



Quality Leader Resource Playbook

Potentially Important Issues	Notes	☒
<u>Within the first 30 days:</u> <u>Job Description</u> – Review a copy of your job description and understand how you will be evaluated. <u>Establish Internal Stakeholder Relationships:</u> Internal Stakeholders • CEO • CMO • CNO • COO • Quality Director • Patient Safety Officer • Infection Prevention Lead • Accreditation/Regulatory Lead • Risk Manager • Clinical Informatics Lead • Data Analytics Lead • Revenue Cycle/Medicare Lead		☐

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- Medicaid/Reimbursement Lead External Stakeholders - WHA Quality Team & CheckPoint Admin Registration quality@wha.org - ForwardHealth WI Medicaid Program Admin ForwardHealth Portal - NHSN Facility Administrator National Healthcare Safety Network (NHSN) Wisconsin Department of Health Services - QualityNet Administrator QualityNet Home - HCAHPS Vendor Contact - Accrediting Body		
<u>Regulatory/Accreditation</u> Regulatory Requirements: Wisconsin hospitals must comply with the federal Medicare Conditions of Participation (42 CFR Part 482) to participate in the Medicare and Medicaid programs. Hospitals are surveyed against these requirements using the CMS State Operations Manual, Appendix A (Hospitals), while Critical Access Hospitals are surveyed using Appendix W (Critical Access Hospitals). Wisconsin hospitals must also comply with applicable state requirements, including Wisconsin Statutes Chapter 50, Subchapter II (Hospitals) and Wisconsin Administrative Code DHS 124 (Hospitals). 1. Are you also accredited by another body (Ex: The Joint Commission, DNV, etc)?		☐

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2. Does your hospital have any specialty certifications? 3. When was the last survey? 4. When is the next survey anticipated? 5. What were the results of the last survey? (get a copy) 6. Are there any outstanding corrective action plans that need to be completed? 7. Is there a process/committee to ensure ongoing readiness? 8. Get familiar with all the standards and regulations related to quality. 9. Find out your role in all the above. 10. Locate the manual, either paper or online and learn to navigate it. 11. Is your Lab surveyed by the same or a different body, and when is their next survey? 12. Are there any other specialty accreditations or certifications you should know about?		
Key Resources and Links: • CMS Conditions of Participation - eCFR :: 42 CFR Part 482 -- Conditions of Participation for Hospitals • State Operations Manual (SOM) Appendix A – Survey Protocol, Regulations and Interpretive Guidelines for Hospitals: https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/som107ap_a_hospitals.pdf • State Operations Manual (SOM) Appendix W – Survey Protocol, Regulations and Interpretive Guidelines for Critical Access Hospitals (CAHs) and Swing Beds in CAHs: https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/som107ap_w_cah.pdf • Wisconsin State Statutes: • Chapter 50 – Hospital Licensing - https://docs.legis.wisconsin.gov/statutes/statutes/50 • Chapter 124 – Hospital Standards - http://docs.legis.wisconsin.gov/code/admin_code/dhs/110/124/_2 • Wisconsin Division of Quality Assurance - https://www.dhs.wisconsin.gov/dqa/index.htm		

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• Hospital Survey Guide - https://www.dhs.wisconsin.gov/publications/p6/p62033.pdf • Accreditation Bodies: • Joint Commission - Home Joint Commission • DNV - Healthcare Certification and Hospital Accreditation services by DNV • Accreditation Commission for Health Care (ACHC), merged with HFAP - https://www.achc.org/about-accreditation/ Helpful Hints: • The WI Division of Quality Assurance performs surveys for the state and CMS. All surveys are unannounced. Causes for an unannounced survey include a complaint survey, a certification survey every 18-36 months (if you are not accredited by another body), or an accreditation validation survey. • If your hospital is accredited, it's important to know who you are accredited by, and where you are in the cycle of unannounced surveys. If your organization is accredited by the Joint Commission, DNV or ACHC, and you have agreed to share a copy of your survey findings with CMS, then you have "CMS deemed status." If you have deemed status, you will not get a regularly scheduled state survey, however, you may be randomly selected for a state validation survey following your accreditation survey. • Hospitals with specialized certification services or programs like stroke, rehab, ECHO, sleep lab, etc. would have a separate survey. These are usually scheduled surveys, so you will have more notice.		
<u>CMS Reporting Requirements & Quality Reporting Programs</u> Quality reporting and benchmarking are essential activities that support quality improvement, patient safety, regulatory compliance, transparency, and health equity. Hospital quality leaders should understand the reporting requirements applicable to their organization, the systems used for data submission, and the individuals responsible for reporting activities.		

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Critical Access Hospitals (CAHs) Critical Access Hospitals (CAHs) are not subject to many of the CMS quality reporting and value-based payment programs that apply to hospitals paid under the Inpatient Prospective Payment System (IPPS). However, CAHs are required to participate in the Medicare Promoting Interoperability Program, unless eligible for an approved exception, to avoid Medicare payment adjustments. The program focuses on the use of Certified Electronic Health Record Technology (CEHRT), interoperability, and the electronic exchange of health information. CAHs are also encouraged to participate in voluntary quality reporting initiatives, including the Medicare Beneficiary Quality Improvement Project (MBQIP), which supports quality improvement, benchmarking, and performance measurement efforts. Many Wisconsin CAHs participate in MBQIP and other reporting activities to support organizational improvement and eligibility for certain grant opportunities. QualityNet & CMS Reporting Systems QualityNet is CMS's primary website for quality reporting programs. It provides access to measure specifications, reporting guidance, educational resources, preview reports, data submission tools, deadlines, and program communications.	•	

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Every hospital should identify and maintain the following roles and access: • Who is the hospital's QualityNet Security Administrator? • Who serves as the backup QualityNet Security Administrator? • Do you have an active HARP (HCQIS Access Roles and Profile) account and multifactor authentication configured? • Do you have access to the Hospital Quality Reporting (HQR) system and relevant CMS applications? • Who is responsible for submitting data to CMS quality reporting programs? • Who reviews CMS preview reports before public reporting on Care Compare? • Who oversees Medicare Promoting Interoperability reporting activities? • Who manages eCQM submission and validation activities? CMS Hospital Quality Reporting Programs Most hospitals participate in one or more CMS quality reporting programs. Understanding which programs apply to your organization is an essential responsibility of the quality leader. Program requirements, measure specifications, reporting deadlines, educational materials, and data submission resources are maintained through QualityNet.		

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Hospital Inpatient Quality Reporting (IQR) Program The Hospital Inpatient Quality Reporting (IQR) Program is a CMS quality reporting program for hospitals paid under the Inpatient Prospective Payment System (IPPS). Hospitals submit quality data that are used for public reporting and support other CMS payment and quality programs. Questions to consider: • Does our hospital participate in the IQR Program? • Which IQR measures are currently required? • Who is responsible for measure submission? • How are measure specifications reviewed and maintained? • How are data validation and quality assurance activities performed? • How are preview reports reviewed prior to public reporting? • What recent changes have occurred in the IQR measure set? Hospital Outpatient Quality Reporting (OQR) Program The Hospital Outpatient Quality Reporting (OQR) Program is a CMS quality reporting program for hospitals providing outpatient services. Hospitals report quality data that are used for public reporting and quality improvement activities.		

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Questions to consider: • Does our hospital participate in the OQR Program? • Which outpatient measures apply to our organization? • How are outpatient data collected and submitted? • Who monitors changes to OQR specifications and reporting requirements? • How are OQR results reviewed and communicated to leadership? Measure Specifications and Reporting Requirements CMS measure specifications and reporting requirements are updated regularly. Quality leaders should know: • Where current IQR and OQR specification manuals are maintained. • Who reviews annual specification updates. • How specification changes are communicated to abstractors, vendors, analytics teams, and clinical departments. • How the organization prepares for changes in reporting requirements, measure definitions, and submission deadlines.		

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Relationship to Other CMS Programs Performance reported through CMS quality reporting programs may contribute to public reporting and may influence additional CMS quality and payment programs, including: • Hospital Value-Based Purchasing (VBP) • Hospital Readmissions Reduction Program (HRRP) • Hospital-Acquired Condition (HAC) Reduction Program • Medicare Promoting Interoperability Program • Care Compare public reporting National Healthcare Safety Network (NHSN) Hospitals should identify the individuals responsible for infection prevention reporting activities within the National Healthcare Safety Network (NHSN). NHSN is the CDC's national infection surveillance system and supports multiple CMS reporting requirements. Key questions: • Who is the NHSN Facility Administrator? • Who serves as the backup NHSN Administrator? • Who enters and validates infection-related data? • Where are NHSN validation reports maintained? • How are NHSN data review and quality assurance processes conducted?		

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Medicare Certification Number (CCN) Know your hospital's Medicare Certification Number (CCN). The CCN is frequently used in CMS reporting systems, accreditation activities, NHSN reporting, public reporting programs, and regulatory communications. • What is your hospital's CCN? • Do key quality, regulatory, and infection prevention leaders know the CCN? Understanding Your Hospital's Reporting Requirements Each hospital should understand which quality measures apply to its services and reporting programs. Questions to consider: • What CMS quality reporting programs apply to our organization? • Which measures are currently collected and reported? • What are the reporting deadlines? • How are performance results reviewed internally? • Which measures are publicly reported? • Who is responsible for monitoring measure specification updates?		

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Measure types may include: • Structural measures • Process measures • Outcome measures • Patient experience measures (e.g., HCAHPS) • Claims-based measures • Electronic Clinical Quality Measures (eCQMs) Data Vendors and Data Collection Identify all external vendors and internal resources involved in quality reporting. Questions to consider: Who are our measure vendors? ○ Clinical process and outcome measures ○ HCAHPS ○ eCQM reporting ○ Registry support vendors • How are measures collected and submitted? • How do we access vendor reports and dashboards? • How are data validated before submission?		

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Internal Quality Reporting Processes Quality leaders should understand how data move from collection to submission. Questions to consider: • Who abstracts or validates measure data? • What training have abstractors received? • How are staff notified when CMS updates measure specifications? • What quality assurance process is used to ensure data accuracy? • How are discrepancies identified and corrected? • What internal committees review performance results? Specialty Facility and Unit Reporting Programs Additional CMS quality reporting requirements may apply to specialty facilities or distinct-part units within an organization. Determine whether any of the following programs apply: • Inpatient Rehabilitation Facilities (IRFs) • Inpatient Rehabilitation Units paid under the IRF PPS • Inpatient Psychiatric Facilities (IPFs) • Inpatient Psychiatric Units paid under the IPF PPS • Long-Term Care Hospitals (LTCHs) • Ambulatory Surgical Centers (ASCs) • End-Stage Renal Disease (ESRD) Facilities		

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- Rural Emergency Hospitals (REHs), if applicable For each applicable program: - Who is responsible for reporting? - What measures are required? - What reporting systems are used? - What deadlines must be met? - How are results reviewed and acted upon? Promoting Interoperability The Medicare Promoting Interoperability Program is a CMS quality program that promotes quality improvement, patient safety, and efficient care through the use of Certified Electronic Health Record Technology (CEHRT) and the secure exchange of health information. Hospital quality leaders should understand their organization's reporting requirements, responsible departments, and performance results. Questions to consider: - Who leads Promoting Interoperability reporting? - What CEHRT system is used? - Are applicable measures being successfully reported? - Are there any hardship exceptions in place? - How are performance results communicated internally?		

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Key Resources and Links: • QualityNet - https://qualitynet.cms.gov/ • Hospital Quality Reporting (HQR): https://hqr.cms.gov Helpful Hints: • People also refer to QualityNet as QNet. • Subscribe to the QualityNet mailing lists appropriate to your setting to ensure you are notified of deadlines, program updates, measure changes, and preview reports. This is located on the QualityNet Home page. • Use the QualityNet Support page to access contact information with questions: https://qualitynet.cms.gov/support. • Hospital specific reports will be placed under the “My QualityNet” tab. Your QualityNet administrator must set you up to access this tab. • Hospital specific reports are eventually removed from the My QualityNet page. It is recommended that you create a directory and file system on your network drive for downloading and organizing your QualityNet reports. • Keep a spreadsheet on your secure network drive for your passwords. The password requirements for all the sites are different, and your passwords are required to change at different times. It is nearly impossible to keep track of all the different passwords you will need (such as for QualityNet, CheckPoint, etc.) • Keep track of the reports you need to run for end of the quarter submission checking. Use this as a guide for subsequent quarterly checks. This will save you a great deal of time each quarter. • QualityNet deadlines are carved in stone. There are no grace periods. • Measure specifications and reporting requirements are not static. CMS updates measure specifications, reporting manuals, submission requirements, and guidance on a regular basis, with major updates typically occurring annually. Quality leaders should ensure appropriate staff monitor QualityNet, CMS communications, and measure-specific guidance throughout the year to remain current with changes. • The best place to review the specifications manuals is the QualityNet website. • CMS changes the measures required for collection through administrative rules published in the Federal Register. The rules for inpatient, psych, LTAC, and inpatient rehab measures are released as proposed rules around April of each year and finalized in August. The rules for outpatient measures are released around May and finalized in November. WHA produces and sends out executive summaries of both the proposed and finalized rules to help you navigate the changes.		

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Potential future measures are released typically by December 1 of each year in the Measures Under Consideration (MUC) list. Pre-Rulemaking MUC Lists and Recommendation Reports The Measures Management System		
<u>Pay for Performance - Hospitals</u> CMS Programs - If your hospital is paid by Medicare under the Inpatient Prospective Payment System (PPS) you are subject to the CMS payment incentive programs. These programs do not apply to critical access hospitals who receive cost-based reimbursement. Find out how your hospital has done in the past and predicted to do in the current year in these programs. - Value Based Purchasing - Readmission Reduction Program - Hospital Acquired Condition Penalty Program Wisconsin's Medicaid Pay for Performance – The state Medicaid program has a hospital pay-for-performance program. The current year guide and hospital specific reports can be found on the ForwardHealth portal. Find out who has been managing this information in the past and how your hospital has done in past years and is predicted to do in the current year. ☐ Who is the organizational lead for Wisconsin Medicaid Pay-for-Performance? ☐ Who receives Medicaid quality performance reports? ☐ What department retains historical Medicaid P4P reports and scorecards? ☐ Who is responsible for forecasting Medicaid incentive opportunities?		

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What managed Medicaid plans have quality incentive arrangements with your organization? Find out if your hospital has any other quality-related P4P programs with commercial insurance carriers.		
Key Resources and Links: CMS Value Based Purchasing - https://qualitynet.cms.gov/inpatient/hvbp CMS Readmission Reduction Program - https://qualitynet.cms.gov/inpatient/hrrp CMS Hospital Acquired Condition Penalty Program - https://qualitynet.cms.gov/inpatient/hac/resources State of Wisconsin Forward Health Portal: https://www.forwardhealth.wi.gov/WIPortal/ Helpful Hints: - CMS changes the pay-for-performance programs and associated measures through administrative rules published in the Federal Register. The value-based purchasing (VBP), readmission penalty (HRRP) and hospital acquired condition (HAC) penalty rules are released as proposed rules each year and finalized in August.		
<u>CMS Reporting and Pay for Performance - Providers</u> CMS requires quality reporting for individual providers under a program called Quality Payment Program (QPP). If a provider is not participating in an Alternative Advanced Payment Model (APM) they must be participating in the Merit Based Incentive Payment System (MIPS) to avoid automatic payment penalties. Both programs require submission of quality data for determining provider incentives and penalties on their Medicare Part B payments.		☐

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2. MIPS requirements are a combination of quality measures you submit, cost measures calculated by CMS, provider meaningful use and clinical improvement activities the provider does. MIPS data gets submitted to CMS once a year at the end of February or March, depending on the option you are using for reporting. 3. Quality data can be submitted for each provider as an individual or as a group. Results of the quality measures are reported on Physician Compare. 4. Which providers at your organization are subject to APM quality measures and which are subject to the MIPS quality requirements? 5. Are any of your providers exempt because of the MIPS low volume threshold? 6. Who is responsible for working with the providers to choose measures each year? 7. How is data being submitted to CMS each spring?		
Key Resources and Links: - Website with good explanations, summaries and participation status checker - https://qpp.cms.gov/ Helpful Hints: - The requirements and list of measures changes each year. CMS updates the administrative rules governing QPP each year, through the Federal Register. The proposed rules are usually released in late spring/early summer and then finalized in November. - Work with providers to understand which measures and clinical improvement activities will give them the highest score to be of the greatest financial benefit.		
<u>Data Collection and Reporting</u> What data are you or members of your department responsible for collecting?		☐

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2. How does it get reported, to whom, and how often? 3. What are the measure specifications for data you are responsible for collecting? 4. Do you have any regular reports that are given to the Board of Directors? 5. Do you have any regular reports for senior leaders, managers, medical staff or others? 6. Verify access to: • QualityNet • HARP • HQR • NHSN • WHA CheckPoint • ForwardHealth Portal • HCAHPS Vendor Portal • Leapfrog and others • Incident Reporting System • EHR Reporting Tools • Board Dashboard • Shared Quality Drive		
Helpful Hints: • Create a system that prompts you, well in advance, for each required report. Think about blocking time in your calendar for report preparation.		
<u>Other Required Reporting and Programs</u> 1. Third Party Contracts - Are you required by any third-party contract to report any clinical quality data? Insurance		☐

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companies may embed requirements for quality data reporting and may use these data in payment incentives or penalties. Contract renewals should be examined carefully for these additions and negotiated prior to renewal whenever possible. Find out who can help you review contracts for this kind of language. 2. MBQIP - If you are a critical access or rural hospital and receive Flex Grant money from the Wisconsin Office of Rural Health you must also report on Medicare Beneficiary Quality Improvement Program (MBQIP) measures. Find out who is responsible for collecting and reporting these measures. 3. Superior Health Quality Alliance (WHA is one of the founding members) has the CMS QIN/QIO contract for the Great Lakes Region. 4. MetaStar: MetaStar works as a subcontractor for Medicare. They are tasked with improving care to Medicare beneficiaries, primarily in the ambulatory and long-term care setting. Participation in MetaStar projects is voluntary. 5. Commence Health (formerly Livanta) (one of CMS's Quality Improvement Organizations): Commence Health works as a subcontractor for Medicare. They are tasked with ensuring Medicare patients receive quality care. They handle Medicare discharge appeals and do random audits of patient records for quality-of-care issues.		
Key Resources and Links: • Wisconsin Office of Rural Health (WORH): https://worh.org/		

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• Medicare Beneficiary Quality Improvement Program (MBQIP): https://www.ruralcenter.org/tasc/mbqip • Superior Health Quality Alliance: https://www.superiorhealthqa.org/ • MetaStar: https://metastar.com/ • Commence Health: https://www.commencehealthqio.cms.gov/en		
<u>Public Reporting – Sites You Need to Know</u> 1. Care Compare - CMS hospital quality results. https://www.medicare.gov/hospitalcompare/search.html? 2. CheckPoint – WHA’s site for reporting results for WI hospitals. All reporting on CheckPoint is voluntary; however, hospitals are encouraged to report all measures that apply to their patient populations. Set-up a call with the CheckPoint administrator at WHA to get a full orientation to CheckPoint, especially the administrative functions you may be responsible for. https://checkpoint.wha.org/ 3. PricePoint – WHA’s site for reporting hospital charges. The data for PricePoint is derived from hospital discharge data set that is managed by the WHA Information Center. http://www.wipricepoint.org/ 4. Leapfrog – Leapfrog is a voluntary hospital survey that about 25% of Wisconsin hospitals complete each year. The results are published on their website, and a portion of the results		☐

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are used in calculating their Hospital Safety Score. http://www.leapfroggroup.org/compare-hospitals 5. Leapfrog Hospital Safety Grade - This is a letter grade (A-F) published by Leapfrog twice per year. A grade is not given to critical access or specialty hospitals. The data sources and methods change regularly. Data is obtained largely from Care Compare and the Leapfrog survey. It is not necessary to complete the Leapfrog survey to get a good safety grade. http://www.hospitalsafetygrade.org/ 6. Joint Commission – If your hospital is Joint Commission accredited you will find results of your core measures on the Joint Commission website. https://www.jointcommission.org/en-us/certification/performance-measurement 7. Wisconsin Collaborative for Healthcare Quality (WCHQ) – WCHQ is a member driven organization that publicly reports and works on improving quality in the ambulatory office practice setting. Most integrated health systems in Wisconsin are members of WCHQ. http://www.wchq.org/ 8. Healthgrades – Ratings of hospitals and doctors based on MedPar (Medicare claims) data. It is important to know the data can be relatively low and Healthgrades charges for assistance in understanding and improving their ratings. https://www.healthgrades.com/ 9. US News & World Report – https://health.usnews.com/best-hospitals many others, just ask WHA for a run down of the list.		

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Helpful Hints: - There is a difference between the public reporting of quality information and the quality ranking that is done by the different organizations. Each organization uses different measures or methods to create its rankings. It is helpful to scan the different rankings periodically and understand the measures and methods used if your scores or rank is low, as you may get asked to comment on it by someone in your organization or an external stakeholder. - Ensure your hospital is reporting all applicable measures to WHA CheckPoint. If you need assistance email quality@wha.org.		
<u>Hospital Committees</u> Do you have responsibility for any of these potential committees including agenda setting, meeting facilitation, minutes and/or participation as a committee member? How do these committees' interface with quality? - Hospital Quality Committee - Board Quality Committee - Medical Staff Quality Committee - Medical Executive Committee/Medical Staff Committee - Credentials Committee - Peer Review Committee - Accreditation Committee - Infection Control Committee - Risk Management Committee - Patient Safety Committee - Utilization Review Committee - Management Meeting		☐

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13. Customer Service Committee 14. Pharmacy and Therapeutics 15. Others?		
Helpful Hints: Add all recurring meetings to Outlook – set recurring reminders for 2 weeks in advance if you are responsible for meeting preparation.		
<u>Medical Staff</u> 1. Is there a physician who holds a leadership role related to quality? 2. Are you involved with the orientation of new physicians/providers? 3. What is the medical staff structure? (Committees, officers, etc.) 4. Are some or all the physicians employed by the hospital/system? 5. Do you have any responsibility for quality in the physician clinics? 6. Do you have to provide physician-quality data/reports regularly? (what data, format, schedule) a. As a part of Credentialing? i. New providers – OPPE ii. Existing providers – FPPE b. Reports to the individual providers? 7. Is there a Peer Review process? a. What triggers a review? b. Who does the reviews?		☐

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c. What is the process for conducting reviews? d. How are the outstanding reviews tracked? e. What is the process for reporting the results? f. Where are the final reviews stored? g. Are there any follow-up actions you are responsible for tracking? 8. Do you have a role in the CMS Quality Payment Program (MIPS) reporting for any clinicians?		
Key Resources and Links: • CMS Quality Payment Plan – mandatory quality reporting program for physicians and other providers - https://qpp.cms.gov/ • Wisconsin Peer Review Statute - 146.37 - https://docs.legis.wisconsin.gov/statutes/statutes/146/37 • Wisconsin Peer Review Statute - 146.38 - https://docs.legis.wisconsin.gov/statutes/statutes/146/38 Helpful Hints: • Add all recurring reports to Outlook to prompt you 1-2 weeks before they are due. • Make sure to secure the peer review and other protected documents carefully.		
<u>Risk Management</u> 1. Who is your insurance carrier? Be sure to locate the contact information of your agent and have it handy. 2. Who is your legal counsel? Be sure to locate the contact information of your attorney's office and have it handy. 3. Does your insurance carrier offer training sessions and education? Be sure to avail yourself of them. 4. Consider joining the Wisconsin Society for Healthcare Risk Management (WSHRM) and attending their conferences.		☐

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5. Ensure a yearly facility Risk Assessment is completed. 6. Be able to perform a Root Cause Analysis using an approved template (such as The Joint Commission template). 7. Understand what a “sentinel event” is and what your hospital’s process is for investigation and follow-up. 8. How does your facility report and track variances/safety events? Does your facility use an electronic variance reporting system? Learn which system is used and how to abstract data for reporting purposes. Who is responsible for ensuring appropriate follow-up is done on significant events?		
Key Resources and Links: • Locate your insurance carrier’s website. • Locate your risk management group’s website. • Locate our legal counsel’s website. • Joint Commission Guide on Conducting a Root Cause Analysis: http://www.jointcommission.org/Framework_for_Conducting_a_Root_Cause_Analysis_and_Action_Plan/ Helpful Hints: • Learn the Wisconsin statutes re: discoverability of documents and protection and attach the appropriate phrase to secure documents. • Find the statute of limitations for keeping documents and evidence (your attorney will advise you).		
<u>Patient Safety</u> 1. Who is the hospital’s Patient Safety Officer? 2. If you are Joint Commission accredited		☐

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a. Ensure that the National Patient Safety Goals are updated each year including the elements of performance for each one (CAUTION: the list of goals is NOT the same for Critical Access Hospitals; they have their own list). b. Be able to perform a Failure Modes Effect Analysis and ensure one is completed every 18 months. 3. Do you have other safety related committees? (Medication safety committee, environmental safety committee, employee safety, etc.) 4. Does your hospital use a “culture of safety” survey with staff? a. Which survey? b. When was the last time it was done? c. What was done with the last set of results? 5. Does your hospital use Clear Text pages for overhead pages? If so, how is the training updated yearly? What visual aids do you have to prompt the staff?		
Key Resources and Links: - Joint Commission National Performance Goals (formerly National Patient Safety Goals, renamed in 2026) - http://www.jointcommission.org/standards_information/npsgs.aspx Helpful Hints: - Publish your National Performance Goals widely each year and retrain staff so they are familiar with them.		
		

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<u>Corporate Compliance</u> If you are responsible for corporate compliance proceed with #2-7 below. If you are not sure, or would like to learn more, then follow items #3-7 below. If you (by your job description or other documentation) are clearly not part of the Corporate Compliance Committee or Plan, you can ignore this section. 1. Who is your hospital's Corporate Compliance Officer? 2. Is there a Corporate Compliance Committee? If yes, how often does it meet? When is the next meeting? What is your role/responsibility in the Committee? 3. Find your hospital's Corporate Compliance Plan – does it contain all the required elements? 4. When was the last risk assessment done? Were any deficiencies identified and if yes, what committees/projects are in place to improve? 5. What method of anonymous reporting exists for employees? How are employees educated about the Plan? 6. What ongoing monitoring is being done? 7. Are there other services/locations on your campus that are covered in the OIG Work Plan (i.e. Nursing Homes, Home Health, DME)?		
Key Resources and Links: Required Reading: • Office of Inspector General (OIG): https://oig.hhs.gov/		

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• OIG Supplemental Workplan for Hospitals: https://oig.hhs.gov/fraud/docs/complianceguidance/012705HospSupplementalGuidance.pdf • CAH Conditions of Participation: C-0151, 485.608(a) (http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/som107ap_w_cah.pdf) • PPS Conditions of Participation: 482.11 http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/downloads/R37SOMA.pdf • Your hospital's Policy and Procedure documents regarding Corporate Compliance. Helpful Hints: Check with your facility's Risk Manager, Liability Carrier, or "Google" for more resources.		
<u>Patient Satisfaction and Customer Relations</u> 1. Who is your vendor for HCAHPS? 2. Become familiar with the questions asked in the HCAHPS survey. 3. How is the data disseminated throughout the institution? How does the Board of Directors see the data? 4. Be familiar with Care Compare and WHA CheckPoint to see where your facility stands in relation to competitors and other hospitals. 5. What other departments are surveyed? How are those results displayed? 6. If your vendor processes survey comments for you who accesses and processes these? 7. When surveying internally, consider all groups that care for patients in any setting. 8. When is your next employee satisfaction survey? How are the results discussed with the participants? Are your volunteers surveyed?		

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9. When is your next medical staff survey? Do you use a vendor? 10. Who handles patient complaints? Get familiar with the CMS Conditions of Participation related to handling complaints. - PPS Hospitals – CoP 482.13 - Critical Access Hospitals – CMS does not have specific standards for CAHs. 11. Do you have a system to record all patient complaints and compliments? 12. Who prepares the follow-up letters after patient contacts? 13. Is there a service recovery program for employees to care for patient complaints at the moment of reporting? 14. What is your customer service program? Who teaches it and how often is it refreshed?		
Key Resources and Links: - HCAHPS - https://hcahpsonline.org/ - CMS Care Compare - https://www.medicare.gov/hospitalcompare/search.html Helpful Hints: - Consider the use of balanced scorecards or dashboard to display the data easily. - HCAHPS is a federal law and cannot be tampered with. You must use an approved survey vendor and are not allowed to survey your inpatients until the process is complete for that discharge. Become familiar with the entire process.		
<u>Quality Improvement (QI) Activities</u> - How are improvement priorities set? - What hospital groups/teams are currently working on QI projects?		☐

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3. What is your role in QI projects? 4. Does your hospital use a model for improvement? (PDSA, Lean, Six Sigma, etc.) If you are not familiar with this model find out how you can get trained. 5. What kind of quality related training have leaders, managers and staff received? 6. How is the progress of projects tracked? 7. Where do the results of projects get reported? 8. Where is the record of past projects to show a surveyor when asked? 9. How is the annual assessment of the effectiveness of the quality program conducted? (This is a CMS requirement.) 10. Is your hospital enrolled in any improvement projects with outside organizations like WHA? 11. Have you met with the WHA Quality Team to understand current statewide quality, patient safety, and health equity initiatives? 12. Are you subscribed to WHA quality communications and regulatory updates?		
Key Resources and Links: • The Team Handbook – by Peter Scholtes – is an excellent resource for basic QI and team facilitation skills. • Institute for Healthcare Improvement (IHI) - is also a great source of basic improvement skills and methods. https://www.ihl.org • WHA Quality Website - provides multiple links and tools for improvement. https://www.wha.org/quality		

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Helpful Hints: • Review recent meeting minutes from these: QI Committee or Council, all sub committees of the Medical Staff (P&T, Surgery, OB, etc.), survey plans of correction, or recent Root Cause Analysis documents. • Ideally your role in quality improvement projects is the role of facilitator and data assistance. If your hospital has quality improvement teams someone with content knowledge and operational responsibility for the outcome of the project should be leading the project. • Ideally all projects that require any change of physicians should have a physician champion and/or physicians on the project team.		
<u>Professional Quality Associations and Certification</u> 1. National Association for Healthcare Quality (NAHQ) – NAHQ hosts an annual fall conference and provides resources to quality professionals. 2. Wisconsin Association for Healthcare Quality (WAHQ) – WAHQ is the state-level version of NAHQ. They host an annual conference each spring, occasional regional educational sessions and produce a newsletter. 3. Certified Professional in Healthcare Quality (CPHQ) – this is a national certification offered by NAHQ. You obtain certification by taking an exam. If you are interested in this there are study materials and review classes available.		
Key Resources and Links: • NAHQ - the NAHQ site also posts information about the CPHQ certification resources and examination. http://www.nahq.org/ • WAHQ - also find information on the CPHQ exam here. https://www.wahq.org/		

Potentially Important Issues	Notes	
Helpful Hints: If you are responsible for additional roles like Risk Management, Infection Control, Corporate Compliance, etc. – there are likely professional associations and certifications that you can access and attain.		

10/20/2026