Lawrence General Hospital

Quality Assessment

&

Performance Improvement Plan

Approved by the Quality of Care Committee

January 17, 2024

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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]

Mission, Vision and Values

Our Mission

Lawrence General Hospital (LGH) 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 ensure 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 healthcare institutions.

Our Vision

Become a stellar regional health system known for the highest quality, highest value, service, efficiency, and compassionate care.

Our Values

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.

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.

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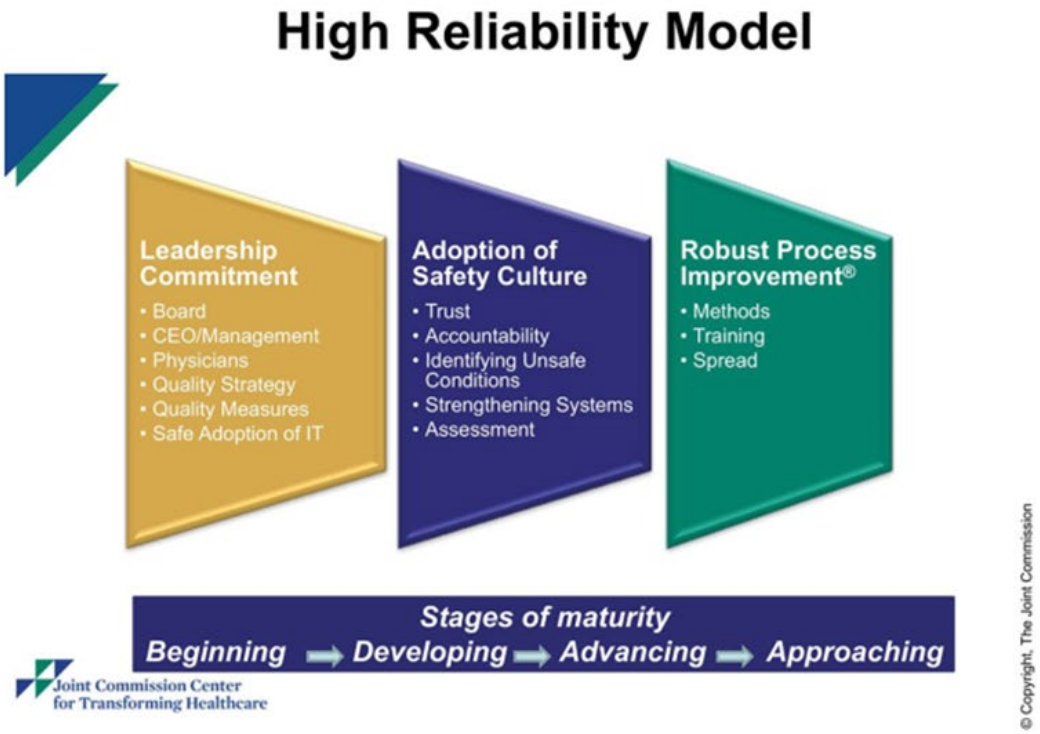
Becoming a High Reliability Organization (HRO)

High reliability health care refers to patient care that is consistently excellent and safe over long periods and across all services and settings. In November 2021, LGH adopted the Joint Commission (JC) High Reliability Health Care Maturity Model to guide our journey towards becoming an HRO. The JC 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 work force 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 carrying out 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:

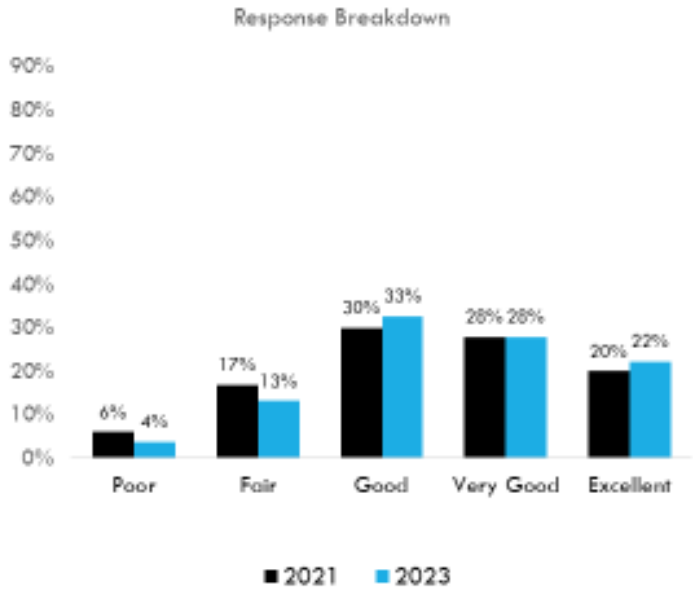
- acknowledgment of the high-risk nature of an organization's activities and the determination to achieve consistently safe operations
- a blame-free environment where individuals can report errors or near misses without fear of reprimand or punishment
- encouragement of collaboration across ranks and 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 HSOPS 2.0 survey was most recently distributed in October 2023 and remained open until December 1, 2023. 582 of 1860 surveys were completed for a response rate of 31%, which was an increase of 2% compared to the 2021 response rate. Summary of results also shows an increase in in scores in every domain.

Summary results are below, and action plans are in development.

Overall Grade on Unit Patient Safety

How would you rate your unit/work area on patient safety?



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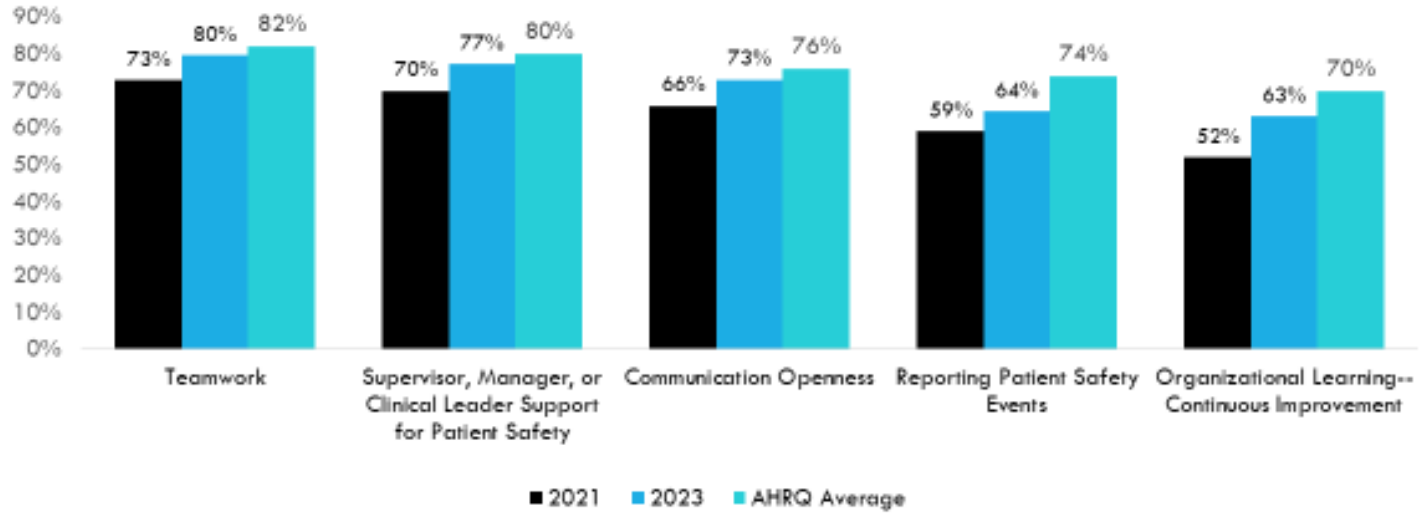
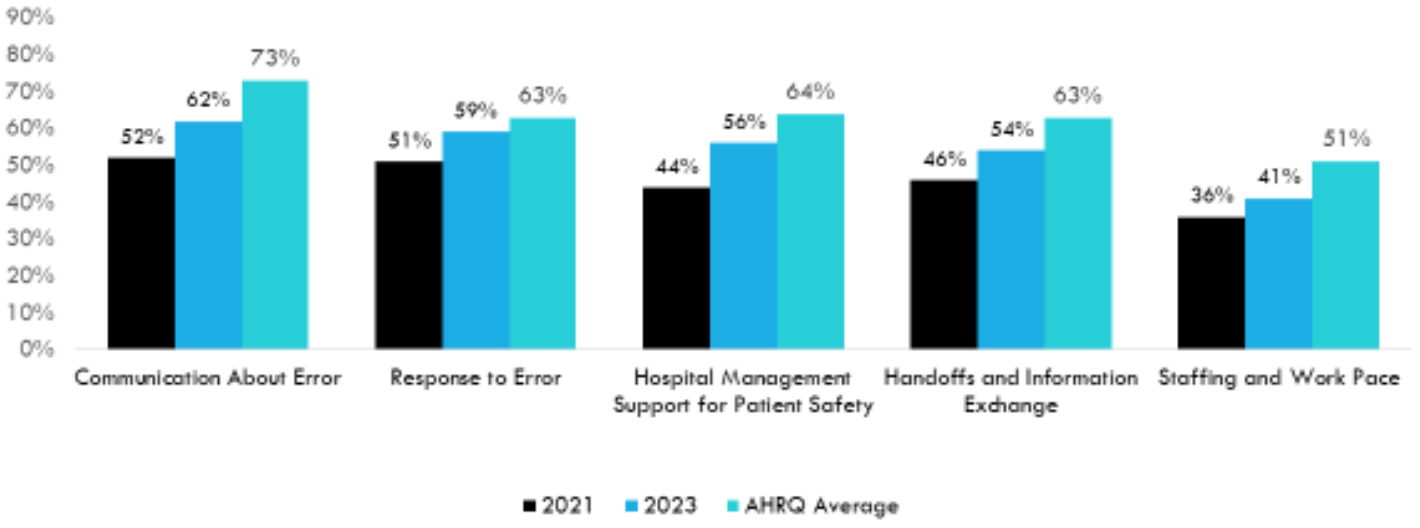
Patient Safety Culture Dimension Report (1 of 2)



Patient Safety Culture Dimension Report (2 of 2)



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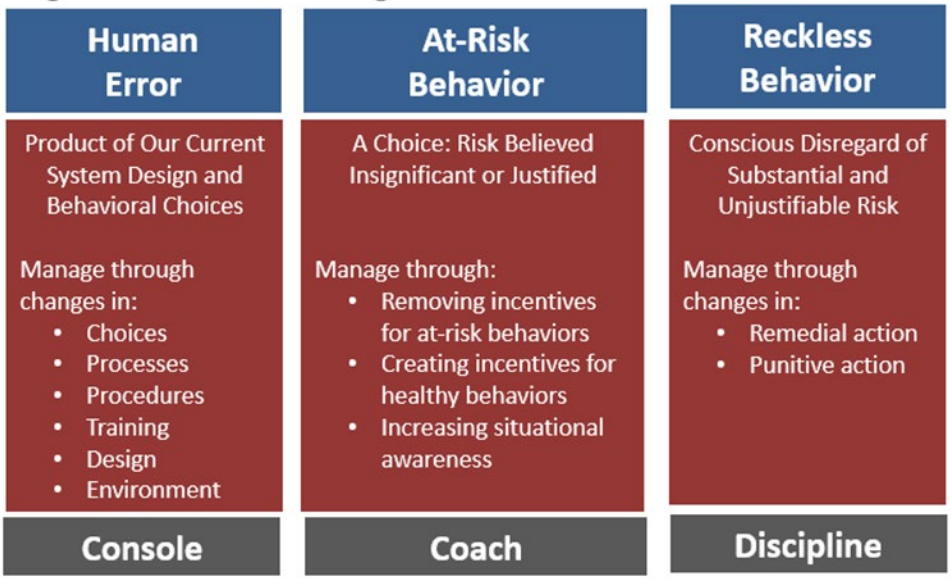
Just Culture

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 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]

Figure 1. Just Culture Algorithm: The Three Behaviors



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Journey to Zero Harm

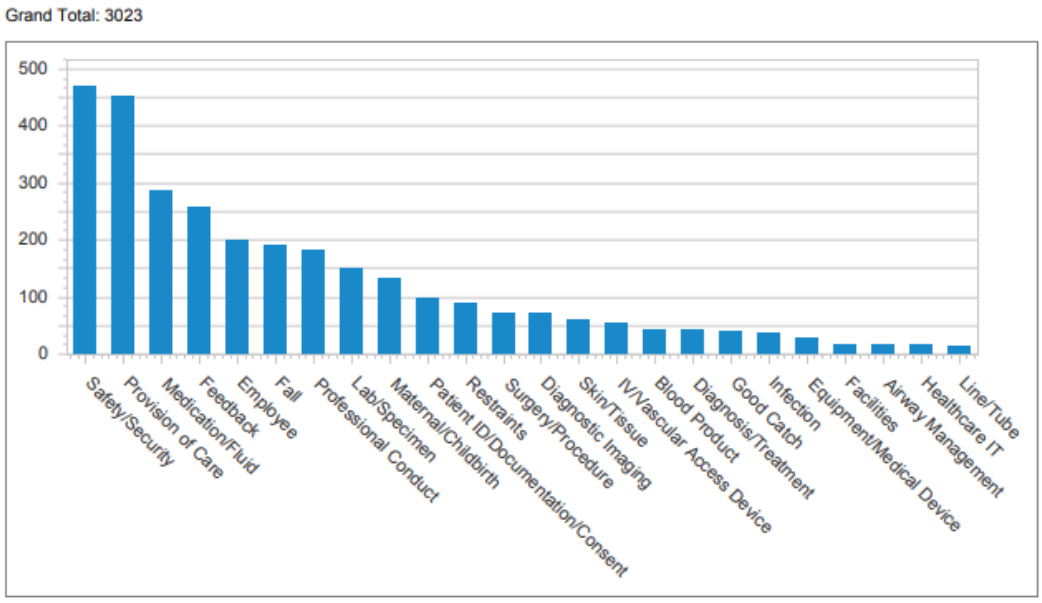
Eliminating preventable harm and Serious Safety Events (SSEs) is a top challenge for the healthcare industry. Lawrence General Hospital continues to optimize the RL6 tracking system, implemented in February 2019. The gold standard RL Solutions electronic safety event reporting system is easier and more 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 a severity level, 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 2023, 3,023 safety reports were filed. The Risk Management Department reviews each submitted incident to verify that the selected category is correct:

General Event Types
Event Date is within Calendar 2023



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.

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 Equity Incentive (HEI) program.

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 2024 measures, deliverables, and action plans will be reviewed by the Quality of Care (QOC) committee as a standing agenda item beginning in CY23. **(See Appendix B)**

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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

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; Risk Manager, 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: Coordinator of Accreditation and Regulatory Readiness (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), Accreditation Coordinator (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 Medical Staff 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.

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.

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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 (see Table 1). 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.

Table 1. Medicare Conditions of Participation:

- **Governing Body** (42 Code of Federal Regulations (CFR) § 482.12)
  - The governing body must be effective and responsible for the conduct of the hospital.
  - The governing body must "ensure that the medical staff is accountable to the governing body for the quality of care provided to patients."
- **Medical Staff (42 CFR § 482.22)**
  - The medical staff is responsible—and accountable to the governing body—for the quality of medical care provided to patients by the hospital.
  - The medical staff must periodically conduct appraisals of its members.

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 and 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 (see Table 2). The "provider feedback report" is placed in the provider's quality file

Table 2. The Joint Commission:

- The governing body must work with the medical staff, but final decisions "are always the responsibility of the governing body," and the medical staff is accountable to the governing body. Introduction to Leadership Structure, Standards LD (Leadership).01.01.01 through LD.01.07.01; LD.01.05.01, Element of Performance (EP) 6) "The hospital's governing body has the ultimate authority and responsibility for the oversight and delivery of health care rendered by licensed independent practitioners...." (CAMH, Overview to Medical Staff (MS) chapter
- Other components of evaluation:
  - MS.08.01.03 Ongoing professional practice evaluation (OPPE): Routine monitoring of current competency for current medical staff members
  - MS.08.01.01 Focused professional practice evaluation (FPPE): Establishing current competency based on concerns from OPPE (focused review) or new medical staff members or new privileges, (proctoring)

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 (NQPC)

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

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.

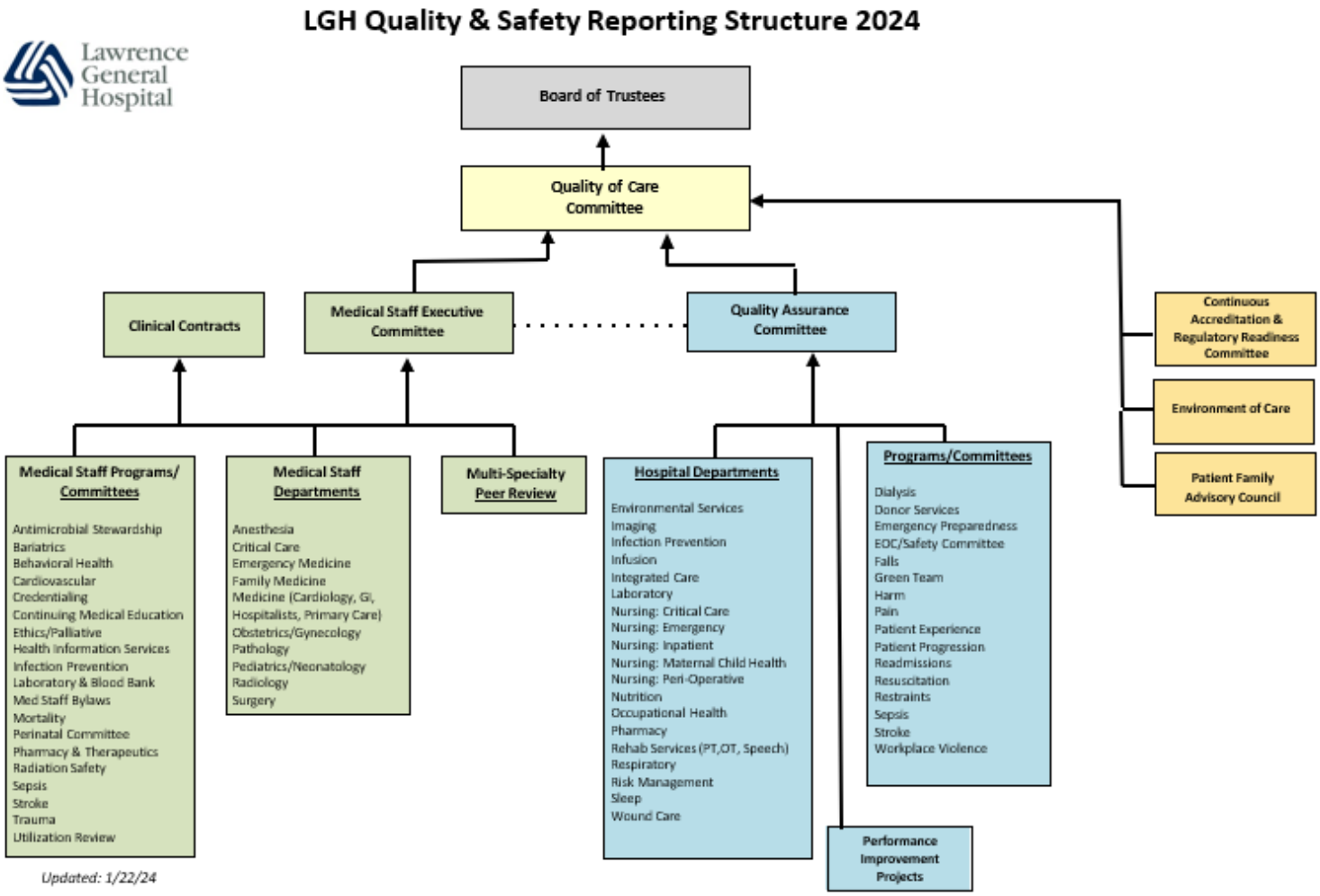
Members: Director Public Safety (Co-Chair), Chief Human Resources Officer (Co-Chair), CNO, CQO, Directors: Ambulatory Services, Security, Emergency Center, Integrated Care, Risk Management, Marketing and Communications, Nurse Managers, Manager Occupational Health, Patient Advocate, Performance Improvement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

2024 Quality and Patient Safety Reporting Structure and Information Flow

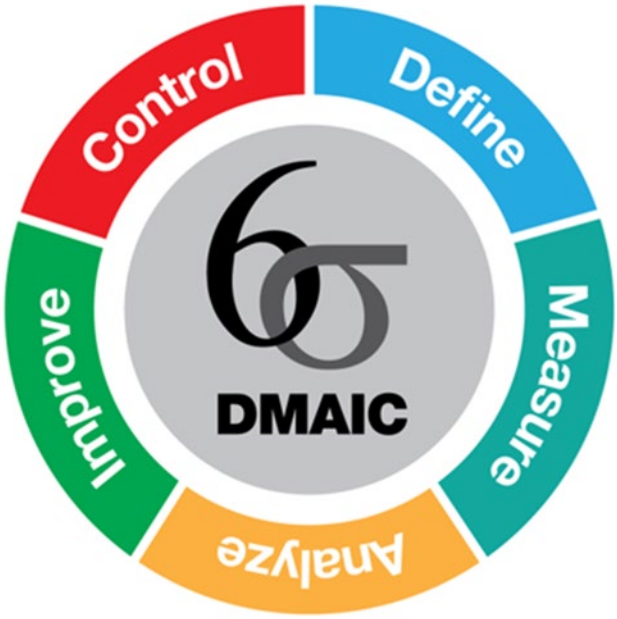


Performance Improvement Principles, Model for Improvement & Change Management, and 2024 Goals

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).

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.



Lawrence General Hospital

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

2024 LGH Quality and Patient Safety

Top Performance Improvement Goals

Staff Safety

- Implement flagging system in EHR to identify at-risk patients.
- Develop standardized work as response to an event.
- Establish a Behavioral Health Response Team
- AVADE training completed on all of EC, EMS, Nursing Assistants, and PSMs.
- Provide education and policy regarding lateral violence, bullying, civility and respect in the workplace.

Patient Satisfaction and Experience

- Improve NRC data aggregation and visual data presentation for key stakeholders.
- Improve response to NRC Service Alerts within 7 days of receipt.
- Improve the following domains from the Hospital Consumer Assessment of Healthcare Providers and Systems Survey (HCAHPS) measures from fiscal year 2023 average to at least the CMS achievement threshold.

Domain	FY23 Average %	CMS Target Floor %	CMS Achievement Threshold %	LGH Goal	% Increase (FY23 Avg to FY24 Target)
Communication with Nurses	77	54	**79**	**79**	2%
Communication with Doctors	77	62	**80**	**80**	3%
Responsiveness Staff	53	40	**66**	**66**	13%
Communication about Medications	58	40	**63**	**63**	5%
Hospital Environment	53	46	**66**	**66**	13%
Discharge Information	86	67	**87**	**87**	1%
Care Transition	48	26	**52**	**52**	4%
Overall Rating of Hospital	62	36	**72**	**72**	10%

Infection Prevention and Control

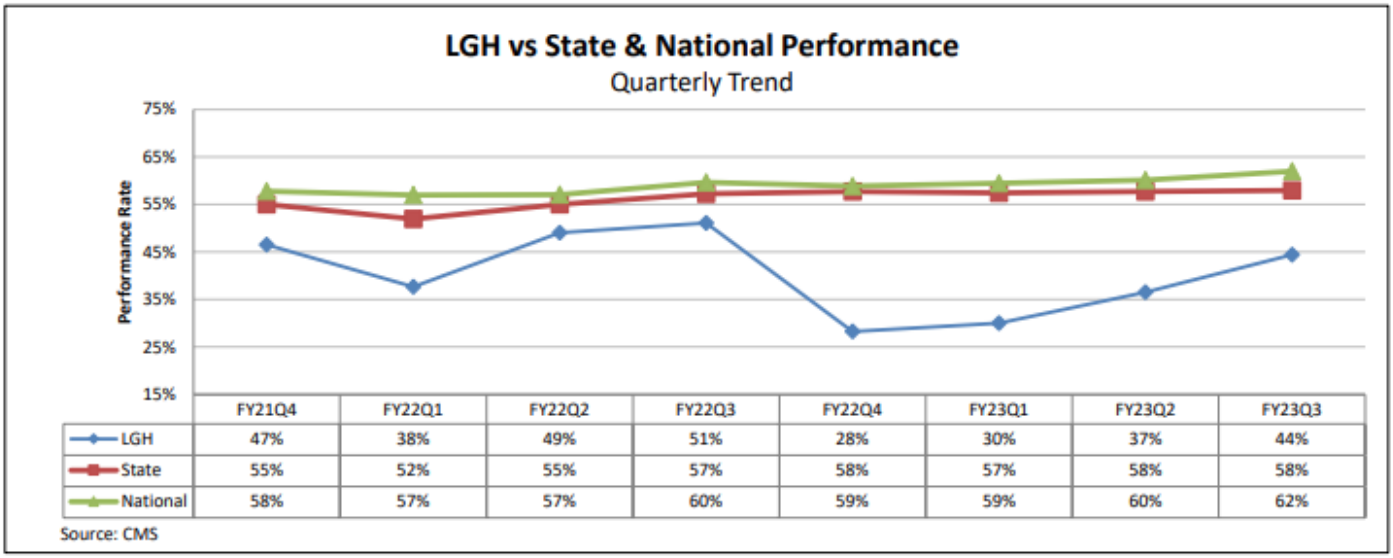
- Improve and maintain rates/standardized infection ratios (SIR) for key hospital acquired infection measures per table below:

Measure	FY23	LGH Goal*
Catheter Associated Urinary Tract Infections (CAUTIs)	**0.629**	SIR ≤ 1.0
Central Line Associated Blood Stream Infection (CLABSI)	**0.000**	SIR ≤ 1.0
Clostridium Difficile Infection (C. diff	**0.247**	SIR ≤ 1.0
Surgical Site Infections (SSI);	**0**	0
Methicillin Resistant Staph Aureus Infection (MRSA)	**2**	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



Appreciative Inquiry (AI)

LGH continues to incorporate appreciative inquiry into all aspects of the improvement process. Appreciative inquiry (AI) is a change management approach that focuses on identifying what is working well, analyzing what is working well and developing strategies to enhance and continue to improve what is working well. According to Bushe, AI "advocates collective inquiry into the best of what is, in order to imagine what could be, followed by collective design of a desired future state that is compelling and thus does not require the use of incentives, coercion or persuasion for planned change to occur". AI attempts to use ways of asking questions and envisioning the future in order to foster positive relationships and build on the present potential of a given person, organization or situation.

The most common AI model utilizes a cycle of four processes:

1. DISCOVER: The identification of organizational processes that work well,
2. DREAM: The envisioning of processes that would work well in the future,
3. DESIGN: Planning and prioritizing processes that would work well, and
4. DEPLOY: The implementation (execution) of the proposed design.

The aim is to build – or rebuild – organizations around what works, rather than trying to fix what doesn't. AI can be used to create the transformative processes and practices appropriate to the culture of a particular organization." "Grounded in the theory of 'social constructionism,' AI recognizes that human systems are constructions of the imagination and are, therefore, capable of change at the speed of imagination. Once organization members shift their perspective, they can begin to invent their most desired future."

The AI model for analysis, decision-making and the creation of strategic change is used in concert with other process improvement methods at the design and deploy stages. The QPS Department staff serves as quality advisors in a consultative role to performance improvement committees, teams, work groups, leaders, and staff throughout the organization.

Departmental-specific quality control such as documentation of quality control checks, and quality assurance activities, such as compliance with hospital policies and procedures and documentation of care -- are the responsibility of the specific department and not within the scope of the QPS Department or the QPS Program. The departmental scope of care and service is used as the foundation for identifying new services, key processes, and patient safety risks – actual or anticipated – that may require ongoing review and improvement.

Physicians, nurses, clinical and non-clinical staff are personally responsible for compliance with practices that assure patient safety and reliability of care and for active participation in quality, safety, peer review, patient satisfaction and performance improvement activities within their scope of responsibility. Directors and managers are responsible for identifying front line staff to participate in these activities, committees, and teams and to provide ongoing communication to their staff regarding the hospital's quality, patient safety and peer review activities and outcomes.

Lawrence General Hospital

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 CY23:

- Temporary relocation of Post-Partum and Med-Surg patients during HVAC upgrade
- Bulk oxygen tank removal and replacement
- Emergency Center Zone 2 Med Gas Oxygen, Medical Air, Medical Vacuum Shutdown
- Tunnel Construction-Generator Power Conversion to Hamblet Building

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.

Lawrence General Hospital

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)

Lawrence General Hospital

Appendix B
HQEIP Year 2 (CY24)

Hospital Quality and Equity Incentive Program | Brief Overview of Measure Specifications Updates for Performance Year 2

December 6, 2023

Measure	Key updates for Performance Year 2
RELDSOGI Data Completeness	• None
HRSN Screening	• For PY2, only supplemental data will be used for measure performance assessment (no administrative data submission required) ○ Supplemental data will be required to be mapped to administrative codes (M1207 and M1208, applicable z-codes); submission template will offer detailed instructions • Members who opt out of screening are now included in the numerator to ensure hospitals are credited for offering screening to those members • Delayed start of reporting period until July 1, 2024 to allow more time for EHR implementation
Quality Performance Disparities Reduction	• 20% of the measure score will be attributed to extraction and reporting of MassHealth member-specific HCAHPS data, beginning July 1, 2024 (Q3). No new sampling will be required. • CQI measures applicable to this measure are listed in the specification
Equity Improvement Interventions	• Clarified scoring approach
Meaningful Access to Healthcare Services for Individuals Preferring a Language Other than English	• Survey streamlined and is P4R only (not scored) • Maintained PY2 option to submit a sample in lieu of a full population to account for EHR update timelines • Weighted two components 50/50 given that survey is non-scored • Measure includes interpreter services and in-language provider delivery for preferred languages other than English (including preferred spoken languages and/or sign languages)
Disability Competent Care	• Clarified relationship to training plan, hospital flexibility in training tools and populations (must be approved within training plan)
Disability Accommodations Needs	• Denominator narrowed to those who responded yes to one of six disability screening questions and/or members with disability, as demonstrated by MassHealth eligibility on the basis of disability and/or through other analytical methods, as reported to acute hospitals by MassHealth for the purpose of this measure • Newly offers an option to sample population for reporting in PY2 (in lieu of reporting on full population) • Because of narrowing of model focus, no longer offering option to start with focus groups • Because of challenge of documentation related to meeting needs, emphasis in PY2 on documentation • Allows categorical, fixed field documentation of needs • Delayed start of reporting period until July 1 to allow more time for EHR implementation
Achievement of External Standards	• None
Patient Experience	• None
Collaboration	• None
All Measures	• Clarifying technical edits

Lawrence General Hospital

Appendix C
Quality Assurance Committee
Data Inventory

Data Inventory

01/08/24

HOSPITAL DEPARTMENTS

Behavioral Health	
	BH Consults Completed
	BH Follow-Up Calls
	Time from BH Consult to Discharge/Transfer (Future)
	Time from Medical Clearance to BH Consult (Future)
Cardiovascular	
	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
Environmental Services	
	Room Turnover Times
	HCAHPS Score: Room Kept Clean During Stay
Imaging	
	Mammography: No Show Trend
	Mammography: No Show Screening by Day
	Mammography: No Show Diagnostics by Day
	CT: Patient Dose Alerts
	Cath Lab & IR Alerts
Infection Prevention	
	HAIs: CLABSI, CAUTI, MRSA, C.DIFF, SSI, VAE (SIR & SUR)
	HAI RCAs
	Hand Hygiene
Infusion (Ambulatory Service)	
	Monitor insurance eligibility completion & infusion booking within 48 hours of infusion order request
	Monitor Electronic Scanning/Faxing infusion orders & paperwork into Meditech to ensure 100% compliance
Integrated Care	
	Monitor HRSN Capture rate FY24
	Compliance rate of initial CM assessment completed within 24 hours of admission
	Compliance rate of daily SNAP documentation
Interpreter Services	
	Monitor compliance rate of preferred language & written language capture
IV Services	
	Central Line Dressing labeled with Date/Time
	Central Lines have Disinfectant Caps on all Catheters
	Central Line Documentation: Yes or No
Laboratory (IP & OP)	

	Blood Bank Product Wastage
	Blood Culture Contamination
	Patient Identification
	Off Sites: Patient Identification
Nursing: Emergency	
	TAR Documentation Compliance
	Restraint Documentation Compliance
	Pediatric Vital Signs Compliance
	Falls
Nursing: ICU, H2, H4, R4, Telemetry	
	Pain Reassessment
	Falls
	HAPI
	HAIs
Nursing: L&D	
	Deliveries by Type
	Delivery Counts by Type, NTSV Rate, Code OB, Mag, Transfers, Readmits on Mag
	PC-01: Elective Delivery prior to 39 Weeks
	PC-02: Cesarean Section (NTSV)
	Fetal Demises < 20 Weeks/Fetal Death > 20 Weeks/Neonatal Deaths
	Maternal Transfers from Labor & Delivery
	Delivery Rates (Counts by Month since CY2018)
	Urgent/Stat Section Data
	Shoulder Dystocia Counts
Nursing: MCH (Mat, Newborn, Pedi)	
	Pain Reassessments
	Medication Scanning
	PC-05: Exclusive Breastfeeding
Nursing: MCH (SCN)	
	Medication Scanning
	PC-06: Unexpected Complications in Term Newborns
	Infants Admitted to SCN and Transferred to Tertiary Facility
Nursing: Perioperative	
	Average Room Turnover Time
	Service Line Average Room Turnover Time
	Same Day Cancellations
	< 24 Hours Cancellations
	Case Volume Cancellation Rate
	Cancellation Reasons
	Monthly First Case On Time Starts Trend
	Handoff Documentation Completion for Surgical Patients
	Fist Case On Time Starts OR Delay Costs
	Delay Reasons
Nutrition	
	Moderate Hypoglycemia
	Imaging with CORTRAK
Occupational Health	
	Sharps Injuries

	Workplace Injuries
	Flu Vaccine Compliance
	N95 Compliance
Patient Access	
	Spoken Language: < 1% records have "unknown" listed
	Patient Identification
	Advance Directives
Pharmacy	
	Smart Pump Dose Error Reduction Software Usage Rate
	Omnicell Override Rate - IP Units
	Barcode Medication Administration Rate - IP Units
	Targeted ADE: Excessive Anticoagulation from Warfarin
	Targeted ADE: Hypoglycemia from Hypoglycemic Medication
	Targeted ADE: Naloxone Reversal from Opioid Administration
	Antimicrobial Stewardship Days of Therapy: All Antimicrobial
	Antimicrobial Stewardship Days of Therapy: Restricted ABX
	Antimicrobial Stewardship Days of Therapy: Meropenem
	Antimicrobial Stewardship Days of Therapy: Piperacillin/Tazobactam
	Antimicrobial Stewardship Days of Therapy: Vancomycin
Population Health	
	ACO Quality Metrics/Performance
	Grant Specific Metrics: SDOH Screening & Referrals
	Community Engagement
Rehabilitation: Ambulatory	
	No Show Rate: AMC/YMCA/Marston St./Dorchester/Brighton
	Patient Satisfaction
	Percentage of Patients with Goals Mostly or Completely Met at Discharge
	Average Percentage Improvement on Validated Clinical Outcome Tools
Rehabilitation: Inpatient	
	PT Consults within 24 Hours
	OT Consults within 24 Hours
	SLT Consults within 24 Hours
	Joint Class Attendance
	OP Rehab at LGH Sites
Respiratory	
	Ventilator Bundle Measures: HOB 30 Degrees, Oral Care q Shift
	Ventilator Bundle Measures: PUD, DVT
	Ventilator Bundle Measures: Sedation Vacation, Weaning Trial, Paired SV & Wean
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
Wound Care	
	Patients with HAPI by Month

Lawrence General Hospital

Patients with HAPI by Unit

PROGRAMS & COMMITTEES

Cardiovascular	
	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
Dialysis	
	Consent for Treatment
	Hand Hygiene
	Hep B Antigen Status
	Pre and Post Weight Performed
	Time Outs
DEI/Health Equity	
	Readmission Rates by Interpreter Needed/Not Needed
	30-Day Mortality Rates by Race
	BCBS Grant: Ambulatory Health Disparities
	MassHealth HQEIP Metrics: RELD, SOGI, HRSN Screening Rates
Donor Services	
	Heart Beating & Asystolic Referrals
	Organ Outcome
	Tissue Outcome
EOC/Facilities/Safety/Emergency Preparedness	
	EOC Semi-Annual Report 2x/Year
	Hazardous Material
	Annual Hazard Vulnerability Analysis (HVA)
	FMEA 2x/Year
	FEMA Incident Command System Compliance
Falls	
	Falls & Falls with Injury
Green Team	
	Carbon Emissions
Harm	
	Harm Dashboard
Mortality	
	Mortality Rates
Pain	
	Pain Assessment and Reassessment
	Opioids
Patient Experience	
	Patient Experience Dashboard by Domain
	English vs Spanish Surveys
Patient Progression	
	Service Line: LOS Analysis

	ALOS by Location
	ALOS by DRG
	ALOS by Disposition
	ALOS by Payor
	Discharge by 12, 3, after 3
	Weekly LOS Trend Run Chart
	Weekly DC Trend Run Chart
	SNAP Barrier to Discharge
	eLOS Outlier monthly breakdown
Policy & Procedure	
	Annual Report
Readmissions	
	Readmission Rates by Quarter: AMI/COPD/HF/PN/THA TKA
	All Cause All Payers 30 day Readmissions
Resuscitation	
	Code Blue Trend: Volume by Month
	Rapid Response Trend: Volume by Month
	Code Blues by Location
	RRTs by Location
	RRT Complete Documentation Trend
Restraints	
	Restraints by Month: RL Violent
	Restraints by Month: Nonviolent
Sepsis	
	Performance by FY
	Performance: Monthly Trend
	LGH vs State & National Performance
	Failure Reasons
Stroke	
	GWTG Stroke Dashboard
	TJC PSC Stroke Dashboard
	Stroke Alert Dashboard
Workplace Violence	
	Workplace Violence Events - Physical & Nonphysical
	AVADE Training

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