UCLA HEALTH SYSTEM
PERFORMANCE IMPROVEMENT & PATIENT SAFETY PLAN
FY 2020

UCLA HEALTH SYSTEM GOALS PROPOSAL

	Threshold	Target	Maximum	End of FY19
Goal: Quality Improvement				
Achieve 25+ points on the MOVERS dashboard	12 Quality Points	21 Quality Points	25+ Quality Points	25+ Quality Points
Goal: Key Initiative Supporting Strategic Plan				
Achieve improvement in appropriate access and capacity measures for UCLA Health	1 out of 4	2 out of 4	3+ out of 4	2 out of 4
Goal: Financial Sustainability				
Achieve net operating margin budget target to sustain needs of Health Sciences	$184.4M = 6.4%	$189.4M = 6.6%	$194.4 = 6.7%	*Projected* $328.0 = 11.6%

UCLA Health Quality MOVERS FY20 Goal Proposal

MOVERS Star Rating (UCLA Health):

MOVERS Dashboard	2018/19 Goals				2019/20 Goals				Changes in goals
	Threshold 1 Point	Target 2 Point	Stretch 3 Points	Site	Threshold 1 Point	Target 2 Point	Stretch 3 Points	Site	
MORTALITY									
- Reduce Risk-Adjusted Mortality Index	.97 (50%)	.92 (40%)	.84 (25%)	RRMC	.95 (50%)	.90 (40%)	.82 (25%)	RRMC	Harder
	.97 (50%)	.92 (40%)	.84 (25%)	SMH	.95 (50%)	.90 (40%)	.82 (25%)	SMH	
-Sepsis Risk-Adjusted Mortality Index	1.21 (50%)	1.16 (40%)	1.04 (25%)	RRMC	1.22 (50%)	1.16 (40%)	1.03 (25%)	RRMC	Harder
	1.02 (50%)	0.95 (40%)	0.70 (25%)	SMH	0.99 (50%)	0.92 (40%)	0.67 (25%)	SMH	
OUTCOMES									
- VBP Quality Performance Ranking	50	55	60	RRMC	50	55	60	RRMC	Sustain
	50	55	60	SMH	50	55	60	SMH	
- Pop-Based Quality Measures				AMB	73.00	78.00	83.00	AMB	New
- HBIPS (Psychiatry)	75.00	85.00	90.00	NPH	75.00	85.00	90.00	NPH	Sustain
VALUE									
- ED ThroughPut (Door to Discharge)	223.50 (B)	216.80 (B*0.97)	212.33 (B*0.95)	RRMC	169.40 (B*1.1)	154.00 (B)	149.38 (B*0.97)	RRMC	New
	140.25 (B)	136.04 (B*0.97)	133.24 (B*0.95)	SMH	105.05 (B*1.1)	95.50 (B)	92.64 (B*0.97)	SMH	
- LOS: Actual Days	6.12 (B)	6.02 (B-.10)	5.92 (B-.20)	All	6.12 (*B)	5.02 (*B-.10)	5.92 (*B-.20)	All	Sustain
- LOS Index	1.07 (B)	1.06 (B-.01)	1.05 (B-.02)	All	1.07 (*B)	1.06 (*B-.01)	1.05 (*B-.02)	All	Sustain
- PRIME	1	2	3	All	3	4	5	All	New
EXPERIENCE									
	85.50	86.50	87.50	RRMC	83.75	84.88	86.00	RRMC	
	85.50	86.50	87.50	SMH	80.75	83.13	85.50	SMH	
- Overall Rating (Pctl)	85.50	86.50	87.50	NPH	54.50	58.75	63.00	NPH	Special Focus
	85.50	86.50	87.50	AMB	75.00	78.00	81.00	AMB	
	85.50	86.50	87.50	ALL	80.12	82.09	84.09	ALL	
READMISSIONS									
- Reduce Preventable Readmissions	11.98 (40%)	11.27 (30%)	10.52 (20%)	RRMC	11.68 (40%)	11.23 (30%)	10.70 (20%)	RRMC	Harder
	11.98 (40%)	11.27 (30%)	10.52 (20%)	SMH	11.68 (40%)	11.23 (30%)	10.70 (20%)	SMH	
SAFETY									
- Strengthen Patient Safety (PSI90)	.76(50%)	.72 (40%)	.66 (25%)	RRMC	.97(50%)	.91 (40%)	.82 (25%)	RRMC	Special Focus
	.76(50%)	.72 (40%)	.66 (25%)	SMH	.97(50%)	.91 (40%)	.82 (25%)	SMH	
- CLABSI	0.90 (B)	0.80 (B-.1)	0.75 (B-.15)	RRMC	1.13 (B)	1.03 (B-.1)	0.98 (B-.15)	RRMC	Special Focus
	2.03 (B)	1.93 (B-.1)	1.88 (B-.15)	SMH	0.63 (B)	0.53 (B-.1)	0.48 (B-.15)	SMH	Harder
- CAUTI	1.35 (B)	1.25 (B-.1)	1.20 (B-.15)	RRMC	1.15 (B)	1.05 (B-.1)	1.00 (B-.15)	RRMC	Harder
	1.02 (B)	0.92 (B-.1)	0.87 (B-.15)	SMH	0.50 (B)	0.40 (B-.1)	0.35 (B-.15)	SMH	Harder

UCLA Health Access/ Capacity FY20 Goal Proposal

CEMRP Goal Levels		
Threshold	**Target**	**Maximum**
1 out of 4	2 out of 4	3+ out of 4

Goal	BASELINE	Target	Achievement
HOSPITAL CAPACITY: Reduce UCLA Health CMI-Adjusted Average Length of Stay from FY19YTD baseline by 1.02% or 0.03 days	2.97 days*	2.94 days	Yes = 1 No = 0
HOSPITAL ACCESS: Exceed FY19YTD annualized amount of inpatient discharges + observation stays + overnight recoveries across all hospital settings for FY20	50,078 stays**	50,078+ stays	Yes = 1 No = 0
AMBULATORY ACCESS: Increase outpatient provider visits by 5% over FY19	2,001,388 encounters***	2,101,458+ encounters	Yes = 1 No = 0
AMBULATORY ACCESS: Maintain current average for Third Next Available Appointment (TNAA) for Primary Care New visits	2 days****	2 days	Yes =1 No = 0

Comments on Baselines
* = FY19 YTD health system CMI-adjusted ALOS
**=FY19 YTD totals annualized; RNPH IP discharges AND RR and SM IP discharges, observation, and overnight recoveries through June 18, 2019
*** = FY19 YTD totals annualized; actuals through June
**** = June 2019 snapshot

PURPOSE

The Performance Improvement and Patient Safety Plan is a description of the organizational, multidisciplinary, and systematic performance improvement function designed to support the Mission, Values, and Philosophy of the UCLA Health System. The intent of the Performance Improvement and Patient Safety Plan is to identify the health system's approach to improving and sustaining its performance through the prioritization, design, implementation, monitoring, and analysis of performance improvement initiatives. Moreover, the Performance Improvement and Safety Plan is an ongoing program that demonstrates measurable improvement in indicators for which there is evidence that they will improve patient outcomes, and identify and reduce medical errors. The Performance Improvement and Patient Safety Plan, with total support of Leadership, will utilize internal and external reference databases in an ongoing effort to design, assess, measure, and improve the delivery of care process and outcomes. In accordance with the Joint Commission (TJC) Standards, Centers for Medicare and Medicaid Services (CMS) Conditions of Participation (COPs), California Department of Health Title XXII and the vision of the facility, the following expectations regarding healthcare delivery at the UCLA Health System have been established:

1) Safe – Avoiding injuries to patients from the care that is intended to help them by:
   a) Recognizing and acknowledging risks and unanticipated adverse events;
   b) Investigating factors that contribute to unanticipated adverse events;
   c) Focusing on processes and systems with minimization of individual blame or retribution for involvement in a medical/healthcare error;

2) Effective – Providing services based on scientific knowledge to all who could benefit and refraining from providing services to those not likely to benefit by:
   a) Reviewing reported risks to identify underlying causes and system changes needed to reduce the likelihood of recurrence;
   b) Initiating actions to reduce these risks and unanticipated adverse events;
   c) Reporting internally risk reduction initiatives and their effectiveness;
   d) Analyzing selected healthcare services before an adverse event occurs to identify system redesign that will reduce the likelihood of error;
   e) Integrating Performance Improvement and Patient Safety priorities into the new design and redesign of all relevant organization processes, functions and services;
   f) Researching ways to improve patient safety and quality;
   g) Conducting systematic planning, analysis and monitoring of performance to improve and sustain advances of processes and outcomes of patient care through interdisciplinary teamwork;

3) Patient-centered – Providing care that is respectful of and responsive to individual patient preferences, needs and values and ensuring that patient values guide all clinical decisions by:
   a) Assuring public transparency of information;
   b) Meeting and exceeding customer's needs and expectations;
   c) Incorporating the patient's perspective in developing care delivery processes;

4) Timely – Reducing wait times and delays for both those who receive and provide care by:
   a) Monitoring performance improvement priorities continuously.

5) Efficient – Avoiding waste of equipment, supplies, ideas and energy by:

a) Implementing evidence based care utilizing standardized order sets, protocols and clinical pathways;
b) Utilizing UCLA LEAN Methodology when developing and evaluating processes;
c) Assuring the application of PI priorities to medical/healthcare errors and organization learning;
d) Assuring organizational learning regarding medical/health care errors and the application of performance improvement principles for resolution;

6) Equitable – Providing care that does not vary in quality because of personal characteristics such as gender, ethnicity, geographic location and socioeconomic status by:
   a) Assuring the highest standard of care is delivered to each patient every time regardless of personal characteristics

SCOPE AND ACTIVITIES

This plan applies to all inpatient services and sites of care provided at UCLA Health System. The Performance Improvement and Patient Safety Program include an ongoing assessment, using internal and external knowledge and experience, to prevent error occurrence and maintain and improve healthcare safety and quality. The UCLA Health System recognizes that patients, staff, visitors and other customers have the right to expect the best possible clinical outcomes, a safe environment and an error free care experience. Therefore, the organization commits to continuous designing, monitoring performance, analyzing data, improving and sustaining performance while undertaking a proactive approach to the identification and mitigation of medical errors. The organization responds quickly, effectively, and appropriately when errors occur. We recognize that the patient has the right to be informed of the results of treatments or procedures including whenever those results differ significantly from anticipated results.

Additional program specifics include:

1) All departments within the organization (patient care and non-patient care departments) are responsible for on-going performance improvement and quality assurance activities. These efforts are monitored through the organizational leadership structure and key indicators are reported to the Clinical Excellence/Quality Outcomes Committee.

2) All departments within the organization (patient care and non-patient care departments) are responsible to report healthcare safety occurrence and potential occurrences. The UCLA Health System has implemented an electronic event reporting system, available on all UCLA Health System computers, to report unexpected events and near misses (reference Event Reports Policy). Summary data from the event reporting system will be aggregated and presented periodically to the Clinical Excellence and Medical Staff Executive Committees who will determine further safety (risk reduction) activities as appropriate.

3) Upon identification of a medical/health care actual or , potential care adverse Event will The Care delivery team

   • Perform in accordance to the event management policy.

   • An effective Patient Safety Program cannot exist without optimal reporting of medical/health care errors and occurrences. Therefore, UCLA Health System adopts a just approach in its management of errors and occurrences. All personnel are *required* to

report suspected and identified medical/health care errors, and should do so without the fear of reprisal in relationship to their employment. This organization supports the concept that errors occur due to a breakdown in systems and processes, and will focus on improving systems and processes.   A focus will be placed on remedial actions and individual development to assist rather than punish staff members.

4) Through review of internal and external data sources (including, but not limited to reports from evidence based medicine centers, the National Quality Forum, the Agency for Healthcare Research and Quality and other federal and state organizations, the Joint Commission and current literature), the Clinical Excellence/Quality Outcomes Committees will select at least one high-risk safety process for a Failure Mode and Effects Analysis (FMEA) annually.

5) The Performance Improvement and Patient Safety Program includes an assessment of staff (including medical staff) opinions, as appropriate, regarding perceptions of risks to patients, the culture of the healthcare environment to facilitate safe practices, and suggestions for improving patient safety and clinical outcomes through culture of safety surveys.

6) The Performance Improvement and Patient Safety Program includes an ongoing assessment of patient satisfaction through the use of a comprehensive survey tool that includes all HCAHPS required elements.

7) Patients, and when appropriate, their families are informed about the outcomes of care, including unanticipated outcomes, or when the outcomes differ significantly from the anticipated outcomes, following guidelines outlined in the Disclosure Policy.

8) Staff will educate patients and their families about their role in helping to facilitate the safe delivery of care. Patient and family safety education interventions are documented in the patient's medical record.

9) Staff will receive education and training during their initial orientation and on an ongoing basis regarding job-related aspects of patient safety, including the need and methods to report and reduce medical/health care errors. In addition, staff will be educated and trained on the provision of an interdisciplinary and collaborative approach to patient care.

10) Medical/health care errors and occurrences, including sentinel events, will be reported in accordance with all state, federal and regulatory body rules, laws and requirements.

11) Leaders will provide feedback to staff when they have identified a safety issue or occurrence.

PERFORMANCE SAFETY PLAN PRIORITIES & GOALS

The hospital's approach to performance improvement is continuously assessed and revised to meet the goal of ensuring that patient outcomes are continually improved and safe patient care is provided. Examples of information utilized to achieve this goal include: variance related data such as medication errors and falls; infection prevention surveillance; sentinel event alerts; and TJC/CMS Quality Measure data, as well as, patient satisfaction reports. The criteria used to prioritize opportunities for improvement include, but are not limited to:

- Patient Safety
- Strategic plan goals/objectives

- Mission/vision
- Quality outcomes
- Patient care operations
- Efficiency of care
- Customer satisfaction

The hospital recognizes that to be effective in improving patient safety there must be an integrated and coordinated approach to reducing errors. While taking into consideration high risk, high volume, high cost and problem prone processes, the UCLA Health System has established the following Performance Improvement/Patient Safety goals:

1. Achieve of a Patient Safety conscious environment integrated throughout the facility.
2. Improve the reporting of medical errors by establishing a policy focusing on corrective actions through staff education for those reporting their errors, rather than punitive or disciplinary actions.
3. Implement confidential electronic Event Reporting process that includes documentation of follow-up and reporting processes.
4. Expand the implementation of evidence-based practices.
5. Monitor hospital-wide indicators for established areas of focus.
6. Reduce the number of medication errors.
7. Monitor patient safety indicators related to an area's specific "Scope of Service."
8. Conduct a proactive risk assessment utilizing the Failure Mode, Effects Analysis Methodology.
9. Monitor and improve areas identified through Patient Satisfaction Surveys.
10. Review the governance of medication management and conduct a Failure Mode, Effects Analysis and assess patient safety and alignment of processes with a culture of safety.

Performance improvement priorities and activities may be reprioritized based on significant organizational performance findings or changes in regulatory requirements, patient population, environment of care, and expectations and needs of patients, staff, or the community. Priorities may be reset by the multidisciplinary hospital quality committee in consultation with Senior Management and Medical Staff leadership.

The following Quality Mission Vision and Movers strategy have been developed and implemented:

UCLA Health

Quality Vision

Honoring the trust of our patients, families, and community by continuously striving to deliver perfect care through excellence in quality, safety, service and affordability.

Principles
Value-based care • No harm • Patient centered • Coordinated care

UCLA Way
Continuous quality improvement • Lean • Culture of safety

Quality "MOVERS"

REDUCING RISK ADJUSTED **MORTALITY**	IMPROVING PROCESS AND **OUTCOMES** MEASURES	IMPLEMENTING **VALUE**-BASED REDESIGN	ENHANCING THE PATIENT **EXPERIENCE**	REDUCING PREVENTABLE **READMISSIONS**	STRENGTHENING PATIENT **SAFETY**
• Sepsis	• CMS core measures	• ValU leadership team	• Nurse communication	• Readmission team (RRI)	• AHRQ PSIs
• Hospice/palliative care	• Population-based MSSP Quality Gate measures	∘ Lean/Six Sigma	• Pain management	∘ CMS: AMI, HF, Pneumonia, COPD	• VTE
• Rapid mortality review		∘ Value quotient	• Discharge information		• Iatrogenic pneumothorax
• Code blue team		∘ TDABC	• Ambulatory staff	• Transitions of Care	• CLABSI
• Rapid response team		• Quality council		∘ Home Health	• CAUTI
		∘ Dept dashboards		∘ SNF	• SSI
		• Nursing quality council			• Decub ulcers

PERFORMANCE IMPROVEMENT METHODOLOGY

The evaluation, monitoring, and improvement methodologies utilized by the UCLA Health System are the FOCUS-PDCA and LEAN process improvement tools. The FOCUS-PDCA steps are as follows:

Find a process to improve
Organize a team that knows the process
Clarify current knowledge of the process
Understand sources of process variation
Select the process improvement

Plan the improvement and continued data collection
Do Improvement, data collection and analysis
Check and study the results
Act to hold the gain and to continue to improve the process

UCLA also employs tools for process improvement and/or redesign and cause-mapping incorporate the concepts of statistical process control, Six Sigma, and lean systems thinking to reduce system variation, delays, and complexity that is detrimental to patient care and safety. The LEAN tools are available on the Mednet home page under "UCLA Operating System". The Cause-mapping resources under Quality Management Services Quality reports.

PLAN

In order to plan and develop effective processes, functions or services, the following key elements are considered when relevant and available:

1. The process design is based on the organization's mission, vision and MOVERS strategic
2. Consideration is given to the needs and expectations of patients, staff, and others, as well as, the direct effect or criticality of the design on patient care.
3. Research of current literature and practice guidelines are reviewed for successful or best practice(s).
4. Development is consistent with sound business practices.
5. Baseline performance expectations are utilized to guide measurement and assessment activities.

Performance monitoring and evaluation standards are department, division, service line and/or population focused. Certain processes are measured on an ongoing basis both in response to occurrences and proactively. Selected processes which are high volume, high risk, high cost and problem prone are measured, analyzed and improved on an ongoing basis.

Performance Improvement projects that are designed or redesigned to monitor expected performance within the hospital are developed to measure, assess, improve and maintain process improvements. Performance levels may be established through comparison performance with other "like" facilities to identify variations or "failure modes." Comparative data is used from the UHC, NHSN, CMS or current/past department performance. Each activity monitored has an established performance level or threshold to measure expected performance. A strategy for maintaining the effectiveness of the redesigned process over time is also implemented.

DO

Data collection is the basis of all Performance Improvement activities and provides a means of measuring performance through which informed decisions can be made.

1. Program data is collected for a comprehensive set of performance measures based on the priorities and frequency established by the leaders of the organization in order to:
   a. Establish a baseline when a process is implemented or redesigned.
   b. Describe process performance or stability.
   c. Describe the dimensions of performance or stability.
   d. Describe the dimensions of performance relevant to functions, processes and outcomes.
   e. Identify areas for improvement including the effect on patients.
   f. Determine whether changes in a process have met objectives
   g. Implement a strategy for maintaining the effectiveness of the redesigned process

over time.
2. Data is collected as a part of continuing measurement, in addition to data collected for priority issues.

CHECK

Program activities involve the assessment process, which includes the necessary disciplines of departments to draw conclusions about the need for more intensive measurement. A systematic process is used to assess collected data in order to determine whether specifications for newly designed processes were met and the level of performance and stability of important existing processes. Priorities for possible improvements or redesign of existing processes, actions taken to improve the performance improvement processes and whether changes in the processes resulted in improvement are also assessed.

Ongoing data collection and PI activities are regularly reported as follows:
- MOVERS Organization, Goals Oversight Team
- PT care units Departments: Clinical Excellence Committee

The assessment process for the Medical Staff is addressed at the time of initial application and continuously through the Ongoing and Focused Profession Practice Evaluations (refer to Policies MS119, MS120, and MS120A) and department level PI activities. The Medical Staff Committee chairpersons are responsible for assessing the Performance Improvement activities related to their assigned committees and recommending policy and operational changes based on analysis of committee related data. In addition, each department/service-line presents annually to the Quality Council regarding achievements and PI activities. Each of the Medical Staff committees submits a monthly report to the Clinical Board and presents regularly to the Quality Council integrating their support of and progress with the MOVERS strategy The Medical Staff committees addressing PI include the following:

- Blood Utilization Review Committee
- Cancer Committee
- Clinical Excellence Committee
- Infection Control Committee
- Pharmacy and Therapeutics Committee
- Trauma Committee
- Surgical and Other Invasive Procedure Review Committee

When data analysis identifies a problem or trend, a corrective action plan will be developed and implemented. These actions may include:

1. **System Changes** – Changes in communication channels, changes in organizational structure, adjustments in staffing and changes in equipment or chart forms.

2. **Knowledge Enhancement** – In-service education, continuing education and circulating informational material.

3. **Intensive Reviews/Focus Studies** – When a medical/health care system error-related occurrence is identified; proactive risk assessment activities are implemented including intensive review and/or a focused study. A data collection tool is developed to address

processes, functions, and services that can be designed or redesigned to prevent trends that may have contributed to the problem. Once all charts are reviewed, a summary report is compiled to report conclusions.

4. **Root Cause Analysis** – When a medical/health care error is classified as a Sentinel Event, the recommended Root Cause Analysis format by TJC is used to detect the underlying causes of the variation. Upon approval by administration, the outlined action plan is implemented.

5. **Causal Analysis** – When a medical/health care error is established as a near miss, a causal analysis is completed to determine the underlying causes of the potential variation, the outlined action plan is implemented.

6. **Failure Mode Effects Analysis** – In accordance with TJC published information regarding the most frequently occurring types of sentinel events and patient safety risk factors, at least one high-risk process is selected annually for proactive risk assessment.

7. **Behavior Changes** – Informal or formal counseling, consulting, changes in assignments, and disciplinary action.

8. **Policy Revisions** – Policies are developed or revised for significant organizational issues that are interdepartmental or mandated to be hospital-wide by accreditation agencies or state/federal legislation. Any potential policy revisions are presented to the Policy Committee to identify the appropriate entity for development, and ensure that input is obtained and incorporated into a final policy statement. Once completed, the committee will submit the policy to the Hospital Administrator for approval, who will then forward it to the Clinical Board for final approval.

9. **Multidisciplinary Process Teams –** Teams are formed as needed and over site is provided by the Quality Leadership Team to investigate and make recommendations when organization-wide performance becomes unacceptable or when a process has been identified to be proactively redesigned. The process team presents the recommendations to the Quality Leadership Team for approval.

10. **Operational Changes** – Any activity that may need to be performed differently in order to expedite a process or improve overall patient care will be examined and changed if appropriate.

The assessment process includes the use of statistical process control techniques/tools as appropriate. When assessment of data indicates a variation in performance or potential risk to patient safety, more intensive measurements and analysis will be conducted, and in addition, the department/service or team will reassess its performance measure.

When a performance measurement does not reach the predetermined optimal threshold, or if it is attained but further evaluation indicates that performance is not acceptable, the Performance Improvement process should continue. If the level of performance shows no improvement for the time frame established by the identified department/service or team plan, an intensive evaluation should be conducted with input from the Quality Leadership Team, or Director regarding the need for continued measurement and additional corrective action.

When any process remains stable or minimal variation is demonstrated in overall performance after two quarters of data collection, the performance measure should be re-evaluated to determine the need to continue measurement, and re-prioritization of performance measurements should occur.

ACT

When opportunities for improving performance are identified, a systematic approach is used to redesign the involved process, or to design a new process. The leadership, through the Clinical Excellence/Quality Outcomes Committees, will establish hospital-wide priorities and provide adequate resources to be effective.
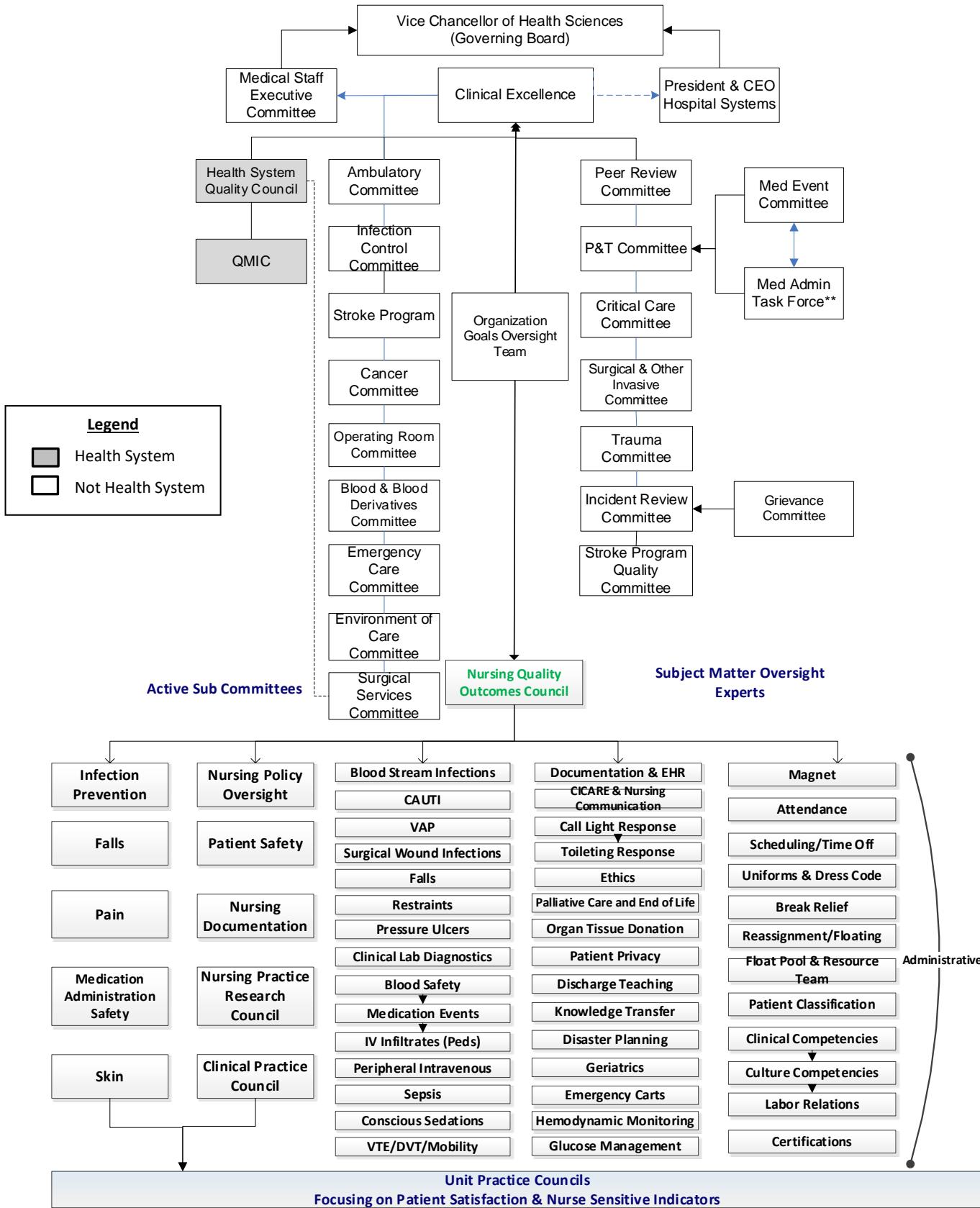
> 1. When a department or service identifies an opportunity for improvement, the department/service will determine if other disciplines or departments will have an impact on the design/redesign of the process. If other disciplines or departments are involved, the opportunity for improvement will be referred to an appointed team.
>
> 2. The assigned team/department will establish priorities for improvement based on the guidelines established in this plan. When necessary, the Quality Leadership Team will assist the team or department/service in establishing priorities.

The Performance Improvement and Patient Safety Plan will be reviewed, evaluated, and revised as necessary to incorporate the most current TJC/CMS/CDPH standards. A summary of evaluation results will be presented to the Clinical Excellence/Quality Outcomes Committees. The annual review will assess, at least, the objectives, scope, organization effectiveness and appropriateness of the program. The plan will be modified as needed based on the results of the annual evaluation. Individual committees and departments will review, evaluate and revise their performance improvement activities and plans annually as part of the organization-wide review.

REPORTING STRUCTURE/ACCOUNTABILITY

The executive responsibility for the Performance Improvement and Patient Safety Program Vice Chancellor, Medical Sciences, acting as the Governing Body for UCLA Ronald Reagan Medical Center. The Medical Staff Executive Committees the President & CEO, Hospital Systems, and the Clinical Excellence/Quality Outcomes Committees ensure implementation of an integrated program throughout the organization.

RONALD REAGAN

Vice Chancellor of Health Sciences
(Governing Board)

Medical Staff Executive Committee

Clinical Excellence

President & CEO Hospital Systems

Health System Quality Council

QMIC

Ambulatory Committee

Infection Control Committee

Stroke Program

Cancer Committee

Operating Room Committee

Blood & Blood Derivatives Committee

Emergency Care Committee

Environment of Care Committee

Surgical Services Committee

Organization Goals Oversight Team

Peer Review Committee

Med Event Committee

P&T Committee

Med Admin Task Force**

Critical Care Committee

Surgical & Other Invasive Committee

Trauma Committee

Incident Review Committee

Grievance Committee

Stroke Program Quality Committee

Legend

(shaded)	Health System
(white)	Not Health System

Active Sub Committees

Nursing Quality Outcomes Council

Subject Matter Oversight Experts

Infection Prevention	**Nursing Policy Oversight**	**Blood Stream Infections**	**Documentation & EHR**	**Magnet**
Falls	**Patient Safety**	**CAUTI**	**CICARE & Nursing Communication**	**Attendance**
Pain	**Nursing Documentation**	**VAP**	**Call Light Response**	**Scheduling/Time Off**
Medication Administration Safety	**Nursing Practice Research Council**	**Surgical Wound Infections**	**Toileting Response**	**Uniforms & Dress Code**
Skin	**Clinical Practice Council**	**Falls**	**Ethics**	**Break Relief**
		Restraints	**Palliative Care and End of Life**	**Reassignment/Floating**
		Pressure Ulcers	**Organ Tissue Donation**	**Float Pool & Resource Team**
		Clinical Lab Diagnostics	**Patient Privacy**	**Patient Classification**
		Blood Safety	**Discharge Teaching**	**Clinical Competencies**
		Medication Events	**Knowledge Transfer**	**Culture Competencies**
		IV Infiltrates (Peds)	**Disaster Planning**	**Labor Relations**
		Peripheral Intravenous	**Geriatrics**	**Certifications**
		Sepsis	**Emergency Carts**	
		Conscious Sedations	**Hemodynamic Monitoring**	
		VTE/DVT/Mobility	**Glucose Management**	

Administrative

Unit Practice Councils
Focusing on Patient Satisfaction & Nurse Sensitive Indicators

SANTA MONICA HOSPITAL

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                          Vice Chancellor of Health Sciences
                                 (Governing Board)

    Medical Staff                    Clinical                    President & CEO
    Executive                        Excellence                  Hospital Systems
    Committee                        Committee
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- Health System Quality Council
  - QMC
- Family Medicine Committee — Includes FM peer review
  - Medicine Committee — Includes Medicine peer review
  - ED Committee — Includes ED peer review
  - OB/GYN Committee — Includes OB/Peri peer review
  - Pediatrics Committee — Includes Peds peer review
  - Surgery Committee — Includes Surgery peer review, Includes Anesthesia peer review, Includes Ortho peer review
  - Bioethics Committee
  - Cancer Committee
- Cardiovascular Committee
  - P&T Committee
  - Infection Prevention
  - Risk Management Committee
  - Utilization Review Committee
  - Grievance Committee (Patient Affairs Committee)
- Med Event Committee
- Med Admin Task Force

Legend

(shaded)	Health System
(white)	Not Health System

- Surgical Services Committee
- Exemplary Professional Performance (Nursing)

Nursing Policy Oversight Committee

Clinical Practice Council

Exemplary Professional Practice	Transformational Leadership	New Knowledge Innovation and Improvements	Structural Empowerment

EPP Subcommittees
- Falls Committee
- Pain Committee
- Skin Care Committee
- Nurse-sensitive Hospital Acquired Infection Committee
- Nursing Pharmacy

- CNIII Portfolio Review Group
- CNII Portfolio Review Group
- UPC Chairs are Members of TL

- Nursing Practice Research Council

Unit Level

Unit Practice Councils
3NW Ortho, 4NW MedSurg, 5NW Geriatrics, 6NW Pediatrics, 4MN Medicine, 5MN Intermediate Care, L&D, Postpartum, NICU, PACU/UPTU, OR, ED Resource Pool

MEDICAL STAFF EXECUTIVE COMMITTEE (MSEC)

The Medical Staff, through the Medical Staff Executive Committee, has the responsibility for the safety and quality of the medical care rendered to UCLA Medical Center patients. The Medical Staff shares responsibility for the Performance Improvement and Patient Safety Plan with Medical Center administration, represented by the President & CEO, Hospital Systems. The Medical Staff, Medical Center Administration and Clinical Excellence Committee share responsibility for reviewing and evaluating aggregate Performance Improvement data and making recommendations, when needed, for further action. The Medical Staff shares responsibility with the UCLA Medical Center Administration for developing and reviewing non-physician professional staff policies and recommending standards for other UCLA Medical Center staff whose conduct directly influences the safety and quality of patient care.

The MSEC also requires each medical staff department/service-line to participate in the Performance Improvement and Patient Safety Program. Each department/service-line identifies opportunities for improvement through individual case review, data analysis or staff reported events. These cases are reviewed with a focus on identifying opportunities for system improvement, clinical education, performance measurement and professional feedback. Process issues are referred to the appropriate department/committee for resolution. Educational opportunities are addressed individually or through group entities such as M&M or Grand Rounds. Professional competency or medical judgment issues are managed through the FPPE or Hospital-Wide Peer Review Committee. Specific responsibilities and processes are delineated in the Medical Staff Bylaws, Rules and Regulations and Department Specific PI Plans

CLINICAL EXCELLENCE

The Clinical Excellence Committee, which represents leadership across UCLA Medical Center, is responsible and accountable for the success of the Medical Center's Performance Improvement and Patient Safety activities. The Committee synthesizes and coordinates Performance Improvement and Patient Safety activities of the Medical Staff and Medical Center. As such, the UCLA Medical Center and Medical Staff have assigned primary responsibility for developing, implementing, monitoring, and integrating their Performance Improvement and Patient Safety activities to the Clinical Excellence Committee. The Committee ensures that activities throughout the organization are consistent with the priorities established by leadership. The Committee systematically reviews reports from patient safety and quality related UCLA Medical Center committees and subcommittees to identify key areas of opportunities. The Committee identifies specific high volume, high risk, high cost and problem prone aspects of care, instructing the appropriate committee or committees (as delineated in the Medical Staff Bylaws) to prioritize their efforts accordingly. Intradepartmental performance improvement activities, when appropriate, are shared with the Clinical Excellence Committee to assure coordination of efforts. Each year the UCLA Medical Center leadership proposes specific improvement efforts they believe should be addressed. Priorities will be communicated to each department and service at the beginning of the year so that these suggestions may be incorporated into their Performance Improvement and Patient Safety programs.

The Clinical Excellence Committee provides Performance Improvement and Patient Safety leadership, including but not limited to:

1. Assuring compliance with national recommendations for patient safety, including the National Patient Safety Goals.

2. Overseeing and setting/resetting priorities for the Medical Center's comprehensive, interdisciplinary Performance Improvement (PI) program;
3. Development of an environment that encourages and empowers staff to identify and address issues through the performance improvement process in a collegial, just manner;
4. Empowering subcommittees to identify opportunities, design performance improvement activities and resolve issues;
5. Monitoring patient safety and quality-related functions;
6. Reviewing reports from subcommittees and making recommendations regarding operational, safety, and quality of care issues;
7. Overseeing of performance measures that are required by accrediting and licensing agencies related to patient safety and quality;
8. Assessing resource utilization and providing oversight to the Utilization Review service;
9. Reviewing medical record documentation compliance trends and recommending operational improvements and actions when appropriate
10. Obtaining input for improvement opportunities from committee's representatives, department heads or representatives, administrative reports including incident reports, survey findings from professional organizations such as the Joint Commission (JC), departmental quality assessment reports, and continuous hospital-wide trend reports on mortality and readmission;
11. Identifying opportunities for interdisciplinary approaches as needed to efficiently and efficaciously resolve problems;
12. Chartering performance improvement teams addressing organizational priorities and review their activities;
13. Referring issues to appropriate performance improvement teams, clinical services, departments or committees;
14. Facilitating dissemination, discussion and understanding of clinical and management Performance Improvement and Patient Safety data;
15. Educating Medical Staff and Medical Center employees in Performance Improvement and Patient Safety principles and processes;
16. Reporting to the MSEC and Medical Center Director's Senior Advisory Group on significant issues;
17. Assuring compliance with accreditation standards and regulatory agency requirements (e.g., ORYX core measures).
18. Monitoring Sentinel Events, Root Cause Analyses, and Adverse Event Investigation findings and action plans.
19. Selecting, approving, and reviewing Failure Mode and Effects Analyses performed by the organization.
20. The Governing Body will receive regular reports regarding Performance Improvement and Patient Safety activities, including actions to improve patient safety and quality both in response to actual occurrences and proactively.

INCIDENT REVIEW COMMITTEE (RRMC Only)

The Incident Review Committee, which includes leadership across Ronald Regan UCLA Medical Center, is responsible for overseeing the effective management of significant actual or near miss events. The Grievance Committee reports to IRC to ensure patient complaint are evaluated for system and Processes issues. The Committee reviews these events, assures causal analysis occurs and solutions are implemented. In addition, the Committee ensures the required reporting to regulatory agencies and the CMS. The Committee adheres to and promotes the principles of high reliability organizations and a just culture.

UCLA Health Quality Measurement and Improvement Committee (QMIC)

The Quality Measurement and Improvement Committee (QMIC) is responsible for measuring and improving the quality of care within clinical departments and across integrated service lines. QMIC will encompass a patient-centered, inter-professional and population-based approach to optimizing clinical outcomes, patient experience, appropriate utilization, and total cost of care. . The QMIC will foster a collaborative learning and sharing environment for physician quality officers interested in improvement science and health services research. The Committee will closely align its efforts with health system goals (ex. MOVERS) and the objectives of advanced payment models. QMIC will report directly to the UCLA Health System Quality Council and collaborate with Department Chairs and the Chief Medical and Quality Officer on various clinical quality initiatives. The members of the QMIC may also serve on relevant committees related to any UCLA Health accountable care organization or clinically integrated network. The Quality Measurement and Improvement Committee is composed of the Department and Division Quality Officers appointed by Clinical Department leadership. The Chairperson shall be nominated by the CMQO, in collaboration with the Committee, and approved by the UCLA Health Quality Council for a term of two years. The term is unlimited as pertains to positions held. The Quality Measurement and Improvement Committee shall meet on a regular basis, at least monthly. The Quality Measurement and Improvement Committee reports to the UCLA Health System Quality Council. Minutes of its meetings will be provided in a timely manner to the Quality Council Chair and the CMQO.

UCLA Health Surgical Services Committee

The Surgical Services Committee is responsible for reviewing the surgical activities within UCLA Health, and making recommendations to the UCLA Health leadership regarding allocation of resources, development of new surgical facilities, and other forms of infrastructure support. It may also make recommendation to the Medical Staff organizations of UCLA Health hospitals regarding initiation or change in Medical Staff policies and procedures relevant to surgical services.
The Surgical Services Committee shall consist of the Chairs of the Departments of Surgery, Head and Neck, Neurosurgery, Obstetrics and Gynecology, Ophthalmology, Urology, and Anesthesiology of the David Geffen School of Medicine at UCLA, and the OR medical directors for UCLA Health surgical suites. Non-voting members include members of UCLA Health administration, such as the Executive Director for Operative Services, the Health System President, COO, CMQO, CNO, SMH CAO, Executive Director for Quality and Safety, and the CMO's. The term is unlimited as pertains to positions held. The Surgical Services Committee shall meet on a regular basis, at least monthly. The Surgical Services Committee reports directly to the Medical Staff Executive Committees of RRMC and SMH and indirectly to the UCLA Health Quality Council. Minutes of its meetings will be provided in a timely manner to the Board.

SPECIFIC STAFF RESPONSIBILITIES
- All staff from every hospital department are responsible to report patient safety occurrences or near misses.
- Patients Relations reports on Patient Satisfaction Surveys and staff questionnaires that solicit information about patient and staff perceptions of risks to patients.
- Hospital Infection Control aggregates and analyzes data related to nosocomial infection, mucocutaneous exposures, and contact tracing and multi-drug resistant organisms.
- The Safety Officer aggregates and analyzes data related to environment of care surveillance and risks, including: safety, security, hazardous materials, and fire prevention.

- Clinical Engineering aggregates, analyzes and reports data related to medical equipment preventive maintenance, incidents, and risks.
- Human Resources with Employee Health aggregates, analyzes and reports data related to staff tuberculosis screening and safety related competencies of staff.
- Pharmacy aggregates, analyzes and reports data related to pharmacist interventions, pharmaceutical inspections, and medication use.
- Risk Management aggregates, analyzes and reports data related to potential risk management issues.
- Medical Records aggregates, analyzes and reports data related to potential medical record documentation issues.
- Nursing aggregates, analyzes and reports data related to nurse sensitive indicators such as hospital acquired pressure ulcers, falls and Unit Practice Council Performance Improvement activities.

DEPARTMENT-BASED PEER REVIEW OPERATING PLAN AND SCOPE: FACULTY AND STAFF

1) All **staff physicians and faculty physicians _with_ medical privileges** at RRMC, SMH, and NPH shall be assigned to an accountable academic department within the David Geffen School of Medicine, for the purpose of meeting organizational and departmental objectives with respect to quality, safety, performance improvement, peer review, regulatory and accreditation requirements, patient experience, value-based care redesign, and population health.
2) The QAPI (Quality Assurance and Performance Improvement) program of the accountable DGSOM Academic Department shall extend to any facility owned and operated by UCLA Health in which staff physicians and faculty practice, regardless of whether he/she has medical staff privileges, as outlined in any memorandum of understanding between the DGSOM and the Health System.
3) Department- and clinical program-based activities and committees designed to improve patient outcomes shall be considered part of the QAPI program of the Medical Staff Executive Committee and is privileged and confidential under Evidence Section Code 1157.
4) The academic departments within the David Geffen School of Medicine shall be responsible for assuring that appropriate peer review activities are conducted for all practicing physicians that are assigned to their departments, including but not limited to:
   a. Case review involving a single discipline or specialty;
   b. Case review that is multidisciplinary, interdepartmental, and/or interprofessional;
   c. Peer review of individual physicians (ex. FPPE or focused professional practice evaluation);
   d. Data review (ex. OPPE or ongoing professional practice evaluation);
   e. Clinical registry review (ex. NSQIP, STS, VQI, CHA reports etc.);
   f. Educational case review conferences (ex. morbidity and mortality conferences);
   g. Case reviews referred by Health Plans or by external providers (outside clinicians and health care facilities).
   h. Case reviews of patient and family complaints and grievances
5) Triggers for peer review of individual physicians include, but are not limited to:
   a. Clinical Care
       i. Clinical judgment
       ii. Technical skills
       iii. Resource utilization
       iv. Safety concerns

<li value="5" style="list-style-type:none">
<ol type="a" start="2" style="list-style-type:none">
v. Patient outcomes

        b. Patient and Family Experience

        c. Physician Wellness

        d. Disruptive Behaviors

        e. Professionalism

6) Department-based peer review activities that require urgent escalation, regardless of practice site and whether or not there is a DGSOM faculty appointment, should be referred to the:

        a. Medical Staff Executive Committee (ex. serious concerns with clinical judgement, technical skills, resource utilization, patient outcomes, safety, supervision of residents, patient privacy and data security concerns, medical record integrity and compliance, disruptive behaviors and professionalism)

        b. Incident Review Committee (ex. system-related issues, sentinel events, never-events, state-reportable events, potentially compensable cases)

        c. Physician Wellness Committee (ex. evaluation and recommended strategies for treating, coaching/mentoring, monitoring, and privileging physicians with respect to disruptive behavior, anger management, mental and physical health issues, and alcohol and drug dependency)

        d. UCLA Health Chief Medical and Quality Officer (ex, immediate escalation for sexual harassment/assault, discrimination, workplace violence, impairment, and retaliation).

7) Peer review findings that a) are not readily amenable to corrective action at the department-level, b) represent an ongoing or potential threat to patient safety, c) are below department expectations for the reasonable delivery of optimal care, or 3) constitute a serious breach professional, ethical, legal, and/or regulatory standards, are referred to the Medical Staff Executive Committee and may result in disciplinary action, or trigger a Fair Hearing Process.

8) It is the expectation of the UCLA Health System that all actual or potential adverse events will be reported in SOFI (Safe Opportunities for Improvement), and that documentation of peer review minutes and findings will be kept in an approved and secure HIPPA-compliant peer review database whenever possible (ex. Quality Management Portal, MIDAS, or RL Solutions).

9) Disruptive Physician Behaviors entered into the SOFI system should be categorized by the reporter into one of the following categories: a) comments undermining trust; b) failure to adhere to safety practices; c) failure to respond to patient care needs; d) lack of concern; e) failure to communicate; f) intimidating/demeaning behavior; g) sexual harassment/assault, h) discrimination, i) workplace violence, j) impairment, k) retaliation

10) Clinical Data Registries (including but not limited to those in Appendix D) and Health System supported clinical databases (ex. SOFI, RL Solutions, MIDAS, Box) shall be considered privileged and confidential under Evidence ode Section 1157 when used for the purpose of peer-review and improving clinical quality and safety.

11) A summary report of department-based peer review activities shall be submitted to the Quarterly Governing Body Meeting by the Medical Staff Executive Committee for review and discussion.

DEPARTMENT-BASED PEER REVIEW OPERATING PLAN AND SCOPE: COMMUNITY PHYSICIANS

1) All **community physicians with medical staff privileges** at RRMC, SMH, and NHP shall be assigned to an accountable hospital department, as outlined in the medical staff bylaws, for the purpose of meeting organizational and departmental objectives with respect to

quality, safety, performance improvement, peer review, regulatory and accreditation requirements, patient experience, value-based care redesign, and population health.

2) Department- and clinical program-based activities and committees designed to improve patient outcomes shall be considered part of the QAPI program of the Medical Staff Executive Committee and is privileged and confidential under Evidence Section Code 1157.

3) The clinical departments within RRMC, SMH, and NPH shall be responsible for assuring that appropriate peer review activities are conducted for all practicing physicians that are assigned to their departments, including but not limited to:
   a. Case review involving a single discipline or specialty;
   b. Case review that is multidisciplinary, interdepartmental, and/or interprofessional;
   c. Peer review of individual physicians (ex. FPPE or focused professional practice evaluation);
   d. Data review (ex. OPPE or ongoing professional practice evaluation);
   e. Clinical registry review (ex. NSQIP, STS, VQI, CHA reports etc.);
   f. Educational case review conferences (ex. morbidity and mortality conferences);
   g. Case reviews referred by Health Plans or by external providers (outside clinicians and health care facilities).
   h. Case reviews of patient and family complaints and grievances

4) Triggers for peer review of individual physicians include, but are not limited to:
   a. Clinical Care
      i. Clinical judgment
      ii. Technical skills
      iii. Resource utilization
      iv. Safety concerns
      v. Patient outcomes
   b. Patient and Family Experience
   c. Physician Wellness
   d. Disruptive Behaviors
   e. Professionalism

5) Department-based peer review activities that require urgent escalation, regardless of practice site and whether or not there is a DGSOM faculty appointment, should be referred to the:
   a. Medical Staff Executive Committee (ex. serious concerns with clinical judgement, technical skills, resource utilization, patient outcomes, safety, supervision of residents, patient privacy and data security concerns, medical record integrity and compliance, disruptive behaviors and professionalism)
   b. Incident Review Committee (ex. system-related issues, sentinel events, never-events, state-reportable events, potentially compensable cases)
   c. Physician Wellness Committee (ex. evaluation and recommended strategies for treating, coaching/mentoring, monitoring, and privileging physicians with respect to disruptive behavior, anger management, mental and physical health issues, and alcohol and drug dependency)
   d. UCLA Health Chief Medical and Quality Officer (ex, immediate escalation for sexual harassment/assault, discrimination, workplace violence, impairment, and retaliation).

6) Peer review findings that a) are not readily amenable to corrective action at the department-level, b) represent an ongoing or potential threat to patient safety, c) are below department expectations for the reasonable delivery of optimal care, or 3) constitute a serious breach professional, ethical, legal, and/or regulatory standards, are referred to the Medical Staff Executive Committee and may result in disciplinary action, or trigger a Fair Hearing Process.

7) It is the expectation of the UCLA Health System that all actual or potential adverse events will be reported in SOFI (Safe Opportunities for Improvement), and that documentation of peer review minutes and findings will be kept in an approved and secure HIPPA-compliant peer review database whenever possible (ex. Quality Management Portal, MIDAS, or RL Solutions).

8) Disruptive Physician Behaviors entered into the SOFI system should be categorized by the reporter into one of the following categories: a) comments undermining trust; b) failure to adhere to safety practices; c) failure to respond to patient care needs; d) lack of concern; e) failure to communicate; f) intimidating/demeaning behavior; g) sexual harassment/assault, h) discrimination, i) workplace violence, j) impairment, k) retaliation

9) Clinical Data Registries (including but not limited to those in Appendix D) and Health System supported clinical databases (ex. SOFI, RL Solutions, MIDAS, Box) shall be considered privileged and confidential under Evidence ode Section 1157 when used for the purpose of peer-review and improving clinical quality and safety.

10) A summary report of department-based peer review activities shall be submitted to the Quarterly Governing Body Meeting by the Medical Staff Executive Committee for review and discussion.

APPENDIX A - DEFINITIONS

Adverse Event: as defined by DPH (CA Health and Safety Code 1279.1), events that cause the death or serious disability of patients, personnel or visitors. (See Appendix B for a list of Adverse Events)

Adverse Event Investigation: Investigation that may lead to a causal analysis of a non-Sentinel Event based on framework described in the Root Cause Analysis and Adverse Event Policy.

Causal Analysis: A structured or informal approach for identifying the basic or causal factor(s) that underlie variation in performance, to prevent recurrence of untoward events.

Clinical Service: Clinical service refers to clinical services of the UCLA Medical Center Medical Staff.

Department: Department refers to departments of the Medical Center (e.g., nursing, pharmacy, clinical laboratory, hospital epidemiology).

Disclosure: Providing information to the patient or the patient's family regarding a sentinel event, or substantive near-miss accident according to the guidelines of the organization's disclosure policy.

Error: An unintended act, either of omission or commission, or an act that does not achieve its intended outcome.

Hazardous Condition: Any set of circumstances (exclusive of the disease or condition for which the patient is being treated) that significantly increases the likelihood of a serious adverse outcome.

Incident: An untoward, undesirable, and usually unanticipated event in a health care organization. Incidents such as patient falls or improper administration of medications are also considered incidents even if there is no permanent effect on the patient.

Intentional Unsafe Acts: Intentional unsafe acts, as they pertain to patients, are any events that result from: a criminal or reckless act, a purposefully unsafe act; an act related to alcohol or substance abuse, impaired provider/staff; or events involving alleged or suspected patient abuse of any kind. Intentional unsafe acts should be addressed in consultation with Human Resource Specialists.

Just Culture: Encourages personal accountability, provides a safe place to report errors, and seeks to learn from mistakes to improve the overall safety of the system.

National Patient Safety Goals: These are evidence based requirements approved by the Joint Commission's Board of Commissioners that reflect optimal patient safety practices.

Near Miss: A Near Miss is an event or situation that could have resulted in an accident, injury or illness, but did not, either by <u>chance</u> or through <u>timely intervention</u> (e.g., surgical or other procedure almost performed on the wrong patient due to lapses in verification of patient identification but caught at the last minute by chance). Near Misses are learning opportunities and afford the chance to develop preventive strategies and actions. Near Misses are evaluated in the same manner as adverse events that result in actual injury.

Patient Safety Practice: A clearly recognizable process or manner of providing care that has an evidence base demonstrating that it reduces the likelihood of harm due to systems, processes or environments of care.

Performance Improvement Practice: A clearly recognizable process or manner of providing care that has an evidence base demonstrating that it improves outcomes of care.

Personal Accountability: The individual involved in the error (potential or actual) will participate in reporting the error, determining what went wrong, identifying a solution, participating in discussions about the error, and taking an active part in improving the system.

Prevention: A future-oriented process that improves performance and productivity; a philosophy of never-ending improvement.

Punitive or Disciplinary Action: The recording of a reported medical/health care error in an employee's permanent file for use during the evaluation process for promotion, salary increases, or references. The requirement of an individual to undergo continuing education, competency training or assessment, or an individual educational plan **is not** a punitive or disciplinary action.

Redesign: Changing a process to create a more effective or safer environment.

Root Cause Analysis: performed for an identified or potential sentinel event as defined by the JC, is a highly structured process for assessing the basic or root factor(s) that underlie the incident and identifying opportunities for risk elimination. Analysis focuses on processes and systems, not individuals.

Sentinel Event: As defined by the JC, an unexpected occurrence involving death or serious physical or psychological injury, or the risk thereof. Serious injury specifically includes loss of limb

or function. The phrase, "or the risk thereof" includes any process variation for which a recurrence would carry a significant chance of a serious adverse outcome. See Appendix B for examples of Sentinel Events and Appendix C for example of incidents not considered Sentinel Events.

Specific definitions related to medication events (i.e., medication errors, adverse drug events, adverse drug reactions, and specific medication events) are included in the Medication Events Policy.

APPENDIX B – ADVERSE EVENT DEFINITIONS

CMS HOSPITAL ACQUIRED CONDITIONS (HAC)
1. Foreign object retained after surgery
2. Air embolism
3. Blood incompatibility
4. Pressure ulcer stage III & IV
5. Falls and trauma
6. Catheter-associated urinary tract infection (UTI)
7. Vascular catheter-associated infection
8. Poor glycemic control
9. Surgical site infection (CABG, Ortho, Bariatric, CIED)
10. Deep vein thrombosis and pulmonary embolism (following total knee and hip)
11. Iatrogenic pneumothorax with venous catheterization

CALIFORNIA DEPARTMENT OF HEALTH ADVERSE EVENTS
Surgical events
1. Wrong body part
2. Wrong patient
3. Wrong procedure
4. Unintentional retention of foreign object
5. Unexpected death during surgery or within 24 hours after anesthesia begins

Product or device events
1. Death/serious disability associated with use of contaminated drug/device/biologic
2. Death/serious disability associated with use/function in ways other than intended
3. Death/serious disability associated with intravascular air embolism, excluding during certain neurosurgical procedures

Patient protection events
1. Infant discharged to wrong person
2. Death/serious disability associated with patient disappearance for more than four hours (excluding adults with capacity)
3. Patient suicide or attempted suicide in the facility resulting in death/serious disability

Care management events
1. Death/serious disability associated with a medication error
2. Death/serious disability associated with administration of ABO-incompatible blood or blood products
3. Maternal death/serious disability associated with labor or delivery in a low-risk pregnancy (with some exclusions)
4. Death/serious disability related to hypoglycemia, onset in hospital

5. Death/serious disability associated with failure to identify and treat hyperbilirubinemia in neonates during first 28 days of life
6. Stage 3, 4 or unstageable ulcer acquired after admission (unless progression to Stage 3 was from a Stage 2 identified at admission)
7. Death/serious disability from spinal manipulation at hospital

Environmental events
1. Death/serious disability associated with an electric shock (excluding planned treatments)
2. Any incident where line designated for oxygen or other gas contains wrong gas or is contaminated by toxic substance
3. Death/serious disability associated with burn in facility
4. Death associated with fall in facility
5. Death/serious disability associated with restraints/bedrails

Criminal events
1. Care ordered or provided by someone impersonating licensed health care provider
2. Abduction of patient, any age
3. Sexual assault of patient
4. Death or significant injury of patient or staff resulting from physical assault
5. Any adverse event that causes death or serious disability of a patient, personal or visitor.

MEDICAL PROVIDER PREVENTABLE CONDITIONS
OPPCs are defined as:
- Wrong surgical or other invasive procedure performed on a patient
- Surgical or other invasive procedure performed on the wrong body part
- Surgical or other invasive procedure performed on the wrong patient

HCACs are defined as:
- Air embolism
- Blood incompatibility
- Catheter-associated urinary tract infection (UTI)
- Falls and trauma that result in fractures, dislocations, intracranial injuries, crushing injuries, burns and electric shock
- Foreign object retained after surgery
- Iatrogenic pneumothorax with venous catheterization
- Manifestations of poor glycemic control
  - Diabetic ketoacidosis
  - Nonketotic hyperosmolar coma
  - Hypoglycemic coma
  - Secondary diabetes with ketoacidosis
  - Secondary diabetes with hyperosmolarity
- Stage III and IV pressure ulcers
- Surgical site infection following:
  - Mediastinitis following coronary artery bypass graft (CABG)
  - Bariatric surgery, including laparoscopic gastric bypass, gastroenterostomy, and laparoscopic gastric restrictive surgery
  - Orthopedic procedures for spine, neck, shoulder, and elbow
  - Cardiac implantable electronic device (CIED) procedures
- Vascular catheter-associated infection

- For non-pediatric/obstetric population, deep vein thrombosis (DVT)/pulmonary embolism (PE) resulting from:
  - Total knee replacement
  - Hip replacement

Frequently Asked Questions about PPCs can be found on this website:

http://www.dhcs.ca.gov/individuals/Pages/PPCFAQ.aspx

JOINT COMMISSION SENTINEL EVENT DEFINITIONS

- Any patient death, paralysis, coma, or other major permanent loss of function associated with a medication error.
- A patient commits suicide within 72 hours of being discharged from a hospital setting that provides staffed around the clock care.
- Any elopement, that is unauthorized departure, of a patient from an around the clock care setting resulting in a temporally related death (suicide, accidental death, or homicide) or permanent loss of function.
- Surgery on the wrong side of the patient's body.
- Any intrapartum (related to the birth process) maternal death.
- Any perinatal death unrelated to a congenital condition in an infant having a birth weight greater than 2,500 grams.
- A patient is abducted from the hospital where he or she receives care, treatment, or services.
- Assault, homicide, or other crime resulting in patient death or major permanent loss of function.
- A patient fall that results in death or major permanent loss of function as a direct result of the injuries sustained in the fall.
- Hemolytic transfusion reaction involving major blood group incompatibilities.
- A foreign body, such as a sponge or forceps that was left in a patient after surgery.

EXAMPLES OF INCIDENTS NOT CONSIDERED TO BE SENTINEL EVENTS AS DEFINED BY THE JOINT COMMISSION

- Any "near miss."
- Full or expected return of limb or bodily function to the same level as prior to the incident by discharge or within two weeks of the initial loss of said function.
- Any sentinel event that has not affected a recipient of care.
- Medication errors that do not result in death or major permanent loss of function.
- Suicide other than in an around the clock care setting or following elopement from such a setting.
- A death or loss of function following a discharge "against medical advice (AMA)."
- Unsuccessful suicide attempts unless resulting in major permanent loss of function.
- Minor degrees of hemolysis not caused by a major blood group incompatibility and with no clinical sequelae.

APPENDIX C: QUALITY INITIATIVES AND REPORTING FREQUENCY

UCLA Ronald Reagan and Santa Monica Medical Center
Quality Initiatives and Reporting Frequency
FY 2020

Quality Measure	Mandatory	Publicly Reported	RR Process	SM Process	Reporting Frequency
INPATIENT QUALITY REPORTING PROGRAM (IQR)					
ED Throughput Core Measure (ED-1 & ED-2)	Federal	Yes	QMS Chart Abstraction	QMS Chart Abstraction	Monthly
eED-1, eED-2	Federal	No	eCQM	eCQM	Annually
Immunization Influenza Core Measure	Federal	Yes	QMS Chart Abstraction	QMS Chart Abstraction	Monthly
Stroke GWTG & Comprehensive Stroke Measures	Federal	Yes	QMS Chart Abstraction	QMS Chart Abstraction	Monthly
eStroke- 2,3,5,6	Federal	No	eCQM	eCQM	Annually
Venous Thromboembolism (VTE-6) Core Measure	Federal	Yes	QMS Chart Abstraction	QMS Chart Abstraction	Monthly
Perinatal Core Measure	Federal	Yes	QMS Chart Abstraction	QMS Chart Abstraction	Monthly
AMI, HF, PN, Stroke, COPD and CABG Mortality	Federal	Yes	Administrative Claims	Administrative Claims	Monthly
Patient Experience- HCAHPS	Federal	Yes	Survey-PI Teams	Pt. Affairs- NRC Picker Pt. Survey results	Monthly
AMI, HF, PN, THA/TKA, COPD, Stroke, CABG and All Cause 30 Day Readmission	Federal	Yes	Chart Abstraction-Multi-disciplinary Team Peer review	Chart Abstraction-Multi-disciplinary Team Peer review	Monthly
AHRQ Patient Safety Indicators- PSI 90 Composite Score- (Pressure Ulcer [Stages III and IV]; Iatrogenic Pneumothorax; Post-op Hip Fracture; Post-op Hemorrhage or Hematoma; Post-op Physiologic and Metabolic Derangement; Post-op Respiratory Failure; Post-	Federal	Yes	Administrative Claims, Validation, Multi-disciplinary PI Team	Administrative Claims, Validation, Multi-disciplinary PI Team	Monthly

Quality Measure	Mandatory	Publicly Reported	RR Process	SM Process	Reporting Frequency
op Pulmonary Embolism (PE) or Deep Vein Thrombosis (DVT); Post-op Sepsis; Post-op Wound Dehiscence; and Accidental Puncture or Laceration)					
AHRQ Patient Safety Indicators-PSI 4 (Death Among Surgical Inpatients)	Federal	Yes	Administrative Claims, Validation, Multi-disciplinary PI Team	Administrative Claims, Validation, Multi-disciplinary PI Team	Monthly
Cardiac Surgery Registry	Federal	Yes	Chart Abstraction-QMS/Direct Difference	N/A	Quarterly
Nurse Sensitive Database	Federal	Yes	Chart Abstraction, Prevalence Study-Nursing	Chart Abstraction, Prevalence Study-Nursing	Quarterly
General Surgery Registry	Federal	Yes	Chart Abstraction-QMS	N/A	Quarterly
Safe Surgery Checklist	Federal	Yes	Submitted via Q-Net	Submitted via Q-Net	Annually
Patient Safety Culture	Federal	Yes	Submitted via Q-Net	Submitted via Q-Net	Annually
Hospital Acquired Catheter Associated Urinary Tract Infection (CAUTI)	Federal	Yes	Chart Abstraction-NHSN CUSP	Chart Abstraction-NHSN Multi-disciplinary Team	Monthly
Hospital Acquired Central Line Bloodstream Infection (CLABI)	Federal	Yes	Chart Abstraction-NHSN Multi-disciplinary Team	Chart Abstraction-NHSN Multi-disciplinary Team	Monthly
Surgical Site Infection within 30 Days	Federal	Yes	Chart Abstraction-NHSN CUSP	Chart Abstraction-NHSN Multi-disciplinary Team	Monthly
Hospital Acquired MRSA Bacteremia	Federal	Yes	Chart Abstraction-NHSN	Chart Abstraction-NHSN	Monthly

Quality Measure	Mandatory	Publicly Reported	RR Process	SM Process	Reporting Frequency
				Multi-disciplinary Team	
Hospital Acquired Clostridium Difficile	Federal	Yes	Chart Abstraction-NHSN	Chart Abstraction-NHSN Multi-disciplinary Team	Monthly
Healthcare Personnel Influenza Vaccine	Federal	Yes	Data entry employee health	Data entry employee health	Annually
Medicare Spending per Beneficiary	Federal	No	Administrative	Administrative	Annually
OUTPATIENT QUALITY REPORTING (OQR)					
ED-3 Throughput Core Measure	Federal	Yes	QMS Chart Abstraction	QMS Chart Abstraction	Monthly
ED-Chest Pain/Acute Myocardial Infarction	Federal	Yes	QMS Chart Abstraction	QMS Chart Abstraction	Monthly
ED-Stroke	Federal		QMS Chart Abstraction	QMS Chart Abstraction	Monthly
MRI Lumbar Spine for low back pain	Federal	Yes	Administrative Claims	Administrative Claims	Quarterly
Mammography Follow-up	Federal	Yes	Administrative Claims	Administrative Claims	Quarterly
Abdomen CT with Contrast	Federal	Yes	Administrative Claims	Administrative Claims	Quarterly
Thoracic CT with Contrast	Federal	Yes	Administrative Claims	Administrative Claims	Quarterly
Cardiac Imaging for Pre-op Risk Assessment for Low Risk Patients	Federal	Yes	Administrative Claims	Administrative Claims	Quarterly
Simultaneous Use of Brain CT and Sinus CT	Federal	Yes	Administrative Claims	Administrative Claims	Quarterly
ED-Head CT Scan Results for Acute Ischemic or Hemorrhagic Stroke who Received Head CT Scan Interpretation Within 45 minutes of Arrival.	Federal	Yes	Administrative Claims	Administrative Claims	Quarterly
Endoscopy/Polyp Surveillance Appropriate Follow-up Interval for Normal Colonoscopy in Average Risk Patients	Federal		Chart Abstraction/QNET	Chart Abstraction/QNET	Quarterly

Quality Measure	Mandatory	Publicly Reported	RR Process	SM Process	Reporting Frequency
Endoscopy/Polyp Surveillance: Colonoscopy Interval for Patients with a History	Federal		Chart Abstraction/QNET	Chart Abstraction/QNET	Quarterly
Tracking Clinical Visits Between Visits	Federal		Administrative Claims	Administrative Claims	Quarterly
ED Left Without Being Seen	Federal	No	QNET	QNET	Annually
Surgical Safety Checklist	Federal		QNET	QNET	Annually
Influenza Vaccination Coverage among Healthcare Personnel	Federal		QNET	QNET	Annually
Volume data on selected surgical procedures	Federal		QNET	QNET	Annually
VALUE BASED PURCHASING (VBP)					
AMI, HF, PN, COPD and CABG Mortality	Federal	Yes	Administrative Claims	Administrative Claims	Monthly
Hospital Acquired Infection (CLABSI, CAUTI, SSI, MRSA, C.diff)	Federal	Yes	Surveillance-NHSN	Surveillance-NHSN	Monthly
THA/TKA Complications	Federal	Yes	Administrative Claims	Administrative Claims	Monthly
Patient Experience- HCAHPS	Federal	Yes	Survey-PI Teams	Pt. Affairs- NRC Picker Pt. Survey results	Monthly
Payment-Standardized Medicare Spending Per Beneficiary (MSPB)	Federal	Yes	Administrative Claims-Data validation	Administrative Claims-Data validation	Quarterly
HOSPITAL ACQUIRED CONDITIONS (HAC) REPORTING PROGRAM					
AHRQ Patient Safety Indicators- PSI 90 Composite Score- (Pressure Ulcer [Stages III and IV]; Iatrogenic Pneumothorax; Central Venous Catheter Related Bloodstream Infection; Post-op Hip Fracture; Post-op Hemorrhage or Hematoma; Post-op Physiologic and Metabolic Derangement; Post-op Respiratory Failure; Post-op Pulmonary Embolism (PE) or Deep Vein Thrombosis	Federal	Yes	Administrative Claims, Validation, Multi-disciplinary PI Team	Administrative Claims, Validation, Multi-disciplinary PI Team	Monthly

Quality Measure	Mandatory	Publicly Reported	RR Process	SM Process	Reporting Frequency
(DVT); Post-op Sepsis; Post-op Wound Dehiscence; and Accidental Puncture or Laceration)					
Hospital Acquired Infection (CLABSI, CAUTI, SSI, MRSA, C.diff)	Federal	Yes	Surveillance-NHSN/Administrative Claims	Surveillance-NHSN/Administrative Claims	Monthly
HOSPITAL READMISSIONS REDUCTION PROGRAM (HRRP)					
AMI, HF,PN, THA/TKA,COPD, and CABG readmissions	Federal	Yes	Administrative Claims-Data validation	Administrative Claims-Data validation	Monthly
JOINT COMMISSION REQUIRED MEASURES					
ED Throughput	TJC	Yes	Abstraction- QMS	Abstraction-QMS	Monthly
eED-1; eED-2	TJC	No	eCQM	eCQM	Annually
Perinatal	TJC	Yes	Abstraction- QMS	Abstraction-QMS	Monthly
eStroke-2,3,5,6	TJC	No	eCQM	eCQM	Annually
VTE-6	TJC	Yes	Abstraction- QMS	Abstraction-QMS	Monthly
Immunization	TJC	Yes	Abstraction- QMS	Abstraction-QMS	Monthly
PE and DVT (PSI)	Federal		Administrative Claims	Administrative Claims-Validation; Multi-Disciplinary Team	Monthly
Readmission 30 Day All Cause	Federal	Yes	Administrative Claims	Administrative Claims-Validation; Multi-Disciplinary Team	Monthly
Adverse Drug Event- C-Difficile due to antibiotic exposure	Federal		Administrative Claims	Administrative Claims-Validation; Multi-Disciplinary Team	Monthly
Adverse Drug Event-Hemorrhage due to anticoagulant exposure	Federal		Administrative Claims	Administrative Claims-Validation;	Monthly
LEAPFROG					

Quality Measure	Mandatory	Publicly Reported	RR Process	SM Process	Reporting Frequency
Computerized Physician Order Entry	No	Yes	Hospital Survey	Hospital Survey	Annually
ICU Physician Staffing	No	Yes	Hospital Survey	Hospital Survey	Annually
Leadership Structures and Systems	No	Yes	Hospital Survey	Hospital Survey	Annually
Culture Measurement, Feedback and Interventions	No	Yes	Hospital Survey	Hospital Survey	Annually
Teamwork Training and Skill Building	No	Yes	Hospital Survey	Hospital Survey	Annually
Identification and Mitigation of Risks and Hazards	No	Yes	Hospital Survey	Hospital Survey	Annually
Nursing Workforce	No	Yes	Hospital Survey	Hospital Survey	Annually
Medication Reconciliation	No	Yes	Hospital Survey	Hospital Survey	Annually
Hand Hygiene	No	Yes	Hospital Survey	Hospital Survey	Annually
Care of Ventilated Patient	No	Yes	Hospital Survey	Hospital Survey	Annually
SCIP Antibiotic Timing	Federal	Yes	CMS Hospital Compare Concurrent Rounds	CMS Hospital Compare Concurrent Rounds	Monthly
SCIP Antibiotic Selection	Federal	Yes	CMS Hospital Compare Concurrent Rounds	Concurrent Rounds Concurrent Rounds	Monthly

APPENDIX D: List of Clinical Data Registries

FY 2020

Name of Data Registry	Measures Associated with Registry	Clinical Department
STS Adult, Congenital & Thoracic	21 NQF measures	Cardiac Surgery
CCORP/OSHPD	30 day mortality, DSWI, IMA, usage, stroke	Cardiac Surgery
NCDR ICD- RR & SMH	CMS mandatory registry for implantable	Cardiac Intervention
NCDR PCI RR & SMH	STEMI Core Measures	Cardiac Intervention
NCDR Action	All GWTG Core Measures	Cardiac Intervention
NCDR-IMPACT	ACHD measures	Cardiac Intervention
NCDR-TVT	CMS mandatory registry for valve replacement	Cardiac Intervention
VQI	Vascular perioperative and one year follow-up data	Vascular Surgery
NVQI	Acute ischemic stroke and cerebral aneurysm	Neurology
NSQIP	Surgical perioperative and 30 days post-op	General Surgery
Pediatric NSQIP	Surgical perioperative and 30 days post-op	Pediatric Surgery
MBASQIP	Bariatric periop and postop	General Surgery
Outcome-GWTG Heart Failure	JC and GWTG measures	Cardiology
Outcome-GWTG AMI	JC and GWTG measures	Cardiology
Outcome-GWTG Stroke	JC and GWTG measures	Neurology

Outcome-GWTG Resuscitation	Cardiopulmonary arrest	Critical Care Committee
Virtual PICU (VPS)	Demographics and clinical plus follow-up	Pediatric Surgery
CHA	Administrative upload only	Pediatric
ELSO-ECMO	Temporary life supports for pts with reversible cardiac and respiratory failure	Cardiac Intervention
Intermac-VAD	Interagency registry for mechanically assisted circulatory support	Cardiac Intervention
LAAO (Left Atrial Appendage Occlusion Registry	Watchman device implantation for atrial fibrillation/stroke prevention	Cardiac Intervention
UNOS-Heart Transplant	Mandatory donor registry for pts in heart waiting list	Heart/Lung Program
UNOS-Lung Transplant	Mandatory donor registry for pts in lung waiting list	Heart/Lung Program
UNOS-Liver/Intestine Transplant	Mandatory donor registry for pts in liver waiting list	Liver Program
UNOS-Pancreas Transplant	Mandatory donor registry for pts in pancreas waiting list	Pancreas Program
UNOS-Kidney Transplant	Mandatory donor registry for pts in kidney waiting list	Kidney Program
Living Donor Paired Exchange	NKF-donor registry for living donors	Kidney Program
SRTR-Heart Transplant Recipients	Graft survival rates of heart transplant recipients	Heart/Lung Program
SRTR-Lung Transplant Recipients	Graft survival rates of lung transplant recipients	Heart/Lung Program
SRTR-Liver/Intestines Transplant Recipients	Graft survival rates of liver transplant recipients	Liver Program
SRTR-Pancreas Transplant Recipients	Graft survival rates of pancreas transplant recipients	Pancreas Program
SRTR-Kidney Transplant Recipients	Graft survival rates of kidney transplant recipients	Kidney Program
CCSP - Cancer Surveillance	Cancer cases abstracted & survivor follow-up	Oncology
NICU-CPQCC	Facilitates the identification of perinatal improvement targets	Pediatric
OB CMQCC CPMS (California)	Reduction of maternal morbidity from hemorrhage	Obstetrics