GUAM MEMORIAL HOSPITAL AUTHORITY
REVIEW AND ENDORSEMENT CERTIFICATION

The signatories on this document acknowledge that they have reviewed and approved the following:

□ Bylaws

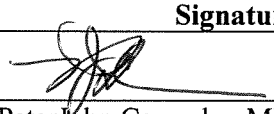
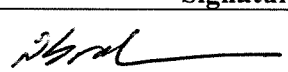
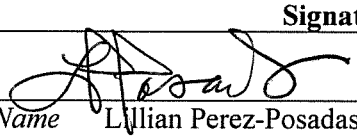
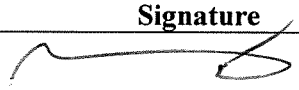
□ Rules & Regulations

✓ **Policies & Procedures**

Submitted by Department/Committee: **Performance Improvement Committee**

Policy No.: **A-PI100**

Title: **QUALITY ASSESSMENT AND PERFORMANCE IMPROVEMENT PLAN**

Reviewed/Endorsed	**Date**	**Signature**
	03/20/2018	
Title	*Name*	PeterJohn Camacho, MPH
	Title	Hospital Administrator/ CEO Performance Improvement Committee Chairperson
Reviewed/Endorsed	**Date**	**Signature**
	02/28/18	
Title	*Name*	James P. Last, MD
	Title	Medical Executive Committee Chairperson
Reviewed/Endorsed	**Date**	**Signature**
	03/21/18	
Title	*Name*	Lillian Perez-Posadas, MSN, RN
	Title	Board of Trustees Quality & Safety Subcommittee Chairperson
Reviewed/Endorsed	**Date**	**Signature**
	03/28/18	
Title	*Name*	Eloy Lizama
	Title	Board of Trustees Chairperson
Reviewed/Endorsed	**Date**	**Signature**
Title	*Name*	
	Title	
Reviewed/Endorsed	**Date**	**Signature**
Title	*Name*	
	Title	

***Use more forms if necessary. All participating departments/committees in developing the policy should provide signature for certification prior to submitting to the Compliance Officer.**

GUAM MEMORIAL HOSPITAL AUTHORITY
ADMINISTRATIVE MANUAL

APPROVED BY:	RESPONSIBILITY:	EFFECTIVE DATE:	POLICY NO.	PAGE
PETERJOHN CAMACHO, MPH Hospital Administrator/CEO	Performance Improvement Committee	Interim Approved: October 26, 2017	A-PI100	1 of 46
TITLE: QUALITY ASSESSMENT AND PERFORMANCE IMPROVEMENT PLAN				
LAST REVIEWED/REVISED: 12/2017				
ENDORSED: PIC --/2018, MEC --/2018, Q&S --/2018, BOT --/2018				

PURPOSE:

To provide a QUALITY ASSESSMENT AND PERFORMANCE IMPROVEMENT (QAPI) process for Guam Memorial Hospital Authority (GMHA) that supports its Vision, Mission, Values and organizational/strategic priorities. The QAPI process is a planned, systematic, data-driven, organization-wide approach and involves all hospital departments and services (including those services furnished under contract or arrangement). It involves the assessment and measurement of processes of care, hospital service and operations, patient outcomes, and when indicated, identifying and implementing changes that enhance performance, improve health outcomes, prevent and reduce harm and errors and promote quality and safety.

These changes are incorporated into new or existing work processes, products or services, and performance is monitored/tracked to ensure that successful improvements are sustained. This process also incorporates mechanisms for compliance with outside regulatory agencies, such as the Centers for Medicare and Medicaid Services (CMS) and The Joint Commission (TJC).

POLICY:

The leaders of GMHA are committed to continually improving the quality and safety of care and services provided by monitoring and assessing care delivery, care outcomes, patient safety, error reduction, and the satisfaction of our customers. The leaders support an environment that encourages the identification of improvement opportunities from all sources throughout the organization and the provision of care and services that is reflective of the organization's Mission, Vision and Values.

MISSION:

GMHA is a semi-autonomous government agency charged with providing quality healthcare services to the public. This is expressed through its Mission statement: "To provide quality patient care in a safe environment".

VISION:

As stated in GMHA's 2013 Strategic Plan, the following vision statement guides all efforts and actions: "To achieve a culture and environment of safety and quality patient care meeting national standards and addressing the needs of the Community in a fiscally responsible, autonomous hospital".

VALUES:

GMHA serves by following core values – Accountability, Cost Effectiveness, Excellence in Service, Safety plus Quality; abbreviated as ACES+Q.

RESPONSIBILITIES:

I. ORGANIZATIONAL QUALITY ASSESSMENT AND PERFORMANCE IMPROVEMENT STRUCTURE AND EXPECTATIONS

The leaders of GMHA are committed to the integration of QAPI activities. Staff leaders understand the fundamental principles of improvement and participate in (1) identifying opportunities for improvement, (2) data collection, (3) data analysis (including staffing analysis), (4) creation and implementation of improvement activities, (5) evaluation activities, (6) reporting activities, (7) QAPI team/project activities, and (8) ongoing education.

A. THE BOARD OF TRUSTEES

The Board of Trustees (BOT) maintains overall responsibility for ensuring the quality and safety of care and services provided by GMHA. The BOT shall delegate implementation responsibility for organization-wide QAPI activities to the Performance Improvement Committee (PIC), Medical Executive Committee (MEC), and Skilled Nursing Facility's Performance Improvement Committee (SNF-PIC).

B. THE QUALITY AND SAFETY SUBCOMMITTEE

The Quality and Safety (Q&S) Subcommittee (formerly known as the Board of Trustees Performance Improvement Subcommittee) shall be chaired by Board of Trustees appointed members, and additionally shall consist of members from the Executive Management Council (EMC), the President of the Medical Staff (MEC Chairperson), the Administrator of Quality, Patient Safety and Regulatory Compliance, the Risk Management Program Officer, and the Performance Improvement Coordinator.

The purpose of the Q&S Subcommittee is to provide oversight and leadership for all activities relative to the hospital's QAPI plan. Information brought forth in this Subcommittee's meeting shall be discussed with the BOT by the Chairperson of this Subcommittee. Likewise, information brought forth in this Subcommittee's meeting shall be brought back to the PIC, MEC, and SNU-PIC *(see attachment I - QAPI Reporting Pathway).*

To comply with requirements under CMS' Conditions of Participation (COPs) (42 CFR §482.21), the following executive responsibilities are outlined (for the BOT, Medical Staff, and Executive Management/Leadership):

1. An ongoing program for quality improvement and patient safety, including the reduction of medical errors, must be defined, implemented, and maintained.
2. The hospital-wide QAPI efforts must address priorities for improved quality of care and patient safety; and all improvement actions must be evaluated.
3. Clear expectations for safety must be established.
4. Adequate resources must be allocated for measuring, assessing, improving, and sustaining the hospital's performance and reducing risk to patients.
5. The determination of the number of distinct improvement projects must be conducted annually.

C. THE PERFORMANCE IMPROVEMENT COMMITTEE

1. Membership: The PIC shall consist of the EMC, the Performance Improvement Coordinator, and other hospital staff as necessary via official appointment by the chairperson. The PIC shall be chaired by the Hospital Administrator/CEO. Additional details on the committee's functions and members' responsibilities are contained within its committee charter.

2. Duties and Responsibility:

    a. Provide oversight and direction to unit/department managers and supervisors, and hospital committee chairpersons on their QAPI indicators/measures.
    b. Prioritize indicators/measures that include high-risk, high-volume, and problem-prone areas identified throughout the organization, which are trended, analyzed, and improved upon by the departments.
        i. The division administrators shall oversee and manage his/her departments' QAPI indicators/measures. This includes organizing division PI meetings per the QAPI monthly rotation schedule *(see attachment II – QAPI Monthly Rotation)*, appointing appropriate division PI minute-takers/ scribes, and ensuring accountability with respect to the QAPI schedule and deadlines *(see attachment III - QAPI Schedule).*
        ii. Hospital committee chairpersons shall oversee and manage his/her committee's QAPI indicators/measures. This includes the inclusion of QAPI-related reporting during committee meetings, appointing of appropriate PI minute-takers/ scribes, and ensuring accountability with respect to the QAPI schedule and deadlines *(see attachment III - QAPI Schedule).*
        iii. Each department and committee is considered a working team, wherein problems and improvement opportunities are identified, actions are planned, implemented, and evaluated, and monitoring is conducted to ensure sustainment of improvement.
    c. Establish, as needed and as directed by the BOT and Q&S Subcommittee (for annual QAPI Projects), a QAPI project/team – an interdepartmental membership team who are the main stakeholders in the planned change. Members of the QAPI project/team shall be appointed by the Hospital Administrator/CEO. These teams shall report to the PIC quarterly on its action status *(See Procedure, Section II, QAPI Projects).*
    d. Oversee the Patient Safety Committee's analysis of sentinel events.
    e. Oversee the Patient Safety Committee's organizational Failure Mode and Effects Analysis (FMEA) and ensure appropriate risk assessments are conducted for identified opportunities.
    f. Ensure that QAPI activities meet the standards and regulations of our regulatory bodies.
    g. Ensure that QAPI education is provided to appropriate staff (to include all department supervisors/managers) on an annual basis.
    h. Ensure that processes are improved through the hospital's improvement methodology (*see Procedure, Section VI, Improvement Methodology*).
    i. Ensure that the hospital analyzes staffing adequacy via data from clinical/service screening indicators (e.g. falls, pressure ulcers, etc.) or human resources screening indicators (e.g. vacancy rates, overtime hours, etc.) to assess and continuously improve staffing adequacy.

i. The members of EMC and PIC will collaborate to produce an annual staffing adequacy report for the Q&S Subcommittee, per the QAPI schedule and deadlines *(see attachment III - QAPI Schedule)*.
ii. Department managers/supervisors and their division administrators will also document staffing analysis (e.g. skill mix, competencies assessment, work flow/process or workload) and related plans of action within their QAPI reports (*see attachment VIII – Department Quarterly Report and attachment IX – Division Administrator Quarterly Matrix Report).*

j. Ensure that the Hospital monitors the safety, quality, and performance of contracted services.
i. Department managers/supervisors and their division administrators will document QAPI relative to contracted services within their QAPI reports (*see attachment VIII – Department Quarterly Report and attachment IX – Division Administrator Quarterly Matrix Report).*
ii. Note: This policy does not remove the hospital's requirements for contract management set forth in Policy No. A-LD700.

k. Report to the Q&S Subcommittee, any adverse outcomes, significant process variations, and actions taken to improve care and address patient safety issues, both proactively and reactively.

D. THE MEDICAL EXECUTIVE COMMITTEE

1. The purpose and function of the Medical Executive Committee (MEC) shall be in accordance with the Medical Staff By-Laws 12.2: Medical Executive Committee.

2. Duties and Responsibilities:

a. The MEC shall receive and act on QAPI data/reports from the clinical departments (to include medical services, nursing services, and professional support services), and its medical departments and subcommittees.
b. The Chairperson, or a representative from the committee, shall report to the Q&S Subcommittee, any adverse outcomes, significant process variations, and actions taken to improve care and address patient and environmental safety, both proactively and reactively.
c. Information on indicators/measures from other hospital departments or committees regarding physicians' performance that is discussed in the Q&S Subcommittee shall be brought to the MEC for a plan of action for improvement.

E. SKILLED NURSING FACILITY PERFORMANCE IMPROVEMENT COMMITTEE (SNF-PIC)

1. In accordance with the CMS Long Term Care (LTC) COPs, the Administrator of the Skilled Nursing Facility shall conduct QAPI meetings on at least a quarterly basis (or more frequently as necessary) to discuss, analyze and act on performance indicators/measures within the facility.

2. Membership: The SNF-PIC shall consist of, at a minimum, its Administrator, Medical Director, Nursing Director, Infection Preventionist, and at least two other SNF staff.

a. Each department that provides services in the SNF shall report their indicators/measures to the SNF Administrator at a frequency determined by the SNF-PIC.

3. Duties and Responsibilities:

a. Oversee and provide direction for the performance indicators/measures that are monitored under the facility's own QAPI plan and program (SNF must fulfill CMS LTC COPs relative to QAPI).
b. Prioritize measures that include high-risk, high-volume and problem-prone areas identified throughout the facility and ensure that the performance measures are trended, analyzed, and improved upon by the departments.
c. Ensure that processes are improved through the SNF-PIC's chosen improvement methodology.
d. Ensure that appropriate FMEA and risk assessments are performed on identified opportunities.
e. The SNF Administrator shall report to the Q&S Subcommittee any adverse outcomes, significant process variations, and actions taken to improve care and address patient and environmental safety, both proactively and reactively.

PROCEDURE:

I. CRITERIA FOR PRIORITIZATION OF IMPROVEMENT OPPORTUNITIES

Prioritization of improvement opportunities shall: (1) be based on the criteria below; (2) be conducted prior to annual QAPI plan creation; and (3) occur at all levels within the organization (i.e. department, division, committee, and executive level). The Q&S Subcommittee and BOT maintains overall decision-making authority. Prior to creating annual QAPI plans, prioritization should be conducted (s*ee attachment IV - QAPI Prioritization Matrix*).

- Is the improvement opportunity related to a high risk process?
- Is the improvement opportunity related to a high volume process?
- Is the improvement opportunity related to a problem prone process?
    - In prioritizing problem-prone processes, the hospital must consider incidence (how often problems occur), prevalence (how widespread in the organization the problem is), and severity (how much and how likely harm could be done).
    - Greater prioritization and importance should be given to problem-prone processes that occur frequently, are pervasive throughout many areas of the hospital (not isolated to one area), and pose the greatest likelihood for harm.
- Does the improvement opportunity support the Hospital's Mission, Vision and Values?
- Does the improvement opportunity reduce medical errors and/or harm?
- Is the improvement opportunity related to improving health outcomes?
- Does the improvement opportunity improve safety?
- Does the improvement opportunity improve quality?
- Does the improvement opportunity improve patient satisfaction?
- Is the improvement opportunity a regulatory requirement that must be monitored and improved upon?

II. QAPI PROJECTS

A. REQUIREMENTS

To comply with CMS' QAPI program COPs (42 CFR §482.21), the hospital must conduct performance improvement projects. The following requirements are outlined:

1. The number and scope of distinct improvement projects must be proportional to the scope and complexity of the hospital's services and operations.
2. The hospital may, as one of its projects, develop and implement an information technology system explicitly designed to improve patient safety and quality of care. This project, in its initial stage of development does not need to demonstrate measurable improvement in indicators related to health outcomes.
3. The hospital must document what quality improvement projects are being conducted, the reasons for conducting these projects, and the measurable progress achieved on these projects.
4. The hospital is not required to participate in a QIO cooperative project, but its own projects are required to be of comparable effort.

B. QAPI PROJECT TEAM REPORTING

QAPI project/teams shall utilize the project/team template, *(see attachment XIII – QAPI Project/Team Template),* along with analyzed data sheets/reports, to report its activities and progress. Reporting shall be at least quarterly, to the PIC. The PIC will also determine which specific rotation month the team should report in.

III. PERFORMANCE MEASURES AND INDICATORS

Performance measures/indicators may address key systems, processes and/or outcomes. They are selected after prioritization is conducted, to promote the monitoring of the effectiveness and safety of services and quality of care. Standards-based, citation-driven or regulatory agency required measures/indicators may also be monitored in order to reflect compliance. Target goals will be stated for performance measures/indicators to reflect the level of performance to be achieved. Benchmark information may be drawn from internal and external sources when available, and may also serve as target goals.

A. ANNUAL EVALUATION/REVIEW

The evaluation/review of performance measures/indicators in one's QAPI plan occurs annually at the end of December and is submitted in January of the next calendar year per the QAPI schedule and deadlines *(see attachment III – QAPI Schedule).* QAPI plan evaluation must utilize the respective annual QAPI plan/program evaluation template *(see attachment VI – Annual QAPI Plan/Program Evaluation)* and must be completed prior to creating the new calendar year's QAPI plan.

B. GUIDANCE FOR CONTINUING OR DISCONTINUING MONITORING

1. In general, indicators or measures that meet the following requirement will be allowed to have reduced monitoring frequency:
    a. Sustained compliance or performance exceeding established goals or 95% (whichever is greater) for a period of 6 months consecutively.

2. The monitoring frequency of such indicators/measures will be reduced from monthly to quarterly for another 6 month period (two quarters).
3. If sustainment continued in this second time frame, the indicator/measure will be allowed to be discontinued completely or have further reduction of monitoring frequency (e.g. yearly basis), based on the approval of the respective division administrator or committee chairperson (e.g. PIC, BOT-Q&S, etc.).
    a. With any change in indicator/measure monitoring, the respective department or committee QAPI Plan must be updated/revised accordingly.
    b. QAPI Plan changes must have the approval and signature of the respective division administrator or committee chairperson (e.g. PIC, BOT-Q&S, etc.).
    c. Approved/signed QAPI Plan changes must be forwarded to the Performance Improvement Coordinator for record-keeping purposes.
4. If sustainment was not continued in this second 6 month period, the monitoring frequency shall revert back to a monthly basis.
5. Standards-related indicators/measures *(see letter C below)* will be continuously monitored, as required by the Hospital's regulatory bodies.
6. QAPI indicators/measures related to Contracted Services have the following guidance:
    a. Requirements set forth in Policy No. A-LD700 must be followed.
    b. If the QAPI indicator/measure is related to a regulatory monitoring standard or requirement *(see letter C below)*, monitoring shall be continuous.

C. PRIORITIES FOR MONITORING – STANDARDS-RELATED INDICATORS

1. In accordance with the Joint Commission Performance Improvement standards, CMS QAPI Conditions of Participation requirements, and CMS Electronic Clinical Quality Measures (eCQMs), the following indicators shall be monitored, analyzed, and improved upon, by the hospital:

    a. Operative or other procedures that place patients at risk of disability or death
    b. All significant discrepancies between preoperative and postoperative diagnoses, including pathological diagnosis
    c. Adverse events related to using moderate or deep sedation or anesthesia
    d. The use of blood and blood components
    e. All reported and confirmed transfusion reactions
    f. The results of resuscitations
    g. Significant medication errors
    h. Significant adverse drug reactions
    i. The use of opioids to determine if they are being used safely (e.g. the tracking of adverse events such as respiratory depression, naloxone use, and the duration and dose of opioid prescriptions)
    j. Data on pain assessment and pain management, including types of interventions and effectiveness
    k. Patient perception of the safety and quality of care, treatment, or services; patient complaints/grievances
    l. CMS eCQMs (e.g. CMS9, CMS31, CMS32, CMS111, etc.)
    m. Data on patient thermal injuries that occur during magnetic resonance imaging exams
    n. Incidents where ferromagnetic objects unintentionally entered the magnetic resonance imaging (MRI) scanner room

o. Injuries resulting from the presence of ferromagnetic objects in the MRI scanner room
p. Incidents where the radiation dose index (computed tomography index [CTDIvol], dose length product [DLP], or size-specific dose estimate [SSDE]) from diagnostic CT examinations exceeded expected dose index ranges identified in imaging protocols. These incidents are then compared to external benchmarks. *Note: This does not apply to dental cone beam CT radiographic imaging studies performed for diagnosis of conditions affecting the maxillofacial region or to obtain guidance for the treatment of such conditions.*
q. Adequacy of Staffing – staffing analysis shall be mandatory for clinical-related departments and divisions (e.g. Nursing Services, Professional-Support Services); and for all other departments and divisions, further TJC guidance is provided in *Section V: Data Analysis.*

2. GMHA considers collecting data on the following:

   a. Staff opinions and needs
   b. Staff perceptions of risk to individuals
   c. Staff suggestions for improving patient safety
   d. Staff willingness to report adverse events
   e. CMS Inpatient Quality Measures (voluntary) or TJC ORYX Measures

3. Additionally, the hospital must comply with CMS expectations for monitoring the following, via its Patient Safety Program and Risk Management Program *(see Related Policies)*:

   a. Medical errors and adverse patient events, wherein the hospital must analyze their causes, and implement preventive actions and mechanisms that include feedback and learning throughout the hospital.

IV. DATA COLLECTION

Data collection shall coincide with the calendar year cycle. It shall be trended over time to display that changes are resulting in improvement. The methods in which data will be collected shall be determined by the departments (and stated in their respective QAPI Plans), with guidance from the PIC as necessary.

The frequency for data collection shall be on a monthly basis (or more/less frequent depending on the measure/indicator being monitored). Use of the monthly trending sheet is requisite for all departments to submit their collected data (*see attachment VII - Monthly Trending Sheet*). For data collected at a frequency that differs from monthly basis, the respective department must customize the trending sheet to accommodate the alternative frequency.

Departments are also encouraged to include data subsets within trending sheets to show how data gets aggregated into an overall performance/compliance result. Data subsets can also serve as a means for drilling down further for specific information.

Other data display techniques (e.g. line or bar graphs, charts, tables, etc.) must also be included within the trending sheet and data analysis section of the quarterly report *(see attachment VIII – Department Quarterly Report)*.

To facilitate the collection of consistent, reliable data, departments are encouraged to consider the following details in formulating their QAPI Plans' data collection methods:

- Identifying the Denominator detail with inclusions and exclusions
- Identifying the Data source for the denominator and include any specific queries to be run or report parameters that must be entered
- Identifying the Numerator detail with inclusions and exclusions
- Identifying the Data source for the numerator and include specific queries to be run, manual steps, or specific sampling parameters
- If different individuals are assigned, identify who collects each data element and calculates the measure/indicator
- Developing a standardized method/tool for auditors or data collectors to utilize

Additional data collection details are built in to the annual QAPI plan template (*see attachment V – Annual QAPI Plan*). All departments are expected to fill in the template details as completely as possible.

V. DATA ANALYSIS

Collected data is transformed into performance information and knowledge when analysis is undertaken. The data should be processed and synthesized so that the organization can make informed assumptions and generalizations about what has happened, why this might vary from what was expected, and what corrective action might be required. The purpose of data analysis is insight. Based on analyzed data, all staff are encouraged to identify opportunities for improvement and changes that will lead to improvement.

Common questions to ask when analyzing performance:

- How does actual performance compare to a goal or standard?
- What factors (e.g. environment, equipment, materials or supply, process or procedure, people or staff) contributed to the performance/compliance/result, and why did the contributing factors happen?
- If there is a significant variance, is corrective action necessary?
    - What are the causes of the variance?
    - Does the process need to be changed?
    - Does the goal or standard need to be changed?
    - Even if the variance is small, should goals be reevaluated to something more challenging?
- Are new goals or measures needed?
- How have existing conditions changed?
- If a trend or pattern exists, what are the causes?
- If data subsets are present, what comparisons can be done amongst them?
- Is the performance measure/indicator improving, degrading, or remaining stable?
- Is the data predictable and is variability in the data predictable and small, or is the process very unpredictable and/or is there large variation in data?
- Is the target goal achievable by the current process?
- Is the current process data stable in a range where the target goal can be achieved?
- Is progress being made to close the gap between actual and the target, or is the gap widening?

TJC Performance Improvement standards provide the following guidance for data analysis of measures/indicators:

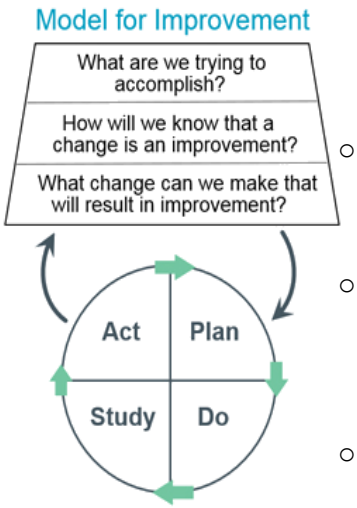
- When undesirable patterns, trends, or variations in performance are identified (based on data analysis or a single undesirable event), the adequacy of staffing (including nurse staffing) must be included in the analysis of possible causes.
- When analysis reveals a problem with the adequacy of staffing, the leaders responsible for the hospital's Patient Safety Committee are informed, in a manner determine by them, of the results of this analysis and actions taken to resolve the identified problem(s).
- At least once a year, the leaders responsible for the hospital's Patient Safety Committee review a written report on the results of any analyses related to the adequacy of staffing and any actions taken to resolve identified problems.

VI. IMPROVEMENT METHODOLOGY

The hospital shall utilize the Model for Improvement as its improvement methodology. Although this methodology originally had its beginnings as a continuous quality improvement tool in the business industry, it adapted into a valuable improvement framework and gained popularity when the Institute for Healthcare Improvement (IHI) began endorsing its use. According to Lau (2015), this model is widely used in healthcare quality and process improvement "because of its ease, logical approach, and emphasis on testing changes using a small-scale and rapid cycle approach" (p. 177).

The Model for Improvement contains 2 parts:

- Three questions which must be answered –
  - What are we trying to accomplish?
  - How will we know that a change is an improvement?
  - What change can we make that will result in improvement?
- The Plan-Do-Study-Act (PDSA) Cycle (for testing the change) –



  - Plan –
    - state the objective of the test
    - state your predictions of what will happen when the change is implemented/tested
    - develop the plan for implementing or testing the change
  - Do –
    - perform the test/implement the change
    - document what you observed, as well as any problems or new issues that arose during the test/change
  - Study –
    - Gather all the data and analyze it
    - Compare the actual results of the test/change with your original predictions
    - Describe what was learned
  - Act –
    - Decide how to proceed –
      - If the test was successful, will the change be adopted into existing or new processes? Will the change be tested in other areas (beyond the pilot area)?
      - If the test was not successful, what modifications to the plan or change will be done before starting the next PDSA cycle?

VII. EVALUATION

The measurement, assessment, and evaluation processes will continue to provide the necessary information about the effectiveness of the improvement. If the identified problem continues to persist despite the implementation of planned improvements, the performance improvement methodology will continue until sustained improvement is achieved. Any findings, conclusions, recommendations, actions taken, and results of the actions taken based on the QAPI process are documented and reported to the appropriate individuals, departments, division administrators, or committees.

VIII. REPORT TEMPLATES

A. PRIORITIZATION MATRIX:

All improvement opportunities and proposed indicators or measures shall undergo prioritization prior to annual QAPI plan creation. The QAPI prioritization matrix template shall be utilized and submitted in early January of each calendar year *(please see attachment IV - QAPI Prioritization Matrix).*

B. ANNUAL QAPI PLAN:

Once prioritization is complete, new measures or indicators can be created and placed within the annual QAPI plan template *(see attachment V – Annual QAPI Plan)*. There is no maximum or minimum number of indicators required; however, all departments/ divisions, and hospital committees should consider the amount of regulatory monitoring they contribute to (e.g. for National Patient Safety Goals, Environment of Care Management Plans, Infection Control, etc.) to maintain a realistic and manageable amount of indicators/measures. Annual QAPI plans are created and submitted in early January of each calendar year. QAPI plans may also be revised or updated throughout the calendar year, as indicators or measures decrease in monitoring frequency, become discontinued, or get added on.

C. ANNUAL QAPI PLAN/PROGRAM EVALUATION:

Annual QAPI plans must be evaluated after the calendar year has completed by using the appropriate plan/program evaluation template *(see attachment VI – Annual QAPI Plan/Program Evaluation).* This evaluation is completed and submitted in early January of each calendar year.

D. MONTHLY TRENDING SHEET:

Trending sheets reflect the performance of all measures/indicators being monitored by departments, over the course of the calendar year. These must be submitted monthly to division administrators and/or hospital committee chairpersons. The monthly trending sheet template serves as the format for this report *(see attachment VII – Monthly Trending Sheet).*

E. DEPARTMENT QUARTERLY REPORT:

Department quarterly reports *(see attachment VIII – Department Quarterly Report)* are used to document the results of data collected for the three months of a given quarter, the subsequent analysis of said data, and the improvement and sustainment activities the department undertook during the quarter. A separate staffing analysis section is required to be completed by clinical divisions such as Nursing Services and Pro-Support Services. At this time, it will be optional for Fiscal Services and Operations Division, unless their data analysis reveals a problem/issue with

people/staffing – at which time they must complete the staffing analysis. Submission deadlines for this report are outlined in the QAPI schedule and deadlines document *(see attachment III – QAPI Schedule).*

F. DIVISION ADMINISTRATOR QUARTERLY MATRIX REPORT:

Division Administrators will summarize significant indicator/measure information from their respective departments on a quarterly basis using their quarterly matrix report template *(see attachment IX – Division Administrator Quarterly Matrix Report).* This report serves as the documented evidence (for the BOT and regulatory agencies) of division administrator accountability for implementing the hospital's QAPI program. Due to the nature of the monthly rotation reporting process (where certain departments report each month to address a quarter's worth of data), quarterly matrices will also coincide with the same rotation reporting process. Submission deadlines for this report are outlined in the QAPI schedule and deadlines document *(see attachment III – QAPI Schedule).*

G. DIVISION ADMINISTRATOR ANNUAL REPORT:

Unlike the quarterly matrix report, the annual report for division administrators *(see attachment X – Division Administrator Annual Report)* discusses the calendar year's QAPI activities for the entire division (i.e. all rotation months). Additionally, administrators discuss: (1) QAPI relative to contracted services (if applicable), (2) staffing analysis and plans of action, (3) a self-evaluation of reporting quality and oversight responsibility, and (4) plans and recommendations for the next calendar year QAPI cycle. This report serves as the documented evidence (for the BOT and regulatory agencies) of division administrator accountability for implementing the hospital's QAPI program. Completion and submission of this report occurs by the end of January each calendar year.

H. CHAIRPERSON QUARTERLY MATRIX REPORT:

Hospital committee chairpersons will summarize significant indicator/measure information from their respective committees on a quarterly basis using their quarterly matrix report template *(see attachment XI – Chairperson Quarterly Matrix Report).* This report serves as the documented evidence (for the BOT and regulatory agencies) of chairperson accountability for managing committee-monitored QAPI indicators/measures. Submission deadlines for this report are outlined in the QAPI schedule and deadlines document *(see attachment III – QAPI Schedule).*

I. CHAIRPERSON ANNUAL REPORT:

The annual report for hospital committee chairpersons (see attachment XII – Chairperson Annual Report) discusses the calendar year's QAPI activities for the respective committee. Additionally, chairpersons discuss: (1) a self-evaluation of reporting quality and oversight responsibility, and (2) plans and recommendations for the next calendar year QAPI cycle. This report serves as the documented evidence (for the BOT and regulatory agencies) of division administrator accountability for implementing the hospital's QAPI program. Completion and submission of this report occurs by the end of January each calendar year.

J. QAPI PROJECT/TEAM TEMPLATE:

As mentioned previously, in Procedure, Section II of this policy, QAPI project/teams shall utilize the project/team template, *(see attachment XIII – QAPI Project/Team Template),* as part of the required reports for submission.

IX. COMMUNICATION (REPORTING PATHWAY AND REPORTING PROCESS)

QAPI information and activities are communicated through the established QAPI Reporting Pathway *(see Attachment I - QAPI Reporting Pathway).* Each department's performance indicators/measures shall be discussed in their staff meetings, in an effort to engage its staff to participate in QAPI activities.

The areas responsible to report to the PIC shall report at their scheduled time as indicated in the QAPI monthly rotation and QAPI schedule (*see attachment II – QAPI Monthly Rotation, and attachment III – QAPI Schedule*).

Dashboards displaying data will be created for the BOT Q&S Subcommittee via the PIC, in addition to the required division administrator and committee chairperson reports. All reports submissions will follow the QAPI schedule *(see attachment III – QAPI Schedule).*

X. EDUCATION

The hospital's executive leaders are responsible for ongoing educational activities related to QAPI. Education may be delivered in written, in-person presentation, or online presentation formats. The frequency of education will be at least annually, but may be more frequent as needed.

XI. CONFIDENTIALITY

In accordance with the Health Insurance Portability and Accountability Act (HIPAA), all QAPI information containing specific patient information shall remain confidential in accordance with the Hospital's policies governing confidentiality and the release of information. General information and summaries will be in final report form for organizational-wide and public dissemination via the BOT.

REFERENCES:

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RELATED POLICIES:

Policy No. A-PS800, Patient Safety Program of the Administrative Manual
Policy No. ----, Risk Management Program of the Risk Management Manual
Policy No. A-LD700, Management and Oversight of External Service Provider Contracts of the Administrative Manual

RESCISSION:

Policy No. A-PI100, Performance Improvement Plan of the Administrative Manual made effective 08/21/2014.

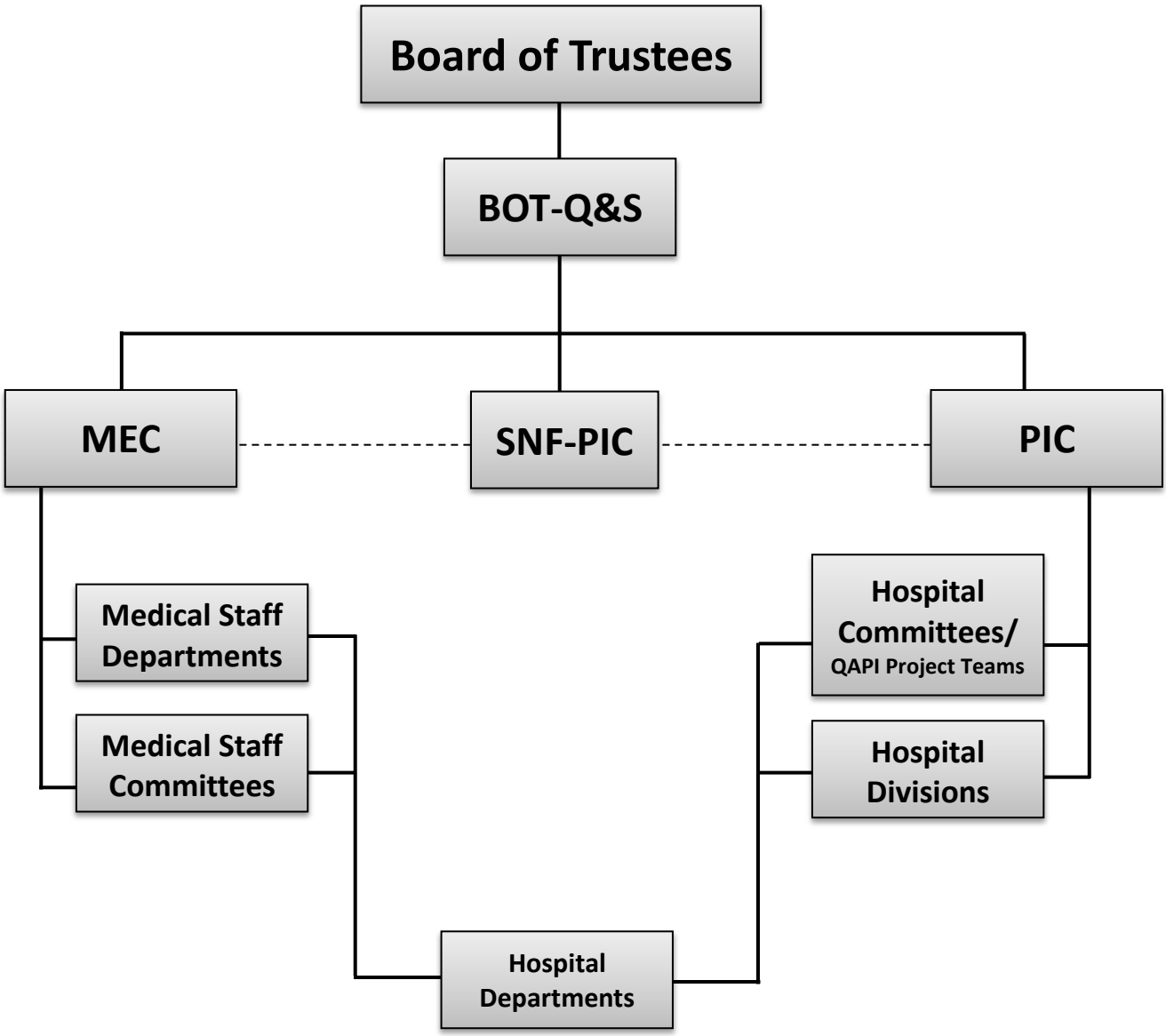
ATTACHMENTS:

I. QAPI REPORTING PATHWAY
II. QAPI MONTHLY ROTATION
III. QAPI SCHEDULE
IV. QAPI PRIORITIZATION MATRIX
V. ANNUAL QAPI PLAN
VI. ANNUAL QAPI PLAN/PROGRAM EVALUATION
VII. MONTHLY TRENDING SHEET
VIII. DEPARTMENT QUARTERLY REPORT
IX. DIVISION ADMINISTRATOR QUARTERLY MATRIX REPORT
X. DIVISION ADMINISTRATOR ANNUAL REPORT
XI. CHAIRPERSON QUARTERLY MATRIX REPORT
XII. CHAIRPERSON ANNUAL REPORT
XIII. QAPI PROJECT/TEAM TEMPLATE

ATTACHMENT I
QAPI REPORTING PATHWAY

Quality Assessment and Performance Improvement Reporting Pathway

Revised September 2017



2017-2018 Quality Assessment & Performance Improvement Monthly Rotation

***NOTE:** ALL Rotation Months must submit written PI reports per the deadlines specified in the QAPI Schedule and Deadlines. This Rotation schedule specifies when Departments'/Units' verbal reports must be done at monthly Division PI meetings.*

MONTH 1 Verbally reports at Division PI meetings: January, April, July, October	MONTH 2 Verbally reports at Division PI meetings: February, May, August, November	MONTH 3 Verbally reports at Division PI meetings: March, June, September, December
• **NURSING** ICU, Med-Surg, Surgical, Tele-PCU • **FISCAL** Pt. Registration, Medical Records • **OPERATIONS** Comm. Center, Human Resources, IT Dept., Guest Relations • **Patient Satisfaction Survey, Patient Complaints & Grievances** • **PRO-SUPPORT** Special Services, Urgent Care, Education Dept., Laboratory Dept. • **MEDICAL SERVICES** Employee Health Svcs., Infection Control • **ENVIRONMENT OF CARE COMMITTEE**	• **NURSING** OR, ER, Hemodialysis, Patient Education • **FISCAL** Patient Affairs • **OPERATIONS** Environmental Services, Facilities Maintenance, Planning Dept. • **PRO-SUPPORT** Pharmacy Dept., Radiology Dept., Dietary Dept. • **MEDICAL SERVICES** Utilization Review, Medical Staff Office • **SKILLED NURSING FACILITY PI COMMITTEE**	• **NURSING** Pediatrics-PICU, OB Ward, Nursery-NICU, Labor & Delivery • **FISCAL** Finance & Payroll • **OPERATIONS** Safety Dept., Security Dept., Materials Management • **EEO Report (Staff Satisfaction Survey, Exit Interview)** • **PRO-SUPPORT** Respiratory Dept., Rehabilitative Svcs., Social Services • **MEDICAL SERVICES** Risk Management • **PATIENT SAFETY COMMITTEE**

COLOR KEY:

GMH DIVISIONS STANDING REPORTS COMMITTEE REPORTS SKILLED NURSING FACILITY

ATTACHMENT III
QAPI SCHEDULE – PAGE 1

GUAM MEMORIAL HOSPITAL AUTHORITY
QUALITY ASSESSMENT AND PERFORMANCE IMPROVEMENT (QAPI)
CY2017-4Q through CY2019-1Q
SCHEDULE AND DEADLINES – as of 10.09.2017

		DEPARTMENT SUBMISSION DEADLINES	DIVISION PI REPORTING	DIVISION ADMIN SUBMISSION DEADLINES	COMMITTEE CHAIRS SUBMISSION DEADLINES	PIC REPORTING	PIC FUNCTIONS/ ACTIVITIES	BOT-Q&S REPORTING	BOT-Q&S FUNCTIONS/ ACTIVITIES
CY17-4Q	OCT	**10/11/2017 BY NOON:** • CY17-3Q Quarterly Report • September Trending Sheet	Month 1 Rotation CY17-3Q			**10/18/2017 @ 1400** Month 1 Rotation CY17-3Q	**QAPI Templates Online Training**	Month 3 Rotation CY17-2Q	
	NOV	**11/15/2017 BY NOON:** October Trending Sheet *(START USING NEW TEMPLATE!)*	Month 2 Rotation CY17-3Q	**11/17/2017 BY NOON:** CY17-3Q Month 2 Rotation Quarterly Report *(START USING NEW TEMPLATE!)*	**11/17/2017 BY NOON:** CY17-3Q SNF QAPI Committee Quarterly Report and Dashboard *(START USING NEW TEMPLATE!)*	**11/22/2017 @ 1400** Month 2 Rotation CY17-3Q	**QAPI Policy Revision and Approval Process**	Month 1 Rotation CY17-3Q	**QAPI Policy Approval**
	DEC	**12/13/2017 BY NOON:** November Trending Sheet	Month 3 Rotation CY17-3Q	**12/15/2017 BY NOON:** CY17-3Q Month 3 Rotation Quarterly Report	**12/15/2018 BY NOON:** CY17-3Q Patient Safety Committee Quarterly Report and Dashboard *(START USING NEW TEMPLATE!)*	**12/20/2017 @ 1400** Month 3 Rotation CY17-3Q	**QAPI Policy Approval Process**	Month 2 Rotation CY17-3Q	**QAPI Policy Approval**
CY18-1Q	JAN	**01/10/2018 BY NOON:** • CY17-4Q Quarterly Report • December Trending Sheet • CY17 QAPI Plan Evaluation *(USE THE NEW TEMPLATES!)*	Month 1 Rotation CY17-4Q	**01/17/2018 BY NOON:** CY17-4Q Month 1 Rotation Quarterly Report	**01/17/2018 BY NOON:** CY17-4Q Environment of Care Committee Quarterly Report and Dashboard *(START USING NEW TEMPLATE!)*	**01/24/2018 @ 1400** Month 1 Rotation CY17-4Q	**01/24/2018 @ 1400** Approve ALL Division CY18 QAPI Plans	Month 3 Rotation CY17-3Q	
		01/17/2018 BY NOON: • CY18 Prioritization Matrix • CY18 QAPI Plan *(USE THE NEW TEMPLATES!)*		**01/31/2018 BY NOON:** CY17 QAPI Annual Report *(USE THE NEW TEMPLATE!)*	**01/31/2018 BY NOON:** CY17 QAPI Annual Report *(USE THE NEW TEMPLATE!)*		**01/31/2018 BY NOON:** CY17 QAPI Program Evaluation		
	FEB	**02/07/2018 BY NOON:** January Trending Sheet	Month 2 Rotation CY17-4Q	**02/14/2018 BY NOON:** CY17-4Q Month 2 Rotation Quarterly Report	**02/14/2018 BY NOON:** CY17-4Q SNF QAPI Committee Quarterly Report and Dashboard	**02/21/2018 @ 1400** Month 2 Rotation CY17-4Q	**Create CY18 PI Plan and PI Projects**	Month 1 Rotation CY17-4Q	
						Review: • CY17 Division Admins Annual QAPI Report • CY17 Committee Chairs Annual QAPI Report • CY17 QAPI Program Evaluation			

ATTACHMENT III
QAPI SCHEDULE – PAGE 2

GUAM MEMORIAL HOSPITAL AUTHORITY
QUALITY ASSESSMENT AND PERFORMANCE IMPROVEMENT (QAPI)
CY2017-4Q through CY2019-1Q
SCHEDULE AND DEADLINES – as of 10.09.2017

		DEPARTMENT SUBMISSION DEADLINES	DIVISION PI REPORTING	DIVISION ADMIN SUBMISSION DEADLINES	COMMITTEE CHAIRS SUBMISSION DEADLINES	PIC REPORTING	PIC FUNCTIONS/ ACTIVITIES	BOT-Q&S REPORTING	BOT-Q&S FUNCTIONS/ ACTIVITIES
	MAR	**03/07/2018 BY NOON:** February Trending Sheet	Month 3 Rotation CY17-4Q	**03/14/2018 BY NOON:** CY17-4Q Month 3 Rotation Quarterly Report	**03/14/2018 BY NOON:** CY17-4Q Patient Safety Committee Quarterly Report and Dashboard	**03/21/2018 @ 1400** Month 3 Rotation CY17-4Q		Month 2 Rotation CY17-4Q	**Propose CY18 PI Plan and PI Projects**
								Review: • CY17 Division Admins Annual QAPI Report • CY17 Committee Chairs Annual QAPI Report • CY17 QAPI Program Evaluation	
CY18-2Q	APR	**04/06/2018 BY NOON:** • CY18-1Q Quarterly Report • March Trending Sheet	Month 1 Rotation CY18-1Q	**04/11/2018 BY NOON:** CY18-1Q Month 1 Rotation Quarterly Report	**04/11/2018 BY NOON:** CY18-1Q Environment of Care Committee Quarterly Report and Dashboard	**04/18/2018 @ 1400** Month 1 Rotation CY18-1Q	**QAPI Policy/Plan Approval Process**	Month 3 Rotation CY17-4Q	**Approve CY18 PI Plan and PI Projects**
	MAY	**05/09/2018 BY NOON:** April Trending Sheet	Month 2 Rotation CY18-1Q	**05/16/2018 BY NOON:** CY18-1Q Month 2 Rotation Quarterly Report	**05/16/2018 BY NOON:** CY18-1Q SNF QAPI Committee Quarterly Report and Dashboard	**05/23/2018 @ 1400** Month 2 Rotation CY18-1Q	**QAPI Policy/Plan Approval Process**	Month 1 Rotation CY18-1Q	**QAPI Policy/Plan Approval Process**
	JUN	**06/06/2018 BY NOON:** May Trending Sheet	Month 3 Rotation CY18-1Q	**06/13/2018 BY NOON:** CY18-1Q Month 3 Rotation Quarterly Report	**06/13/2018 BY NOON:** CY18-1Q Patient Safety Committee Quarterly Report and Dashboard	**06/20/2018 @ 1400** Month 3 Rotation CY18-1Q	**QAPI PLAN/POLICY TRAINING**	Month 2 Rotation CY18-1Q	
CY18-3Q	JUL	**07/06/2018 BY NOON:** • CY18-2Q Quarterly Report • June Trending Sheet	Month 1 Rotation CY18-2Q	**07/11/2018 BY NOON:** CY18-2Q Month 1 Rotation Quarterly Report	**07/11/2018 BY NOON:** CY18-2Q Environment of Care Committee Quarterly Report and Dashboard	**07/18/2018 @ 1400** Month 1 Rotation CY18-2Q		Month 3 Rotation CY18-1Q	
	AUG	**08/08/2018 BY NOON:** July Trending Sheet	Month 2 Rotation CY18-2Q	**08/15/2018 BY NOON:** CY18-2Q Month 2 Rotation Quarterly Report	**08/15/2018 BY NOON:** CY18-2Q SNF QAPI Committee Quarterly Report and Dashboard	**08/22/2018 @ 1400** Month 2 Rotation CY18-2Q		Month 1 Rotation CY18-2Q	
	SEP	**09/07/2018 BY NOON:** August Trending Sheet	Month 3 Rotation CY18-2Q	**09/12/2018 BY NOON:** CY18-2Q Month 3 Rotation Quarterly Report	**09/12/2018 BY NOON:** CY18-2Q Patient Safety Committee Quarterly Report and Dashboard	**09/19/2018 @ 1400** Month 3 Rotation CY18-2Q	**Review:** Staffing Adequacy Annual Report (08/17-08/18)	Month 2 Rotation CY18-2Q	

ATTACHMENT III
QAPI SCHEDULE – PAGE 3

GUAM MEMORIAL HOSPITAL AUTHORITY
QUALITY ASSESSMENT AND PERFORMANCE IMPROVEMENT (QAPI)
CY2017-4Q through CY2019-1Q
SCHEDULE AND DEADLINES – as of 10.09.2017

		DEPARTMENT SUBMISSION DEADLINES	DIVISION PI REPORTING	DIVISION ADMIN SUBMISSION DEADLINES	COMMITTEE CHAIRS SUBMISSION DEADLINES	PIC REPORTING	PIC FUNCTIONS/ ACTIVITIES	BOT-Q&S REPORTING	BOT-Q&S FUNCTIONS/ ACTIVITIES
					09/12/2018 BY NOON: EMC/PIC Staffing Adequacy Annual Report (08/17-08/18)				
CY18-4Q	OCT	**10/10/2018 BY NOON:** • CY18-3Q Quarterly Report • September Trending Sheet	Month 1 Rotation CY18-3Q	**10/17/2018 BY NOON:** CY18-3Q Month 1 Rotation Quarterly Report	**10/17/2018 BY NOON:** CY18-3Q Environment of Care Committee Quarterly Report and Dashboard	**10/24/2018 @ 1400** Month 1 Rotation CY18-3Q		Month 3 Rotation CY18-2Q	**Review:** Staffing Adequacy Annual Report (08/17-08/18)
	NOV	**11/07/2018 BY NOON:** October Trending Sheet	Month 2 Rotation CY18-3Q	**11/14/2018 BY NOON:** CY18-3Q Month 2 Rotation Quarterly Report	**11/14/2018 BY NOON:** CY18-3Q SNF QAPI Committee Quarterly Report and Dashboard	**11/21/2018 @ 1400** Month 2 Rotation CY18-3Q		Month 1 Rotation CY18-3Q	
	DEC	**12/07/2018 BY NOON:** November Trending Sheet	Month 3 Rotation CY18-3Q	**12/12/2018 BY NOON:** CY18-3Q Month 3 Rotation Quarterly Report	**12/12/2018 BY NOON:** CY18-3Q Patient Safety Committee Quarterly Report and Dashboard	**12/19/2018 @ 1400** Month 3 Rotation CY18-3Q		Month 2 Rotation CY18-3Q	
CY19-1Q	JAN	**01/09/2019 BY NOON:** • CY18-4Q Quarterly Report • December Trending Sheet • CY18 QAPI Plan Evaluation	Month 1 Rotation CY18-4Q	**01/16/2018 BY NOON:** CY18-4Q Month 1 Rotation Quarterly Report	**01/16/2019 BY NOON:** CY18-4Q Environment of Care Committee Quarterly Report and Dashboard	**01/23/2019 @1400** Month 1 Rotation CY18-4Q	**01/23/2019 @ 1400** Approve ALL Division CY19 QAPI Plans	Month 3 Rotation CY18-3Q	
		01/16/2019 BY NOON: CY19 QAPI Plan		**01/30/2018 BY NOON:** CY18 QAPI Annual Report	**01/30/2018 BY NOON:** CY18 QAPI Annual Report		**01/30/2019 BY NOON:** CY18 QAPI Program Evaluation		
	FEB	**02/08/2019 BY NOON:** January Trending Sheet	Month 2 Rotation CY18-4Q	**02/13/2019 BY NOON:** CY18-4Q Month 2 Rotation Quarterly Report	**02/13/2019 BY NOON:** CY18-4Q SNF QAPI Committee Quarterly Report and Dashboard	**02/20/2019 @ 1400** Month 2 Rotation CY18-4Q	**Create CY18 PI Plan and PI Projects**	Month 1 Rotation CY18-4Q	
						Review: • CY18 Division Admins Annual QAPI Report • CY18 Committee Chairs Annual QAPI Report • CY18 QAPI Program Evaluation			

ATTACHMENT III

QAPI SCHEDULE – PAGE 4

GUAM MEMORIAL HOSPITAL AUTHORITY

QUALITY ASSESSMENT AND PERFORMANCE IMPROVEMENT (QAPI)

CY2017-4Q through CY2019-1Q

SCHEDULE AND DEADLINES – as of 10.09.2017

	DEPARTMENT SUBMISSION DEADLINES	DIVISION PI REPORTING	DIVISION ADMIN SUBMISSION DEADLINES	COMMITTEE CHAIRS SUBMISSION DEADLINES	PIC REPORTING	PIC FUNCTIONS/ ACTIVITIES	BOT-Q&S REPORTING	BOT-Q&S FUNCTIONS/ ACTIVITIES
MAR	**03/08/2019 BY NOON:** February Trending Sheet	Month 3 Rotation CY18-4Q	**03/13/2019 BY NOON:** CY18-4Q Month 3 Rotation Quarterly Report	**03/13/2019 BY NOON:** CY18-4Q Patient Safety Committee Quarterly Report and Dashboard	**03/20/2019 @ 1400** Month 3 Rotation CY18-4Q		Month 2 Rotation CY18-4Q	**Propose CY18 PI Plan and PI Projects**
							Review: • CY18 Division Admins Annual QAPI Report • CY18 Committee Chairs Annual QAPI Report • CY18 QAPI Program Evaluation	

ATTACHMENT IV
QAPI PRIORITIZATION MATRIX

QUALITY ASSESSMENT & PERFORMANCE IMPROVEMENT (QAPI)

DEPARTMENT/DIVISION/COMMITTEE NAME

Prioritization Matrix

Purpose: *This tool is meant to assist with the decision-making process when determining which improvement opportunity to act on and include in the annual QAPI Plan.*

Instructions: *For each improvement opportunity, assign the appropriate amount of points per column, as applicable. If an individual prioritization criterion does not apply to the improvement opportunity, do not assign any points, and indicate "N/A" for "not applicable". Indicate the total number of points per improvement opportunity in the "total points" column. Greater priority should be given to those opportunities with higher total points.*

Improvement Opportunity	Prioritization Criteria										TOTAL POINTS
	High Risk	High Volume	Problem Prone	Supports Mission, Vision, Values	Reduces Medical Errors/ Harm	Improves Health Outcomes	Improves Safety	Improves Quality	Improves Patient Satisfaction	Regulatory Requirement	
	3 points	*3 points*	*3 base points PLUS points from below:*	*1 point*	*3 points*	*3 points*	*2 points*	*2 points*	*1 point*	*3 points*	
			Incidence: (how often it occurs) ☐ Frequently – 4 points ☐ Sometimes – 3 points ☐ Not Often – 2 points ☐ Rarely – 1 point ***Prevalence/Scope: (how widespread is it)*** ☐ Hospital-wide – 3 points ☐ Many areas – 2 points ☐ Single area – 1 point ***Severity: (how likely to cause harm)*** ☐ High likelihood – 3 points ☐ Moderate likelihood – 2 points ☐ Low likelihood – 1 point									
			Incidence: (how often it occurs) ☐ Frequently – 4 points ☐ Sometimes – 3 points ☐ Not Often – 2 points ☐ Rarely – 1 point ***Prevalence/Scope: (how widespread is it)*** ☐ Hospital-wide – 3 points ☐ Many areas – 2 points ☐ Single area – 1 point ***Severity: (how likely to cause harm)*** ☐ High likelihood – 3 points ☐ Moderate likelihood – 2 points ☐ Low likelihood – 1 point									

ATTACHMENT V

ANNUAL QAPI PLAN – PAGE 1

Guam Memorial Hospital Authority

Click here to enter text.

Quality Assessment and Performance Improvement Plan

PART Choose an item. **OF** Choose an item.

Choose an item.

QAPI PLAN ELEMENTS	Indicator/Measure Choose an item. Click here to enter text.	Indicator/Measure Choose an item. Click here to enter text.	Indicator/Measure Choose an item. Click here to enter text.	Indicator/Measure Choose an item. Click here to enter text.
1. Specific **EVIDENCE supports that the Indicator improves** any of the following: health outcomes, quality, safety, efficiency, customer service, cost-effectiveness, accountability. *Examples of **EVIDENCE** – standards or guidelines from a nationally recognized organization, hospital specific evidence, peer-reviewed research, etc.* ***Structural Measure** – measures the hospital's capacity and conditions in which care or services are provided by looking at factors such as staffing, facilities, health IT systems, etc.* ***Process Measure** – measures how parts of a system or steps in a process are performing.* ***Outcome Measure** – measures the results of health care or a service. This could include whether the patient's health improved, or whether the patient was satisfied with the services received.*	***Indicator/Measure improves:*** ☐ Health Outcomes ☐ Quality ☐ Safety ☐ Efficiency ☐ Customer Service ☐ Cost Effectiveness ☐ Accountability	***Indicator/Measure improves:*** ☐ Health Outcomes ☐ Quality ☐ Safety ☐ Efficiency ☐ Customer Service ☐ Cost Effectiveness ☐ Accountability	***Indicator/Measure improves:*** ☐ Health Outcomes ☐ Quality ☐ Safety ☐ Efficiency ☐ Customer Service ☐ Cost Effectiveness ☐ Accountability	***Indicator/Measure improves:*** ☐ Health Outcomes ☐ Quality ☐ Safety ☐ Efficiency ☐ Customer Service ☐ Cost Effectiveness ☐ Accountability
	Indicator/Measure prevents/ reduces: ☐ Medical Errors/ Patient Harm	***Indicator/Measure prevents/ reduces:*** ☐ Medical Errors/ Patient Harm	***Indicator/Measure prevents/ reduces:*** ☐ Medical Errors/ Patient Harm	***Indicator/Measure prevents/ reduces:*** ☐ Medical Errors/ Patient Harm
	Specific Evidence: Click here to enter text.	***Specific Evidence:*** Click here to enter text.	***Specific Evidence:*** Click here to enter text.	***Specific Evidence:*** Click here to enter text.
	Indicator/Measure is a(n): ☐ Structural Measure ☐ Process Measure ☐ Outcome Measure	*Indicator/Measure is a(n):* ☐ Structural Measure ☐ Process Measure ☐ Outcome Measure	*Indicator/Measure is a(n):* ☐ Structural Measure ☐ Process Measure ☐ Outcome Measure	*Indicator/Measure is a(n):* ☐ Structural Measure ☐ Process Measure ☐ Outcome Measure
2. The **scope** of data collection is appropriate for the indicator/measure. *ALL applicable areas, ALL applicable staff/patients, and ALL applicable time frames that should be monitored are accounted for.*	***Data Collection Scope:*** Click here to enter text.	***Data Collection Scope:*** Click here to enter text.	***Data Collection Scope:*** Click here to enter text.	***Data Collection Scope:*** Click here to enter text.
3. The **method and frequency** of data collection are specified, in detail, to reduce the risk of invalid or inaccurate data collection and results. *Exact guidance as to how audits or monitoring is to be conducted is provided.*	***Data Collection Method:*** *Sample Source:* Click here to enter text.	***Data Collection Method:*** *Sample Source:* Click here to enter text.	***Data Collection Method:*** *Sample Source:* Click here to enter text.	***Data Collection Method:*** *Sample Source:* Click here to enter text.
*Examples of **Sample Sources** – paper medical records (identify specific document/form by name, such as H&PE, Discharge Summary, Operative Report, etc.); electronic health record (identify specific location/documentation type, such as flowsheets,*	*Sampling Method and Sample Size:* Click here to enter text.	*Sampling Method and Sample Size:* Click here to enter text.	*Sampling Method and Sample Size:* Click here to enter text.	*Sampling Method and Sample Size:* Click here to enter text.
	Sample Inclusion Criteria:	*Sample Inclusion Criteria:*	*Sample Inclusion Criteria:*	*Sample Inclusion Criteria:*

ATTACHMENT V

ANNUAL QAPI PLAN – PAGE 2

Guam Memorial Hospital Authority

Click here to enter text.

Quality Assessment and Performance Improvement Plan

PART Choose an item. **OF** Choose an item.

Choose an item.

QAPI PLAN ELEMENTS	**Indicator/Measure** Choose an item. **Click here to enter text.**	**Indicator/Measure** Choose an item. **Click here to enter text.**	**Indicator/Measure** Choose an item. **Click here to enter text.**	**Indicator/Measure** Choose an item. **Click here to enter text.**
nurse's notes, etc.); direct observations (identify what will be observed in detail).	Click here to enter text.	Click here to enter text.	Click here to enter text.	Click here to enter text.
*Examples of **Sampling Methods and Sample Sizes** – Simple Random Sampling (random selection of a **minimum of 50 medical records** from a list of records for the entire month – done via Excel randomization); Convenience Sampling (**10 direct observations** conducted whenever the opportunity becomes available during the month); Systematic Random Sampling (every Nth sample will be chosen from a list of medical records until the **minimum sample size of 50 medical records** is achieved; Nth sample determined by the formula – the total number of records for the month divided by 50 minimum records); Stratified Random Sampling (3 Strata – 7-3 shift, 3-11 shift, and 11-7 shift; 5 randomly chosen refrigerator temp checks for each shift, from the monthly log sheet – for a **total of 15 samples for the month**).*	*Sample Exclusion Criteria:* Click here to enter text.	*Sample Exclusion Criteria:* Click here to enter text.	*Sample Exclusion Criteria:* Click here to enter text.	*Sample Exclusion Criteria:* Click here to enter text.
***Inclusion Criteria** – characteristics the sample must have to be included in the audit*	*Indicator/Measure Result Expressed As:* ☐ Volume or Numerical Count ☐ Percentage – see Operational Definition below ☐ Rate - see Operational Definition below Type of Rate: ☐ Prevalence Rate ☐ Incidence Rate	*Indicator/Measure Result Expressed As:* ☐ Volume or Numerical Count ☐ Percentage – see Operational Definition below ☐ Rate - see Operational Definition below Type of Rate: ☐ Prevalence Rate ☐ Incidence Rate	*Indicator/Measure Result Expressed As:* ☐ Volume or Numerical Count ☐ Percentage – see Operational Definition below ☐ Rate - see Operational Definition below Type of Rate: ☐ Prevalence Rate ☐ Incidence Rate	*Indicator/Measure Result Expressed As:* ☐ Volume or Numerical Count ☐ Percentage – see Operational Definition below ☐ Rate - see Operational Definition below Type of Rate: ☐ Prevalence Rate ☐ Incidence Rate
***Exclusion Criteria** – characteristics that disqualifies or "throws out" a sample (so it will not be audited)* ***Prevalence** – number of current cases (new and preexisting) at a specified point in time (point prevalence) or specified period in time (period prevalence) divided by the population at the same specified point in time (point prevalence) or average or mid-interval population (period prevalence)* ***Incidence** – number of new cases during specified time interval divided by the population at the start of time interval (attack rate or risk) or the average population during time interval (incidence rate)*	*Operational Definition (if applicable):* Numerator: Click here to enter text. Denominator: Click here to enter text.	*Operational Definition (if applicable):* Numerator: Click here to enter text. Denominator: Click here to enter text.	*Operational Definition (if applicable):* Numerator: Click here to enter text. Denominator: Click here to enter text.	*Operational Definition (if applicable):* Numerator: Click here to enter text. Denominator: Click here to enter text.
***Numerator** – the number of samples that met the sample compliance criteria* ***Denominator** – the total number of samples audited*	*Sample Compliance Criteria:* Click here to enter text.	*Sample Compliance Criteria:* Click here to enter text.	*Sample Compliance Criteria:* Click here to enter text.	*Sample Compliance Criteria:* Click here to enter text.
***Sample Compliance Criteria** – characteristics the sample must have to be considered compliant.* ***Sample Non-Compliance Criteria** – characteristics the sample must have to be considered non-compliant.*	*Sample Non-Compliance Criteria:* Click here to enter text.	*Sample Non-Compliance Criteria:* Click here to enter text.	*Sample Non-Compliance Criteria:* Click here to enter text.	*Sample Non-Compliance Criteria:* Click here to enter text.
NOTE: If the indicator's or measure's Data Collection Method requires a separate, detailed, step-by-step	***Data Collection Frequency:*** Click here to enter text.	***Data Collection Frequency:*** Click here to enter text.	***Data Collection Frequency:*** Click here to enter text.	***Data Collection Frequency:*** Click here to enter text.

ATTACHMENT V

ANNUAL QAPI PLAN – PAGE 3

Guam Memorial Hospital Authority

Click here to enter text.

Quality Assessment and Performance Improvement Plan

PART Choose an item. **OF** Choose an item.

Choose an item.

QAPI PLAN ELEMENTS	Indicator/Measure Choose an item. Click here to enter text.	Indicator/Measure Choose an item. Click here to enter text.	Indicator/Measure Choose an item. Click here to enter text.	Indicator/Measure Choose an item. Click here to enter text.
instruction guide (due to its length), IT MUST BE ATTACHED WITH THIS PI PLAN.				
4. **Specific Audit/Data Collection Tools** and **Data Collection Schedules** are utilized and followed, for **CONSISTENT and ACCURATE data**. *NOTE: The corresponding Audit/Data Collection Tool MUST BE ATTACHED with this QAPI Plan.* *NOTE: Although department/unit staff may play a role in collecting data as auditors, the OVERALL RESPONSIBILITY REMAINS THAT OF THE UNIT SUPERVISOR OR DEPARTMENT HEAD.*	***Audit/Data Collection Tool:*** ☐ Checklist ☐ Survey/Questionnaire/Interview ☐ Observation Tool ☐ Other Customized Audit Sheet ***ATTACH AUDIT/DATA TOOL WITH THIS QAPI PLAN*** ***Data Collection Schedule:*** AUDITOR NAME(S): Click here to enter text. PLANNED DATA COLLECTION SCHEDULE: Click here to enter text. WHAT WILL BE DONE TO ENSURE TIMELY AND ACCURATE DATA COLLECTION: ☐ Unit Supervisor / Department Head will be the Alternate Auditor ☐ Contingency audit/data collection time will be scheduled ☐ Unit Supervisor / Department Head will educate all Auditors on this PI Plan, Data Collection Methodology, and Audit/Data Collection Schedule and Tool(s). ☐ Other: Click here to enter text.	***Audit/Data Collection Tool:*** ☐ Checklist ☐ Survey/Questionnaire/Interview ☐ Observation Tool ☐ Other Customized Audit Sheet ***ATTACH AUDIT/DATA TOOL WITH THIS QAPI PLAN*** ***Data Collection Schedule:*** AUDITOR NAME(S): Click here to enter text. PLANNED DATA COLLECTION SCHEDULE: Click here to enter text. WHAT WILL BE DONE TO ENSURE TIMELY AND ACCURATE DATA COLLECTION: ☐ Unit Supervisor / Department Head will be the Alternate Auditor ☐ Contingency audit/data collection time will be scheduled ☐ Unit Supervisor / Department Head will educate all Auditors on this PI Plan, Data Collection Methodology, and Audit/Data Collection Schedule and Tool(s). ☐ Other: Click here to enter text.	***Audit/Data Collection Tool:*** ☐ Checklist ☐ Survey/Questionnaire/Interview ☐ Observation Tool ☐ Other Customized Audit Sheet ***ATTACH AUDIT/DATA TOOL WITH THIS QAPI PLAN*** ***Data Collection Schedule:*** AUDITOR NAME(S): Click here to enter text. PLANNED DATA COLLECTION SCHEDULE: Click here to enter text. WHAT WILL BE DONE TO ENSURE TIMELY AND ACCURATE DATA COLLECTION: ☐ Unit Supervisor / Department Head will be the Alternate Auditor ☐ Contingency audit/data collection time will be scheduled ☐ Unit Supervisor / Department Head will educate all Auditors on this PI Plan, Data Collection Methodology, and Audit/Data Collection Schedule and Tool(s). ☐ Other: Click here to enter text.	***Audit/Data Collection Tool:*** ☐ Checklist ☐ Survey/Questionnaire/Interview ☐ Observation Tool ☐ Other Customized Audit Sheet ***ATTACH AUDIT/DATA TOOL WITH THIS QAPI PLAN*** ***Data Collection Schedule:*** AUDITOR NAME(S): Click here to enter text. PLANNED DATA COLLECTION SCHEDULE: Click here to enter text. WHAT WILL BE DONE TO ENSURE TIMELY AND ACCURATE DATA COLLECTION: ☐ Unit Supervisor / Department Head will be the Alternate Auditor ☐ Contingency audit/data collection time will be scheduled ☐ Unit Supervisor / Department Head will educate all Auditors on this PI Plan, Data Collection Methodology, and Audit/Data Collection Schedule and Tool(s). ☐ Other: Click here to enter text.
5. The **data aggregation methodology** (the way smaller or broken down data sets a.k.a. subsets, are combined into an overall number / average / rate) is specified. Subsets of data, when feasible, allow for the **comparison of performance** among department sections or hospital units.	***Data Aggregation Method:*** Click here to enter text.	***Data Aggregation Method:*** Click here to enter text.	***Data Aggregation Method:*** Click here to enter text.	***Data Aggregation Method:*** Click here to enter text.

Guam Memorial Hospital Authority
Click here to enter text.
Quality Assessment and Performance Improvement Plan
PART Choose an item. **OF** Choose an item.
Choose an item.

QAPI PLAN ELEMENTS	**Indicator/Measure** Choose an item. Click here to enter text.	**Indicator/Measure** Choose an item. Click here to enter text.	**Indicator/Measure** Choose an item. Click here to enter text.	**Indicator/Measure** Choose an item. Click here to enter text.
Aggregation Methodology *Examples: Nursing unit monitors performance of staff documentation for all 3 shifts, and TOTALS up all numerators and denominators to come up with the department's OVERALL compliance percentage for the month. An Operations department has broken down and monitors each step in a process; since these steps are not similar, an AVERAGE performance percentage is calculated with all steps to express the process' OVERALL performance percentage.* ***Data Subsets Comparison*** *Example: The hospital's hand hygiene indicator data is not only broken down per hospital service division, but also further into specific nursing units, pro-support departments, medical staff departments, etc. Comparison is performed by displaying the data in a table format/ pie graph / bar graph, etc.*	***Data Subsets Comparison Method:*** Click here to enter text.	***Data Subsets Comparison Method:*** Click here to enter text.	***Data Subsets Comparison Method:*** Click here to enter text.	***Data Subsets Comparison Method:*** Click here to enter text.
6. The indicator's or measure's **Goal is specified**, with its specific **source identified.**	***Indicator/Measure Goal:*** Click here to enter text.	***Indicator/Measure Goal:*** Click here to enter text.	***Indicator/Measure Goal:*** Click here to enter text.	***Indicator/Measure Goal:*** Click here to enter text.
	Source of Goal: Click here to enter text.	***Source of Goal:*** Click here to enter text.	***Source of Goal:*** Click here to enter text.	***Source of Goal:*** Click here to enter text.
7. When available, **Performance Benchmarks** (e.g. benchmarks established by nationally recognized organizations, etc.) are **used for comparison**.	***Research was conducted and:*** ☐ Benchmark is available – see below ☐ Benchmark is not available – none exists	***Research was conducted and:*** ☐ Benchmark is available – see below ☐ Benchmark is not available – none exists	***Research was conducted and:*** ☐ Benchmark is available – see below ☐ Benchmark is not available – none exists	***Research was conducted and:*** ☐ Benchmark is available – see below ☐ Benchmark is not available – none exists
	Benchmark: Click here to enter text.	***Benchmark:*** Click here to enter text.	***Benchmark:*** Click here to enter text.	***Benchmark:*** Click here to enter text.
	Benchmark Source: Click here to enter text.	***Benchmark Source:*** Click here to enter text.	***Benchmark Source:*** Click here to enter text.	***Benchmark Source:*** Click here to enter text.

SIGNATURES AND APPROVALS:	***DEPARTMENT HEAD NAME & TITLE:*** Click here to enter text.	***DIVISION ADMINISTRATOR NAME & TITLE:*** Click here to enter text.
	DEPARTMENT HEAD SIGNATURE:	***DIVISION ADMINISTRATOR SIGNATURE:***
	DATE: Click here to enter a date.	***DATE:*** Click here to enter a date.

Guam Memorial Hospital Authority
Click here to enter text.
Quality Assessment and Performance Improvement Plan & Program Evaluation Form
PART Choose an item. **OF** Choose an item.
Choose an item.

For ALL QAPI indicators/measures in your department's QAPI Plan, please answer the following evaluation questions.

ELEMENTS TO BE EVALUATED	**Indicator/Measure** Choose an item. Click here to enter text.	**Indicator/Measure** Choose an item. Click here to enter text.	**Indicator/Measure** Choose an item. Click here to enter text.	**Indicator/Measure** Choose an item. Click here to enter text.
1. Is there **evidence** that the indicator/measure is related to any of the following: improved - health outcomes, quality, safety, efficiency, customer service, cost-effectiveness, accountability; prevention and reduction of medical errors? NOTE: This should have been **documented** in the QAPI Plan. *Examples of EVIDENCE – standards or guidelines from a nationally recognized organization, hospital specific evidence, peer-reviewed research, etc.*	☐ Yes ☐ No ***Provide specific evidence:*** Click here to enter text.	☐ Yes ☐ No ***Provide specific evidence:*** Click here to enter text.	☐ Yes ☐ No ***Provide specific evidence:*** Click here to enter text.	☐ Yes ☐ No ***Provide specific evidence:*** Click here to enter text.
2. Is the **scope** of data collection appropriate for the indicator/measure? NOTE: Are ALL areas that should be monitored, accounted for in the indicator/measure? NOTE: This should have been **documented** in the QAPI plan and reflected in QAPI reports data. *Example of appropriate SCOPE – Hand Hygiene observations being monitored in ALL hospital patient care areas, and include ALL applicable staff, such as Nursing, Medical Staff, Operations staff, Pro-Support Staff, etc.*	☐ Yes ☐ No ***Provide specific evidence:*** Click here to enter text.	☐ Yes ☐ No ***Provide specific evidence:*** Click here to enter text.	☐ Yes ☐ No ***Provide specific evidence:*** Click here to enter text.	☐ Yes ☐ No ***Provide specific evidence:*** Click here to enter text.
3. Is the **method and frequency** of data collection specified? NOTE: This should have been **documented** in the QAPI Plan. NOTE: When you specify, in detail, the METHOD and FREQUENCY of data collection, you will reduce the risk of invalid or inaccurate data collection, and provide exact guidance as to how audits or monitoring is to be conducted. *Examples: chart reviews of medical records, electronic health records, MARs, log books, etc.; monthly observations, or monthly audits; samples obtained via a specified source, and how samples are chosen for*	☐ Yes ☐ No ***Provide specific evidence:*** Click here to enter text.	☐ Yes ☐ No ***Provide specific evidence:*** Click here to enter text.	☐ Yes ☐ No ***Provide specific evidence:*** Click here to enter text.	☐ Yes ☐ No ***Provide specific evidence:*** Click here to enter text.

Guam Memorial Hospital Authority
Click here to enter text.
Quality Assessment and Performance Improvement Plan & Program Evaluation Form
PART Choose an item. **OF** Choose an item.
Choose an item.

ELEMENTS TO BE EVALUATED	**Indicator/Measure** Choose an item. Click here to enter text.	**Indicator/Measure** Choose an item. Click here to enter text.	**Indicator/Measure** Choose an item. Click here to enter text.	**Indicator/Measure** Choose an item. Click here to enter text.
auditing (what excludes or includes samples from auditing?), etc.; how compliance is determined (what is compliant, vs. non-compliant?)				
4. Is there **evidence** that data is actually collected in the manner and frequency specified for this indicator/measure? NOTE: If there have been incidences of ***late, incomplete, or wrong/ inaccurate data collection at any point this CY***, response should be "No" and further details should be provided.	☐ Yes ☐ No ***Provide specific evidence:*** Click here to enter text.	☐ Yes ☐ No ***Provide specific evidence:*** Click here to enter text.	☐ Yes ☐ No ***Provide specific evidence:*** Click here to enter text.	☐ Yes ☐ No ***Provide specific evidence:*** Click here to enter text.
5. If department staff play a role in data collection, is **collection consistent** with the specifications for how data should be collected? NOTE: If there have been incidences where ***staff turnover affected data collection practices (no handoff of proper collection methods)***, or incidences where ***staff failed to collect data per the specifications***, response should be "No" and further details should be provided.	☐ Yes ☐ No ☐ N/A ***Provide specific evidence:*** Click here to enter text.	☐ Yes ☐ No ☐ N/A ***Provide specific evidence:*** Click here to enter text.	☐ Yes ☐ No ☐ N/A ***Provide specific evidence:*** Click here to enter text.	☐ Yes ☐ No ☐ N/A ***Provide specific evidence:*** Click here to enter text.
6. Is the **collected data aggregated** (combined from smaller or broken down data sets into an overall number/ average/ rate) in accordance with the department's or hospital's methodology specified for this indicator/measure? NOTE: This DATA AGGREGATION METHODOLOGY should have been **documented** in the QAPI Plan and reflected in QAPI reports data. *Examples: Nursing unit monitors performance of staff documentation for all 3 shifts, and TOTALS up all numerators and denominators to come up with the department's OVERALL compliance percentage for the month. An Operations department has broken down and monitors each step in a process; since these steps are not similar, an AVERAGE performance percentage is calculated with all steps to express the process' OVERALL performance percentage.*	☐ Yes ☐ No ☐ N/A ***Provide specific evidence:*** Click here to enter text.	☐ Yes ☐ No ☐ N/A ***Provide specific evidence:*** Click here to enter text.	☐ Yes ☐ No ☐ N/A ***Provide specific evidence:*** Click here to enter text.	☐ Yes ☐ No ☐ N/A ***Provide specific evidence:*** Click here to enter text.
7. Is the **collected data analyzed**?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No

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Click here to enter text.
Quality Assessment and Performance Improvement Plan & Program Evaluation Form
PART Choose an item. **OF** Choose an item.
Choose an item.

ELEMENTS TO BE EVALUATED	**Indicator/Measure** Choose an item. Click here to enter text.	**Indicator/Measure** Choose an item. Click here to enter text.	**Indicator/Measure** Choose an item. Click here to enter text.	**Indicator/Measure** Choose an item. Click here to enter text.
NOTE: the ANALYSIS of all data should have been **documented** in QAPI reports. NOTE: data ***ANALYSIS*** includes any of the following activities – investigating **root causes** behind the data results (consider all contributing factors and **why** they occurred – human, technological, environment, education, systems, communication, etc.); comparison of results to benchmarks, standards or goals; identification of trends or patterns in the data; determining what conditions or changes are required to bridge the gap in performance; etc.	***Provide specific evidence:*** Click here to enter text.	***Provide specific evidence:*** Click here to enter text.	***Provide specific evidence:*** Click here to enter text.	***Provide specific evidence:*** Click here to enter text.
8. If the indicator is the type that measures a **rate**, is the **rate calculated for points in time and over time** (prevalence, incidence, etc.), and is **comparison made to performance benchmarks** when available (e.g. benchmarks established by nationally recognized organizations)? NOTE: the details regarding how the rates were calculated and what benchmarks were being compared against should have been **documented** in the QAPI Plan. NOTE: the COMPARISON of RATES should have been **documented** in QAPI reports.	☐ Yes ☐ No ☐ N/A ***Provide specific evidence:*** Click here to enter text.	☐ Yes ☐ No ☐ N/A ***Provide specific evidence:*** Click here to enter text.	☐ Yes ☐ No ☐ N/A ***Provide specific evidence:*** Click here to enter text.	☐ Yes ☐ No ☐ N/A ***Provide specific evidence:*** Click here to enter text.
9. When feasible, is **aggregated data broken down** into subsets that allow **comparison** of performance **among department sections or hospital units** covered by the indicator/measure? NOTE: This DATA AGGREGATION METHODOLOGY should have been **documented** in the QAPI Plan with comparisons reflected in QAPI reports data, if applicable. *Example: The hospital's hand hygiene indicator data is not only broken down per hospital service division, but also further into specific nursing units, pro-support departments, medical staff departments, etc.*	☐ Yes ☐ No ☐ N/A ***Provide specific evidence:*** Click here to enter text.	☐ Yes ☐ No ☐ N/A ***Provide specific evidence:*** Click here to enter text.	☐ Yes ☐ No ☐ N/A ***Provide specific evidence:*** Click here to enter text.	☐ Yes ☐ No ☐ N/A ***Provide specific evidence:*** Click here to enter text.
10. If the data analysis identified areas	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No

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Click here to enter text.
Quality Assessment and Performance Improvement Plan & Program Evaluation Form
PART Choose an item. **OF** Choose an item.
Choose an item.

ELEMENTS TO BE EVALUATED	**Indicator/Measure** Choose an item.	**Indicator/Measure** Choose an item.	**Indicator/Measure** Choose an item.	**Indicator/Measure** Choose an item.
	Click here to enter text.	Click here to enter text.	Click here to enter text.	Click here to enter text.
needing improvement, is there **documented evidence that the department instituted interventions** (activities and/or projects) to address them? NOTE: the INTERVENTIONS or PROJECTS should have been **documented** in QAPI reports. NOTE: Utilizing the SAME interventions or actions repeatedly to address improvement needs should NOT be considered sufficient.	***Provide specific evidence:*** Click here to enter text.	***Provide specific evidence:*** Click here to enter text.	***Provide specific evidence:*** Click here to enter text.	***Provide specific evidence:*** Click here to enter text.
11. Are **interventions evaluated** for success? NOTE: the EVALUATION of all interventions should have been **documented** in QAPI reports.	☐ Yes ☐ No ***Provide specific evidence:*** Click here to enter text.	☐ Yes ☐ No ***Provide specific evidence:*** Click here to enter text.	☐ Yes ☐ No ***Provide specific evidence:*** Click here to enter text.	☐ Yes ☐ No ***Provide specific evidence:*** Click here to enter text.
12. If interventions taken were not successful, were **new interventions developed**? NOTE: the development of NEW INTERVENTIONS should have been **documented** in QAPI reports.	☐ Yes ☐ No ***Provide specific evidence:*** Click here to enter text.	☐ Yes ☐ No ***Provide specific evidence:*** Click here to enter text.	☐ Yes ☐ No ***Provide specific evidence:*** Click here to enter text.	☐ Yes ☐ No ***Provide specific evidence:*** Click here to enter text.
13. If interventions were successful, did **evaluation continue** longer to assess if success was sustained? NOTE: the CONTINUED EVALUATION to assess sustainment should have been **documented** in QAPI reports. Guidance is provided in Policy A-PI100.	☐ Yes ☐ No ***Provide specific evidence:*** Click here to enter text.	☐ Yes ☐ No ***Provide specific evidence:*** Click here to enter text.	☐ Yes ☐ No ***Provide specific evidence:*** Click here to enter text.	☐ Yes ☐ No ***Provide specific evidence:*** Click here to enter text.
14. Did the indicator/measure **consistently meet or exceed greater than 90% compliance** for a **consecutive period of 6 months** during the calendar year? NOTE: This guidance is provided in Policy A-PI100.	☐ Yes ☐ No ***Provide specific evidence:*** Click here to enter text.	☐ Yes ☐ No ***Provide specific evidence:*** Click here to enter text.	☐ Yes ☐ No ***Provide specific evidence:*** Click here to enter text.	☐ Yes ☐ No ***Provide specific evidence:*** Click here to enter text.
15. If you answered "Yes" to number 14, was the guidance for continuing or discontinuing monitoring in Policy A-PI100 followed accordingly?	☐ Yes ☐ No ☐ N/A ***Provide specific evidence:*** Click here to enter text.	☐ Yes ☐ No ☐ N/A ***Provide specific evidence:*** Click here to enter text.	☐ Yes ☐ No ☐ N/A ***Provide specific evidence:*** Click here to enter text.	☐ Yes ☐ No ☐ N/A ***Provide specific evidence:*** Click here to enter text.

Guam Memorial Hospital Authority
Click here to enter text.
Quality Assessment and Performance Improvement Plan & Program Evaluation Form
PART Choose an item. **OF** Choose an item.
Choose an item.

ELEMENTS TO BE EVALUATED	**Indicator/Measure** Choose an item. Click here to enter text.	**Indicator/Measure** Choose an item. Click here to enter text.	**Indicator/Measure** Choose an item. Click here to enter text.	**Indicator/Measure** Choose an item. Click here to enter text.
NOTE: If guidance in policy was not followed, please provide explanation.				
16. Based on the indicator's or measure's current CY performance/ compliance percentage/ rate, will it continue to be monitored in the next CY?	☐ CONTINUE ☐ DISCONTINUE ***Provide justification:*** Click here to enter text.	☐ CONTINUE ☐ DISCONTINUE ***Provide justification:*** Click here to enter text.	☐ CONTINUE ☐ DISCONTINUE ***Provide justification:*** Click here to enter text.	☐ CONTINUE ☐ DISCONTINUE ***Provide justification:*** Click here to enter text.

SIGNATURES AND APPROVALS:	***DEPARTMENT HEAD NAME & TITLE:*** Click here to enter text.	***DIVISION ADMINISTRATOR NAME & TITLE:*** Click here to enter text.
	DEPARTMENT HEAD SIGNATURE:	***DIVISION ADMINISTRATOR SIGNATURE:***
	DATE: Click here to enter a date.	***DATE:*** Click here to enter a date.

ATTACHMENT VII
MONTHLY TRENDING SHEET – PAGE 1

DEPARTMENT
CY ____ TRENDING SHEET

PERFORMANCE KEY: ★ Better than Expected ◆ Expected ■ Needs more work ● Worse than expected ⊘ No Data Collected

INDICATORS	GOAL	JAN	FEB	MAR	Q1	APR	MAY	JUN	Q2	JUL	AUG	SEP	Q3	OCT	NOV	DEC	Q4	CY____
VOLUME INDICATORS																		
					0				0				0				0	0
					0				0				0				0	0
					0				0				0				0	0
					0				0				0				0	0
					0				0				0				0	0
STRUCTURAL INDICATORS/ MEASURES																		
1. TOTAL AMOUNT OF OVERTIME HOURS PER MONTH ***(lower amount is desired)***		0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Staff Position 1 Overtime Hours					0				0				0				0	0
Staff Position 2 Overtime Hours					0				0				0				0	0
Staff Position 3 Overtime Hours					0				0				0				0	0
					0				0				0				0	0
2. STAFF VACANCY RATE PER MONTH ***(lower percentage is desired)***		#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!
Number of VACANT Positions		0	0	0		0	0	0		0	0	0		0	0	0		
Total Number of POSITIONS (vacant plus filled)		0	0	0		0	0	0		0	0	0		0	0	0		
Data Breakdown																		
Position 1 Vacancy Rate Per Month		#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!
Position 1 Number of VACANT Positions																		
Position 1 Total Number of Positions (vacant plus filled)																		
Position 2 Vacancy Rate Per Month		#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!
Position 2 Number of VACANT Positions																		
Position 2 Total Number of Positions (vacant plus filled)																		
Position 3 Vacancy Rate Per Month		#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!
Position 3 Number of VACANT Positions																		
Position 3 Total Number of Positions (vacant plus filled)																		
QUALITY ASSESSMENT/ PERFORMANCE IMPROVEMENT (QAPI) INDICATORS/ MEASURES																		
1. INDICATOR/ MEASURE NAME		#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!
Numerator description	goal%																	
Denominator description																		
Indicator/Measure Improves: ☐ Health/Patient Outcomes ☐ Quality ☐ Safety ☐ Efficiency ☐ Patient Satisfaction/ Service ☐ Cost Effectiveness/ Savings ☐ Accountability	★ > ___% ◆ > ___%																	
Indicator/ Measure Type: ☐ Process ☐ Outcome	■ > ___%																	
Result Expressed As: ☐ Percentage ☐ Rate																		
Type of Rate (if applicable): ☐ *Incidence* ☐ *Prevalence*	● < ___%																	
Sample Size & Scope:																		
Data Collection Method:																		
Data Collection Frequency:	⊘ No Data																	
2. INDICATOR/ MEASURE NAME		#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!
Numerator description	goal%																	
Denominator description																		
Indicator/Measure Improves: ☐ Health/Patient Outcomes ☐ Quality ☐ Safety ☐ Efficiency ☐ Patient Satisfaction/ Service ☐ Cost Effectiveness/ Savings ☐ Accountability	★ > ___% ◆ > ___%																	

New Trending Sheet Template [Revised 08/2017]

DEPARTMENT
CY ____ TRENDING SHEET

PERFORMANCE KEY:	★ Better than Expected	◆ Expected	■ Needs more work	● Worse than expected	No Data Collected

INDICATORS	GOAL	JAN	FEB	MAR	Q1	APR	MAY	JUN	Q2	JUL	AUG	SEP	Q3	OCT	NOV	DEC	Q4	CY____
Indicator/ Measure Type: ☐ Process ☐ Outcome **Result Expressed As:** ☐ Percentage ☐ Rate *Type of Rate (if applicable):* ☐ *Incidence* ☐ *Prevalence* **Sample Size & Scope:** **Data Collection Method:** **Data Collection Frequency:**	■ > ___% ● < ___% No Data																	
3. INDICATOR/ MEASURE NAME Numerator description Denominator description	goal%	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!
Indicator/Measure Improves: ☐ Health/Patient Outcomes ☐ Quality ☐ Safety ☐ Efficiency ☐ Patient Satisfaction/ Service ☐ Cost Effectiveness/ Savings ☐ Accountability **Indicator/ Measure Type:** ☐ Process ☐ Outcome **Result Expressed As:** ☐ Percentage ☐ Rate *Type of Rate (if applicable):* ☐ *Incidence* ☐ *Prevalence* **Sample Size & Scope:** **Data Collection Method:** **Data Collection Frequency:**	★ > ___% ◆ > ___% ■ > ___% ● < ___% No Data																	
4. INDICATOR/ MEASURE NAME Numerator description Denominator description	goal%	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!
Indicator/Measure Improves: ☐ Health/Patient Outcomes ☐ Quality ☐ Safety ☐ Efficiency ☐ Patient Satisfaction/ Service ☐ Cost Effectiveness/ Savings ☐ Accountability **Indicator/ Measure Type:** ☐ Process ☐ Outcome **Result Expressed As:** ☐ Percentage ☐ Rate *Type of Rate (if applicable):* ☐ *Incidence* ☐ *Prevalence* **Sample Size & Scope:** **Data Collection Method:** **Data Collection Frequency:**	★ > ___% ◆ > ___% ■ > ___% ● < ___% No Data																	

Prepared By: [NAME/TITLE] _____ Date _____

Submitted By: [NAME/TITLE]
Department Manager/Supervisor _____ Date _____

Reviewed and Approved By: [NAME/TITLE]
Division Administrator _____ Date _____

QUALITY ASSESSMENT & PERFORMANCE IMPROVEMENT (QAPI) REPORT

DEPARTMENT NAME

Choose an item. - Choose an item.

QAPI Indicator/ Measure NAME
Choose an item.**:**

DATA COLLECTION

Choose an item. **Result: enter result** Choose an item.	Choose an item. **Result: enter result** Choose an item.	Choose an item. **Result: enter result** Choose an item.	Choose an item. **Average: enter result** Choose an item.
Compared to Choose an item. , this result was Choose an item.	Compared to Choose an item. , this result was Choose an item.	Compared to Choose an item. , this result was Choose an item.	Compared to Choose an item. , this result was Choose an item.
If Month 1 was Not Applicable or Data was NOT collected, explain below: Click here to enter text.	*If Month 2 was Not Applicable or Data was NOT collected, explain below:* Click here to enter text.	*If Month 3 was Not Applicable or Data was NOT collected, explain below:* Click here to enter text.	*If the Quarter was Not Applicable or Data was NOT collected, explain below:* Click here to enter text.

DATA ANALYSIS

Trends or Patterns Observed:
Click here to enter text.

Data Subsets Comparison(s):
Click here to enter text.

Contributing Factors *(factors that influenced results/ compliance/ performance)* **& Reasons Why/Causes** *(why the contributing factors happened)*:

Environment:	Click here to enter text.	**WHY/Causes:**	Click here to enter text.
Equipment:	Click here to enter text.	**WHY/Causes:**	Click here to enter text.
Materials/Supply:	Click here to enter text.	**WHY/Causes:**	Click here to enter text.
Process/Procedure:	Click here to enter text.	**WHY/Causes:**	Click here to enter text.
People:	Click here to enter text.	**WHY/Causes:**	Click here to enter text.

NOTE: *For People/staff-related factors, and for Clinical-related departments/divisions (Nursing Svcs., Pro-Support Svcs.) - the subsequent Staffing Analysis section in this template* ***MUST BE COMPLETED****.*

IMPROVEMENT & SUSTAINMENT

PDSA Background:
This was Choose an item..

PDSA Cycle Aim *(We aimed to improve/sustain this/these, by how much/at this level, and by when)*:
Click here to enter text.

PLAN		DO	
WHO did the action/change:	**WHAT action/change was done:**	**WHEN was the action/change done:**	**Results, Findings, Observations:**
Click here to enter text.	Click here to enter text.	Click here to enter a date.	Click here to enter text.
Click here to enter text.	Click here to enter text.	Click here to enter a date.	Click here to enter text.
Click here to enter text.	Click here to enter text.	Click here to enter a date.	Click here to enter text.

QUALITY ASSESSMENT & PERFORMANCE IMPROVEMENT (QAPI) REPORT

DEPARTMENT NAME

Choose an item. - Choose an item.

Click here to enter text.	Click here to enter text.	Click here to enter a date.	Click here to enter text.

STUDY		ACT
Based on the results/findings/observations - we performed analysis & learned the following:	**PDSA Cycle Aim was:**	**The next steps we will take as a result of this cycle:**
Click here to enter text.	Choose an item.	Choose an item.

OTHER COMMENTS
Click here to enter text.

QAPI Indicator/ Measure NAME

Choose an item.**:**

DATA COLLECTION			
Choose an item. **Result: enter result** Choose an item.	Choose an item. **Result: enter result** Choose an item.	Choose an item. **Result: enter result** Choose an item.	Choose an item. **Average: enter result** Choose an item.
Compared to Choose an item. , this result was Choose an item.	Compared to Choose an item. , this result was Choose an item.	Compared to Choose an item. , this result was Choose an item.	Compared to Choose an item. , this result was Choose an item.
If Month 1 was Not Applicable or Data was NOT collected, explain below: Click here to enter text.	*If Month 2 was Not Applicable or Data was NOT collected, explain below:* Click here to enter text.	*If Month 3 was Not Applicable or Data was NOT collected, explain below:* Click here to enter text.	*If the Quarter was Not Applicable or Data was NOT collected, explain below:* Click here to enter text.

DATA ANALYSIS	
	Trends or Patterns Observed: Click here to enter text.
	Data Subsets Comparison(s): Click here to enter text.

Contributing Factors *(factors that influenced results/ compliance/ performance)* **&** **Reasons Why/Causes** *(why the contributing factors happened)*:			
Environment:	Click here to enter text.	**WHY/Causes:**	Click here to enter text.
Equipment:	Click here to enter text.	**WHY/Causes:**	Click here to enter text.
Materials/Supply:	Click here to enter text.	**WHY/Causes:**	Click here to enter text.
Process/Procedure:	Click here to enter text.	**WHY/Causes:**	Click here to enter text.
People:	Click here to enter text.	**WHY/Causes:**	Click here to enter text.

NOTE: *For People/staff-related factors, and for Clinical-related departments/divisions (Nursing Svcs., Pro-Support Svcs.) - the subsequent* ***Staffing Analysis*** *section in this template* ***MUST BE COMPLETED****.*

IMPROVEMENT & SUSTAINMENT	
PDSA Background: This was Choose an item..	**PDSA Cycle Aim** *(We aimed to improve/sustain this/these, by how much/at this level, and by when)*: Click here to enter text.

QUALITY ASSESSMENT & PERFORMANCE IMPROVEMENT (QAPI) REPORT

DEPARTMENT NAME

Choose an item. - Choose an item.

PLAN		DO	
WHO did the action/change:	**WHAT action/change was done:**	**WHEN was the action/change done:**	**Results, Findings, Observations:**
Click here to enter text.	Click here to enter text.	Click here to enter a date.	Click here to enter text.
Click here to enter text.	Click here to enter text.	Click here to enter a date.	Click here to enter text.
Click here to enter text.	Click here to enter text.	Click here to enter a date.	Click here to enter text.
Click here to enter text.	Click here to enter text.	Click here to enter a date.	Click here to enter text.

STUDY		ACT
Based on the results/findings/observations - we performed analysis & learned the following:	**PDSA Cycle Aim was:**	**The next steps we will take as a result of this cycle:**
Click here to enter text.	Choose an item.	Choose an item.

OTHER COMMENTS
Click here to enter text.

STAFFING ANALYSIS	**Staffing Analysis** *completion is mandatory for: (1) Clinical-related departments/divisions (Nursing Svcs., Pro-Support Svcs.), (2) Quality or Safety indicators/measures that did not perform as expected, (3) any undesirable event, and (4) any QAPI indicator/measure where People/staff-related factors were documented as contributing to results/performance/compliance, in Data Analysis sections in this template.*			
	Choose an item. **Vacancy Rate: rate**	Choose an item. **Vacancy Rate: rate**	Choose an item. **Vacancy Rate: rate**	Choose an item. **Average Rate: rate**
	Choose an item. **OT hours: hours**	Choose an item. **OT hours: hours**	Choose an item. **OT hours: hours**	Choose an item. **Total Hours: hours**
	Skill Mix Assessment: *(the right people, with the right skills, in the right place at the right time; balance of novice vs. experienced, licensed vs. unlicensed, certified vs. uncertified, appropriate shift/ location/duty placement for staff mix, etc.)* **Explain:** Click here to enter text.			
	Competency Assessment: *(details regarding required/applicable orientations, trainings, educations, and competencies – their statuses/completion/compliance, etc.)* **Explain:** Click here to enter text.			
	Work Flow/Process or Workload Assessment: *(details regarding volume of duties/treatments/procedures, census levels, acuity levels, simplicity or complexity of work flow/process, etc.)* **Explain:** Click here to enter text.			

Prepared & Submitted By: NAME/TITLE Department Manager/Supervisor	Click here to enter a date. Date	Reviewed & Approved By: NAME/TITLE Division Administrator	Click here to enter a date. Date

GMHA BOARD OF TRUSTEES – QUALITY & SAFETY SUBCOMMITTEE
QUALITY ASSESSMENT & PERFORMANCE IMPROVEMENT (QAPI) REPORT

Click here to enter text. - Choose an item.

Choose an item. - Choose an item.

DATA COLLECTION		DATA ANALYSIS	IMPROVEMENT & SUSTAINMENT PLANS			
INDICATOR/ MEASURE	**WHAT?** (Contributing Factors that caused the performance decline OR increase)	**WHY?** (Analysis / Reasons – why did the contributing factors happen?)	**ACTIONS DONE or PLAN OF ACTION TO EXECUTE** (address the reasons)	**WHEN?** (When was the action completed? OR When will the action be completed?)	**WHO?** (responsible person for executing the action)	**STATUS?** (done, ongoing, pending, explain)

CONTRACTED SERVICES						
INDICATOR/ MEASURE	**WHAT?** (Contributing Factors that caused the performance decline OR increase)	**WHY?** (Analysis / Reasons – why did the contributing factors happen?)	**ACTIONS DONE or PLAN OF ACTION TO EXECUTE** (address the reasons)	**WHEN?** (When was the action completed? OR When will the action be completed?)	**WHO?** (responsible person for executing the action)	**STATUS?** (done, ongoing, pending, explain)

GMHA BOARD OF TRUSTEES – QUALITY & SAFETY SUBCOMMITTEE
QUALITY ASSESSMENT & PERFORMANCE IMPROVEMENT (QAPI) REPORT

Click here to enter text. - Choose an item.
Choose an item. - Choose an item.

STAFFING ANALYSIS					
UNIT, DEPT. SECTION, ETC.	VACANCY RATE	OT HOURS	SKILL MIX	COMPETENCIES	WORK FLOW/ PROCESS OR WORKLOAD

STAFFING PLAN OF ACTION			
ACTIONS DONE or PLAN OF ACTION TO EXECUTE	WHEN? (When was the action completed? OR When will the action be completed?)	WHO? (responsible person for executing the action)	STATUS? (done, ongoing, pending, explain)

Prepared & Submitted By: NAME/TITLE
Division Administrator

Click here to enter a date.
Date

ATTACHMENT X
DIVISION ADMINISTRATOR ANNUAL REPORT – PAGE 1

GMHA BOARD OF TRUSTEES – QUALITY & SAFETY SUBCOMMITTEE
QUALITY ASSESSMENT & PERFORMANCE IMPROVEMENT (QAPI) REPORT
Click here to enter text.
Choose an item. – **Annual Evaluation**

For all departments/units from all three Rotation Months, please address/evaluate the following elements.

Indicator/ Measure Selection & Prioritization

Did the Rotation Months select indicators or measures that supported or was related to any of the following: improvement of health outcomes, quality, safety, efficiency, customer service, cost effectiveness, accountability; prevention/reduction of medical errors/patient harm? *To support your answer, please explain the process your division undertook to ensure appropriate indicators/measures were selected.*

Click here to enter text.

Did the Rotation Months prioritize improvement activities and monitoring for its selected indicators/measures? *To support your answer, please explain how this prioritization occurred, and how you were involved as Division Administrator.*

Click here to enter text.

Scope Appropriateness

Did the Rotation Months appropriately address the scope of monitoring? *To support your answer, please explain how the Rotation Months ensured that all areas, shifts, and patient populations that SHOULD have been monitored, were accounted for in all indicators/measures (discuss if any assessment of scope applicability was conducted).*

Click here to enter text.

Data Collection Methodology/ Specifications

Did the Data Collection Methodology/Specifications of all indicators/measures for the Rotation Months result in valid, timely and accurate data? *To support your answer, please provide details on the presence or absence of the following: incidences of incomplete or late data collection and submission; incidences of inaccurate data collection due to improper auditing methods (not following the specifications for auditing); incidences of data collector(s) turnover/absence/leave, with or without proper handoff/teaching of proper auditing methods/specifications.*

Click here to enter text.

If the indicators/measures for the Rotation Months required data subsets to be aggregated into an overall number, was the method for this aggregation followed, per specifications? *To support your answer, please provide details on the presence or absence of any deviation from the aggregation methods/specifications, and the impact it had (if any) on data accuracy and validity.*

Click here to enter text.

Did the Rotation Months have adequate resources for Data Collection activities? *To support your answer, please provide details on the presence or absence of adequate auditing times/days (to include data compilation and entry onto templates/sheets); any incidences of data collector(s) turnover/absence/leave and the impact it had (if any) on data collection.*

Click here to enter text.

Data Analysis, Trends and Patterns Identification, Comparisons

Did the Rotation Months conduct robust data analyses to uncover root causes behind data/results/performance? *To support your answer, please explain (in detail) how this Rotation Month conducted analyses (what tools/methods were used).*

Click here to enter text.

How did the Rotation Months graphically display data?

Click here to enter text.

In its analysis of data, how did the Rotation Months identify trends and patterns?

Click here to enter text.

In its analysis of data, how did the Rotation Months conduct comparisons? *To support your answer, please also explain what was used for the comparisons, e.g. external benchmarks, internal historical data, etc.*

Click here to enter text.

Did the Rotation Months have adequate resources for Data Analysis activities? *To support your answer, please provide details on the presence or absence of adequate analysis times/days (to include time spent utilizing analysis tools, and displaying data in graphical form); any incidences of department supervisor/manager turnover/absence/leave and the impact it had (if any) on data analysis.*

Click here to enter text.

ATTACHMENT X
DIVISION ADMINISTRATOR ANNUAL REPORT – PAGE 2

GMHA BOARD OF TRUSTEES – QUALITY & SAFETY SUBCOMMITTEE
QUALITY ASSESSMENT & PERFORMANCE IMPROVEMENT (QAPI) REPORT
Click here to enter text.
Choose an item. – **Annual Evaluation**

Improvement (PDSA methodology) and Sustainment

Describe how effective the Rotation Months were at utilizing the PDSA methodology (cycle of planning, implementing, evaluating) for improvements and sustainment.

Click here to enter text.

If the Rotation Months determined interventions were unsuccessful, were NEW interventions created and subsequently implemented and evaluated? *To support your answer, please provide details on the presence or absence of failure to create new interventions.*

Click here to enter text.

If the Rotation Months determined interventions were successful, did monitoring and evaluation continue to assess for sustainment? *To support your answer, please provide details on the presence or absence of continued evaluation for assessment of sustainment.*

Click here to enter text.

Did the Rotation Months have adequate resources for Improvements and Sustainment activities? *To support your answer, please provide details on the presence or absence of improvements (via data collection, analysis results, etc.), and presence or absence of sustained improvement.*

Click here to enter text.

Contracted Services

Describe how effective the Rotation Months were at reporting QAPI related to Contracted Services (if applicable) throughout the calendar year. *To support your answer, please provide details on whether or not QAPI related requirements were fulfilled (e.g. monitoring/data collection, data display, analysis, trends and pattern identification, improvements and sustainment, and reporting).*

Click here to enter text.

Staffing Analysis and Plans of Action

Describe how effective the Rotation Months were at reporting QAPI related Staffing Analyses throughout the calendar year. *To support your answer, please provide details on whether or not QAPI requirements were fulfilled (e.g. monitoring/data collection, skill mix assessment, competency assessment, work flow/ process or workload assessment, improvements and sustainment, and reporting).*

Click here to enter text.

As Division Administrator, what plans of action did you create, implement, and/ or sustain, (in collaboration with both Human Resources Department and the Rotation Months), to address Staffing Effectiveness and adequacy?

Click here to enter text.

As a result of this calendar year's Staffing Analyses and Plans of Action, has staffing effectiveness and adequacy improved? *To support your answer, please provide details of what criteria was met in order to determine improvement or lack of improvement in staffing adequacy.*

Click here to enter text.

Division Administrator Reporting Quality and QAPI Oversight/Responsibility

For this calendar year, evaluate the quality of your own QAPI reports (as Division Administrator) to the Quality and Safety Subcommittee and Board of Trustees. *To support your answer, please explain how well you summarized and addressed this Rotation Month's QAPI activities throughout this calendar year, in order to provide meaningful and actionable information for board-level decision making.*

Click here to enter text.

For this calendar year, evaluate your effectiveness and/or success (as Division Administrator) in fulfilling the oversight/responsibilities required via the Hospital's QAPI program/policy.

Click here to enter text.

Future Plans and Recommendations

Based on this Evaluation, what plans will you create and implement to ensure that the Click here to enter text.

ATTACHMENT X
DIVISION ADMINISTRATOR ANNUAL REPORT – PAGE 3

GMHA BOARD OF TRUSTEES – QUALITY & SAFETY SUBCOMMITTEE
QUALITY ASSESSMENT & PERFORMANCE IMPROVEMENT (QAPI) REPORT
Click here to enter text.
Choose an item. – **Annual Evaluation**

Rotation Months succeed with satisfying QAPI Program requirements in the next Calendar Year?	
Based on this Evaluation and your oversight of the Rotation Months' QAPI monitoring and activities, what new recommendations for monitoring, improvement opportunities, and performance improvement projects can you make to the Quality & Safety Subcommittee and to the Board of Trustees for the next Calendar Year?	Click here to enter text.

Prepared & Submitted By: NAME/TITLE
Division Administrator

Click here to enter a date.
Date

GMHA BOARD OF TRUSTEES – QUALITY & SAFETY SUBCOMMITTEE
QUALITY ASSESSMENT & PERFORMANCE IMPROVEMENT (QAPI) REPORT

Click here to enter text.

Choose an item. - Choose an item.

DATA COLLECTION		DATA ANALYSIS	IMPROVEMENT & SUSTAINMENT PLANS			
INDICATOR/ MEASURE	WHAT? (Contributing Factors that caused the performance decline OR increase)	WHY? (Analysis / Reasons – why did the contributing factors happen?)	ACTIONS DONE or PLAN OF ACTION TO EXECUTE (address the reasons)	WHEN? (When was the action completed? OR When will the action be completed?)	WHO? (responsible person for executing the action)	STATUS? (done, ongoing, pending, explain)

Click here to enter a date.

Prepared & Submitted By: NAME/TITLE
Committee Chairperson

Date

ATTACHMENT XI
CHAIRPERSON QUARTERLY MATRIX REPORT

ATTACHMENT XII
CHAIRPERSON ANNUAL REPORT – PAGE 1

GMHA BOARD OF TRUSTEES – QUALITY & SAFETY SUBCOMMITTEE
QUALITY ASSESSMENT & PERFORMANCE IMPROVEMENT (QAPI) REPORT
Click here to enter text.
Choose an item. **– Annual Evaluation**

For the QAPI activities the committee undertook, please address/evaluate the following elements.

Indicator/ Measure Selection & Prioritization

Did the committee select indicators or measures that supported or was related to any of the following: improvement of health outcomes, quality, safety, efficiency, customer service, cost effectiveness, accountability; prevention/reduction of medical errors/patient harm? *To support your answer, please explain the process the committee undertook to ensure appropriate indicators/measures were selected.*

Click here to enter text.

Did the committee prioritize improvement activities and monitoring for its selected indicators/measures? *To support your answer, please explain how this prioritization occurred, and how you were involved as Committee Chairperson.*

Click here to enter text.

Scope Appropriateness

Did the committee appropriately address the scope of monitoring? *To support your answer, please explain how the committee ensured that all areas, shifts, and patient populations that SHOULD have been monitored, were accounted for in all indicators/measures (discuss if any assessment of scope applicability was conducted).*

Click here to enter text.

Data Collection Methodology/ Specifications

Did the Data Collection Methodology/Specifications of all indicators/measures for the committee result in valid, timely and accurate data? *To support your answer, please provide details on the presence or absence of the following: incidences of incomplete or late data collection and submission; incidences of inaccurate data collection due to improper auditing methods (not following the specifications for auditing); incidences of data collector(s) turnover/absence/leave, with or without proper handoff/teaching of proper auditing methods/specifications.*

Click here to enter text.

If the indicators/measures for the committee required data subsets to be aggregated into an overall number, was the method for this aggregation followed, per specifications? *To support your answer, please provide details on the presence or absence of any deviation from the aggregation methods/specifications, and the impact it had (if any) on data accuracy and validity.*

Click here to enter text.

Did the committee have adequate resources for Data Collection activities? *To support your answer, please provide details on the presence or absence of adequate auditing times/days (to include data compilation and entry onto templates/sheets); any incidences of data collector(s) turnover/absence/leave and the impact it had (if any) on data collection.*

Click here to enter text.

Data Analysis, Trends and Patterns Identification, Comparisons

Did the committee conduct robust data analyses to uncover root causes behind data/results/performance? *To support your answer, please explain (in detail) how the committee conducted analyses (what tools/methods were used).*

Click here to enter text.

How did the committee graphically display data?

Click here to enter text.

In its analysis of data, how did the committee identify trends and patterns?

Click here to enter text.

In its analysis of data, how did the committee conduct comparisons? *To support your answer, please also explain what was used for the comparisons, e.g. external benchmarks, internal historical data, etc.*

Click here to enter text.

Did the committee have adequate resources for Data Analysis activities? *To support your answer, please provide details on the presence or absence of adequate analysis times/days (to include time spent utilizing analysis tools, and displaying data in graphical form); any incidences of department supervisor/manager turnover/absence/leave and the impact it had (if any) on data analysis.*

Click here to enter text.

ATTACHMENT XII
CHAIRPERSON ANNUAL REPORT – PAGE 2

GMHA BOARD OF TRUSTEES – QUALITY & SAFETY SUBCOMMITTEE
QUALITY ASSESSMENT & PERFORMANCE IMPROVEMENT (QAPI) REPORT
Click here to enter text.
Choose an item. – **Annual Evaluation**

Improvement (PDSA methodology) and Sustainment

Describe how effective the committee was at utilizing the PDSA methodology (cycle of planning, implementing, evaluating) for improvements and sustainment.

Click here to enter text.

If the committee determined interventions were unsuccessful, were NEW interventions created and subsequently implemented and evaluated? *To support your answer, please provide details on the presence or absence of failure to create new interventions.*

Click here to enter text.

If the committee determined interventions were successful, did monitoring and evaluation continue to assess for sustainment? *To support your answer, please provide details on the presence or absence of continued evaluation for assessment of sustainment.*

Click here to enter text.

Did the committee have adequate resources for Improvements and Sustainment activities? *To support your answer, please provide details on the presence or absence of improvements (via data collection, analysis results, etc.), and presence or absence of sustained improvement.*

Click here to enter text.

Committee Chairperson Reporting Quality and QAPI Oversight/Responsibility

For this calendar year, evaluate the quality of your own QAPI reports (as Committee Chairperson) to the Quality and Safety Subcommittee and Board of Trustees. *To support your answer, please explain how well you summarized and addressed the committee's QAPI activities throughout this calendar year, in order to provide meaningful and actionable information for board-level decision making.*

Click here to enter text.

For this calendar year, evaluate your effectiveness and/or success (as Committee Chairperson) in fulfilling the oversight/responsibilities required via the Hospital's QAPI program/policy.

Click here to enter text.

Future Plans and Recommendations

Based on this Evaluation, what plans will you create and implement to ensure that the committee succeeds with satisfying QAPI Program requirements in the next Calendar Year?	Click here to enter text.
Based on this Evaluation and your oversight of the committee's QAPI monitoring and activities, what new recommendations for monitoring, improvement opportunities, and performance improvement projects can you make to the Quality & Safety Subcommittee and to the Board of Trustees for the next Calendar Year?	Click here to enter text.

Prepared & Submitted By: NAME/TITLE
Committee Chairperson

Click here to enter a date.
Date

ATTACHMENT XIII
QAPI PROJECT/TEAM TEMPLATE – PAGE 1

GUAM MEMORIAL HOSPITAL AUTHORITY
QAPI PROJECT TEAM
Click here to enter text.

Document last updated: Click here to enter text.

Purpose

Why was this Team created?

Click here to enter text.

What is the overall GOAL for this Team?

Click here to enter text.

What are the Team's objectives/aims?

Click here to enter text.

Who or What is impacted?

If the Team does not act and implement changes for improvement, who or what will be impacted, and how?

Click here to enter text.

Possible Solutions and Selection of the Change

Based on pre-project data analysis and discussions with the Team, what possible solutions were considered?

Click here to enter text.

Which change did the Team ultimately decide to implement and why?

Click here to enter text.

Expected Benefit

What benefit does the Team expect as a result of implementing this change?

Click here to enter text.

Team Members and Resources

Who is the Team accountable to for reporting (who will oversee the Team and its activities), and how often will reporting occur?

Click here to enter text.

What specific documentation/data/information/report will be submitted to this Team's overseeing person/committee?

Click here to enter text.

Team Leader: Click here to enter text.
Team Co-Leader: Click here to enter text.
Team Facilitator: Click here to enter text.
Team Recorder: Click here to enter text.

NOTE: *Team Recorder will maintain all recorded minutes, agendas, documents, reports, attendance sheets, etc. in a Team Binder. Team Facilitator will coordinate meeting dates, times and locations, and ensure that meeting materials are provided to all Team members a week prior to each meeting. Team Leader and Co-Leader will receive all Team reports, data, documents, etc. from responsible Team members, a week and a half prior to each meeting. Both Leaders will work together with the Recorder and Facilitator to create the meeting agendas and to update this Project Team template, plus ensure all materials are provided to the Team members. Both Leaders will report (verbally and with the written documentation/requirements) to the overseeing person/committee on behalf of the Team. Team members will be responsible for implementing actions, collecting data, and providing feedback in the form of documented reports. Members will submit all information to both Team Leaders, a week and a half prior to each meeting.*

Team Members (Name, Title, Department/Unit):	Meeting Dates and Times, Locations:
Click here to enter text.	Click here to enter text.

Deliverables

What is the Team expected to deliver, in order to start implementing the change and PDSA cycle(s)?

WHAT WILL BE DELIVERED:	BY WHEN:	BY WHO:
Click here to enter text.	Click here to enter text.	Click here to enter text.

Constraints

Please identify any barriers that exist which may create difficulties in accomplishing this Team's Goal.

ATTACHMENT XIII
QAPI PROJECT/TEAM TEMPLATE – PAGE 2

GUAM MEMORIAL HOSPITAL AUTHORITY
QAPI PROJECT TEAM
Click here to enter text.
Document last updated: Click here to enter text.

Click here to enter text.

Success Factors

What leadership and resources are needed to make this project a success?

Click here to enter text.

ATTACHMENT XIII
QAPI PROJECT/TEAM TEMPLATE – PAGE 3

GUAM MEMORIAL HOSPITAL AUTHORITY
QAPI PROJECT TEAM
Click here to enter text.
Document last updated: Click here to enter text.

Model for Improvement

What are we trying to accomplish? Click here to enter text.

How will we know that a change is an improvement? Click here to enter text.

What change can we make that will result in improvement? Click here to enter text.

PDSA Cycle Number: Choose an item. **PDSA Cycle Time Period:** *From:* Click here to enter a date. *To:* Click here to enter a date.

PDSA Background: *This is* Choose an item.

PLAN

List the tasks needed to set up this test of change	Person Responsible	When to be done	Where to be done

Predict what will happen when the test is carried out	Measures to determine if the prediction succeeds (Operational Definition, Data collection methodology or specifications, etc.)

DO

Describe what actually happened when you ran the test (what did you observe)

STUDY

Describe the measured results (data), how they compared to the predictions, and what was learned from the data analysis
PDSA Cycle Aim was: Choose an item.

ACT

If the PDSA Cycle Aim was accomplished/met: ***How will the Team adopt successful actions from this PDSA Cycle into existing or new processes and subsequently monitor for sustained success?***
If the PDSA Cycle Aim was <u>NOT</u> accomplished/met: ***Based on what was learned, describe what modifications to the plan will be made for the next PDSA cycle.***