Partnership to Advance Tribal Health (PATH) Quality Assurance and Performance Improvement (QAPI) Program Toolkit

A step-by-step guide to implementing QAPI in your hospital
# Table of Contents

WHAT IS QAPI? .................................................................................................................. 1  
QAPI Features ..................................................................................................................... 2  
Illustrating QAPI in Action ................................................................................................. 3  
Five Elements for Framing QAPI in Hospitals ..................................................................... 5  
Action Steps for QAPI .......................................................................................................... 8  
  STEP 1: Leadership Responsibility and Accountability ...................................................... 8  
  STEP 2: Develop a Deliberate Approach to Teamwork ....................................................... 9  
  STEP 3: Take Your QAPI “Pulse” with a Self-Assessment .................................................. 10  
  STEP 4: Identify Your Organization’s Guiding Principles .................................................. 10  
  STEP 5: Develop Your QAPI Plan ...................................................................................... 10  
  STEP 6: Conduct a QAPI Awareness Campaign .................................................................. 11  
  STEP 7: Develop a Strategy for Collecting and Using QAPI Data ...................................... 12  
  STEP 8: Identify Your Gaps and Opportunities .................................................................. 12  
  STEP 9: Prioritize Quality Opportunities and Charter PIPs .............................................. 13  
  STEP 10: Plan, Conduct and Document PIPs .................................................................... 14  
  STEP 11: Getting to the “Root” of the Problem .................................................................. 15  
  STEP 12: Take Systemic Action ....................................................................................... 16  
  QAPI Principles Summarized ............................................................................................ 17  
QAPI Tools and Related Resources ................................................................................... 18  
  QAPI PROCESS TOOLS .................................................................................................. 18  
  QAPI TOPIC TOOLS ....................................................................................................... 18  
  QAPI RESOURCES .......................................................................................................... 19  
Appendix A .......................................................................................................................... 20  
  Guide for Developing Purpose, Guiding Principles and Scope for QAPI .......................... 21  
    STEP 1. LOCATE OR DEVELOP YOUR ORGANIZATION’S VISION STATEMENT .......... 21  
    STEP 2. LOCATE OR DEVELOP YOUR ORGANIZATION’S MISSION STATEMENT ........ 21  
    STEP 3. DEVELOP A PURPOSE STATEMENT FOR QAPI ............................................. 21  
    STEP 4. ESTABLISH GUIDING PRINCIPLES ................................................................. 21  
    STEP 5. DEFINE THE SCOPE OF QAPI IN YOUR ORGANIZATION .............................. 22  
    STEP 6. ASSEMBLE DOCUMENTS ............................................................................... 22  
Guide for Developing a QAPI Plan ....................................................................................... 23  
Goal Setting Worksheet ....................................................................................................... 23
WHAT IS QAPI?

QAPI is the merger of two complementary approaches to quality management, Quality Assessment or Assurance (QA) and Performance Improvement (PI). Both involve using information but differ in key ways:

- **QA** is a process of meeting quality standards and assuring care reaches an acceptable level. Hospitals typically set QA thresholds to comply with regulations. They may also create standards that go beyond regulations. QA is a reactive and retrospective effort to examine why a facility failed to meet certain standards. QA activities do improve quality, but improvement efforts frequently end once the standard is met.
- **PI** (also called Quality Improvement [QI]) is a proactive and continuous study of processes. The intent is to prevent or decrease the likelihood of problems by identifying areas of opportunity and testing new approaches to fix underlying causes of persistent/systemic problems. PI can make good quality even better.

Click here to go to the “What Is QAPI?” on-demand training.

The chart below was adapted from the Health Resources and Services Administration (HRSA) and shows some key differences between QA and PI efforts.

<table>
<thead>
<tr>
<th></th>
<th>QUALITY ASSESSMENT/ASSURANCE</th>
<th>PERFORMANCE IMPROVEMENT</th>
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<tbody>
<tr>
<td><strong>Motivation</strong></td>
<td>Measuring compliance with standards</td>
<td>Continuously improving processes to meet standards</td>
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<tr>
<td><strong>Means</strong></td>
<td>Inspection</td>
<td>Prevention</td>
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<tr>
<td><strong>Attitude</strong></td>
<td>Required, reactive</td>
<td>Chosen, proactive</td>
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<tr>
<td><strong>Focus</strong></td>
<td>Outliers: “bad apples” Individuals</td>
<td>Processes or systems</td>
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<tr>
<td><strong>Scope</strong></td>
<td>Medical provider</td>
<td>Patient care</td>
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<tr>
<td><strong>Responsibility</strong></td>
<td>Few</td>
<td>All</td>
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**QA + PI = QAPI**

QA and PI combine to form QAPI, a comprehensive approach to ensuring high quality care. QAPI is a data-driven, proactive approach to improving the quality of care and services in hospitals. The activities of QAPI involve members at all levels of the organization to:

- identify opportunities for improvement;
- address gaps in systems or processes;
- develop and implement an improvement or corrective plan; and
- continuously monitor effectiveness of interventions.
WHY QAPI IS IMPORTANT?

Once QAPI is launched and sustained, many people report it is a rewarding and even enjoyable way of working. The rewards of QAPI include:

- Competencies that equip you to solve quality problems and prevent their recurrence
- Competencies that allow you to seize opportunities to achieve new goals
- Fulfillment for providers of care, as they become active partners in performance improvement
- Above all, better care and better quality of life for your patients

Click here to go to the “Why QAPI Matters” on-demand training.

Launching or growing your QAPI program is not necessarily quick or easy, but it is feasible, important and exciting in all hospitals. As staff see processes and outcomes improve, it generates more enthusiasm and dedication to creating an organizational culture of improvement.

It’s like being a new driver...

At first, a new driver must concentrate and coordinate so many actions and cues that driving feels nerve-wracking, confusing and intimidating. Yet, with practice, driving safely becomes easier, comes more naturally and ushers in new confidence and opportunities. In the same way, with practice and experience, improvement work will get easier and will take you to new places in your quality management.

QAPI Is Already Part of Your Work.

Though the QAPI term may be new, the concepts are not. Improvement is already a part of your everyday work and thought processes. Maybe you recognize some of the statements below as things you are already doing:

- You create systems to achieve compliance with new or revised hospital regulations or accreditation standards.
- You track, investigate and try to prevent recurrence of adverse events.
- You compare the quality of your hospital to that of other hospitals.
- You receive, investigate and respond to concerns or complaints, including adjusting processes to prevent similar, future events.
- You proactively prepare for and practice emergency response situations.
- You adjust your daily processes or work plan based on extenuating circumstances such as public health emergencies, supply chain interruptions or temporary staffing shortages.
- You seek feedback from patients, families and frontline providers to find out how you can better serve their needs.

All staff are responsible for and play a key role in QAPI. The activities of QAPI depend on members at all levels of the organization to identify opportunities for improvement, address gaps in systems or processes, develop and implement an improvement or corrective plan, and continuously monitor effectiveness of interventions.

Click here to go to the “Who Is Responsible for QAPI?” on-demand training.
QAPI Features

QAPI emphasizes improvements that cannot only elevate the care and experience of all patients, but also improve the work environment for providers. With QAPI, your organization will use a systems approach to actively pursue improvement, not just respond to external requirements. Look at the following list of QAPI features. How many are you already applying regularly?

- Using data to identify your quality problems and measuring impact of action plans
- Building on patients’ own goals for health, wellness and care experience
- Bringing meaningful patient and family voices into goals and evaluating progress
- Incorporating providers in a shared QAPI mission
- Developing interdisciplinary Performance Improvement Project (PIP) teams
- Performing a Root Cause Analysis to get to the heart of the reason for a problem
- Undertaking systemic change to eliminate problems at the source
- Developing a feedback and monitoring system to sustain continuous improvement

Illustrating QAPI in Action

The scenario below illustrates how a quality committee might develop a plan of correction in response to deficiencies identified during a survey. The example shows how facilities often react to regulatory non-compliance with a “band-aid” approach. The activities described are representative of the types of corrections that are often submitted to Survey Agencies and accepted. It addresses the immediate problem and then takes steps to prevent recurrence of the problem.

Scenario 1

**The Issue:** Hospital ABC received deficiencies during a survey, because two refrigerators were found to be out of temperature range. It was found the temperatures were not monitored and documented daily.

**What Hospital ABC Did:** The quality committee developed a plan of correction, which contained the following components:

- Purchasing and calibrating digital thermometers
- Creating a new monitoring form
- Providing staff education on the new form and process

They stated they would conduct audits of daily refrigerator temperatures for three months and report results to the quality committee.

The next case study shows a facility with effective QAPI systems in place to identify issues proactively before trends become serious problems. A hospital chooses a limited number of PIP projects in “high-risk, high volume, problem-prone” areas.
Scenario 2

The Issue: During the monthly QAPI meeting at Hospital ABC, the pharmacy department shared there have been several days when no one documented refrigerator temperatures. This is concerning, because there are several medications and vaccines that need to be stored within a specific temperature range. If the refrigerators are not held within that range, medications and vaccines stored will need to be thrown out at great cost to the facility and patients. Although other issues and opportunities for improvement were identified at the meeting, the QAPI committee decided to launch a performance improvement project (PIP) on temperature monitoring, because it is a high-risk problem for patients and the facility.

What Hospital ABC Did: The QAPI committee chartered an interdisciplinary PIP team composed of at least one representative from pharmacy, lab, nursing, maintenance and quality/safety. The team studied the issue, and then performed a root cause analysis (RCA) to help direct a plan of action. The RCA revealed several underlying factors, which included the following:

- The process relied on a single employee (a technician that checked the refrigerators each morning), and no process existed for ensuring that duty was completed if he was gone for the day.
- The documentation form was confusing and stored in a book on a shelf far away from the refrigerators.
- Staff lacked an understanding of how and when to monitor temperatures and document properly.
- One of the refrigerators varied highly in temperature and was past due for annual maintenance.

Based on the identified underlying causes, the PIP team recommended the following interventions:

- Develop a process to ensure all refrigerator temperatures are monitored and documented daily, with the consideration of an electronic/automatic monitoring and alarm system.
- Update and simplify the documentation form and post a copy of the form on the front of each refrigerator.
- Educate all appropriate staff on how and when to monitor temps and how to document.
- Revise the maintenance schedule and create a maintenance monitoring system that will provide alerts that due dates are coming at 30 days, seven days and one day before due date.

The interventions were implemented for the pharmacy refrigerators. The PIP team collected data using the temperature monitoring sheets and the maintenance schedule.

After three months, they found both refrigerators and the maintenance plan were well monitored and documented.

Hospital ABC decided to adopt and expand the changes to other areas of the facility. They received no deficiencies related to temperature monitoring or equipment maintenance on the following survey. Using QAPI allowed them to identify and correct developing issues before they escalated to larger problems.
Five Elements for Framing QAPI in Hospitals

There are five strategic elements that serve as the foundational building blocks to effective QAPI programs.

Click here to go to “What Is a QAPI Program?” on-demand training.

The five elements are your strategic framework for developing, implementing and sustaining your QAPI program. Keep the following in mind:

- The elements are all closely related. You are likely to be working on them all at once. They may all need attention at the same time, because they will all apply to the improvement initiatives you choose.
- Your plan is based on your own hospital’s programs and services, the needs of your particular patients and your assessment of your current quality challenges and opportunities.
- Your written QAPI plan, processes and policies should address all five elements.
THE FIVE FOUNDATIONAL ELEMENTS

Element 1: Design and Scope
A QAPI program must be ongoing and comprehensive and regularly evaluates the full range of services offered by the facility, including all clinical and non-clinical departments and contracted services (e.g., environmental services such as laundry or maintenance services provided by external organizations, direct patient care services such as mobile radiology or locum provider or nurse staffing services). Additionally, the QAPI program must include review of key care programs such as infection prevention and control, risk management, patient experience and engagement, emergency preparedness and staff engagement and wellbeing. When fully implemented, the QAPI program should address all systems of care and management practices and should utilize the best available evidence to define and measure goals. Hospitals must have a written QAPI plan adhering to these principles that is reviewed at least annually.

Click here to go to “What Is a QAPI Plan?” on-demand training.

Element 2: Governance and Leadership
The governing body and administration of the hospital develops a culture that involves input from facility staff, patients and their families and/or representatives. The governing body assures adequate resources exist to conduct QAPI efforts. This includes
- designating one or more persons to be accountable for leading the QAPI program;
- developing leadership and facility-wide training on QAPI skills, tools and processes; and
- budgeting resources including staff time, equipment and space as needed.

The governing body should foster a culture where QAPI is a value and organizational cornerstone by
- setting and communicating clear behavioral expectations for safety, continuous improvement and patient-centered care and experience;
- creating an atmosphere where staff are comfortable identifying and reporting quality problems, potential problems and opportunities for improvement and holds staff accountable to behaviors in line with the facility’s mission, values and policies; and
- daily demonstrating these expectations and values in word and deed.

Element 3: Data Collection and Analysis
The facility puts systems in place to monitor care and services through data from multiple sources. Feedback systems actively incorporate input from staff, patients, families and others as appropriate. This element includes using Performance Indicators to monitor a wide range of care processes and outcomes. Analysis includes reviewing findings against benchmarks and/or targets the facility has established for performance and evaluating the impact of changes as each is implemented. It also includes tracking, investigating, and monitoring Adverse Events that must be investigated every time they occur, and action plans implemented to prevent recurrences.

Click here to go to “What Is Data?” and “How Do We Use Data for QAPI?” on-demand training.

Element 4: Patient Safety
Patient safety is the absence of preventable harm to a patient during the process of health care and reduction of risk of unnecessary harm associated with health care. Many published studies show that significant numbers of patients are harmed during health care, resulting in increased length of stay in health care facilities or even permanent injury or death. It is important that facilities adopt various process-improvement techniques to identify inefficiencies, ineffective care, and preventable errors in their systems to then improve patient safety.

As part of the QAPI program, a hospital must include a system that addresses patient safety, all cause harm, and high-risk areas such as blood transfusions, medication safety, emergency care, surgery and/or procedures in the operating room, obstetrics, and infection control and sterilization. The facility must foster and maintain leadership and staff commitment to safety by creating and enforcing clear policies and processes, using data to drive and monitor safety improvements, communicating outcomes and improvement goals, and involving patients and/or families in care planning and process improvement efforts.
Element 5: Performance Improvement

A performance improvement project (PIP) is a concentrated effort on a particular problem. A hospital conducts PIPs to examine and improve care or services in areas that the facility identifies as needing improvement. A PIP involves systematic gathering information to understand issues or problems, making changes to the process and measuring the impact of that change to determine if it resulted in improvement.

Additionally, hospitals are expected to develop policies and procedures and demonstrate proficiency in the use of root cause analyses (RCAs) and corrective action planning and implementation. A hospital should also look comprehensively across all involved systems to prevent future events and promote sustained improvement and also apply learnings from each PIP facility-wide as appropriate. This element is rooted in the concept of continuous learning and improvement.

Click here to go to the following on-demand trainings:
- “How Do We Know What to Improve?”
- “What Is a PI Project?”
- “How Do You Structure a Project?”
- “How Do You Define a Project Aim?”
- “How Do We Know What Change to Test?”
Action Steps for QAPI

The most important aspect of QAPI is effective implementation. The next few sections detail action steps that may help you on your road to implementing QAPI. They do not need to be achieved sequentially, but each step builds on other QAPI principles.

STEP 1: Leadership Responsibility and Accountability

Creating a culture to support QAPI efforts begins with leadership. Support from the top is essential, and that support should foster the active participation of every employee. The administrator and senior leaders must create an environment that promotes QAPI and involves all employees.

Executive leadership sets the tone and provides resources. Their challenge is to help staff and QAPI efforts flourish in each hospital.

Put a Personal Face on Quality Issues
Leadership should
- give patients, family and staff the opportunity to meet board members and executive leaders to generate support for QAPI;
- tour the organization regularly, meeting with patients and staff;
- choose the person(s) who will lead your QAPI program in conjunction with executive management. QAPI needs champions.

Here are some ways leadership can take action:

Develop a steering committee, a team that will provide QAPI leadership.
The steering committee has overall responsibility to develop and modify the QAPI plan, review information and set priorities for PIPs. The steering committee charters teams to work on particular problems. It reviews results and determines the next steps. The steering committee must learn and use systems thinking. Systems thinking is a perspective that considers how things influence one another as a whole, rather than individual elements, or static “snapshots.” Executive leadership such as the CEO and/or the director of nursing should be part of this structure. It is also important to have a medical director or physician representative who is actively engaged in the QAPI committee.

The QAPI committee should be comprised of representatives from all key departments, meet at least quarterly (though monthly is recommended) and establish permanent and time-limited workgroups that report their respective PIP progress and monitoring data.

Provide resources for QAPI, including equipment and training.
Staff and providers may need time to attend team meetings during working hours, requiring others to cover their clinical duties for a period of time. Equipment might include anything from additional computers to low-cost supplies like posters to create story boards or copies of resource or training materials. Leadership may want to consider sending one or more team members to a specialized training.

Establish a climate of open communication and respect.
Leadership may wish to consider
- having an open-door policy to communicate with staff and providers;
- emphasizing communication across shifts and between department heads; and/or
- creating an environment where staff feel free to bring quality concerns forward without fear of punishment.
Understand your hospital’s current culture and how it will promote performance improvement. Create the expectation that everyone in your hospital is working on improving care and services. Establish an environment where patients and families feel free to speak up to identify areas that need improvement. Expect and build effective teamwork among departments and staff.

**STEP 2: Develop a Deliberate Approach to Teamwork**

Teamwork is a core component of QAPI and is too often taken for granted. Improvement ideas and projects should be discussed with all interested and impacted parties. The perspectives and opinions of each team member is different and valuable and key to sustained success.

Characteristics of an effective team include the following:
- Having a clear purpose
- Having defined roles for each team member to play
- Having a commitment to achieve engagement from each member

QAPI relies on teamwork in several ways:
- Task-oriented teams may be specially formed to investigate a particular problem, and their work may be limited and focused.
- PIP teams are formed for longer-term work on an issue.
- When chartering a PIP, careful consideration must be given to the purpose of the PIP and type of members needed to achieve that purpose. Here are some examples:
  - A PIP team with the goal of preventing patient and visitor falls decided grounds personnel needed to be on that team so procedures for snow removal, sidewalk repair and railings could be considered.
  - A PIP team working on increasing patient access included a staffing service representative from the provider staffing service.
  - After a PIP team began working on the problem of anxiety among hospital patients, the members realized many of the affected patients reported reassurance from the chaplain and asked the QAPI committee to add him to the team.
  - A PIP team working on reducing falls asked the housekeeping department to be involved as it considered root causes of falls and realized equipment in the corridors and clutter in the bathrooms contributed.

Generally, each team should be composed of interdisciplinary members. For example, a concern with medication administration should include nursing and pharmacy team members. However, other disciplines such as medical records, health information technology (HIT) staff or patients and family members would bring the depth and breadth of different and valuable perspectives to the improvement team.

Family members and patients may be team members, though for confidentiality reasons, they may not review certain data or information that identifies individuals. PIP teams need to plan for sufficient communication, including face-to-face meetings to get to know each other and plan the work. Leadership needs to convey that being on a PIP team is an important part of the job, not something to put aside if other things come up. Leadership must support improvement through action and provision of resources to enable staff to provide clinical care, complete daily assignments and participate on QAPI teams as needed.
**STEP 3: Take Your QAPI “Pulse” with a Self-Assessment**

To get you started, try using a self-assessment tool to take your QAPI pulse. It will assist you in evaluating the extent to which components of QAPI are in place within your organization and help you identify areas requiring further development.

You may use a self-assessment tool as you begin work on QAPI and for annual or semiannual evaluation of your organization’s progress. You should complete the tool with input from the entire QAPI team and organizational leadership. This is meant to be an honest reflection of your progress with QAPI. The results of this assessment will direct you to areas you need to work on to establish and grow QAPI and a culture of improvement in your organization.

Check out the QAPI Review Worksheet for Hospitals to evaluate your hospital’s QAPI program. You may also want to review the QI Continuum Worksheet, an assessment meant to help inform action planning.

**STEP 4: Identify Your Organization’s Guiding Principles**

It is important to lay a foundation that will help you think about what principles will guide your decision-making and help you set priorities. Hospitals are complex organizations, with numerous departments performing different functions that interact with and depend on each other. Establishing a purpose and guiding principles will unify the facility by tying the work being done to a fundamental purpose or philosophy. These principles will help guide your facility in determining programmatic priorities.

Use the “Guide for Developing Purpose, Guiding Principles and Scope for QAPI” to establish the principles that will give your organization direction. The team completing this assignment should include senior leadership. Taking time to articulate the purpose, develop guiding principles and define the scope will help you understand how QAPI will be used and integrated into your organization. This information will also help your organization develop a written QAPI plan.

Go to Appendix A for the Guide for Developing Purpose, Guiding Principles and Scope for QAPI.

**STEP 5: Develop Your QAPI Plan**

Your plan will assist you in achieving what you have identified as the purpose, guiding principles and scope for QAPI. This is a living document that you may revisit as your facility evolves.

A written QAPI plan guides the hospital’s quality efforts and serves as the main document to support implementation of QAPI. The plan describes purpose, goals and scope of the program based on the unique characteristics and services of the hospital. The QAPI plan should also define the QAPI committee, including membership and frequency of meetings. You should review and refine your QAPI plan at least annually.

You may use the Guide for Developing a QAPI Plan to help you create a comprehensive plan that addresses the full range and scope of care and services provided by your organization.

Go to Appendix A for the Guide for Developing a QAPI Plan.
COMMUNICATE WITH ALL STAFF AND PROVIDERS

- Let everyone know about your QAPI plan—often and in multiple ways.
- Plan ongoing provider education beyond single exposures. The goal is widespread awareness of QAPI initiatives.
- Train through dialogue, examples and exercises. Transform the material in this guide into smaller pieces and easily understood ideas. Use your hospital’s own experiences with certain providers or patients as part of the learning materials.
- Convey the message that QAPI is about systems of care, management practices and business practices—systems that should support quality and/or acceptable business practices, or they must change. Use examples to get the message across and ask staff to think of examples of their own.
- Be sure consultants, contractors and collaborating agencies are also aware of your QAPI approach. Maybe you have several vendors coming in and out of your facility. They each have a role in your system.
- Convey the message that any and every employee is expected to raise quality concerns and suggest improvement ideas, that it is safe to do so and that everyone is encouraged to think about systems.
- Discuss the hard questions: What is meant by a culture of safety here in our hospital? How does the facility try to balance issues of safety and patient experience? These types of questions often do not have easy answers, but QAPI opens up these types of issues for discussion and deeper thinking.

Try this... An exercise where groups that cross disciplines and roles brainstorm the various ways their work influences the work of others.

For example, nursing staff may find that their work is interrupted because maintenance staff is completing important work in the unit. Also seek examples where patient experience did not prevail. For instance, emergency department personnel need to limit family visitation to two people at a time due to the size of the emergency department rooms. Brainstorm how to solve problems like these, even if jobs and routines would change.

*If systems do not exist, they may need to be developed.*

*If systems impeded quality, they must be changed.*

COMMUNICATE WITH PATIENTS AND FAMILIES

- Make sure all patients and families know their views are sought, valued and considered in facility decision-making and process improvements by announcing and discussing QAPI in patient and family councils and via other venues.
- Ask patients and family members to tell you about their quality concerns. Many facilities today are using some type of customer satisfaction survey. Results should be used to identify opportunities for improvement that will proactively have an impact on all patients and their families.
- Try to view concerns through patients’ eyes. For example, getting back to a patient in 10 minutes may seem responsive, but may feel like an eternity to the patient. How would that feel to a patient waiting for help to the bathroom?
- Consider including QAPI information in routine communications to families.

Family and patient complaints are often underused for process improvement, and yet they are a valuable way of identifying more general problems.
STEP 7: Develop a Strategy for Collecting and Using QAPI Data

Your team will decide what data to monitor routinely. Areas to consider may include:

- Patient charts and documentation
- Incident reporting data
- Complaints from patients, families and staff
- Readmissions and utilization of services
- Patient satisfaction survey results
- Staff satisfaction survey results
- Centers for Medicare & Medicaid Services (CMS) and The Joint Commission (TJC) survey results and deficiencies
- Business and administrative processes including:
  - Billing and financial information
  - Staffing patterns and turnover
  - Provider credentialing and privileging

This data will require systematic organization and interpretation to achieve meaningful reporting and action. Otherwise, it would only be a collection of unrelated diverse data and may not be useful. Compare this to an individual patient’s health. You must connect many pieces of information to reach a diagnosis. You also need to connect many pieces of information to learn your hospital’s quality baseline, goals and capabilities.

Your team should set targets for performance in the areas you are monitoring. A target is a measurable and quantifiable goal. Your goal may be to reduce wrong site surgeries to zero. If so, even one instance will be too many. In other cases, you may have both short- and long-term goals. For example, your immediate goal may be reducing readmissions by 15%, and then subsequently by an additional 10%. Think of your facility or organization as an athlete who keeps beating his or her own personal record.

Identifying benchmarks for performance is an essential component of using data effectively with QAPI. A benchmark is a standard of comparison. You may wish to look at your performance compared to hospitals in your state and nationally by using Medicare Care Compare or another reliable database. Some states also have state report cards. You may compare your hospital to other facilities, but because every facility is unique, the most important benchmarks are often based on your own performance, for example, seeking to improve hand-washing compliance to 90% in three months based on a finding of 66% in the prior quarter. After achieving 90% for some period of time, the benchmark can be raised higher as part of ongoing, continuous improvement.

You’ll want to develop a plan for the data you collect. Determine who collects the data and how often, who reviews the data and analyzes the results, and what success looks like. Collecting information is not helpful unless it is actually used. Be purposeful about your data collection. It is meant to be meaningful, not recreational. A project that has achieved and sustained 100% for many months is no longer a priority for improvement. It is time to choose a new project.

STEP 8: Identify Your Gaps and Opportunities

This step involves reviewing your sources of information to determine if gaps or patterns exist in your systems of care that could result in quality problems or opportunities for improvements. During this step, you may decide to spend more time discussing the quality themes you have identified with patients and staff. They may pick up patterns you have not yet identified, and they may have ideas about what is at the root of the problem. Consider hosting a series of small group meetings with your staff and arrange to meet with your patient and family engagement council (if applicable).

This step should lead to the next steps involving PIPs. Such projects are expected to be chosen to deal with “high risk, high volume, problem-prone areas” related to quality of care or quality of life. Take time to notice what you are doing well. That is important, too, and deserves recognition. While you are celebrating accomplishments, you can also begin to set priorities for improvement around issues the team identifies.
Prioritizing opportunities for improvement is a key step in the process of translating data into action. As you continue to implement QAPI, you and your team will do the following:

- Prioritize opportunities for more intensive improvement work. Problems versus opportunities are a matter of perspective and often require discussion.
- Choose problems or issues you consider important (consider if the issue is high risk, high frequency and/or problem prone).
- Consider how many PIPs your facility can devote attention to at one time and prioritize which problem(s) will become the focus for a PIP.

All identified problems need attention and usually from more than one person, but they do not all require PIPs. Begin some PIPs with problems you think you can solve relatively easily. A quick win is worthwhile.

**Charter PIP Teams**

We use the word “charter” on purpose. A PIP is more than a casual effort. Chartering implies the team has been entrusted with a mission, and it reports back to the QAPI committee at specific intervals. Being part of a formally chartered PIP team must be interpreted as an important assignment that team members and their supervisors must take seriously. The development of a charter adds strength, importance and formality to the PIP process.

The team typically has a leader, either appointed by leadership or by the team itself. Soon after it begins its work, the PIP team should develop a proposed timeline, specific improvement goals and metrics and indicate the needed budget (if any).

Use the Goal Setting Worksheet to help your PIP team establish appropriate goals for organizational quality measures, informal improvement initiatives and PIPs.

*See Appendix A for the Goal Setting Worksheet.*
Careful planning of PIPs includes identifying areas to work on through your comprehensive data review which are meaningful and important to your patients. It is important to focus your PIPs by defining the scope, so they do not become overwhelming.

You and your team may
- consider each PIP a learning process;
- determine what information you need for the PIP;
- determine a timeline and communicate it to the steering committee.
- identify and request any needed supplies or equipment;
- select or create measurement tools as needed;
- prepare and present results;
- use a problem-solving model like PDSA (Plan-Do-Study-Act);
- report results to the QAPI committee.

**Plan-Do-Study-Act (PDSA) Model**

During a PIP, you will try out some changes and then see whether they make a difference in the area you are trying to improve.

**PLAN phase:** The team learns more about the problem, plans for how improvement would be measured and plans for any changes that might be implemented.

**DO phase:** The plan is carried out, including the selected measures.

**STUDY phase:** The team summarizes what was learned.

**ACT phase:** The team and leadership determine what should be done next. The change can be adapted (and re-studied), adopted (perhaps expanded to other areas) or abandoned. That decision determines the next steps in the cycle.
A major challenge in process improvement is getting to the heart of the problem or opportunity.

There is danger in starting with a solution without thoroughly exploring the problem. Multiple factors may have contributed, and/or the problem may be a symptom of a larger issue. What seems like a simple issue may involve a number of departments.

**Root cause analysis** (RCA) is a term used to describe a systematic process for identifying contributing causal factors that underlie variations in performance. This structured method of analysis is designed to get to the underlying cause of a problem, which then leads to identification of effective interventions that can be implemented to make improvements.

RCAs help teams understand that the most immediate or seemingly obvious reason for the problem or an event may not be the real reason for why an event occurred. The RCA process leads to digging deeper and looking for the reasons behind the reasons. This process will generally lead to the identification of more than one root cause. The root cause(s) and any contributing factors can then be sorted into categories to facilitate the identification of various actions that can be taken to make improvements.

RCAs focus primarily on systems and processes, not individual performance.

The RCA process takes practice but can be a valuable tool for performance improvement. To get familiar with RCA, you and your team may consider:

- studying case examples of RCAs;
- applying RCA to an adverse event and discussing this technique with the team; and/or
- building RCA examples into training opportunities.

[Click here to go to “Identifying Causes of Problems through RCA” on-demand training](#).
Identifying root causes is only the first step in improving performance. Next, you will want to implement changes or corrective actions that will result in improvement or reduce the chance of the event recurring. This is often the most challenging step in the process. Common solutions such as providing more staff training/education or asking clinicians to “be more careful” do not change the process or system. These proposed solutions are based on two assumptions:

1. Lack of knowledge contributed to the event.
2. If a person is educated or trained, the mistake will not happen again.

Choosing actions tightly linked to the root causes and that lead to a system or process change are considered to have a higher likelihood of being effective. Actions that simply support the current process are considered “weaker” and should not be selected as the sole intervention. The goal is to make changes that will result in lasting improvement. Avoiding quick fixes and weak actions is vital to achieving that goal.

To be effective, interventions or corrective actions should target the elimination of root causes, offer long term solutions to the problem and have a greater positive than negative impact on other processes. In addition, interventions must be achievable, objective and measurable.

Pilot Test
Start small! Think about testing or “piloting” changes in one area of your facility before launching throughout the hospital. Some changes have unintended consequences.

The Department of Veterans Affairs National Center for Patient Safety’s Hierarchy of Actions\(^1\) classifies corrective actions as:

**Weak:** Actions that depend on staff to remember their training or what is written in the policy. Weak actions enhance or enforce existing processes. Examples of weak actions:

- Double checks
- Warnings/labels
- New policies/procedures/memoranda
- Training/education
- Additional study

**Intermediate:** Actions are somewhat dependent on staff remembering to do the right thing, but they provide tools to help staff remember or promote clear communication. Intermediate actions modify existing processes. Examples of intermediate actions:

- Decrease workload
- Software enhancements/modifications
- Eliminate/reduce distraction
- Checklists/cognitive aids/triggers/prompts
- Eliminate look-alike and sound-alike
- Read back
- Enhanced documentation/communication
- Build in redundancy

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Strong: Actions that do not depend on staff to remember to do the right thing. The action may not eliminate the vulnerability but provides strong controls. Strong actions change or re-design the process. They help detect and warn so there is an opportunity to correct before the error reaches the patient. They may involve hard stops that will not allow the process to continue unless something is corrected or gives the chance to intervene to prevent significant harm.

Examples of strong actions:

- Physical changes – grab bars, non-slip strips on tubs/showers
- Forcing functions or constraints – design of gas lines so only oxygen can be connected to oxygen lines
- Electronic medical records – cannot continue charting unless all fields are filled in
- Simplifying – unit dose

Prevent future problems by developing and testing strong actions.

Click here to go to “Corrective Action Hierarchy” on-demand training.

Remember Hospital ABC’s PIP in Scenario 2 about the refrigerator temperatures? Many of the QAPI action steps discussed in this guide are found in this scenario. Here are some of the key highlights:

- The facility had a structured steering committee for directing the QAPI activities (Step 1).
- The facility established performance measures and was conducting routine monitoring (Step 6).
- The facility used data to identify gaps or opportunities for improvement (Step 8).
- The QAPI steering committee used prioritization to decide when to conduct PIPs (Step 9).
- The QAPI steering committee created an interdisciplinary team, and as seen in this example, each discipline in the team brought a unique perspective that contributed to a balanced and comprehensive analysis (Step 2).
- The QAPI steering committee gave each team member real responsibility to study the issue, analyze the data and recommend corrective actions (Step 2).
- The PIP team explored the issue and designed interventions using a PDSA model (Steps 9 and 10).
- The PIP team’s investigation revealed several underlying systemic issues and made recommendations that addressed those systems, rather than focusing on individual behavior (Step 12).

QAPI Principles Summarized

- QAPI may not be new to your facility, but there is likely room for improvement. If you already have a QAPI program and/or committee, consider beginning by evaluating or re-evaluating your program with the QAPI Self-Assessment Tool.
- QAPI leadership starts at the top with executive management and the governing board in each hospital.
- Start using systems thinking as you assess your own QAPI efforts and develop a QAPI plan. Think of your entire facility or community as you plan for monitoring, as you conduct PIPs and particularly as you think about the way problems might be caused and how care is organized.
- Involve the people directly working in a process to improve that process. These are the people who really know what happens at any point in the process. It is crucial to focus on organization-wide inclusion, not for the sake of inclusion, but to truly understand what is going on in any given process.
- Communication about QAPI should be continuous throughout the whole organization. QAPI principles and ongoing training should be built into a facility-wide educational effort that involves all staff, patients and families.
- Patients’ perspectives need to be considered in setting QAPI priorities. Solicit patients’ viewpoints and talk to patients and families about quality as they experience it.
Two important components of your QAPI plan will be setting priorities and chartering PIP teams. Everyone should have an opportunity to participate in these activities.

Create a record of QAPI activities. Consider using past experience as a resource as you move ahead. Keeping an ongoing record of QAPI achievements may help to sustain the improvements regardless of crises or changes in leadership. Build it into your plan.

Celebrate and reward successes! We often forget to do this, but it is incredibly important for sustaining momentum and enthusiasm for improvement.

### QAPI Tools and Related Resources

#### QAPI PROCESS TOOLS

These are tools that help make QAPI processes work. They include the following:

- Checklists
- Templates
- Flow charts
- Reporting forms or outlines
- Worksheets

QAPI process tools are important to

- organize multiple tasks;
- enhance communication within and across teams;
- help generate ideas and reach decisions;
- keep information organized and accessible;
- track successes and challenges using data.

QAPI is largely about well functioning and tightly coordinated systems that can identify, solve and prevent problems effectively. Using QAPI can improve diverse aspects of care and services as well as patient, family, provider and staff experience and satisfaction. **Tools can help.**

#### QAPI TOPIC TOOLS

QAPI Topic Tools are used to study and improve particular topic areas. Many tools are available to assess care processes and outcomes and to allow you to follow progress in areas you want to track and/or improve. Topic tools can take many forms, ranging from simple to complex, and they use multiple sources of information.

- **Checklists or audits completed by staff and providers** – Checklists can be used to review records of various kinds to determine all steps have been taken, for example, a discharge or fall prevention checklist.

- **Rating forms completed by providers** – For example, patients’ mood states are rated when patients cannot respond to direct questions.

- **Structured observation** (e.g., observations of interactions among patients and providers or of physical environments) – Observations are objective and made at specific times and places. Later they may be summarized into a score.

- **Direct interviews with patients and family** – Such tools, sometimes called patient self-report tools, may be related to single areas of functioning.

- **Protocols to guide providers’ behavior to improve quality in a particular area** – Such protocols may include procedures and forms meant to shape provider behavior around medication administration, respecting patients’ rights, etc. This comprehensive set of tools could be considered a QAPI process toolkit as well.

Hospitals may wish to select established tools that have been tested and use them consistently.
**QAPI RESOURCES**

**Partnership to Advance Tribal Health (PATH)**
Your hospital is served by a PATH partner. To find out more about PATH: [https://comagine.org/program/partnership-to-advance-tribal-health](https://comagine.org/program/partnership-to-advance-tribal-health)

**Agency for Healthcare Research and Quality (AHRQ)**
The Department of Defense and the AHRQ developed the TeamSTEPPS® program to optimize performance among teams of health care professionals and improve collaboration and communication. [https://www.ahrq.gov/teamstepps/index.html](https://www.ahrq.gov/teamstepps/index.html)

**Department of Veterans Affairs**
National Center for Patient Safety supports and leads the patient safety activities for all Veterans Affairs (VA) medical centers and has developed tools, including root cause analysis investigations. [https://www.patientsafety.va.gov/professionals/onthejob/rca.asp](https://www.patientsafety.va.gov/professionals/onthejob/rca.asp)

**Institute for Health Care Improvement (IHI)**
IHI uses the Model for Improvement as the framework to guide improvement work. The Model for Improvement, developed by Associates in Process Improvement, is a simple but powerful tool for accelerating improvement. Learn about the fundamentals of the Model for Improvement and testing changes on a small scale using Plan-Do-Study-Act (PDSA) cycles. [http://www.ihi.org/knowledge/Pages/HowtoImprove/default.aspx](http://www.ihi.org/knowledge/Pages/HowtoImprove/default.aspx)

**Institute for Patient and Family-Centered Care (IPFCC)**
IPFCC advances the understanding and practice of patient- and family-centered care. In partnership with patients, families and health care professionals, IPFCC seeks to integrate these concepts into all aspects of health care. [www.ipfcc.org](http://www.ipfcc.org)

**Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS)**
The HCAHPS is the first national, standardized, publicly reported survey of patients’ perspectives of hospital care. HCAHPS (pronounced "H-caps"), also known as the CAHPS Hospital Survey, is a survey instrument and data collection methodology for measuring patients’ perceptions of their hospital experience. While many hospitals have collected information on patient satisfaction for their own internal use, until HCAHPS, there was no national standard for collecting and publicly reporting information about patient experience of care that allowed valid comparisons to be made across hospitals locally, regionally and nationally. [https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/HospitalQualityInits/HospitalHCAHPS](https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/HospitalQualityInits/HospitalHCAHPS)

**Agency for Healthcare Research and Quality (AHRQ)**
The Guide to Patient and Family Engagement in Hospital Quality and Safety is a tested, evidence-based resource to help hospitals work as partners with patients and families to improve quality and safety. [https://www.ahrq.gov/professionals/systems/hospital/engagingfamilies/guide.html](https://www.ahrq.gov/professionals/systems/hospital/engagingfamilies/guide.html)
Appendix A
Guide for Developing Purpose, Guiding Principles and Scope for QAPI

**Directions:** Use this tool to establish the purpose, guiding principles and scope for QAPI in your organization. The team completing this worksheet should include senior leadership. Taking time to articulate the purpose, develop guiding principles and define the scope will help you to understand how QAPI will be used and integrated into your organization. This information will also help your organization to develop a written QAPI plan. Use these step-by-step instructions to create a separate document that may be used as a preamble to your QAPI plan.

**STEP 1. LOCATE OR DEVELOP YOUR ORGANIZATION’S VISION STATEMENT**

A **vision statement** is sometimes called a picture of your organization in the future. It is your inspiration and the framework for your strategic planning. Consider involving staff in the development of your vision statement. Post it for everyone to view.

For example, the vision of the Good Samaritan Society is to create an environment where people are loved, valued and at peace.

**STEP 2. LOCATE OR DEVELOP YOUR ORGANIZATION’S MISSION STATEMENT**

A **mission statement** describes the purpose of your organization. The mission statement should guide the actions of the organization, spell out its overall goal, provide a path and guide decision-making. It provides the framework or context within which the company’s strategies are formulated. As above, get caregivers involved in establishing your organizations mission.

For example, Mayo Clinic’s mission statement is: To inspire hope and contribute to health and wellbeing by providing the best care to every patient through integrated clinical practice, education and research.

**STEP 3. DEVELOP A PURPOSE STATEMENT FOR QAPI**

A **purpose statement** describes how QAPI will support the overall vision and mission of the organization. If your organization does not have a vision or mission statement, the purpose statement can still be written and would state what your organization intends to accomplish through QAPI.

For example, the purpose of QAPI in our organization is to take a proactive approach to continually improving the way we care for and engage with our patients, staff and other partners so that we may realize our vision to [reference aspects of vision statement here]. To do this, all employees will participate in ongoing QAPI efforts that support our mission by [reference aspects of mission statement here].

**STEP 4. ESTABLISH GUIDING PRINCIPLES**

**Guiding Principles** describe the organization’s beliefs and philosophy pertaining to QAPI. The principles should guide what the organization does, why it does it and how.

For example:
- Guiding Principle #1: QAPI has a prominent role in our management and board functions, on par with monitoring reimbursement and maximizing revenue.
- Guiding Principle #2: Our organization uses QAPI to make decisions and guide our day-to-day operations.
- Guiding Principle #3: The outcome of QAPI in our organization is the quality of care and the quality of life of our patients.
- Guiding Principle #4: In our organization, QAPI includes all employees, all departments and all services provided.
- Guiding Principle #5: QAPI focuses on systems and processes, rather than individuals. The emphasis is on identifying system gaps rather than on blaming individuals.
- Guiding Principle #6: Our organization makes decisions based on data, which includes the input and experience of employees, patients, health care practitioners, families and other stakeholders.
- Guiding Principle #7: Our organization sets goals for performance and measures progress toward those goals.
- Guiding Principle #8: Our organization supports performance improvement by encouraging our employees to support each other as well as be accountable for their own professional performance and practice.
- Guiding Principle #9: Our organization has a culture that encourages, rather than punishes, employees who identify errors or system breakdowns.

Add any additional Guiding Principles that may be important to your hospital. Review the five QAPI elements to ensure you identify and capture guiding principles for your organization.

**STEP 5. DEFINE THE SCOPE OF QAPI IN YOUR ORGANIZATION**

The *Scope* outlines what types of care and services are provided by the organization that impact clinical care, patient safety and experience of care. Be sure to incorporate the care and services delivered by all departments.

**For example:**

<p>| |</p>
<table>
<thead>
<tr>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Emergency Department</td>
</tr>
<tr>
<td>Discharge Planning</td>
</tr>
<tr>
<td>Housekeeping</td>
</tr>
<tr>
<td>Maintenance</td>
</tr>
</tbody>
</table>

Once the list of care and service area has been identified, you can determine how each will use QAPI to assess, monitor and improve performance on an ongoing basis.

**STEP 6. ASSEMBLE DOCUMENTS**

Once you’ve completed steps 1-5, assemble the vision and mission statements, guiding principles and scope of QAPI into a separate document that may be used as a preamble to your QAPI plan. This document will help you articulate the goals and objectives of your organization. QAPI will help you get there. Consider posting for all to see.

The next step is to develop a written QAPI plan that will meet your purpose, guiding principles and comprehensive scope described above. See “Guide for Developing a QAPI Plan.”
Directions: The QAPI plan will guide your organization’s performance improvement efforts. Prior to developing your plan, complete the Guide to Develop Purpose, Guiding Principles and Scope for QAPI. Your QAPI plan is intended to assist you in achieving what you have identified as the purpose, guiding principles and scope for QAPI. Therefore, this information is needed before you begin working on your plan. This is a living document that you will continue to refine and revisit. Use these step-by-step instructions to create your QAPI plan. This plan should reflect input from caregivers representing all roles and disciplines within your organization.

I. QAPI Goals
   Based on the Guide to Develop Purpose, Guiding Principles and Scope for QAPI, indicate the QAPI goals that your plan will strive to meet. Goals should be specific, measurable, actionable, relevant and have a timeline for completion. (See Goal Setting Worksheet.)

II. Scope
   a. Describe how QAPI is integrated into all care and service areas of your organization.
   b. Describe how the QAPI plan will address:
      i. Clinical care
      ii. Patient and staff safety
      iii. Patient and staff experience (e.g., individualized goals for care)
   c. Describe how QAPI will aim for safety and high quality with all clinical interventions while emphasizing autonomy and choice in daily life for patients (or patient’s agents).
   d. Describe how QAPI will utilize the best available evidence (e.g., data, national benchmarks, published best practices, clinical guidelines) to define and measure goals.

III. Guidelines for Governance and Leadership
   a. Describe how QAPI is integrated into the responsibilities and accountabilities of top-level management and the board of directors (if applicable).
   b. Describe how QAPI will be adequately resourced.
      i. Designate one or more persons to be accountable for QAPI leadership and for coordination.
      ii. Indicate the plan for developing leadership and facility-wide training on QAPI.
      iii. Describe the plan to provide staff time, equipment and technical training as needed for QAPI.
      iv. Indicate how you will determine if resources are adequate for QAPI.
   c. Describe how your staff will become and remain proficient with process improvement tools and techniques. How will you assess their level of proficiency?
   d. QAPI leadership
      i. While everyone in the organization is involved in QAPI, you will likely have a small group of individuals who will provide the backbone or structure for QAPI in your organization. Who will be part of this group? Many of these individuals may be on your current QAA committee.
      ii. Describe how this group of people will work together, communicate and coordinate QAPI activities. This could include but is not limited to:
         ▪ Establishing a format and frequency for meetings.
         ▪ Establishing a method for communication between meetings.
         ▪ Establishing a designated way to document and track plans and discussions addressing QAPI.
      iii. Describe how the QAPI activities will be reported to the governing body; i.e., Board of Directors, CEO.

IV. Feedback, Data Systems and Monitoring
   a. Describe the overall system that will be put in place to monitor care and services, drawing data from multiple sources.
   b. Identify the sources of data that you will monitor through QAPI.
i. Input from staff, patients, families and others
ii. Adverse events
iii. Performance indicators
iv. Survey findings
v. Complaints

c. Describe the process for collecting the above information.
d. Describe the process for analyzing the above information, including how findings will be reviewed against benchmarks and/or targets established by the facility.
e. Describe the process to communicate the above information. What types of reports will be used? One way to accomplish this is to use a dashboard or dashboards for individual performance improvement projects (PIPs).
f. Identify who will receive this information (i.e., executive leadership, QAPI leadership, patient/family council, hospital staff), in what format and how frequently information will be disseminated.

V. Guidelines for Performance Improvement Projects (PIPs)

a. Describe the overall plan for conducting PIPs to improve care or services.
   i. Indicate how potential topics for PIPs will be identified.
   ii. Describe criteria for prioritizing and selecting PIPs, areas important and meaningful for the specific type and scope of services unique to the facility require a concentrated effort on a particular problem in one area of the facility or facility-wide.
   iii. Indicate how and when PIP charters will be developed.

b. Describe the process for reporting the results of PIPs. Identify who will receive this information (i.e., quality committee, patient/family council, hospital staff), in what format and how frequently information will be disseminated.

c. Describe how to designate PIP teams and establish and describe a process for assembling teams to work on specific PIPs.

d. Define the required characteristics for any PIP team. This may include that the team be interdisciplinary (i.e., representing each of the job roles affected by the project), that the team include patient representation (as appropriate) and that a qualified team leader is selected (i.e., ability to coordinate, organize and direct all activities of the project team). Describe how PIP teams should document and report their work.

e. Describe your process for documenting PIPs, including highlights, progress and lessons learned. For example, what project documentation templates will you use consistently and file electronically in a standardized fashion for future reference?

VI. Systematic Analysis and Systemic Action

a. Any change that is made has the potential to have broader impact than intended. If you are trying to make a change to a specific system or process, it is important to recognize any “unintended” consequences of your actions. Describe how your organization will identify these consequences which may be either positive or negative.

b. Describe the process you will use to ensure you are getting at the underlying causes of issues, rather than applying quick fixes that address symptoms only.

c. Describe how you will monitor to ensure that interventions or actions are implemented and effective in making and sustaining improvements.

VII. Communications

Outline the audiences for QAPI communications and the frequency and format of these communications.

VIII. Evaluation

a. Describe the process for assessing QAPI in your organization on an ongoing basis. (For example, using the QAPI Self-Assessment Tool)

b. Describe the purpose of this evaluation, e.g., to help your organization expand your skills in QAPI and increase the impact of QAPI in your organization.
IX. Establishment of Plan
   a. Date your plan.
   b. Determine when you will revisit the plan (e.g., at least annually).
   c. Determine how you will track revisions or updates to the plan.
Directions: Goal setting is important for any measurement related to performance improvement. This worksheet is intended to help QAPI teams establish appropriate goals for individual measures and with performance improvement projects. Goals should be clearly stated and describe what the organization or team intends to accomplish. Use this worksheet to establish a goal by following the SMART formula outlined below. Note that setting a goal does not involve describing what steps will be taken to achieve the goal.

Describe the business problem to be solved:

Use the SMART formula to develop a goal:

**SPECIFIC**
Describe the goal in terms of 3 “W” questions:

| What do we want to accomplish? |
| Who will be involved/affected? |
| Where will it take place? |

**MEASURABLE**
Describe how you will know if the goal is reached:

| What is the measure you will use? |
| What is the current data figure (e.g., count, percent, rate) for that measure? |
| What do you want to increase/decrease that number to? |
ATTAINABLE
Defend the rationale for setting the goal measure above:

Did you base the measure or figure you want to attain on a best practice/average score/benchmark?

Is the goal measure set so low that it is not challenging enough?

Does the goal measure require a stretch without being too unreasonable?

RELEVANT

Briefly describe how the goal will address the business problem stated above.

TIME-BOUND
Define the timeline for achieving the goal:

What is the target date for achieving this goal?

Write a goal statement based on the SMART elements above. The goal should be descriptive but concise enough that it can be easily communicated and remembered. It is a good idea to post the written goal somewhere visible and regularly communicate the goal during meetings to stay focused and remind staff everyone is working toward the same aim.

[Example: Increase the number of patients with a vaccination against both influenza and pneumococcal disease documented in their medical record from 61% to 90% by December 31, 2024.]