Quality Improvement Guide

July 2023

ICE

ICE Health Service Corps

Foreword

The Quality Improvement Program Guide supplements IHSC Directive 11-02, *Quality Improvement Program*. It explains concepts, assigns responsibilities, and details the procedures related to the Quality Improvement (QI) Program. The IHSC QI Program includes aspects of quality improvement, quality assurance, and risk management. This guide also references the IHSC *Root Cause Analysis Guide* and IHSC Directive 11-06, *Risk Management*.

The intended audience of this guide are the IHSC health staff who support health care operations within ICE-owned detention facilities.

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I. OVERVIEW OF THE QUALITY IMPROVEMENT PROGRAM

A. Program Purpose

The U.S. Immigration and Customs Enforcement (ICE) Health Service Corps (IHSC) Medical Quality Management Unit (MQMU) oversees the QI Program. This program provides a framework for a collaborative, organization-wide, systematic approach to improve IHSC clinical performance. The QI approach uses data to monitor, assess, and improve the quality of patient care delivered at IHSC-staffed facilities.

B. Quality Improvement Program

IHSC's QI Program monitors and improves the health care delivered in IHSC-staffed facilities. MQMU leads IHSC's monitoring efforts through the national QI Program. Local facility health care program managers (FHPM) or their designees, help develop and implement improvement strategies within their facility. The FHPM monitors and implements the local QI program with the assistance of the local QI committee.

The regional compliance specialist (RCS) liaises between MQMU and the facilities and serves as the primary QI resource for the FHPM. The National Quality Assurance Committee (NQA) and the Local QI committee use performance measures to determine the quality of care provided to noncitizens within IHSC-staffed facilities.

C. Performance Measures

The NQA Committee develops the national performance measures to objectively assess the quality of care being provided at IHSC-staffed facilities. MQMU reports the status of these measures for quality improvement efforts. The QI Program based these measures on clinical aspects and administrative processes of health care. These indicators measure the effectiveness and efficiency of processes, as well as clinical and administrative outcomes. IHSC facilities establish local measures in consultation with MQMU staff to address local challenges. The performance measure development workgroup determines national measures addressed by all IHSC-staffed facilities.

The criteria must be:

- Quantifiable.
- Administrative or clinical in nature, and measure both processes and outcomes.

- Aligned with accreditation, detention, and community standards of care and measure the needs and expectations of noncitizens and staff in delivering and receiving quality health care.

II. Staff Responsibilities

A. Chief, Medical Quality Management Unit

- Oversees the national QI program and IHSC-wide QI activities to identify opportunities for change.
- Identifies needs that incorporate national accreditation standards, laws, and focused on performance improvement and patient safety.
- Forwards recommendations to senior leadership that require action from the IHSC NQA Committee.
- Ensures organizational support for implementation of QI and patient safety activities.
- Provides consultation when needed to ensure accurate completion of the Root Cause Analysis (RCA) process.
- Liaises and collaborates with the MCMU, standards application and compliance issues in non-IHSC-staffed facilities.

B. Regional Compliance Specialist

- Oversees and manages IHSC QI program activities using a variety of activities, tools, and methods, to improve quality, assess, reduce risks, and ensure safe practices.
- Provides technical assistance on administrative or clinical issues, to clarify detention standards, clinical practice, and policy.
- Coordinates scheduling, agenda, and meeting minutes for monthly or quarterly regional meetings.
- Manages data collection, analyses, and dissemination within IHSC, ensuring statistical analyses and comparative processes are included.
- Monitors trends in processes and outcomes of care and reports to senior leadership, local facility leadership, and external sources, as appropriate.
- Assists IHSC-staffed facilities in identifying QI opportunities and initiatives, recommends solutions for facility issues and concerns, and implements organizational QI plans and follow-up activities.

- Evaluates QI program activities at field sites to provide evaluation reports with recommendations for change, modifications, or health and safety needs to the respective health services administrator (HSA) and IHSC leadership.
- Assists with QI education, training, development, and implementation for all IHSC staff.
- Collaborates with IHSC units and field staff to ensure IHSC staff integrate the quality functions.
- Participates in QI policy development.
- Reviews or revises the IHSC national QI plan at least annually.
- Oversees intra- and inter-organizational preparation QI reports and ensures evidence of collaborative multi-disciplinary input.
- Informs senior leadership of public policies, regulations, guidance, legislative, and health care trends that may affect QI, patient safety, agency-specific health care, and other related health care initiatives.
- Collaborates with the IHSC Medical Education and Development Unit (MEDU) to develop data-driven and staff-identified training for IHSC staff.
- Conducts random chart audits to identify and assess any clinical care, processes, or system failures.
- Submits QI activity quarterly reports to the MQMU chief.
- Conducts compliance site visits as assigned.

C. QI Risk Management Program Manager or Designee

- Guides IHSC staff in the RM Program and collaborates to identify and assess process-related vulnerabilities to reduce risk and adverse patient events or harm.
- Oversees FHPM and risk management team activities.
- Participates in the risk management guide development, review, and revision process, conducted at least every three years.
- Collaborates with the IHSC MEDU to develop risk management training based on data and identified needs.
- Submits quarterly reports of activities to the MQMU chief.
- Conducts compliance site visits as assigned.

D. QI Risk Manager

- Provides guidance to IHSC staff regarding the RM program. Collaborates with IHSC units to identify, assess, and proactively reduce risk to the agency.
- Collaborates with the FHPM and the RCS to establish RCA action plans.
- Assists staff in RCA and writing incident reports.
- Collaborates with the facility FHPM to monitor, track, and review incident reports to determine potential procedural or process risks to IHSC.
- Supports and maintains the culture of safety within IHSC.

E. National Quality Improvement Coordinator

The national QI coordinator is responsible for supporting the activities of the national QI Program.

- Helps IHSC-staffed facilities identify QI opportunities, recommend solutions for facility issues, and implement organizational QI plans with follow-up activities.
- Provides technical assistance, advice, and consultation to field staff when interpreting and applying QI related standards, regulations, and policies.
- Reports trends in processes and outcomes of care to senior leadership, local facility leadership, and external sources, as appropriate.
- Tracks and reports quarterly audit results from all facilities. Determines accuracy and appropriateness of data based on policy and processes.
- Facilitates development and implementation of QI education and training for all IHSC staff.
- Directs the collection, analyses, and dissemination of data within IHSC to include basic statistical analyses and comparative processes.
- Collaborates with IHSC units and field staff to ensure IHSC staff perform quality functions.
- Assists with completing assigned reports.

F. Quality Assurance Performance Improvement Officer

Supports MQMU with the development and delivery of QI initiatives for IHSC headquarters and field sites through program monitoring QI tools, form development, performance measurement, and data analysis.

- Assists with the development and implementation of agency QI policies, initiatives, and activities.

- Collects, analyzes, and disseminates QI data with statistical analysis.
- Analyzes data, identifies trends, and assists in developing action plans.
- Uses data to make decisions that guide QI program changes.
- Assists with developing intra- and inter-organizational QI reports and deliverables to ensure dissemination to stakeholders.
- Advises IHSC senior leadership on significant or recurring medical QI issues and recommends steps to address issues across IHSC.
- Collaborates with ICE and IHSC programs in the development of educational programs identified during the QI process.
- Participates in the development and revision of agency QI policies.

G. Senior Compliance Program Administrator

Oversees the IHSC Patient Education Program. Reviews and investigates compliance relative to conditions of detention as they relate to the health of noncitizens in ICE custody.

- Collaborates with IHSC unit programs to develop and manage data collection and analysis used to improve the Patient Education Program.
- Oversees the national accrediting body programs.
- Oversees the Compliance Program site visit process.
- Maintains internal audit tools and processes for IHSC-staffed facilities.
- Supervises the establishment and development of the IHSC Patient Education Program.
- Aggregates required data, monitors care processes and outcomes, as well as maintains accreditation compliance with external auditing bodies Reports results to the MQMU chief, IHSC senior leadership, local leadership, and external sources, as appropriate.

H. Health Services Administrator

The Health Services Administrator (HSA) is responsible for health care-related administrative functions in IHSC-staffed facilities. Specific to the QI program, the HSA:

- Collaborates with the clinical director to ensure QI activities maintain an interdisciplinary composition.
- Reviews facility QI plans, activities, reports, and correspondence with the Clinical Director.

- Supports and assists IHSC and Enforcement and Removal Operations (ERO) staff involved in sentinel events.

I. Clinical Director

Oversees and integrates QI and patient safety activities related to clinical care, in conjunction with the HSA, as appropriate.

- Ensures the interdisciplinary teams working on QI activities involve clinical providers of varying disciplines (e.g., medical and dental services).
- Analyzes and integrates findings from QI activities into local clinical care procedures when appropriate.
- Suggests QI activities that evaluate the clinical care at the facility.

J. Regional Leadership

- Comprises an RHSA, regional CD, regional advanced practice provider (APP), and regional nurse managers (NM). Leadership may also include pharmacy, dental, and behavioral health, as needed.
- Collaborates with RCS on QI program changes affecting the agency.

K. Facility Health Care Program Manager or Designee

- Liaises between the local QI committee and the national QI coordinator.
- Chairs the local QI committee.
- Represents their medical facility in quarterly national QI meetings.
- Coordinates the local QI activities and reports required and requested data to IHSC HQ.
- Ensures all IHSC field staff complete QI program training, during orientation and annually thereafter.
- Develops metrics and implements action plans for local studies/tracking and those identified by the national QI Committee incorporating all applicable patient safety initiatives.
- Submits quarterly QI reports to the national QI coordinator.
- Conducts risk management activities as outlined in the risk management guide.
- Integrates QI and patient safety activities in conjunction with respective facility environmental health and safety staff with HSA oversight as appropriate.

L. Local Triad

- Consists of the local HSA, NM, and CD.
- Collaborates with the FHPM to implements QI and RM programs within their facility.

M. All IHSC Health Services Staff

- Responsible for their individual roles in QI, RM, and patient safety.
- Create a safe environment by meeting organizational and professional standards, following identified best practices, and mitigating unsafe conditions or situations.
- Complete organization- or unit-based orientation and participate in ongoing patient safety education.
- Voluntarily report all close calls or near misses, adverse events, and/or sentinel events.
- Initiate immediate corrective steps by securing all supplies or equipment to avoid a patient safety event.
- Educate and empower patients to actively participate in the health care processes.
- Stay current on recommended best or safe practices and safety alerts.

III. National Quality Improvement Program

Agency leaders develop and implement the National QI Program. Each facility's local QI program must understand how local data compare to the agency's national data. MQMU collect data based on the established national performance measures (NPM) and other leadership-directed requests.

A. National Performance Measure Development Workgroup

The NPM Development Workgroup comprises subject matter experts (SME) from each of the clinical service area, staff, and headquarters leadership. The Workgroup annually reviews the NPMs, data results, and recommends modifications to the National Quality Assurance (NQA) Committee, as needed.

Each clinical service area recommends new NPMs, depending on agency trends from internal audit findings, external accreditation findings, and external performance improvement benchmarks (e.g., U.S. Preventative Services Task Force (USPSTF) and Health care Effectiveness Data and Information Set (HEDIS). The NQA Committee determines which NPMs IHSC ultimately adopts.

The Workgroup annually conducts a National QI Program review based on the Annual NPM Report. The MQMU program management staff present the outcomes identified from the review to the NQA Committee. The NQA Committee uses this information for program improvement.

B. National Quality Assurance Committee

The NQA Committee provides operational leadership of QI activities at all IHSC levels. Committee members consist of senior IHSC leadership and other IHSC SMEs, as indicated in the NQA charter. Each quarter, the committee collaborates to improve quality of patient care and safety, and appropriate use of resources. The Committee reviews RM and QI trends to identify, prioritize, implement, and evaluate opportunities to improve the national QI program. The Committee annually reviews and approves NPMs.

The NQA Committee:

- Identifies, prioritizes, implements, and evaluates opportunities to improve organizational processes and systems.
- Reviews and approves QI measures and indicators annually.
- Recommends QI activities according to impact upon patient outcomes and safety.
- Facilitates a multidisciplinary collaborative approach to improve the quality of patient care and safety, and appropriate use of resources.
- Facilitates development and implementation of Develop and delivers QI education and training for all IHSC staff.

C. National Performance Measures

The NPM Development Workgroup meets annually to review and determine the NPMs. The workgroup comprises SMEs from each clinical service area and IHSC leadership. Measures may change annually resulting from workgroup recommendations.

Each clinical service area (See Table 1) should have national performance measures based on trends from internal audits, external accreditation reviews, and external performance improvement benchmarks (e.g., USPSTF and HEDIS).

The RCS collects national data quarterly, shares data, and assists assigned facilities with improvement plans, as needed. The FHPM documents the workplan improvements for each measure using a workplan (discussed in Section III-C). *Please refer to the NPM Technical Resource Sheet for more detailed information.*

Table 1. Service Areas and Quality National Performance Measures

Clinical Service Areas (7)	Example Quality Performance Measures*
Pediatrics	Hypertension Diabetes Mellitus Hemoglobin A1C Human Immunodeficiency Virus Asthma Coronary Artery Disease Pregnancy Screening Dental Timeout Medication Errors Diabetic Neuropathy Foot Exam Medication Reconciliation Tobacco Depression Prenatal Care Pediatric BMI Percentile No antibiotics – Pediatric Upper Respiratory Infection
Obstetrics and Gynecology	
Dental	
Chronic Care Services	
Pharmacy	
Behavioral Health	
Nursing	

The NPM Development Workgroup identifies processes requiring review. This includes both a numerator and denominator statement that defines the population and what it measures, or the desired outcome. The numerator indicates the number of the population that meets the defined measure, and the denominator indicates the total number of the population being studied.

Example: Outcome measure - Management of diabetes, a current HgbA1c Level of 7% or less in diabetes patients managed on oral medication or insulin.

- Numerator: *Number of patients with diabetes with HgbA1c level 7% or less who are on oral medication or insulin evaluated during this reporting period.*
- Denominator: *Total number of patients with diabetes on oral hypoglycemics or insulin with HgbA1c level evaluated during reporting period*.

Example: Outcome measured - Control of hypertension (HTN), a current blood pressure of less than140/90 on patients prescribed medication for the diagnosis of hypertension.

- Numerator: *Number of patients with HTN on antihypertensive medication with a current BP reading less than140/90 during this reporting period.*
- Denominator: *Total number of patients with HTN on antihypertensive medication evaluated during this reporting period.*

D. Local Quality Improvement Program

The local QI program includes all improvement activities identified, monitored, and implemented at the facility level. FHPMs oversee all local program activities.

The local program must have a local QI committee responsible for the development and implementation of improvement projects. The local QI program must document the process and outcome improvements in the internal QI plan on an annual basis. The RCS supports and guides the local facility for QI needs.

E. Local Quality Improvement Committee

Each medical facility's leadership establishes and maintains a local QI committee to improve performance and promoting patient safety. The local committee is a multidisciplinary team determined by the governing body. The FHPM leads the committee. A facility physician must be involved in the committee.

The local QI committee:

- Meets quarterly to discuss identified areas of improvement.
- Identifies local problems from the QI quarterly data reports, incident reports, local surveys, or audits. The committee assigns an individual or team to conduct studies on these issues.
- Assigns a team to complete a health care failures mode effect analysis (HFMEA). All facilities, including staging facilities, must complete an annual HFMEA review.
- Completes an annual QI program effectiveness review by reviewing QI studies and the QI, administrative, and/or staff meeting minutes, or other pertinent written materials.

F. Local Performance Measures

The QI committee develops one or more local performance measures (LPM) using five of the 11 applicable service areas (See Table 2). IHSC internal audits, external accreditation reviews, and the HFMEA may reveal deficiencies requiring development an action plan that may be counted toward the five LPMs.

The QI committee defines each measure by a numerator and denominator statement, as discussed with the NPMs. The QI committee collects data locally from the studies completed based on selected LPMs. The QI committee works to implement improvement processes, as needed, based on collected data.

The RCS shares the data with the facility, and the facility then develops improvement plans based on the data. The FHPM uses a QI workplan to document the facility's progress for the local performance measure to determine compliance with established goals. . Each facility must use a process or an outcome study to address an improvement measure on a yearly basis. Refer to the "Plan-Do-Study-Act" (PDSA).

Table 2. Service Areas and Quality Local Performance Measures

Service Areas	Quality Performance Measures
Intake processing Acute care Medication services Chronic care services Intra-system transfer services Scheduled off-site services Unscheduled on-site and off-site services Mental health services Dental services Ancillary services Medical Housing Unit	Accessibility Appropriateness of clinical decision making Continuity Timeliness Effectiveness (outcomes) Efficiency Prescriber-patient interaction Safety

Example: The national and local levels track current blood pressures of less than 140/90 on diagnosed patients prescribed antihypertensives.

Local Measure

- Service Area - *Chronic Care.*
- Quality Performance Measure - *Effectiveness (outcomes).*

Measure Statement: *Control of HTN, a current blood pressure reading of less than140/90 on diagnosed patients prescribed anti-hypertensives.*

National Measure

- Service Area - *Chronic Care.*
- Quality Performance Measure – ***Control of HTN**, a current blood pressure reading of less than140/90 on diagnosed patients on anti-hypertensives.*

G. Local Quality Improvement Work Plan

A local QI work plan contains activities planned for a given performance measure. Each facility must have a work plan for each performance measure that describes targeted goals for the year, and methods to achieve those goals. There are 15 national measures and five local measures from which to choose.

If a performance measure is within the established threshold, the workplan must document how the facility plans to sustainably maintain the measure, and discuss the monitoring plan. A national measure can also serve as a local measure; however, only one work plan can cover the dual measure.

The local clinical QI committee inputs data and plan improvement information and reviews the Quality Improvement Workplan at least quarterly or more frequently. See the following workflow workplan schema and an example:

Performance Measure: Track intake processing timeliness

- Determine goal: To decrease wait time of the intake process from 12 hours to 11 hours.
- Collect Data: After two quarters of tracking data, wait time had not decreased to set goal of 11 hours.
- Plan: Update your workplan by answering the following questions:
    i. Should the interventions change?
    ii. Was the goal realistic?
    iii. Are there more barriers not originally identified?
    iv. Changes to interventions in a workplan may be necessary throughout the year.

H. Internal Quality Improvement Program

The internal QI program fosters continuous quality improvement in IHSC facilities' processes to improve the timeliness, effectiveness, efficiency, and management control of IHSC facilities' quality improvement activities. Each facility's internal program uses a reporting system or dashboard to track committee meetings, workplans, RCA studies within the local facility.

Internal QI program Reporting System Criteria.

At a minimum, IHSC facility staff must:

- Use FHPM dashboard to track all QI activities outlined in the local QI program including NPMs and process or outcome studies;
- Define individual processes required for any activity designed to produce a desired outcome;
- Develop measures for critical processes involved in the attainment of the outcome (e.g., management of diabetes, management of HTN);
- Set performance goals for each measure;

- Include reason for failure to meet goals and the plan to achieve success (e.g., the facility fails to meet established goals for several indicators, the facility may need to prioritize its improvement efforts); and
- Identify the information the site collects, how often staff collect information, and how staff share the information with all facility staff.

The FHPM or designee must conduct quarterly reviews of the above reporting system including all activities for monitoring, rapid identification, correcting problems, and spreading best practices based on health care outcomes.

I. Annual Review and Report

The responsible physician or designee at each facility completes annual health record reviews using the MQMU Health Record Review tool.

If the designee has a non-clinical background, the responsible physician cosigns the review and addresses any deficiencies.

The FHPM or designee at each facility develops QI annual reports. Annual reports must include:

- Summary of activities completed for the year.
- Trainings.
- All quarterly data.
- QI studies, to include numerical data and graphs.
- Future initiatives and recommendations based on data.

Annual Quality Improvement Reports must represent the entire fiscal year. The report must include a comparative analysis of data from year to year to identify trends.

Information from the annual report supports potential changes to annual QI plans. The FHPM or designee must provide local annual reports to IHSC MQMU by the end of February in the next fiscal year.

IV. General Improvement Systems

A. Data Monitoring, Trending, and Evaluation

The QI analysis and reporting process identifies and prioritizes opportunities for improvement. The quality assurance performance improvement officer and RCS identify patterns, trends, and opportunities for improvement at the national and at the local level.

The FHPM or designee tracks and trends data at the local level to identify opportunities for improvement and evaluation of the local QI program.

IHSC staff collects data through the local program and are analyzed, prioritized, and acted upon by multiple disciplines with the local facility.

The RCS acts as the liaison to share local and national data between HQ and local facilities. The RCS provides the data quarterly or as directed by the NQA Committee. QI data informs decisions that may improve organizational systems, and result in safe patient care. IHSC monitors national and local data gathered from performance measures, incident reporting, and health records:

1. FHPMs at each IHSC facility, at a minimum, collect local NPM data and review national data received from HQ to identify trends. These measures capture patient safety-related events and allow the organization an opportunity to track and trend aggregate data for effective analysis.
2. To develop customized queries and report as directed by the NQA Committee.
3. To provide data analysis using queries and reports that include information to any level of management. This information highlights the contributing factors associated with patient safety events and prevents reoccurrence.

   FHPMs must review local data monthly to identify trends. FHPMs must conduct quarterly data analysis and reporting prior to the local QI committee meetings. They provide the findings to committee members prior to scheduled meetings. The FHPM or designee presents the quarterly review. The analysis must consist of a review of incident reports, inspection reports, and improvement plans. The FHPM or designee presents corrective action recommendations if the results of the review fall below compliance thresholds as determined by the FHPM, or designee. The FHPM or designee reports and provides charts, if applicable, to the meeting agenda for review and discussion. See Committee Meeting Template on the MQMU SharePoint page.

B. Improvement Process

QI committee members identify opportunities for improvement through data collection and analysis. They prioritize opportunities for action and use the PDSA methodology to make improvements.

1. **Plan**: The QI committee prepares to deliver health care and creates a system to evaluate effectiveness. This requires involvement of the local QI committee and IHSC leadership.
2. **Do**: QI committee members perform the planned activity, or action, or deliver the planned services. The QI team measures identified problems with health care or processes and high risk, high volume, or problem prone.

The QI team measures health care processes against the following dimensions:

- Health care delivery according to standards and clinical guidelines.
- Services that are available, timely, effective, and continuous.
- Services that are safe and efficient.

3. **Study**: The QI team compares previous results to other comparable services measured at similar facilities. See Appendices G and H for templates for both process and outcome studies.

- Process Studies - What processes were used to get to the achieved outcome? Were the processes effective? Did the processes flow as expected? Do the processes need changing?
- Outcome Studies - What is the expected outcome? Can you measure the outcome? Following the study, do you get the expected outcome?

4. **Act:** Using the results of the study data, determine if the planned services were effective, resulted in a positive outcome, increased efficacy, or improved patient safety. Based on results, the local QI committee funnels the recommended improvement strategies through their chain of command, which starts with the RCS. Recommendations may include additional training or education.

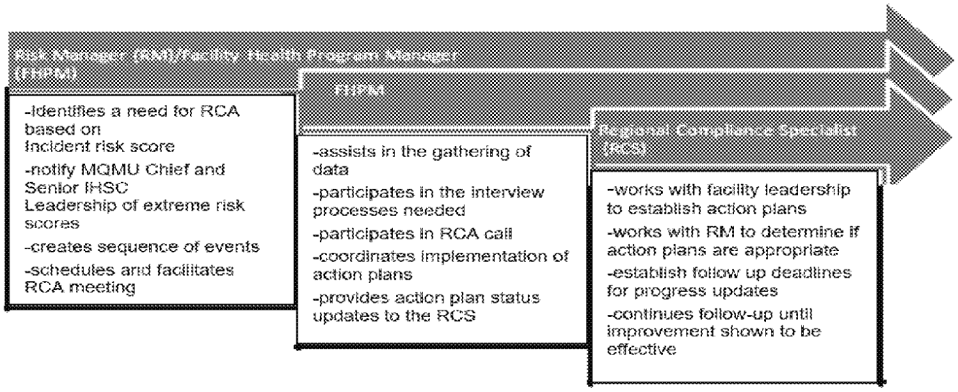
- Modify the process if the outcome did not meet established goals.
- If the process was effective, then expand to a wider study population to evaluate the process for consistency.
- Implement the process with approval from IHSC units with oversight of the process.

The local QI committee and facility HSA assesses the QI program's effectiveness annually and the PDSA model cycles back to "**Plan.**"

C. Risk Management and Assessment

Risk management focuses on the promotion of patient safety and the use of evidence-based risk analysis within the IHSC health care service system. It includes clinical and administrative activities to identify, evaluate, and reduce risk of injury to patients. It identifies potential risk, prevention of risk exposure, and management of real or potential adverse incidents. Risk managers collaborate with unit chiefs regarding incident reporting, RCA, and tracking of undesirable outcomes to ensure improvement processes or plans are in place and addressed.

Risk managers identify and address in collaboration with local staff concerns identified from the QI system risk assessment through action plans. Refer to IHSC 11-06 G-01, *Risk Management Guide*.



D. RCA Process

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E. Completing the RCA Form

The FHPM uses the IHSC RCA form to document demographic information, an event summary, the event type, and the assigned RCA reviewers. The FHPM, in collaboration with the respective risk manager, completes a preliminary sequence of events and process review on the RCA form found in IHSC 11-06 G-01, *Risk Management*, Appendices H and I.

1. During the RCA meeting(s), the team describes and documents the process used in providing care and compares it to the intended processes. The team identifies each process vulnerability as an (a) incidental finding, (b) contributing factor, or (C) root cause. Incidental findings are not actionable.
2. Each contributing factor and root cause require an action plan.

F. Success Action Plan (SAP)

During the RCA meeting(s), the team documents each contributing factor and root cause as part of the SAP:

1. Risk Reduction Strategy Section: The action plan that addresses the root cause or contributing factor.
2. Implementation due date: The initiation date of the action plans.
3. Classification of the AP section: The SAP is the classification method of corrective action used to implement the action plan to address training, staffing, equipment, communication, standard operating procedure, or policy.
4. Responsible Party Section: Staff who implement and complete the plan.
5. Measurement Strategy and Expected Outcome Section: Describes the measure, the study or tracking time period, and the expected level of compliance.
6. Action Plan Follow Up Date: The date the FHPM follows up with the RCS for the action plan status.
7. Compliance Level Achieved: States whether he compliance level was met. If not, facility staff must document the specific actions taken, with a justification of why they chose that particular action. Staff must submit periodic updates until the facility completes or closes the action item.
8. Completion: Documents “yes” or “no” if the action plan has effectively addressed the process vulnerability. The FHPM provides all documentation supporting measurable outcomes to the RCS for consideration of action plan completion.

9. Immediate improvement measures section: Documents if any prompt actions were implemented prior to the documentation of the RCA.
10. Headquarters Recommendations for National Implementation Section: Documents any suggested agency wide process improvement strategies.

The risk manager and RCS review and sign the completed RCA document. The RCS routes the RCA document to the MQMU chief, deputy assistant director of Health Care Compliance, and the assistant director for review and signature. The RCS saves the signed document in a restricted area on the MQMU SharePoint page.

V. DEFINITIONS

1. **Actual event** - A situation or circumstance that occurred with or without harm to the patient. (IHSC Operational Definition)
2. **Adverse event** - An occurrence or condition associated with the provision of health care or services that harm the patient. Adverse events may be due to acts of commission or omission.
3. **Aggregate** - To combine standardized data and information collected over time. (IHSC Operational Definition)
4. **Assessment** - The systematic collection and review of patient specific data. (IHSC Operational Definition)
5. **Close Call** - See "Near Miss."
6. **Criteria** - Expected level of achievement, or specifications compared to performance or quality. (IHSC Operational Definition)
7. **Datum (singular); Data (plural)** - Material facts or clinical observations that analysts have not interpreted.
8. **Evaluation** - Analysis of collected, compiled, and organized data pertaining to important aspects of care. Analysts compare data with predetermined, clinical benchmarks. Analysts determine variations from criteria to be accepted or unaccepted and identify problems or opportunities to improve care.
9. **Governing Body** - Refers to the individuals, group, or agency that has ultimate authority and responsibility for establishing policy, maintaining quality of care, and providing for organizational management and planning. (IHSC Operational Definition)
10. **Health Care Failure Mode and Effect Analysis (HFMEA)** - The HFMEA is a prospective risk assessment methodology that identifies and improves steps in a process before errors occur. It seeks to ensure a safe and clinically desirable outcome.

HFMEA is a bottom-up approach to analyzing processes, system designs, and performance.

11. **Health Record Review** - Systematic review of the health record using a standardized form or audit tool to determine whether specific elements related to qualify of care provided are adequately documented.
12. **Incidental Finding** - Finding that does not require immediate action; however, analysts should track and monitor the finding to ensure corrective actions are not needed.
13. **Measure** - To collect quantifiable data about a dimension of performance of a function or process. (IHSC Operational Definition)
14. **Measurement** - The systematic process of data collection, repeated over time or at a single point in time. (IHSC Operational Definition)
15. **Near Miss (also known as Close Call)** - An event or situation that could have harmed a patient but did not, either by chance or through timely intervention. Officials identified the event and resolved it before reaching the patient. Such events are known as "close call" incidents.
16. **Outcome Study** - An outcome study examines whether expected outcomes of patient care were achieved by (1) identifying a patient clinical problem; (2) conducting a baseline study; (3) developing and implementing a clinical corrective action plan; and (4) restudying the problem to assess the effectiveness of the corrective action plan.
17. **Outcome** - The result of the performance or non-performance of a function or process. (IHSC Operational Definition)
18. **Patient safety event** - An incident or error that occurred, or almost occurred, that caused, or had the potential for causing, harm to a patient. (IHSC Operational Definition)
19. **Performance improvement (PI)** - The continuous study and adaptation of functions and processes to increase the probability of achieving desired outcomes and better meeting the needs of individuals, populations, and other users of services.
20. **Performance Measure** – A set of standardized national or local indicators used to assess the performance of the facility's health care delivery in safeguarding of health safety, and in the mitigation of health risk.
21. **Process** - A goal-directed, interrelated series of actions, events, mechanisms, or steps. A series of actions directed to achieve a goal.

22. **Process Study** - A process study that examines the effectiveness of the health care delivery process by (1) identifying a facility problem; (2) conducting a baseline study; (3) developing and implementing a clinical corrective action plan; and (4) restudying the problem to assess the effectiveness of the corrective action plan.
23. **Quality Assurance (QA)** - Systematic monitoring and evaluation of the various aspects of a project, service, or facility to ensure nationally recognized standards of care are met.
24. **Quality Improvement (QI)** - Quality improvement is a prospective and retrospective review aimed at improvement. Instead of attributing blame, the review process creates systems to prevent errors from happening.
25. **Risk assessment** - A method used to evaluate the probability of a patient safety event to minimize the risk of the event occurring. (IHSC Operational Definition)
26. **Risk management (RM)** - Risk management is a process and system that includes clinical and administrative activities that organizations undertake to identify, evaluate, and reduce the risk of injury to patients. It involves identification of risk potential, prevention of risk exposure, and the management of real or potential adverse incidents.
27. **Root cause analysis (RCA)** - A multidisciplinary analysis tool used to identify basic or contributing factors associated with an unwanted outcome and sentinel event.
28. **Sentinel event (SE)** - An unexpected occurrence involving death or serious physical or psychological injury, or an unrelated risk to the natural course of the patient's illnesses or underlying condition. Serious injury specifically includes loss of limb or function. Unrelated risk includes any process or variation for which a recurrence would carry a risk of adverse outcome. Such events are called "sentinel" because they signal the need for immediate investigation and proactive response on the part of the organization.
29. **Standard** - A statement that defines the structures and processes that must be in place in an organization to enhance the quality of care. (IHSC Operational Definition).
30. **Success Action plan** - The end product of a root cause analysis or health care failure mode and effects analysis that identifies the risk reduction strategies the organization intends to implement to prevent the recurrence of similar adverse events in the future. (IHSC Operational Definition).

VI. REFERENCES

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