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| --- | --- | --- | --- | --- | --- |
| **Hospital Name** | | | | | |
| **QI Focus** | | | | | |
| QI Focus: | If your institution is planning to address multiple focus areas of the workflow as part of your intervention, please complete a QI Implementation Project Charter for each area of focus.  **Example:**  *Assessment* | | | | |
| QI Focus Goal(s): | Brief statement(s) that identify improvement goal(s) for chosen QI Focus area. It is recommended to limit this statement to two sentences. Goal statement(s) are encouraged to be specific, measureable, achievable, relevant, and time-bound.  **Example:**  *Increase the number of patient referrals to a dietitian for patients admitted from the Emergency Department by December 31st 2017, in order to properly assess at-risk patients*  *Increase awareness of how to administer an assessment* | | | | |
| Target Date for Achieving Goals: | Target date for achieving desired goals for QI Focus area. This can be the end of the Post-Implementation period or sooner for applicable small improvement goals.  **Example:**  *October 31, 2017* | | | | |
| **QI Intervention Implementation Strategy** | | | | | |
| QI Intervention: | No more than 3 sentences to describe what and how your team will be implementing change in your hospital to achieve your QI Focus Goals.  **Example:**  *Pilot automated referral to dietitian feature in the electronic health record (EHR)*  *Educate clinical staff about the importance of addressing malnutrition* | | | | |
| Intervention Start Date and End Date: | Estimated intervention start date and target date for achieving goals.  **Example:**  Start: July 17, 2017; End: October 31, 2017 | | | | |
| Project Team Members Assisting with Implementation:\* | **Name/Title/Email:** | | | **Role/Responsibilities:** | |
| **Name/Title/Email:** | | | **Role/Responsibilities:** | |
| Internal Actions Needed for Implementation:\*  This section is for teams to document actions needed to implement their intervention in their facility and assign a team member for each action needed. | **Action 1:**  Actions needed at your hospital to start up and implement your intervention.  **Example:**  *Schedule a meeting with Jan from our education department* | | **Team Member Responsible:**  **Example:**  *Hillary Clark* | | **Target Date:**  **Example:**  *June 16, 2017* |
| **Action 2:** | | **Team Member Responsible:** | | **Target Date:** |
| **Action 3:** | | **Team Member Responsible:** | | **Target Date:** |
| **QI Intervention Monitoring Strategy** | | | | | |
| eCQMs:\*  Data used to inform eCQM reporting and to measure success(es). | **eCQM 1:**  **Example:**  *Completion of a Nutrition Assessment for those Identified as At-Risk by a Malnutrition Screening within 24 hours* | **Goal Measured:**  **Example:**  *Increase the number of patient referrals to a dietitian for patients admitted from the Emergency Department by December 31st 2017, in order to properly assess at-risk patients* | | | **Data Review Frequency:**  **Example:**  *Monthly* |
| **eCQM 2:** | **Goal Measured:** | | | **Data Review Frequency:** |
| **eCQM 3:** | **Goal Measured:** | | | **Data Review Frequency:** |
| Quality Indicator(s):\*  Measures, either developed by your team or pulled from the MQii Toolkit, that use inpatient administrative data to measure success(es). Recommend including measures to assess the implementation process as well as the outcome of your intervention where possible. | **Indicator 1:**  **Example:**  *Name of nurse who submitted referrals* | **Goal Measured:**  **Example:**  *Increase the number of patient referrals to a dietitian for patients admitted from the Emergency Department by December 31st 2017, in order to properly assess at-risk patients* | | | **Data Source:**  **Example:**  *EHR*  **Data Review Frequency:**  **Example:**  *Monthly by team and hospital leadership* |
| **Indicator 2:** | **Goal Measured:** | | | **Data Source:**  **Data Review Frequency:** |
| **Indicator 3:** | **Goal Measured:** | | | **Data Source:**  **Data Review Frequency:** |
| Other:\*  Metrics that use non-patient level data to measure success(es). Recommend including metrics to assess the implementation process, as well as the outcome of your intervention, where possible. | **Example:**  *Percentage of improvement from baseline on Knowledge Attainment survey following training* | **Goal Measured:**  **Example:**  *Increase awareness of how to administer an assessment* | | | **Data Source:**  **Example:**  *Awareness Survey*  **Data Review Frequency:**  *1-week following Assessment training* |
|  | **Goal Measured:** | | | **Data Source:**  **Data Review Frequency:** |
|  | **Goal Measured:** | | | **Data Source:**  **Data Review Frequency:** |
| **Team Operations** | | | | | |
| Team Management | Activities for maintaining communications with team members regularly and the approach for decision-making throughout the implementation period.  **Example:**  *The team will meet once per week on Tuesday mornings from 9 a.m. - 10 a.m. Decisions will be made by consensus, guided by criteria analysis where needed. If a consensus cannot be reached, the Project Champion will make the final decision.* | | | | |
| Potential Implementation Barriers | Consider any and all potential barriers that could impede progress implementing this intervention. For each identified barriers, include potential solutions. | | | | |

\*Add as many rows as needed

*Optional*

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| Team Member Initials: |  | Date: |  |
| Team Member Initials: |  | Date: |  |
| Team Member Initials: |  | Date: |  |
| Team Member Initials: |  | Date: |  |
| Team Member Initials: |  | Date: |  |
| Team Member Initials: |  | Date: |  |