The Committee for Clinical Excellence Scorecard

Purpose:
The CCE Scorecard has been developed in order to facilitate the following:

a) Consistent, well defined reporting method for all areas
b) Inclusion of quality data from multiple areas in reporting structure
c) Enhanced understanding and attention of each departmental leader on quality performance and QI in their areas
d) Elimination of the need to defer reports of quality data due to inability of departmental representative to attend meetings
e) Quick, intuitive review of facility-wide quality data and quality improvement / performance improvement action plans by administration and leadership at any time via the intranet
f) Single entry of quality data by each department leader – scorecard can be adapted and shared at departmental, service-line, and facility wide meetings.
g) Continual focus on facility-wide departmental quality, leading to quick, meaningful development of Annual Quality Report and flow of objectives into the next fiscal year – provides evidence of continuous, relevant quality journey. (Journey to Clinical Excellence)
h) Ease of reporting through the CCE, QRC/MEC, QPSC and the Board
i) Overall enhanced focus on facility-wide clinical quality performance and QI activities

Design/Components:

Inclusive of all Areas/Departments on the CCE Reporting Schedule. The scorecard includes horizontal divisions according to reporting schedule: monthly and the A, B, and C quarterly reporting groups.

The CCE Scorecard currently includes three tabs or worksheets. A fourth tab is being developed, as follows:

1) **Performance**: The first tab includes the metrics and performance trended for the current fiscal year. Also included on this worksheet are the data source and both monthly and year-to-date targets for each metric, as appropriate. The metric performance sheet is designed to support data that is reported monthly or quarterly. For quarterly data, the first two months of the quarter will be grayed-out, and the quarterly performance will be indicated in the last month of the quarter. If a metric is off target, the cell indicating performance will be colored red with white text.

2) **Metric Definitions**: The seconds tab includes metric definitions. All metrics included on the performance tab are defined by the leader responsible for data entry. This should only be necessary once at the initiation of the scorecard, and when metrics are changed or updated. Also included on this tab are explanations for target determination. This will
help others to understand the rationale for each target, whether it is based on an internal, system, or national benchmark, or is enforced by a regulatory agency.

3) **Action Plans:** The third tab is for Action Plans. If the most current performance for a metric is off target (whether this is for the month or quarter—for data reported by quarter), the leader should enter a short explanation on this page. This will demonstrate what is being done to improve, and when the intervention should have an impact on the data (the review date). If a metric remains off target, the action plan will not require update, unless the review date has passed. Therefore, in setting a review date, leaders should allow enough time for the intervention to impact data being displayed. For example, if the action plan is to impact data that is on a delayed schedule, the current intervention may not be evident for several months, in this case, the review date should be set accordingly, so anyone reviewing the scorecard understands not to expect an immediate improvement based on this intervention. All action plans should be maintained on the Scorecard for the entire fiscal year, so improvement activities are evident and can be tracked. Even when an action plan is updated or modified, the previous intervention should never be deleted. Rather, the new information should be typed under the first with a new review date.

4) **Goals:** A fourth tab is being built into the Scorecard. This will include annual goals for each area. This will facilitate the development of a summary at the end of the fiscal year that will form the annual quality report. Each leader will access this tab at the end of the fiscal year to document whether each goal was met, to close out those that were, and to define deficits, carry forward action plans, and advance continued goals onto the Scorecard for the next fiscal year.

**Reporting/Maintenance:**

Please see attached reporting schedule. This will be given in hard copy and emailed to all CCE members, and to all listed as responsible parties for departmental data.

**Data and action plans/updates are due the 15th of each reporting month.** Areas reporting quarterly are welcome to submit monthly data on a monthly basis and QM will update the Master Scorecard on the Share drive as the data is received. Data that is reported quarterly, is due the 15th of the reporting month, but should be submitted as soon as it is available.

Maintaining this Scorecard will require focused commitment from all in maintaining departmental data. **Deferring of quality reports is no longer an option**—data must be populated and available for report, including action plans, on the scheduled reporting date. Action plans do not require a lot of detail—one to two lines of explanation of the intervention will suffice, along with a responsible party and f/u date. If
the Director of QM has questions, she will call for more detail and facilitate adjustment to the action plan as needed. Failure to report data at least one week before the CCE meeting – according to the reporting schedule – will lead to escalation to the VP of the delinquent area and to the COO.

The CCE Scorecard will be reported at the CCE meeting, QRC and QPSC monthly according to the attached reporting schedule. Reports flow on a monthly basis from QRC to MEC. The CCE Scorecard will be reviewed at the Board, as requested, and at least twice annually. The CCE Scorecard will be used to facilitate presentation of the Annual Quality Report at CCE, QRC, MEC, EMT, QPSC, and the Board.

**Responsibility:**

*Quality Management* is most appreciative to all departmental leaders for their efforts in the initial development of the CCE Scorecard. QM will work with each area to maintain the data and action plans. QM is available and wants to help to maintain the CCE Scorecard as an important, useful tool for all.

**Departmental Leaders** – Maintain Scorecard up to date – updating data (and action plans, as necessary) by the 15th of the month according to the reporting schedule. Utilize scorecard regularly in tracking and analysis of quality data and QI activities.

**Quality Management** – Development of Scorecard. Ensure that Scorecard is complete and ready for monthly reporting, using escalation, as necessary. Resource to all in determination of metrics, goals, action plans, etc. Utilization of scorecard in analysis and reporting of quality data and QI activities. Work with Departmental leaders in development of Annual Quality Report, and new annual goals for each fiscal year.

**Executive Staff** – Enforce accountability in timely completion of scorecard by all departments. Utilize scorecard in tracking and analysis of quality data and QI activities. Provide feedback to CCE on metrics, goals, and action plans.

**Medical Staff** – Utilize scorecard in tracking and analysis of quality data and QI activities. Provide feedback to CCE on metrics, goals, and action plans.

**Board** – Utilize scorecard in tracking and analysis of quality data and QI activities. Provide feedback to CCE on metrics, goals, and action plans.