Guam Memorial Hospital Authority
Aturidåt Espetåt Mimuriåt Guåhan

850 GOV. CARLOS CAMACHO ROAD
OKA, TAMUNING, GUAM 96911
TEL: 647-2444 or 647-2330
FAX: (671) 649-0145

April 4, 2018

VIA HAND DELIVERY

Honorable Benjamin J. F. Cruz
Speaker of I Minatrentai Kuattro Na Liheslaturan Guåhan
163 Chalan Santo Papa
Hagåtña, GU 96910

GLH 34-18-1712
Speaker Benjamin J.F. Cruz
APR 04 2018
Time: 8:01 AM PM File No.
Received By:

RE: Reporting Requirements for Boards and Commissions

Dear Speaker Cruz:

Hafa Adai! In accordance with Ch. 8 of Title 5 GCA, Section 38, §8113.1, Reporting Requirements for Boards and Commissions, enclosed is a compact disc containing electronic copies of all materials presented and discussed at the GMHA Board of Trustees meeting held on March 28, 2018 at 6:00 p.m. in the Daniel L. Webb Conference Room.

Please contact Mr. Theo Pangelinan from our Board Office at 647-2104 if you have any questions.

Regards,

PeterJohn D. Camacho, M.P.H.
Hospital Administrator/CEO

2018 APR -4 AM 8:21

1712

$550K in contributions sitting at GEDA

By John O'Connor
john@postguam.com

About $550,000 in qualifying certificate cash contributions are waiting to be used at the Guam Economic Development Authority, according to administrator Jay Rojas.

The money can be invested in higher education, public health or other community investments depending on the stipulations in the respective QC.

The Guam Regional Medical City, for example, submits annual contributions to GEDA in lieu of taxes. These contributions go to health care, public safety, higher education and economic development.

The hospital was to submit $500,000 in fiscal 2016 and $750,000 in fiscal 2017. Another $1 million is expected in calendar year 2018 for a total of $2.25 million. The contributions are to increase to $1.2 million after the hospital's fifth year in operation. The contributions increase again to $1.4 million annually after the 10th year and will remain up to the 20th year.

Only about $1 million from the hospital has been received so far. About $500,000 went to GEDA for economic development, according to GEDA documents, leaving about $419,000 in GRMC contributions that have not been disbursed.

GEDA does not utilize general fund monies and derives about one-third of its funding through contributions from the QC program.

The rest comes from bond-issuance fees and leases of government property. The agency budgeted for about $857,000 in QC revenue for fiscal 2018.

The $550,000 in QC contributions available are on top of what is already budgeted for fiscal 2018.

Rojas said the money is available upon official request by the QC holder or an agency.

Some of the $550,000 is to be invested in the Guam Memorial Hospital. GMH is in the process of finalizing a list of equipment it would like to purchase.

GMH awaits decision from Joint Commission

By Kevin Kerrigan
kevin@postguam.com

Guam Memorial Hospital is awaiting a verdict from the Joint Commission on the hospital's proposed corrective action plan.

GMH administrator Peter-John Camacho was expecting an answer last week on the plan he submitted to the Joint Commission earlier this month detailing the steps that would be taken to address the deficiencies found during a Joint Commission survey in January.

No response had been received from the Joint Commission as of Friday afternoon, he said.

That January Joint Commission survey cited management problems and facility issues at GMH, some of which had been cited before and could pose a risk to patient safety. The result was a preliminary denial of accreditation for the public hospital.

Camacho declined to provide a copy of his corrective action plan to The Guam Daily Post until he hears back from the Joint Commission.

Addressing issues

However, he said that some of the issues cited in the January survey already have been dealt with. The stained ceiling tiles have been replaced, he said, and efforts have begun to encourage the staff and community physicians to become more involved in hospital operations.

Approval of the corrective action plan could lead to a reversal of the preliminary denial of accreditation, said Camacho.

Apart from the status of the corrective action plan, GMH has launched a separate appeals process over the Joint Commission's January survey which resulted in the preliminary denial of accreditation. Camacho said he's not expecting a decision on the hospital's appeal of that finding until sometime in April.

Guam Memorial Hospital Authority
Aturidåt Espetåt Mimuriåt Guåhan
850 Governor Carlos G. Camacho Road
Tamuning, Guam 96913

PUBLIC NOTICE

BOARD OF TRUSTEES MEETING

Date: Wednesday, March 28, 2018
Time: 6:00 p.m.
Place: 1st Floor, Daniel L. Webb Conference Room

You may contact Toni Tenorio at 647-2218, Monday through Friday from 8:00 a.m. to 5:00 p.m. for special accommodations, auxiliary aids, or other services.

/s/ PeterJohn D. Camacho, M.P.H.
Hospital Administrator/CEO

This advertisement was paid for with government funds.

Core Tech Foundation, Inc.
Statement of Financial Position
As of December 31, 2017

Assets	2017
Cash	$ 5,539
Total Assets	5,539
Liabilities & Fund Balance	
Total Net Assets	$ 5,539

Statement of Revenues / Expenditures and Change in Fund Balance
For the year ended December 31, 2017

Contributions	$ 56,000
Deductions / Expenditures	62,226
Net change in fund balance	$ (6,226)

Submitted by Conchita Bathan, Director
388 South Marine Corps Drive, Ste 400, Tamuning Guam, 96913

GEORGE WASHINGTON SR HIGH SCHOOL CLASS OF '71
P.O. BOX 341
HAGATNA, GUAM 96932

Financial Report Ending December 2016

Balance from 2015	$ 5,445.73
Revenues:	
Membership Dues	$ 211.00
Donations	$ 82.00
Banana Festival	$ 3,148.00
45th Banquest Tickets	$ 4,412.00
Total Deposits	$ 7,853.00
Total Revenue	$ 13,298.73
Expenses:	
Banquet, Banana, Picnic Expenses	$ 1,969.67
Banquet Grand Prize	$ 388.99
Rex/Tax	$ 52.50
Bank Image Fees	$ 17.50
45th Class Reunion	$ 3,630.00
Reimbursement of Awards, printing, booth...misc	$ 795.00
Quarterly Events	$ 435.00
Total Expenses	$ 7,288.66
Balance as of December 2016	$ 6,010.07

/s/ Arlene Tainatongo, Committee Treasurer

GEORGE WASHINGTON SR HIGH SCHOOL CLASS OF '71
P.O. BOX 341
HAGATNA, GUAM 96932

Financial Report Ending December 2017

Balance from 2016	$ 6,010.07
Revenues:	
Banana Festival Funds	$ 3,011.00
Membership Dues	$ 43.00
Banana Festival Cash Donations	$ 22.00
Total Deposits	$ 3,076.00
Total Revenue	$ 9,086.07
Expenses:	
Medical Assistant Donation	$ 200.00
Banana Festival Expenses	$ 954.49
Quarterly Events	$ 1,238.50
Misc Cash Expenses	$ 110.00
Total Expenses	$ 2,502.99
Balance as of December 2017	$ 6,583.08

/s/ Arlene Tainatongo, Committee Treasurer

Bordallo introduces Guam Land Return Act

Del. Madeleine Bordallo introduced a bill that aims to reduce federal land ownership on Guam and return excess land to local families, hold the U.S military accountable for promises made related to the military buildup, and increase federal reimbursement to the government for compact impact.

The Guam Land Return Act of 2018, if enacted, would authorize the federal government to transfer federal property – including land, vehicles and heavy equipment designated as "surplus" – to the government of Guam at no cost to taxpayers or the federal or local governments. Bordallo's legislation proposes to make available amounts claimed by the local government as unreimbursed compact-impact funds as an offset for the fair market value of the lands, according to Bordallo's office.

The government of Guam has been trying to get additional federal funds for the cost of hosting regional immigrants who enter Guam under their island nations' compact agreements with the United States.

"I recognize GovGuam's fiscal crisis caused by the Trump tax law, and my bill allows Guam to use unreimbursed compact impact to offset the costs of lands to be returned," Bordallo stated. "This is yet another way to increase federal reimbursement to Guam for compact impact while overcoming congressional budget rules."

The congresswoman's bill also seeks to codify the Department of Defense's "net-negative" commitment to hold fewer lands on Guam at the conclusion of the buildup than it held in 2011. The legislation would require the Defense Department to maintain a public online inventory of all federally held lands to be returned to the government under the net-negative commitment and provide a mechanism for the governor to request additional land to be included.



CAMPAIGN: *Del. Madeleine Bordallo announces her bid for a ninth term at the Plaza de España in Hagåtña in February. Post file photo*

'Reducing the federal land footprint'

"My bill also holds the military accountable for reducing the federal land footprint as the buildup proceeds, as was promised to the people of Guam and me personally," stated Bordallo, who is seeking re-election. "I believe that this process should be transparent and that lands returned should be real concessions to the people of Guam."

(Daily Post Staff)



INMATE DEATH: *The Department of Corrections Adult Correctional Facility in Mangilao is pictured. Prison personnel on Tuesday morning found an inmate unresponsive at the facility. He was declared dead at the scene. Post file photo*

Inmate found dead

A Department of Corrections inmate was found unresponsive by prison personnel Tuesday morning.

DOC Deputy Director Kate Baltazar said the inmate, housed in the Post 3 medical housing unit, was discovered at 6:05 a.m.

Medical staff from the DOC-Guam Memorial Hospital clinic conducted a check of the inmate and declared him dead at the scene. Preliminary reports indicate the inmate had died of natural causes, DOC management stated.

Baltazar said the last check prior to the discovery was conducted at 5:30 a.m.

The death comes a day after legislative public safety committee oversight chairperson Sen. Telena Nelson called for a Department of Justice independent investigation into potential civil rights violations of DOC detainees and inmates.

The senator is asking the Justice Department to look into possible violations of the Civil Rights of Institutionalized Persons Act – a federal law enacted with the intent of protecting the rights of people in correctional facilities, nursing homes, mental health facilities and other institutions.

Nelson first told The Guam Daily Post of her intention to seek assistance from the Justice Department on Jan. 9, the same day the Guam Police Department and DOC jointly announced the FBI would provide an assessment of the agencies' investigations into the death of detainee Manson Isar, also known as Ernest Manson.

Isar was beaten to death late last year, allegedly at the hands of several other detainees.

Nelson has been critical of DOC following Isar's death, as well as other events that transpired under the department's watch.

The senator pointed to the alleged assaults on federal detainee Katlyn Scully and local inmate Justin Meno.

Scully was allegedly assaulted by inmate Innocensia Nimeisa while the two were held at the DOC women's facility in Mangilao. DOC personnel reportedly did nothing to intervene and attempted to persuade Scully not to file a criminal report, according to her lawyer.

Meno, an inmate in the maximum-security Post 6 wing, was found in the wing's yard hog-tied and severely beaten with a bloody rag stuffed into his mouth in March 2017. Meno died in September 2017 from a tumor in his throat that obstructed his airway, according to Guam's chief medical examiner.

As part of her request, Nelson also provided the U.S. Attorney's Office with information related to DOC standard operating procedures regarding activities of inmates outside prison confines, inmate accountability, and the accidental release of inmates and detainees.

There have been at least two cases since February in which a detainee or inmate was freed accidentally.

(Daily Post Staff)

GUAM ENVIRONMENTAL PROTECTION AGENCY
AHENSIAN PRUTEKSION LINA'LA GUAHAN

NOTICE OF PUBLIC COMMENTING

GUAM 2018 303(d) LIST OF IMPAIRED WATERS

The Clean Water Act (CWA) requires states to provide every two years an assessment of the quality of all their waters [section 305(b)] and a list of those that are impaired or threatened [section 303(d)].

This list of water bodies and supporting documents are available to the public at the Guam EPA Main Office, located at 17-3304 Mariner Avenue, Tiyan Guam 96913-1617. The list and supporting documents are available Monday through Friday (excluding holidays) from the hours of 8:00 a.m. to 5:00 p.m.

The public and other stakeholders are invited to comment on the 2018 Guam 303(d) List of Impaired Waters.

PUBLIC COMMENTING PERIOD: MARCH 6, 2018 - APRIL 9, 2018

Written comments may be submitted by hand delivery or by mail to the Guam EPA Main Office at:
Guam Environmental Protection Agency, Attention: Administrator
BLDG #17-3304 Mariner Avenue, Tiyan Barrigada, GU 96913-1617
Comments must be received by 5 p.m. April 6, 2018.
No fax submittals will be accepted.

The final decision to accept this list or make any changes will be decided after all comments have been considered. Please bring this information to the attention of all persons who may be interested in this matter.

Sincerely,
/s/ WALTER S. LEON GUERRERO
Guam Environmental Protection Agency Administrator

THIS ADVERTISEMENT WAS PAID WITH FEDERAL FUNDS.

TODO Y NILALA Y TANO MAN UNO - ALL LIVING THINGS OF THE EARTH ARE ONE.

671-300-4751 /GuamEPA @guamepa www.guamepa.com

Guam Memorial Hospital Authority
Aturidåt Espetåt Mimuriåt Guåhan
850 Governor Carlos G. Camacho Road
Tamuning, Guam 96913

PUBLIC NOTICE

BOARD OF TRUSTEES MEETING

Date: Wednesday, March 28, 2018
Time: 6:00 p.m.
Place: 1st Floor, Daniel L. Webb Conference Room

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/s/ PeterJohn D. Camacho, M.P.H.
Hospital Administrator/CEO

This advertisement was paid for with government funds.

GMHA Board of Trustees
AGENDA

Wednesday, March 28, 2018 | 6:00 p.m. | Daniel L. Webb Conference Room

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I. CALL MEETING TO ORDER AND DETERMINATION OF QUORUM

Note: Five (5) members establish a quorum.

II. ACCEPTANCE OF REGULAR SESSION MINUTES

A. March 8, 2018

III. OLD BUSINESS

IV. NEW BUSINESS

A. FY-2019 GMHA Budget Proposal

V. BOARD SUBCOMMITTEE REPORTS

A. Joint Conference and Professional Affairs
   1. Resolution No. 2018-16, Relative to the Reappointment of Active Medical Staff Privileges
   2. Resolution No. 2018-17, Relative to the Reappointment of Active Associate Medical Staff Privileges
   3. Resolution No. 2018-18, Relative to the Appointment of Provisional Medical Staff Privileges
   4. Resolution No. 2018-19, Relative to the Appointment of Active Medical Staff Privileges
   5. Resolution No. 2018-20, Relative to the Reappointment of Allied Health Provisional Staff Privileges
   6. Resolution No. 2018-21, Relative to the Appointment of Allied Health Provisional Staff Privileges

B. Quality and Safety
   1. Regulatory Compliance Updates
   2. Policy No. A-PI100, Quality Assessment and Performance Improvement Plan

C. Human Resources
   1. Resolution No. 2018-22, Relative to Approving the Creation of the Accreditation Coordinator Position for the Compliance Office
   2. Resolution Nos. 2018-23 through 2018-33, Relative to Retirements

D. Facilities, Capital Improvement, and Information Technology

E. Governance, Bylaws, and Strategic Planning

F. Finance and Audit
   1. Resolution No. 2018-34, Relative to Approving Forty (40) New Fees

GMHA Board of Trustees
AGENDA

Wednesday, March 28, 2018 | 6:00 p.m. | Daniel L. Webb Conference Room

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VI. ADMINISTRATORS REPORTS

A. Hospital Administrator/CEO
B. Associate Administrator of Medical Services
C. Acting Associate Administrator of Professional Support Services
D. Assistant Administrator of Nursing Services
E. Chief Financial Officer
F. Medical Staff President

VII. PUBLIC COMMENT

VIII. ADJOURN MEETING

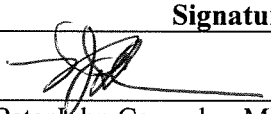
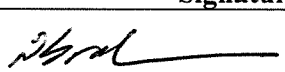
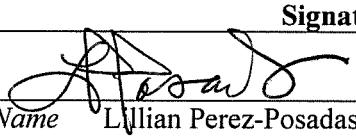
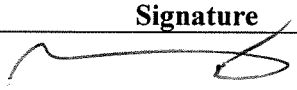
GUAM MEMORIAL HOSPITAL AUTHORITY
REVIEW AND ENDORSEMENT CERTIFICATION

The signatories on this document acknowledge that they have reviewed and approved the following:

□ Bylaws — Submitted by Department/Committee: **Performance Improvement Committee**

□ Rules & Regulations — Policy No.: **A-PI100**

✓ **Policies & Procedures** — Title: **QUALITY ASSESSMENT AND PERFORMANCE IMPROVEMENT PLAN**

	Date	Signature
Reviewed/Endorsed	03/20/2018	
Title	*Name* PeterJohn Camacho, MPH *Title* Hospital Administrator/ CEO Performance Improvement Committee Chairperson	
Reviewed/Endorsed	02/28/18	
Title	*Name* James P. Last, MD *Title* Medical Executive Committee Chairperson	
Reviewed/Endorsed	03/21/18	
Title	*Name* Lillian Perez-Posadas, MSN, RN *Title* Board of Trustees Quality & Safety Subcommittee Chairperson	
Reviewed/Endorsed	03/28/18	
Title	*Name* Eloy Lizama *Title* Board of Trustees Chairperson	
Reviewed/Endorsed		
Title	*Name* *Title*	
Reviewed/Endorsed		
Title	*Name* *Title*	

***Use more forms if necessary. All participating departments/committees in developing the policy should provide signature for certification prior to submitting to the Compliance Officer.**

GUAM MEMORIAL HOSPITAL AUTHORITY
ADMINISTRATIVE MANUAL

APPROVED BY:	RESPONSIBILITY:	EFFECTIVE DATE:	POLICY NO.	PAGE
PETERJOHN CAMACHO, MPH Hospital Administrator/CEO	Performance Improvement Committee	Interim Approved: October 26, 2017	A-PI100	1 of 46
TITLE: QUALITY ASSESSMENT AND PERFORMANCE IMPROVEMENT PLAN				
LAST REVIEWED/REVISED: 12/2017				
ENDORSED: PIC --/2018, MEC --/2018, Q&S --/2018, BOT --/2018				

PURPOSE:

To provide a QUALITY ASSESSMENT AND PERFORMANCE IMPROVEMENT (QAPI) process for Guam Memorial Hospital Authority (GMHA) that supports its Vision, Mission, Values and organizational/strategic priorities. The QAPI process is a planned, systematic, data-driven, organization-wide approach and involves all hospital departments and services (including those services furnished under contract or arrangement). It involves the assessment and measurement of processes of care, hospital service and operations, patient outcomes, and when indicated, identifying and implementing changes that enhance performance, improve health outcomes, prevent and reduce harm and errors and promote quality and safety.

These changes are incorporated into new or existing work processes, products or services, and performance is monitored/tracked to ensure that successful improvements are sustained. This process also incorporates mechanisms for compliance with outside regulatory agencies, such as the Centers for Medicare and Medicaid Services (CMS) and The Joint Commission (TJC).

POLICY:

The leaders of GMHA are committed to continually improving the quality and safety of care and services provided by monitoring and assessing care delivery, care outcomes, patient safety, error reduction, and the satisfaction of our customers. The leaders support an environment that encourages the identification of improvement opportunities from all sources throughout the organization and the provision of care and services that is reflective of the organization's Mission, Vision and Values.

MISSION:

GMHA is a semi-autonomous government agency charged with providing quality healthcare services to the public. This is expressed through its Mission statement: "To provide quality patient care in a safe environment".

VISION:

As stated in GMHA's 2013 Strategic Plan, the following vision statement guides all efforts and actions: "To achieve a culture and environment of safety and quality patient care meeting national standards and addressing the needs of the Community in a fiscally responsible, autonomous hospital".

VALUES:

GMHA serves by following core values – Accountability, Cost Effectiveness, Excellence in Service, Safety plus Quality; abbreviated as ACES+Q.

RESPONSIBILITIES:

I. ORGANIZATIONAL QUALITY ASSESSMENT AND PERFORMANCE IMPROVEMENT STRUCTURE AND EXPECTATIONS

The leaders of GMHA are committed to the integration of QAPI activities. Staff leaders understand the fundamental principles of improvement and participate in (1) identifying opportunities for improvement, (2) data collection, (3) data analysis (including staffing analysis), (4) creation and implementation of improvement activities, (5) evaluation activities, (6) reporting activities, (7) QAPI team/project activities, and (8) ongoing education.

A. THE BOARD OF TRUSTEES

The Board of Trustees (BOT) maintains overall responsibility for ensuring the quality and safety of care and services provided by GMHA. The BOT shall delegate implementation responsibility for organization-wide QAPI activities to the Performance Improvement Committee (PIC), Medical Executive Committee (MEC), and Skilled Nursing Facility's Performance Improvement Committee (SNF-PIC).

B. THE QUALITY AND SAFETY SUBCOMMITTEE

The Quality and Safety (Q&S) Subcommittee (formerly known as the Board of Trustees Performance Improvement Subcommittee) shall be chaired by Board of Trustees appointed members, and additionally shall consist of members from the Executive Management Council (EMC), the President of the Medical Staff (MEC Chairperson), the Administrator of Quality, Patient Safety and Regulatory Compliance, the Risk Management Program Officer, and the Performance Improvement Coordinator.

The purpose of the Q&S Subcommittee is to provide oversight and leadership for all activities relative to the hospital's QAPI plan. Information brought forth in this Subcommittee's meeting shall be discussed with the BOT by the Chairperson of this Subcommittee. Likewise, information brought forth in this Subcommittee's meeting shall be brought back to the PIC, MEC, and SNU-PIC *(see attachment I - QAPI Reporting Pathway).*

To comply with requirements under CMS' Conditions of Participation (COPs) (42 CFR §482.21), the following executive responsibilities are outlined (for the BOT, Medical Staff, and Executive Management/Leadership):

1. An ongoing program for quality improvement and patient safety, including the reduction of medical errors, must be defined, implemented, and maintained.
2. The hospital-wide QAPI efforts must address priorities for improved quality of care and patient safety; and all improvement actions must be evaluated.
3. Clear expectations for safety must be established.
4. Adequate resources must be allocated for measuring, assessing, improving, and sustaining the hospital's performance and reducing risk to patients.
5. The determination of the number of distinct improvement projects must be conducted annually.

C. THE PERFORMANCE IMPROVEMENT COMMITTEE

1. Membership: The PIC shall consist of the EMC, the Performance Improvement Coordinator, and other hospital staff as necessary via official appointment by the chairperson. The PIC shall be chaired by the Hospital Administrator/CEO. Additional details on the committee's functions and members' responsibilities are contained within its committee charter.

2. Duties and Responsibility:

    a. Provide oversight and direction to unit/department managers and supervisors, and hospital committee chairpersons on their QAPI indicators/measures.
    b. Prioritize indicators/measures that include high-risk, high-volume, and problem-prone areas identified throughout the organization, which are trended, analyzed, and improved upon by the departments.
        i. The division administrators shall oversee and manage his/her departments' QAPI indicators/measures. This includes organizing division PI meetings per the QAPI monthly rotation schedule *(see attachment II – QAPI Monthly Rotation)*, appointing appropriate division PI minute-takers/ scribes, and ensuring accountability with respect to the QAPI schedule and deadlines *(see attachment III - QAPI Schedule).*
        ii. Hospital committee chairpersons shall oversee and manage his/her committee's QAPI indicators/measures. This includes the inclusion of QAPI-related reporting during committee meetings, appointing of appropriate PI minute-takers/ scribes, and ensuring accountability with respect to the QAPI schedule and deadlines *(see attachment III - QAPI Schedule).*
        iii. Each department and committee is considered a working team, wherein problems and improvement opportunities are identified, actions are planned, implemented, and evaluated, and monitoring is conducted to ensure sustainment of improvement.
    c. Establish, as needed and as directed by the BOT and Q&S Subcommittee (for annual QAPI Projects), a QAPI project/team – an interdepartmental membership team who are the main stakeholders in the planned change. Members of the QAPI project/team shall be appointed by the Hospital Administrator/CEO. These teams shall report to the PIC quarterly on its action status *(See Procedure, Section II, QAPI Projects).*
    d. Oversee the Patient Safety Committee's analysis of sentinel events.
    e. Oversee the Patient Safety Committee's organizational Failure Mode and Effects Analysis (FMEA) and ensure appropriate risk assessments are conducted for identified opportunities.
    f. Ensure that QAPI activities meet the standards and regulations of our regulatory bodies.
    g. Ensure that QAPI education is provided to appropriate staff (to include all department supervisors/managers) on an annual basis.
    h. Ensure that processes are improved through the hospital's improvement methodology (*see Procedure, Section VI, Improvement Methodology*).
    i. Ensure that the hospital analyzes staffing adequacy via data from clinical/service screening indicators (e.g. falls, pressure ulcers, etc.) or human resources screening indicators (e.g. vacancy rates, overtime hours, etc.) to assess and continuously improve staffing adequacy.

i. The members of EMC and PIC will collaborate to produce an annual staffing adequacy report for the Q&S Subcommittee, per the QAPI schedule and deadlines *(see attachment III - QAPI Schedule)*.
ii. Department managers/supervisors and their division administrators will also document staffing analysis (e.g. skill mix, competencies assessment, work flow/process or workload) and related plans of action within their QAPI reports (*see attachment VIII – Department Quarterly Report and attachment IX – Division Administrator Quarterly Matrix Report).*

j. Ensure that the Hospital monitors the safety, quality, and performance of contracted services.
i. Department managers/supervisors and their division administrators will document QAPI relative to contracted services within their QAPI reports (*see attachment VIII – Department Quarterly Report and attachment IX – Division Administrator Quarterly Matrix Report).*
ii. Note: This policy does not remove the hospital's requirements for contract management set forth in Policy No. A-LD700.

k. Report to the Q&S Subcommittee, any adverse outcomes, significant process variations, and actions taken to improve care and address patient safety issues, both proactively and reactively.

D. THE MEDICAL EXECUTIVE COMMITTEE

1. The purpose and function of the Medical Executive Committee (MEC) shall be in accordance with the Medical Staff By-Laws 12.2: Medical Executive Committee.

2. Duties and Responsibilities:

a. The MEC shall receive and act on QAPI data/reports from the clinical departments (to include medical services, nursing services, and professional support services), and its medical departments and subcommittees.
b. The Chairperson, or a representative from the committee, shall report to the Q&S Subcommittee, any adverse outcomes, significant process variations, and actions taken to improve care and address patient and environmental safety, both proactively and reactively.
c. Information on indicators/measures from other hospital departments or committees regarding physicians' performance that is discussed in the Q&S Subcommittee shall be brought to the MEC for a plan of action for improvement.

E. SKILLED NURSING FACILITY PERFORMANCE IMPROVEMENT COMMITTEE (SNF-PIC)

1. In accordance with the CMS Long Term Care (LTC) COPs, the Administrator of the Skilled Nursing Facility shall conduct QAPI meetings on at least a quarterly basis (or more frequently as necessary) to discuss, analyze and act on performance indicators/measures within the facility.

2. Membership: The SNF-PIC shall consist of, at a minimum, its Administrator, Medical Director, Nursing Director, Infection Preventionist, and at least two other SNF staff.

a. Each department that provides services in the SNF shall report their indicators/measures to the SNF Administrator at a frequency determined by the SNF-PIC.

3. Duties and Responsibilities:

a. Oversee and provide direction for the performance indicators/measures that are monitored under the facility's own QAPI plan and program (SNF must fulfill CMS LTC COPs relative to QAPI).
b. Prioritize measures that include high-risk, high-volume and problem-prone areas identified throughout the facility and ensure that the performance measures are trended, analyzed, and improved upon by the departments.
c. Ensure that processes are improved through the SNF-PIC's chosen improvement methodology.
d. Ensure that appropriate FMEA and risk assessments are performed on identified opportunities.
e. The SNF Administrator shall report to the Q&S Subcommittee any adverse outcomes, significant process variations, and actions taken to improve care and address patient and environmental safety, both proactively and reactively.

PROCEDURE:

I. CRITERIA FOR PRIORITIZATION OF IMPROVEMENT OPPORTUNITIES

Prioritization of improvement opportunities shall: (1) be based on the criteria below; (2) be conducted prior to annual QAPI plan creation; and (3) occur at all levels within the organization (i.e. department, division, committee, and executive level). The Q&S Subcommittee and BOT maintains overall decision-making authority. Prior to creating annual QAPI plans, prioritization should be conducted (s*ee attachment IV - QAPI Prioritization Matrix*).

- Is the improvement opportunity related to a high risk process?
- Is the improvement opportunity related to a high volume process?
- Is the improvement opportunity related to a problem prone process?
    - In prioritizing problem-prone processes, the hospital must consider incidence (how often problems occur), prevalence (how widespread in the organization the problem is), and severity (how much and how likely harm could be done).
    - Greater prioritization and importance should be given to problem-prone processes that occur frequently, are pervasive throughout many areas of the hospital (not isolated to one area), and pose the greatest likelihood for harm.
- Does the improvement opportunity support the Hospital's Mission, Vision and Values?
- Does the improvement opportunity reduce medical errors and/or harm?
- Is the improvement opportunity related to improving health outcomes?
- Does the improvement opportunity improve safety?
- Does the improvement opportunity improve quality?
- Does the improvement opportunity improve patient satisfaction?
- Is the improvement opportunity a regulatory requirement that must be monitored and improved upon?

II. QAPI PROJECTS

A. REQUIREMENTS

To comply with CMS' QAPI program COPs (42 CFR §482.21), the hospital must conduct performance improvement projects. The following requirements are outlined:

1. The number and scope of distinct improvement projects must be proportional to the scope and complexity of the hospital's services and operations.
2. The hospital may, as one of its projects, develop and implement an information technology system explicitly designed to improve patient safety and quality of care. This project, in its initial stage of development does not need to demonstrate measurable improvement in indicators related to health outcomes.
3. The hospital must document what quality improvement projects are being conducted, the reasons for conducting these projects, and the measurable progress achieved on these projects.
4. The hospital is not required to participate in a QIO cooperative project, but its own projects are required to be of comparable effort.

B. QAPI PROJECT TEAM REPORTING

QAPI project/teams shall utilize the project/team template, *(see attachment XIII – QAPI Project/Team Template),* along with analyzed data sheets/reports, to report its activities and progress. Reporting shall be at least quarterly, to the PIC. The PIC will also determine which specific rotation month the team should report in.

III. PERFORMANCE MEASURES AND INDICATORS

Performance measures/indicators may address key systems, processes and/or outcomes. They are selected after prioritization is conducted, to promote the monitoring of the effectiveness and safety of services and quality of care. Standards-based, citation-driven or regulatory agency required measures/indicators may also be monitored in order to reflect compliance. Target goals will be stated for performance measures/indicators to reflect the level of performance to be achieved. Benchmark information may be drawn from internal and external sources when available, and may also serve as target goals.

A. ANNUAL EVALUATION/REVIEW

The evaluation/review of performance measures/indicators in one's QAPI plan occurs annually at the end of December and is submitted in January of the next calendar year per the QAPI schedule and deadlines *(see attachment III – QAPI Schedule).* QAPI plan evaluation must utilize the respective annual QAPI plan/program evaluation template *(see attachment VI – Annual QAPI Plan/Program Evaluation)* and must be completed prior to creating the new calendar year's QAPI plan.

B. GUIDANCE FOR CONTINUING OR DISCONTINUING MONITORING

1. In general, indicators or measures that meet the following requirement will be allowed to have reduced monitoring frequency:
    a. Sustained compliance or performance exceeding established goals or 95% (whichever is greater) for a period of 6 months consecutively.

2. The monitoring frequency of such indicators/measures will be reduced from monthly to quarterly for another 6 month period (two quarters).
3. If sustainment continued in this second time frame, the indicator/measure will be allowed to be discontinued completely or have further reduction of monitoring frequency (e.g. yearly basis), based on the approval of the respective division administrator or committee chairperson (e.g. PIC, BOT-Q&S, etc.).
    a. With any change in indicator/measure monitoring, the respective department or committee QAPI Plan must be updated/revised accordingly.
    b. QAPI Plan changes must have the approval and signature of the respective division administrator or committee chairperson (e.g. PIC, BOT-Q&S, etc.).
    c. Approved/signed QAPI Plan changes must be forwarded to the Performance Improvement Coordinator for record-keeping purposes.
4. If sustainment was not continued in this second 6 month period, the monitoring frequency shall revert back to a monthly basis.
5. Standards-related indicators/measures *(see letter C below)* will be continuously monitored, as required by the Hospital's regulatory bodies.
6. QAPI indicators/measures related to Contracted Services have the following guidance:
    a. Requirements set forth in Policy No. A-LD700 must be followed.
    b. If the QAPI indicator/measure is related to a regulatory monitoring standard or requirement *(see letter C below)*, monitoring shall be continuous.

C. PRIORITIES FOR MONITORING – STANDARDS-RELATED INDICATORS

1. In accordance with the Joint Commission Performance Improvement standards, CMS QAPI Conditions of Participation requirements, and CMS Electronic Clinical Quality Measures (eCQMs), the following indicators shall be monitored, analyzed, and improved upon, by the hospital:

    a. Operative or other procedures that place patients at risk of disability or death
    b. All significant discrepancies between preoperative and postoperative diagnoses, including pathological diagnosis
    c. Adverse events related to using moderate or deep sedation or anesthesia
    d. The use of blood and blood components
    e. All reported and confirmed transfusion reactions
    f. The results of resuscitations
    g. Significant medication errors
    h. Significant adverse drug reactions
    i. The use of opioids to determine if they are being used safely (e.g. the tracking of adverse events such as respiratory depression, naloxone use, and the duration and dose of opioid prescriptions)
    j. Data on pain assessment and pain management, including types of interventions and effectiveness
    k. Patient perception of the safety and quality of care, treatment, or services; patient complaints/grievances
    l. CMS eCQMs (e.g. CMS9, CMS31, CMS32, CMS111, etc.)
    m. Data on patient thermal injuries that occur during magnetic resonance imaging exams
    n. Incidents where ferromagnetic objects unintentionally entered the magnetic resonance imaging (MRI) scanner room

o. Injuries resulting from the presence of ferromagnetic objects in the MRI scanner room
p. Incidents where the radiation dose index (computed tomography index [CTDIvol], dose length product [DLP], or size-specific dose estimate [SSDE]) from diagnostic CT examinations exceeded expected dose index ranges identified in imaging protocols. These incidents are then compared to external benchmarks. *Note: This does not apply to dental cone beam CT radiographic imaging studies performed for diagnosis of conditions affecting the maxillofacial region or to obtain guidance for the treatment of such conditions.*
q. Adequacy of Staffing – staffing analysis shall be mandatory for clinical-related departments and divisions (e.g. Nursing Services, Professional-Support Services); and for all other departments and divisions, further TJC guidance is provided in *Section V: Data Analysis.*

2. GMHA considers collecting data on the following:

   a. Staff opinions and needs
   b. Staff perceptions of risk to individuals
   c. Staff suggestions for improving patient safety
   d. Staff willingness to report adverse events
   e. CMS Inpatient Quality Measures (voluntary) or TJC ORYX Measures

3. Additionally, the hospital must comply with CMS expectations for monitoring the following, via its Patient Safety Program and Risk Management Program *(see Related Policies)*:

   a. Medical errors and adverse patient events, wherein the hospital must analyze their causes, and implement preventive actions and mechanisms that include feedback and learning throughout the hospital.

IV. DATA COLLECTION

Data collection shall coincide with the calendar year cycle. It shall be trended over time to display that changes are resulting in improvement. The methods in which data will be collected shall be determined by the departments (and stated in their respective QAPI Plans), with guidance from the PIC as necessary.

The frequency for data collection shall be on a monthly basis (or more/less frequent depending on the measure/indicator being monitored). Use of the monthly trending sheet is requisite for all departments to submit their collected data (*see attachment VII - Monthly Trending Sheet*). For data collected at a frequency that differs from monthly basis, the respective department must customize the trending sheet to accommodate the alternative frequency.

Departments are also encouraged to include data subsets within trending sheets to show how data gets aggregated into an overall performance/compliance result. Data subsets can also serve as a means for drilling down further for specific information.

Other data display techniques (e.g. line or bar graphs, charts, tables, etc.) must also be included within the trending sheet and data analysis section of the quarterly report *(see attachment VIII – Department Quarterly Report)*.

To facilitate the collection of consistent, reliable data, departments are encouraged to consider the following details in formulating their QAPI Plans' data collection methods:

- Identifying the Denominator detail with inclusions and exclusions
- Identifying the Data source for the denominator and include any specific queries to be run or report parameters that must be entered
- Identifying the Numerator detail with inclusions and exclusions
- Identifying the Data source for the numerator and include specific queries to be run, manual steps, or specific sampling parameters
- If different individuals are assigned, identify who collects each data element and calculates the measure/indicator
- Developing a standardized method/tool for auditors or data collectors to utilize

Additional data collection details are built in to the annual QAPI plan template (*see attachment V – Annual QAPI Plan*). All departments are expected to fill in the template details as completely as possible.

V. DATA ANALYSIS

Collected data is transformed into performance information and knowledge when analysis is undertaken. The data should be processed and synthesized so that the organization can make informed assumptions and generalizations about what has happened, why this might vary from what was expected, and what corrective action might be required. The purpose of data analysis is insight. Based on analyzed data, all staff are encouraged to identify opportunities for improvement and changes that will lead to improvement.

Common questions to ask when analyzing performance:

- How does actual performance compare to a goal or standard?
- What factors (e.g. environment, equipment, materials or supply, process or procedure, people or staff) contributed to the performance/compliance/result, and why did the contributing factors happen?
- If there is a significant variance, is corrective action necessary?
    - What are the causes of the variance?
    - Does the process need to be changed?
    - Does the goal or standard need to be changed?
    - Even if the variance is small, should goals be reevaluated to something more challenging?
- Are new goals or measures needed?
- How have existing conditions changed?
- If a trend or pattern exists, what are the causes?
- If data subsets are present, what comparisons can be done amongst them?
- Is the performance measure/indicator improving, degrading, or remaining stable?
- Is the data predictable and is variability in the data predictable and small, or is the process very unpredictable and/or is there large variation in data?
- Is the target goal achievable by the current process?
- Is the current process data stable in a range where the target goal can be achieved?
- Is progress being made to close the gap between actual and the target, or is the gap widening?

TJC Performance Improvement standards provide the following guidance for data analysis of measures/indicators:

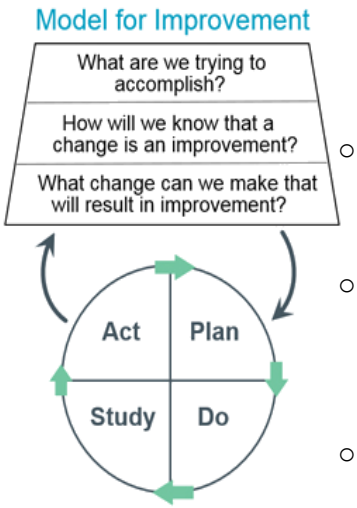
- When undesirable patterns, trends, or variations in performance are identified (based on data analysis or a single undesirable event), the adequacy of staffing (including nurse staffing) must be included in the analysis of possible causes.
- When analysis reveals a problem with the adequacy of staffing, the leaders responsible for the hospital's Patient Safety Committee are informed, in a manner determine by them, of the results of this analysis and actions taken to resolve the identified problem(s).
- At least once a year, the leaders responsible for the hospital's Patient Safety Committee review a written report on the results of any analyses related to the adequacy of staffing and any actions taken to resolve identified problems.

VI. IMPROVEMENT METHODOLOGY

The hospital shall utilize the Model for Improvement as its improvement methodology. Although this methodology originally had its beginnings as a continuous quality improvement tool in the business industry, it adapted into a valuable improvement framework and gained popularity when the Institute for Healthcare Improvement (IHI) began endorsing its use. According to Lau (2015), this model is widely used in healthcare quality and process improvement "because of its ease, logical approach, and emphasis on testing changes using a small-scale and rapid cycle approach" (p. 177).

The Model for Improvement contains 2 parts:

- Three questions which must be answered –
  - What are we trying to accomplish?
  - How will we know that a change is an improvement?
  - What change can we make that will result in improvement?
- The Plan-Do-Study-Act (PDSA) Cycle (for testing the change) –



  - Plan –
    - state the objective of the test
    - state your predictions of what will happen when the change is implemented/tested
    - develop the plan for implementing or testing the change
  - Do –
    - perform the test/implement the change
    - document what you observed, as well as any problems or new issues that arose during the test/change
  - Study –
    - Gather all the data and analyze it
    - Compare the actual results of the test/change with your original predictions
    - Describe what was learned
  - Act –
    - Decide how to proceed –
      - If the test was successful, will the change be adopted into existing or new processes? Will the change be tested in other areas (beyond the pilot area)?
      - If the test was not successful, what modifications to the plan or change will be done before starting the next PDSA cycle?

VII. EVALUATION

The measurement, assessment, and evaluation processes will continue to provide the necessary information about the effectiveness of the improvement. If the identified problem continues to persist despite the implementation of planned improvements, the performance improvement methodology will continue until sustained improvement is achieved. Any findings, conclusions, recommendations, actions taken, and results of the actions taken based on the QAPI process are documented and reported to the appropriate individuals, departments, division administrators, or committees.

VIII. REPORT TEMPLATES

A. PRIORITIZATION MATRIX:

All improvement opportunities and proposed indicators or measures shall undergo prioritization prior to annual QAPI plan creation. The QAPI prioritization matrix template shall be utilized and submitted in early January of each calendar year *(please see attachment IV - QAPI Prioritization Matrix).*

B. ANNUAL QAPI PLAN:

Once prioritization is complete, new measures or indicators can be created and placed within the annual QAPI plan template *(see attachment V – Annual QAPI Plan)*. There is no maximum or minimum number of indicators required; however, all departments/ divisions, and hospital committees should consider the amount of regulatory monitoring they contribute to (e.g. for National Patient Safety Goals, Environment of Care Management Plans, Infection Control, etc.) to maintain a realistic and manageable amount of indicators/measures. Annual QAPI plans are created and submitted in early January of each calendar year. QAPI plans may also be revised or updated throughout the calendar year, as indicators or measures decrease in monitoring frequency, become discontinued, or get added on.

C. ANNUAL QAPI PLAN/PROGRAM EVALUATION:

Annual QAPI plans must be evaluated after the calendar year has completed by using the appropriate plan/program evaluation template *(see attachment VI – Annual QAPI Plan/Program Evaluation).* This evaluation is completed and submitted in early January of each calendar year.

D. MONTHLY TRENDING SHEET:

Trending sheets reflect the performance of all measures/indicators being monitored by departments, over the course of the calendar year. These must be submitted monthly to division administrators and/or hospital committee chairpersons. The monthly trending sheet template serves as the format for this report *(see attachment VII – Monthly Trending Sheet).*

E. DEPARTMENT QUARTERLY REPORT:

Department quarterly reports *(see attachment VIII – Department Quarterly Report)* are used to document the results of data collected for the three months of a given quarter, the subsequent analysis of said data, and the improvement and sustainment activities the department undertook during the quarter. A separate staffing analysis section is required to be completed by clinical divisions such as Nursing Services and Pro-Support Services. At this time, it will be optional for Fiscal Services and Operations Division, unless their data analysis reveals a problem/issue with

people/staffing – at which time they must complete the staffing analysis. Submission deadlines for this report are outlined in the QAPI schedule and deadlines document *(see attachment III – QAPI Schedule).*

F. DIVISION ADMINISTRATOR QUARTERLY MATRIX REPORT:

Division Administrators will summarize significant indicator/measure information from their respective departments on a quarterly basis using their quarterly matrix report template *(see attachment IX – Division Administrator Quarterly Matrix Report).* This report serves as the documented evidence (for the BOT and regulatory agencies) of division administrator accountability for implementing the hospital's QAPI program. Due to the nature of the monthly rotation reporting process (where certain departments report each month to address a quarter's worth of data), quarterly matrices will also coincide with the same rotation reporting process. Submission deadlines for this report are outlined in the QAPI schedule and deadlines document *(see attachment III – QAPI Schedule).*

G. DIVISION ADMINISTRATOR ANNUAL REPORT:

Unlike the quarterly matrix report, the annual report for division administrators *(see attachment X – Division Administrator Annual Report)* discusses the calendar year's QAPI activities for the entire division (i.e. all rotation months). Additionally, administrators discuss: (1) QAPI relative to contracted services (if applicable), (2) staffing analysis and plans of action, (3) a self-evaluation of reporting quality and oversight responsibility, and (4) plans and recommendations for the next calendar year QAPI cycle. This report serves as the documented evidence (for the BOT and regulatory agencies) of division administrator accountability for implementing the hospital's QAPI program. Completion and submission of this report occurs by the end of January each calendar year.

H. CHAIRPERSON QUARTERLY MATRIX REPORT:

Hospital committee chairpersons will summarize significant indicator/measure information from their respective committees on a quarterly basis using their quarterly matrix report template *(see attachment XI – Chairperson Quarterly Matrix Report).* This report serves as the documented evidence (for the BOT and regulatory agencies) of chairperson accountability for managing committee-monitored QAPI indicators/measures. Submission deadlines for this report are outlined in the QAPI schedule and deadlines document *(see attachment III – QAPI Schedule).*

I. CHAIRPERSON ANNUAL REPORT:

The annual report for hospital committee chairpersons (see attachment XII – Chairperson Annual Report) discusses the calendar year's QAPI activities for the respective committee. Additionally, chairpersons discuss: (1) a self-evaluation of reporting quality and oversight responsibility, and (2) plans and recommendations for the next calendar year QAPI cycle. This report serves as the documented evidence (for the BOT and regulatory agencies) of division administrator accountability for implementing the hospital's QAPI program. Completion and submission of this report occurs by the end of January each calendar year.

J. QAPI PROJECT/TEAM TEMPLATE:

As mentioned previously, in Procedure, Section II of this policy, QAPI project/teams shall utilize the project/team template, *(see attachment XIII – QAPI Project/Team Template),* as part of the required reports for submission.

IX. COMMUNICATION (REPORTING PATHWAY AND REPORTING PROCESS)

QAPI information and activities are communicated through the established QAPI Reporting Pathway *(see Attachment I - QAPI Reporting Pathway).* Each department's performance indicators/measures shall be discussed in their staff meetings, in an effort to engage its staff to participate in QAPI activities.

The areas responsible to report to the PIC shall report at their scheduled time as indicated in the QAPI monthly rotation and QAPI schedule (*see attachment II – QAPI Monthly Rotation, and attachment III – QAPI Schedule*).

Dashboards displaying data will be created for the BOT Q&S Subcommittee via the PIC, in addition to the required division administrator and committee chairperson reports. All reports submissions will follow the QAPI schedule *(see attachment III – QAPI Schedule).*

X. EDUCATION

The hospital's executive leaders are responsible for ongoing educational activities related to QAPI. Education may be delivered in written, in-person presentation, or online presentation formats. The frequency of education will be at least annually, but may be more frequent as needed.

XI. CONFIDENTIALITY

In accordance with the Health Insurance Portability and Accountability Act (HIPAA), all QAPI information containing specific patient information shall remain confidential in accordance with the Hospital's policies governing confidentiality and the release of information. General information and summaries will be in final report form for organizational-wide and public dissemination via the BOT.

REFERENCES:

§482.21 Condition of Participation: Quality assessment and performance improvement program. Title 42 Code of Federal Regulations, Chapter IV – Centers for Medicare & Medicaid Services, Department of Public Health and Human Services. Subchapter G – Standards and Certification. Part 482 – Conditions of Participation for Hospitals. Volume 5, October 1, 2016. Retrieved from: https://www.gpo.gov/fdsys/pkg/CFR-2016-title42-vol5/xml/CFR-2016-title42-vol5-sec482-21.xml

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RELATED POLICIES:

Policy No. A-PS800, Patient Safety Program of the Administrative Manual
Policy No. ----, Risk Management Program of the Risk Management Manual
Policy No. A-LD700, Management and Oversight of External Service Provider Contracts of the Administrative Manual

RESCISSION:

Policy No. A-PI100, Performance Improvement Plan of the Administrative Manual made effective 08/21/2014.

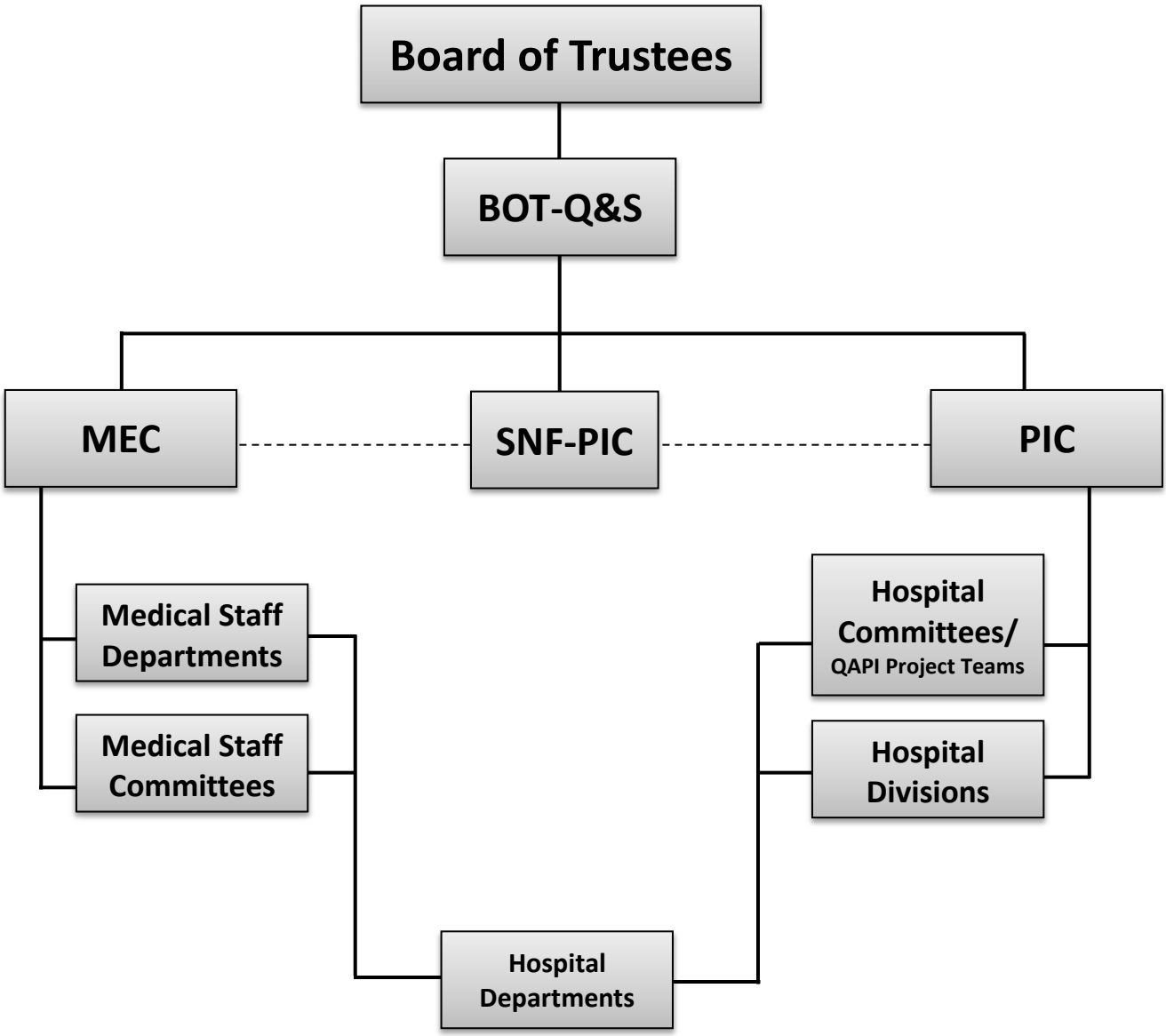
ATTACHMENTS:

I. QAPI REPORTING PATHWAY
II. QAPI MONTHLY ROTATION
III. QAPI SCHEDULE
IV. QAPI PRIORITIZATION MATRIX
V. ANNUAL QAPI PLAN
VI. ANNUAL QAPI PLAN/PROGRAM EVALUATION
VII. MONTHLY TRENDING SHEET
VIII. DEPARTMENT QUARTERLY REPORT
IX. DIVISION ADMINISTRATOR QUARTERLY MATRIX REPORT
X. DIVISION ADMINISTRATOR ANNUAL REPORT
XI. CHAIRPERSON QUARTERLY MATRIX REPORT
XII. CHAIRPERSON ANNUAL REPORT
XIII. QAPI PROJECT/TEAM TEMPLATE

ATTACHMENT I
QAPI REPORTING PATHWAY

Quality Assessment and Performance Improvement Reporting Pathway

Revised September 2017



2017-2018 Quality Assessment & Performance Improvement Monthly Rotation

***NOTE:** ALL Rotation Months must submit written PI reports per the deadlines specified in the QAPI Schedule and Deadlines. This Rotation schedule specifies when Departments'/Units' verbal reports must be done at monthly Division PI meetings.*

MONTH 1 Verbally reports at Division PI meetings: January, April, July, October	MONTH 2 Verbally reports at Division PI meetings: February, May, August, November	MONTH 3 Verbally reports at Division PI meetings: March, June, September, December
• **NURSING** ICU, Med-Surg, Surgical, Tele-PCU • **FISCAL** Pt. Registration, Medical Records • **OPERATIONS** Comm. Center, Human Resources, IT Dept., Guest Relations • **Patient Satisfaction Survey, Patient Complaints & Grievances** • **PRO-SUPPORT** Special Services, Urgent Care, Education Dept., Laboratory Dept. • **MEDICAL SERVICES** Employee Health Svcs., Infection Control • **ENVIRONMENT OF CARE COMMITTEE**	• **NURSING** OR, ER, Hemodialysis, Patient Education • **FISCAL** Patient Affairs • **OPERATIONS** Environmental Services, Facilities Maintenance, Planning Dept. • **PRO-SUPPORT** Pharmacy Dept., Radiology Dept., Dietary Dept. • **MEDICAL SERVICES** Utilization Review, Medical Staff Office • **SKILLED NURSING FACILITY PI COMMITTEE**	• **NURSING** Pediatrics-PICU, OB Ward, Nursery-NICU, Labor & Delivery • **FISCAL** Finance & Payroll • **OPERATIONS** Safety Dept., Security Dept., Materials Management • **EEO Report (Staff Satisfaction Survey, Exit Interview)** • **PRO-SUPPORT** Respiratory Dept., Rehabilitative Svcs., Social Services • **MEDICAL SERVICES** Risk Management • **PATIENT SAFETY COMMITTEE**

COLOR KEY:

GMH DIVISIONS  STANDING REPORTS  COMMITTEE REPORTS  SKILLED NURSING FACILITY 

LAST REVISED 12/27/2017

ATTACHMENT III
QAPI SCHEDULE – PAGE 1

GUAM MEMORIAL HOSPITAL AUTHORITY
QUALITY ASSESSMENT AND PERFORMANCE IMPROVEMENT (QAPI)
CY2017-4Q through CY2019-1Q
SCHEDULE AND DEADLINES – as of 10.09.2017

		DEPARTMENT SUBMISSION DEADLINES	DIVISION PI REPORTING	DIVISION ADMIN SUBMISSION DEADLINES	COMMITTEE CHAIRS SUBMISSION DEADLINES	PIC REPORTING	PIC FUNCTIONS/ ACTIVITIES	BOT-Q&S REPORTING	BOT-Q&S FUNCTIONS/ ACTIVITIES
CY17-4Q	OCT	**10/11/2017 BY NOON:** • CY17-3Q Quarterly Report • September Trending Sheet	Month 1 Rotation CY17-3Q			**10/18/2017 @ 1400** Month 1 Rotation CY17-3Q	**QAPI Templates Online Training**	Month 3 Rotation CY17-2Q	
	NOV	**11/15/2017 BY NOON:** October Trending Sheet *(START USING NEW TEMPLATE!)*	Month 2 Rotation CY17-3Q	**11/17/2017 BY NOON:** CY17-3Q Month 2 Rotation Quarterly Report *(START USING NEW TEMPLATE!)*	**11/17/2017 BY NOON:** CY17-3Q SNF QAPI Committee Quarterly Report and Dashboard *(START USING NEW TEMPLATE!)*	**11/22/2017 @ 1400** Month 2 Rotation CY17-3Q	**QAPI Policy Revision and Approval Process**	Month 1 Rotation CY17-3Q	**QAPI Policy Approval**
	DEC	**12/13/2017 BY NOON:** November Trending Sheet	Month 3 Rotation CY17-3Q	**12/15/2017 BY NOON:** CY17-3Q Month 3 Rotation Quarterly Report	**12/15/2018 BY NOON:** CY17-3Q Patient Safety Committee Quarterly Report and Dashboard *(START USING NEW TEMPLATE!)*	**12/20/2017 @ 1400** Month 3 Rotation CY17-3Q	**QAPI Policy Approval Process**	Month 2 Rotation CY17-3Q	**QAPI Policy Approval**
CY18-1Q	JAN	**01/10/2018 BY NOON:** • CY17-4Q Quarterly Report • December Trending Sheet • CY17 QAPI Plan Evaluation *(USE THE NEW TEMPLATES!)*	Month 1 Rotation CY17-4Q	**01/17/2018 BY NOON:** CY17-4Q Month 1 Rotation Quarterly Report	**01/17/2018 BY NOON:** CY17-4Q Environment of Care Committee Quarterly Report and Dashboard *(START USING NEW TEMPLATE!)*	**01/24/2018 @ 1400** Month 1 Rotation CY17-4Q	**01/24/2018 @ 1400** Approve ALL Division CY18 QAPI Plans	Month 3 Rotation CY17-3Q	
		01/17/2018 BY NOON: • CY18 Prioritization Matrix • CY18 QAPI Plan *(USE THE NEW TEMPLATES!)*		**01/31/2018 BY NOON:** CY17 QAPI Annual Report *(USE THE NEW TEMPLATE!)*	**01/31/2018 BY NOON:** CY17 QAPI Annual Report *(USE THE NEW TEMPLATE!)*		**01/31/2018 BY NOON:** CY17 QAPI Program Evaluation		
	FEB	**02/07/2018 BY NOON:** January Trending Sheet	Month 2 Rotation CY17-4Q	**02/14/2018 BY NOON:** CY17-4Q Month 2 Rotation Quarterly Report	**02/14/2018 BY NOON:** CY17-4Q SNF QAPI Committee Quarterly Report and Dashboard	**02/21/2018 @ 1400** Month 2 Rotation CY17-4Q	**Create CY18 PI Plan and PI Projects**	Month 1 Rotation CY17-4Q	
						Review: • CY17 Division Admins Annual QAPI Report • CY17 Committee Chairs Annual QAPI Report • CY17 QAPI Program Evaluation			

ATTACHMENT III
QAPI SCHEDULE – PAGE 2

GUAM MEMORIAL HOSPITAL AUTHORITY
QUALITY ASSESSMENT AND PERFORMANCE IMPROVEMENT (QAPI)
CY2017-4Q through CY2019-1Q
SCHEDULE AND DEADLINES – as of 10.09.2017

		DEPARTMENT SUBMISSION DEADLINES	DIVISION PI REPORTING	DIVISION ADMIN SUBMISSION DEADLINES	COMMITTEE CHAIRS SUBMISSION DEADLINES	PIC REPORTING	PIC FUNCTIONS/ ACTIVITIES	BOT-Q&S REPORTING	BOT-Q&S FUNCTIONS/ ACTIVITIES
	MAR	**03/07/2018 BY NOON:** February Trending Sheet	Month 3 Rotation CY17-4Q	**03/14/2018 BY NOON:** CY17-4Q Month 3 Rotation Quarterly Report	**03/14/2018 BY NOON:** CY17-4Q Patient Safety Committee Quarterly Report and Dashboard	**03/21/2018 @ 1400** Month 3 Rotation CY17-4Q		Month 2 Rotation CY17-4Q	**Propose CY18 PI Plan and PI Projects**
								Review: • CY17 Division Admins Annual QAPI Report • CY17 Committee Chairs Annual QAPI Report • CY17 QAPI Program Evaluation	
CY18-2Q	APR	**04/06/2018 BY NOON:** • CY18-1Q Quarterly Report • March Trending Sheet	Month 1 Rotation CY18-1Q	**04/11/2018 BY NOON:** CY18-1Q Month 1 Rotation Quarterly Report	**04/11/2018 BY NOON:** CY18-1Q Environment of Care Committee Quarterly Report and Dashboard	**04/18/2018 @ 1400** Month 1 Rotation CY18-1Q	**QAPI Policy/Plan Approval Process**	Month 3 Rotation CY17-4Q	**Approve CY18 PI Plan and PI Projects**
	MAY	**05/09/2018 BY NOON:** April Trending Sheet	Month 2 Rotation CY18-1Q	**05/16/2018 BY NOON:** CY18-1Q Month 2 Rotation Quarterly Report	**05/16/2018 BY NOON:** CY18-1Q SNF QAPI Committee Quarterly Report and Dashboard	**05/23/2018 @ 1400** Month 2 Rotation CY18-1Q	**QAPI Policy/Plan Approval Process**	Month 1 Rotation CY18-1Q	**QAPI Policy/Plan Approval Process**
	JUN	**06/06/2018 BY NOON:** May Trending Sheet	Month 3 Rotation CY18-1Q	**06/13/2018 BY NOON:** CY18-1Q Month 3 Rotation Quarterly Report	**06/13/2018 BY NOON:** CY18-1Q Patient Safety Committee Quarterly Report and Dashboard	**06/20/2018 @ 1400** Month 3 Rotation CY18-1Q	**QAPI PLAN/POLICY TRAINING**	Month 2 Rotation CY18-1Q	
CY18-3Q	JUL	**07/06/2018 BY NOON:** • CY18-2Q Quarterly Report • June Trending Sheet	Month 1 Rotation CY18-2Q	**07/11/2018 BY NOON:** CY18-2Q Month 1 Rotation Quarterly Report	**07/11/2018 BY NOON:** CY18-2Q Environment of Care Committee Quarterly Report and Dashboard	**07/18/2018 @ 1400** Month 1 Rotation CY18-2Q		Month 3 Rotation CY18-1Q	
	AUG	**08/08/2018 BY NOON:** July Trending Sheet	Month 2 Rotation CY18-2Q	**08/15/2018 BY NOON:** CY18-2Q Month 2 Rotation Quarterly Report	**08/15/2018 BY NOON:** CY18-2Q SNF QAPI Committee Quarterly Report and Dashboard	**08/22/2018 @ 1400** Month 2 Rotation CY18-2Q		Month 1 Rotation CY18-2Q	
	SEP	**09/07/2018 BY NOON:** August Trending Sheet	Month 3 Rotation CY18-2Q	**09/12/2018 BY NOON:** CY18-2Q Month 3 Rotation Quarterly Report	**09/12/2018 BY NOON:** CY18-2Q Patient Safety Committee Quarterly Report and Dashboard	**09/19/2018 @ 1400** Month 3 Rotation CY18-2Q	**Review:** Staffing Adequacy Annual Report (08/17-08/18)	Month 2 Rotation CY18-2Q	

ATTACHMENT III
QAPI SCHEDULE – PAGE 3

GUAM MEMORIAL HOSPITAL AUTHORITY
QUALITY ASSESSMENT AND PERFORMANCE IMPROVEMENT (QAPI)
CY2017-4Q through CY2019-1Q
SCHEDULE AND DEADLINES – as of 10.09.2017

		DEPARTMENT SUBMISSION DEADLINES	DIVISION PI REPORTING	DIVISION ADMIN SUBMISSION DEADLINES	COMMITTEE CHAIRS SUBMISSION DEADLINES	PIC REPORTING	PIC FUNCTIONS/ ACTIVITIES	BOT-Q&S REPORTING	BOT-Q&S FUNCTIONS/ ACTIVITIES
					09/12/2018 BY NOON: EMC/PIC Staffing Adequacy Annual Report (08/17-08/18)				
CY18-4Q	OCT	**10/10/2018 BY NOON:** • CY18-3Q Quarterly Report • September Trending Sheet	Month 1 Rotation CY18-3Q	**10/17/2018 BY NOON:** CY18-3Q Month 1 Rotation Quarterly Report	**10/17/2018 BY NOON:** CY18-3Q Environment of Care Committee Quarterly Report and Dashboard	**10/24/2018 @ 1400** Month 1 Rotation CY18-3Q		Month 3 Rotation CY18-2Q	**Review:** Staffing Adequacy Annual Report (08/17-08/18)
	NOV	**11/07/2018 BY NOON:** October Trending Sheet	Month 2 Rotation CY18-3Q	**11/14/2018 BY NOON:** CY18-3Q Month 2 Rotation Quarterly Report	**11/14/2018 BY NOON:** CY18-3Q SNF QAPI Committee Quarterly Report and Dashboard	**11/21/2018 @ 1400** Month 2 Rotation CY18-3Q		Month 1 Rotation CY18-3Q	
	DEC	**12/07/2018 BY NOON:** November Trending Sheet	Month 3 Rotation CY18-3Q	**12/12/2018 BY NOON:** CY18-3Q Month 3 Rotation Quarterly Report	**12/12/2018 BY NOON:** CY18-3Q Patient Safety Committee Quarterly Report and Dashboard	**12/19/2018 @ 1400** Month 3 Rotation CY18-3Q		Month 2 Rotation CY18-3Q	
CY19-1Q	JAN	**01/09/2019 BY NOON:** • CY18-4Q Quarterly Report • December Trending Sheet • CY18 QAPI Plan Evaluation	Month 1 Rotation CY18-4Q	**01/16/2018 BY NOON:** CY18-4Q Month 1 Rotation Quarterly Report	**01/16/2019 BY NOON:** CY18-4Q Environment of Care Committee Quarterly Report and Dashboard	**01/23/2019 @1400** Month 1 Rotation CY18-4Q	**01/23/2019 @ 1400** Approve ALL Division CY19 QAPI Plans	Month 3 Rotation CY18-3Q	
		01/16/2019 BY NOON: CY19 QAPI Plan		**01/30/2018 BY NOON:** CY18 QAPI Annual Report	**01/30/2018 BY NOON:** CY18 QAPI Annual Report		**01/30/2019 BY NOON:** CY18 QAPI Program Evaluation		
	FEB	**02/08/2019 BY NOON:** January Trending Sheet	Month 2 Rotation CY18-4Q	**02/13/2019 BY NOON:** CY18-4Q Month 2 Rotation Quarterly Report	**02/13/2019 BY NOON:** CY18-4Q SNF QAPI Committee Quarterly Report and Dashboard	**02/20/2019 @ 1400** Month 2 Rotation CY18-4Q	**Create CY18 PI Plan and PI Projects**	Month 1 Rotation CY18-4Q	
						Review: • CY18 Division Admins Annual QAPI Report • CY18 Committee Chairs Annual QAPI Report • CY18 QAPI Program Evaluation			

ATTACHMENT III

QAPI SCHEDULE – PAGE 4

GUAM MEMORIAL HOSPITAL AUTHORITY

QUALITY ASSESSMENT AND PERFORMANCE IMPROVEMENT (QAPI)

CY2017-4Q through CY2019-1Q

SCHEDULE AND DEADLINES – as of 10.09.2017

	DEPARTMENT SUBMISSION DEADLINES	DIVISION PI REPORTING	DIVISION ADMIN SUBMISSION DEADLINES	COMMITTEE CHAIRS SUBMISSION DEADLINES	PIC REPORTING	PIC FUNCTIONS/ ACTIVITIES	BOT-Q&S REPORTING	BOT-Q&S FUNCTIONS/ ACTIVITIES
MAR	**03/08/2019 BY NOON:** February Trending Sheet	Month 3 Rotation CY18-4Q	**03/13/2019 BY NOON:** CY18-4Q Month 3 Rotation Quarterly Report	**03/13/2019 BY NOON:** CY18-4Q Patient Safety Committee Quarterly Report and Dashboard	**03/20/2019 @ 1400** Month 3 Rotation CY18-4Q		Month 2 Rotation CY18-4Q	**Propose CY18 PI Plan and PI Projects**
							Review: • CY18 Division Admins Annual QAPI Report • CY18 Committee Chairs Annual QAPI Report • CY18 QAPI Program Evaluation	

ATTACHMENT IV
QAPI PRIORITIZATION MATRIX

QUALITY ASSESSMENT & PERFORMANCE IMPROVEMENT (QAPI)

DEPARTMENT/DIVISION/COMMITTEE NAME

Prioritization Matrix

Purpose: *This tool is meant to assist with the decision-making process when determining which improvement opportunity to act on and include in the annual QAPI Plan.*

Instructions: *For each improvement opportunity, assign the appropriate amount of points per column, as applicable. If an individual prioritization criterion does not apply to the improvement opportunity, do not assign any points, and indicate "N/A" for "not applicable". Indicate the total number of points per improvement opportunity in the "total points" column. Greater priority should be given to those opportunities with higher total points.*

Improvement Opportunity	Prioritization Criteria										TOTAL POINTS
	High Risk	High Volume	Problem Prone	Supports Mission, Vision, Values	Reduces Medical Errors/ Harm	Improves Health Outcomes	Improves Safety	Improves Quality	Improves Patient Satisfaction	Regulatory Requirement	
	3 points	*3 points*	*3 base points PLUS points from below:*	*1 point*	*3 points*	*3 points*	*2 points*	*2 points*	*1 point*	*3 points*	
			Incidence: (how often it occurs) ☐ Frequently – 4 points ☐ Sometimes – 3 points ☐ Not Often – 2 points ☐ Rarely – 1 point ***Prevalence/Scope: (how widespread is it)*** ☐ Hospital-wide – 3 points ☐ Many areas – 2 points ☐ Single area – 1 point ***Severity: (how likely to cause harm)*** ☐ High likelihood – 3 points ☐ Moderate likelihood – 2 points ☐ Low likelihood – 1 point								
			Incidence: (how often it occurs) ☐ Frequently – 4 points ☐ Sometimes – 3 points ☐ Not Often – 2 points ☐ Rarely – 1 point ***Prevalence/Scope: (how widespread is it)*** ☐ Hospital-wide – 3 points ☐ Many areas – 2 points ☐ Single area – 1 point ***Severity: (how likely to cause harm)*** ☐ High likelihood – 3 points ☐ Moderate likelihood – 2 points ☐ Low likelihood – 1 point								

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Quality Assessment and Performance Improvement Plan

PART Choose an item. **OF** Choose an item.

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QAPI PLAN ELEMENTS	**Indicator/Measure** Choose an item. Click here to enter text.	**Indicator/Measure** Choose an item. Click here to enter text.	**Indicator/Measure** Choose an item. Click here to enter text.	**Indicator/Measure** Choose an item. Click here to enter text.
1. Specific **EVIDENCE supports that the Indicator improves** any of the following: health outcomes, quality, safety, efficiency, customer service, cost-effectiveness, accountability. *Examples of **EVIDENCE** – standards or guidelines from a nationally recognized organization, hospital specific evidence, peer-reviewed research, etc.* ***Structural Measure** – measures the hospital's capacity and conditions in which care or services are provided by looking at factors such as staffing, facilities, health IT systems, etc.* ***Process Measure** – measures how parts of a system or steps in a process are performing.* ***Outcome Measure** – measures the results of health care or a service. This could include whether the patient's health improved, or whether the patient was satisfied with the services received.*	***Indicator/Measure improves:*** ☐ Health Outcomes ☐ Quality ☐ Safety ☐ Efficiency ☐ Customer Service ☐ Cost Effectiveness ☐ Accountability	***Indicator/Measure improves:*** ☐ Health Outcomes ☐ Quality ☐ Safety ☐ Efficiency ☐ Customer Service ☐ Cost Effectiveness ☐ Accountability	***Indicator/Measure improves:*** ☐ Health Outcomes ☐ Quality ☐ Safety ☐ Efficiency ☐ Customer Service ☐ Cost Effectiveness ☐ Accountability	***Indicator/Measure improves:*** ☐ Health Outcomes ☐ Quality ☐ Safety ☐ Efficiency ☐ Customer Service ☐ Cost Effectiveness ☐ Accountability
	Indicator/Measure prevents/ reduces: ☐ Medical Errors/ Patient Harm	***Indicator/Measure prevents/ reduces:*** ☐ Medical Errors/ Patient Harm	***Indicator/Measure prevents/ reduces:*** ☐ Medical Errors/ Patient Harm	***Indicator/Measure prevents/ reduces:*** ☐ Medical Errors/ Patient Harm
	Specific Evidence: Click here to enter text.	***Specific Evidence:*** Click here to enter text.	***Specific Evidence:*** Click here to enter text.	***Specific Evidence:*** Click here to enter text.
	Indicator/Measure is a(n): ☐ Structural Measure ☐ Process Measure ☐ Outcome Measure	*Indicator/Measure is a(n):* ☐ Structural Measure ☐ Process Measure ☐ Outcome Measure	*Indicator/Measure is a(n):* ☐ Structural Measure ☐ Process Measure ☐ Outcome Measure	*Indicator/Measure is a(n):* ☐ Structural Measure ☐ Process Measure ☐ Outcome Measure
2. The **scope** of data collection is appropriate for the indicator/measure. *ALL applicable areas, ALL applicable staff/patients, and ALL applicable time frames that should be monitored are accounted for.*	***Data Collection Scope:*** Click here to enter text.	***Data Collection Scope:*** Click here to enter text.	***Data Collection Scope:*** Click here to enter text.	***Data Collection Scope:*** Click here to enter text.
3. The **method and frequency** of data collection are specified, in detail, to reduce the risk of invalid or inaccurate data collection and results. *Exact guidance as to how audits or monitoring is to be conducted is provided.* *Examples of **Sample Sources** – paper medical records (identify specific document/form by name, such as H&PE, Discharge Summary, Operative Report, etc.); electronic health record (identify specific location/documentation type, such as flowsheets,*	***Data Collection Method:*** *Sample Source:* Click here to enter text.	***Data Collection Method:*** *Sample Source:* Click here to enter text.	***Data Collection Method:*** *Sample Source:* Click here to enter text.	***Data Collection Method:*** *Sample Source:* Click here to enter text.
	Sampling Method and Sample Size: Click here to enter text.	*Sampling Method and Sample Size:* Click here to enter text.	*Sampling Method and Sample Size:* Click here to enter text.	*Sampling Method and Sample Size:* Click here to enter text.
	Sample Inclusion Criteria:	*Sample Inclusion Criteria:*	*Sample Inclusion Criteria:*	*Sample Inclusion Criteria:*

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QAPI PLAN ELEMENTS	**Indicator/Measure** Choose an item.	**Indicator/Measure** Choose an item.	**Indicator/Measure** Choose an item.	**Indicator/Measure** Choose an item.
	Click here to enter text.	**Click here to enter text.**	**Click here to enter text.**	**Click here to enter text.**
nurse's notes, etc.); direct observations (identify what will be observed in detail).	Click here to enter text.	Click here to enter text.	Click here to enter text.	Click here to enter text.
*Examples of **Sampling Methods and Sample Sizes** – Simple Random Sampling (random selection of a **minimum of 50 medical records** from a list of records for the entire month – done via Excel randomization); Convenience Sampling (**10 direct observations** conducted whenever the opportunity becomes available during the month); Systematic Random Sampling (every Nth sample will be chosen from a list of medical records until the **minimum sample size of 50 medical records** is achieved; Nth sample determined by the formula – the total number of records for the month divided by 50 minimum records); Stratified Random Sampling (3 Strata – 7-3 shift, 3-11 shift, and 11-7 shift; 5 randomly chosen refrigerator temp checks for each shift, from the monthly log sheet – for a **total of 15 samples for the month**).*	*Sample Exclusion Criteria:* Click here to enter text.	*Sample Exclusion Criteria:* Click here to enter text.	*Sample Exclusion Criteria:* Click here to enter text.	*Sample Exclusion Criteria:* Click here to enter text.
***Inclusion Criteria** – characteristics the sample must have to be included in the audit*	*Indicator/Measure Result Expressed As:* ☐ Volume or Numerical Count ☐ Percentage – see Operational Definition below ☐ Rate - see Operational Definition below Type of Rate: ☐ Prevalence Rate ☐ Incidence Rate	*Indicator/Measure Result Expressed As:* ☐ Volume or Numerical Count ☐ Percentage – see Operational Definition below ☐ Rate - see Operational Definition below Type of Rate: ☐ Prevalence Rate ☐ Incidence Rate	*Indicator/Measure Result Expressed As:* ☐ Volume or Numerical Count ☐ Percentage – see Operational Definition below ☐ Rate - see Operational Definition below Type of Rate: ☐ Prevalence Rate ☐ Incidence Rate	*Indicator/Measure Result Expressed As:* ☐ Volume or Numerical Count ☐ Percentage – see Operational Definition below ☐ Rate - see Operational Definition below Type of Rate: ☐ Prevalence Rate ☐ Incidence Rate
***Exclusion Criteria** – characteristics that disqualifies or "throws out" a sample (so it will not be audited)* ***Prevalence** – number of current cases (new and preexisting) at a specified point in time (point prevalence) or specified period in time (period prevalence) divided by the population at the same specified point in time (point prevalence) or average or mid-interval population (period prevalence)* ***Incidence** – number of new cases during specified time interval divided by the population at the start of time interval (attack rate or risk) or the average population during time interval (incidence rate)*	*Operational Definition (if applicable):* Numerator: Click here to enter text. Denominator: Click here to enter text.	*Operational Definition (if applicable):* Numerator: Click here to enter text. Denominator: Click here to enter text.	*Operational Definition (if applicable):* Numerator: Click here to enter text. Denominator: Click here to enter text.	*Operational Definition (if applicable):* Numerator: Click here to enter text. Denominator: Click here to enter text.
***Numerator** – the number of samples that met the sample compliance criteria* ***Denominator** – the total number of samples audited* ***Sample Compliance Criteria** – characteristics the sample must have to be considered compliant.*	*Sample Compliance Criteria:* Click here to enter text.	*Sample Compliance Criteria:* Click here to enter text.	*Sample Compliance Criteria:* Click here to enter text.	*Sample Compliance Criteria:* Click here to enter text.
***Sample Non-Compliance Criteria** – characteristics the sample must have to be considered non-compliant.*	*Sample Non-Compliance Criteria:* Click here to enter text.	*Sample Non-Compliance Criteria:* Click here to enter text.	*Sample Non-Compliance Criteria:* Click here to enter text.	*Sample Non-Compliance Criteria:* Click here to enter text.
NOTE: If the indicator's or measure's Data Collection Method requires a separate, detailed, step-by-step	***Data Collection Frequency:*** Click here to enter text.	***Data Collection Frequency:*** Click here to enter text.	***Data Collection Frequency:*** Click here to enter text.	***Data Collection Frequency:*** Click here to enter text.

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QAPI PLAN ELEMENTS	**Indicator/Measure** Choose an item. Click here to enter text.	**Indicator/Measure** Choose an item. Click here to enter text.	**Indicator/Measure** Choose an item. Click here to enter text.	**Indicator/Measure** Choose an item. Click here to enter text.
instruction guide (due to its length), IT MUST BE ATTACHED WITH THIS PI PLAN.				
4. **Specific Audit/Data Collection Tools** and **Data Collection Schedules** are utilized and followed, for **CONSISTENT and ACCURATE data**. *NOTE: The corresponding Audit/Data Collection Tool MUST BE ATTACHED with this QAPI Plan.* *NOTE: Although department/unit staff may play a role in collecting data as auditors, the OVERALL RESPONSIBILITY REMAINS THAT OF THE UNIT SUPERVISOR OR DEPARTMENT HEAD.*	***Audit/Data Collection Tool:*** ☐ Checklist ☐ Survey/Questionnaire/Interview ☐ Observation Tool ☐ Other Customized Audit Sheet ***ATTACH AUDIT/DATA TOOL WITH THIS QAPI PLAN*** ***Data Collection Schedule:*** AUDITOR NAME(S): Click here to enter text. PLANNED DATA COLLECTION SCHEDULE: Click here to enter text. WHAT WILL BE DONE TO ENSURE TIMELY AND ACCURATE DATA COLLECTION: ☐ Unit Supervisor / Department Head will be the Alternate Auditor ☐ Contingency audit/data collection time will be scheduled ☐ Unit Supervisor / Department Head will educate all Auditors on this PI Plan, Data Collection Methodology, and Audit/Data Collection Schedule and Tool(s). ☐ Other: Click here to enter text.	***Audit/Data Collection Tool:*** ☐ Checklist ☐ Survey/Questionnaire/Interview ☐ Observation Tool ☐ Other Customized Audit Sheet ***ATTACH AUDIT/DATA TOOL WITH THIS QAPI PLAN*** ***Data Collection Schedule:*** AUDITOR NAME(S): Click here to enter text. PLANNED DATA COLLECTION SCHEDULE: Click here to enter text. WHAT WILL BE DONE TO ENSURE TIMELY AND ACCURATE DATA COLLECTION: ☐ Unit Supervisor / Department Head will be the Alternate Auditor ☐ Contingency audit/data collection time will be scheduled ☐ Unit Supervisor / Department Head will educate all Auditors on this PI Plan, Data Collection Methodology, and Audit/Data Collection Schedule and Tool(s). ☐ Other: Click here to enter text.	***Audit/Data Collection Tool:*** ☐ Checklist ☐ Survey/Questionnaire/Interview ☐ Observation Tool ☐ Other Customized Audit Sheet ***ATTACH AUDIT/DATA TOOL WITH THIS QAPI PLAN*** ***Data Collection Schedule:*** AUDITOR NAME(S): Click here to enter text. PLANNED DATA COLLECTION SCHEDULE: Click here to enter text. WHAT WILL BE DONE TO ENSURE TIMELY AND ACCURATE DATA COLLECTION: ☐ Unit Supervisor / Department Head will be the Alternate Auditor ☐ Contingency audit/data collection time will be scheduled ☐ Unit Supervisor / Department Head will educate all Auditors on this PI Plan, Data Collection Methodology, and Audit/Data Collection Schedule and Tool(s). ☐ Other: Click here to enter text.	***Audit/Data Collection Tool:*** ☐ Checklist ☐ Survey/Questionnaire/Interview ☐ Observation Tool ☐ Other Customized Audit Sheet ***ATTACH AUDIT/DATA TOOL WITH THIS QAPI PLAN*** ***Data Collection Schedule:*** AUDITOR NAME(S): Click here to enter text. PLANNED DATA COLLECTION SCHEDULE: Click here to enter text. WHAT WILL BE DONE TO ENSURE TIMELY AND ACCURATE DATA COLLECTION: ☐ Unit Supervisor / Department Head will be the Alternate Auditor ☐ Contingency audit/data collection time will be scheduled ☐ Unit Supervisor / Department Head will educate all Auditors on this PI Plan, Data Collection Methodology, and Audit/Data Collection Schedule and Tool(s). ☐ Other: Click here to enter text.
5. The **data aggregation methodology** (the way smaller or broken down data sets a.k.a. subsets, are combined into an overall number / average / rate) is specified. Subsets of data, when feasible, allow for the **comparison of performance** among department sections or hospital units.	***Data Aggregation Method:*** Click here to enter text.	***Data Aggregation Method:*** Click here to enter text.	***Data Aggregation Method:*** Click here to enter text.	***Data Aggregation Method:*** Click here to enter text.

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Quality Assessment and Performance Improvement Plan

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QAPI PLAN ELEMENTS	Indicator/Measure Choose an item. Click here to enter text.	Indicator/Measure Choose an item. Click here to enter text.	Indicator/Measure Choose an item. Click here to enter text.	Indicator/Measure Choose an item. Click here to enter text.
Aggregation Methodology *Examples: Nursing unit monitors performance of staff documentation for all 3 shifts, and TOTALS up all numerators and denominators to come up with the department's OVERALL compliance percentage for the month. An Operations department has broken down and monitors each step in a process; since these steps are not similar, an AVERAGE performance percentage is calculated with all steps to express the process' OVERALL performance percentage.* ***Data Subsets Comparison*** *Example: The hospital's hand hygiene indicator data is not only broken down per hospital service division, but also further into specific nursing units, pro-support departments, medical staff departments, etc. Comparison is performed by displaying the data in a table format/ pie graph / bar graph, etc.*	***Data Subsets Comparison Method:*** Click here to enter text.	***Data Subsets Comparison Method:*** Click here to enter text.	***Data Subsets Comparison Method:*** Click here to enter text.	***Data Subsets Comparison Method:*** Click here to enter text.
6. The indicator's or measure's **Goal is specified**, with its specific **source identified.**	***Indicator/Measure Goal:*** Click here to enter text.	***Indicator/Measure Goal:*** Click here to enter text.	***Indicator/Measure Goal:*** Click here to enter text.	***Indicator/Measure Goal:*** Click here to enter text.
	Source of Goal: Click here to enter text.	***Source of Goal:*** Click here to enter text.	***Source of Goal:*** Click here to enter text.	***Source of Goal:*** Click here to enter text.
7. When available, **Performance Benchmarks** (e.g. benchmarks established by nationally recognized organizations, etc.) are **used for comparison**.	***Research was conducted and:*** ☐ Benchmark is available – see below ☐ Benchmark is not available – none exists	***Research was conducted and:*** ☐ Benchmark is available – see below ☐ Benchmark is not available – none exists	***Research was conducted and:*** ☐ Benchmark is available – see below ☐ Benchmark is not available – none exists	***Research was conducted and:*** ☐ Benchmark is available – see below ☐ Benchmark is not available – none exists
	Benchmark: Click here to enter text.	***Benchmark:*** Click here to enter text.	***Benchmark:*** Click here to enter text.	***Benchmark:*** Click here to enter text.
	Benchmark Source: Click here to enter text.	***Benchmark Source:*** Click here to enter text.	***Benchmark Source:*** Click here to enter text.	***Benchmark Source:*** Click here to enter text.

SIGNATURES AND APPROVALS:	*DEPARTMENT HEAD NAME & TITLE:* Click here to enter text.	*DIVISION ADMINISTRATOR NAME & TITLE:* Click here to enter text.
	DEPARTMENT HEAD SIGNATURE:	*DIVISION ADMINISTRATOR SIGNATURE:*
	DATE: Click here to enter a date.	*DATE:* Click here to enter a date.

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Quality Assessment and Performance Improvement Plan & Program Evaluation Form
PART Choose an item. **OF** Choose an item.
Choose an item.

For ALL QAPI indicators/measures in your department's QAPI Plan, please answer the following evaluation questions.

ELEMENTS TO BE EVALUATED	**Indicator/Measure** Choose an item. Click here to enter text.	**Indicator/Measure** Choose an item. Click here to enter text.	**Indicator/Measure** Choose an item. Click here to enter text.	**Indicator/Measure** Choose an item. Click here to enter text.
1. Is there **evidence** that the indicator/measure is related to any of the following: improved - health outcomes, quality, safety, efficiency, customer service, cost-effectiveness, accountability; prevention and reduction of medical errors? NOTE: This should have been **documented** in the QAPI Plan. *Examples of EVIDENCE – standards or guidelines from a nationally recognized organization, hospital specific evidence, peer-reviewed research, etc.*	☐ Yes ☐ No ***Provide specific evidence:*** Click here to enter text.	☐ Yes ☐ No ***Provide specific evidence:*** Click here to enter text.	☐ Yes ☐ No ***Provide specific evidence:*** Click here to enter text.	☐ Yes ☐ No ***Provide specific evidence:*** Click here to enter text.
2. Is the **scope** of data collection appropriate for the indicator/measure? NOTE: Are ALL areas that should be monitored, accounted for in the indicator/measure? NOTE: This should have been **documented** in the QAPI plan and reflected in QAPI reports data. *Example of appropriate SCOPE – Hand Hygiene observations being monitored in ALL hospital patient care areas, and include ALL applicable staff, such as Nursing, Medical Staff, Operations staff, Pro-Support Staff, etc.*	☐ Yes ☐ No ***Provide specific evidence:*** Click here to enter text.	☐ Yes ☐ No ***Provide specific evidence:*** Click here to enter text.	☐ Yes ☐ No ***Provide specific evidence:*** Click here to enter text.	☐ Yes ☐ No ***Provide specific evidence:*** Click here to enter text.
3. Is the **method and frequency** of data collection specified? NOTE: This should have been **documented** in the QAPI Plan. NOTE: When you specify, in detail, the METHOD and FREQUENCY of data collection, you will reduce the risk of invalid or inaccurate data collection, and provide exact guidance as to how audits or monitoring is to be conducted. *Examples: chart reviews of medical records, electronic health records, MARs, log books, etc.; monthly observations, or monthly audits; samples obtained via a specified source, and how samples are chosen for*	☐ Yes ☐ No ***Provide specific evidence:*** Click here to enter text.	☐ Yes ☐ No ***Provide specific evidence:*** Click here to enter text.	☐ Yes ☐ No ***Provide specific evidence:*** Click here to enter text.	☐ Yes ☐ No ***Provide specific evidence:*** Click here to enter text.

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Quality Assessment and Performance Improvement Plan & Program Evaluation Form
PART Choose an item. **OF** Choose an item.
Choose an item.

ELEMENTS TO BE EVALUATED	**Indicator/Measure** Choose an item. Click here to enter text.	**Indicator/Measure** Choose an item. Click here to enter text.	**Indicator/Measure** Choose an item. Click here to enter text.	**Indicator/Measure** Choose an item. Click here to enter text.
auditing (what excludes or includes samples from auditing?), etc.; how compliance is determined (what is compliant, vs. non-compliant?)				
4. Is there **evidence** that data is actually collected in the manner and frequency specified for this indicator/measure? NOTE: If there have been incidences of ***late, incomplete, or wrong/ inaccurate data collection at any point this CY***, response should be "No" and further details should be provided.	☐ Yes ☐ No ***Provide specific evidence:*** Click here to enter text.	☐ Yes ☐ No ***Provide specific evidence:*** Click here to enter text.	☐ Yes ☐ No ***Provide specific evidence:*** Click here to enter text.	☐ Yes ☐ No ***Provide specific evidence:*** Click here to enter text.
5. If department staff play a role in data collection, is **collection consistent** with the specifications for how data should be collected? NOTE: If there have been incidences where ***staff turnover affected data collection practices (no handoff of proper collection methods)***, or incidences where ***staff failed to collect data per the specifications***, response should be "No" and further details should be provided.	☐ Yes ☐ No ☐ N/A ***Provide specific evidence:*** Click here to enter text.	☐ Yes ☐ No ☐ N/A ***Provide specific evidence:*** Click here to enter text.	☐ Yes ☐ No ☐ N/A ***Provide specific evidence:*** Click here to enter text.	☐ Yes ☐ No ☐ N/A ***Provide specific evidence:*** Click here to enter text.
6. Is the **collected data aggregated** (combined from smaller or broken down data sets into an overall number/ average/ rate) in accordance with the department's or hospital's methodology specified for this indicator/measure? NOTE: This DATA AGGREGATION METHODOLOGY should have been **documented** in the QAPI Plan and reflected in QAPI reports data. *Examples: Nursing unit monitors performance of staff documentation for all 3 shifts, and TOTALS up all numerators and denominators to come up with the department's OVERALL compliance percentage for the month. An Operations department has broken down and monitors each step in a process; since these steps are not similar, an AVERAGE performance percentage is calculated with all steps to express the process' OVERALL performance percentage.*	☐ Yes ☐ No ☐ N/A ***Provide specific evidence:*** Click here to enter text.	☐ Yes ☐ No ☐ N/A ***Provide specific evidence:*** Click here to enter text.	☐ Yes ☐ No ☐ N/A ***Provide specific evidence:*** Click here to enter text.	☐ Yes ☐ No ☐ N/A ***Provide specific evidence:*** Click here to enter text.
7. Is the **collected data analyzed**?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No

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Quality Assessment and Performance Improvement Plan & Program Evaluation Form
PART Choose an item. **OF** Choose an item.
Choose an item.

ELEMENTS TO BE EVALUATED	**Indicator/Measure** Choose an item. Click here to enter text.	**Indicator/Measure** Choose an item. Click here to enter text.	**Indicator/Measure** Choose an item. Click here to enter text.	**Indicator/Measure** Choose an item. Click here to enter text.
NOTE: the ANALYSIS of all data should have been **documented** in QAPI reports. NOTE: data ***ANALYSIS*** includes any of the following activities – investigating **root causes** behind the data results (consider all contributing factors and **why** they occurred – human, technological, environment, education, systems, communication, etc.); comparison of results to benchmarks, standards or goals; identification of trends or patterns in the data; determining what conditions or changes are required to bridge the gap in performance; etc.	***Provide specific evidence:*** Click here to enter text.	***Provide specific evidence:*** Click here to enter text.	***Provide specific evidence:*** Click here to enter text.	***Provide specific evidence:*** Click here to enter text.
8. If the indicator is the type that measures a **rate**, is the **rate calculated for points in time and over time** (prevalence, incidence, etc.), and is **comparison made to performance benchmarks** when available (e.g. benchmarks established by nationally recognized organizations)? NOTE: the details regarding how the rates were calculated and what benchmarks were being compared against should have been **documented** in the QAPI Plan. NOTE: the COMPARISON of RATES should have been **documented** in QAPI reports.	☐ Yes ☐ No ☐ N/A ***Provide specific evidence:*** Click here to enter text.	☐ Yes ☐ No ☐ N/A ***Provide specific evidence:*** Click here to enter text.	☐ Yes ☐ No ☐ N/A ***Provide specific evidence:*** Click here to enter text.	☐ Yes ☐ No ☐ N/A ***Provide specific evidence:*** Click here to enter text.
9. When feasible, is **aggregated data broken down** into subsets that allow **comparison** of performance **among department sections or hospital units** covered by the indicator/measure? NOTE: This DATA AGGREGATION METHODOLOGY should have been **documented** in the QAPI Plan with comparisons reflected in QAPI reports data, if applicable. *Example: The hospital's hand hygiene indicator data is not only broken down per hospital service division, but also further into specific nursing units, pro-support departments, medical staff departments, etc.*	☐ Yes ☐ No ☐ N/A ***Provide specific evidence:*** Click here to enter text.	☐ Yes ☐ No ☐ N/A ***Provide specific evidence:*** Click here to enter text.	☐ Yes ☐ No ☐ N/A ***Provide specific evidence:*** Click here to enter text.	☐ Yes ☐ No ☐ N/A ***Provide specific evidence:*** Click here to enter text.
10. If the data analysis identified areas	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No

Guam Memorial Hospital Authority
Click here to enter text.
Quality Assessment and Performance Improvement Plan & Program Evaluation Form
PART Choose an item. **OF** Choose an item.
Choose an item.

ELEMENTS TO BE EVALUATED	**Indicator/Measure** Choose an item. Click here to enter text.	**Indicator/Measure** Choose an item. Click here to enter text.	**Indicator/Measure** Choose an item. Click here to enter text.	**Indicator/Measure** Choose an item. Click here to enter text.
needing improvement, is there **documented evidence that the department instituted interventions** (activities and/or projects) to address them? NOTE: the INTERVENTIONS or PROJECTS should have been **documented** in QAPI reports. NOTE: Utilizing the SAME interventions or actions repeatedly to address improvement needs should NOT be considered sufficient.	***Provide specific evidence:*** Click here to enter text.	***Provide specific evidence:*** Click here to enter text.	***Provide specific evidence:*** Click here to enter text.	***Provide specific evidence:*** Click here to enter text.
11. Are **interventions evaluated** for success? NOTE: the EVALUATION of all interventions should have been **documented** in QAPI reports.	☐ Yes ☐ No ***Provide specific evidence:*** Click here to enter text.	☐ Yes ☐ No ***Provide specific evidence:*** Click here to enter text.	☐ Yes ☐ No ***Provide specific evidence:*** Click here to enter text.	☐ Yes ☐ No ***Provide specific evidence:*** Click here to enter text.
12. If interventions taken were not successful, were **new interventions developed**? NOTE: the development of NEW INTERVENTIONS should have been **documented** in QAPI reports.	☐ Yes ☐ No ***Provide specific evidence:*** Click here to enter text.	☐ Yes ☐ No ***Provide specific evidence:*** Click here to enter text.	☐ Yes ☐ No ***Provide specific evidence:*** Click here to enter text.	☐ Yes ☐ No ***Provide specific evidence:*** Click here to enter text.
13. If interventions were successful, did **evaluation continue** longer to assess if success was sustained? NOTE: the CONTINUED EVALUATION to assess sustainment should have been **documented** in QAPI reports. Guidance is provided in Policy A-PI100.	☐ Yes ☐ No ***Provide specific evidence:*** Click here to enter text.	☐ Yes ☐ No ***Provide specific evidence:*** Click here to enter text.	☐ Yes ☐ No ***Provide specific evidence:*** Click here to enter text.	☐ Yes ☐ No ***Provide specific evidence:*** Click here to enter text.
14. Did the indicator/measure **consistently meet or exceed greater than 90% compliance** for a **consecutive period of 6 months** during the calendar year? NOTE: This guidance is provided in Policy A-PI100.	☐ Yes ☐ No ***Provide specific evidence:*** Click here to enter text.	☐ Yes ☐ No ***Provide specific evidence:*** Click here to enter text.	☐ Yes ☐ No ***Provide specific evidence:*** Click here to enter text.	☐ Yes ☐ No ***Provide specific evidence:*** Click here to enter text.
15. If you answered "Yes" to number 14, was the guidance for continuing or discontinuing monitoring in Policy A-PI100 followed accordingly?	☐ Yes ☐ No ☐ N/A ***Provide specific evidence:*** Click here to enter text.	☐ Yes ☐ No ☐ N/A ***Provide specific evidence:*** Click here to enter text.	☐ Yes ☐ No ☐ N/A ***Provide specific evidence:*** Click here to enter text.	☐ Yes ☐ No ☐ N/A ***Provide specific evidence:*** Click here to enter text.

Guam Memorial Hospital Authority
Click here to enter text.
Quality Assessment and Performance Improvement Plan & Program Evaluation Form
PART Choose an item. **OF** Choose an item.
Choose an item.

ELEMENTS TO BE EVALUATED	**Indicator/Measure** Choose an item. Click here to enter text.	**Indicator/Measure** Choose an item. Click here to enter text.	**Indicator/Measure** Choose an item. Click here to enter text.	**Indicator/Measure** Choose an item. Click here to enter text.
NOTE: If guidance in policy was not followed, please provide explanation.				
16. Based on the indicator's or measure's current CY performance/ compliance percentage/ rate, will it continue to be monitored in the next CY?	☐ CONTINUE ☐ DISCONTINUE ***Provide justification:*** Click here to enter text.	☐ CONTINUE ☐ DISCONTINUE ***Provide justification:*** Click here to enter text.	☐ CONTINUE ☐ DISCONTINUE ***Provide justification:*** Click here to enter text.	☐ CONTINUE ☐ DISCONTINUE ***Provide justification:*** Click here to enter text.

SIGNATURES AND APPROVALS:	***DEPARTMENT HEAD NAME & TITLE:*** Click here to enter text.	***DIVISION ADMINISTRATOR NAME & TITLE:*** Click here to enter text.
	DEPARTMENT HEAD SIGNATURE:	***DIVISION ADMINISTRATOR SIGNATURE:***
	DATE: Click here to enter a date.	***DATE:*** Click here to enter a date.

ATTACHMENT VII
MONTHLY TRENDING SHEET – PAGE 1

DEPARTMENT
CY ____ TRENDING SHEET

PERFORMANCE KEY: ★ Better than Expected ◆ Expected ■ Needs more work ● Worse than expected ⊘ No Data Collected

INDICATORS	GOAL	JAN	FEB	MAR	Q1	APR	MAY	JUN	Q2	JUL	AUG	SEP	Q3	OCT	NOV	DEC	Q4	CY____
VOLUME INDICATORS																		
					0				0				0				0	0
					0				0				0				0	0
					0				0				0				0	0
					0				0				0				0	0
					0				0				0				0	0
STRUCTURAL INDICATORS/ MEASURES																		
1. TOTAL AMOUNT OF OVERTIME HOURS PER MONTH *(lower amount is desired)*		0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Staff Position 1 Overtime Hours					0				0				0				0	0
Staff Position 2 Overtime Hours					0				0				0				0	0
Staff Position 3 Overtime Hours					0				0				0				0	0
					0				0				0				0	0
2. STAFF VACANCY RATE PER MONTH *(lower percentage is desired)*		#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!
Number of VACANT Positions		0	0	0		0	0	0		0	0	0		0	0	0		
Total Number of POSITIONS (vacant plus filled)		0	0	0		0	0	0		0	0	0		0	0	0		
Data Breakdown																		
Position 1 Vacancy Rate Per Month		#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!
Position 1 Number of VACANT Positions																		
Position 1 Total Number of Positions (vacant plus filled)																		
Position 2 Vacancy Rate Per Month		#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!
Position 2 Number of VACANT Positions																		
Position 2 Total Number of Positions (vacant plus filled)																		
Position 3 Vacancy Rate Per Month		#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!
Position 3 Number of VACANT Positions																		
Position 3 Total Number of Positions (vacant plus filled)																		
QUALITY ASSESSMENT/ PERFORMANCE IMPROVEMENT (QAPI) INDICATORS/ MEASURES																		
1. INDICATOR/ MEASURE NAME		#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!
Numerator description	goal%																	
Denominator description																		
Indicator/Measure Improves: ☐ Health/Patient Outcomes ☐ Quality ☐ Safety ☐ Efficiency ☐ Patient Satisfaction/ Service ☐ Cost Effectiveness/ Savings ☐ Accountability	★ >___% ◆ >___%																	
Indicator/ Measure Type: ☐ Process ☐ Outcome	■ >___%																	
Result Expressed As: ☐ Percentage ☐ Rate																		
Type of Rate (if applicable): ☐ *Incidence* ☐ *Prevalence*	● <___%																	
Sample Size & Scope:																		
Data Collection Method:	⊘ No Data																	
Data Collection Frequency:																		
2. INDICATOR/ MEASURE NAME		#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!
Numerator description	goal%																	
Denominator description																		
Indicator/Measure Improves: ☐ Health/Patient Outcomes ☐ Quality ☐ Safety ☐ Efficiency ☐ Patient Satisfaction/ Service ☐ Cost Effectiveness/ Savings ☐ Accountability	★ >___% ◆ >___%																	

New Trending Sheet Template [Revised 08/2017]

DEPARTMENT
CY ____ TRENDING SHEET

PERFORMANCE KEY: ★ Better than Expected ◆ Expected ■ Needs more work ● Worse than expected ⊘ No Data Collected

INDICATORS	GOAL	JAN	FEB	MAR	Q1	APR	MAY	JUN	Q2	JUL	AUG	SEP	Q3	OCT	NOV	DEC	Q4	CY____
Indicator/ Measure Type: ☐ Process ☐ Outcome **Result Expressed As:** ☐ Percentage ☐ Rate *Type of Rate (if applicable):* ☐ *Incidence* ☐ *Prevalence* **Sample Size & Scope:** **Data Collection Method:** **Data Collection Frequency:**	■ > ___% ● < ___% ⊘ No Data																	
3. INDICATOR/ MEASURE NAME Numerator description Denominator description	goal%	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!
Indicator/Measure Improves: ☐ Health/Patient Outcomes ☐ Quality ☐ Safety ☐ Efficiency ☐ Patient Satisfaction/ Service ☐ Cost Effectiveness/ Savings ☐ Accountability **Indicator/ Measure Type:** ☐ Process ☐ Outcome **Result Expressed As:** ☐ Percentage ☐ Rate *Type of Rate (if applicable):* ☐ *Incidence* ☐ *Prevalence* **Sample Size & Scope:** **Data Collection Method:** **Data Collection Frequency:**	★ > ___% ◆ > ___% ■ > ___% ● < ___% ⊘ No Data																	
4. INDICATOR/ MEASURE NAME Numerator description Denominator description	goal%	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!
Indicator/Measure Improves: ☐ Health/Patient Outcomes ☐ Quality ☐ Safety ☐ Efficiency ☐ Patient Satisfaction/ Service ☐ Cost Effectiveness/ Savings ☐ Accountability **Indicator/ Measure Type:** ☐ Process ☐ Outcome **Result Expressed As:** ☐ Percentage ☐ Rate *Type of Rate (if applicable):* ☐ *Incidence* ☐ *Prevalence* **Sample Size & Scope:** **Data Collection Method:** **Data Collection Frequency:**	★ > ___% ◆ > ___% ■ > ___% ● < ___% ⊘ No Data																	

Prepared By: [NAME/TITLE] Date

Submitted By: [NAME/TITLE]
Department Manager/Supervisor Date

Reviewed and Approved By: [NAME/TITLE]
Division Administrator Date

New Trending Sheet Template [Revised 08/2017]

QUALITY ASSESSMENT & PERFORMANCE IMPROVEMENT (QAPI) REPORT

DEPARTMENT NAME

Choose an item. - Choose an item.

QAPI Indicator/ Measure NAME Choose an item.:			
DATA COLLECTION			
Choose an item. **Result: enter result** Choose an item.	Choose an item. **Result: enter result** Choose an item.	Choose an item. **Result: enter result** Choose an item.	Choose an item. **Average: enter result** Choose an item.
Compared to Choose an item. , this result was Choose an item.	Compared to Choose an item. , this result was Choose an item.	Compared to Choose an item. , this result was Choose an item.	Compared to Choose an item. , this result was Choose an item.
If Month 1 was Not Applicable or Data was NOT collected, explain below: Click here to enter text.	*If Month 2 was Not Applicable or Data was NOT collected, explain below:* Click here to enter text.	*If Month 3 was Not Applicable or Data was NOT collected, explain below:* Click here to enter text.	*If the Quarter was Not Applicable or Data was NOT collected, explain below:* Click here to enter text.
DATA ANALYSIS			
		Trends or Patterns Observed: Click here to enter text.	
		Data Subsets Comparison(s): Click here to enter text.	
Contributing Factors *(factors that influenced results/ compliance/ performance)* **& Reasons Why/Causes** *(why the contributing factors happened)*:			
Environment: Click here to enter text.		**WHY/Causes:** Click here to enter text.	
Equipment: Click here to enter text.		**WHY/Causes:** Click here to enter text.	
Materials/Supply: Click here to enter text.		**WHY/Causes:** Click here to enter text.	
Process/Procedure: Click here to enter text.		**WHY/Causes:** Click here to enter text.	
People: Click here to enter text.		**WHY/Causes:** Click here to enter text.	
***NOTE:** For People/staff-related factors, and for Clinical-related departments/divisions (Nursing Svcs., Pro-Support Svcs.) - the subsequent **Staffing Analysis** section in this template **MUST BE COMPLETED**.*			
IMPROVEMENT & SUSTAINMENT			
PDSA Background: This was Choose an item..	**PDSA Cycle Aim** *(We aimed to improve/sustain this/these, by how much/at this level, and by when)*: Click here to enter text.		
PLAN		**DO**	
WHO did the action/change:	**WHAT action/change was done:**	**WHEN was the action/change done:**	**Results, Findings, Observations:**
Click here to enter text.	Click here to enter text.	Click here to enter a date.	Click here to enter text.
Click here to enter text.	Click here to enter text.	Click here to enter a date.	Click here to enter text.
Click here to enter text.	Click here to enter text.	Click here to enter a date.	Click here to enter text.

QUALITY ASSESSMENT & PERFORMANCE IMPROVEMENT (QAPI) REPORT

DEPARTMENT NAME

Choose an item. - Choose an item.

Click here to enter text.	Click here to enter text.	Click here to enter a date.	Click here to enter text.

STUDY		ACT
Based on the results/findings/observations - we performed analysis & learned the following:	**PDSA Cycle Aim was:**	**The next steps we will take as a result of this cycle:**
Click here to enter text.	Choose an item.	Choose an item.

OTHER COMMENTS

Click here to enter text.

QAPI Indicator/ Measure NAME

Choose an item.**:**

DATA COLLECTION

Choose an item. **Result: enter result** Choose an item.	Choose an item. **Result: enter result** Choose an item.	Choose an item. **Result: enter result** Choose an item.	Choose an item. **Average: enter result** Choose an item.
Compared to Choose an item. , this result was Choose an item.	Compared to Choose an item. , this result was Choose an item.	Compared to Choose an item. , this result was Choose an item.	Compared to Choose an item. , this result was Choose an item.
If Month 1 was Not Applicable or Data was NOT collected, explain below: Click here to enter text.	*If Month 2 was Not Applicable or Data was NOT collected, explain below:* Click here to enter text.	*If Month 3 was Not Applicable or Data was NOT collected, explain below:* Click here to enter text.	*If the Quarter was Not Applicable or Data was NOT collected, explain below:* Click here to enter text.

DATA ANALYSIS

Trends or Patterns Observed:

Click here to enter text.

Data Subsets Comparison(s):

Click here to enter text.

Contributing Factors *(factors that influenced results/ compliance/ performance)* **& Reasons Why/Causes** *(why the contributing factors happened)*:

Environment:	Click here to enter text.	**WHY/Causes:**	Click here to enter text.
Equipment:	Click here to enter text.	**WHY/Causes:**	Click here to enter text.
Materials/Supply:	Click here to enter text.	**WHY/Causes:**	Click here to enter text.
Process/Procedure:	Click here to enter text.	**WHY/Causes:**	Click here to enter text.
People:	Click here to enter text.	**WHY/Causes:**	Click here to enter text.

***NOTE:** For People/staff-related factors, and for Clinical-related departments/divisions (Nursing Svcs., Pro-Support Svcs.) - the subsequent **Staffing Analysis** section in this template **MUST BE COMPLETED**.*

IMPROVEMENT & SUSTAINMENT

PDSA Background: This was Choose an item..	**PDSA Cycle Aim** *(We aimed to improve/sustain this/these, by how much/at this level, and by when)*: Click here to enter text.

QUALITY ASSESSMENT & PERFORMANCE IMPROVEMENT (QAPI) REPORT

DEPARTMENT NAME

Choose an item. - Choose an item.

PLAN		DO	
WHO did the action/change:	**WHAT action/change was done:**	**WHEN was the action/change done:**	**Results, Findings, Observations:**
Click here to enter text.	Click here to enter text.	Click here to enter a date.	Click here to enter text.
Click here to enter text.	Click here to enter text.	Click here to enter a date.	Click here to enter text.
Click here to enter text.	Click here to enter text.	Click here to enter a date.	Click here to enter text.
Click here to enter text.	Click here to enter text.	Click here to enter a date.	Click here to enter text.

STUDY		ACT
Based on the results/findings/observations - we performed analysis & learned the following:	**PDSA Cycle Aim was:**	**The next steps we will take as a result of this cycle:**
Click here to enter text.	Choose an item.	Choose an item.

OTHER COMMENTS
Click here to enter text.

STAFFING ANALYSIS	**Staffing Analysis** *completion is mandatory for: (1) Clinical-related departments/divisions (Nursing Svcs., Pro-Support Svcs.), (2) Quality or Safety indicators/measures that did not perform as expected, (3) any undesirable event, and (4) any QAPI indicator/measure where People/staff-related factors were documented as contributing to results/performance/compliance, in Data Analysis sections in this template.*			
	Choose an item. **Vacancy Rate: rate**	Choose an item. **Vacancy Rate: rate**	Choose an item. **Vacancy Rate: rate**	Choose an item. **Average Rate: rate**
	Choose an item. **OT hours: hours**	Choose an item. **OT hours: hours**	Choose an item. **OT hours: hours**	Choose an item. **Total Hours: hours**
	Skill Mix Assessment: *(the right people, with the right skills, in the right place at the right time; balance of novice vs. experienced, licensed vs. unlicensed, certified vs. uncertified, appropriate shift/location/duty placement for staff mix, etc.)* **Explain:** Click here to enter text.			
	Competency Assessment: *(details regarding required/applicable orientations, trainings, educations, and competencies – their statuses/completion/compliance, etc.)* **Explain:** Click here to enter text.			
	Work Flow/Process or Workload Assessment: *(details regarding volume of duties/treatments/procedures, census levels, acuity levels, simplicity or complexity of work flow/process, etc.)* **Explain:** Click here to enter text.			

Prepared & Submitted By: NAME/TITLE Department Manager/Supervisor	Click here to enter a date. Date	Reviewed & Approved By: NAME/TITLE Division Administrator	Click here to enter a date. Date

GMHA BOARD OF TRUSTEES – QUALITY & SAFETY SUBCOMMITTEE
QUALITY ASSESSMENT & PERFORMANCE IMPROVEMENT (QAPI) REPORT

Click here to enter text. - Choose an item.

Choose an item. - Choose an item.

DATA COLLECTION		DATA ANALYSIS	IMPROVEMENT & SUSTAINMENT PLANS			
INDICATOR/ MEASURE	WHAT? (Contributing Factors that caused the performance decline OR increase)	WHY? (Analysis / Reasons – why did the contributing factors happen?)	ACTIONS DONE or PLAN OF ACTION TO EXECUTE (address the reasons)	WHEN? (When was the action completed? OR When will the action be completed?)	WHO? (responsible person for executing the action)	STATUS? (done, ongoing, pending, explain)

CONTRACTED SERVICES						
INDICATOR/ MEASURE	WHAT? (Contributing Factors that caused the performance decline OR increase)	WHY? (Analysis / Reasons – why did the contributing factors happen?)	ACTIONS DONE or PLAN OF ACTION TO EXECUTE (address the reasons)	WHEN? (When was the action completed? OR When will the action be completed?)	WHO? (responsible person for executing the action)	STATUS? (done, ongoing, pending, explain)

GMHA BOARD OF TRUSTEES – QUALITY & SAFETY SUBCOMMITTEE
QUALITY ASSESSMENT & PERFORMANCE IMPROVEMENT (QAPI) REPORT

Click here to enter text. - Choose an item.
Choose an item. - Choose an item.

STAFFING ANALYSIS					
UNIT, DEPT. SECTION, ETC.	VACANCY RATE	OT HOURS	SKILL MIX	COMPETENCIES	WORK FLOW/ PROCESS OR WORKLOAD

STAFFING PLAN OF ACTION			
ACTIONS DONE or PLAN OF ACTION TO EXECUTE	WHEN? (When was the action completed? OR When will the action be completed?)	WHO? (responsible person for executing the action)	STATUS? (done, ongoing, pending, explain)

Prepared & Submitted By: NAME/TITLE
Division Administrator

Click here to enter a date.
Date

ATTACHMENT X
DIVISION ADMINISTRATOR ANNUAL REPORT – PAGE 1

GMHA BOARD OF TRUSTEES – QUALITY & SAFETY SUBCOMMITTEE
QUALITY ASSESSMENT & PERFORMANCE IMPROVEMENT (QAPI) REPORT

Click here to enter text.

Choose an item. – **Annual Evaluation**

For all departments/units from all three Rotation Months, please address/evaluate the following elements.

Indicator/ Measure Selection & Prioritization

Did the Rotation Months select indicators or measures that supported or was related to any of the following: improvement of health outcomes, quality, safety, efficiency, customer service, cost effectiveness, accountability; prevention/reduction of medical errors/patient harm? *To support your answer, please explain the process your division undertook to ensure appropriate indicators/measures were selected.*

Click here to enter text.

Did the Rotation Months prioritize improvement activities and monitoring for its selected indicators/measures? *To support your answer, please explain how this prioritization occurred, and how you were involved as Division Administrator.*

Click here to enter text.

Scope Appropriateness

Did the Rotation Months appropriately address the scope of monitoring? *To support your answer, please explain how the Rotation Months ensured that all areas, shifts, and patient populations that SHOULD have been monitored, were accounted for in all indicators/measures (discuss if any assessment of scope applicability was conducted).*

Click here to enter text.

Data Collection Methodology/ Specifications

Did the Data Collection Methodology/Specifications of all indicators/measures for the Rotation Months result in valid, timely and accurate data? *To support your answer, please provide details on the presence or absence of the following: incidences of incomplete or late data collection and submission; incidences of inaccurate data collection due to improper auditing methods (not following the specifications for auditing); incidences of data collector(s) turnover/absence/leave, with or without proper handoff/teaching of proper auditing methods/specifications.*

Click here to enter text.

If the indicators/measures for the Rotation Months required data subsets to be aggregated into an overall number, was the method for this aggregation followed, per specifications? *To support your answer, please provide details on the presence or absence of any deviation from the aggregation methods/specifications, and the impact it had (if any) on data accuracy and validity.*

Click here to enter text.

Did the Rotation Months have adequate resources for Data Collection activities? *To support your answer, please provide details on the presence or absence of adequate auditing times/days (to include data compilation and entry onto templates/sheets); any incidences of data collector(s) turnover/absence/leave and the impact it had (if any) on data collection.*

Click here to enter text.

Data Analysis, Trends and Patterns Identification, Comparisons

Did the Rotation Months conduct robust data analyses to uncover root causes behind data/results/performance? *To support your answer, please explain (in detail) how this Rotation Month conducted analyses (what tools/methods were used).*

Click here to enter text.

How did the Rotation Months graphically display data?

Click here to enter text.

In its analysis of data, how did the Rotation Months identify trends and patterns?

Click here to enter text.

In its analysis of data, how did the Rotation Months conduct comparisons? *To support your answer, please also explain what was used for the comparisons, e.g. external benchmarks, internal historical data, etc.*

Click here to enter text.

Did the Rotation Months have adequate resources for Data Analysis activities? *To support your answer, please provide details on the presence or absence of adequate analysis times/days (to include time spent utilizing analysis tools, and displaying data in graphical form); any incidences of department supervisor/manager turnover/absence/leave and the impact it had (if any) on data analysis.*

Click here to enter text.

ATTACHMENT X
DIVISION ADMINISTRATOR ANNUAL REPORT – PAGE 2

GMHA BOARD OF TRUSTEES – QUALITY & SAFETY SUBCOMMITTEE
QUALITY ASSESSMENT & PERFORMANCE IMPROVEMENT (QAPI) REPORT
Click here to enter text.
Choose an item. – **Annual Evaluation**

Improvement (PDSA methodology) and Sustainment

Describe how effective the Rotation Months were at utilizing the PDSA methodology (cycle of planning, implementing, evaluating) for improvements and sustainment.

Click here to enter text.

If the Rotation Months determined interventions were unsuccessful, were NEW interventions created and subsequently implemented and evaluated? *To support your answer, please provide details on the presence or absence of failure to create new interventions.*

Click here to enter text.

If the Rotation Months determined interventions were successful, did monitoring and evaluation continue to assess for sustainment? *To support your answer, please provide details on the presence or absence of continued evaluation for assessment of sustainment.*

Click here to enter text.

Did the Rotation Months have adequate resources for Improvements and Sustainment activities? *To support your answer, please provide details on the presence or absence of improvements (via data collection, analysis results, etc.), and presence or absence of sustained improvement.*

Click here to enter text.

Contracted Services

Describe how effective the Rotation Months were at reporting QAPI related to Contracted Services (if applicable) throughout the calendar year. *To support your answer, please provide details on whether or not QAPI related requirements were fulfilled (e.g. monitoring/data collection, data display, analysis, trends and pattern identification, improvements and sustainment, and reporting).*

Click here to enter text.

Staffing Analysis and Plans of Action

Describe how effective the Rotation Months were at reporting QAPI related Staffing Analyses throughout the calendar year. *To support your answer, please provide details on whether or not QAPI requirements were fulfilled (e.g. monitoring/data collection, skill mix assessment, competency assessment, work flow/ process or workload assessment, improvements and sustainment, and reporting).*

Click here to enter text.

As Division Administrator, what plans of action did you create, implement, and/ or sustain, (in collaboration with both Human Resources Department and the Rotation Months), to address Staffing Effectiveness and adequacy?

Click here to enter text.

As a result of this calendar year's Staffing Analyses and Plans of Action, has staffing effectiveness and adequacy improved? *To support your answer, please provide details of what criteria was met in order to determine improvement or lack of improvement in staffing adequacy.*

Click here to enter text.

Division Administrator Reporting Quality and QAPI Oversight/Responsibility

For this calendar year, evaluate the quality of your own QAPI reports (as Division Administrator) to the Quality and Safety Subcommittee and Board of Trustees. *To support your answer, please explain how well you summarized and addressed this Rotation Month's QAPI activities throughout this calendar year, in order to provide meaningful and actionable information for board-level decision making.*

Click here to enter text.

For this calendar year, evaluate your effectiveness and/or success (as Division Administrator) in fulfilling the oversight/responsibilities required via the Hospital's QAPI program/policy.

Click here to enter text.

Future Plans and Recommendations

Based on this Evaluation, what plans will you create and implement to ensure that the Click here to enter text.

ATTACHMENT X
DIVISION ADMINISTRATOR ANNUAL REPORT – PAGE 3

GMHA BOARD OF TRUSTEES – QUALITY & SAFETY SUBCOMMITTEE
QUALITY ASSESSMENT & PERFORMANCE IMPROVEMENT (QAPI) REPORT
Click here to enter text.
Choose an item. – **Annual Evaluation**

Rotation Months succeed with satisfying QAPI Program requirements in the next Calendar Year?	
Based on this Evaluation and your oversight of the Rotation Months' QAPI monitoring and activities, what new recommendations for monitoring, improvement opportunities, and performance improvement projects can you make to the Quality & Safety Subcommittee and to the Board of Trustees for the next Calendar Year?	Click here to enter text.

Click here to enter a date.

Prepared & Submitted By: NAME/TITLE
Division Administrator

Date

ATTACHMENT XI

CHAIRPERSON QUARTERLY MATRIX REPORT

GMHA BOARD OF TRUSTEES – QUALITY & SAFETY SUBCOMMITTEE
QUALITY ASSESSMENT & PERFORMANCE IMPROVEMENT (QAPI) REPORT

Click here to enter text.

Choose an item. - Choose an item.

DATA COLLECTION		DATA ANALYSIS	IMPROVEMENT & SUSTAINMENT PLANS			
INDICATOR/ MEASURE	WHAT? (Contributing Factors that caused the performance decline OR increase)	WHY? (Analysis / Reasons – why did the contributing factors happen?)	ACTIONS DONE or PLAN OF ACTION TO EXECUTE (address the reasons)	WHEN? (When was the action completed? OR When will the action be completed?)	WHO? (responsible person for executing the action)	STATUS? (done, ongoing, pending, explain)

Click here to enter a date.

Prepared & Submitted By: NAME/TITLE
Committee Chairperson

Date

ATTACHMENT XII
CHAIRPERSON ANNUAL REPORT – PAGE 1

GMHA BOARD OF TRUSTEES – QUALITY & SAFETY SUBCOMMITTEE
QUALITY ASSESSMENT & PERFORMANCE IMPROVEMENT (QAPI) REPORT

Click here to enter text.

Choose an item. **– Annual Evaluation**

For the QAPI activities the committee undertook, please address/evaluate the following elements.

Indicator/ Measure Selection & Prioritization

Did the committee select indicators or measures that supported or was related to any of the following: improvement of health outcomes, quality, safety, efficiency, customer service, cost effectiveness, accountability; prevention/reduction of medical errors/patient harm? *To support your answer, please explain the process the committee undertook to ensure appropriate indicators/measures were selected.*

Click here to enter text.

Did the committee prioritize improvement activities and monitoring for its selected indicators/measures? *To support your answer, please explain how this prioritization occurred, and how you were involved as Committee Chairperson.*

Click here to enter text.

Scope Appropriateness

Did the committee appropriately address the scope of monitoring? *To support your answer, please explain how the committee ensured that all areas, shifts, and patient populations that SHOULD have been monitored, were accounted for in all indicators/measures (discuss if any assessment of scope applicability was conducted).*

Click here to enter text.

Data Collection Methodology/ Specifications

Did the Data Collection Methodology/Specifications of all indicators/measures for the committee result in valid, timely and accurate data? *To support your answer, please provide details on the presence or absence of the following: incidences of incomplete or late data collection and submission; incidences of inaccurate data collection due to improper auditing methods (not following the specifications for auditing); incidences of data collector(s) turnover/absence/leave, with or without proper handoff/teaching of proper auditing methods/specifications.*

Click here to enter text.

If the indicators/measures for the committee required data subsets to be aggregated into an overall number, was the method for this aggregation followed, per specifications? *To support your answer, please provide details on the presence or absence of any deviation from the aggregation methods/specifications, and the impact it had (if any) on data accuracy and validity.*

Click here to enter text.

Did the committee have adequate resources for Data Collection activities? *To support your answer, please provide details on the presence or absence of adequate auditing times/days (to include data compilation and entry onto templates/sheets); any incidences of data collector(s) turnover/absence/leave and the impact it had (if any) on data collection.*

Click here to enter text.

Data Analysis, Trends and Patterns Identification, Comparisons

Did the committee conduct robust data analyses to uncover root causes behind data/results/performance? *To support your answer, please explain (in detail) how the committee conducted analyses (what tools/methods were used).*

Click here to enter text.

How did the committee graphically display data?

Click here to enter text.

In its analysis of data, how did the committee identify trends and patterns?

Click here to enter text.

In its analysis of data, how did the committee conduct comparisons? *To support your answer, please also explain what was used for the comparisons, e.g. external benchmarks, internal historical data, etc.*

Click here to enter text.

Did the committee have adequate resources for Data Analysis activities? *To support your answer, please provide details on the presence or absence of adequate analysis times/days (to include time spent utilizing analysis tools, and displaying data in graphical form); any incidences of department supervisor/manager turnover/absence/leave and the impact it had (if any) on data analysis.*

Click here to enter text.

ATTACHMENT XII
CHAIRPERSON ANNUAL REPORT – PAGE 2

GMHA BOARD OF TRUSTEES – QUALITY & SAFETY SUBCOMMITTEE
QUALITY ASSESSMENT & PERFORMANCE IMPROVEMENT (QAPI) REPORT
Click here to enter text.
Choose an item. – **Annual Evaluation**

Improvement (PDSA methodology) and Sustainment

Describe how effective the committee was at utilizing the PDSA methodology (cycle of planning, implementing, evaluating) for improvements and sustainment.

Click here to enter text.

If the committee determined interventions were unsuccessful, were NEW interventions created and subsequently implemented and evaluated? *To support your answer, please provide details on the presence or absence of failure to create new interventions.*

Click here to enter text.

If the committee determined interventions were successful, did monitoring and evaluation continue to assess for sustainment? *To support your answer, please provide details on the presence or absence of continued evaluation for assessment of sustainment.*

Click here to enter text.

Did the committee have adequate resources for Improvements and Sustainment activities? *To support your answer, please provide details on the presence or absence of improvements (via data collection, analysis results, etc.), and presence or absence of sustained improvement.*

Click here to enter text.

Committee Chairperson Reporting Quality and QAPI Oversight/Responsibility

For this calendar year, evaluate the quality of your own QAPI reports (as Committee Chairperson) to the Quality and Safety Subcommittee and Board of Trustees. *To support your answer, please explain how well you summarized and addressed the committee's QAPI activities throughout this calendar year, in order to provide meaningful and actionable information for board-level decision making.*

Click here to enter text.

For this calendar year, evaluate your effectiveness and/or success (as Committee Chairperson) in fulfilling the oversight/responsibilities required via the Hospital's QAPI program/policy.

Click here to enter text.

Future Plans and Recommendations

Based on this Evaluation, what plans will you create and implement to ensure that the committee succeeds with satisfying QAPI Program requirements in the next Calendar Year?	Click here to enter text.
Based on this Evaluation and your oversight of the committee's QAPI monitoring and activities, what new recommendations for monitoring, improvement opportunities, and performance improvement projects can you make to the Quality & Safety Subcommittee and to the Board of Trustees for the next Calendar Year?	Click here to enter text.

Prepared & Submitted By: NAME/TITLE
Committee Chairperson

Click here to enter a date.
Date

ATTACHMENT XIII
QAPI PROJECT/TEAM TEMPLATE – PAGE 1

GUAM MEMORIAL HOSPITAL AUTHORITY
QAPI PROJECT TEAM
Click here to enter text.

Document last updated: Click here to enter text.

Purpose

Why was this Team created?

Click here to enter text.

What is the overall GOAL for this Team?

Click here to enter text.

What are the Team's objectives/aims?

Click here to enter text.

Who or What is impacted?

If the Team does not act and implement changes for improvement, who or what will be impacted, and how?

Click here to enter text.

Possible Solutions and Selection of the Change

Based on pre-project data analysis and discussions with the Team, what possible solutions were considered?

Click here to enter text.

Which change did the Team ultimately decide to implement and why?

Click here to enter text.

Expected Benefit

What benefit does the Team expect as a result of implementing this change?

Click here to enter text.

Team Members and Resources

Who is the Team accountable to for reporting (who will oversee the Team and its activities), and how often will reporting occur?

Click here to enter text.

What specific documentation/data/information/report will be submitted to this Team's overseeing person/committee?

Click here to enter text.

Team Leader: Click here to enter text. **Team Facilitator:** Click here to enter text.
Team Co-Leader: Click here to enter text. **Team Recorder:** Click here to enter text.

NOTE: *Team Recorder will maintain all recorded minutes, agendas, documents, reports, attendance sheets, etc. in a Team Binder. Team Facilitator will coordinate meeting dates, times and locations, and ensure that meeting materials are provided to all Team members a week prior to each meeting. Team Leader and Co-Leader will receive all Team reports, data, documents, etc. from responsible Team members, a week and a half prior to each meeting. Both Leaders will work together with the Recorder and Facilitator to create the meeting agendas and to update this Project Team template, plus ensure all materials are provided to the Team members. Both Leaders will report (verbally and with the written documentation/requirements) to the overseeing person/committee on behalf of the Team. Team members will be responsible for implementing actions, collecting data, and providing feedback in the form of documented reports. Members will submit all information to both Team Leaders, a week and a half prior to each meeting.*

Team Members (Name, Title, Department/Unit):	Meeting Dates and Times, Locations:
Click here to enter text.	Click here to enter text.

Deliverables

What is the Team expected to deliver, in order to start implementing the change and PDSA cycle(s)?

WHAT WILL BE DELIVERED:	BY WHEN:	BY WHO:
Click here to enter text.	Click here to enter text.	Click here to enter text.

Constraints

Please identify any barriers that exist which may create difficulties in accomplishing this Team's Goal.

ATTACHMENT XIII
QAPI PROJECT/TEAM TEMPLATE – PAGE 2

GUAM MEMORIAL HOSPITAL AUTHORITY
QAPI PROJECT TEAM
Click here to enter text.
Document last updated: Click here to enter text.

Click here to enter text.

Success Factors

What leadership and resources are needed to make this project a success?

Click here to enter text.

ATTACHMENT XIII
QAPI PROJECT/TEAM TEMPLATE – PAGE 3

GUAM MEMORIAL HOSPITAL AUTHORITY
QAPI PROJECT TEAM
Click here to enter text.
Document last updated: Click here to enter text.

Model for Improvement

What are we trying to accomplish? Click here to enter text.

How will we know that a change is an improvement? Click here to enter text.

What change can we make that will result in improvement? Click here to enter text.

PDSA Cycle Number: Choose an item. **PDSA Cycle Time Period:** *From:* Click here to enter a date. *To:* Click here to enter a date.

PDSA Background: *This is* Choose an item.

PLAN

List the tasks needed to set up this test of change	Person Responsible	When to be done	Where to be done

Predict what will happen when the test is carried out	Measures to determine if the prediction succeeds (Operational Definition, Data collection methodology or specifications, etc.)

DO

Describe what actually happened when you ran the test (what did you observe)

STUDY

Describe the measured results (data), how they compared to the predictions, and what was learned from the data analysis
PDSA Cycle Aim was: Choose an item.

ACT

If the PDSA Cycle Aim was accomplished/met: ***How will the Team adopt successful actions from this PDSA Cycle into existing or new processes and subsequently monitor for sustained success?***
If the PDSA Cycle Aim was <u>NOT</u> accomplished/met: ***Based on what was learned, describe what modifications to the plan will be made for the next PDSA cycle.***

GMHA Board of Trustees
ATTENDANCE SHEET
Wednesday, March 28, 2018 | 6:00 p.m. | Daniel L. Webb Conference Room

NAME	TITLE	SIGNATURE
Board Members:		
Eloy S. Lizama	Chairperson	
Lillian Perez-Posadas	Vice-chairperson	
Melissa Waibel	Secretary	
	Treasurer	
Sharon Davis	Trustee	
Sonia L. Siliang	Trustee	
Ricardo M. Terlaje	Trustee	
	Ex-officio Member	
Hospital Management:		
PeterJohn D. Camacho	Hospital Administrator/CEO	
Benita A. Manglona	Chief Financial Officer	
Zennia C. Pecina	Assistant Administrator of Nursing Services	
Vincent A. Duenas, MD	Associate Hospital Administrator of Medical Services	
Kozue Shimabukuro, MD	Assistant Associate Hospital Administrator of Medical Services	off-island
James Last, MD	Medical Staff President	
Guests:		
Carlos P. Flores Uzame	Analyst DOC	

Minutes of the Regular Meeting of the Guam Memorial Hospital Authority Board of Trustees

March 8, 2018 | 6:00 p.m.
Daniel L. Webb Conference Room

ATTENDANCE

Board Members:
Eloy Lizama
Lillian Posadas
Melissa Waibel
Sharon Davis
Dr. Ricardo Terlaje
Sonia Siliang

Executive Management:
PeterJohn Camacho
Benita Manglona
Edward Birn
Dr. Vincent Duenas
Dr. James Last
Zennia Pecina – Excused
Dr. Kozue Shimabukuro – Excused

ISSUE/TOPIC/DISCUSSIONS	DECISION(S)/ACTION(S)	RESPONSIBLE PARTY	REPORTING TIMEFRAME	STATUS
**** * * This meeting was scheduled as a make-up for the Board's February 2018 meeting that was canceled * * ****				
I. CALL MEETING TO ORDER AND DETERMINATION OF QUORUM				
	After notices were duly issued pursuant to *Title 5 Guam Code Annotated, Chapter 8 Open Government Law, Section 8107(a)* and with a quorum present, Trustee Lizama called to order the regular meeting of the GMHA Board of Trustees at 6:02 p.m. on Thursday, March 8, 2018 in the Daniel L. Webb Conference Room of the GMHA located in Tamuning, Guam.	Trustee Lizama	None	Informational
**** * * The meeting began with each Board member and executive manager introducing themselves to Trustee Sonia Siliang whose membership was recently confirmed by the 34th Guam Legislature. * * ****				
II. ACCEPTANCE OF REGULAR SESSION MINUTES				
A. <u>December 13, 2017</u>	A draft of the December 13, 2017 meeting minutes was distributed and reviewed. Trustee Posadas motioned and it was seconded by Trustee Waibel to approve the minutes as printed. The motion carried with all ayes.	All Trustees	None	Approved/ Closed
III. OLD BUSINESS				
There were no old business matters for discussion.	No decisions or actions taken.	None	None	None
IV. NEW BUSINESS				
A. Policy No. 6170-1, Determination of Death	It was noted that these policies had surpassed the 3-year requirement for review, and that there were no significant changes. The Division Heads provided brief explanations of the purposes for each policy Trustee Posadas motioned and it was seconded by Trustee Waibel to approve Policy No. 6170-1	All Board members	None	Approved

	with reference to the nursing policy on determination of death. The motion carried with all ayes.			
B. Policy No. 6170-4, Impaired Practitioner Guidelines	Trustee Terlaje motioned and it was seconded by Trustee Waibel to approve Policy No. 6170-4 as printed. The motion carried with all ayes.	All Board members	None	Approved
C. Policy No. 6170-16, Focused Professional Practice Evaluation	Trustee Waibel motioned and it was seconded by Trustee Posadas to approve Policy No. 6170-16 with reference to the section of the Medical Staff Bylaws that addresses FPPE's. The motion carried with all ayes.	All Board members	None	Approved
D. Policy No. 6190-3, Patient Satisfaction Survey	Trustee Posadas motioned and it was seconded by Trustee Terlaje to approve Policy No. 6190-3 as printed. The motion carried with all ayes. *Note: This policy was approved as written; however, the Guest Relations department will be asked to explore other methods for patients to take the surveys (e.g., online, in other languages, etc.). Also, the Quality & Safety subcommittee will research CMS requirements for items that are required to be included in the survey and recommend further revisions, if any.*	All Board members	None	Approved
E. Policy No. A-RI210, Patient Rights for children and Adolescents	Trustee Waibel motioned and it was seconded by Trustee Terlaje to approve Policy No. A-RI210 as printed. The motion carried with all ayes.	All Board members	None	Approved
F. Resolution No. 2018-08, Relative to the Delegation of Complaint Resolutions to the Performance Improvement Committee	Mr. Camacho explained that this resolution was developed as part of an accreditation requirement, wherein the GMHA must be able to provide evidence that the Board of Trustees delegated the "Complaint Resolution Committee" to management. This delegation requires management to review grievances and complaints, identify trends, patterns and developments, and to develop processes for improvement. Management would then report findings to the Board of Trustees.	All Board members	None	Approved

	Trustee Waibel motioned and it was seconded by Trustee Posadas Resolution no. 2018-08 as printed. The motion carried with all ayes.			
V. BOARD SUB-COMMITTEE REPORTS				
A. <u>Joint Conference and Professional Affairs (JCPA) Subcommittee</u>				
1. Resolution No. 2018-09, Relative to the Appointment of Provisional Medical Staff Privileges (exp. 01/31/19) for: • Anu Taylor, MD • John Dougherty, MD • Felix Cabrera, MD • Jennifer Chang, MD • George Bocobo, MD • Rose Todd, MD	Trustee Waibel motioned and it was seconded by Trustee Davis to approve Resolution No. 2018-09 as presented. The motion carried with all ayes.	All Board members	None	Approved
2. Resolution No. 2018-10, Relative to the Appointment of Provisional Medical Staff Privileges (exp. 01/31/19) for: • Carolyn Ward, CNM • Adrian Medina, CNM	Trustee Waibel motioned and it was seconded by Trustee Davis to approve Resolution No. 2018-10 as presented. The motion carried with all ayes.	All Board members	None	Approved
3. Resolution No. 2018-11, Relative to the Reappointment of Active Medical Staff Privileges (exp. 01/31/20) for: • Dennis Sarmiento, MD • Edgar Magcalas, MD • Daniel Hafner, MD	Trustee Waibel motioned and it was seconded by Trustee Posadas to approve Resolution No. 2018-11 as presented. The motion carried with all ayes.	All Board members	None	Approved
4. Resolution No. 2018-12, Relative to the Appointment of Provisional Medical Staff Privileges for Noel Silan, DPM on the Condition that he be Placed on a Focused Professional Practice Evaluation	Dr. Terlaje informed the Board that the JCPA subcommittee discussed concerns over Dr. Silan's history with medical records compliance at the GMHA but recommended the Board's approval on the condition that he is placed on a FPPE for monitoring. Trustee Posadas motioned and it was seconded by Trustee Waibel to approve Resolution No. 2018-12 as presented. The motion carried with all ayes.	All Board members	None	Approved
5. Resolution No. 2018-15, Relative to Approving Revisions to the Medical	It was noted that the Board's review and approval was required for revisions to the	All Board members	None	Approved

Staff Bylaws and Rules and Regulations	Medical Staff Bylaws and Rules and Regulations. Also noted, was that the JCPA subcommittee reviewed these revisions in November 2017 and recommended the Board's approval. Trustee Posadas motioned and it was seconded by Trustee Davis to approve Resolution No. 2018-15 as presented. The motion carried with all ayes.			
B. <u>Quality and Safety Subcommittee</u> • Regulatory Compliance Updates	Trustee Posadas reported the following: • the patient safety program policy was discussed but was still a work in progress. In the meantime, an interim policy was approved and disseminated to all employees; • resulting from findings from the patient satisfaction survey, the nursing division was in the process of training the staff on AIDET (Acknowledge, Introduce, Duration, Explanation, and Thank You), a communication tool that would help improve patient satisfaction; • resulting from the January 4 – 5, 2018 survey by the Joint Commission, the GMHA was placed on preliminary denial of accreditation. It was clarified that, although it was a downgrade, the GMHA was still considered accredited; • the GMHA submitted its corrective actions to the Joint Commission. A response is pending on whether it was accepted.	Trustees Posadas	Updates to be reported at the next scheduled meeting.	Informational
C. <u>Human Resources Subcommittee</u> 1. Resolution No. 2018-13, Relative to the appointment of PeterJohn D. Camacho, M.P.H., Hospital Administrator/CEO of the Guam Memorial Hospital Authority	Ms. Waibel informed the Board that the purpose of this resolution was to extend Mr. Camacho's contract which expired in February 2018. She mentioned that the Human Resources subcommittee initiated the performance appraisal review process. Once the template is developed the Board members would be asked to provide their input. A contract renewal is anticipated, but dependent on the outcome of the performance	All Board members	None	Approved

	appraisal. Trustee Terlaje motioned and it was seconded by Trustee Posadas to approve Resolution No. 2018-13 as presented. The motion carried with all ayes.			
2. Resolution No. 2018-14, Relative to Amending Board Resolution No. 2018-01, Remuneration of Internal Medicine Clinical Providers	It was clarified that this resolution was to correct the effective date from September 17, 2017 to November 26, 2017. Dr. Duenas explained that the increase was necessary for recruitment and retention purposes and due to the increase in patient load resulting from the clinics turning over the care of their patients to the hospitalists. Trustee Posadas motioned and it was seconded by Trustee Davis to approve Resolution No. 2018-14 as presented. The motion carried with all ayes.	All Board members	None	Approved
D. <u>Facilities, Capital Improvement Projects (CIP), and Information Technology Subcommittee</u>	Referring to the Hospital's Prioritized Needs List, Trustee Davis pointed out that the replacement of the main electrical distribution panel and the 1.6 Meg Genset that was purchased in 1974 were among the most critical capital projects. She had requested for the subcommittee members to develop a "What is going to fail next" list which would be used as visual of the projects (both funded and unfunded) that were truly critical. She mentioned that the Hospital will see a cost-savings in utilities with the recent commissioning of the 200+ solar panels (≈$75K in electricity) and VOIP phone installations. Mrs. Manglona mentioned that Hospital will be including all capital improvement projects in the FY-2019 budget request. Trustee Davis suggested having a grant writer on staff to research and write grants to support	Trustees Davis	Updates to be reported at the next scheduled meeting.	Informational

	capital projects, a task that may be assigned to the Director of Hospital Business Development and Strategic Planning.			
E. Governance, Bylaws and Strategic Planning Subcommittee	Trustee Waibel informed the Board that the organizational chart was reviewed and deferred back to the Executive Management Council for further revisions. Changes in the medical staff order and incorporation of the proposed nursing clinical ladder were necessary.	Trustees Waibel and Terlaje	Updates to be reported at the next scheduled meeting.	Informational
F. Finance and Audit Subcommittee	The financial related matters were discussed under the Chief Financial Officer's report.	Trustee Lizama	Updates to be reported at the next scheduled meeting.	Informational
VI. ADMINISTRATORS' REPORTS				
A. Hospital Administrator/CEO	Mr. Camacho expressed his apologies for not being able to prepare a written report for the Board, due to all the ongoing activities involving the GMHA. He stated that he would develop his report and provide it to the members sometime following the meeting.	Mr. Camacho	Updates to be reported at the next scheduled meeting.	Informational
B. Associate Administrator of Medical Services	Medical staff related matters were mentioned in previous discussions. Dr. Duenas had nothing further to report to the Board.	Dr. Duenas	Updates to be reported at the next scheduled meeting.	Informational
C. Associate Administrator of Professional Support Services	Dr. Shimabukuro was not present to provide her report.	Dr. Shimabukuro	Updates to be reported at the next scheduled meeting.	Informational
D. Assistant Administrator of Nursing Services	Ms. Pecina was not present to provide her report.	Ms. Pecina	Updates to be reported at the next scheduled meeting.	Informational
E. Chief Financial Officer	Mrs. Manglona informed the Board that payroll may not be met on Mar. 9, 2018 if a subsidy was not received from the Department of Administration. She stated that meeting payroll had always been a challenge, but that this situation was different	Mrs. Manglona	Updates to be reported at the next scheduled meeting.	Informational

	given the government's current financial situation. It was noted that gross payroll was $3.5M, net payroll was $2.2M, and payables for physicians was $.5M. Mrs. Manglona stated that the best-case scenario was having enough cash to meet net payroll, and the worst-case would be a delay in releasing checks and EFTs. Mr. Camacho informed the Board that the staff would have to be notified of the possible delay in payroll via an advisory. An advisory will be disseminated first thing Friday morning. Mrs. Manglona mentioned several actions taken to improve billing and collections, such as, appealing to insurance companies for payments, pursuing the rebasing for TEFRA adjustments, and submitting adjustment requests annually (absent the permanent rebase) to name a few. After thorough discussions regarding services provided by the Hospital and the need to identify cost-saving measures, the Board gave management consent to consider implementation of the following, if necessary: • discontinue clinic operations for the Department of Corrections; • consolidate the Urgent Care Clinic with the Emergency Room; • relocate the Skilled Nursing Unit to the main facility; and • raise hospital rates (by 50% or more). A motion was made by Trustee Posadas and it was seconded by Trustee Davis. The motion carried with all ayes.	Mr. Camacho All Board members	March 9, 2018 None	Informational Approved
F. <u>Medical Staff President</u>	Dr. Last introduced himself as the new Medical Staff President. He informed the Board that he was in the process of becoming familiarized with	Dr. Last	Updates to be reported at the next scheduled	Informational

	his responsibilities as part of his new role, and that his goal was to get the medical staff up to speed and more participative with regulatory compliance.		meeting.	
VII.PUBLIC COMMENT				
	None	None	None	None
VIII. ADJOURNMENT				
	There being no further business matters for discussion, Chairman Mr. Lizama declared the meeting adjourned at 8:38 p.m., motioned by Trustee Davis and seconded by Trustee Posadas. The motion carried with all ayes.	Chairman Lizama	None	Approved

Transcribed by: _____
Theo M. Palgelinan
Administrative Assistant

Submitted by: _____
Melissa Waibel
Secretary, Board of Trustees

CERTIFICATION OF APPROVAL OF MINUTES: The minutes of the March 8, 2018 regular session meeting was accepted and approved by the GMHA Board of Trustees on this 28th day of March 2018.

Certified by: _____
Eloy S. Lizama
Chairman, Board of Trustees

Guam Memorial Hospital Authority
Aturidåt Espetåt Mimuriåt Guåhan

850 GOV. CARLOS CAMACHO ROAD
OKA, TAMUNING, GUAM 96911
TEL: 647-2444 or 647-2330
FAX: (671) 649-0145

BOARD OF TRUSTEES
Official Resolution No. 2018-16

"RELATIVE TO THE REAPPOINTMENT OF ACTIVE MEDICAL STAFF PRIVILEGES"

Practitioner	Department	Specialty	Expiration Date
Darius Richardson, M.D.	Surgery	Oral & Maxillofacial	February 28, 2020
Kimberly Walton, M.D.	OB/GYN	OB/GYN	February 28, 2020
Vincent S. Duenas, D.O.	Medicine	Internal Medicine	February 28, 2020

WHEREAS, the above listed practitioners met the basic requirements for Active Medical Staff Membership as determined by the appropriate Medical Staff Departments and Committees pursuant to the GMHA Medical Staff Bylaws, Article IV, Section 4.2; and

WHEREAS, the Medical Executive Committee on February 28, 2018 and the Joint Conference and Professional Affairs Committee on March 15, 2018 recommended approval of Active Medical Staff Membership reappointment for the above listed practitioners; and

WHEREAS, all reappointments to Active Medical Staff Membership require Board approval; now, therefore be it

RESOLVED, that the Board of Trustees approves this recommendation to reappoint the above named practitioners to Active Medical Staff as recommended; and, be it further

RESOLVED, that the Board of Trustees directs the Hospital Administrator to duly notify the practitioners listed above and all Hospital and Medical Departments of these reappointments; and be it further

RESOLVED, that the Board of Trustees Chairperson certifies and the Board of Trustees Secretary attests to the adoption of this Resolution.

DULY AND REGULARLY ADOPTED ON THIS 28th DAY OF MARCH, 2018.

Certified by:

Eloy S. Lizama
Chairperson, Board of Trustees

Attested by:

Melissa Waibel
Secretary, Board of Trustees

Guam Memorial Hospital Authority
Aturidåt Espetåt Mimuriåt Guåhan

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OKA, TAMUNING, GUAM 96911
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BOARD OF TRUSTEES
Official Resolution No. 2018-17

"RELATIVE TO THE REAPPOINTMENT OF ACTIVE ASSOCIATE MEDICAL STAFF PRIVILEGES"

Practitioner	Department	Specialty	Expiration Date
John Merillat, MD.	Medicine	Cardiology	February 28, 2020

WHEREAS, the above listed practitioners met the basic requirements for Active Associate Medical Staff Membership as determined by the appropriate Medical Staff Departments and Committees pursuant to the GMHA Medical Staff Bylaws, Article IV, Section 4.2; and

WHEREAS, the Medical Executive Committee on February 28, 2018 and the Joint Conference and Professional Affairs Committee on March 15, 2018 recommended approval of Active Associate Medical Staff Membership reappointment for the above listed practitioners; and

WHEREAS, all reappointments to Active Associate Medical Staff Membership require Board approval; now, therefore be it

RESOLVED, that the Board of Trustees approves this recommendation to reappoint the above named practitioners to Active Associate Medical Staff as recommended; and, be it further

RESOLVED, that the Board of Trustees directs the Hospital Administrator to duly notify the practitioners listed above and all Hospital and Medical Departments of these reappointments; and, be it further

RESOLVED, that the Board of Trustees Chairperson certifies and the Board of Trustees Secretary attests to the adoption of this Resolution.

DULY AND REGULARLY ADOPTED ON THIS 28th DAY OF MARCH, 2018.

Certified by:

Eloy S. Lizama
Chairperson, Board of Trustees

Attested by:

Melissa Waibel
Secretary, Board of Trustees

Guam Memorial Hospital Authority
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BOARD OF TRUSTEES
Official Resolution No. 2018-18

"RELATIVE TO THE APPOINTMENT OF PROVISIONAL MEDICAL STAFF PRIVILEGES"

Practitioner	Department	Specialty	Expiration Date
Jacqueline Michaud, D.O.	Medicine	Internal Medicine	February 28, 2019

WHEREAS, the above listed practitioners met the basic requirements for Provisional Medical Staff Membership as determined by the appropriate Medical Staff Departments and Committees pursuant to the GMHA Medical Staff Bylaws, Article IV, Section 4.3; and

WHEREAS, the Medical Executive Committee on February 28, 2018 and the Joint Conference and Professional Affairs Committee on March 15, 2018, recommended approval of Provisional Medical Staff Membership appointment for the above listed practitioner; and

WHEREAS, all appointments to Provisional Medical Staff Membership require Board approval; now, therefore be it

RESOLVED, that the Board of Trustees approves this recommendation to appoint the above named practitioners to Provisional Medical Staff as recommended; and, be it further

RESOLVED, that the Board of Trustees directs the Hospital Administrator to duly notify the practitioners listed above and all Hospital and Medical Departments of these appointments; and, be it further

RESOLVED, that the Board of Trustees Chairperson certifies and the Board of Trustees Secretary attests to the adoption of this Resolution.

DULY AND REGULARLY ADOPTED ON THIS 28th DAY OF MARCH, 2018.

Certified by:

Eloy S. Lizama
Chairperson, Board of Trustees

Attested by:

Melissa Waibel
Secretary, Board of Trustees

Guam Memorial Hospital Authority
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BOARD OF TRUSTEES
Official Resolution No. 2018-19

"RELATIVE TO THE APPOINTMENT OF ACTIVE MEDICAL STAFF PRIVILEGES"

Practitioner	Department	Specialty	Expiration Date
Rachael Consoli, M.D.	OB/GYN	OB/GYN	February 28, 2020
Kenneth Tan, M.D.	Radiology	Diagnostic Radiology	February 28, 2020

WHEREAS, the above listed practitioners met the basic requirements for Active Medical Staff Membership as determined by the appropriate Medical Staff Departments and Committees pursuant to the GMHA Medical Staff Bylaws, Article IV, Section 4.3; and

WHEREAS, the Medical Executive Committee on February 28, 2018 and the Joint Conference and Professional Affairs Committee on March 15, 2018, recommended approval of Active Medical Staff Membership appointment for the above listed practitioner; and

WHEREAS, all appointments to Active Medical Staff Membership require Board approval; now, therefore be it

RESOLVED, that the Board of Trustees approves this recommendation to appoint the above named practitioners to Active Medical Staff as recommended; and, be it further

RESOLVED, that the Board of Trustees directs the Hospital Administrator to duly notify the practitioners listed above and all Hospital and Medical Departments of these appointments; and, be it further

RESOLVED, that the Board of Trustees Chairperson certifies and the Board of Trustees Secretary attests to the adoption of this Resolution.

DULY AND REGULARLY ADOPTED ON THIS 28th DAY OF MARCH, 2018.

Certified by:

Eloy S. Lizama
Chairperson, Board of Trustees

Attested by:

Melissa Waibel
Secretary, Board of Trustees

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BOARD OF TRUSTEES
Official Resolution No. 2018-20

"RELATIVE TO THE REAPPOINTMENT OF ALLIED HEALTH PROVISIONAL STAFF PRIVILEGES"

Practitioner	Department	Specialty	Expiration Date
Kevin Sullivan, CRNA	Anesthesia	Certified Registered Nurse Anesthetist	February 28, 2020

WHEREAS, the above listed practitioners met the basic requirements for Allied Health Professional Staff Membership as determined by the appropriate Medical Staff Departments and Committees pursuant to the GMHA Medical Staff Bylaws, Article VII, Section 7.2; and

WHEREAS, the Medical Executive Committee on February 28, 2018 and the Joint Conference and Professional Affairs Committee on March 15, 2018, recommended approval of Allied Health Provisional Staff Membership reappointment for the above listed practitioner; and

WHEREAS, all reappointments to Allied Health Professional Staff Membership require Board approval; now, therefore be it

RESOLVED, that the Board of Trustees approves this recommendation to appoint the above named practitioners to Allied Health Professional Staff as recommended; and, be it further

RESOLVED, that the Board of Trustees directs the Hospital Administrator to duly notify the practitioners listed above and all Hospital and Medical Departments of these reappointments; and, be it further

RESOLVED, that the Board of Trustees Chairperson certifies and the Board of Trustees Secretary attests to the adoption of this Resolution.

DULY AND REGULARLY ADOPTED ON THIS 28th DAY OF MARCH, 2018.

Certified by:

Eloy S. Lizama
Chairperson, Board of Trustees

Attested by:

Melissa Waibel
Secretary, Board of Trustees

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BOARD OF TRUSTEES
Official Resolution No. 2018-21

"RELATIVE TO THE APPOINTMENT OF ALLIED HEALTH PROVISIONAL STAFF PRIVILEGES"

Practitioner	Department	Specialty	Expiration Date
Kirsten Blomberg, CNM.	Ob/Gyn	Cert. Nurse Midwife	February 28, 2019

WHEREAS, the above listed practitioners met the basic requirements for Allied Health Professional Staff Membership as determined by the appropriate Medical Staff Departments and Committees pursuant to the GMHA Medical Staff Bylaws, Article VII, Section 7.2; and

WHEREAS, the Medical Executive Committee on February 28, 2018 and the Joint Conference and Professional Affairs Committee on March 15, 2018, recommended approval of Allied Health Provisional Staff Membership appointment for the above listed practitioner; and

WHEREAS, all appointments to Allied Health Professional Staff Membership require Board approval; now, therefore be it

RESOLVED, that the Board of Trustees approves this recommendation to appoint the above named practitioners to Allied Health Professional Staff as recommended; and, be it further

RESOLVED, that the Board of Trustees directs the Hospital Administrator to duly notify the practitioners listed above and all Hospital and Medical Departments of these appointments; and, be it further

RESOLVED, that the Board of Trustees Chairperson certifies and the Board of Trustees Secretary attests to the adoption of this Resolution.

DULY AND REGULARLY ADOPTED ON THIS 28th DAY OF MARCH, 2018.

Certified by:

Eloy S. Lizama
Chairperson, Board of Trustees

Attested by:

Melissa Waibel
Secretary, Board of Trustees

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BOARD OF TRUSTEES
Official Resolution No. 2018-22

"RELATIVE TO APPROVING THE CREATION OF THE ACCREDITATION COORDINATOR POSITION FOR THE COMPLIANCE OFFICE"

WHEREAS, the Compliance Office provides support to medical and hospital staff for the improvement of clinical care, patient safety and compliance and regulatory requirements; and

WHEREAS, this area coordinates activities to assure compliance with The Joint Commission, the Centers for Medicare and Medicaid Services (CMS) and other regulatory programs in order to make a difference in patient care and healthcare quality; and

WHEREAS, the Compliance Office is staffed with an incumbent holding a position that may not be properly classified; and

WHEREAS, the creation of the Accreditation Coordinator position for the Compliance Office is proposed for better operational efficiency; and

WHEREAS, the provisions of §6303.1, Chapter 6, Title 4 of the Guam Code Annotated have been met and no comments from the public were received; and

WHEREAS, the Board of Trustees Human Resources subcommittee, on November 21, 2017, recommended approval of the creation of the Accreditation Coordinator position; now, therefore be it

RESOLVED, that the Board of Trustees accepts the recommendation of the Board of Trustees Human Resources subcommittee and approves the creation of the Accreditation Coordinator position; and, be it further

RESOLVED, that the Hospital Administrator/CEO is directed to initiate the administrative processes to bring to fruition the utilization of this position; and, be it further

RESOLVED, that the Board of Trustee Chairperson certifies and the Board of Trustee Secretary attests to the adoption of this Resolution.

DULY AND REGULARLY ADOPTED ON THIS 28th DAY OF MARCH, 2018.

Certified by:

Eloy S. Lizama
Chairperson, Board of Trustees

Attested by:

Melissa Waibel
Secretary, Board of Trustees

Accreditation Coordinator

NATURE OF WORK IN THIS CLASS:

This is complex technical work involved in coordinating and monitoring the hospital-wide compliance of accreditation regulations and standards for continual readiness with all aspects of accreditation.

An employee in this class will coordinate the overall assessment, design/development and implementation of the hospital-wide regulatory compliance and continuous survey readiness plan.

ILLUSTRATIVE EXAMPLES OF WORK: (Any one position may not include all the duties listed, nor do the examples cover all the duties which may me be performed).

Assist in all accreditation and regulatory activities.

Coordinate and facilitate functional chapter teams to determine compliance and recommend improvements in operational processes.

Coordinate the hospital's tracer program and develop, communicate, implement and track action plans identifying gaps in care or compliance.

Review and prepare response for purposes of the Joint Commission and CMS Surveys.

Review and recommend changes, additions, or deletions of policies and/or procedures, performance improvement plan, patient safety plan, management of information plan, environment of care management plan, and other organization plans.

Monitor regulatory websites for new information and is involved in the development, assessment and achievement of the hospital's readiness for compliance.

Participate in providing consultation and education of the hospital's regulatory and accreditation issues.

Prepare reports on findings, outcomes and recommendations.

Coordinate the annual Joint Commission Focused Standards Assessment (FSA), and compile and disseminate pertinent survey information.

Participate and make recommendations related to root cause analyses.

MINIMUM KNOWLEDGE, ABILITIES AND SKILLS:

Skill in writing Evidence of Standard Compliance (ESC) responses.

Skill in developing and maintaining interpersonal relationships with healthcare professionals and hospital leadership.

Skill in direct patient care in a hospital setting.

Basic computer and technological skills.

Knowledge of The Joint Commission (TJC) and Centers for Medicare and Medicaid Services (CMS), Conditions of Participation (CoP) standards; and survey preparation.

Knowledge of healthcare accreditation process.

Ability to collect and organize data.

Ability to evaluate and recommend and initiate changes to improve program effectiveness.

Ability to work effectively with employees and the public.

Ability to communicate effective, orally and in writing.

Ability to work independently and within teams.

MINIMUM EXPERIENCE AND TRAINING REQUIREMENTS:

A. Six (6) months of experience in regulatory compliance and or accreditation work in a hospital setting; Two (2) years and six (6) months of experience in clinical and or ancillary care services in a hospital setting and a Bachelor's degree in healthcare or health sciences field; or

B. One year of experience in regulatory compliance and or accreditation standards in a hospital setting; four (4) years of clinical and or ancillary care services in a hospital setting; and an Associate's degree in healthcare or health sciences field; or

C. Six years of experience in clinical and or ancillary care services in a hospital setting; and graduation from high school or its equivalent.

SPECIAL QUALIFICATION REQUIREMENT:

Employee must complete ten (10) contact hours of continuing education per year in the field of hospital accreditation in order to maintain competency; or
Obtain and maintain Certified Joint Commission Professional Certification within three years of hire into the position. Employee must maintain status of being a Certified Joint Commission Professional Certification-Eligible by the end of the second year of hire as a condition of employment.

Established:		
Job Evaluation:		
Know How:	EI2	230
Problem Solving:	E3 (33%)	76
Accountability:	D2C	87
Total Points:		393
Pay Grade:	N (General Pay Plan)	

Approved:

Eloy S. Lizama, Chairman, Board of Trustees

Date: 3/28/18

Guam Memorial Hospital Authority
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BOARD OF TRUSTEES
Official Resolution No. 2018-23

"RELATIVE TO COMMENDING AUGUSTINA C. SALAS FOR HER DEDICATION AND COMMITMENT TO THE GUAM MEMORIAL HOSPITAL AUTHORITY"

WHEREAS, throughout her employment at the Guam Memorial Hospital Authority (GMHA), she dedicated herself to meeting the hospital's mission "To provide quality patient care in a safe environment." and related services to the people of Guam; and

WHEREAS, the Authority is privileged to work with AUGUSTINA C. SALAS who showed integrity whenever she worked with the various customers ensuring that all needs, concerns and are in the best interest for the Authority and people of Guam we serve; and

WHEREAS, since her employment at Guam Memorial Hospital Authority in the position of a Hospital Environmental Services Technician I, her duties were conducted with commitment, pride and loyalty; and

WHEREAS, that the Board of Trustees does extend its recognition and gratitude to AUGUSTINA C. SALAS on the occasion of her RETIREMENT and best wishes to her family and does hope she will enjoy many successes in the future; now, therefore be it

RESOLVED, that the Board of Trustees Chairman certifies and the Secretary attests to the adoption of this Resolution; and, be it further

RESOLVED, that this Resolution shall be presented to AUGUSTINA C. SALAS and a copy be placed in her personnel file.

DULY AND REGULARLY ADOPTED ON THIS 28th DAY OF MARCH, 2018.

Certified by:

Eloy S. Lizama
Chairperson, Board of Trustees

Attested by:

Melissa Waibel
Secretary, Board of Trustees

Guam Memorial Hospital Authority
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BOARD OF TRUSTEES
Official Resolution No. 2018-24

"RELATIVE TO COMMENDING ALFONSINA S.N. REYES FOR HER DEDICATION AND COMMITMENT TO THE GUAM MEMORIAL HOSPITAL AUTHORITY"

WHEREAS, throughout her employment at the Guam Memorial Hospital Authority (GMHA), she dedicated herself to meeting the hospital's mission "To provide quality patient care in a safe environment." and related services to the people of Guam; and

WHEREAS, the Authority is privileged to work with ALFONSINA S.N. REYES who showed integrity whenever she worked with the various customers ensuring that all needs, concerns and are in the best interest for the Authority and people of Guam we serve; and

WHEREAS, since her employment at Guam Memorial Hospital Authority in the position of a Clerk II, her duties were conducted with commitment, pride and loyalty; and

WHEREAS, that the Board of Trustees does extend its recognition and gratitude to ALFONSINA S.N. REYES on the occasion of her RETIREMENT and best wishes to her family and does hope she will enjoy many successes in the future; now, therefore be it

RESOLVED, that the Board of Trustees Chairman certifies and the Secretary attests to the adoption of this Resolution; and, be it further

RESOLVED, that this Resolution shall be presented to ALFONSINA S.N. REYES and a copy be placed in her personnel file.

DULY AND REGULARLY ADOPTED ON THIS 28th DAY OF MARCH, 2018.

Certified by:

Eloy S. Lizama
Chairperson, Board of Trustees

Attested by:

Melissa Waibel
Secretary, Board of Trustees

Guam Memorial Hospital Authority
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BOARD OF TRUSTEES
Official Resolution No. 2018-25

"RELATIVE TO COMMENDING EDITH A. PALMA FOR HER DEDICATION AND COMMITMENT TO THE GUAM MEMORIAL HOSPITAL AUTHORITY"

WHEREAS, throughout her employment at the Guam Memorial Hospital Authority (GMHA), she dedicated herself to meeting the hospital's mission "To provide quality patient care in a safe environment." and related services to the people of Guam; and

WHEREAS, the Authority is privileged to work with EDITH A. PALMA who showed integrity whenever she worked with the various customers ensuring that all needs, concerns and are in the best interest for the Authority and people of Guam we serve; and

WHEREAS, since her employment at Guam Memorial Hospital Authority in the position of a Hospital Environmental Services Technician I, her duties were conducted with commitment, pride and loyalty; and

WHEREAS, that the Board of Trustees does extend its recognition and gratitude to EDITH A. PALMA on the occasion of her RETIREMENT and best wishes to her family and does hope she will enjoy many successes in the future; now, therefore be it

RESOLVED, that the Board of Trustees Chairman certifies and the Secretary attests to the adoption of this Resolution; and, be it further

RESOLVED, that this Resolution shall be presented to EDITH A. PALMA and a copy be placed in her personnel file.

DULY AND REGULARLY ADOPTED ON THIS 28th DAY OF MARCH, 2018.

Certified by:

Eloy S. Lizama
Chairperson, Board of Trustees

Attested by:

Melissa Waibel
Secretary, Board of Trustees

Guam Memorial Hospital Authority
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BOARD OF TRUSTEES
Official Resolution No. 2018-26

"RELATIVE TO COMMENDING LORENZO D. DEVELLES FOR HIS DEDICATION AND COMMITMENT TO THE GUAM MEMORIAL HOSPITAL AUTHORITY"

WHEREAS, throughout his employment at the Guam Memorial Hospital Authority (GMHA), he dedicated himself to meeting the hospital's mission "To provide quality patient care in a safe environment." and related services to the people of Guam; and

WHEREAS, the Authority is privileged to work with LORENZO D. DEVELLES who showed integrity whenever he worked with the various customers ensuring that all needs, concerns and are in the best interest for the Authority and people of Guam we serve; and

WHEREAS, since his employment at Guam Memorial Hospital Authority in the position of a Nurse Aide II, his duties were conducted with commitment, pride and loyalty; and

WHEREAS, that the Board of Trustees does extend its recognition and gratitude to LORENZO D. DEVELLES on the occasion of his RETIREMENT and best wishes to his family and does hope he will enjoy many successes in the future; now, therefore be it

RESOLVED, that the Board of Trustees Chairman certifies and the Secretary attests to the adoption of this Resolution; and, be it further

RESOLVED, that this Resolution shall be presented to LORENZO D. DEVELLES and a copy be placed in his personnel file.

DULY AND REGULARLY ADOPTED ON THIS 28th DAY OF MARCH, 2018.

Certified by:

Eloy S. Lizama
Chairperson, Board of Trustees

Attested by:

Melissa Waibel
Secretary, Board of Trustees

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BOARD OF TRUSTEES
Official Resolution No. 2018-27

"RELATIVE TO COMMENDING MARIA TERESA A. PALAD FOR HER DEDICATION AND COMMITMENT TO THE GUAM MEMORIAL HOSPITAL AUTHORITY"

WHEREAS, throughout her employment at the Guam Memorial Hospital Authority (GMHA), she dedicated herself to meeting the hospital's mission "To provide quality patient care in a safe environment." and related services to the people of Guam; and

WHEREAS, the Authority is privileged to work with MARIA TERESA A. PALAD who showed integrity whenever she worked with the various customers ensuring that all needs, concerns and are in the best interest for the Authority and people of Guam we serve; and

WHEREAS, since her employment at Guam Memorial Hospital Authority in the position of a Staff Nurse II, her duties were conducted with commitment, pride and loyalty; and

WHEREAS, that the Board of Trustees does extend its recognition and gratitude to MARIA TERESA A. PALAD on the occasion of her RETIREMENT and best wishes to her family and does hope she will enjoy many successes in the future; now, therefore be it

RESOLVED, that the Board of Trustees Chairman certifies and the Secretary attests to the adoption of this Resolution; and, be it further

RESOLVED, that this Resolution shall be presented to MARIA TERESA A. PALAD and a copy be placed in her personnel file.

DULY AND REGULARLY ADOPTED ON THIS 28th DAY OF MARCH, 2018.

Certified by:

Eloy S. Lizama
Chairperson, Board of Trustees

Attested by:

Melissa Waibel
Secretary, Board of Trustees

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BOARD OF TRUSTEES
Official Resolution No. 2018-28

"RELATIVE TO COMMENDING WINSTON G. VILLARUEL FOR HIS DEDICATION AND COMMITMENT TO THE GUAM MEMORIAL HOSPITAL AUTHORITY"

WHEREAS, throughout his employment at the Guam Memorial Hospital Authority (GMHA), he dedicated himself to meeting the hospital's mission "To provide quality patient care in a safe environment." and related services to the people of Guam; and

WHEREAS, the Authority is privileged to work with WINSTON G. VILLARUEL who showed integrity whenever he worked with the various customers ensuring that all needs, concerns and are in the best interest for the Authority and people of Guam we serve; and

WHEREAS, since his employment at Guam Memorial Hospital Authority in the position of a Staff Nurse II, his duties were conducted with commitment, pride and loyalty; and

WHEREAS, that the Board of Trustees does extend its recognition and gratitude to WINSTON G. VILLARUEL on the occasion of his RETIREMENT and best wishes to his family and does hope he will enjoy many successes in the future; now, therefore be it

RESOLVED, that the Board of Trustees Chairman certifies and the Secretary attests to the adoption of this Resolution; and, be it further

RESOLVED, that this Resolution shall be presented to WINSTON G. VILLARUEL and a copy be placed in his personnel file.

DULY AND REGULARLY ADOPTED ON THIS 28th DAY OF MARCH, 2018.

Certified by:

Eloy S. Lizama
Chairperson, Board of Trustees

Attested by:

Melissa Waibel
Secretary, Board of Trustees

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BOARD OF TRUSTEES
Official Resolution No. 2018-29

"RELATIVE TO COMMENDING JOSEPHINE A. EUSTAQUIO FOR HER DEDICATION AND COMMITMENT TO THE GUAM MEMORIAL HOSPITAL AUTHORITY"

WHEREAS, throughout her employment at the Guam Memorial Hospital Authority (GMHA), she dedicated herself to meeting the hospital's mission "To provide quality patient care in a safe environment." and related services to the people of Guam; and

WHEREAS, the Authority is privileged to work with JOSEPHINE A. EUSTAQUIO who showed integrity whenever she worked with the various customers ensuring that all needs, concerns and are in the best interest for the Authority and people of Guam we serve; and

WHEREAS, since her employment at Guam Memorial Hospital Authority in the position of a Hospital Nurse Supervisor II, her duties were conducted with commitment, pride and loyalty; and

WHEREAS, that the Board of Trustees does extend its recognition and gratitude to JOSEPHINE A. EUSTAQUIO on the occasion of her RETIREMENT and best wishes to her family and does hope she will enjoy many successes in the future; now, therefore be it

RESOLVED, that the Board of Trustees Chairman certifies and the Secretary attests to the adoption of this Resolution; and, be it further

RESOLVED, that this Resolution shall be presented to JOSEPHINE A. EUSTAQUIO and a copy be placed in her personnel file.

DULY AND REGULARLY ADOPTED ON THIS 28th DAY OF MARCH, 2018.

Certified by:

Eloy S. Lizama
Chairperson, Board of Trustees

Attested by:

Melissa Waibel
Secretary, Board of Trustees

Guam Memorial Hospital Authority
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BOARD OF TRUSTEES
Official Resolution No. 2018-30

"RELATIVE TO COMMENDING CECILIA S.N. CAMPOS FOR HER DEDICATION AND COMMITMENT TO THE GUAM MEMORIAL HOSPITAL AUTHORITY"

WHEREAS, throughout her employment at the Guam Memorial Hospital Authority (GMHA), she dedicated herself to meeting the hospital's mission "To provide quality patient care in a safe environment." and related services to the people of Guam; and

WHEREAS, the Authority is privileged to work with CECILIA S.N. CAMPOS who showed integrity whenever she worked with the various customers ensuring that all needs, concerns and are in the best interest for the Authority and people of Guam we serve; and

WHEREAS, since her employment at Guam Memorial Hospital Authority in the position of a Nurse Aide II, her duties were conducted with commitment, pride and loyalty; and

WHEREAS, that the Board of Trustees does extend its recognition and gratitude to CECILIA S.N. CAMPOS on the occasion of her RETIREMENT and best wishes to her family and does hope she will enjoy many successes in the future; now, therefore be it

RESOLVED, that the Board of Trustees Chairman certifies and the Secretary attests to the adoption of this Resolution; and, be it further

RESOLVED, that this Resolution shall be presented to CECILIA S.N. CAMPOS and a copy be placed in her personnel file.

DULY AND REGULARLY ADOPTED ON THIS 28th DAY OF MARCH, 2018.

Certified by:

Eloy S. Lizama
Chairperson, Board of Trustees

Attested by:

Melissa Waibel
Secretary, Board of Trustees

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BOARD OF TRUSTEES
Official Resolution No. 2018-31

"RELATIVE TO COMMENDING EDDIE C. MENO FOR HIS DEDICATION AND COMMITMENT TO THE GUAM MEMORIAL HOSPITAL AUTHORITY"

WHEREAS, throughout his employment at the Guam Memorial Hospital Authority (GMHA), he dedicated himself to meeting the hospital's mission "To provide quality patient care in a safe environment." and related services to the people of Guam; and

WHEREAS, the Authority is privileged to work with EDDIE C. MENO who showed integrity whenever he worked with the various customers ensuring that all needs, concerns and are in the best interest for the Authority and people of Guam we serve; and

WHEREAS, since his employment at Guam Memorial Hospital Authority in the position of a Maintenance Supervisor, his duties were conducted with commitment, pride and loyalty; and

WHEREAS, that the Board of Trustees does extend its recognition and gratitude to EDDIE C. MENO on the occasion of his RETIREMENT and best wishes to his family and does hope he will enjoy many successes in the future; now, therefore be it

RESOLVED, that the Board of Trustees Chairman certifies and the Secretary attests to the adoption of this Resolution; and, be it further

RESOLVED, that this Resolution shall be presented to EDDIE C. MENO and a copy be placed in his personnel file.

DULY AND REGULARLY ADOPTED ON THIS 28th DAY OF MARCH, 2018.

Certified by:

Eloy S. Lizama
Chairperson, Board of Trustees

Attested by:

Melissa Waibel
Secretary, Board of Trustees

Guam Memorial Hospital Authority
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BOARD OF TRUSTEES
Official Resolution No. 2018-32

"RELATIVE TO COMMENDING FELY N. DE VERA FOR HER DEDICATION AND COMMITMENT TO THE GUAM MEMORIAL HOSPITAL AUTHORITY"

WHEREAS, throughout her employment at the Guam Memorial Hospital Authority (GMHA), she dedicated herself to meeting the hospital's mission "To provide quality patient care in a safe environment." and related services to the people of Guam; and

WHEREAS, the Authority is privileged to work with FELY N. DE VERA who showed integrity whenever she worked with the various customers ensuring that all needs, concerns and are in the best interest for the Authority and people of Guam we serve; and

WHEREAS, since her employment at Guam Memorial Hospital Authority in the position of a Nurse Aide II, her duties were conducted with commitment, pride and loyalty; and

WHEREAS, that the Board of Trustees does extend its recognition and gratitude to FELY N. DE VERA on the occasion of her RETIREMENT and best wishes to her family and does hope she will enjoy many successes in the future; now, therefore be it

RESOLVED, that the Board of Trustees Chairman certifies and the Secretary attests to the adoption of this Resolution; and, be it further

RESOLVED, that this Resolution shall be presented to FELY N. DE VERA and a copy be placed in her personnel file.

DULY AND REGULARLY ADOPTED ON THIS 28th DAY OF MARCH, 2018.

Certified by:

Eloy S. Lizama
Chairperson, Board of Trustees

Attested by:

Melissa Waibel
Secretary, Board of Trustees

Guam Memorial Hospital Authority
Aturidåt Espetåt Mimuriåt Guåhan

850 GOV. CARLOS CAMACHO ROAD
OKA, TAMUNING, GUAM 96911
TEL: 647-2444 or 647-2330
FAX: (671) 649-0145

BOARD OF TRUSTEES
Official Resolution No. 2018-33

"RELATIVE TO COMMENDING ENRIE M. ABAYA FOR HER DEDICATION AND COMMITMENT TO THE GUAM MEMORIAL HOSPITAL AUTHORITY"

WHEREAS, throughout her employment at the Guam Memorial Hospital Authority (GMHA), she dedicated herself to meeting the hospital's mission "To provide quality patient care in a safe environment." and related services to the people of Guam; and

WHEREAS, the Authority is privileged to work with ENRIE M. ABAYA who showed integrity whenever she worked with the various customers ensuring that all needs, concerns and are in the best interest for the Authority and people of Guam we serve; and

WHEREAS, since her employment at Guam Memorial Hospital Authority in the position of a Ward Clerk, her duties were conducted with commitment, pride and loyalty; and

WHEREAS, that the Board of Trustees does extend its recognition and gratitude to ENRIE M. ABAYA on the occasion of her RETIREMENT and best wishes to her family and does hope she will enjoy many successes in the future; now, therefore be it

RESOLVED, that the Board of Trustees Chairman certifies and the Secretary attests to the adoption of this Resolution; and, be it further

RESOLVED, that this Resolution shall be presented to ENRY M. ABAYA and a copy be placed in her personnel file.

DULY AND REGULARLY ADOPTED ON THIS 28th DAY OF MARCH, 2018.

Certified by:

Eloy S. Lizama
Chairperson, Board of Trustees

Attested by:

Melissa Waibel
Secretary, Board of Trustees

Guam Memorial Hospital Authority
Aturidåt Espetåt Mimuriåt Guåhan

850 GOV. CARLOS CAMACHO ROAD
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BOARD OF TRUSTEES
Official Resolution No. 2018-34

"RELATIVE TO APPROVING FORTY (40) NEW FEES"

WHEREAS, Public Law 26-66, places the rate making authority of the Guam Memorial Hospital Authority under the GMHA Board of Trustees; and

WHEREAS, the GMHA Board of Trustees has reviewed the Public Law 26-66; and

WHEREAS, a Public Hearing was held on December 13, 2017 and oral comments and written testimony have been solicited for the forty (40) new fees comprised of the following Hospital departments: Central Sterile Room, Radiology, Operating Room, Laboratory and Special Services; and

WHEREAS, the GMHA Board of Trustees has reviewed the list of new fees and found the same to be in order; now, therefore be it,

RESOLVED, that the GMHA Board of Trustees directs the Hospital Administrator/CEO to continue to proceed with the adjudication process of these 40 new fee items; and, be it further

RESOLVED, that the Chairperson certifies and the Secretary attests to the adoption of this resolution.

DULY AND REGULARLY ADOPTED ON THIS 28th DAY OF MARCH, 2018.

Certified by:

Eloy S. Lizama
Chairperson, Board of Trustees

Attested by:

Melissa Waibel
Secretary, Board of Trustees

GUAM MEMORIAL HOSPITAL AUTHORITY
SUMMARY OF NEW FEE ITEMS/SERVICES
for Submission to the 34th Guam Legislature
Public Hearing on December 13, 2017

NO	CHARGE CODE	DESCRIPTION	FEE MODEL RATE	DEPARTMENT
1	1724601	TOOTHETTE SUCTION SYSTEM	$ 11.86	CENTRAL STERILE ROOM
2	2076641	US-BREAST UNIL COMPLETE	$ 191.00	RADIOLOGY
3	2076642	US-BREAST UNIL LIMITED	$ 158.00	RADIOLOGY
4	2077065	DX MAMMO INCL CAD UNIL	$ 73.00	RADIOLOGY
5	2077066	DX MAMMO INCL CAD BIL	$ 109.00	RADIOLOGY
6	2077067	SCREEN MAMMO BIL INCL CAD	$ 85.00	RADIOLOGY
7	2106005	CATH HNB5.0-38-100-P G06005	$ 458.85	RADIOLOGY
8	2108376	CATH PICC 3FR 50CM G08376	$ 510.83	RADIOLOGY
9	2150319	BALLOON PAT4-14-170-2-20G50319	$ 958.56	RADIOLOGY
10	7000202	NAIL FEMUR TFNA LT 10MMX400MM	$ 3,915.20	OPERATING ROOM
11	7000320	NAIL FEMUR TFNA RT 10MMX420MM	$ 3,915.20	OPERATING ROOM
12	7000942	RELOAD ETS 45MM 4.1MM TR45G	$ 335.16	OPERATING ROOM
13	7000943	RELOAD ETS 45MM 2.5MM TR45W	$ 618.36	OPERATING ROOM
14	7002018	NAIL FEMUR TFNA LT 10MMX320MM	$ 3,915.20	OPERATING ROOM
15	7002019	NAIL FEMUR TFNA RT 10MMX340MM	$ 3,915.20	OPERATING ROOM
16	7002022	NAIL FEMUR TFNA LT 10MMX360MM	$ 3,915.20	OPERATING ROOM
17	7002023	NAIL FEMUR TFNA RT 10MMX360MM	$ 3,915.20	OPERATING ROOM
18	7002024	NAIL FEMUR TFNA RT 10MMX380MM	$ 3,915.20	OPERATING ROOM
19	7002025	NAIL FEMUR TFNA LT 10MMX380MM	$ 3,915.20	OPERATING ROOM
20	7011020	NAIL FEMUR TFNA 12MMX170MM	$ 2,937.79	OPERATING ROOM
21	7012020	NAIL FEMUR TFNA LT 10MMX340MM	$ 3,915.20	OPERATING ROOM
22	7020010	NAIL FEMUR TFNA RT 10MMX400MM	$ 3,915.20	OPERATING ROOM
23	7020150	NAIL FEMUR TFNA RT 10MMX320MM	$ 3,915.20	OPERATING ROOM
24	7021020	NAIL FEMUR TFNA RT 10MMX300MM	$ 3,915.20	OPERATING ROOM
25	7040020	NAIL FEMUR TFNA LT 10MMX420MM	$ 3,915.20	OPERATING ROOM
26	7041020	NAIL FEMUR TFNA LT 10MMX300MM	$ 3,915.20	OPERATING ROOM
27	7050020	NAIL FEMUR TFNA RT 10MMX440MM	$ 3,915.20	OPERATING ROOM
28	7060020	NAIL FEMUR TFNA LT 10MMX440MM	$ 3,915.20	OPERATING ROOM
29	7070020	NAIL FEMUR TFNA 10MMX170MM	$ 2,937.79	OPERATING ROOM
30	7090020	NAIL FEMUR TFNA 11MMX170MM	$ 2,937.79	OPERATING ROOM
31	7881210	BRAF GENE ANALYSIS	$ 466.13	LABORATORY
32	7881275	KRAS GENE ANALYSIS	$ 491.30	LABORATORY
33	7881311	NRAS GENE ANALYSIS	$ 419.43	LABORATORY
34	9304750	KIT 3 VALVE MANIFOLD	$ 632.26	SPECIAL SERVICES
35	9330303	CONTRAST INJECTION LINE 60"	$ 180.89	SPECIAL SERVICES

36	9380932	CATH JDK RT 4CM 5F 100CM 0 S-P	$	77.42	SPECIAL SERVICES
37	9380933	CATH JDK LT 4CM 5F 100CM 0 S-P	$	77.42	SPECIAL SERVICES
38	9380934	CATH MLTP B1 6FR 100CM 0 S-P	$	77.42	SPECIAL SERVICES
39	9380935	CATH MLTP A2 5FR 100CM 2 S-P	$	77.42	SPECIAL SERVICES
40	9382101	TRAY PARACENTESIS PIGTAIL	$	387.09	SPECIAL SERVICES

********** LAST ITEM **********

I certify that this listing of items comprises all fees required by law for submission at this time to be complete as presented here.

Frumen A. Patacsil
Hospital Quality Improvement Specialist

12/1/17
Date

1st Endorsement of Concurrence:
I concur and further certify that this listing of items are exempted under Section 9301(i) to Article 3, Chapter 9, Division 1 of Title 5 of the Guam Code Annotated and in compliance with Title10 GCA Part 2 Division 4 Chapter 80 §80109

Benita A. Manglona
Chief Financial Officer

12/1/17

12/1/17
Date