

Network Hospital Responsibility

Reference specific language present in contract with network hospital.

§485.603 Rural health network
CAH and Consulting Hospital desire to enhance the continuity of health care delivery among all levels of care needed by patients in CAH's service area by entering into this Network Agreement to formalize the parties' understanding concerning the transfer and referral of patients on a non-exclusive basis between their respective facilities, to address what communications systems are or will be used between their facilities and the manner and methods involved in the transportation of patients between the parties or other referral centers under emergency and non-emergency situations. This Agreement also contains the parties' understanding regarding arrangements for quality assurance and credentialing.

(b) The members of the organization have entered into agreements regarding -
(1) Patient referral and transfer;
(2) The development and use of communications systems, including, where feasible, telemetry systems and systems for electronic sharing of patient data; and
(3) The provision of emergency and nonemergency transportation among members.
(c) Each CAH has an agreement with respect to credentialing and quality assurance with at least –
(1) One hospital that is a member of the network when applicable;
(2) One QIO or equivalent entity: or
(3) One other appropriate and qualified entity identified in the State rural health care plan.

I. PATIENT REFERRAL AND TRANSFERS
Patient Transfers. To comply with the requirements of Public Law 105-33, § 4201, CAH will identify for transfer, patients that require services that are not offered by CAH. Such patients will be transferred to Consulting Hospital or to another hospital that provides the needed services. Consulting Hospital is required to accept the patients referred by CAH; however, this requirement is no greater than that required by the Emergency Medical Treatment and Active Labor Act, 42 U.S.C. § 1395dd, (EMTALA/COBRA).

II. EMERGENCY AND NON-EMERGENCY TRANSPORTATION
Emergency Transfers. CAH and Consulting Hospital seek to provide patients with immediate access to emergency treatment, and if advanced or specialized care is required, to provide a mechanism to deliver such available care. Policies and protocols for emergency transfers have been established by both hospitals and should be followed for all emergency transfers to or from CAH, and for those emergency transfers between CAH and Consulting Hospital.

III. COMMUNICATION SYSTEMS
Communications between systems of the network and referral facility may include the electronic sharing of patient data, telemetry and medical records if such systems exist and as agreed upon by facilities and in compliance HIPAA laws/ regulations.

IV. CREDENTIALING
CAH has established a medical staff credentialing process to support its governing body in carrying out its responsibilities in granting privileges to physicians and mid-level practitioners practicing at CAH.

CAH, in accordance with its medical staff bylaws and rules and regulations, shall be responsible for the credentialing and privileging process of its own medical staff and allied health practitioners including, but not limited to PA's, NPs, CNMs, and surgical technicians/assistants.

Review/audit of CAH's credential files will be performed by:
(1) One hospital that is a member of the network
(2) One QIO or equivalent entity; or
(3) One other appropriate and qualified entity identified in the State rural health care plan.

This review will include, but is not limited to, review of current licensure and certification, delineation of privileges and comparison of delineated privileges to the scope of services provided by the CAH.

Unless otherwise agreed, CAH and Consulting Hospital agree that each facility shall continue to credential members of its own medical staff and mid-level practitioners in accord with each facility's respective medical staff bylaws and rules and regulations subject to the control and supervision of each facility's governing body. No joint credentialing process for purposes of establishing joint or cross medical staff membership or for purposes of joint credentialing of mid-level practitioners is intended by this Agreement unless otherwise agreed by the parties.

V. QUALITY ASSURANCE
Consulting Hospital shall, upon request of CAH, assist the quality assurance committee in the development and implementation of CAH's quality improvement plan which meets the requirements of 42 C.F.R. § 485.641, which may include identifying areas in need of improvement, developing appropriate remedies to address these areas, and educating CAH and staff as to quality issues ("QI Plan"). Such assistance may include participation in Network quality meetings, Network review meetings, CAH Quality Committee meetings and/or Network quality education meetings.

Consulting Hospital shall, upon request of CAH, conduct a performance review of CAH's quality assurance program, which review shall include an evaluation of CAH's compliance with the QI Plan. CAH will provide the results of the performance review to the quality assurance committee for the committee's review, action and forwarding to CAH's governing body.

Medical records review as part of the quality and medical necessity of medical care at CAH, in accordance with the requirements of 42 C.F.R. Section 485.616(b), shall be performed by direct inspection by:
1. One hospital that is a member of the Network
2. Consulting Hospital or designated employee of
3. Physician affiliated with the Network and/or Consulting

Hospital; or

4. Peer review organization currently under contract with the CAH for this service by analysis of CAH's internal chart audits, or by examination of external peer review reports.

Consulting Hospital shall, upon request of CAH, provide external peer review assistance in accordance with Network policies and procedures.

Example

[Hospital name] 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 and performance improvement plan. The CAH network allows us to work with other Critical Access Hospitals to identify appropriate measures of quality and performance improvement for CAHs, provides a mechanism to meet licensure and certification requirements for outside quality review, and to establish best practices to implement at [Hospital name].

Confidentiality

Reference up-to-date state statutes

Example

Information created or caused to be created by this Performance Improvement Plan is protected by Neb. Rev. Stat. Section 71-7912.

The interviews, reports, statements, other data, proceedings and records of the performance improvement team 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 performance improvement team or sub-committee(s) shall disclose information concerning matters submitted to, considered by, or issuing from the performance improvement team 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 [Hospital name] president/CEO.

Comparative Databases, Benchmarks and Professional Practice Standards/ Best Practices

[Hospital name] 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.

Quality Improvement Processes and Methodology

Example #1

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

Example #2

A structured process quality and improvement method such as:

- Lean
- Plan, Do, Study, Act (PDSA)
- Rapid Cycle Improvement
- Constraints Management
- Six Sigma (DMAIC)
- Benchmarking
- Dashboards and/or Scorecards
- Federal Emergency Management Agency (FEMA)
- Root Cause Analysis (RCA)
- Etc.

Quality and performance 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 performance improvement teams.

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

A report, which provides summary data about selected indicators, prepared for the board, quality council and medical staff.

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

Our methodology/process includes:

- Ongoing monitoring and data collection
- Problem identification and data analysis
- Identification/implementation if actions (90 day plans)
- Evaluation/enhancement of actions
- Measures to improve quality on a continuous basis and sustain excellence

Communication

Example

[Hospital name] Quality Council provides oversight of performance improvement activities. The quality and organizational improvement director facilitates performance improvement activities and functions as the central clearing house for quality data and information collected throughout the facility. Data tracking, trending and aggregates from a variety of sources will be used to prepare reports for the governing board, quality council and the medical staff. Communication on organizational and departmental performance is ongoing via Balanced Score Cards.

Education

"Everyone in the organization is responsible for quality and safety. Therefore, educating all employees at all levels of the organization is critical to the success of QPI. Because the most common cause of failure in any QPI effort is uninvolved or indifferent top and middle management, it is essential that all leaders be educated from the start. Training should begin at the top and cascade down through the organization."
(White, 2012, p. 79).

Example

All staff are given the responsibility and authority to participate in [Hospital name] 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 [Hospital name].

Annual Evaluation

Reference specific language present in contract with network hospital.

§485.641 Condition of Participation: Periodic Evaluation and Quality Assurance Review

§485.641 (a) Standard: Periodic Evaluation (1) The CAH carries out or arranges for a periodic evaluaiton of its total program. The evaluation is done at least once a year and includes review of Survey Procedures.

§485.641 (a)(1)

- How is information obtained to be included in the periodic evaluation?
- How does the CAH conduct the periodic evaluation?
- Who is responsible for conducting the periodic evaluation?

Example

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.

LDHHS Rules & Regulations for Hospitals:
http://www.sos.ne.gov/rules-and-regs/regsearch/Rules/Health_and_Human_Services_System/Title-175/Chapter-09.pdf

tate Operations Manual Appendix W Survey Protocol, Regulations and Interpretive Guidelines for Critical Access Hospitals (CAH) and Swing Beds in CAHs:
http://www.cms.hhs.gov/manuals/Downloads/som107ap_w_cah.pdf

References

Duquette, C.E. (2012). Leadership and Management. Q Solutions: Essential Resources for the Healthcare Quality Professional, (3rd ed.). National Association for Healthcare Quality: Glenview, IL.

White, S.V. (2012). Quality and Performance Improvement. Q Solutions: Essential Resources for the Healthcare Quality Professional, (3rd ed.). National Association for Healthcare Quality: Glenview, IL.

Notes

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