Lawrence General Hospital

Quality Assessment

&

Performance Improvement Plan

Approved by the Quality of Care Committee

April 16, 2025

Lawrence General Hospital

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Introduction

The Centers for Medicare and Medicaid (CMS) conditions of participation have specific requirements for a Quality Assessment and Performance Improvement Program (42 CFR § 482.21). It states that "the hospital must develop, implement, and maintain an effective, ongoing, hospital-wide, data-driven quality assessment and performance improvement program. The hospital's governing body must ensure that the program reflects the complexity of the hospital's organization and services, involves all hospital departments and services (including those services furnished under contract or arrangement), and focuses on indicators related to improved health outcomes and the prevention and reduction of medical errors. The hospital must maintain and demonstrate evidence of its Quality Assessment and Performance Improvement (QAPI) Program for review by CMS." [1]

The LGH QAPI Program, designed to support and enhance our mission, vision, and values, provides a framework for continual assessment and improvement of our performance by promoting high reliability, a culture of safety, and just culture aimed at eliminating preventable patient harm, reducing readmissions, and improving the patient and family experience.

Mission, Vision, and Values

Mission

Lawrence General Hospital is a not-for-profit hospital providing quality medical care and related services to the people of the Greater Lawrence community. Our physicians and caregivers offer treatment to all patients, regardless of their race, ethnicity, national origin, gender, religion, age, marital status, sexual orientation, gender identity, socioeconomic status, veteran status, disability, and other characteristics that make our patients and employees unique.

Every member of our clinical team works to assure the level of care the Hospital provides, supporting community education and research to improve the health of the citizens of the Merrimack Valley. To the extent that they enable us to enhance our ability to deliver on our mission and expand our range of services, we work closely and collaboratively with other health care institutions.

Vision

Become the region's destination community-focused hospital and health system.

Lawrence General Hospital

Values

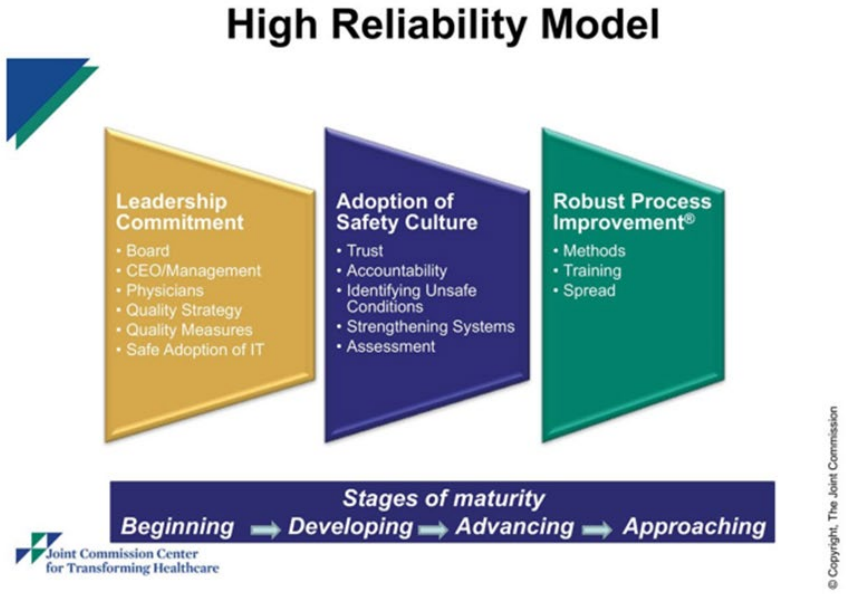
To achieve the highest levels of quality and patient satisfaction, the Hospital's philosophy of care focuses around these six core values:

- ***Equity*** – We work to ensure that all individuals have the opportunity to access high quality health care.
- ***Inclusivity*** – We embrace diversity and foster a culture of inclusion and belonging.
- ***Quality*** – We value quality by our actions, and we strive for excellence.
- ***Integrity*** – We build honest and ethical relationships.
- ***Compassion*** – We empathize with the physical, emotional, and spiritual needs of the sick and injured.
- ***Service*** – We respond to and try to exceed the expectations of those served by or involved in our organization.

Becoming a High Reliability Organization (HRO)

High reliability health care refers to patient care that is consistently excellent and safe over extended periods and across all services and settings. In November 2021, LGH adopted the Joint Commission (TJC) High Reliability Health Care Maturity Model to guide our journey towards becoming an HRO. The TJC constructed a framework that health care organizations can use to accelerate their progress toward the ultimate goal of zero harm. The framework is organized around three major domains of change required to achieve high reliability:

- Leadership committed to the goal of zero harm.
- An organizational safety culture where all staff can speak up about things that would negatively impact the organization.
- An empowered workforce that employs process improvement tools to address the improvement opportunities they find and drive significant and lasting change.



The "Leadership" component of the framework focuses on leadership's role in setting goals related to high reliability and zero patient harm across the organization. The CEO and management aim for high reliability and zero harm in all vital clinical processes. Physicians throughout the organization routinely lead and participate in clinical quality improvement activities. The quality strategy is one of the organization's highest priority strategic goals and key quality measures are routinely displayed internally as well as publicly reported. Reward and recognition systems focus on quality and safety accomplishments, information technology (IT) is adopted with patient safety in mind and IT solutions are integral to sustaining improved quality.

The "Culture of Safety" component of the framework includes trust, where high levels of measured trust exist in all clinical areas, in addition to adherence to self-policing policies on codes of behavior. Accountability is when staff recognize and act on their personal accountability for maintaining a culture of safety, and when there are equitable and transparent disciplinary procedures which are fully adopted across the organization.

Unsafe conditions are routinely identified by frontline staff, reported, and acted upon, leading to early problem resolution before patients are harmed. Results of actions related to patient safety are routinely communicated throughout the organization. System defenses are proactively assessed, and weaknesses proactively repaired. Safety culture measures are part of the strategic metrics reported to the Board, and systematic improvement initiatives are in place and underway to achieve a fully functioning safety culture.

The "Robust Process Improvement" component of the framework includes widespread deployment and adoption of highly effective process improvement tools throughout the organization. Training in robust process improvement is mandatory for all staff at a level appropriate to their jobs. Process improvement methods include tools and methodology in Six Sigma and the DMAIC model for improvement. Improvement work is adopted widely throughout the organization, and patients and families are engaged in redesigning care processes.

Culture of Safety, Just Culture, and our Journey to Zero Harm

Culture of safety

LGH has been advancing the concept of a culture of safety for several years. The concept originated from studies of high reliability organizations that were able to minimize adverse events despite conducting intrinsically complex and hazardous work. It requires a commitment to safety at all levels of the organization. A culture of safety encompasses these key features:

- acknowledgment of the high-risk nature of an organization's activities and the determination to achieve consistently safe operations
- a blame-free environment where individuals can report errors or near misses without fear of reprimand or punishment

- encouragement of collaboration across ranks and disciplines to seek solutions to patient safety problems
- organizational commitment of resources to address safety concerns [2]

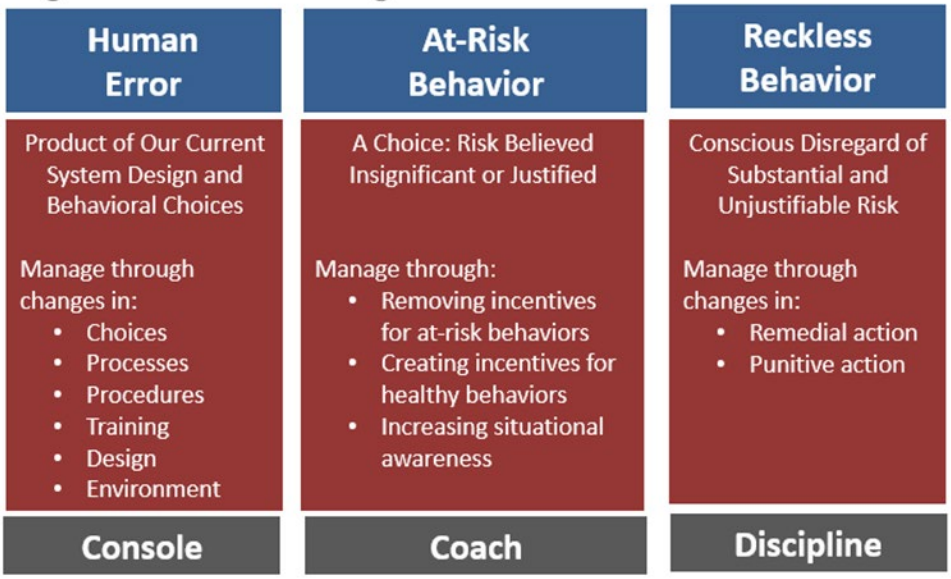
In 2004, the Agency for Healthcare Research and Quality (AHRQ) released the original Surveys on Patient Safety Culture™ (SOPS®) Hospital Survey. The survey is distributed on a bi-annual cadence. The AHRQ SOPS 2.0 survey was most recently distributed in October 2023 and remained open until December 1, 2023. Action Plans based on results continue to be reviewed and updates are shared with leaders. Plans are in development to distribute the SOPS® Hospital Survey system wide this October 2025.

Just Culture

The concept of Just Culture goes hand-in-hand with a culture of safety. It emphasizes that mistakes are generally a product of a faulty organizational culture, rather than solely brought about by the person or persons directly involved. In a Just Culture, employees feel safe and protected when voicing concerns about safety, and feel free to discuss their own actions during an actual or potential adverse event. Human error is not viewed as the cause of an adverse event, but rather a symptom of an imperfect system. [3] There is a thoughtful review of the event to better understand systemic failures and vulnerabilities. This is not to say that people are not accountable for their actions or that there are not circumstances where discipline is warranted. In fact, a critical aspect of a Just Culture is the perceived fairness of the procedures used to draw the line between conduct deserving of discipline and conduct for which discipline is neither appropriate nor helpful. [4] Caregivers and staff should feel respected, supported, and safe when voicing concerns or seeking assistance regarding a quality or safety issue.

During a root cause analysis investigating adverse events and medical errors we look at three types of behavior: human error, at-risk behavior, and reckless behavior. Each type of behavior has a different cause, so a different response is required (Figure 1). [5] Human errors are mistakes that are managed through changes in the environment, design, policies, procedures, and training. At-risk behavior is a choice that is believed to be either justified or insignificant and is managed through increasing situational awareness, creating incentives

Figure 1. Just Culture Algorithm: The Three Behaviors



for healthy behaviors, and removing incentives for at-risk behavior. Reckless behavior is a conscious disregard of substantial risk, can be criminal behavior, and is managed through remedial or disciplinary action.[6,7,8]

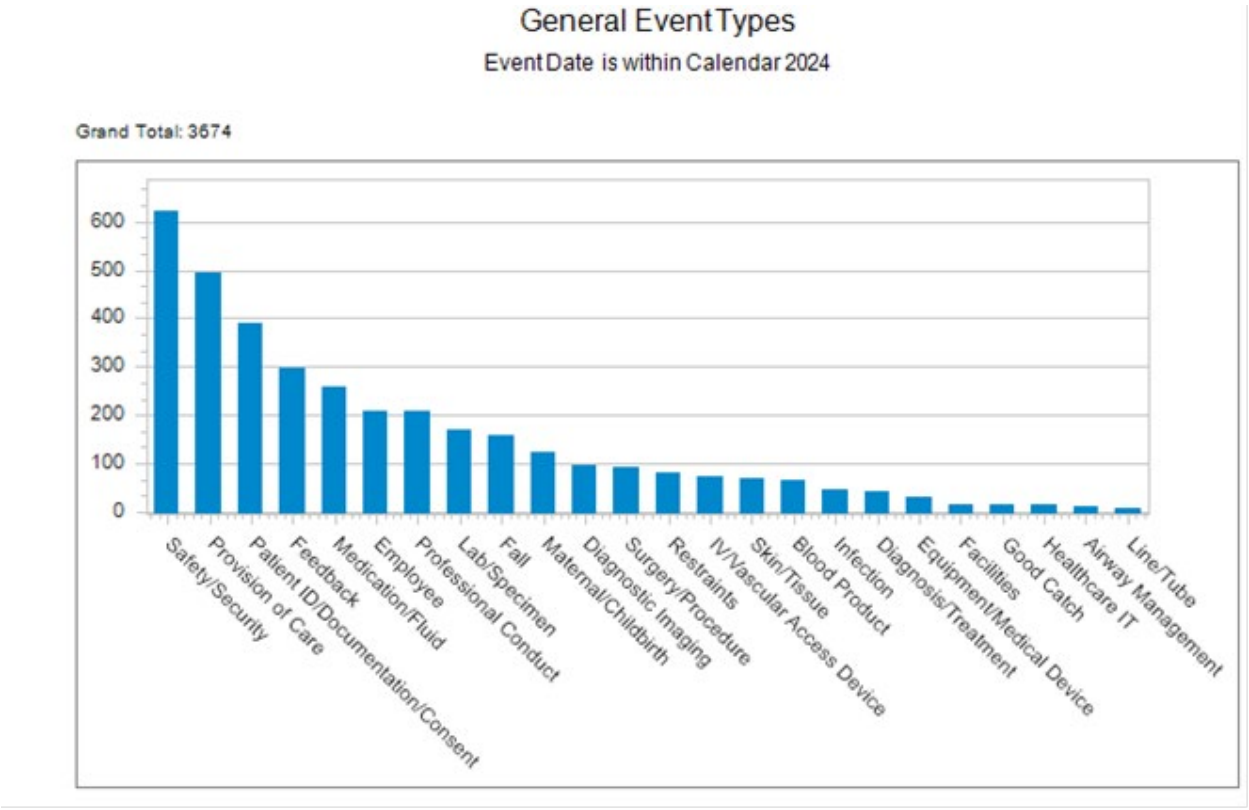
Journey to Zero Harm

Eliminating preventable harm and Serious Safety Events (SSEs) is a top challenge for the healthcare industry. Lawrence General Hospital continues to optimize the RL6 tracking system, implemented in February 2019. The gold standard RL Solutions electronic safety event reporting system is easier and more efficient for the user and for the system administrator. The system is available for all employees and physicians to report on unusual or unexpected safety incidents, near misses and patient complaints and grievances. Department managers automatically receive emails alerting them to incidents that occur in their department. All events are reviewed by risk managers and aggregate data are analyzed for trends and patterns.

> ***A Serious Safety Event (SSE) is a deviation from generally accepted practice or process that reaches the patient and causes severe harm or death.***
> *ASHRM White Paper*[7]

Event reporting is necessary to identify issues, document the investigation, and record any appropriate action plan. It also allows identification of trends that may drive a focused action plan and that may benefit other multi-disciplinary team members. The event reporting system serves as a guide towards process improvement while emphasizing the principles of "just culture" to create a non-punitive environment that is enhanced through education and coaching.

To report an event, a user, who has the option to remain anonymous, categorizes an event, assigns initial severity level (final severity level assigned by risk management only), and provides a brief but detailed description of the event or incident. Demographic information is entered to allow for a focused evaluation. Notifications of new incidents are sent to department managers, who are then asked to review the reported incident in their area and provide appropriate follow-up. During calendar year 2024, 3,674 safety reports were filed. The Risk Management Department reviews each submitted incident to verify that the selected category is correct:



Each week, the Executive Safety Event Review Committee, co-led by the Director of Quality, Medical Education and Population Health and the Director of Risk Management, and with representation from the medical staff, nursing leadership and leadership from Clinical Support Services, convenes. All safety concerns entered into RL6 from the prior week are reviewed which enables members to identify trends, prioritize where to focus resources, assess corrective action plans and formulate safety solutions and system improvements. The incident reporting system is also utilized as a mechanism to record any auditing processes that were recommended to evaluate whether interventions were sustained, and desired outcomes obtained. One charge of the above group, utilizing the information from the RL6 system, is to determine if events qualify for external regulatory reporting to the Department of Public Health, or to the Board of Registration in Medicine as a Safety and Quality Report.

A National Action Plan to Advance Patient Safety

Despite substantial effort over the past 20 years, preventable harm in health care remains a major concern in the United States. Though much evidence-based, effective best practices related to harm reduction have been identified, they are seldom shared nationally and implemented effectively across multiple organizations.
Reducing preventable harm requires a concerted, persistent, coordinated effort by all stakeholders, and a total systems approach to safety. Total systems safety requires coordination at many levels, which in turn necessitates robust collaboration among all stakeholders.

By harnessing the knowledge and insights of influential federal agencies, leading health care organizations, patient and family advocates, and respected industry experts into a set of actionable and effective recommendations, *Safer Together: A National Action Plan to Advance Patient Safety (NAP)* provides clear direction for making significant advances toward safer care and reduced harm across the continuum of care. The Self-Assessment Tool is an essential resource designed to help health care organizations evaluate their safety readiness, identify opportunities for improvement, and track progress over time. The 2024 updated version of the tool aligns with the recommendations in Safer Together: A National Action Plan to Advance Patient Safety (National Action Plan) and incorporates the latest insights and best practices from global safety initiatives. By using the Self-Assessment Tool, health care organizations can better understand their current strengths and challenges, engage interdisciplinary teams, and develop actionable plans to advance patient and workforce safety. The Self-Assessment Tool has been enhanced to align with key national and global frameworks, including:

- The Centers for Medicare & Medicaid Services (CMS) National Quality Strategy
- The CMS Patient Safety Structural Measure (PSSM) and Health Equity Structural Measure (HESM)
- The US Department of Health and Human Services National Action Alliance for Patient and Workforce Safety
- The World Health Organization (WHO) Global Patient Safety Action Plan

Scoring has been revised to reflect stages of maturity: Beginning (Score 1), Making Progress (Score 2), Significant Impact (Score 3), and Exemplary (Score 4); new options for "Unsure" and Score 0 provide greater accuracy in four foundational areas:

- Culture, Leadership, and Governance
- Patient and Family Caregiver Engagement
- Workforce Safety and Well-Being
- Learning System

During Patient Safety Awareness Week in March 2025, leaders from clinical operations completed the assessment survey and results are being interpreted with recommended action plans.

MassHealth 1115 Medicaid Waiver

In December 2022, MassHealth approved the RY2023 acute hospital RFA. The amendment fully establishes the new Clinical Quality Incentive (CQI) program effective January 1, 2023, which will measure hospital clinical performance for MassHealth patients. MassHealth also formalized the interim payment methodology for the new hospital Health Quality and Equity Incentive Program (HQEIP).

The CQI program measures are grouped into four Core Quality Measure Domains that are applicable to all acute hospitals. Further, there are two Specialty Quality Measure Domains that are applicable to those

hospitals that provide certain services. Twenty-six clinical quality measures are specified across these six domains with additional ones being considered for future years. Measure domains include (1) Care Coordination/ Integration, (2) Care for Acute and Chronic Conditions, (3) Patient Safety, (4) Patient Experience, (5) Perinatal Care, and (6) Behavioral Health Care. **(see Appendix A)**

In December 2022, LGH signed the *Hospital Quality and Equity Incentive Program Participation and Collaboration Attestation*. One of MassHealth's key goals in this waiver is to improve quality of care and advance health equity, with a focus on initiatives addressing health-related social needs and health disparities demonstrated by variation in quality performance. MassHealth's Hospital Quality and Equity Incentive Program (HQEIP) aims to incentivize participating private acute hospitals to achieve these goals by 1) attaining complete, beneficiary-reported demographic and health-related social needs data, 2) identifying disparities, analyzing root causes, and intervening on identified disparities to reduce disparities in access and quality outcomes, and 3) establishing organizational capacity for health equity and collaborating with health system and community partners.

All CQI and HQEIP 2025 measures, deliverables, and action plans will be reviewed by the Quality of Care (QOC) committee as a standing agenda item. **(See Appendix B)**

Quality Governance and Leadership Structure

The Board of Trustees, the Quality of Care Committee, Senior Leadership and Medical Staff Leadership, working through the organization's standing committees, will establish priorities for performance improvement. Criteria for prioritization are based on high-volume, high-risk, problem-prone, patient experience and cost-related issues. In addition, data collected from performance improvement and risk reduction activities shall be considered in establishing priorities. Established priorities for improvement will be identified annually.

Prioritization of problems/issues/needs is based upon the following considerations (in decreasing order):

1. Problems/issues/needs with critical impact on patient care;
2. Problems/issues/needs with significant impact on patient care;
3. Problems/issues/needs with financial impact on the organization;
4. Problems/issues/needs with significant impact on public relations;
5. The availability of human resources to investigate/work on the issue or implement the action.

Hospital Level Governance

LGH Board of Trustees (BOT) via the Quality of Care Committee (QOC)

It is the duty of the Board to ensure that patient care is safely delivered within the guidelines established by the medical staff and hospital leadership while meeting all standards and regulations. The BOT, through the

QOC, is responsible for monitoring and reporting on quality of care and organization-wide performance with available resources. The authority to fulfill the goals of improving organizational performance is delegated to, and the responsibility of, the LGH Medical Staff and Hospital Administration with oversight by the QOC.

QOC is a standing medical peer review committee comprised of physicians, senior level administration, and Board members (in accordance with Article IV, Section 7 of the Hospital Bylaws) for the purpose of conducting and providing oversight of medical peer review, quality, patient safety, risk management, patient experience and performance improvement activities (in accordance with Article III, Section 3.1 of the Hospital Bylaws). QOC provides oversight of regulatory requirements and activities related to the Massachusetts Board of Registration in Medicine (BORiM).

Members: LGH Trustees (5-9), CEO/President, Chief Operating Officer (COO), Chief Medical Officer (CMO), Chief Nursing Officer (CNO), Chief Quality Officer (CQO), Medical Dir. for Quality, Dir. of Risk Management, and invited Medical Staff members and hospital staff.

Administration

LGH Administration shall be responsible for fulfilling the goals of improving organizational performance as follows:

1. Allocate resources for development, implementation and ongoing process improvement related to the organization's quality and safety strategies.
2. Ensure that key internal processes and activities throughout the organization are continuously and systematically measured, assessed, shared, and improved.
3. Provide guidance in establishing priorities for performance improvement projects based on established criteria and outcomes.
4. Analyze and assess the effectiveness of the QAPI Plan.

Members: CEO & President and Senior Leadership

Medical Staff Executive Committee (MEC)

The Medical Executive Staff are responsible for the ongoing quality of medical care and professional services provided by all credentialed staff and for providing guidance to organization-wide quality and safety endeavors. At least one member of the medical staff participates in the LGH Quality Assurance Committee. The responsibilities of the Medical Staff Executive Committee (MEC) include, but are not limited to:

- The credentialing process for the medical staff and allied professionals including ongoing professional practice evaluation (OPPE) and focused professional practice evaluation (FPPE)
- Monitoring, assessing, and improving the quality of medical care
- Peer review activities
- Reporting outcomes of their work to the Board of Trustees and Quality of Care Committee.

Members: Medical Staff President, Vice President, Secretary, Treasurer, three at-large members, and the Department Chiefs of Surgery, Medicine, Family Medicine, Obstetrics and Gynecology, Pediatrics, Anesthesiology and Pain Management, Emergency Services, Pathology and Radiology, each of whom shall have voting rights. The Hospital CEO, COO, CMO, CNO, CQO, Director of Risk Management, Director of the Residency Program, Medical Director of Quality, Chair of the Credentials Committee, Director of the Hospitalist Service, and a physician representative of the governing body shall attend the MEC meetings in an ex-officio capacity without a vote. The three at-large members shall be elected by and from the Senior Medical Staff for a one-year term.

Quality Assurance Committee (QAC)

The QAC is a standing committee given delegated responsibility from the hospital leadership team to oversee the ongoing evaluation of quality metrics and appropriateness of care as compared to benchmarks, and to make recommendations to improve care and the patient experience **(see Appendix C)**. The committee receives and evaluates regular departmental and programmatic quality reports on monitored measures and outcomes from organizational leaders. Objectives include:

- Ensure department-level and programmatic-level monitoring of the quality and appropriateness of care using objective and relevant measures based on standards and benchmarks.
- Evaluate safety event reports and recommend follow-up on identified trends.
- Oversee ongoing compliance with infection prevention and control standards and processes.
- Identify and develop performance improvement action plans as indicated by outcomes or noted problems.
- Maintain a reporting schedule for departments and programs to ensure communication and follow up of Performance Improvement activities.

Members: CQO (Chair), COO , CNO, Medical Dir. of Quality, Directors: Emergency Nursing, Ambulatory Svs., Cardiovascular, Infection Prevention/Control, Lab & Radiology, Hospitalist Program, Integrated Care, Nuclear Medicine, Respiratory Therapy, Risk Management, Surgical Services, Professional Development, Pharmacy, Quality Data Measurement & Analytics, Managers; H2, H4, H5, ICU, R2; Performance Improvement Specialists, , Patient/Family Advisors and others as necessary.

Continuous Accreditation and Regulatory Readiness Committee (CARRP)

CARRP provides oversight of compliance with accreditation and regulatory standards related to clinical care as defined by The Joint Commission, the Centers for Medicare and Medicaid Conditions of Participation, and the Department of Public Health licensure requirements and regulations. As a validation of its importance, CARRP reports directly to the QOC. CARRP's main goal is to ensure a continuous organization-wide state of ongoing readiness regarding accreditation and regulatory compliance while fully engaging leaders in the process.

Members: Director of Regulatory Compliance (Co-Chair), CQO (Co-Chair), COO, CMO, CNO, CHRO, Chief Compliance Officer (CCO), Chief IS Officer (CIO), Directors: Laboratory & Radiology Services, Facilities, Emergency Preparedness, Emergency Center, Compliance, Health Information Services, Risk Management, Perioperative Services, Pharmacy, and Physician Services; Performance Improvement Specialists, Manager Infection Prevention and Control, Manager Professional Development and Risk Manager.

Environment of Care Safety Council (EOC Safety Council)

The Environment of Care Safety Council (EOC Safety Council) is interdisciplinary with an overall goal of assessing the potential risk of injury to patients, staff, and visitors, minimizing the risk of loss or damage to facilities or equipment assets, and implementing programs to minimize such risks. The EOC Safety Council also develops, implements, and monitors a comprehensive environment of care safety program. The Committee reports its activities to the QAC. Those activities include:

1. Development and implementation of EOC plans and assessments as required by regulations
2. Identification and implementation of EOC corrective action plans
3. Evaluation of plan outcomes
4. Ongoing environmental surveillance activities, such as environmental rounds
5. Annual review and revision of the Committee's charter as appropriate

Members: LGH Safety Officer (Co-Chair), Director of Regulatory Compliance (Co-Chair), Facilities Building Manager, Directors: Security, Pre-Hospital EMS/ Emergency Preparedness Coordinator, Infection Prevention and Control, Facility Operations, Building Manager, Nuclear Medicine, Pharmacy, Outpatient Services, , Performance Improvement Specialist, Bio-medical Engineering, Laboratory, Manager Occupational Health, Director, EVS, and Risk Management

Executive Safety Event Review Committee

A weekly executive RL6 case review of patient care issues including unexpected outcomes is performed by the COO, CQO, CMO, CNO, CHRO, CIO, Director of Quality, and Director of Risk Management . This group reviews adverse events and assists with responses to events such as root cause analyses. Appropriate cases are then referred to the medical or nursing staff. The incident reporting system is also utilized as a mechanism to record any auditing processes that were recommended to evaluate whether the interventions were sustained, and the desired outcomes obtained. One charge of the above group, utilizing the information within the RL6 system, is to determine if events qualify for external regulatory reporting to the Department of Public Health, or to the Board of Registration in Medicine, as a Safety and Quality Report.

Infection Prevention and Control Committee (IPC)

The Infection Prevention and Control Committee (IPC) is a multidisciplinary committee charged with coordination, implementation and evaluation of a comprehensive infection prevention and control program. The IPC provides advice and guidance to all departments regarding practice of infection control, strategies for surveillance, prevention and control of facility associated infections, antimicrobial resistance, and related events to ensure the safety of clients, visitors, and staff members. IPC also intervenes to enforce infection control policies and procedures which includes initiating and terminating isolation procedures, arranging for appropriate client placement and may include discharging patients from LGH. The IPC also has the authority to plan, monitor and update infection control policies and procedures; surveillance of infections, product evaluation, investigation of infection outbreaks or clusters, and development of infection control procedures for all departments.

Members: Director, Infection Prevention and Control (Co-Chair), Infection Prevention Physician (Co-Chair), Environmental Services, Facilities, IV Team, Materials Management, Nursing Leadership, Occupational Health, Pharmacy, Risk Management, Sterile Processing, Wound Care

Multi-Specialty Peer Review Committee (MSPR)

MSPR is a standing medical peer review committee comprised of physicians from multiple specialties and hospital representatives for the purpose of conducting medical peer review of cases referred from medical departmental meetings, medical staff department chiefs, the Chief Medical Officer, President of the Medical Staff and/or risk management staff. Recommendations from the peer review process are shared with the MEC and the QOC.

Members: Medical Dir. for Quality, Medical Staff President, Chiefs of Services, CNO, CQO, Dir. Of Risk Management.

Medical Staff Peer Review

Peer review is a required process whereby doctors evaluate the quality of their colleagues' work in order to ensure that prevailing standards of care are being met. Medical peer review occurs at medical staff departmental meetings presided over by the Chief of the department. The Chiefs review the cases that are referred to them by the quality/risk management staff and determine the merits of further review at the medical staff department meeting. Cases reviewed may be completely resolved and not require further action or referred to the Multi-Specialty Peer Review Committee for further review or to the Medical Executive Committee for action. Results of quality review and peer review activities are made available to the medical department chiefs for the purpose of review and consideration for medical staff reappointment. The credentialing and privileging process involves a series of activities designed to collect, verify, and evaluate data relevant to a practitioner's professional performance. These activities serve as the foundation

for objective, evidence-based decisions regarding appointment to membership on the medical staff, and recommendations for renewed privileges.

Ongoing & Focused Professional Practice Evaluation (OPPE/FPPE)

Ongoing Professional Practice Evaluation (OPPE) is a process designed to continuously evaluate practitioner performance. The process requires the medical staff to conduct an ongoing evaluation of each practitioner's professional performance. The process allows potential problems to be identified, resolved, and fosters an efficient evidence-based privilege renewal process. Physician/provider attribution is the foundation to develop accurate physician specific data that will serve as the basis of the OPPE provider feedback reports. The data is based on the type of privileges granted, and relevant to the procedures performed and medical conditions managed. The data is pulled from a myriad of sources and displayed on a "provider feedback report." The medical staff department chief approves the data elements for their department. As physician-specific data is gathered, feedback reports are provided to both the physician and the Chief and reviewed on a regular basis. OPPE feedback reports are distributed every 6 months to over 500 credentialed providers. Data is identified for each of the categories required by The Joint Commission. The "provider feedback report" is placed in the provider's quality file in the Medical Staff Office. The Chief has the authority and responsibility to identify when a practice pattern issue should be addressed. At the time of reappointment, the provider feedback report and other data are reviewed by the Credentials Committee members, who make a recommendation to the Board of Trustees.

Focused Professional Practice Evaluation (FPPE) is used when a practitioner has the credentials to suggest competence, but additional information or a period of evaluation is needed to confirm competence in the organizational setting or if questions arise regarding a practitioner's ongoing professional practice during the course of the OPPE review. Aggregate results of peer review activities are summarized and reported to the MEC and the QOC. Results of peer review activities may also be utilized in the hospital's quality, patient safety, and peer review program to improve organizational performance.

Nursing Practice and Quality Council (NQQC)

The NPQC provides oversight for the development, implementation, and evaluation of nursing practice in accordance with regulatory requirements and evidence-based practice. The Council:

- Coordinates quality improvement efforts across patient care services
- Fosters a spirit of inquiry related to clinical practice
- Provides a venue for collaboration and information sharing between all others who develop patient care standards
- Reviews and revises policies, procedures, and standards of care
- Consults on interdepartmental issues that impact patient care
- Participates in the adoption of new clinical products and equipment
- Provides input for the revision and approval of nursing documentation standards

- Supports peer review
- Recognizes achievements in nursing practice

Members: Director Professional Development (Co-Chair), Performance Improvement Specialist (Co-Chair), Manager Infection Control, Population Health, Emergency Nursing, Surgical Nursing, Nurse Managers, Professional Development Specialists, Nurse Informaticists, Unit-based Practice Council Chairs.

Patient Experience Steering Committee (PXC)

The Patient Experience Steering Committee is responsible for developing a patient-centered comprehensive strategy focused on improving the patient and employee experience. PXC members strive to gain a clear understanding of what matters to our patients, set clear and accurate expectations with patients and employees, and identify key drivers of the patient experience to improve outcome measures associated with communication, responsiveness, and patient loyalty. The PXC develops strategies to improve the patient experience and satisfaction and leads implementation efforts.

Members: CNO (Co-Chair), Patient Advocate (Co-Chair), CQO, Directors: Ambulatory Services, Facilities, Hospitalist Service, Laboratory & Radiology, Pharmacy, Manager Professional Development, ED Physician, GLHC representative, Medical Affairs representative, Nurse Directors, Nurse Managers, Performance Improvement Specialist, Registration representative, Security representative, Volunteer Services representative.

Patient and Family Advisory Council (PFAC)

The Patient and Family Advisory Council (PFAC) is intended to facilitate patient and family participation in hospital care and decision-making, information sharing, and policy and program development. The PFAC embraces the Institute for Family Centered Care core concepts of dignity and respect, information sharing, participation, and collaboration. PFAC advises the hospital on matters including, but not limited to, patient and provider relationships, quality improvement initiatives, and patient education on safety and quality to the extent allowed by state and federal law. Annually on October 1, the hospital prepares a written report documenting the hospital's compliance with 105 CMR 130.1800 and 130.1801 and describing the Council's accomplishments during the preceding year. The hospital also makes the reports required in 105 CMR 130.1800(A)(2) & (3) publicly available through electronic or other means, and to the Department of Public Health upon request.

Members: CNO (Co-Chair), Manager, Volunteer (Co-Chair), CEO, CQO, President of Medical Staff, Patient Advocate, Volunteer Representative, Community Advisor, and several Patient-Family Advisors.

Workplace Violence Committee (WPV)

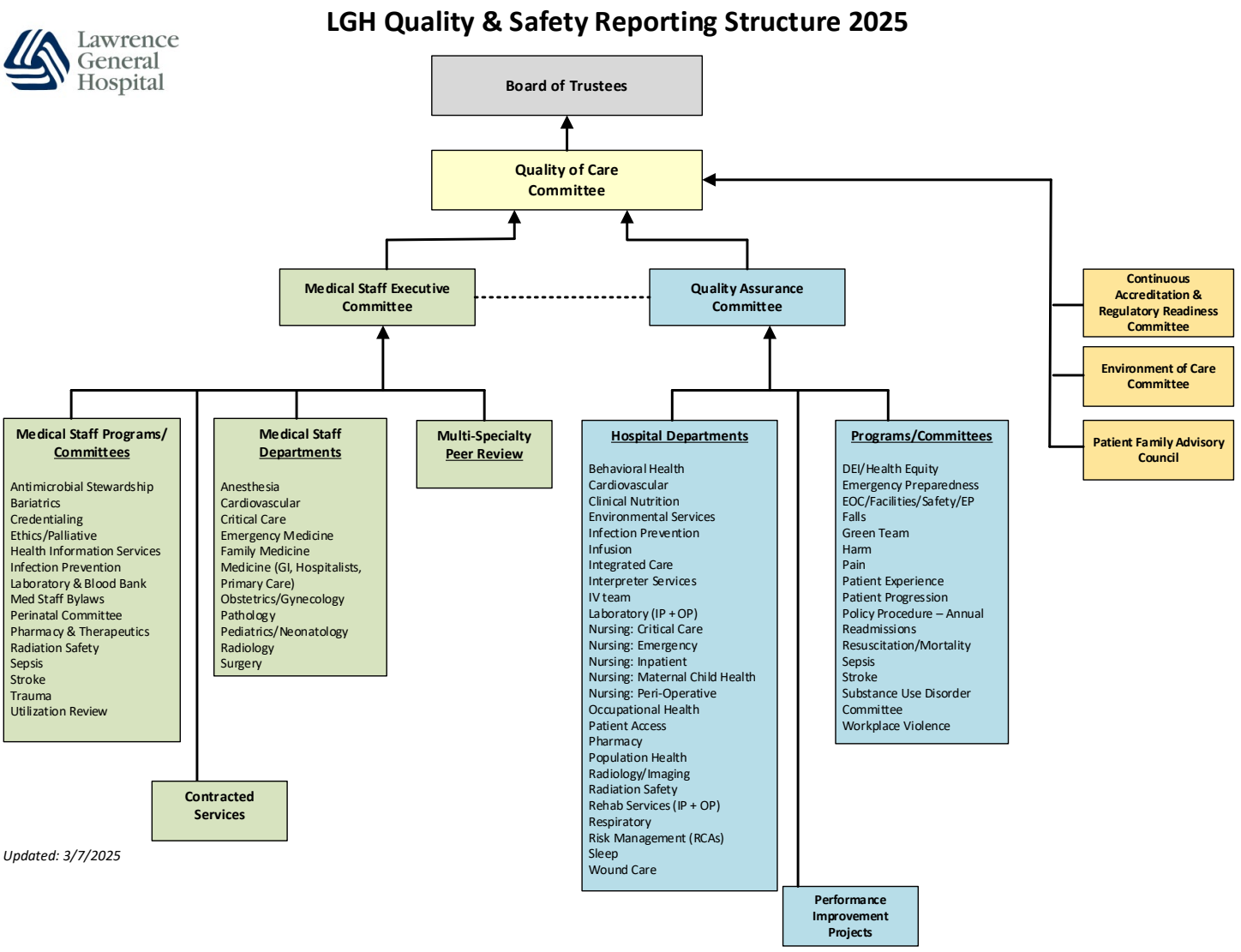
The Workplace Violence Prevention Committee ensures appropriate measures are taken to provide a safe and secure work environment for all Lawrence General Hospital staff, providers, patients, volunteers, and visitors. This includes developing policies and procedures to prevent threatening or intimidating conduct and actual violence within the hospital setting.

Members: Director Public Safety (Co-Chair), Chief Human Resources Officer (Co-Chair), CNO, CQO, Directors: Ambulatory Services, Security, Emergency Center, Integrated Care, Risk Management, Marketing and Communications, Nurse Managers, Manager Occupational Health, Patient Advocate, Performance Improvement Specialist, and selected staff members.

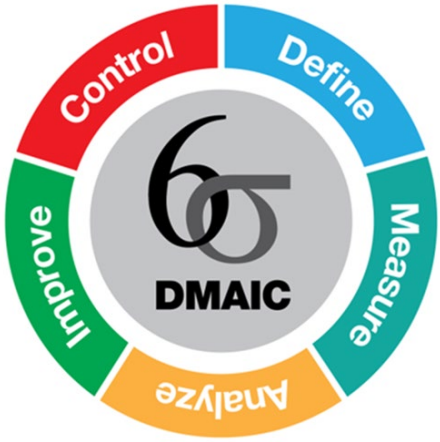
Quality Department and Data Measurement & Analytics

The Quality Department's Mission is to catalyze continual improvement in the quality and experience of care for our patients and its Vision is to drive meaningful and sustainable improvements in quality and patient experience by helping create a shared desire by everyone in the organization to improve the system of care. The functions of the Quality Department include patient advocacy, accreditation and regulatory readiness and response, infection prevention and control, supporting the patient experience, patient safety, performance improvement, risk management, and quality measurement, analytics, and reporting. The collection, aggregation, analysis, and presentation of quality data from multiple data sources is complex and labor-intensive. LGH data measurement includes submissions to the Centers for Medicare and Medicaid (CMS) for value-based purchasing, the Joint Commission, MassHealth pay-for-performance, commercial insurance companies, the Leapfrog Safety Grade, and a number of specific service lines including the Cath Lab, Bariatrics, Maternity, Primary Stroke Service, American College of Pathology, National Databases for Nursing Quality Indicators, etc.

2025 Quality and Patient Safety Reporting Structure and Information Flow



Performance Improvement Principles, Model for Improvement & Change Management, and 2025 Goals



Improving the quality of care, enhancing patient safety, patient satisfaction and the patient experience requires the ability to implement improvements to processes of care and services provided to patients and their family members. This Plan incorporates classic quality improvement principles and draws upon techniques developed by recognized leaders in process improvement, Shewhart, Deming, Codman, Smith, and organizations such as the Institute for Healthcare Improvement (IHI), Association of Healthcare Research and Quality (AHRQ), National Quality Forum (NQF) and the Institute of Medicine (IOM). The following Performance Improvement Projects were identified as priorities in CY24:

- Pain Management
- Improving Average Time from EC to Inpatient Once Bed Assigned
- Medication Reconciliation
- Transition Record
- Interventions Provided or Offered for Alcohol Use
- Treatment Provided or Offered at Discharge for Alcohol & Other Drug Use Disorder

Six Sigma

The organization primarily utilizes the process improvement methodology Six Sigma. 6σ is a set of techniques and tools for process improvement. It was introduced by American engineer Bill Smith while working at Motorola in 1986. A six sigma process is one in which 99.99966% of all opportunities to produce some feature of a part are statistically expected to be free of defects. Six Sigma strategies seek to improve quality by identifying and removing the causes of defects and minimizing variability in processes. This is done by using empirical and statistical quality management methods and by hiring people who serve as Six Sigma experts. In 2021, LGH onboarded a new CQO and two Performance Improvement Specialists, all trained in Six Sigma.

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THE DMAIC PROCESS

Define the problem, improvement activity, opportunity for improvement, the project goals, and customer (internal and external) requirements.

- Project charter to define the focus, scope, direction, and motivation for the improvement team
- Voice of the customer to understand feedback from current and future customers indicating offerings that satisfy, delight, and dissatisfy them
- Value stream map to provide an overview of an entire process, starting and finishing at the customer, and analyzing what is required to meet customer needs

Measure process performance.

- Process map for recording the activities performed as part of a process
- Capability analysis to assess the ability of a process to meet specifications
- Pareto chart to analyze the frequency of problems or causes

Analyze the process to determine root causes of variation and poor performance (defects).

- Root cause analysis (RCA) to uncover causes
- Failure mode and effects analysis (FMEA) for identifying possible product, service, and process failures
- Multi-vari chart to detect different types of variation within a process

Improve process performance by addressing and eliminating the root causes.

- Design of experiments (DOE) to solve problems from complex processes or systems where there are many factors influencing the outcome and where it is impossible to isolate one factor or variable from the others
- Kaizen event to introduce rapid change by focusing on a narrow project and using the ideas and motivation of the people who do the work

Control the improved process and future process performance.

- Quality control plan to document what is needed to keep an improved process at its current level by using statistical process control (SPC) for monitoring process behavior
- 5S to create a workplace suited for visual control
- Mistake proofing (poka-yoke) to make errors impossible or immediately detectable

Lawrence General Hospital

2025 LGH Quality and Patient Safety

Top Performance Improvement Goals

Staff Safety

- Develop Workplace Violence Diver Diagram based on Joint Commission Standards
- Develop standardized work as response to an event.
- Establish a Behavioral Health Response Team
- Complete AVADE training on all of EC, EMS, Nursing Assistants, and PSMs.
- Provide education and policy regarding lateral violence, bullying, civility, and respect in the workplace for internal and external stakeholders

Patient Satisfaction and Experience

- Update and improve NRC data aggregation and visual data presentation for key stakeholders.
- Improve the following domains from the Hospital Consumer Assessment of Healthcare Providers and Systems Survey (HCAHPS) measures from fiscal year 2024 average to at least the CMS achievement threshold.

Domain	FY24 Avg %	FY27 CMS Benchmark %	FY27 CMS Achievement Threshold %	LGH Goal	% Increase Needed – FY24 Avg to FY27 Target
Communication with Nurses	77.6	**86.3**	**77.3**	**78**	1%
Communication with Doctors	78.3	**86.3**	**77.5**	**78**	1%
Communication about Medications	60.2	**70.1**	**58.1**	**59**	1%
Hospital Cleanliness and Quietness	54.9	**77.7**	**63.4**	**64**	10%
Discharge Information	85.8	**91.5**	**86**	**87**	2%
Overall Rating of Hospital	63.2	**84**	**68.8**	**69**	6%

Infection Prevention and Control

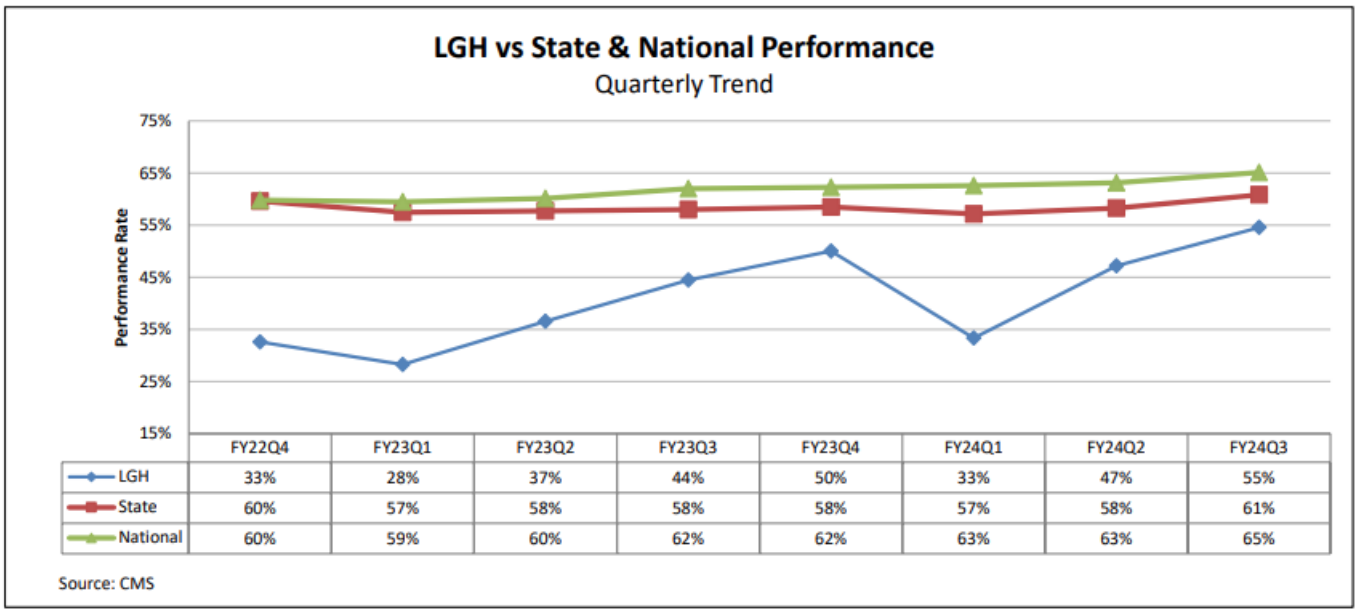
- Continue to maintain and improve rates/standardized infection ratios (SIR) for key hospital acquired infection measures per table below:

Measure	FY24	LGH Goal*
Catheter Associated Urinary Tract Infections (CAUTIs)	**0.365**	SIR ≤ 1.0
Central Line Associated Blood Stream Infection (CLABSI)	**0.000**	SIR ≤ 1.0
Clostridium Difficile Infection (C. diff)	**0.155**	SIR ≤ 1.0
Surgical Site Infections (SSI);	**1.429**	SIR ≤ 1.0
Methicillin Resistant Staph Aureus Infection (MRSA)	**0.464**	SIR ≤ 1.0
Hand Hygiene Compliance – all patient care departments	**Goal Met**	100 observations per department per quarter**

*Based on Centers for Disease Control National Health Safety Network
**Considerable achievement for Leapfrog Survey

Sepsis

- Meet or exceed state and national sepsis bundle compliance rates



	FY22Q4	FY23Q1	FY23Q2	FY23Q3	FY23Q4	FY24Q1	FY24Q2	FY24Q3
LGH	33%	28%	37%	44%	50%	33%	47%	55%
State	60%	57%	58%	58%	58%	57%	58%	61%
National	60%	59%	60%	62%	62%	63%	63%	65%

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Proactive Risk Assessment

Lawrence General Hospital consistently seeks to reduce the risk of patient harm events by conducting proactive risk assessments. The purpose of the assessment is to identify a problem prone process, estimate how likely it is to occur, pick the most likely outcome, and prioritize improvement opportunities. LGH closely monitors its compliance with Joint Commission's National Patient Safety Goals. This proactive approach is undertaken so that processes, functions, and services can be designed or redesigned to prevent harm to patients.

In addition, a minimum of two Failure Mode Effects and Analysis (FMEA) will be conducted at least once a year. This method of identifying and preventing potential failures before they occur is designed to enhance patient safety through a proactive process. It acknowledges that errors are inevitable and preventable and anticipates errors to minimize their impact. The following FMEAs were completed in CY24:

- 911 and Phone Outage
- Meditech Downtime
- Santagati Building /Surgical Services Water Shutdown
- Radiation Safety/Exposure

FMEA- key

KEY:

Effect	SEVERITY of Effect	Ranking
Hazardous without warning	Very high severity ranking when a potential failure mode affects safe system operation without warning	10
Hazardous with warning	Very high severity ranking when a potential failure mode affects safe system operation with warning	9
Very High	System inoperable with destructive failure without compromising safety	8
High	System inoperable with equipment damage	7
Moderate	System inoperable with minor damage	6
Low	System inoperable without damage	5
Very Low	System operable with significant degradation of performance	4
Minor	System operable with some degradation of performance	3
Very Minor	System operable with minimal interference	2
None	No effect	1

PROBABILITY of Failure	Failure Prob	Ranking
Very High: Failure is almost inevitable	>1 in 2	10
	1 in 3	9
High: Repeated failures	1 in 8	8
	1 in 20	7
Moderate: Occasional failures	1 in 80	6
	1 in 400	5
	1 in 2,000	4
Low: Relatively	1 in 15,000	3
	1 in 150,000	2
Remote: Failure is unlikely	<1 in 1,500,000	1

On an ongoing basis, the Chief Quality Officer involves, as appropriate, members of the medical staff, senior leadership, hospital managers and hospital staff in risk analyses of major medical services/processes. Risk Management and Quality and Patient Safety Department staff collect error-reduction data from benchmark healthcare organizations and other industries. This information includes, but is not limited to, the following:

- Joint Commission Sentinel Event Alerts
- ISMP Medication Safety Alerts
- CDC Bulletins
- CMS Quality Reporting Programs
- Debriefings
- Daily Safety Huddles
- RCA
- FMEAs

Reappraisal

The objectives, plan, scope, organization, and effectiveness of the activities to assess and improve the quality of the services provided will be appraised at least annually to assure that this program is achieving its objectives and demonstrating impact and improvement. Recommendations will be brought to the Chief Medical Officer and Chief Nursing Officer for consideration.

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Appendix A
1115 Waiver Clinical Quality Indicators

Core Domain Quality	Measure ID#	Measure Steward: Measure Name
Care Coordination/Integration		
	CCM-1	CMS: Reconciled medication list received by discharged patient
	CCM-2	CMS: Transition record with specified data elements received by discharge patient
	CCM-3	CMS: Timely transmission of transition record within 48 hours at discharge
	CCI-1	NCQA PCR: Plan All-Cause Readmissions Adult (7-Day and 30-Day) - Treated as two-sub measures or 1 measure
	PED-1	Pediatric All-Condition Readmission Measure (NQF2393)
	CCI-2	NCQA FUM: Follow-up After ED Visit for Mental Illness (NQF 3489) (7-Day and 30-Day) - Treated as 1 measure which includes 2 sub-measures
	CCI-3	NCQA FUA: Follow-up After ED Visit for Alcohol or Other Drug Abuse or Dependence (NQF 3488) (7-Day and 30-Day) - Treated as 1 measure which includes 2 sub-measures
Care for Acute and Chronic Conditions		
	SUB-2	TJC SUB-2: Alcohol Use – Brief Intervention Provided or Offered (NQF 1664)
	SUB-3	TJC SUB-3: Alcohol & Other Drug Use Disorder – Treatment provided/offered at Discharge (NQF 1663)
	OP-1e	CMS 506v5: Safe Use of Opioids – Concurrent Prescribing (NQF 3316e)
	PED-2	Pediatric measure in lieu of Sub-2 NQF 0058: Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis
	PED-3	Pediatric measure in lieu of Sub-3 Bronchodilator use in the ED and in-patient settings, with reductions in chest radiography, viral testing, and antibiotic use
Patient Safety		
	PSI-90	AHRQ: Patient Safety and Adverse Events Composite
	HAI-1	CDC: Central Line-Associated Bloodstream Infection (CLABSI)
	HAI-1	CMS: CLABSI – Pediatric ICU
	HAI-2	CDC: Catheter-Associated Urinary Tract Infection (CAUTI)

	HAI-3	CDC: Methicillin-Resistant Staphylococcus Aureus bacteremia (MRSA)
	HAI-4	CDC: Clostridium Difficile Infection (CDI)
	HAI-5	CDC: Surgical Site Infections: Colon and abdominal hysterectomy surgeries (SSI)
Patient Experience		
	HCAHPS	AHRQ: Hospital Consumer Assessment of Healthcare Provider Systems Survey (HCAHPS) This measure includes 7 survey dimensions: 1) nurse communication, 2) doctor communication, 3) responsiveness of Hospital staff, 4) communication about medicines, 5) discharge information, 6) overall rating and 7) three item care transition.
Perinatal Care		
	MAT-4	TJC PC-02: Cesarean Birth, NTSV (NQF 0471)
	NEWB-3	TJC PC-06: Unexpected Newborn Complications in Term Infants (NQF 0716)
	PMSM-1	EOHHS: Perinatal Morbidity Structural Measure (Note: PMSM-1 includes a survey question that aligns with the CMS (00418) Maternal Morbidity Structural Measure)
Behavioral Health Care		
	BHC-1	NCQA FUH: Follow-up After Hospitalization for Mental Illness (NQF 0576) (7-Day and 30-Day) – Treated as 1 measure which includes 2 sub-measures
	BHC-2	CMS IPFQR: Medication Continuation Following Inpatient Psychiatric Discharge (NQF3205)
	BHC-3	CMS IPFQR: Screening for Metabolic Disorders (SMD)

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Appendix B
HQEIP Year 3 (CY25)

Domain 1: Demographic and Health-Related Social Needs (HRSN) Data

Measure	Hospital Deliverable	Anticipated Due Date Hospital	ACO/MCO Deliverable	Anticipated Due Date ACO/MCO
RELDSOGI Data Completeness	Enhanced Demographics Data File	Quarterly	RELDSOGI Member Data Set	Monthly
RELDSOGI Data Completeness	RELDSOGI Mapping & Verification	September 1, 2024	RELDSOGI Mapping & Verification	September 1, 2024
HRSN Screening	HRSN Screening Data: Supplemental File	June 30, 2025	HRSN Screening Data: Supplemental File	June 30, 2025

Domain 2: Equitable Quality and Access

Measure	Hospital Deliverable	Anticipated Due Date Hospital	ACO/MCO Deliverable	Anticipated Due Date ACO/MCO
Quality Performance Disparities Reduction	Stratified Performance Report	After March 31, 2025	Stratified Performance Report	After March 31, 2025
Equity Improvement Interventions	PIP2 Mid-year Planning Report	November 12, 2024	PIP2 Mid-year Planning Report	November 12, 2024
Equity Improvement Interventions	PIP1 Planning (Baseline) Report Resubmission	August 30, 2024	PIP1 Planning (Baseline) Report Resubmission	August 30, 2024
Equity Improvement Interventions	PIP2 Planning (Baseline) Report	March 30, 2025	PIP2 Planning (Baseline) Report	March 30, 2025
Language Access	Language Services Self-Assessment Survey	January 31, 2025	Language Services Self-Assessment Survey	March 31, 2025
Language Access	Language Access Data: Supplemental File	June 30, 2025	Language Access Data:	June 30, 2025 (ACO)

Measure	Hospital Deliverable	Anticipated Due Date Hospital	ACO/MCO Deliverable	Anticipated Due Date ACO/MCO
			Supplemental File	September 1, 2025 (MCO)
Disability Accommodation Needs	Disability Accommodation Needs Data: Supplemental File	June 30, 2025	N/A	N/A
Disability Accommodation Needs	Disability Accommodation Needs Report	March 31, 2025	Disability Accommodation Needs Assessment Report	January 31, 2025
Disability Competent Care	N/A	N/A	Disability Competent Care Training Plan	May 1, 2024
Disability Competent Care	Disability Competent Care Training Report	March 31, 2025	Disability Competent Care Training Report	March 31, 2025

Domain 3: Capacity and Collaboration

Measure	Hospital Deliverable	Anticipated Due Date Hospital	ACO/MCO Deliverable	Anticipated Due Date ACO/MCO
Patient Experience : Communication, Courtesy, and Respect	Patient Experience : HCAHPS Data	June 30, 2025	Member Experience Assessment Report	March 31, 2025
External Standards for Health Equity	TJC Health Care Equity Certification Report	January 31, 2025	External Standards for Health Equity Report	January 31, 2025

Supporting Health Equity Deliverables

Hospital Deliverable	Anticipated Due Date Hospital	ACO/MCO Deliverable	Anticipated Due Date ACO/MCO
Health Quality and Equity Strategic Plan	December 31, 2024	Health Quality and Equity Strategic Plan	December 31, 2024

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Appendix C
Quality Assurance Committee
Data Inventory

Behavioral Health	
	Follow-Up w/in 7 Days after ED Visit for Mental Illness (FUM,GLFHC-attributed C3 ACO Members) #
	Average ED Boarding Time in Hours
	Ratio of BH Follow-Up Calls Completed VS BH Consults Completed
	Time from Medical Clearance to BH Consult (Future)
Cardiovascular	
	Improve on decreasing LOS for AMI
	Improve on decreasing LOS for STEMI
	Improve on decreasing LOS for Uncomplicated STEMI
	Door to Balloon Time
	Door to EKG Time: STEMI, All Other ACS, EMS to EKG (STEMI only)
	Cath PCI Registry: Composite Medications at Discharge, LOS Uncomplicated STEMI
	Chest Pain Accreditation: Arrival to Initial Troponin Result
	Heart Failure Accreditation: Daily Weights
Clinical Nutrition	
	Reduce Rate of Moderate Hypoglycemia Events
	Reduce Rate of Severe Hypoglycemia Events
	Improve user ability to estimate placement during bedside NG Tube Placement with CORTRAK
	Fire Suppression (1x)
Environmental Services	
	Room Turnover Times (Future)
	HCAHPS Score: Room Kept Clean During Stay
	ATP Testing (Future)
Infection Prevention	
	HAIs: CLABSI, CAUTI, MRSA, C. DIFF, SSI, VAE (SIR & SUR)
	Hand Hygiene
Infusion (Ambulatory Service)	
	Monitor insurance eligibility completion & infusion booking within 48 hours of infusion order request
	Transition from Paper Based to EMR
Integrated Care	
	Implement Plan to Screen for Social Drivers of Health
	Timely Screening & ID of Care Needs
	Compliance rate of daily SNAP documentation
Interpreter Services	
	Monitor compliance rate of preferred language & written language capture
	Ensure Equitable Access to Quality Linguistic Services
IV Team	
	Central Line Dressing labeled with Date/Time
	Central Lines have Disinfectant Caps on all Catheters
	Central Line Checklist Completed
Laboratory (IP & OP)	
	Blood Bank Product Wastage: FFP
	Blood Culture Contamination
	Patient Identification/Includes Offsite
Nursing: Emergency	

	TAR Documentation Compliance
	Reduce total number of violent restraint events
	Pediatric Vital Signs Compliance
	Reduce total number of Falls w/ Injury
	Reduce total number of Falls
Nursing: H2, H4, R4	
	Improve on Pain Reassessment Compliance
	Reduce Falls
	Reduce HAPI
Nursing: ICU & Telemetry	
	Improve on Pain Reassessment Compliance
	Reduce Falls
	Reduce HAPI
	Reduce # of Non-Violent Restraint events
Nursing: L&D	
	Medication Scanning
	Post-Op Temperature Control-Use of Bair Hugger
	Pre-Op Checklist Compliance
Nursing: MCH (Pedi)	
	Pain Reassessments
	Medication Scanning
	Asthma Education Compliance
	NAS Documentation
Nursing: MCH (Maternity & Newborn)	
	Medication Scanning both units
	Pain Reassessments Maternity
	MA Newborn Screening Report
Nursing: MCH (SCN)	
	Medication Scanning
	MA Newborn Screening Report
	Procedural Time Out Compliance
Nursing: Perioperative	
	Average Room Turnover Time
	Monthly First Case On Time Starts Trend
	Pre-Procedure Checklist: Handoff Documentation Completion for Surgical Patients
Occupational Health	
	Workplace Injuries: DART Rate
	Annual TB Education & Screenings
	N95 Compliance
Patient Access	
	Spoken Language: <0.10% records have "unknown" listed
	Patient Identification
	Advance Directives
Pharmacy	
	Smart Pump Dose Error Reduction Software Usage Rate
	Med Events: Incorrect Dose
	Med Events: Incorrect Dose & Med Not Available
Population Health	
	ACO Quality Metrics/Performance
	CMA Patients Screened for SDOH
	Community Engagement
Radiology/Imaging	

	Mammography: No Show Trend Routine Screenings
	Mammography: No Show Trend Diagnostics
Radiation Safety	
	CT: Patient Dose Alerts
	Cath Lab & IR Alerts
	Staff Radiation Exposure
Rehabilitation: OP/Ambulatory	
	No Show Rate: AMC/YMCA/Marston St./Dorchester/Brighton
	Patient Satisfaction: Net Promoter Score
	Average Percentage Improvement on Validated Clinical Outcome Tools: Functional Outcomes
	Percentage of Patients with Goals Mostly or Completely Met at Discharge: Not Available going forward
Rehabilitation: IP/Inpatient	
	PT Consults within 24 Hours
	OT Consults within 24 Hours
	SLT Consults within 24 Hours
Respiratory	
	Patient Assessed for Pause in Sedation
	Spontaneous Breathing Trial
	Paired SV & SBT
Risk	
	Safety Events: General Event Types with Top 3
	Safety Events: Specific Event Types with Top 3
	SREs
	RCA Action Plans
Sleep: Lab & Clinic	
	Total Referrals for Sleep Lab
	Lead time from referral to patient appointment
	No Call No Show Rates
	Lead time from referral to patient appointment
	No Call No Show Rates
Wound Care	
	Decrease HAPI All Units

PROGRAMS & COMMITTEES

DEI/Health Equity	
	Readmission Rates by Interpreter Needed/Not Needed
	30-Day Mortality Rates by Race
	Ambulatory Health Disparities
	MassHealth HQEIP Metrics: RELD, SOGI, HRSN Screening Rates
EOC/Facilities/Safety/Emergency Preparedness	
	EOC Semi-Annual Report 2x/Year
Falls	
	Reduce overall Inpatient/Outpatient Falls
	Reduce overall Inpatient/Outpatient Falls w/ Injury
	Reduce inpatient (Med Surg/C Care) Falls
Green Team	
	Reduce Carbon Emissions by 50% in 2030
Harm	

	Harm Dashboard
Pain	
	Pain Assessment and Reassessment Opioid Administration requiring Narcan reversal
Patient Experience	
	Patient Experience Dashboard by Domain
Patient Progression	
	LOS for all inpatient units Discharges before 3p patients going home self-care Discharges before 12 noon patients going home self-care
Policy & Procedure	
	Annual Report
Readmissions	
	Reduce Medicare AMI 30-day readmissions Reduce Medicare HF 30-day readmissions Reduce Medicare COPD 30-day readmissions
Resuscitation & Mortality	
	Rapid Response Documentation Compliance Meditech Decrease # Rapid Response Calls Transferred to Higher Level of Care Decrease # Readmission back to ICU w/in 24 hours transfer out Mortality Rates
Sepsis	
	Performance by FY Staff Completion Sepsis Education Provider Completion Sepsis Education
Stroke	
	Stroke Risk Factor Documentation Dysphagia Screen Documentation Follow up phone calls dc'd stroke patients GWTG Stroke Dashboard TJC PSC Stroke Dashboard
Substance Use Disorder Committee	
	*metric under development
Workplace Violence	
	AVADE Training Total # of Injuries w/ Lost Time Total # of Events by Location: EC vs Inpatient Total # of Events by Month

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