Quality Assessment, Performance Improvement, and Patient Safety Plan FY 2019

I. Introduction

a. Purpose

The purpose of the Quality Assessment, Performance Improvement (QAPI) and Patient Safety Plan is to support the University of Toledo Medical Center (UTMC) mission and strategic vision by outlining priorities, objectives and overall improvement strategies.

b. Mission

The mission of The University of Toledo Medical Center is to improve the human condition by providing patient-centered, university-quality care.

c. Strategic Vision

Transition UTMC to a high performing hospital focused on Primary Care, Behavior Health, Orthopedics and Consultative Services.

d. Situation

The landscape surrounding UTMC is dynamic owing to many factors, including the University of Toledo College of Medicine and Life Sciences' (COMLS) academic affiliation agreement. At the same time, CMS (the Centers for Medicare and Medicaid Services) has placed greater emphasis on measurement of value-based care: *Hospital Compare* Quality Star Rating system, the Value-Based Purchasing (VBP) Program, the Readmissions Reduction Program (RRP), and the Hospital Acquired Condition (HAC) Program. UTMC must adapt its Quality and Safety plan to this situation.

e. University of Toledo Goal for UTMC

Grow the reputation and visibility of health care in Toledo provided by UT physicians, health-care providers, residents and students.

f. UTMC Strategic (multi-year) Quality Objectives

In order to support the overall mission, strategic vision, and goals for UTMC we have outlined the following objectives.

i. Achieve *Hospital Compare* Overall Quality Rating of 3-Stars by December 2019
ii. Eliminate UTMC's Hospital-acquired condition (HAC) reduction program penalty and neutralize Value-Based Purchasing related penalties by December 2019
iii. Improve clinical documentation
iv. Improve health quality information management
v. Maintain accreditation and certification readiness

g. Fiscal Year 2019 QAPI and Patient Safety Plan Objectives

We have outlined our FY 2019 objectives to support the UTMC strategic objectives. We have organized them according to the dimensions of quality: safety, timeliness, effectiveness, efficiency, equity, and patient-centeredness. The most important objective is safety. We will employ CMS (the Centers for Medicare and Medicaid Services), Vizient, the Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS), and UTMC data sources to measure our progress toward meeting objectives.

1. Safety
    a. Patient safety indicators (PSIs)
        i. Decrease pressure ulcers (PSI03) to below Vizient median
        ii. Decrease postoperative respiratory failure (PSI11) to below Vizient median
        iii. Decrease perioperative pulmonary embolism and deep vein thrombosis rate (PSI12) to below Vizient median
        iv. Maintain postoperative sepsis rate (PSI13) to below Vizient median
    b. Healthcare-associated infections
        i. Decrease the surgical site infection rate below the Center for Disease Control-National Healthcare Safety Network (CDC-NHSN) standardized infection rate (SIR) threshold
        ii. Decrease the catheter-related blood stream infection rate below the CDC-NHSN SIR threshold
        iii. Decrease the catheter-associated urinary tract infection rate below the CDC-NHSN SIR threshold
        iv. Decrease the *Clostridium difficile* infection rate below the CDC-NHSN SIR threshold
    c. Improve hand-hygiene to achieve an average above 90%
    d. Improve Operating Room (OR) safety culture to achieve self-reported OR safety of at least 80% in all domains
    e. Decrease service line specific mortality rates below Vizient index

2. Timeliness
    a. Maintain Emergency Department (ED) to admission time below Vizient median

3. Effectiveness
    a. Decrease 30-day readmission rates to below Vizient median rate

4. Efficiency
    a. Analyze patient flow in order to decrease service line specific length of stay (LOS) below the Vizient index
    b. Analyze OR processes in order to improve OR on-time start percentage to above 80% for UTMC surgical services
    c. Improve clinical documentation capture of Medicare Severity Diagnosis Related Groups (MS-DRGs) complication or comorbidity (CC) or a major complication or comorbidity (MCC) (i.e., MS-DRG CC/MCC) to the Vizient median

5. Equitable
    a. Decrease median time from ED arrival to departure for all races and low socio-economic statuses

6. Patient-centeredness
    a. Achieve 32nd HCAHPS percentile (for rating the hospital overall)
    b. Achieve Vizient ranking of 25 for patient-centeredness domain

7. Maintain accreditation and certification readiness (Table 1).

II. Structure and Leadership

a. The Chief Executive Officer (CEO) in consultation with the Chief Medical Officer (CMO) and other key hospital leaders is responsible for developing the Quality Assessment, Performance Improvement and Patient Safety Plan. These leaders set priorities, provides leader emphasis, and allocates resources to support the plan.
b. Execution of the plan carried out by committees, working groups, departments, and services (Figure 1). These committees, working groups, departments, and services operationalize the plan, defining, refining, implementing, and monitoring. These bodies are comprised of physicians and appropriate hospital staff.
c. Each clinical department will develop performance improvement initiatives that align with the UTMC quality and safety plan.
d. The CMO oversees the plan as the Chair of the Quality and Patient Safety Council. This oversight ensures quality and safety activity alignment within the organization and allows for collaboration while avoiding redundancy. The Quality and Patient Safety Council reports to the Medical Staff Executive Committee, which in turn reports to the Clinical Affairs Committee of the Board of Trustees (Figure 2).

III. Quality Assessment and Performance Improvement Process

a. Setting Priorities

Quality priorities align with UTMC objectives and meet regulatory requirements. The CEO outlines, priorities, but obtains input from other hospital leaders and service chiefs. Other issues (e.g., external benchmark projects, analysis of patient safety event reports, sentinel event analysis, or standard of care findings) may also receive priority. UTMC uses decision matrices along with other modalities to aid in developing priorities (Table 2).

b. Model for Quality Assessment and Performance Improvement

UTMC will transition during this year to employing the widely used Institute for Healthcare Improvement (IHI) model. This model is comprised of the following questions/steps:

i. What is the aim (what is trying to be accomplished)?
ii. What will be measured (how will we know a change is an improvement)?
iii. What change/intervention will be made?
iv. Following these three questions, we execute the PDSA cycle (Plan-Do-Study-Act) (Figure 3).

Alternatively, during this transition, staff members may use the PMAAR model (Plan, Measure, Analyze, Act, and Review) (Figure 4). This cyclical model incorporates defining

the opportunity, identifying the objective, collecting and measuring the data, analyzing performance while comparing with objectives, determining action steps and initiatives as appropriate based on performance, educating and re-measuring.

v. The Quality and Patient Safety Plan is flexible in order to accommodate change.

c. Developing Measure Specifications

Committees and working groups outline quality measures and metrics. UTMC relies on Vizient, CMS, and organic resources for actionable data. Committees and working groups develop written measurement specifications along with data abstraction tools with assistance from Quality Management personnel.

d. Reporting and Implementation

Committees, working groups, departments, and services will report findings to the Quality Management Department. The Quality Management Department is responsible for disseminating important information throughout the organization, in such formats as the Performance Improvement Quarterly report and/or other acceptable formats. Annually or more frequently as necessary, findings from committees, working groups, departments and services will be presented at the Quality and Patient Safety Council, with minutes from the council presented to the Medical Executive Committee. UTMC performance improvement activities may also be shared in the following modes:

i. Departmental in-services on special quality performance improvement topics
ii. Presentations to students, residents, staff and faculty
iii. Reports of clinical data distributed to the Clinical Affairs Committee of the Board of Trustees, Executive Committee of the Medical Staff, members of management and leadership teams
iv. Display of duality data on individual hospital units

IV. Medical Staff and Clinical Department and Services Quality and Safety Responsibilities

a. Medical Staff Committees

All UTMC committees report their plans and activities to the Quality and Patient Safety Council at least annually. As medical staff committees, several key committees must also submit their activities (in the form of minutes) to the Medical Executive Committee. These committees and their activities include:

vi. Blood and Laboratory Utilization Committee (BUC): The purpose of the committee is to ensure the safe, effective, and efficient use of blood products and appropriate use of the laboratory resources. The committee annually reports their plan and findings to the Quality & Patient Safety Council.

vii. Cancer Committee: The purpose of the committee is to ensure quality care in patients with cancer. Cancer Conference presentations occur monthly, which includes all major cancer sites treated at UTMC. The Cancer Committee plans and conducts a minimum of two outcome studies annually. The committee annually reports their plan and findings to the Quality & Patient Safety Council.

viii. Infection Control Committee: The purpose of the committee is to ensure safe care by instituting and overseeing evidence-based infection control practices. The

committee also ensures integration and oversight of the antimicrobial stewardship program. The committee meets no less than quarterly to review and evaluate the hospital-wide infection control activities. The committee annually reports their plan and findings to the Quality & Patient Safety Council.

ix. Health Information Management Committee: The purpose of the committee is to ensure the timely completion and accuracy of medical documentation (e.g., history and physical). The committee monitors regulatory requirements for completion of required documentation. The committee annually reports their plan and findings to the Quality & Patient Safety Council.

x. Medical Staff Executive Committee: The Medical Staff Executive Committee is delegated the primary authority over activities related to quality assessment and performance improvement of the professional services provided by individuals with clinical privileges. The Executive Committee meets monthly, and receives and acts upon reports and recommendations from medical staff committees.

xi. Operating Room (OR) Services Committee: The purpose of the committee is to ensure the delivery of quality surgical care. The committee reviews all adverse events and mortalities that occur in the OR. The committee annually reports their plan and findings to the Quality & Patient Safety Council.

xii. Pharmacy and Therapeutics Committee: The purpose of the committee is to oversee all aspects of quality related to the selection, ordering, transcribing, preparing, dispensing, administering, and monitoring of medications throughout UTMC. In addition, they maintain and make recommendations to the drug formulary. The committee works closely with nursing, Infection Control, and other medical staff departments in developing policies and monitoring. Pharmacy is responsible for tracking and monitoring medication errors and adverse events and reporting findings to the Quality & Patient Safety Committee. The committee annually reports their plan and findings to the Quality & Patient Safety Council.

xiii. Procedural Case Review Committee: The purpose of the committee is to review operative and other high-risk procedures for appropriateness. The committee reviews adverse surgical events and confirms operative diagnosis concurrence through autopsy and tissue pathology evaluation. The committee selects high-risk patient populations based on identified problem prone or high-risk procedures. The committee meets at least quarterly and annually reports their plan and findings to the Quality and Patient Safety Council.

xiv. Trauma Committee: The purpose of the committee is to provide quality oversight for the Trauma program. The committee annually reports their plan and findings to the Quality and Patient Safety Council.

b. Clinical Departments and Services

xv. Each clinical department and service is responsible for establishing specific quality improvement indicators, which align with the hospital-wide plan. Clinical

departments and services annually report their plans and findings to the Quality and Patient Safety Council.

V. Safety

a. Safety is the most important aspect of quality care. UTMC integrates the patient safety with all quality assessment and performance improvement activities. It encompasses risk assessment and avoidance tactics such as conducting a "Failure Mode Effect Analysis" (FMEA). FMEA is a proactive risk assessment, which examines a process in detail including sequencing of events, assessing actual and potential risk, failure, or points of vulnerability, and prioritizes areas for improvement based on the potential impact on patient care.

b. The Quality Management department proactively institutes action plans based on findings from the "Sentinel Event Alert" provided by the Joint Commission.

c. All patient safety events in the safety program track and trend or initiate activities that address process, system, protocol, or equipment events. This includes near miss occurrences and unsafe conditions, as well as findings from adverse events. As the entire organization reports patient safety events, this component integrates all departments into the safety program.

d. The Quality Management department facilitates execution of action plans derived from Root Cause Analysis activities, including those from Sentinel Events.

VI. Oversight and Information Sharing

a. Committees, working groups, departments and services report quality assessment and performance improvement information to the Quality and Patient Safety Council. The Quality and Patient Safety Council submits minutes to the Medical Staff Executive Committee, which in turn reports to the Clinical Affairs Committee of the Board of Trustees. Additionally, the Clinical Affair Committee approves the annual Quality Assessment, Performance Improvement and Patient Safety Plan and monitors completion of the plan. The various duties of these oversight committees are further defined below:

   i. The Board of Trustees of the University of Toledo: establishes, maintains, supports, and exercises oversight of the quality monitoring and performance improvement function of UTMC. The Board of Trustees fulfills its responsibilities related to the quality assessment, performance improvement, and safety functions through its Clinical Affairs Committee.

   ii. The Clinical Affairs Committee of the Board of Trustees: reviews and provides feedback related to quality reports submitted to the committee and the Board of Trustees. The Clinical Affairs Committee approves the annual plan and annual reappraisal. They are also responsible for making recommendations to enhance the Quality Assessment, Performance Improvement and Patient Safety Plan.

   iii. The Executive Committee of the Medical Staff: provides oversight for reporting quality initiatives from the medical staff committees and hospital initiatives.

VII. Resources

a. The Quality Management Department supports and facilitates ongoing organizational quality assessment, performance improvement, and patient safety activities. The Quality Management Department assists physicians and hospital staff with developing and executing quality improvement projects.

b. The duties of the Quality Management Department include:
   i. Promoting patient safety through evidence-based clinical programs and initiatives
   ii. Ensuring accreditation and certification readiness (e.g., Joint Commission)
   iii. Management of quality databases (e.g., Vizient, CDC databases)
   iv. Collaboration with all departments and services to execute the quality and patient safety plan (e.g., assisting with performance improvement projects) and achieve hospital objectives
   v. Collaboration with Medical Staff Office/Central Verification Office (CVO) for physician assessments
   vi. Quality improvement training and education
   vii. Preparation of all salient quality and safety plans and reports
   viii. Collaboration with health information management to aid in accurate documentation
   ix. Dissemination of patient safety event reports to departments, Quality and Patient Safety Council, and other key groups in the organization
   x. Patient safety event and sentinel event report tracking and analysis
   xi. Coordinating and leading root cause analyses for sentinel events and other occurrences requiring intense analysis
   xii. Coordinating and ensuring completion of action plans related to sentinel events or failure mode effect analysis (FMEA) projects
   xiii. Organizing performance improvement projects for issues found in patient safety event reports

VIII. Summary

The Quality Assessment, Performance Improvement, and Patient Safety Plan provides the objectives and framework for UTMC to implement quality assessment, performance improvement, and safety activities. These activities improve patient outcomes, patient experience, and patient safety in a comprehensive, methodical, and systematic manner and compliment the Hospital Plan for the Provision of Collaborative Patient Care Services.

IMMUNITY/CONFIDENTIALITY CLAUSES

The Quality and Patient Safety Council is a UTMC quality assurance committee as referenced in the Ohio Revised Code. Those sections of the Ohio Revised Code pertaining to immunity and confidentiality apply to the Quality and Patient Safety Council.

Ohio Revised Code §2305.24 (eff. 9/29/2009)

> "Any information, data, reports, or records made available to a quality assurance committee or utilization committee of a hospital or long-term care facility or of any not-for-profit health care corporation that is a member of the hospital or long-term care facility or of which the hospital or long-term care facility is a member are confidential and shall be used by the committee and the committee members only in the exercise of the proper functions of the committee.

No physician, institution, hospital, or long-term care facility furnishing information, data, reports, or records to a committee with respect to any patient examined or treated by the physician or confined in the institution, hospital, or long-term care facility shall, by reason of the furnishing, be deemed liable in damages to any person, or be held to answer for betrayal of a professional confidence within the meaning and intent of section 4731.22 of the Revised Code."

Original Date: 9/87
Revised:

- Utilization Management Plan 4/90
- Quality Assessment Plan 6/90
- Quality Assessment and Improvement Plan 7/92
- Patient Care and Service Improvement Plan 1/93
- Quality Improvement Plan 1/94
- Quality Improvement Plan 1/95
- Quality Improvement Plan 1/96
- Quality Improvement Plan 1/97
- Quality Improvement Plan 1/98
- Quality Improvement Plan 1/99
- Performance Improvement Plan 4/99
- Performance Improvement Plan 6/99
- Performance Improvement Plan 9/00
- Performance Improvement Plan 3/02
- Performance Improvement Plan 5/03
- Performance Improvement Plan 12/04
- Performance Improvement Plan 6/06
- Performance Improvement Plan 11/07
- Quality and Patient Safety Plan 12/08
- Quality and Patient Safety Plan 2/2010
- Quality and Patient Safety Plan 2/2012
- Quality and Patient Safety Plan 12/2012
- Quality Assessment, Performance Improvement and Patient Safety Plan, 11/2013
- Quality Assessment, Performance Improvement and Patient Safety Plan, 1/2015
- Quality Assessment, Performance Improvement and Patient Safety Plan, 7/2015
- Quality Assessment, Performance Improvement and Patient Safety Plan, 8/2016
- Quality Assessment, Performance Improvement and Patient Safety Plan, 8/2017

Dan Barbee
Chief Executive Officer

Michael Ellis, M.D.
Chief Medical Officer

Samer Khouri MD.
Chief of Staff

Table 1

Regulatory Agencies
Continuous Readiness

Program	Accreditation Organization	Next Visit
Behavioral Health - Community	Ohio Department of Mental Health	02-2019
Transplant	UNOS/OPTN - Deceased Program	04-2019
Transplant	UNOS/OPTN - Living Donor Program	04-2019
Behavioral Health - Inpatient	Ohio Department of Mental Health	05-2019
Lab	College of American Pathologists (CAP)	05-2019
Trauma	American College of Surgeons - Trauma	06-2019
Cardiac Cath	Ohio Department of Health	08-2019
Stroke	The Joint Commission	08-2019
Advanced Heart Failure Intra-cycle call	The Joint Commission	08-2019
Lab	American Society for Histocompatibility and Immunogenetics	09-2019
Pharmacy	Ohio Board of Pharmacy	3-2020
Advanced Heart Failure Certification	The Joint Commission	8-2020
Stroke Intra-cycle Call	The Joint Commission	9-2020
Behavioral Health Services	The Joint Commission	11-2020
Home Care (DME for DCC Renee's Survivor Shop)	The Joint Commission	11-2020
Hospital	The Joint Commission	11-2020
Eleanor N. Dana Cancer Center	Commission on Cancer	05-2021
Transplant	Centers for Medicare and Medicaid Service - Transplant	08-2021
Hemodialysis	Ohio Department of Health	09-2021
Emergency Preparedness	Ohio Department of Health	09-2021

Figure 1

Quality & Patient Safety Initiative
Care and Safety Oversight

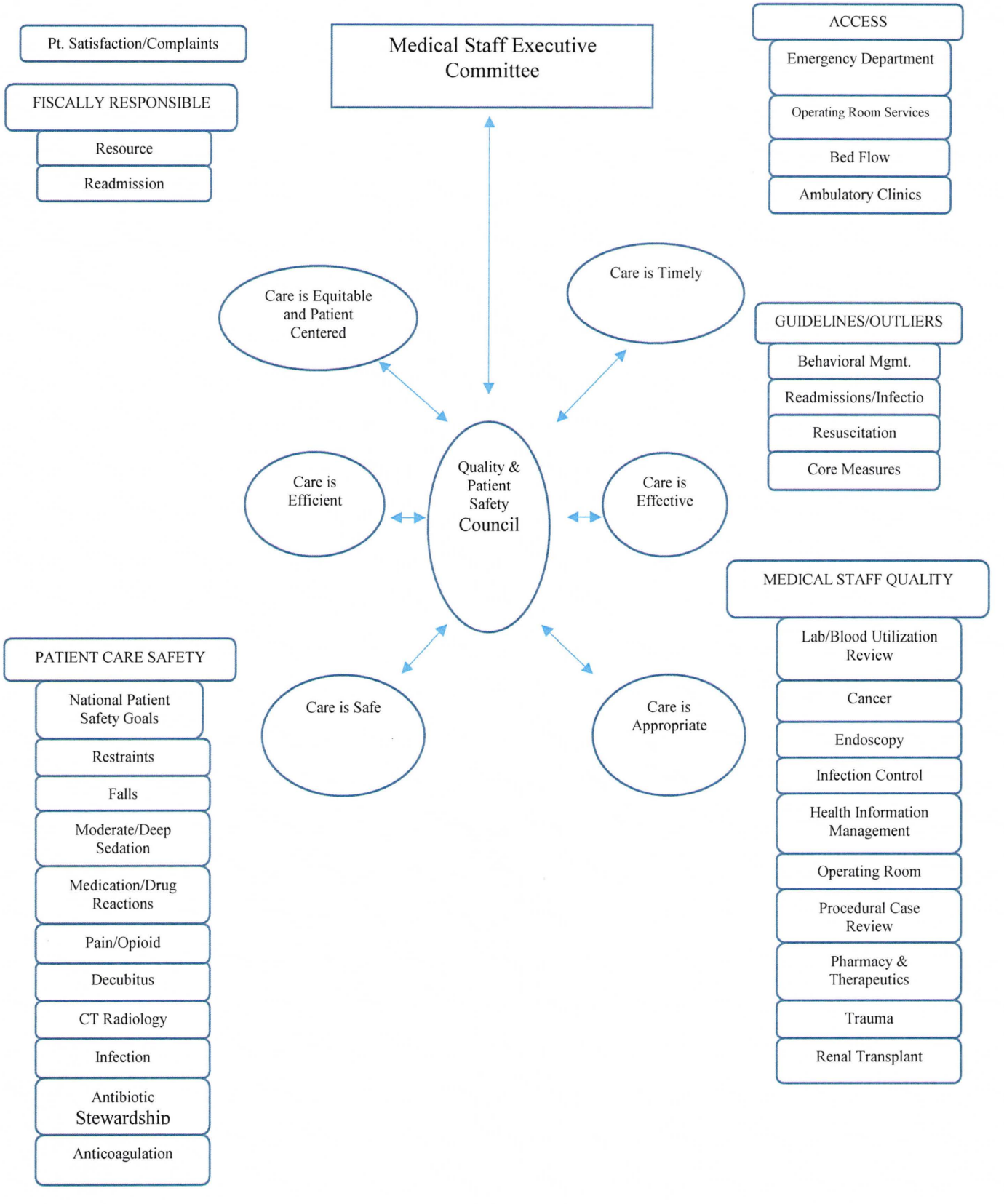

Figure 2

COMMITTEE STRUCTURE

October 2018

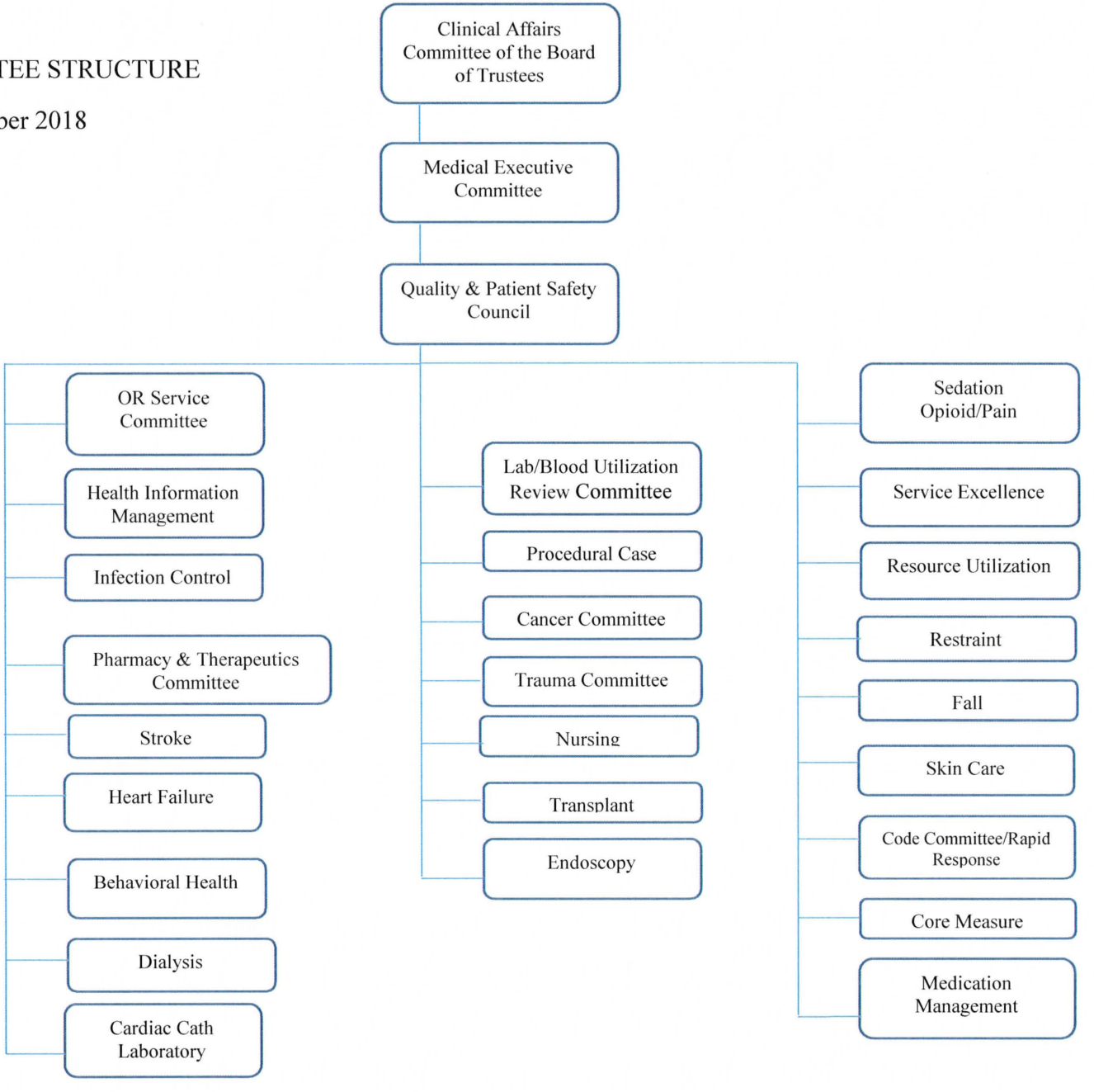

Table 2

PRIORITIZATION MATRIX –FY 2019
Quality and Patient Safety Goals

Improve Patient Safety & Quality

Opportunity	High Risk	High Volume	Problem Prone	Important to Mission	Customer Satisfaction	Staff Satisfaction	Physician Satisfaction	Clinical Outcome	Safety	Regulatory Requirement
Hospital Acquired Conditions	✓		✓	✓	✓			✓	✓	
Patient Safety Events	✓			✓	✓	✓	✓	✓	✓	
Pain Management – Safe opiod use	✓		✓	✓	✓	✓	✓	✓	✓	✓

Improve Resource Utilization

Opportunity	High Risk	High Volume	Problem Prone	Important to Mission	Customer Satisfaction	Staff Satisfaction	Physician Satisfaction	Clinical Outcome	Safety	Regulatory Requirement
Reduce Readmission	✓		✓	✓	✓			✓	✓	

Improve Satisfaction

Opportunity	High Risk	High Volume	Problem Prone	Important to Mission	Customer Satisfaction	Staff Satisfaction	Physician Satisfaction	Clinical Outcome	Safety	Regulatory Requirement
Patient Satisfaction	✓		✓	✓	✓	✓	✓	✓	✓	✓
Perception of Safety	✓		✓	✓	✓	✓	✓	✓	✓	✓
Complaint Management	✓		✓	✓	✓	✓	✓	✓	✓	✓

Reduce Infection Rates

Opportunity	High Risk	High Volume	Problem Prone	Important to Mission	Customer Satisfaction	Staff Satisfaction	Physician Satisfaction	Clinical Outcome	Safety	Regulatory Requirement
Clostridium Difficile	✓		✓	✓	✓	✓	✓	✓	✓	✓
Blood Stream Infections	✓		✓	✓	✓			✓	✓	✓
Hand Hygiene	✓		✓	✓	✓			✓	✓	✓
Surgical Site Infections	✓		✓	✓	✓			✓	✓	✓
UTI	✓		✓	✓	✓			✓	✓	✓

Monitor External Regulatory Compliance Indicators

Opportunity	High Risk	High Volume	Problem Prone	Important to Mission	Customer Satisfaction	Staff Satisfaction	Physician Satisfaction	Clinical Outcome	Safety	Regulatory Requirement
Resuscitation	✓							✓	✓	✓
Sedation/Analgesia	✓							✓	✓	✓
Pain		✓	✓	✓	✓	✓	✓	✓	✓	✓
Resource Utilization				✓						✓
CORE Measures			✓	✓				✓	✓	✓
Adverse Drug Reaction	✓		✓	✓				✓	✓	✓
Organ Conversion				✓						✓
Restraints				✓	✓			✓	✓	✓

Opportunity	High Risk	High Volume	Problem Prone	Important to Mission	Customer Satisfaction	Staff Satisfaction	Physician Satisfaction	Clinical Outcome	Safety	Regulatory Requirement
Lab/Blood Utilization	✓			✓				✓	✓	✓
Operative/Invasive procedures.	✓		✓	✓				✓	✓	✓
Seclusion	✓			✓				✓	✓	✓
Behavioral Management	✓			✓				✓	✓	✓
Mortality/Autopsy				✓						✓
Hazard Management				✓					✓	✓
Operative Diagnosis Concurrence	✓			✓				✓	✓	✓
NPSG	✓			✓					✓	
CT Radiology indicators	✓	✓		✓	✓			✓	✓	✓
Suicide Risk	✓		✓	✓				✓	✓	✓
Falls	✓		✓	✓	✓			✓	✓	✓
Medication Errors	✓			✓	✓	✓	✓	✓	✓	✓
Patient Throughput	✓			✓	✓	✓	✓			✓
Antimicrobial Stewardship	✓		✓	✓				✓	✓	✓
Contracted Services	✓			✓			✓	✓	✓	✓
ECT	✓		✓	✓	✓	✓	✓	✓	✓	✓
Detox	✓		✓	✓	✓			✓	✓	✓

Figure 3

Plan-Do-Study-Act
Quality & Patient Safety Cycle

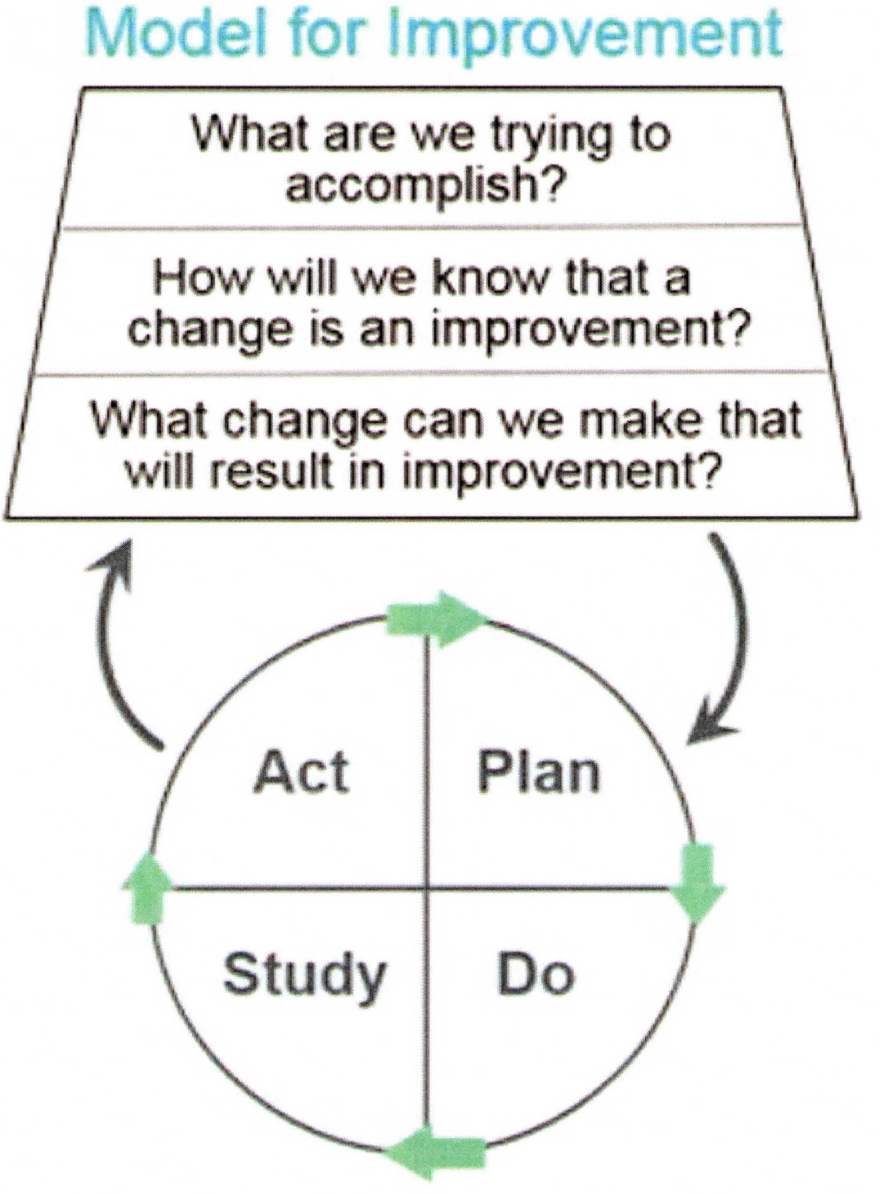

Figure 3

QUALITY PERFORMANCE IMPROVEMENT QUARTERLY REPORT
THE PDSA QUALITY CYCLE

Team/Disciplines: _____

Plan (Aim): (Identify your problem using priorities from the Quality and Patient Safety Annual Plan or issues identified as affecting important outcomes of care, treatment or service.)

1. Describe the objective:
2. List questions and make predictions:
3. Specify how to carry out the cycle:
    a. Who
    b. What
    c. Where
    d. When
4. How will cycle results be measured:

Do (Intervention): (Carry out the plan, observe impact, document problems, collect data and gather informal feedback. Display the data over time, on a "run chart" and against a comparative, an internal or external goal or benchmark. Note observations.)

Study (Measures): (Study results—analyze and study data. Compare results to predictions. What did you learn? Summarize quantitative and qualitative analysis. Quantitative: Which way is the experience moving - up down or static over time? Is this desirable or undesirable? Is the process in control, or does it have a lot of variation? How does the experience compare to the Goal or Benchmark. Qualitative: Why is this happening? Consider all reasons. What are the contributing factors? What does this mean?)

Act (Analyses): (What did you conclude from this cycle review? Refine the change based on what was learned from the do/study. Did the implementation work or not? If it did not work, what can you do differently in next cycle to address this? If it did work, can you spread across entire practice? Should this continue to be measured? Should another indicator be introduced?)

Contact Person Completing Form: _____ **Dept.**_____

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Figure 4

Plan-Measure-Analyze-Act

Quality & Patient Safety Cycle

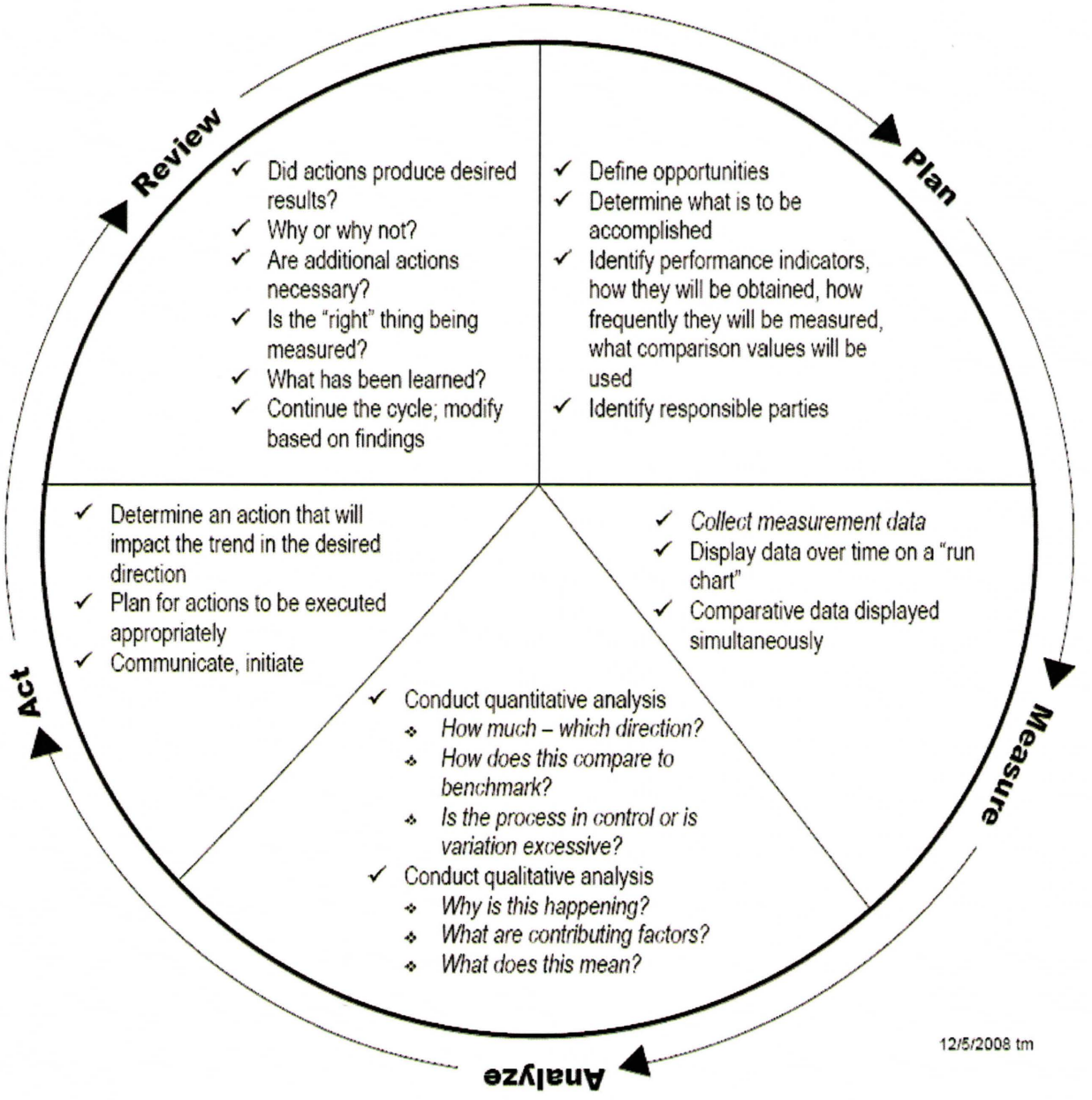

Figure 4

QUALITY PERFORMANCE IMPROVEMENT QUARTERLY REPORT
THE PMAAR QUALITY CYCLE

Team/Disciplines: _____

Plan: (Define your work using priorities from the Quality and Patient Safety Annual Plan or issues identified as affecting important outcomes of care, treatment or service. Determine what is to be accomplished, what indicators will be used, how they will be obtained, where the benchmarks and other comparative data will come from, how frequently monitoring will occur and who are the responsible parties.)

Measure: (Use existing data where possible. Indicators should reflect the issue at hand. Display the data over time, on a "run chart" and against a comparative, an internal or external goal or benchmark.)

Analyze: (Conduct quantitative and qualitative analysis. Quantitative: Which way is the experience moving - up down or static over time? Is this desirable or undesirable? Is the process in control, or does it have lots of variation? Is this special cause variation? How does the experience compare to the Goal or Benchmark. Qualitative: Why is this happening? (Consider all reasons) How do I know for sure? What are the contributing factors? What does this mean?)

Act: (Determine an action or actions that will impact the trend in the desirable direction. Invent, brainstorm, and cogitate. Plan for the actions to be carried out appropriately; communicate, assign responsibility and effective dates)

Review: (A successful intervention should cause a noticeable change in the experience within a reasonable period. Are the actions attaining the desired results? If yes, are additional actions needed? What will it take to sustain improvements? If no, was enough time allowed? Are additional actions necessary? Is the "right" thing being measured? Should this continue to be measured? Should another indicator be introduced? What has been learned? Continue and or modify based on how these questions have been answered)

Contact Person Completing Form: _____ **Dept.** _____

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