

Walter Reed National Military Medical Center Quality Council Charter

Purpose

The Quality Council

- Assesses and describes WRNMMC's posture relative to selected industry benchmarks for health care quality and patient safety.
- Identifies and implements effective strategies to improve and sustain our performance against these benchmarks.
- Serves as the primary forum for effective, instant and multi-channel performance improvement and patient safety communications among invested organization leaders and stakeholders.

Chartering Authority

The WRNMMC Quality Council (QC) is chartered by the Director, Walter Reed National Military Medical Center.

Scope of Authority

The WRNMMC Quality Council is a decision-making body, subject to the guidance of the Board of Directors and the Hospital Director.

Decision-making

The QC is co-chaired by the WRNMMC Chief of Staff and the Assistant Chief of Staff for Quality, who will manage the decision-making process, which will be a consensus model. This model is based on the principles of: (1) making decisions that are in the best interests our patients and their families; (2) listening to the views of others; (3) critical thinking and encouraging dissenting opinions in the spirit of working toward unity; (4) voting only after adequate relevant discussion to avoid premature or uninformed decision-making.

A yes vote signals that the member either supports a proposal or can accept it, even if not their first choice. A no vote signals that the member does not support the proposal, in which case the member is expected to articulate objections. Members may cast a vote of abstention. The Chief of Staff is the final arbiter. The Assistant Chief of Staff for Quality is the final arbiter in the absence of the Chief of Staff. Once a decision is made, it becomes our collective decision with the full support of each and all members in its execution.

In order to preserve the complete product of the Council's decisions, all dissenting opinions, and the rationale(s) for same, shall be captured in the minutes.

Scope of Practice

The WRNMMC Quality Council will:

- Identify or develop reliable performance benchmarks for quality and patient safety.
- Accurately describe WRNMMC's position in relation to these benchmarks.
- Develop, implement and sustain effective strategies to improve WRNMMC's performance to these benchmarks.
- Charter, no less frequently than every 18 months, pro-active risk reduction activities (Failure Modes and Effects Analysis [FMEA]).
- Serve as a venue for the complete integration of graduate medical education (GME) and hospital quality and patient safety programs.
- Minimize the administrative burden of performance improvement so that our limited resources are invested in system/process analysis and change, versus the generation of minutes and reports.
- Drive the quality functions through established lines of leadership and authority, reinforcing that the primary responsibility of medical leadership is the provision of safe, high-quality care and services.
- Ensure the WRNMMC Annual and Strategic plans establish and drive priorities for quality.

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Membership

- Chief of Staff (Co-Chair)
- ACoS for Quality (Co-Chair)
- ACoS, for Special Assistants
- Chair, ECOMS
- Chair, ECONS (Director for Nursing)
- Assistant Director, Nursing
- Assistant Director, Administration (Co-Chair, EOC Committee)
- Assistant Director, Readiness & Operations
- Assistant Director, Surgery
- Assistant Director, Medicine
- Assistant Director, Education, Training and Research
- Assistant Director, Resources
- Assistant Director, Clinical Support Services
- Assistant Director, Behavioral Health
- Assistant Director, Dental
- DiLorenzo TRICARE Health Clinic Representative
- Operations Innovation
- USUHS Family Health Clinic
- Simulation Center (Sim Center) Representative
- Senior Enlisted Representative(s)
- Pharmacy Representative
- House Staff – Medicine
- House Staff – Surgery
- House Staff – Behavioral Health
- House Staff - Pediatrics
- Medical Director, Health Care Operations
- Assistant Director, NICOE
- Patient Safety Program Manager
- Risk Manager
- Performance Improvement Coordinator
- Chief, Patient Relations Department
- Chief, Joint Commission Accreditation
- Staff Legal Representative/JAG
- Chief, Infection Prevention & Control
- Assistant Director, Graduate Medical Education
- Chair, Medication Management Function Team
- Chair, Ethics Committee
- Chair, CLER Committee

Sub-Committees

The Quality Council will charter teams and standing sub-committees as needed to execute its mission. Currently, the Council has chartered the following sub-committees:

- Environment of Care Committee – Chair: Director for Administration
- Medication Management Function Team – Chair: David Green, PharmD

Business Rules

Meeting Schedule

The Quality Council will meet three times each month. Two QC Working Sessions will meet on the 2nd and 4th Wednesday of each month from 1300 – 1500. One Quality Forum, composed of the Chairs and representatives from the Council will meet with the Board of Directors and SELs on the 3rd Monday of each month, from 0830 – 0930.

Agendas

Meeting Agendas will be approved by the QC Chairs. Agendas will be populated and provided to expected attendees no later than close-of-business the Monday prior the Wednesday Working Sessions and the Wednesday prior to the Monday Forum. Calls for agenda items will go out by close-of-business the Monday (10 days) prior to the next week's Working Session meeting, with responses required for consideration no later than close-of-business the Wednesday prior to the meeting (48 hours from agenda call).

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Attendance

Attendance by all Council members is mandatory. Each member is expected to designate a permanent substitute, who will attend in the member's absence. The substitute is to receive all meeting materials and briefs, and prepared to vote. Attendance will be recorded using the grid provided as enclosure (1).

Minutes and Issue Tracking

Minutes will be recorded using the CRAFE Template provided as enclosure (2) and issue tracking will be accomplished using the excel Issue Tracking Template provided as enclosure (3).

Minutes will be approved within 10 days by at least one Chair after querying the members electronically for accuracy.

Reporting

Reports to the Council will be presented in the WRNMMC Quality Council Report Template provided as enclosure (4).

Benchmarking

The primary function of the Quality Council begins with the identification, careful definition and implementation of reliable industry benchmarks for quality and patient safety. Potential quality and patient safety benchmarks are listed as enclosure (5). Each of these benchmarks shall be fully defined, using the WRNMMC Indicator Definition Template, as enclosure (6).

The organization's position against selected benchmarks shall be captured and displayed graphically via the Quality Council Dashboard, and communicated monthly to the WRNMMC Board of Directors. Council initiatives in response to these data will be chartered by the QC, and that charter and team progress will be captured and reported, using the WRB Plan of Action and Milestones (POAM) Template, enclosure (7), and summarized and preserved using the WRB Quality Improvement Report (QIR) Template, enclosure (8).

JEFFREY B. CLARK
BG, MC
Director

WRNMMC Quality Council Attendance Grid

Members	2014											
	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
CoS (Chair)												
ACoS, Quality (Co-Chair)												
ACoS, Special Assistants												
Chair, ECOMS												
Chair, ECONS/DNS												
AD – Nursing												
AD – Readiness and Operations												
AD – Administration												
AD – Surgery												
AD – Medicine												
AD – Education/Training/Research												
AD – Resources												
AD – Clinical Support												
AD – Behavioral Health												
AD – Dental												
Representative - DTHC												
Representative – Pharmacy												
House Staff – Medicine												
House Staff – Surgery												
House Staff – Behavioral Health												
House Staff – Pediatrics												
Medical Director, HCOPS												
AD – NICoE												
Risk Manager												
PS Program Manager												
PI Coordinator												
Chief, Patient Relations												
Chief, Joint Commission Accreditation												
Representative – Staff Legal												
Chief, Infection Prev/Ctrl												
AD – GME												
Chair, MMFT												
Chair, Ethics Committee												
Chair, CLER Committee												
Representative – Simulation Center												

Key:

P=Present

E=Excused

P/A=Represented by Acting

A=Absent/unexcused

WRNMMC Quality Council Attendance Grid

Comments:

Key:

P=Present

E=Excused

P/A=Represented by Acting

A=Absent/unexcused

MEMORANDUM

From: Chair, Quality Council
To: Director, Walter Reed National Military Medical Center

Subj: MINUTES OF [DATE] QUALITY COUNCIL WORKING SESSION

Encl: (1) Agenda
(2) Attendance Roster
(3) – (x) Quality Council Reports

1. The Chair, Quality Council convened the meeting at (time)
2. Old Business
 - a. YYMMDD##: Issue title
 - (1) Discussion:
 - (2) Conclusion(s);
 - (3) Recommendation(s):
 - (4) Action Individual:
 - (5) Follow-up date:
 - (6) Evaluation:
3. New Business
 - a. YYMMDD##: Issue title
 - (1) Discussion:
 - (2) Conclusion(s);
 - (3) Recommendation(s):
 - (4) Action Individual:
 - (5) Follow-up date:
4. Administrative Announcements
5. The meeting was adjourned at (time).



Walter Reed
National Military
Medical Center

Quality Council Improvement Report

Date:

Presenter Name:

Initiative Name



- TJC Standard and EP (if applicable):
- Corresponding Strategic Pillar and/or Foundation:

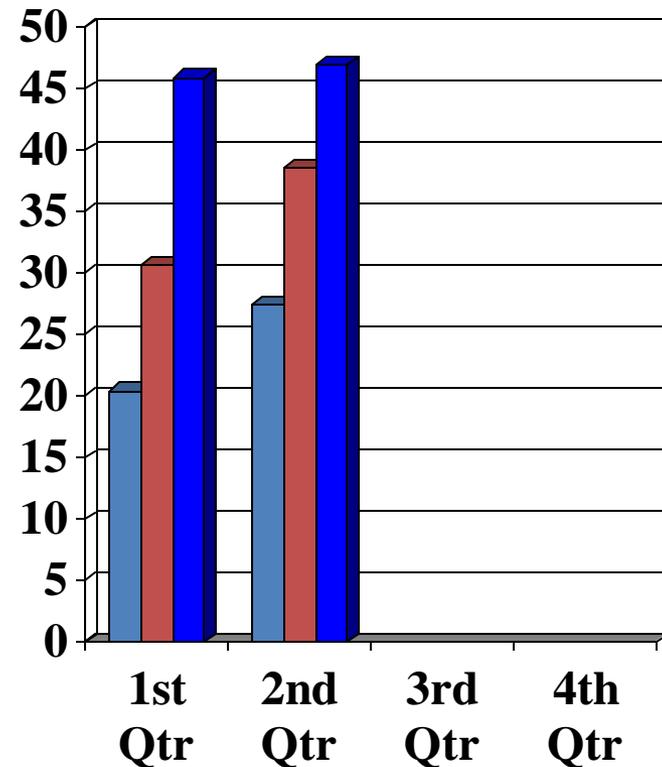
- Quality Council Champion
- Team Leader
- Team Members





Pre-Intervention Data

- Show data which drove the decision to intervene.
- Identify source of data, sampling methodology and statistical tool(s) used.





- What intervention(s) was/were selected, how they were selected (FOCUS-PDCA?)
- How was the intervention implemented?
- How is improvement to be measured (metrics w/thresholds)?





Intervention(s)

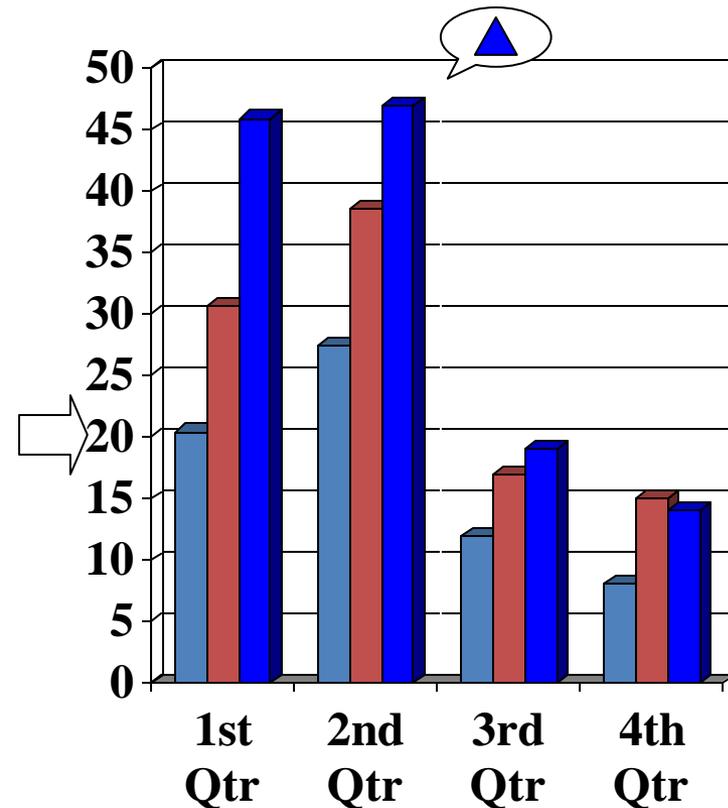
- Intervention which produced the quality improvement (describe in detail the steps taken, pitfalls encountered, resource requirements and time factors)





Post-Intervention Data

- Show data demonstrating impact of intervention(s).
- Identify source of data, sampling methodology and statistical tool(s) used.





- Evaluation - *Provide your team's analysis of the impact of the intervention(s), both expected and unexpected.*
- *Was it effective?*
- *Were the results expected?*
- *Were there any unexpected results – were there any collateral impacts resulting from the intervention(s)?*
- *What is your team's plan for sustainment?*
- *Are the gains being held?*



Recommendations going forward

- *What are your team's recommendations going forward?*
- *Is there any assistance that is required?*
- *Does the team need help with resources, participation, buy-in, or any other obstacles?*
- *Are there opportunities to export these lessons to other parts of the organization?*



Potential benchmarks for quality and patient safety may include the following:

- Patient Safety Measures
 - NPSG Implementation
 - Patient Safety Triggers Data
 - Restraint & Seclusion Data
 - Unplanned elevations in care
 - Unplanned returns to the MOR
 - ED Visits within 72 Hrs. Of Outpatient Visit
 - Implementation and sustainment of recommendations from
 - Root Cause Analyses (RCAs)
 - Sentinel Event Alerts Gap Analyses (SEA)
 - Failure Modes and Effects Analyses (FMEA)
- Clinical Measures
 - Outcomes Measures
 - Oryx risk-adjusted outcomes measures
 - NSQIP
 - NPIC
 - College of Thoracic Surgeons database performance
 - Device Associated Infections (DAI)
 - Surgical Site Infections (SSI)
 - Unplanned re-admissions (Code Red)
 - Hospital-Acquired Venous Thromboembolism (VTE) incidence
 - Hospital-Acquired Pressure Ulcer Incidence
 - Process Measures
 - CPG Implementation & Performance
 - Oryx Performance
 - Accountability Measure Performance Index
 - HEDIS Performance
- Accreditation Readiness
 - Joint Commission
 - Accreditation Survey recommendations
 - Mock Survey recommendations
 - Tracer Team findings
 - Environment of Care Team recommendations
 - Medication Management Function Team (MMFT) Tracer recommendations
 - PFP/S3 Data
 - Continuous Accreditation Readiness (CAR) self-assessment data
 - Staffing Effectiveness data
 - Patient Flow data
 - ACGME/CLER
 - College of American Pathologists (CAP)
 - Tumor Registry
 - Other accreditations/certifications/etc.
- Patient Satisfaction
- Staff Satisfaction

WRNMC Indicator Definition Template

Indicator Name		Rationale For Selection	
Data Source(s)		Points of Contact	Reporting Frequency
Numerator			
Denominator			
Formula/Definition		Targets/Benchmarks	
		Red:	Yellow: Green:
		Benchmark Source	
Exclusion Criteria (if applicable)			
Inclusion Criteria (if necessary)			
Comments/Remarks			

WRNMMC Quality Council
Quality Improvement Report (QIR) Template

Date of Report:

Issue Number (if applicable):

Issue Title:

TJC Standard and EP (if applicable):

Corresponding Strategic Pillar and/or Foundation:

Team Leader:

Quality Council Champion:

Team Members:

-

Abstract:

Briefly outline the scope of the process or function (not the problem). Be sure to include department(s) involved [i.e., is this cross-departmental? Cross-functional?]. Also, illustrate patient impact (demographics, numbers, risk) and/or cost impact (dollars, manhours).

Key Words:

List keywords to assist us with cataloging.

Discussion:

Pre-Intervention Data

Show data that drove the decision to intervene, and your/your team's conclusions on the data.

Identify the data source(s), any sampling methodology and statistical tool(s) used.

The Plan

What interventions were selected, how (techniques/methods).

How were the interventions implemented?

Who implemented them?

How was success defined and measured?

The Intervention

Describe in detail the steps taken, pitfalls/obstacles encountered, resource requirements and time factors.

Post Intervention Data

Show the data's response to the interventions taken (both positive and negative)

Identify the data source(s), any sampling methodology and statistical tool(s) used.

Note: The data source(s), sampling and analysis should include an identical method to that used in the Pre-Intervention, to afford a credible and valid comparison.

WRNMMC Quality Council
Quality Improvement Report (QIR) Template

Evaluation

Provide your team's analysis of the impact of the intervention(s), both expected and unexpected.

- *Was it effective?*
- *Were the results expected?*
- *Were there any unexpected results – were there any collateral impacts resulting from the intervention(s)?*
- *What is your team's plan for sustainment?*
- *Are the gains being held?*

Recommendations Going Forward

What are your team's recommendations going forward?

Is there any assistance that is required?

Does the team need help with resources, participation, buy-in, or any other obstacles?

Are there opportunities to export these lessons to other parts of the organization?