QI PLAN FY2025

MARCH 2025

Kewa Pueblo Health Corporation
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Contents

Introduction

The Kewa Pueblo Health Corporation (KPHC) operates as a Public Law 93-638 program in partnership with the Indian Health Service (IHS) and the Department of Health and Human Services (HHS). This health center is located in Santo Domingo, New Mexico, and serves Santo Domingo tribal members and members of surrounding tribes and pueblos. The Santo Domingo Health Center (SDHC) provides primary care outpatient services and walk-in services (including basic lab services); in addition to ancillary clinical services including audiology, behavioral health, case management, dental, diabetes case management, nursing, optometry, pediatrics, pharmacy, physical therapy, podiatry, public health, radiology, transportation, wound care, and serves as an active hub for external referrals for specialty care when clinically necessary through our Purchased and Referred Care (PRC) procurement program.

KPHC currently has 6 full-time physicians, 4 full-time mid-level providers, several contract specialists, over 160 employees and contractors, as well as volunteers to serve our community and patients – all of which are honored to care for our patients and community while delivering an extraordinary patient experience to the residents of Santo Domingo.

It is the Mission of the Kewa Pueblo Health Corporation to ensure health and wellness through excellence in health care with respect to culture. Our vision is to be an active and reliable resource to promote Healthy People; (a) Healthy Community; (and) Healthy Lifestyle(s). Consequently, the Quality Management & Improvement Program (QMIP) for the Kewa Pueblo Health Corporation ultimately serves to monitor, measure, research, test, and implement clinical and operational improvements that fulfill our mission and vision in service of the Santo Domingo Pueblo and surrounding tribal communities.

Through collaborative efforts, we will enable a safer patient-led healthcare service, making it easier for patients and families to navigate the healthcare system. Our efforts are driven by our pledge to serve our community.

Program Scope

The entire programmatic scope of healthcare delivery services and supporting administrative, fiscal, and ancillary functions operate within the framework of Kewa Pueblo Health Corporation's 2025-2028 Strategic Alignment Map (Appendix I), which identifies four (4) primary organizational outcomes/goals that have been approved by the Kewa Pueblo Health Corporation Health Board:

1. Align KPHC's patient value proposition to improve the patient experience;
2. Promote long term sustainability, growth, and transparency in operations;
3. Design and maintain consistent, compliant, safe, and effective processes; and
4. Strengthen organizational capital to fulfill dynamic industry and community needs.

Cascading these directives down to an operational level, Kewa Pueblo Health Corporation's 2025-2028 Strategic Alignment Map further defines sixteen (16) primary strategic directives that guides all organizational activities and quality improvement efforts. KPHC's Quality Management Improvement program's scope is thus integrated with each of these directives and accomplished in the normal day-to-day operations they govern including:

1. Assurance that the treatment provided incorporates evidence-based, effective clinical practices;
2. That the treatment and services are appropriate to each patient's needs and available when needed;
3. Risk to patients, providers, and others is minimized, and errors in the delivery of services are prevented;
4. Patients' individual needs and expectations are respected; patients—or those whom they designate—have the opportunity to participate in decisions regarding their treatment; and services are provided with sensitivity and care;
5. Procedures treatments, and services are provided in a timely and efficient manner, with appropriate coordination and continuity across all phases of care and all providers of care;
6. Supporting functions such as administrative execution and intervention; business office and 3rd party collections activities; budget formulation and implementation processes; surveys and information gathering mechanisms; policy and procedural development; and hiring and training of staff to support the goals of KPHC.

Purpose and Overview

Purpose

The purpose of the KPHC Quality Improvement Plan is to provide guidance for the KPHC's Quality Improvement (QI) efforts. The plan provides a framework for QI processes and activities as well as a plan to measure and monitor KPHC's progress towards QI goals while fostering a culture of quality improvement.

Overview of Quality

Quality is achieved when the work of the company is based on science and the best available evidence, is linked with health outcomes that are most important to the corporation and the patients it serves, and is performed in an acceptable manner, often defined by specific standards.

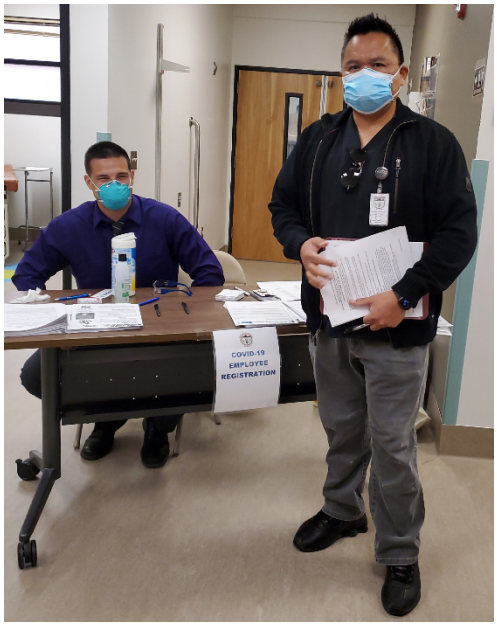
Quality Improvement Plan (QIP)

KPHC continues to build on the progress towards improving our performance in three key areas: **Safe Transitions** relating to ensuring sufficient and appropriate information is given at the time the patient leaves the facility; **Safe Workplace** related to reducing the number of incidents resulting from workplace violence/harassment and the like; and **Safe Care** related to improving patient outcomes through our population health metrics in alignment with the Government Performance and Results Act (GPRA) measurements.

These priority areas of focus will carry forward into the 2025 QIP with the aim of enhancing the quality of services at KPHC, empowering our people, and delivering an extraordinary patient experience.

This plan outlines the intersection between the Quality program, risk management, and infection prevention.

QIP Initiatives on a Page



1 Safe Care

Patient Outcomes: Improving care and health outcomes utilizing tools in Nextgen and the Population Health module.

2 Safe Transitions

Information Upon Departure: Ensuring patients and families have, and understand, the information they need to safely manage their health at home.

3 Safe Workplace

Fostering a safe work environment that promotes trust and understanding through consistent adherence to policies and procedures.

QMI Values

Quality Management Improvement at Kewa Pueblo Health Corporation is a systematic approach to assessing our services and improving them in accordance with our strategic goals and the best practices and benchmarks in the healthcare industry. In addition, Kewa Pueblo Health Corporation's approach to quality improvement is founded on the following values:

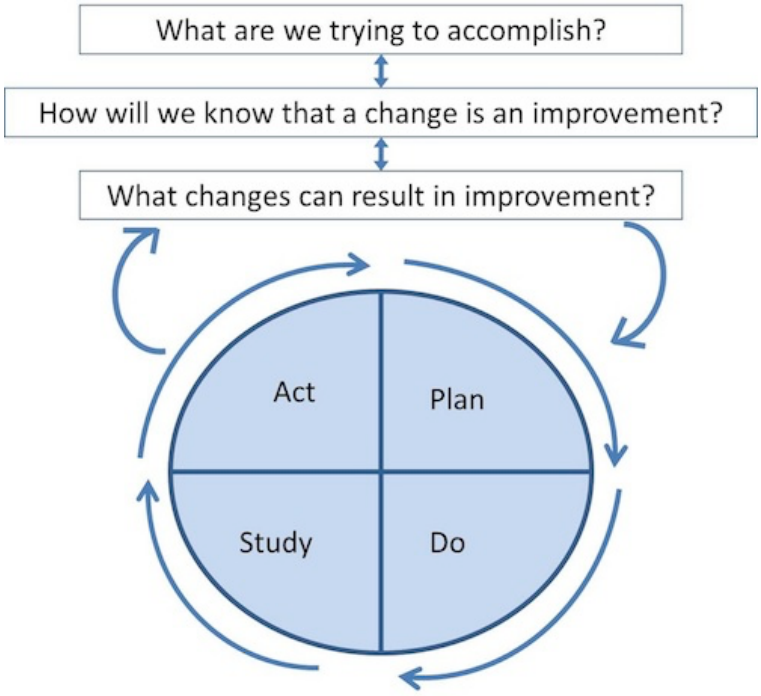
1. *A focus on the Patient Experience*: Kewa Pueblo Health Corporation strives to understand the value-creation chain of our operations and focus on improvements which create value to meet or exceed our patient's experience and expectations.
2. *Engaged Leadership*: Vision, direction, and support of quality improvement activities by the Health Board and executive leadership of Kewa Pueblo Health Corporation are key to performance improvement. Moreover, engaged involvement of organizational leadership assures that quality improvement initiatives are consistent with pursuing our mission and/or strategic plan.
3. *Quality Improvement through Employee Empowerment*: Performance improvement is systemic and thus requires investment in training and professional development of staff. Involvement at the point of delivery with patients as well as "behind the scenes" with tribal leaders, co-workers, and other stakeholders is essential for empowerment.
4. *Data-Driven Decision-Making*: Successful QMI processes are initiated on data analysis and create data feedback loops, using sound evidence to inform changes to practices and operations and further results measurement.
5. *Governance:* QMI processes are integrated with and rely upon compliance with organizational standards. Governance related to access control, levels of access, secure data archiving and succession plans allow for successful QMI efforts.
6. *Standardization:* Alignment and standardization of operational workflows, data collection, analysis and interpretation are necessary for improving efficiencies and ensuring accurate data reporting.
7. ***Prevention over Correction*: One of the primary long-term goals of our QMI program is to design effective processes to achieve excellent outcomes from the outset rather than fix processes after the fact.**

Key Quality Terms

In order for KPHC to understand Quality and how it operates under its roof, staff need to comprehend the basic Quality Improvement terms utilized:

- *Quality Improvement*: "Quality improvement in healthcare is the use of a deliberate and defined improvement process, such as Plan-Do-Check-Act, which is focused on activities that are responsive to community needs and improving population health. It refers to a continuous and ongoing effort to achieve measureable improvements in the efficiency, effectiveness, performance, accountability, outcomes, and other indicators of quality in services or processes which achieve equity and improve the health of the community" (Accreditation Coalition Workgroup, 2009)
- *Quality 'Improvement' versus 'Activity'*: A quality improvement study results when monitoring reveals that the current performance is less than the performance goal. A quality activity results when monitoring has revealed that the performance goal has been met, it can remain in the quality improvement program but because a gap was not identified it does not qualify as an improvement study.
- *Quality Management Improvement (QMI):* An ongoing effort to increase KPHC's approach to managing performance and motivate improvement. QMI is an ongoing effort to improve the efficiency, effectiveness, quality, or performance of services, processes, capacities, and outcomes. These efforts can seek "incremental" improvement over time or "breakthrough" all at once.
- *Quality Assurance (QA):* QA is a process that measures compliance with previously established standards and expectations.
- *QI Methods*: A variety of practices exist to assist in QI efforts. The PDSA/PDCA or Shewhart Cycle, Lean, Six Sigma, Lean Six Sigma, DMAIC, Performance Excellence, Model for Improvement, and Malcolm Baldridge National Quality Standards.
- *PDSA*: The Plan-Do-Study-Act (PDSA) method is the most widely used, simple approach for quality improvement projects. PDSA and PDCA may be used interchangeably.
- *QI Tools*: A variety of tools to identify how processes, programs, and services can be improved. Tools include prioritization matrices, flow charts, cause-and-effect or fishbone diagrams, Pareto charts, scatter diagrams, control/run charts, brainstorming, logic models, SWOT analysis and numerous others.
- *Metrics*: A collection of terms used in setting goals, indicators, measures, standards, baseline and benchmarks. The metrics are defining during the Plan phase of the PDSA model and are vital in monitoring the progress of quality improvement projects:
    - Measure: A basis for comparing performance or quality through quantification.

- Indicators: A measure which helps quantify the achievement of a goal; end result which lets us know if we are achieving a goal; measurable; refers to populations, whether or not they receive services.
- Standard: An established level of performance or quality; the minimum acceptable measurement expected or desired.
- Goal: Broad, general statement of what will be achieved and how things will be different; what it takes to reach the vision (MUST be measurable).
- Benchmark: Target to be reached; a near-term standard with which an indicator or particular performance measure is compared to a level of performance established as a standard of quality.
- Baseline: An initial measurement of population or program.
- Performance measure: A measure of how well a program is working; work performed and results achieved; its efficiency and effectiveness; refers to client population/those who receive services; may relate to knowledge, skills, attitudes, values, behavior, condition or status (e.g. % of patients who keep their appointments).



Authority and Organizational Responsibilities

Authority

As the governing body of the Kewa Pueblo Health Corporation, the Health Board is ultimately responsible for assuring that:

- High quality care is delivered to our patients;
- The organization continues growing and is financially viable;
- Operations are effective, efficient, and compliant; and
- Organizational culture is conducive to continuous improvement initiatives.

Consequently, the Health Board maintains the authority to establish, maintain oversight of, and adjust QMI program initiatives, and delegates various responsibilities through organizational positions and committees to fulfill this charge as outlined below.

Organizational Responsibilities

Health Board/Governing Body:

- Develops and approves Kewa Pueblo Health Corporation's Strategic Alignment Map and corresponding organizational budget, measures and goals on an annual basis;
- Reviews the progress of the QMI program annually; and
- Receives and reviews an annual evaluation of the QMI program for effectiveness.

Chief Executive Officer:

- Assumes operational authority and leadership for the QMI program, including the establishment of a Quality Management Improvement Committee charter and appointment of members to the committee;
- Determines the allocation of resources for implementation and execution of the QMI program from year-to-year;
- Assigns additional administrative responsibilities for the QMI program as required.

Quality Management & Improvement Committee (QMIC):

- Develops, prioritizes, plans, and implements specific QMI interventions and initiatives (which might include process redesign, operational changes, policy development, equipment purchases, trainings, etc.) under the Strategic Alignment Map framework to improve quality and performance at KPHC;
- Assists staff and departments in linking specific interventions and initiatives to measurable objectives to monitor and measure improvement on a consistent basis;

- Maintains a schedule of committee meetings—no less than once per quarter—to monitor, adjust, and review the QMI Plan, and to establish and communicate reporting dates, resource needs, events, etc.; and
- Assign staff to collect and analyze data and conduct intensive review of cases involving their department.
- Develop and implement corrective action plans when deficiencies or gaps are identified to maintain compliance with AAAHC accreditation standards.

Medical Executive Committee:

- Consults to guide the identification, development, and implementation of specific clinical actions and/or interventions for the QMI program, with an expressed focus on improving the quality of care and patient value that is routinely delivered by KPHC.
- Ensures the timely evaluation and/or completion of case and peer reviews, medical record reviews, pharmacy and therapeutic reviews, transfer appropriateness, credentialing and privileging progress, utilization reviews, and other reports from all Medical Staff Committees as described in the Bylaws of the Medical Staff; and
- Reports on the progress of QMI clinical quality measures to the Health Board no less than annually, as coordinated by the CEO.

Department Directors/Managers:

- Guides the identification, development, and implementation of actions and/or interventions for the QMI program, with an expressed focus on improving operations within their respective departments; and
- Reports on the progress of QMI department quality measures to the Health Board no less than annually, as coordinated by the CEO.

Quality Improvement Director (QID):

- Manages and oversees the Quality Improvement Plan (QIP); and
- Develops the QIP on an annual basis for QMI Committee, ELT, and Board approval
- Establishes reports and communication tools for progress in the QMI program to be delivered to the Health Board, tribal leaders, staff, community members, and other stakeholders.

Alignment of QI with Other KPHC Programs

Kewa Pueblo Health Corporation's Strategic Alignment Map

KPHC's Strategic Alignment Map (SAM) focuses on core objectives to improve the health and well-being of the residents and community that it serves. These objectives are aligned with the sixteen (16) strategic plan priority areas (Appendix E). Each Quality Improvement project is aligned with the SAM and is indicated on the Nomination Form that is submitted with each project. Project Sponsors are to fill this out for tracking and for an understanding of where the project aligns with the SAM.

Peer Review/Credentialing

The KPHC's QI program will work closely with the medical staff to help ensure that the medical staff is operating at the best patient centered care that is possible. The QMI Committee will help the Medical Executive Committee (MEC) to come up with quality indicators for provider performance. The Quality Director is responsible for compiling the Ongoing Professional Practice Evaluation (OPPE) and Focused Professional Practice Evaluation (FPPE) data and presenting that to MEC and the Health Board. The QMIC committee will provide guidance on condition specific peer review as requested.

Risk Management and Compliance

The KPHC's QI program will integrate with the Risk Management program to ensure there is a strong, engaged staff to help identify potential risk-related events. The QI program will help to proactively resolve patient complaints and patient safety issues.

KPHC is committed to ensure the compliance of all internal and external staff members with applicable federal, state, and regional standards. The Compliance Officer shall report any data analyses to QMIC on at least a quarterly basis. It may include, but not limited to total number of complaints, source of complaints, total of substantiated complaints, total of remedial actions by remedial action type (education/training, disciplinary action, etc.), allegations of fraud, waste, and abuse, etc.

Infection Prevention & Control & Safety

The Infection Prevention and Control Program integrates with QI through shared membership on committees (QMIC and IPC). This integration is evidenced by coordination and development of annual Infection Prevention and Control Program updates, annual risk assessments, and surveillance plans. Further, the IPC will work to identify areas that need improvement to ensure safe effective patient care through monitoring activities.

Goals and Objectives

Ongoing Goals

From a comprehensive perspective, Kewa Pueblo Health Corporation's Quality Management Improvement Program seeks:

- To maintain a high rate of compliance with national and industry standards and professional guidelines.
- To produce outcomes that compare favorably with national, regional, and internal outcome benchmarks by utilizing the Nextgen database and population health dashboard to compare to GPRA measurements.
- To recognize and minimize the potential for patient harm and clinical error in a timely and efficient manner.
- To achieve a high rate of patient and community satisfaction regarding patient centeredness and equitable treatment.
- To maintain a high level of staff satisfaction regarding administrative support and responsiveness to their needs and concerns and coordinate efforts to improve staff retention.
- To recognize and respond to the health needs of the community.
- To maintain human and physical resources to meet the health care needs of the community.
- To support the increase and collection of revenues to sustain high-quality care.
- Promote preventive efforts for improved patient outcomes and cost savings.
- To maintain a high level of compliance with medical record documentation requirements.
- To sustain a safe and secure environment for staff, patients, and visitors.
- To maintain performance improvement and reporting requirements of external agencies.
- To maintain data governance and standardization efforts to ensure accurate reporting of metrics used for decision making, assessments, and identifying areas of improvement.
- To maintain productivity; and
- To maintain comprehensive staff onboarding and annual training.

With the roles and responsibilities above, KPHC develops, prioritizes, plans, and undertakes specific initiatives and projects under the Strategic Alignment Map framework and, in doing so, defines goals and specific objectives to be accomplished each year.

The QMI goals link to strategic directives on Kewa Pueblo Health Corporation's Strategic Alignment Map; utilize quantitative and/or qualitative measures to assess progress; and are designed to demonstrate the value/impact of chosen initiatives or interventions on the issue at hand. QMI activities are intended to further progress on QMI goals and may include process redesign, operational changes, policy development, equipment purchases, and/or training initiatives. For FY 2025, QMI goals will support the vision and mission of KPHC and align with the sixteen (16) strategic directives outlined on the Strategic Alignment Map, unless otherwise modified by the QMIC (Appendix E).

Performance Measurement

Performance Measurement in Kewa Pueblo Health Corporation's QMI program is the process of regularly assessing the results produced by the program. Quality Improvement involves taking action as needed based on the results of data analysis and opportunities for performance improvement. The purpose of performance measurement is to:

- Assess the stability of processes or outcomes to determine whether there is an undesirable degree of variation or a failure to perform at an expected level.
- Identify problems and opportunities to improve the performance of processes;
- Assess the outcome of the care provided; and
- Assess whether a new or improved process meets performances expectations.

Performance measures are quantitative tools that provide information about the performances of a clinic's process, services, functions, or outcomes. Factors considered in developing and implementing performance measures for Kewa Pueblo Health Corporation include:

- Relevance to our mission and vision, and whether the measure addresses the population served.
- Clinical importance, including whether it addresses a clinically important process of high volume, high risk, or frequent concern;
- The relationship between the measure and the process, system, or outcome being measured.
- The relationship of the measurement to the capabilities and the cost involved and the resources that are available; and
- Whether the measurement can be easily understood; measures a variable over which the program has some control; and can be changed by reasonable quality improvement efforts.

Performance assessment under KPHC's QMI will be accomplished by comparing actual performance on a measure with:

- Our own performance over time (internal benchmarking).
- Pre-established standards, goals, or expected levels of performance (external benchmarking).
- Information concerning evidence-based and/or best practices.

Data reporting will fall under various categories and require validation. QI activities will be prioritized in the following areas, however additional reporting may be completed as needed to make data-driven decisions.

- Trending
    - Internal and external benchmarking
- Claims analysis and coding audits
- Frequency and severity data
- Credentialing activity and peer review
- Provider and staff education
    - New hires
    - Annual training
- Risk management and patient safety activities.

Quality Improvement Projects

Introduction

The QMIC will solicit ideas for quality improvement project ideas, prioritize projects according to the quality improvement goals, and assist with implementation. Staff and administration are encouraged to work together in creating new quality improvement projects utilizing the Nomination Questionnaire (Appendix B).

Identification and Prioritization of QI Opportunities

Throughout the year, the Quality Improvement Committee will identify and/or approve QI opportunities through one or more of the following avenues:

- Executive Leadership Team (ELT) requests
- The Accreditation Improvement Plan (following AAAHC)
- Agency-wide assessments and/or surveys, such as the annual employee survey
- KPHC's CEO, Board members, or staff may recommend improvement activity by identifying opportunities through monitoring or job functions
- Areas for improvement are identified through surveys; data analysis, and recommendations of external auditors or regulatory bodies such as AAAHC.

Project Guidelines

There are two different life-cycles of projects at KPHC: Rapid Improvement Projects and Standard QMI Projects. Each of these are dependent on the project's intended outcome:

- Rapid Improvement Projects are intended to see if the project would benefit from becoming a bigger Standard QMI project (Appendix C: Rapid Improvement Event Form).
    - The life-cycle of this project is typically a month or two.
    - If after this cycle is done, it is determined it might benefit to have a bigger more encompassing project put forth, i.e. one affecting all departments, the staff member may choose to do so.
    - These projects are to help solicit more staff involvement in the QI process.
- Standard QMI Projects are typically longer projects and affect more than one department. (Appendix D: 10-step form)
    - These projects can last anywhere from 6 months to a year or more.
    - These can envelope the Rapid Improvement Projects, if one took place.
    - These are time consuming projects with a "Dashboard/Storyboard" at the end which is presented at the QMI meetings.

Documentation and Reporting of QI Projects

Ongoing Reporting

On an ongoing basis, each project manager/sponsor will monitor their project. If there are necessary changes that are being presented while the project is taking place, the project manager is to make sure to make note of these when closing out a project.

Project End Reporting

Stand QI Projects: Once a standard project is complete, the project sponsor will finalize their storyboard and submit to the QMIC for review and suggestions for improvement. Once done, QMIC will send their recommendations to the ELT for review and the storyboard will be placed on the company's website.

Rapid Improvement Projects: Rapid Improvement Projects are to have a final report to QMIC. Once a quarter, QID will report to the CEO on how many Rapid Improvement Projects have been completed or in progress for the Board to review.

QMIC to ELT Reporting

The QMIC will send a quarterly report to the ELT of ongoing projects and the submissions. The QI Director and/or QMIC Chairman will track and monitor all projects and submit the quarterly report to Health Board.

Quality Management & Improvement Committee Members

Member Title	Role	Service Area
Director of QA/QI	Chairperson	Quality
Director of Behavioral Health	Member	Behavioral Health
Director of Dental Services	Member	Dental
Director of Facilities	Member	Facilities
Director of HIMS	Member	Health Information Management
Director of Optometry	Member	Optometry
Director of Pharmacy	Member	Pharmacy
Director of Purchase Referred Care	Member	Purchase Referred Care
Director of Public Health	Member	Public Health
Infection Preventionist	Member	Infection Prevention/Employee Health
Case Management	Member	Outpatient Department
Safety Manager	Member	Safety
Chief Medical Officer	Member	Executive Leadership
Quality Data Analyst	Member	Quality
Clinical Informatics Coordinator	Member	Quality
Director of Nursing	Member	Outpatient Department
Executive Assistant to the CEO	Recorder	Administration
CEO	Ex-Oficio	Executive leadership
Compliance Officer	Member	HIPAA Compliance

Quality Management Improvement Training

QI principles, tools, and techniques will be provided to staff on a continual basis in an effort to build a quality-focused culture at KPHC. A summary of QI training and participation will be provided to the QI Committee annually.

1. All staff will receive an annual orientation to include an overview of KPHC's QI initiative, its major components, and how these components support the goals of their department.
2. All staff are required to complete training on incident reporting and navigating KPHC's electronic incident reporting system.

Additional trainings will be provided as needed; for instance, staff training in the use of evidence-based and model practices at the request of QI team leads/sponsors.

The QMI Committee recommends opportunities for recognition of staff participating in QI efforts in their department. The committee should make concrete efforts to recognize and thank staff for participating in QI teams and using QI methods and tools in their daily work. Additionally, staff who complete the training program outlined above will receive a certificate of completion.

QI Training Resources

QI training is typically done through the Institute for Healthcare Improvement (IHI) on an annual basis and staff can utilize their allocated budgeted training dollars to attend training courses.

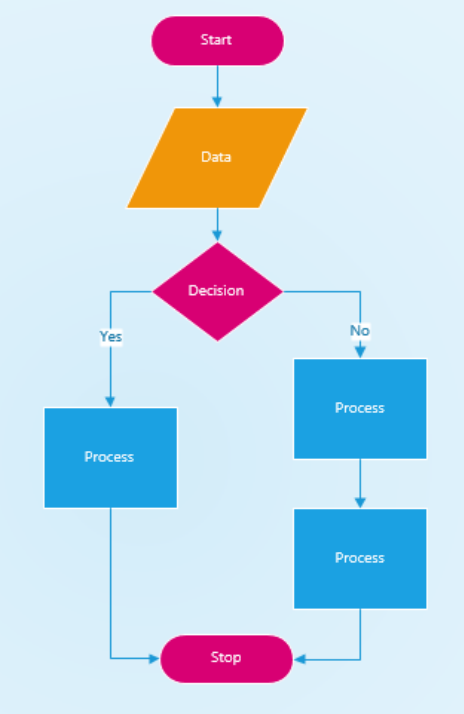
Quality Management & Improvement Metrics

S.A.M. Domain	Indicator	Performance Goal
DESIGN & MAINTAIN CONSISTENT, COMPLIANT, **SAFE**, & EFFECTIVE PROCESSES	GPRA measures performance	Increase from previous year across the MEC accepted indicators
	QMI Projects Approved	≥ 5
	Medication Errors; impacting patient outcomes	no increase from previous year
	Adverse events	Zero adverse events

Appendix A – Quality Improvement Tools

The following are some of the tools available to assist in the Quality Improvement process.

1. **Flow Charting**: Use of a diagram in which graphic symbols depict the nature and flow of the steps in a process. This tool is particularly useful in the early stages of a project to help the team understand how the process currently works. The "as-is" flow chart may be compared to how the process is intended to work. At the end of the project, the team may want to then re-plot the modified process to show how the redefined process should occur. The benefits of a flow chart are that it:
    a. Is a pictorial representation that promotes understanding of the process
    b. Is a potential training tool for employees
    c. Clearly shows the problem areas and the processes needed for improvement.



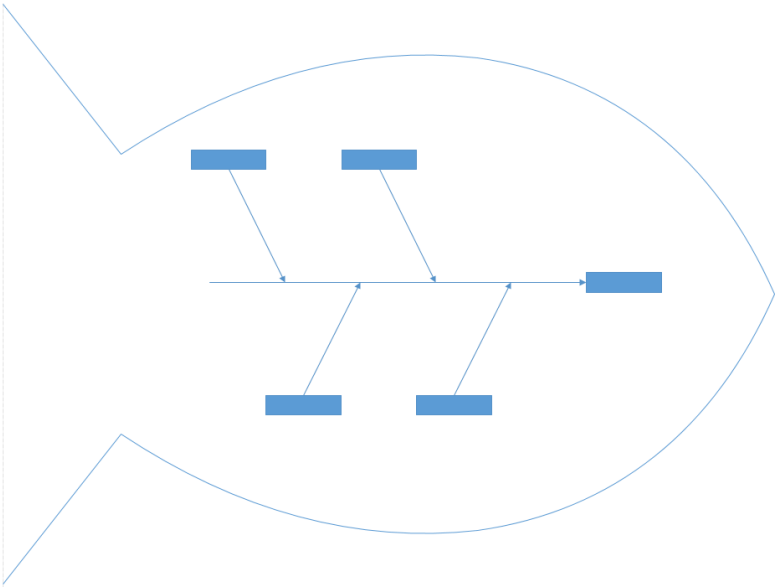
Flow charting allows the team to identify the actual flow-of-event sequence in a process.

2. **Brainstorming:** A tool used by teams to bring out the ideas of each individual and present them in an orderly fashion to the rest of the team. Essential to brainstorming is to provide an environment free of criticism. Team members generate issues and agree to "defer judgement" on the relative value of each idea. Brainstorming is used when one wants to generate a large number of ideas about issues to tackle, possible causes, approaches to use, or actions to take. The advantages of brainstorming are that it:
    a. Encourages creativity;
    b. Rapidly produces a large number of ideas;
    c. Equalizes involvement by all team members;
    d. Fosters a sense of ownership in the final decision as all members actively participate; and

e. Provides input to other tools: “brain stormed” ideas can be put into an affinity diagram or they can be reduced by multi-voting.

3. **Affinity Diagram:** The Affinity Diagram is often used to group ideas generated by brainstorming. It is a tool that gathers large amounts of language data (ideas, issues, opinions) and organizes them into groupings based on their natural relationship. The affinity process is a good way to get people, who work on a creative level, to address difficult, confusing, unknown or disorganized issues. The affinity process is formalized in a graphic representation called an affinity diagram. This process is useful to:
    a. Sift through large volumes of data; and
    b. Encourage new patterns of thinking.

    As a rule of thumb, if less than 15 items of information have been identified, the affinity process is not needed.
4. **Cause and Effect Diagram (also called a fishbone or Ishikawa diagram):** This is a tool that helps identify, sort, and display. It is a graphic representation of the relationship between a given outcome and all the factors that influence the outcome. This tool helps to identify the basic root causes of a problem. The structure of the diagram helps team members think in a very systematic way. The benefits of a cause-and-effect diagram are that it:
    a. Helps the team to determine the root causes of a problem or quality characteristic using a structured approach;
    b. Encourages group participation and utilizes group knowledge of the process;
    c. Uses an orderly, easy-to-read format to diagram cause-and-effect relationships;
    d. Indicates possible causes of variation in a process;
    e. Increases knowledge of the process; and
    f. Identifies areas where data should be collected for additional study.

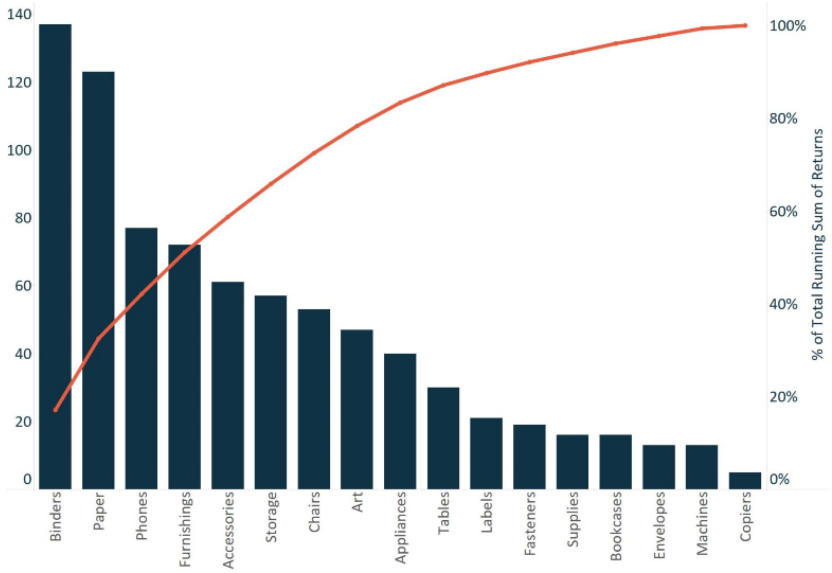


Cause and effect diagrams allow the team to identify and graphically display all possible causes related to a process, procedure or system failure.

5. **Histogram:** This is a vertical bar chart which depicts the distribution of a data set at a single point in time. A histogram facilitates the display of a large set of measurements presented in a table, showing where the majority of values fall in a measurement scale and the amount of variation. The histogram is used in the following situations:
    a. To graphically represent a large data set by adding specification limits one can compare; or

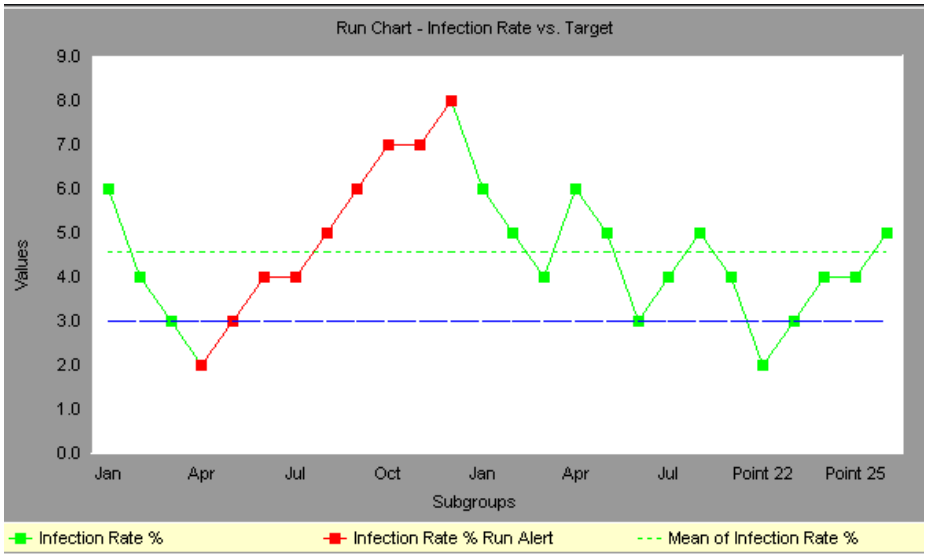
b. To process results and to determine if a current process was able to produce positive results assist to with decision-making.

6. **Pareto Chart:** Named after the Pareto Principle which indicates that 80% of the trouble comes from 20% of the problems. It is a series of bars on a graph, arranged in descending order of frequency. The height of each bar reflects the frequency of an item. Pareto charts are useful throughout the performance improvement process - helping to identify which problems need further study, which causes to address first, and which are the "biggest problems." Benefits and advantages include:
    a. Focus on most important factors and help to build consensus; and
    b. Allows for allocation of limited resources.



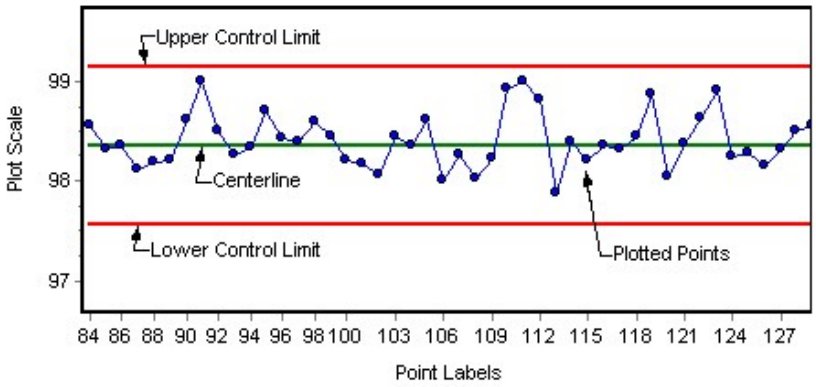
The "Pareto Principle" says 20% of the source causes 80% of the problem. Pareto charts allow the team to graphically focus on the areas and issues where the greatest opportunities to improve performance exist.

7. **Run Chart:** Most basic tool to show how a process performs over time. Data points are plotted in temporal order on a line graph. Run charts are most effectively used to assess and achieve process stability by graphically depicting signals of variation. A run chart can help to determine whether or not a process is stable, consistent and predictable. Simple statistics such as median and range may also be displayed. The run chart is most helpful in:
    a. Understanding variation in process performance;
    b. Monitoring process performance over time to detect signals of change; and
    c. Depicting how a process performed over time, including variation.



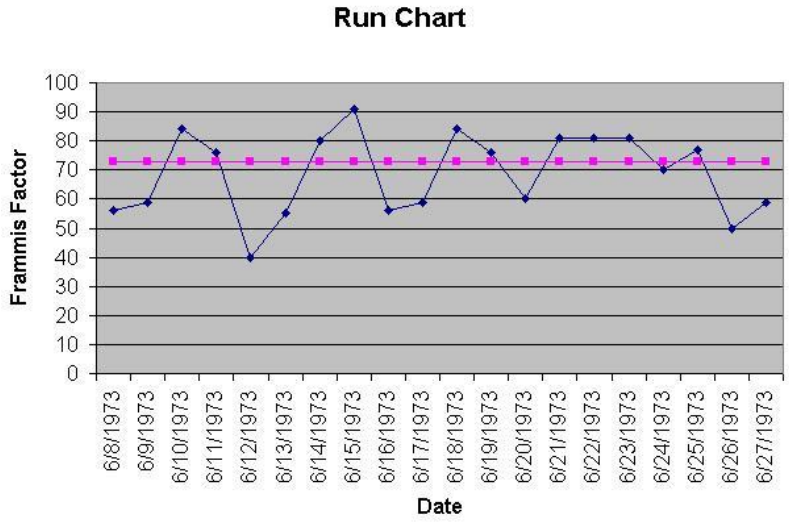
Allows the team to see changes in performance over time. The diagram can include a trend line to identify possible changes in performance.

8. **Control Chart:** A control chart is a statistical tool used to distinguish between variation in a process resulting from common causes and variation resulting from special causes. Special Cause Variation refers to unexpected glitches that affect a process. Common cause variation is variation that results simply from the numerous, ever-present differences in the process. Control charts can help to maintain stability in a process by depicting when a process may be affected by special causes. The consistency of a process is usually characterized by showing if data fall within control limits based on plus or minus specific standard deviations from the center line. Control charts are used to:
    a. Monitor process variation over time;
    b. Help to differentiate between special and common cause variation;
    c. Assess the effectiveness of change on a process; and
    d. Illustrate how a process performed during a specific period.



Using upper control limits (UCLs) and lower control limits (LCLs) that are statistically computed, the team can identify statistically significant changes in performance. This information can be used to identify opportunities to improve performance or measure the effectiveness of a change in a process, procedure, or system.

9. **Bench Marking:** A benchmark is a point of reference by which something can be measured, compared, or judged. It can be an industry standard against which a program indicator is monitored and found to be above, below, or comparable to the benchmark.



10. **Root Cause Analysis:** A root cause analysis is a systematic process for identifying the most basic factors/causes that underlie variation in performance.

Appendix B – Nomination Questionnaire

Kewa Pueblo Health Corporation

Quality Management & Improvement Project Nomination Questionnaire

Name: Click or tap here to enter text.. **Title:** Click or tap here to enter text.
Date: Click or tap here to enter text.

1. Please describe the underlying issue or the process you would like to improve:
   Click or tap here to enter text.

2. KPHC Primary Outcome Alignment:
   ☐ Align KPHC's Patient Value Proposition to Improve the Patient Experience
   ☐ Promote Long Term Sustainability, Growth, and Transparency in Operations
   ☐ Design and Maintain Consistent, Compliant, Safe, & Effective Processes
   ☐ Strengthen Organizational Capital to Fulfil Dynamic Industry & Community Needs

3. Do you have information/evidence/data available to support the need to work on this topic?
   ☐ Yes ☐ No

a. If yes, please explain how the data shows a need for improvement:
   Click or tap here to enter text.

4. How was this process issue/problem identified?
   ☐ Performance Management System
   ☐ Program Audit
   ☐ Grant Audit
   ☐ Process Improvement
   ☐ Other (please specify): Click here to enter text.

5. What kind of improvement will result? (Check all that apply)
   ☐ Increased efficiency
   ☐ Improved safety
   ☐ Improved quality of service
   ☐ Improved use of resources
   ☐ Improved teamwork and communications
   ☐ Improved working conditions and employee morale
   ☐ Enhanced employee performance
   ☐ Reduced waste
   ☐ Satisfied customers and/or stakeholders
   ☐ Reduced cost
   ☐ Other (please specify Click or tap here to enter text.

Appendix B – Nomination Questionnaire

Kewa Pueblo Health Corporation

6. Describe what change you expect to *see* in the program/process? (Example: Fewer errors in data entry; reduced wait time): Click here to enter text.

7. Who will benefit? (Check all that apply)
   - ☐ Program
   - ☐ Service Area
   - ☐ Department
   - ☐ External Stakeholders
   - ☐ Public
   - ☐ Other (please specify): Click or tap here to enter text..

8. Optional: Do you have a project plan/charter in mind?
   ☐ Yes ☐ No
   a. If yes, please describe. Consider project scope, measures of success, resources (time and money), limitations and barriers, timelines, etc.
   Click or tap here to enter text.

9. Have you previously discussed this with your coordinator?
   ☐ Yes ☐ No

Quality Improvement Committee Review (Office Use Only):
Date: Click or tap here to enter text.
☐ Approved
☐ Returned for Further Development/Alignment
Date sent to ELT for Approval: Click or tap here to enter text.

Appendix C – Rapid Improvement Event Report

Rapid Improvement Event Report: ___/___/___ Days

AIM Statement/Initiative: *What are we trying to accomplish?*
To get our glaucoma and glaucoma suspect patients to return for their regular monitoring visits and to resume therapy if they have discontinued. Many patients have been lost to follow up due to COVID-19. The goal is to prevent a preventable cause of vision loss.

**fill in highlighted areas*

Smallest Change Necessary: 1 patient
Scope: All patients seen since 08/2017 with diagnoses of any type of glaucoma or glaucoma suspect/preglaucoma
Planning Timeframe: May and June, 2021 **Next Review Date (Next Qtr):** 10/2021
Materials/Resources: Paper and staff time

Measures:

How will we know that a change is an improvement?	*How much?*	*By When?*
Patients with glaucoma and glaucoma suspect diagnoses are scheduled for visits	Preventing blindness in one patient makes the project worthwhile	Within a minimum of thirty (30) days of initial contact with patient, patient will be scheduled and seen.

Small tests of change: *What change can we make that will result in improvement?*

PLAN *What changes are to be made?*	**DO** *What do we predict? Plan?*	**STUDY** *Document observations* ***w/data source:***	**ACT** *What is next?*
1. Recalling patients that have not returned for glaucoma follow-ups and monitoring.	We predict that patients with a diagnosed type of glaucoma or suspected glaucoma will be scheduled and seen within thirty days of initial contact. We plan to schedule appointments for these patients. High risk patients will be recalled first, low risk second.	Patients are scheduled and show for their appointments and testing which will be verified in their patient chart in NextGen.	Testing recall methods (phone calls/letters) to get patients back for care. Educating patients on the importance of theses visits in the future.

Appendix C – Rapid Improvement Event Report

Rapid Improvement Event Report: ___/___/___ Days

Key Measures *attach graph/tables	Baseline	__7__ Days	__14__ Days	__21__ Days	Goal: 30 Days
Metric:					
Metric:					
Metric:					

Appendix D – 10-Step Study Form

Phase II: Quality Improvement Study 10-Steps
[INSERT Study Title]
[INSERT Project lead and department]

Component 1	Description:	Hints for Getting Started
	A statement of purpose of the QI activity that includes a description of the known or suspected problem, and explains why it is significant to the organization.	*Briefly state your known or suspected problem. * Describe why it is important for your organization to address this problem.
	Use the space below to state the purpose of the QI study you are conducting, and to describe why it is important for your organization to address this problem.	

Component 2	Description:	Hints for Getting Started
	Identification of the performance goal against which the organization will compare its current performance in the area of study.	Determine and describe the level of performance your organization wants to achieve in the area of study. For example, if you are studying medication error rates, your goal might be to have zero medication errors. If you are studying rates of compliance with a particular policy, your goal might be 100% compliance. Before setting your goal, it is often useful to determine if there are internal or external benchmarks available to help you decide on a goal that is both realistic and constructive. Zero occurrences or 100% compliance may not be realistic for every issue you study.
	Use the space below to identify the performance goal for the QI study you are conducting.	

Component 3	Description:	Hints for Getting Started
	Description of the data that have been or will be collected in order to determine the organization's current performance in the area of study.	Determine the following: 1. What data is needed in order to verify: * Whether the problem actually exists (if this is uncertain) * Frequency and severity of the problem expressed as a number or percentage. * Source(s) of the problem 2. How will the data be collected? For example, if you are studying medication error rates, what information do you need in order to determine your current error rates? How will you collect that information?
	Use the space below to describe the data you will collect for the QI study you are conducting, and how you will collect it.	

Appendix D – 10-Step Study Form

Component 4	Description:	Hints for Getting Started
	Evidence of Data	Describe the data you actually collected. For example, did you review X number of charts for patient visits that occurred from Month A to Month F? What did you look at in those charts?? What information did you extract from them? How did you record the data that you collected? At this point you are not trying to describe your conclusions about the data- just the data itself.
	AFTER YOU HAVE COLLECTED THE DATA FOR THE QI STUDY, use the space below to briefly describe the data collected.	

Component 5	Description:	Hints for Getting Started
	Data analysis that describes findings about the frequency, severity, and sources of the problem(s).	1. Carefully analyze the data you have collected. (The complexity of analysis you need to do will depend on various factors, such as the amount and type of data you have collected.) 2. Determine what the data tells you about whether the suspected problem actually exists. Describe how the data was analyzed and your findings (conclusions) regarding whether or not the problem exists. 3. If the problem DOES exist, determine what the data tells you about the frequency, severity, and source(s) of the problem(s).
	Use the space below to briefly state your comparison of current performance vs. goal for the QI study you are conducting.	

Component 6	Description:	Hints for Getting Started
	A comparison of the organization's current performance in the area of study against the previously identified performance goal.	Compare the results of your data analysis to the performance goal you identified in Component 2. For example, if the data indicates that you are currently have 65% compliance and the goal is 90% compliance, a simple statement to that effect is sufficient.
	Use the space below to briefly state your comparison of current performance vs. goal for the QI study you are conducting.	

Component 7	Description:	Hints for Getting Started
	Implementation of corrective action(s) to resolve identified problem(s).	1. Based on what you have learned about the frequency, severity, and source(s) of the problem(s), determine what corrective action(s) you will take to improve your performance in the area of study. 2. Implement the selected corrective action(s) and determine the appropriate length of time until re-measurement is to occur.
	Use the space below to describe what corrective action(s) were taken for the QI study you are conducting, including how the corrective actions were implemented.	

Appendix D – 10-Step Study Form

Component 8	Description:	Hints for Getting Started
	Re-measurement (a second round of data collection and analysis) to objectively determine whether the corrective actions have achieved sustained demonstrate improvement.	1. At the designed re-measurement time, repeat the steps shown for Components 4 and 5. 2. Compare the results of your second round of data collection and analysis to the performance goal you identified as Component 2, and determine whether the corrective actions have achieved the desired performance goal.
	Use the space below to describe the second round of data collected and how you collected it. Also state your comparison of the new current performance vs. goal for the QI study you are conducting.	

Component 9	Description:	Hints for Getting Started
	If the initial corrective action(s) did not achieve and/or sustain the desired improved performance, implementation of additional corrective action(s) and continued re-measurement until the problem is resolved.	1. Determine whether this step is applicable to the study you are conducting. If you have met and are sustaining your performance goal, this step does not apply. 2. If this step does apply, repeat the steps shown for Components 7 and 8 until your performance goal has been achieved in a sustainable manner.
	**USE THE SPACE BELOW TO INDICATE WHETHER THIS STEP APPLIES TO THE QI STUDY YOU ARE CONDUCTING. IF IT APPLIES, DESCRIBE WHAT ADDITIONAL CORRECTIVE ACTION(S) WERE TAKEN FOR THE QI STUDY YOU ARE CONDUCTING, INCLUDING HOW THE CORRECTIVE ACTIONS WERE IMPLENTED. ALSO DESCRIBE THE ADDITIONAL ROUND OF DATA COLLECTED AND HOW YOU COLLECTED IT, AND STATE YOUR COMPARISON OF THE NEW CURRENT PERFORMANCE VS. GOAL FOR THE QI STUDY YOU ARE CONDUCTING.*	

Component 10	Description:	Hints for Getting Started
	Communication of the findings of the quality improvement activities: *to the governing body *throughout the organization, as appropriate	1. Report your QI study and its results to your governing body. Ensure that the governing body's review of the report is appropriately documented. 2. Determine who else in the organization needs to know about the results of the study. Communicate the findings to those people, and document that this has occurred. 3. Determine whether other educational activities of the organization should reflect the findings of the study. If so, take appropriate steps to have this occur.
	**USE THE SPACE BELOW TO DESCRIBE HOW THE RESULTS OF THE STUDY WILL BE REVIEWED BY THE GOVERNING BODY, AND HOW THIS REVIEW WILL BE DOCUMENTED. ALSO DESCIBE OTHER GROUPS THAT WILL BE NOTIFIED OF THE STUDY'S RESULTS, AND HOW THIS NOTIFICATION WILL TAKE PLACE, AND EDUCATIONAL ACTIVITIES THAT WILL TAKE PLACE AS A RESULT OF THE STUDY.*	

Date submitted to KPHC Health Board _____

Health Board Chair signature _____

Appendix E – Strategic Alignment Map