REGENCY HOSPITAL OF MINNEAPOLIS LLC
RESPONSE TO REQUEST FOR ADDITIONAL INFORMATION

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Table of Attachments

I. Background Information

1. Provide a comprehensive list, location, years in operation, and number of beds for all Select Medical Long-term Acute Care Hospitals.

Please see Attachment A.

2. Describe any specific community engagement activities already undertaken related to the proposed hospital beyond the list of relevant organizations.

All engagements undertaken by Regency Hospital of Minneapolis at its Golden Valley location will be applicable to the Proposed LTACH. Regency is engaged with the local Twin Cities community through several community organizational efforts initiated by Minnesota Brain Injury Alliance, Friends of Redeemer United, Minnesota "No to Homelessness" project, and Haven Housing at Saint Anne's Place. Its employees volunteer their time with these organizations throughout the year, and the employees of the Proposed LTACH would similarly be given an opportunity to get involved.

3. Share any details on the intent to obtain accreditation for the hospital by a national trade group such as the Joint Commission.

The Proposed LTACH will be accredited by the Joint Commission as a satellite location under the Regency Hospital of Minneapolis' accreditation.

II. Project Need and Access

1. Provide a count of the number of licensed beds that were made available at Regency's Golden Valley location, and the average daily census over the past five years at that location.

	2019	2020	2021	2022	2023 Projected
ADC	62.9	63.4	63.7	63.1	60.9
Operational Beds	66	66	66	66	66

2. Provide additional details describing how the projected utilization volumes (average daily census and patient days) on pages 8 & 12 of the application were estimated.

a. The 2023 Conversion Rate is calculated using the information available as of November 2023.

Actual Patient Volumes				
RHC - Golden Valley	**Year**	**Referrals**	**Admission**	**Conversion Rate**
	2021	2,025	624	31%
	2022	2,002	577	29%
	2023	1,759	516	29%

b. The 2023 Conversion Rate is calculated using the information available as of November 2023.

Additional Patients that will be redirected from GV to the Region's Satellite				
St. Paul Market	**Year**	**Referrals**	**Admission**	**Conversion Rate**
	2021	583	205	35%
	2022	563	156	28%
	2023	390	101	26%

c. As noted in the Plan submitted, Regency expects an average of 80% occupancy over the first five years of operation. The below calculations are made using an average length of stay of 30 days.

Regions Satellite: Patient volume required to reach 80% occupancy			
	Referrals	**Admission**	**Conversion Rate**
Required for 80 % Occupancy	625	208	
Current GV volume - redirected estimated	600	204	34%
Additional St. Paul Volume 12.5%	75	26	35%
Additional Western WI Volume 10%	63	16	25%
Estimated Total Volume	738	246	33%

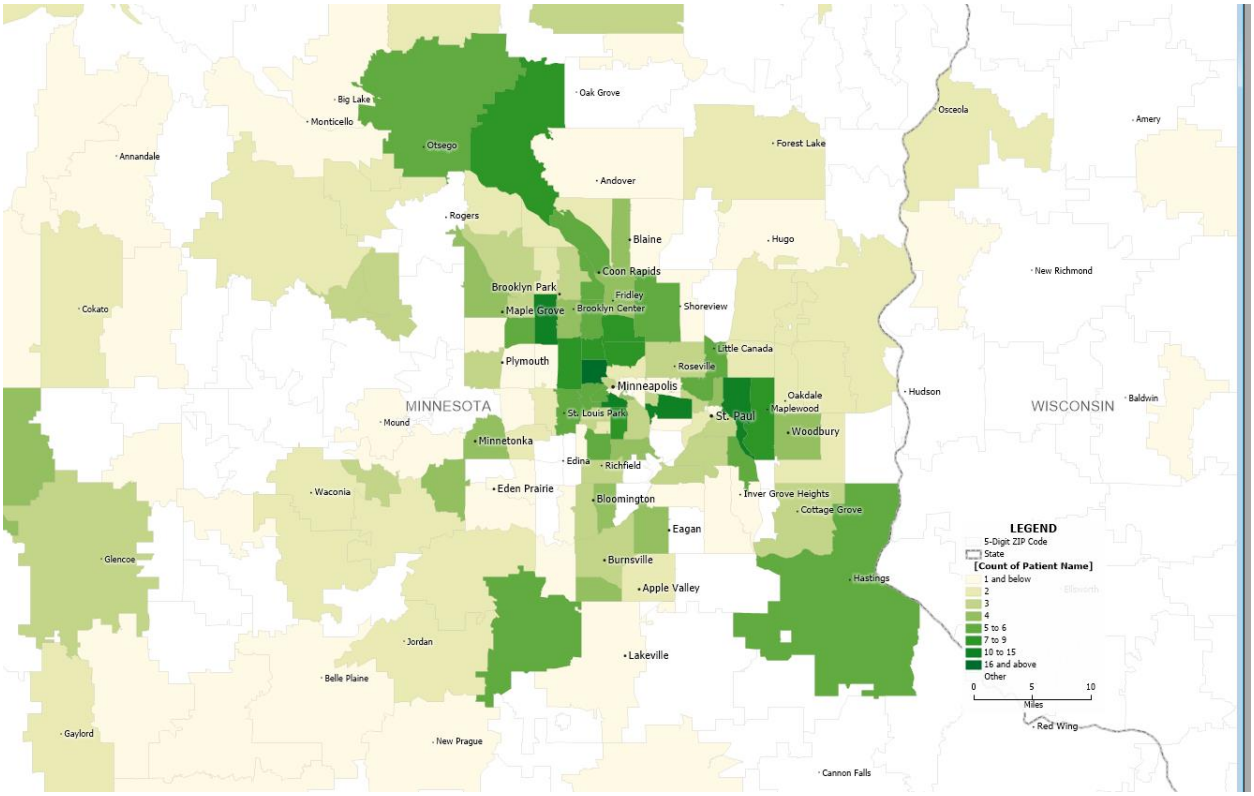
3. Describe the types of conditions or patient profile that will be treated at the proposed hospital.

The Proposed LTACH will offer services for the following conditions: cardiac conditions, infectious disease, medically complex care, neurologic conditions, pulmonary conditions, including ventilator liberation, renal disorders, wound care, and brain disorders. The conditions treated at the Proposed LTACH will mirror those currently treated at Regency's Golden Valley location. For more information on the scope of services provided, please see https://www.regencyhospital.com/locations-and-tours/mn/golden-valley/minneapolis/

4. Provide data or information related to the number of the proposed primary service area that Regency Hospital did not take due to lack of beds or decided not to come to Regency due to distance concerns.

Regency receives qualitative feedback when a patient determines not to be admitted to its Golden Valley location; however, it does not specifically track reasons for its conversion rate. Regency is aware that several acute care hospital case managers from which it accepts referrals do not refer patients to Regency who, prior to the time of referral, state that they will not travel to the Golden Valley location. Therefore, Regency is also subject to this phantom impact of lack of referral due to location for patients located a greater distance away from its Golden Valley location.

In addition, see below for a map of patient admissions by county in Minnesota over the last 12 months. Regency expects that the Proposed LTACH location in St. Paul will be a more convenient location for a large portion of its patients.



III. Potential Financial and Staffing Impact on Other Hospitals

1. **The current labor market for these positions is already competitive. Please share any additional details, on future Select Medical efforts to expanding this workforce, such as training programs or specific steps with local universities and schools to attract and retain additional rehabilitation professionals.**

   a. Many of the Proposed LTACH staff will be a shared workforce with the main campus in Golden Valley. This includes leadership, and other ancillary administration, and the creation of a staffing pool of nurses and nursing assistants.
   b. Regency will deploy its current recruitment team to assess and recruit talent in the St. Paul market to the extent there is need beyond the staffing pool.
   c. Considering that this will be a functioning satellite, Regency will use the main campus in Golden Valley to develop talent through its RN New Graduate Program. This will begin well prior to the opening of the Proposed LTACH.

2. **Provide staffing data by unit for the Regency Hospital of Minneapolis location from the most recent four quarters similar to that provided by other Minnesota hospitals to the Minnesota Hospital Association at the following web page: https://www.mnhospitals.org/data-reporting/mandatory-reporting/nurse-staffing-data.**

Regency does not track this information for its Golden Valley location. Below is the planned staffing levels for the Proposed LTACH.

	Planned FTE
Nurses	46
Other Assistive Personnel	58
Work Hours Per Patient Day	11.4

IV. Financial Access to Nonpaying or Low-Income Patients

1. **Provide a current and projected breakdown of patients by health insurance coverage in table format.**

	Current	Projected
Medicare	17.1%	17.0%
Medicare Advantage	17.7%	18.0%
Medicaid / Medicaid HMO	39.8%	40.0%
Self-Pay / Charity	0.0%	0.0%
Commercial	24.5%	24.0%
Other Payers	0.9%	1.0%
Total Patient Days	100.0%	100.0%

2. **Describe how the 'Financial Hardship Prohibition Against Waivers of Co-pays and Deductibles' information is disseminated to patients and caregivers.**

   In accordance with The No Surprises Act[1] and Minnesota law[2] The 'Financial Hardship Prohibition Against Waivers of Co-pays and Deductibles' information is posted at Regency Hospital, will be posted at the Proposed LTACH's physical location, and is also available on Regency's website here: https://www.regencyhospital.com/no-surprises-act/

3. **Provide the amount of charity care provided for the most recent two complete fiscal years as a total and as a percent of operating expenses.**

   Regency is partnering with Regions Hospital for its Proposed LTACH in order to better serve the community served by Regions, as well as other charitable acute care hospitals in St. Paul and surrounding areas. Historically, Regency Hospital of Minneapolis has predominately admitted both Medicare and Medicaid patients, with Medicare patients making up over 1/3 of its admissions. Regency expects these numbers to be similar for the Proposed LTACH.

[1] 45 CFR § 149.410, 45 CFR § 149.420, 45 CFR § 149.430, and 45 CFR § 149.440
[2] Minn. Stat. § 62K.11

V. Quality and Patient Experience of Care

1. Provide the most recent three years of quality data for Regency Hospital of Minneapolis and how it compares to national and Minnesota hospital performance (for M Health Fairview Bethesda Hospital).[3]

a.

Quality Indicators for 2023

NHSN Infections

Measure	Rate	Bench	SIR/SUR	Rank
CLABSI	0.0	0.90		1
CAUTI	1.1	1.30		2
CL Util	0.18	0.36		1
Cath Util	0.22	0.32		2

HCAHPS

Measure	Rate	Bench	Rank
Overall	0.99	0.82	1
Recommend	0.89	0.84	3
RR	0.89	0.63	1

Risk & Outcomes

Measure	Rate	Bench	Rank
Falls	0.00	0.14	1
ACT	0.21	0.13	4
Restraint	0.15	0.10	4
Agency	0.0%	20.0%	1

Other Infections

Measure	Rate	Bench	Rank
CDIFF	0.0	2.30	1
MRSA	0.3	0.0	3
VRE	0.1	0.0	2
MDRO	0.9	0.0	3
ESBL	0.3	0.0	3
CRE	0.0	0.0	1

Pressure Injuries

Measure	Rate	Bench	Rank
HAPI	0.0	0.50	1
New / Worsened	0.4%	1.0%	1

Respiratory

Measure	Rate	Bench	Rank
Util	23%	31%	3
Wean	74%	67%	1
Decannulation	41%	--	2
Speaking Valve	52%	--	1

[3] The following Quality Indicators are tracked through a proprietary internal dashboard. See below for notes on the categories. The benchmarks are general based on industry standards as adopted by Select Medical for Select Medical locations. Rank is on a 1 - 4 quartile as benchmarked across Select Medical locations.

- NHSN Infections are in-house acquired infection rates.
  - CLABS: Central Line Infections
  - CAUTI: Catheter UTI's
- HCAHPS are hospital consumer assessment of healthcare providers, which measures satisfaction as reported to CMS. This measures how many patients provided a 9 to 10 in satisfaction ranking.
  - RR: return rate based on admissions
- Pressure Injuries measure hospital acquired pressure injuries.
  - HAPI: Hospital Acquired Pressure Injury
- Risk & Outcomes are measured per location
  - Falls only constitute falls with injury
  - ACT: Acute Care Transfers for continued ICU or surgical care

b.

Quality Indicators for 2022

NHSN Infections				
Measure	**Rate**	**Bench**	**SIR/SUR**	**Rank**
CLABSI	0.5	0.90		2
CAUTI	0.8	1.30		2
CL Util	0.19	0.39		1
Cath Util	0.22	0.32		1

HCAHPS			
Measure	**Rate**	**Bench**	**Rank**
Overall	0.93	0.81	1
Recommend	0.84	0.83	4
RR	0.90	0.61	1

Risk & Outcomes			
Measure	**Rate**	**Bench**	**Rank**
Falls	0.09	0.14	2
ACT	0.25	0.13	4
Restraint	0.20	0.12	4
Agency	0.0%	15.0%	1

Other Infections			
Measure	**Rate**	**Bench**	**Rank**
CDIFF	0.9	2.30	1
MRSA	0.2	0.0	2
VRE	0.3	0.0	3
MDRO	0.3	0.0	2
ESBL	0.3	0.0	3
CRE	0.0	0.0	1

Pressure Injuries			
Measure	**Rate**	**Bench**	**Rank**
HAPI	0.0	0.60	1
New / Worsened	0.2%	1.0%	1

Respiratory			
Measure	**Rate**	**Bench**	**Rank**
Util	19%	25%	2
Wean	75%	67%	1
Decannulation	54%	--	1
Speaking Valve	57%	--	1

c.

Quality Indicators for 2021

NHSN Infections				
Measure	**Rate**	**Bench**	**SIR/SUR**	**Rank**
CLABSI	0.6	0.90		2
CAUTI	1.3	1.30		3
CL Util	0.21	0.42	0.42	1
Cath Util	0.27	0.32	0.92	2

HCAHPS			
Measure	**Rate**	**Bench**	**Rank**
Overall	0.97	0.79	1
Recommend	0.91	0.81	2
RR	0.91	0.59	1

Risk & Outcomes			
Measure	**Rate**	**Bench**	**Rank**
Falls	0.04	0.16	1
ACT	0.25	0.13	4
Restraint	0.25	0.12	4
Agency	0.0%	15.0%	1

Other Infections			
Measure	**Rate**	**Bench**	**Rank**
CDIFF	0.4	2.60	1
MRSA	0.5	0.0	4
VRE	0.1	0.0	2
MDRO	0.7	0.0	3
ESBL	0.3	0.0	3
CRE	0.0	0.0	1

Pressure Injuries			
Measure	**Rate**	**Bench**	**Rank**
HAPI	0.2	0.60	2
New / Worsened	0.8%	1.0%	3

Respiratory			
Measure	**Rate**	**Bench**	**Rank**
Util	29%	25%	3
Wean	81%	64%	1
Decannulation	58%	--	1
Speaking Valve	57%	--	1

2. **Provide a narrative description of steps taken to improve quality of care for issues such as pressure ulcers/pressure injuries that are new or worsened, falls with major injury during stay, and other relevant quality metrics.**

   a. See Attachment B and Attachment C.

Attachment A

STATE	PROVIDER NAME/ADDRESS	LICENSED BED COUNT	Opening/Acquisition Date
AL	**Select Specialty Hospitals, Inc. d/b/a Select Specialty Hospital - Birmingham** 2010 Brookwood Medical Center Drive, 3rd Floor Birmingham, AL 35209-6804 Jefferson County	38	02/26/01
AR	**Select Specialty Hospital - Fort Smith, Inc.** 1001 Towson Avenue, 6th Floor Fort Smith, AR 72901-4921 Sebastian County	34	12/27/00
AR	**Regency Hospital of Northwest Arkansas LLC (Springdale)** 609 West Maple Avenue, 6th Floor Springdale, AR 72764-5335 Washington County	25 Med/surg	09/01/2010 opened 09/2004
AZ	**Select Specialty Hospital - Phoenix, Inc.** 350 West Thomas Road, 3rd Floor Phoenix, AZ 85013-4409 Maricopa County	48	07/31/98
AZ	**Select Specialty Hospital - Arizona, Inc. (Phoenix Downtown Campus)** 1111 East McDowell Road, 11th Floor Phoenix, AZ 85006-2749 Maricopa County	32	12/31/01
AZ	**Select Specialty Hospital - Tucson, LLC (Select Specialty Hospital - Tucson Northwest)** 2025 West Orange Grove Road Tucson, AZ 85704 (pharmacy on 2nd Floor) *lease has zip as 85714* Pima County	30	07/01/21
AZ	**Select Specialty Hospital - Tucson, LLC (Select Specialty Hospital - Tucson East)** 5301 East Grant Road, 1st Floor Unit 650 Tucson AZ 85712 Pima County	28	05/15/23
CA	**Vibra Hospital of San Diego, LLC d/b/a Select Specialty Hospital - San Diego** 555 Washington Street San Diego, CA 92103 San Diego County	110 (6 ICU 104 general)	01/17/19

STATE	PROVIDER NAME/ADDRESS	LICENSED BED COUNT	Opening/Acquisition Date
DE	**Select Specialty Hospital - Wilmington, Inc.** 501 West 14th Street, 9th Floor Wilmington, DE 19801 Newcastle County	33	01/13/99
FL	**Victoria HealthCare, Inc. d/b/a Select Specialty Hospital - Miami** 955 Northwest 3rd Street Miami, FL 33128-1274 Miami-Dade County	47	12/31/02
FL	**Select Specialty Hospital - Orlando, Inc. (South Campus)** 5579 South Orange Avenue Orlando, FL 32809-3493 Orange County	64	06/11/07
FL	**Select Specialty Hospital - Orlando, Inc. (North Campus)** 2250 Bedford Road Rollins Orlando, FL 32803-1443 Orange County	35	01/01/05
FL	**Select Specialty Hospital - Panama City, Inc.** 615 North Bonita Avenue Panama City, FL 32401-3623 Bay County	30	01/01/05
FL	**Select Specialty Hospital - Miami Lakes, Inc.** 14001 NW 82nd Avenue Miami Lakes, FL 33016 Miami-Dade County	52 med/sur g (8 ICU) 60	04/03/19
FL	**Select Specialty Hospital - Fort Myers, Inc.** 3050 Champion Ring Road Fort Myers, FL 33905 Lee County	60	04/03/19
FL	**Select Specialty Hospital - The Villages, Inc.** 5050 County Road 472 Oxford, FL 34484 Sumter County	40	04/03/19
FL	**Select Specialty Hospital - Tallahassee, Inc.** 1554 Surgeons Drive Tallahassee, FL 32308-4631 Leon County	48	08/27/07

STATE	PROVIDER NAME/ADDRESS	LICENSED BED COUNT	Opening/Acquisition Date
FL	**Select Specialty Hospital - Gainesville, LLC** 1600 SW Archer Road, 5th Floor Gainesville, FL 32608-1316 Alachua County	48	01/07/08
FL	**Select Specialty Hospital - Daytona Beach, Inc.** 301 Memorial Medical Parkway, 11th Floor Daytona Beach, FL 32117-5167 Volusia County	34 med/surg	04/10/15
FL	**Select Specialty Hospital - Palm Beach, Inc.** 3060 Melaleuca Lane Lake Worth, FL 33461-5174 Palm Beach County	60	03/12/08
FL	**Select Specialty Hospital - Pensacola, Inc.** 7000 Cobble Creek Drive Pensacola, FL 32504-8638 Escambia County **DPU Suite 2 **d/b/a Select Medical Rehabilitation - Pensacola**	74 (14 DPU)	02/19/08
GA	**Select Specialty Hospital - Savannah, Inc.** 5353 Reynolds Street Savannah, GA 31405-6015 Chatham County	40	01/01/05
GA	**Select Specialty Hospital - Augusta, Inc.** 1537 Walton Way Augusta, GA 30904-3764 Richmond County	80	01/01/05
GA	**Select Specialty Hospital - Midtown Atlanta, LLC** 705 Juniper Street, NE Atlanta, GA 30308-1307 Fulton County	72	06/28/16
GA	**Regency Hospital Company of Macon, LLC (Macon Campus)** **d/b/a Regency Hospital of Central Georgia** 535 Coliseum Drive Macon, GA 31217-0104 Bibb County	60 Med/Surg	04/11/11
IA	**Select Specialty Hospital - Quad Cities, Inc.** 1227 East Rusholme Street, 3rd Floor Davenport, IA 52803-2459 Scott County	35	05/16/06

STATE	PROVIDER NAME/ADDRESS	LICENSED BED COUNT	Opening/Acquisition Date
IA	**Select Specialty Hospital - Des Moines, Inc.** 1111 6th Avenue, 4th Floor Main Des Moines, IA 50314-2610 Polk County	30	03/28/14
IN	**Select Specialty Hospital - Evansville, LLC** 400 Southeast 4th Street Evansville, IN 47713-1206 Vanderburgh County	60	01/01/05
IN	**Regency Hospital of Northwest Indiana LLC** 4321 Fir Street, 4th Floor East Chicago, IN 46312-3049 Lake County	38 Med/surg	09/01/2010 opened 01/2006
IN	**Regency Hospital of Northwest Indiana LLC (Porter County)** 3630 Willowcreek Road, 3rd Floor Portage, IN 46368-5075 Porter County	23 Med/surg	09/10/2010 opened 07/2003
KS	**Select Specialty Hospital - Kansas City, Inc.** 1731 North 90th Street Kansas City, KS 66112-1689 Wyandotte County	40	12/16/98
KS	**Select Specialty Hospital - Wichita, Inc.** 929 North St. Francis Street, 6th Floor North Tower Wichita, KS 67214-3821 Sedgwick County	48	06/16/00
KY	**Select Specialty Hospital - Lexington, Inc. (Central Kentucky)** 217 South 3rd Street, 4th Floor Danville, KY 40422-182 Boyle County	30	06/02/20
KY	**Select Specialty Hospital - Northern Kentucky, LLC** 85 North Grand Avenue Fort Thomas, KY 41075-1793 Campbell County	33	01/16/12
MI	**Select Specialty Hospital - Flint, Inc.** 401 South Ballenger Highway Flint, MI 48532-3638 Genesee County	26	12/16/98

STATE	PROVIDER NAME/ADDRESS	LICENSED BED COUNT	Opening/Acquisition Date
MI	**Select Specialty Hospital - Macomb County, Inc.** 215 North Avenue Mount Clemens, MI 48043-1716 Macomb County	36	12/16/98
MI	**Select Specialty Hospital - Macomb County, Inc. (d/b/a Select Specialty Hospital - Oakland)** 44405 Woodward Avenue, 7th and 8th Floors Pontiac, MI 48341-1601 Oakland County	30	06/11/01
MI	**Select Specialty Hospital - Macomb County, Inc. (d/b/a Select Specialty Hospital--Grosse Pointe)** 22101 Moross Road Detroit, MI 48236-2148 Wayne County	26	04/04/06
MI	**Select Specialty Hospital - Ann Arbor, Inc.** 5301 East Huron River Drive, 7th Floor Ypsilanti, MI 48197-1051 Washtenaw County	36	12/16/98
MI	**Select Specialty - Downriver, LLC (d/b/a Select Specialty Hospital - Wyandotte, LLC)** 2333 Biddle Avenue, 8th Floor Wyandotte, MI 48192-4668 Wayne County	35	01/07/14
MI	**Select Specialty - Downriver, LLC (d/b/a Select Specialty Hospital - Northwest Detroit)** 6071 West Outer Drive, 7th Floor Detroit, MI 48235-2624 Wayne County	36	12/11/01
MI	**Select Specialty Hospital - Saginaw, Inc.** 1447 North Harrison Street, 7th and 8th Floors Saginaw, MI 48602-4727 Saginaw County	32	06/27/02
MI	**Select Specialty Hospital - Kalamazoo, Inc. d/b/a Select Specialty Hospital - Battle Creek** 300 North Avenue, Units 6100A Hall and 6200B Hall Battle Creek, MI 49017-3307 Calhoun County	25	01/01/05
MI	**Special Care Hospital, LLC d/b/a Select Specialty Hospital - Corewell Health Grand Rapids** 1840 Wealthy Street, SE, 5th Floor	36	08/01/17

STATE	PROVIDER NAME/ADDRESS	LICENSED BED COUNT	Opening/Acquisition Date
	Grand Rapids, MI 49506-2921 Kent County		
MN	**Regency Hospital of Minneapolis, LLC** 1300 Hidden Lakes Parkway Golden Valley, MN 55422-4286 Hennepin County	92 Med/surg	9/1/2010 opened 09/2005
MO	**Intensiva Hospital of Greater St. Louis, Inc. d/b/a Select Specialty Hospital - St. Louis** 300 1st Capitol Drive, 1st Floor (1A and 1B) St. Charles, MO 63301-2844 Saint Charles County	33	04/04/00
MO	**Intensiva Hospital of Greater St. Louis, Inc. d/b/a Select Specialty Hospital - Town and Country** 3015 North Ballas Road, 5th Floor St. Louis, MO 63131 Saint Louis County	38	01/16/18
MO	**Select Specialty Hospital - Springfield, Inc.** 1630 East Primrose Street Springfield, MO 65804-7929 Greene County **DPU Suite 2 **d/b/a Select Medical Rehabilitation - Springfield**	60 (6 ICU) *16 DPU	02/12/08
MS	**Select Specialty Hospital - Gulf Coast, Inc. (Select Specialty Hospital - Gulfport)** 4500 13th Street, 3rd Floor Gulfport, MS 39501 Harrison County	36	01/11/00
MS	**Regency Hospital Company of Meridian LLC** 1102 Constitution Avenue, 2nd Floor Meridian, MS 39301-4001 Lauderdale County	40 Med/surg	09/01/2010 opened 01/2003
MS	**Select Specialty Hospital - Jackson, Inc.** 5903 Ridgewood Road Jackson, MS 39211-3700 Hinds County	53	07/29/02
MS	**Select Specialty Hospital - Belhaven, LLC** 1225 North State Street Jackson, MS 39202-2064 Hinds County	36 (8 ICU) **temp 8 beds.	08/02/16

STATE	PROVIDER NAME/ADDRESS	LICENSED BED COUNT	Opening/Acquisition Date
	**admin. 1200 North State Street, #400 Jackson, MS 39202		
NC	**Select Specialty Hospital - Durham, Inc.** 3643 North Roxboro Road Durham, NC 27704-2702 Durham County	30	06/16/03
NC	**Select Specialty Hospital - Greensboro, Inc. d/b/a Select Specialty Hospital - Greensboro at The Moses H. Cone Memorial Hospital** 1200 North Elm Street, 5th Floor Greensboro, NC 27401-1020 Guilford County	30	09/15/09
NE	**Select Specialty Hospital - Omaha, Inc. (Central Campus)** 1870 South 75th Street Omaha, NE 68124-1700 Douglas County	52 (8 ICU)	08/19/03
NJ	**Select Specialty Hospital - Northeast New Jersey, Inc. (Rochelle Park Campus)** 96 Parkway Rochelle Park, NJ 07662-4200 Bergen County	62	1/1/2005
NJ	**Acuity Hospital of New Jersey, LLC (Select Specialty Hospital - Atlantic City)** 1925 Pacific Avenue, 5th Floor LTACH Atlantic City, NJ 08401 Atlantic County	30	10/01/21
NJ	**Acuity Specialty Hospital, LLC (Select Specialty Hospital - Willingboro)** 218 A Sunset Rd, 3rd Floor Willingboro, NJ 08046 Burlington County (Admin office is on 1st Floor) **Acuity changing name from Lourdes Specialty Hospital of Southern New Jersey, LLC	69	10/01/21
OH	**Select Specialty Hospital - Northeast Ohio, Inc. (Canton Campus)** 1320 Mercy Drive, 6th Floor Canton, OH 44708-2614 Stark County	30	11/18/03

STATE	PROVIDER NAME/ADDRESS	LICENSED BED COUNT	Opening/Acquisition Date
OH	**Select Specialty Hospital - Cincinnati, Inc.** 2139 Auburn Avenue, 3 West Cincinnati, OH 45219 Hamilton County	30	01/19/20
OH	**Select Specialty Hospital - Cincinnati, Inc. (d/b/a Select Specialty Hospital - Cincinnati North)** 10500 Montgomery Road Cincinnati, OH 45242- Hamilton County	41 Med/surg	11/01/17
OH	**Select Specialty Hospital - Columbus, Inc.** 1087 Dennison Avenue Columbus, OH 43201-3201 Franklin County	152 Med/surg 10 ICU (total 162)	07/31/98
OH	**Select Specialty Hospital - Youngstown, Inc.** 1044 Belmont Avenue Youngstown, OH 44501-1006 Mahoning County	31	06/09/99
OH	**Select Specialty Hospital - Akron, LLC** 200 East Market Street Akron, OH 44308-1315 Summit County	54 Med/surg 6 ICU (total 60)	11/04/08
OH	**Regency Hospital of North Central Ohio LLC (Cleveland East)** 4200 Interchange Corporate Center Road Warrensville Heights, OH 44128-5631 Cuyahoga County	44 Med/surg	09/01/2010 opened 7/2007
OH	**Regency Hospital of North Central Ohio LLC (Cleveland West)** 6990 Engle Road Middleburg Heights, OH 44130-3420 Cuyahoga County	43 Med/surg	09/01/2010 opened 04/2007
OH	**Select Specialty Hospital - Zanesville, Inc. (d/b/a Select Specialty Hospital - Southeast Ohio)** 2000 Tamarack Road, 2nd Floor Newark, OH 43055-1183 Licking County	35	07/21/15
OH	**Select Specialty Hospital - Cleveland, LLC (Fairhill)** 11900 Fairhill Road Cleveland, OH 44120-1062 Cuyahoga County	68	6/1/2016

STATE	PROVIDER NAME/ADDRESS	LICENSED BED COUNT	Opening/Acquisition Date
OH	**Regency Hospital of Toledo LLC** 5220 Alexis Road Sylvania, OH 43560-2504 Lucas County	45 Med/surg	09/01/2010 opened 05/2007
OH	**Regency Hospital of Toledo, LLC (Regency Hospital - Oregon)** 2600 Navarrre Ave., 4th and 5th Floors Oregon, OH 43616 Lucas County	31 Med/Surg	02/07/23
OH	**Regency Hospital of Columbus LLC (d/b/a Select Specialty Hospital - Columbus South)** 1430 South High Street Columbus, OH 43207-1045 Franklin County	43 Med/surg	08/14/07
OH	**Select Specialty Hospital - Boardman, Inc.** 8049 South Avenue Boardman, OH 44512-6154 Mahoning County	45	06/14/02
OH	**Select Specialty Hospital - Boardman, Inc. (Select Specialty Hospital - Trumbull)** 1350 East Market Street, 9th Floor Warren, OH 44483 Trumbull County	34	06/14/22
OK	**Select Specialty Hospital - Tulsa/Midtown, LLC** 744 West 9th Street, 5th and 6th Floors Tulsa, OK 74127 Tulsa County **Pharmacy on 6th Floor	46	10/15/20
OK	**Select Specialty Hospital - Oklahoma City, Inc. (West)** 3524 Northwest 56th Street Oklahoma City, OK 73112-4518 Oklahoma County	60 Med/surg 12 ICU (total 72)	07/31/1998
PA	**Select Specialty Hospital - Johnstown, Inc.** 320 Main Street Johnstown, PA 15901-4305 Cambria County	39	12/16/98
PA	**Select Specialty Hospital - Laurel Highlands, Inc.** 1 Mellon Way, 3rd Floor Latrobe, PA 15650-1197 Westmoreland County	40	08/04/00

STATE	PROVIDER NAME/ADDRESS	LICENSED BED COUNT	Opening/Acquisition Date
PA	**Select Specialty Hospital - Erie, Inc.** 252 West 11th Street Erie, PA 16501-1702 Erie County	50	10/24/00
PA	**Select Specialty Hospital - Central Pennsylvania, L.P. (Harrisburg Campus)** 111 South Front Street, 5th Floor Harrisburg, PA 17101-2010 Dauphin County	38	10/22/08
PA	**Select Specialty Hospital - Central Pennsylvania, L.P. (Camp Hill Campus)** 503 North 21st Street, 5th Floor Camp Hill, PA 17011-2204 Cumberland County	31	06/18/01
PA	**Select Specialty Hospital - Central Pennsylvania, L.P. (York Campus)** 1701 Innovation Drive, 5th Floor York, PA 17408 York County	23	06/24/22
PA	**Select Specialty Hospital - Pittsburgh/UPMC, Inc.** 200 Lothrop Street, MUH E824 Pittsburgh, PA 15213-2536 Allegheny County	32	01/01/05
PA	**Select Specialty Hospital - Pittsburgh/UPMC, Inc. (Select Specialty Hospital - Alle Kiski)** 1301 Carlisle Street Natrona Heights, PA 15065 Allegheny County	35	10/01/19
PA	**Select Specialty Hospital - McKeesport, Inc.** 1500 5th Avenue, Crawford, 6th Floor McKeesport, PA 15132-2422 Allegheny County	30	01/01/05
SC	**Regency Hospital Company of South Carolina, LLC (Florence)** 805 Pamplico Highway, 2nd and 3rd Floors Florence, SC 29504-2576 Florence County	44 Med/surg	09/01/2010 opened 07/2001
SC	**Regency Hospital of Greenville, LLC** 1 St. Francis Drive, 4th Floor Greenville, SC 29601-3955 (Admin space: 317 St Francis Drive, Ste 210, Greenville, SC 29601-3955) Greenville County	32 Med/surg	09/01/2010 opened 12/2004

STATE	PROVIDER NAME/ADDRESS	LICENSED BED COUNT	Opening/Acquisition Date
SD	**Select Specialty Hospital - Sioux Falls, Inc. d/b/a Select Specialty Hospital - South Dakota** 1305 West 18th Street Sioux Falls, SD 57105-0401 Minnehaha County	24	12/11/12
TN	**Select Specialty Hospital - West Tennessee, LLC** 620 Skyline Drive, 5th and 6th Floors Jackson, TN 38301 Madison County	50	03/28/23
TN	**Select Specialty Hospital - Nashville, LLC** 2000 Hayes Street, Suite 500 Nashville, TN 37203-2318 (Suite 1502 physical space hospital) Davidson County	70	07/31/98
TN	**Select Specialty Hospital - Nashville, LLC (Select Specialty Hospital - Nashville West)** 4220 Harding Pike, 6th Floor Nashville, TN 37205 Davidson County	30	01/20/22
TN	**Select Specialty Hospital - Memphis, Inc.** 1265 Union Avenue, 10th Floor Memphis, TN 38104 Shelby County	39	07/31/98
TN	**Select Specialty Hospital - North Knoxville, Inc.** 7557B Dannaher Drive, Suite 145 Powell, TN 37849-3568 Knox County	33	03/24/15
TN	**Select Specialty Hospital - North Knoxville, Inc. (Knoxville Campus)** 501 19th Street 6th and 7th Floors Knoxville, TN 37916-2307 Knox County	32	01/18/22
TN	**Select Specialty Hospital - TriCities, Inc.** 1 Medical Park Boulevard, 5th Floor West Bristol, TN 37620-7430 **Pharmacy Ste 458 West Sullivan County	35	03/20/00
TX	**Select Specialty Hospital - Dallas, Inc. (Plano)** 1100 Allied Drive, 4th Floor Plano, TX 75093 Collin County	30	06/16/22

STATE	PROVIDER NAME/ADDRESS	LICENSED BED COUNT	Opening/Acquisition Date
TX	**Select Specialty Hospital - Dallas, Inc. (Dallas Downtown)** 2700 Walker Way Desoto, TX 75115 Dallas County	40 (12 ICU)	10/03/23
TX	**Select Specialty Hospital - Longview, Inc.** 700 East Marshall Avenue, 1st and Ground Floors West Longview, TX 75601-5580 Gregg County	32	01/01/05
VA	**LTACH at Riverside, LLC (Select Specialty Hospital - Hampton Roads)** 500 J. Clyde Morris Boulevard, 4th Floor East and 4th Floor Annex Newport News, VA 23601 Newport News City	25	08/20/19
VA	**Long Term Acute Care Hospital of Northern Virginia, LLC (Inova Specialty Hospital)** 2501 Parkers Lane, 4th Floor Alexandria, VA 22306 Fairfax County	32	05/23/23
VA	**Coastal Virginia Rehabilitation, LLC (d/b/a Riverside Rehabilitation Hospital)** 250 Josephs Drive Yorktown, VA 23693 York County	50	08/20/19
VA	**Select Specialty Hospital - Richmond, Inc.** 2220 Edward Holland Drive Richmond, VA 23230 Henrico County	60	06/13/23
WI	**Select Specialty Hospital - Milwaukee, Inc.** 8901 West Lincoln Avenue, 2nd Floor West Allis, WI 53227-2409 Milwaukee County	34	03/10/99
WI	**Select Specialty Hospital - Milwaukee, Inc. (St. Francis Campus)** 3237 South 16th Street, 5th Floor Milwaukee, WI 53215-4526 Milwaukee County	29	11/15/17
WI	**Select Specialty Hospital - Madison, Inc.** 801 Braxton Place Madison, WI 53715-1415 Dane County	52 Med/Surg 6 ICU (total 58)	09/07/06

STATE	PROVIDER NAME/ADDRESS	LICENSED BED COUNT	Opening/Acquisition Date
WV	**LTACH Morgantown, LLC** **(Select Specialty Hospital - Morgantown)** 1200 JD Anderson Dr., 4th Floor Morgantown, WV 26505 Monongalia County	34	10/01/21
WV	**Acuity Specialty Hospital Ohio Valley, LP** **(Select Specialty Hospital - Weirton)** 601 Colliers Way, 9th Floor Weirton, WV 26062 Brooke County	20	10/01/21
WV	**Acuity Specialty Hospital Ohio Valley, LP** **(Select Specialty Hospital - Wheeling)** 500 Medical Park, 2nd Floor Wheeling, WV 26003 Ohio County	29	10/01/21
WV	**Select Specialty Hospital - Charleston, Inc.** 3200 MacCrokle Ave., SE, 3N and 3E Charleston, WV 25304 Kanawha County	32	08/15/23

Quality Assessment and Performance Improvement Plan (QAPI)

I. Purpose

The Hospital's Quality Assessment and Performance Improvement (QAPI) Program provides a description of the important processes or outcomes related to patient care and Hospital operations and delineates the roles and responsibilities of leadership, physicians and other clinicians and support staff in designing, measuring, assessing and improving performance.

II. Philosophy, Goals and Objectives

A. Philosophy

The Quality Assessment and Performance Improvement Program is established in accordance with our five core values, six cultural behaviors, and four key results as well as the Select Medical mission and vision of providing quality, cost effective care to patients who are adolescent through geriatric adults, including the chronically critically ill. The most common conditions treated are: complex medical including renal failure, infectious disease, neurological illnesses/injury, cardiovascular disease, multisystem failures complex respiratory diagnosis requiring ventilator management and weaning; and recalcitrant wounds. Our interdisciplinary team of professionals is committed to integrating care in a manner that improves healthcare outcomes and service initiatives while respecting the rights of patients, families and constituents.

The Hospital recognizes that ongoing quality assessment and performance improvement (QAPI) is the cornerstone of exceptional patient outcomes and Hospital operations. QAPI activities are interdisciplinary placing emphasis on process improvement.

B. Goals and Objectives

The Hospital will incrementally improve patient outcomes and Hospital operations by meeting and exceeding constituent expectations and needs through systematically measuring, assessing, and improving our performance. We will:

1. Establish a systematic interdisciplinary mechanism to measure and assess the Hospital's ability to do the right thing and to do it well using the dimensions of performance: **appropriateness**, **care and respect**, **efficiency**, **timeliness**,

efficacy, **effectiveness**, **safety**, **continuity** and **availability** of patient care through routine data collection and analysis;
2. Identify known, suspected or potential (close calls) opportunities to improve patient care and employee safety processes and outcomes and Hospital operations, as well as opportunities for further improvement in currently acceptable performance;
3. Establish ongoing measures that enable the Hospital to improve patient care processes and outcomes and Hospital operations, as well as opportunities for further improvement in currently acceptable performance;
4. Use appropriate statistical techniques to measure performance and display data;
5. Establish mechanisms to prioritize opportunities for improvement that have the greatest potential impact on patient care outcomes, Hospital operations and key constituent satisfaction;
6. Monitor the performance of processes that involve risks or may result in adverse events;
7. Define interventions, evaluate the actions taken and document resolution to known, suspected or potential problems or re-design the plan for improvement and begin the "Performance Improvement Cycle" again;
8. Collect data to monitor performance in areas targeted for further study;
9. Intensively analyze undesirable patterns or trends in performance and adverse events;
10. Ensure coordination and integration of all performance improvement activities by maintaining an Organization Improvement Committee (OIC) as the forum for information exchange, collaboration, prioritization and monitoring;
11. Communicate performance improvement activities and findings to Hospital leaders, physicians and other clinicians, and support staff to ensure their participation in the program;
12. Compare internal performance over time with other sources of information and to like organizations nationally;
13. Identify the on-going educational needs of leaders, clinicians and support personnel relative to the competencies required to improve patient care processes and outcomes and Hospital operations;
14. Assist staff to improve processes and outcomes by allocating resources, assigning personnel, and providing time and information systems to support ongoing quality assessment and performance improvement activities;
15. Coordinate quality assessment and performance improvement activities and findings on processes and outcomes including: performance indicators; customer needs, expectations, and satisfaction; infection control; environment of care; patient safety; utilization management; risk management, quality controls; and pharmacy and therapeutics;
16. Integrate medical staff performance improvement activities with those of the Hospital;
17. Participate as an integral component of the community, working in partnership to continuously improve access to care and the continuity of patient care services;

18. Monitor and comply with policies, standards, regulations and rules set by the Governing Body, Medical Staff, The Joint Commission (TJC), local, state, and federal governments and other regulatory or accrediting bodies; and
19. Sustain improved performance.

III. Hospital Priorities

A. Increase customer satisfaction by meeting or exceeding customer expectations and needs.

B. Apply the methodology of continuous performance improvement to:
   1. Change and/or do business through the use of empirical data that is compiled into meaningful information that can be assessed and subjected to analytical problem solving techniques;
   2. Add value to our services through demonstrated improvement in quantitative and qualitative data related to service **efficacy**, and **appropriateness** as well as **availability**, **timeliness**, **effectiveness**, **safety**, **continuity**, **efficiency**, and **respectful caring** delivery of services;

C. Involve employees, physicians and the community in collaborative and interactive efforts to accept no level of customer dissatisfaction, improve bottom line performance and market share, empower individuals and teams, and create a culture committed to quality and high ethical standards.

D. Ensure alarm system safety by developing a plan that:
   1. Includes input from the medical staff and clinical departments;
   2. Addresses the risk to patients if the alarm signal is not attended to or if it malfunctions;
   3. Reviews the need for specific alarm signals and/or if they unnecessarily contribute to alarm noise and fatigue;
   4. Reviews the potential for patient harm based on internal incident history; and
   5. Includes a review of published best practices and guidelines.

E. Ensure appropriate patient pain assessment and pain management, including safe opioid prescribing, by developing a plan that:
   1. Identifies a Hospital leader or leadership team that is responsible for pain management and safe opioid prescribing and develops and monitors performance improvement activities;
   2. Provides for non-pharmacologic pain treatment modalities, such as the application of heat/cold;
   3. Provides staff and licensed independent practitioners with educational resources and programs to improve pain assessment, pain management, and the safe use of opioid medications based on the identified needs of its patient population.
   4. Provides information to staff and licensed independent practitioners on available services for consultation and referral of patients with complex pain management needs.

5. Identifies opioid treatment programs that can be used for patient referrals;
6. Facilitates practitioner and pharmacist access to the Prescription Drug Monitoring Program databases; and
7. Includes working with clinical staff to identify and acquire the equipment needed to monitor patients who are at high risk for adverse outcomes from opioid treatment.

F. Identify and address the disparities that the hospitals unique patient population faces to increase equitable healthcare.

IV. Governance, Authority and Accountability

The Governing Board bares ultimate responsibility for assuring the quality and appropriateness of patient care and Hospital operations provided by its leaders, physicians and other clinicians and support staff. The Governing Board shall ensure that there is an on-going systematic interdisciplinary mechanism to measure, assess and improve the Hospital's ability to do the right thing and to do it well for suspected or potential opportunities to improve patient care processes and outcomes and Hospital operations.

As appropriate, the Governing Board shall delegate responsibility for implementing the Quality Assessment and Performance Improvement Program to the Hospital leaders. Specific responsibilities and activities are delineated in this program, which shall be reviewed and approved by the Governing Board on an annual basis.

Leadership must role model the principles of total quality management, the larger concept encompassing quality assessment and continuous performance improvement activities and the important functions that foster such activities.

The Hospital leadership has the following responsibilities:

- Set priorities for performance improvement activities;
- Allocate adequate resources for design, measurement, assessment and improvement;
- Provide the Hospital employees ongoing training on performance improvement activities and methodologies that will equip them to effectively meet and exceed constituent needs and expectations; and
- Design and participate in a communication system that fosters open sharing of performance improvement information and the coordination of internal improvement activities.

V. Scope and Organization

Processes with a direct or indirect impact on patient care delivery, outcomes and cost, as well as the quality of Hospital operations shall be reviewed under the program. QAPI activities shall be divided into three major categories **medical staff**; **patient focused functions**; and **Hospital operations**.

Each employee of the Hospital shall participate in the Performance Improvement program. This belief pervades all interactions and transactions we perform on an ongoing basis and establishes a culture that supports and rewards continuous performance improvement.

The program integrates external customers who directly affect the processes within our organization and who are partners in the provision of the healthcare continuum.

The plan is in effect twenty-four (24) hours a day, seven (7) days a week, three-hundred-sixty-five (365) days a year.

A. Medical Staff

1. The Medical Director shall ensure an on-going systematic process for monitoring, measuring, assessing and improving care delivery processes, clinical outcomes and appropriateness of care provided.
2. The Medical Director shall be responsible for identifying indicators and criteria for measurement for use in monitoring and evaluating the quality of patient care delivered by the medical staff.
3. The Medical Director shall be ultimately responsible for ensuring that there is a process in place for recommending clinical privileges, monitoring the clinical performance of all privileged staff, recommending medical staff for appointment and re-appointment and providing continuing education and other corrective or supportive interventions, as needed.
4. The Medical Executive Committee shall meet at least four times per year to review findings of the medical staff performance improvement activities. Minutes of these meetings will present a summary of cases reviewed, adverse trends or opportunities identified and corrective actions initiated.
5. At a minimum, the following performance indicators shall be measured and assessed by the medical staff, through the appropriate committee structure or interdisciplinary performance improvement team on a concurrent basis:
    a) mortality/autopsy
    b) organ donation
    c) operative/invasive procedure(s)
    d) moderate sedation
    e) blood and blood products
    f) CAUTI & CLABSI
    g) customer satisfaction
    h) medical record delinquency
    i) specialty/privilege specific indicators (refer to Credentialing policies and procedures for FPPE and OPPE)
    j) antimicrobial stewardship (refer to Pharmacy policies), and
    k) pain assessment, pain management, and safe opioid prescribing.

B. Patient Focused Functions

1. The Director of Quality Management/Patient Safety Officer ensures an on-going systematic process for monitoring, measuring, assessing and improving care delivery processes, clinical outcomes and appropriateness of care provided.
2. The Quality Physician Program Director and/or Medical Director supports the Hospital's quality, risk, patient safety, and infection control programs.
3. At a minimum, the following services, either Hospital-owned or contracted, shall participate:
    a) dialysis
    b) PICC line placement
    c) diagnostic (lab, radiology etc.)
    d) food and nutrition
    e) environmental services, housekeeping and plant operations
    f) laundry/linen
    g) nursing
    h) rehabilitation therapy
    i) respiratory therapy
    j) pharmaceutical, and
    k) case management.
4. At a minimum, performance indicators shall be designed to measure high risk, high volume, high cost, problem prone processes to include but not be limited to:
    a) medication use
    b) pain management and safe opioid prescribing
    c) restraint use
    d) falls and fall prevention
    e) pressure injuries (worsening of existing injuries and development of new injuries), and
    f) infection control as described in the IC Annual Evaluation and PI Plan.

   Outcomes will be measured at specific intervals. Outcome scales will be used to collect and assess indicator data related to:
    a) Ventilator wean rate, and
    b) Patient perception of care.
5. Utilization Review as described in the Case Management QAPI Plan.
6. The infection control process includes data about Healthcare Acquired Infection Risks (trends, and rates that stimulate ongoing study to improve prevention and control activities and reduce Healthcare Acquired Infection rates to the lowest possible levels). Infection control activities are reported to the Organizational Improvement Committee for integration into the overall program at least quarterly.
7. Food and Nutrition ensures:
    a) appropriateness of food and nutrition products to meet the patient's needs

b) proper conditions of storage and preparation of food and nutrition products
c) honoring of patient's cultural, religious and ethnic food preferences, when possible
d) offering of substitutes of equal nutritional value when patients refuse the food served
e) assigning responsibilities for all activities involved in safely and accurately providing food and nutrition products
f) appropriately storing food brought in by patients and or patient representatives, and
g) accommodating special diets and altered diet schedules.

8. On admission, patients and/or their representatives are provided information on whom to contact to file a complaint or grievance. Patient satisfaction surveys are administered at the time of discharge. The patient and/or patient representative is strongly encouraged to complete the survey related to their perception of care and services provided throughout their Hospital stay.
9. Each service participates in the interdisciplinary quality assurance performance improvement team (QAPI Team), as appropriate, to ensure collaboration and enhance program effectiveness. A summary of QAPI Team activities is provided to the OIC, MEC and Governing Board at least quarterly.

C. Hospital Operations

1. Organizational leaders shall ensure an ongoing systematic process for monitoring, measuring, assessing, and improving functions that support delivery of quality care in the most appropriate setting, utilizing resources efficiently:
    a) Improving Organization Performance
    b) Management of the Environment of Care
    The Hospital designs a safe, accessible, effective, and efficient environment of care and monitors the six management plans as follows:
        - Safety management
        - Security management
        - Hazardous Materials and Waste management
        - Fire Prevention
        - Medical Equipment management
        - Utilities management
    c) Emergency Operations
    d) Management of Human Resources
        1. The leaders' planning process defines the qualifications, competencies, and staffing necessary to fulfill the Hospital's mission:
            - employees receive and understand their position description on hire; and
            - turnover rates are monitored and reported to the Governing Body quarterly.

2. Staff are assessed for competency:
   - performance evaluations are completed at the end of the probationary period and at least annually thereafter; and
   - demonstration of competency (completetion of skills checklist) at the end of the probationary period and annually thereafter.
3. The leaders promote employee safety through enforcement of the Bloodborne Pathogen Exposure Plan and Safe Patient Handling techniques
   - At hire and annually, employees receive training regarding BBFE and safe patient handling
   - Work place injuries are measured, analyzed by the QAPI Team monthly and reported to the Governing Board quarterly

e) Management of Information
1. The Hospital assesses information management needs as a result of QAPI Team activities, licensing, accrediting, and regulatory body requirements, purchasers, payors, and participation in national databases.
2. Medical records are reviewed for completeness, accuracy, legibility, and timely completion.

f) Customer satisfaction surveys
1. Data collected through structured processes will be measured and assessed at least annually to determine customer satisfaction for:
   - patients,
   - Hospital employees,
   - physicians, and
   - referral sources.

g) Compliance Plan
1. Select Medical employees shall be familiar with and conduct their activities in full compliance with the Select Medical Code of Conduct.
2. A self-attestation shall be signed on hire, and via annual re-education and training thereafter.

h) Clinical audits
1. Hospital is expected to maintain a constant state of regulatory and accreditation compliance and readiness.
   - Audits may be conducted by Select Medical Regional Clinical and Quality Team members
   - Results of these audits will be provided to the Hospital CEO, Chair of the Governing Board (Region Vice President) Senior V.P. of Clinical Services, V.P. Survey and Regulatory Preparedness, and VP Quality & Patient Safety
   - Patient and system tracers will be completed by QAPI Team members. Results of these tracers will be reported to the OIC, MEC and Governing Board at least quarterly and utilized as a

source for data collection, compliance status and improvement opportunities.

i) Patient Safety
   1. The Patient Safety Program shall include:
      a. Continual monitoring and evaluation of the effectiveness of the program
      b. A pro-active risk analysis (FMEA) of a high risk process is completed at a minimum of once every 18 months
      c. Integration of patient, patient representative and staff perceptions of risk and suggestions for improving
      d. Mechanism for disclosure of serious medical errors
      e. Root cause analysis of all potential and actual sentinel events and hazardous conditions
      f. Integration of recommendations from TJC sentinel event alert, and
      g. Integration of TJC national patient safety goals (NPSG).
   2. To enhance the effectiveness of performance improvement activities, organizational leaders may participate in interdisciplinary performance improvement teams to ensure collaboration.

VI. Structure for Improvement

A. Design

As the need or an opportunity arises to establish new services or significantly change existing services or processes, the Hospital will consider the following:

- Is the process, function, or service consistent with the purpose, belief, values and the Hospital's mission, vision, and other strategic plans?
- Has the Hospital listened to its customers' ideas, needs, and expectations about how a well-designed process, function, or service would operate?
- What do the experts, as well as scientific methodology, and other reference databases tell the Hospital about the design?
- What databases are available and appropriate to provide information on the outcomes of the performance of such processes, functions, or services?
- What is the availability of resources?

The answers to these questions along with legal, regulatory and accreditation requirements provide a basic set of quality standards and expected outcomes that can be measured, assessed, and improved over time.

The basic premise of this design is to decrease variation in the performance of processes. The design is created after leaders set priorities by the process owners, suppliers and customers with input from experts as necessary.

B. Measurement

Measurement is the foundation of all performance improvement activities. Once the existing level of performance is known, the team can make informed judgements about the stability of existing processes, identify oppportunities for the standardization of the performance of processes, identify the need to redesign processes, and decide if improvement or redesigns of processes meet objectives for improved outcomes.

Measurement and the collection of data, focuses simultaneously on multiple subjects, including:

- Processes and outcomes
- A comprehensive set of performance standards or indicators
- High-risk, high volume, and/or problem-prone processes, and
- Customer satisfaction.

The frequency of measurement is related to the process or outcome measured and the purpose of the measurement.

Leaders set priorities for measurement. The QAPI Team measures processes chosen for intensive assessment and improvement.

The product of measurement is a performance database that provides aggregate information about process performance, outcomes, satisfaction, cost, and judgments about quality.

C. Assessment

Based on the objective measurement of the performance of existing processes and outcomes, the organization will display data using appropriate statistical methods and tools to enhance interpretive analysis. Analysis of the collected data includes:

- assessment of the current level of performance and the stability of the process measured
- identification of areas for improvement
- determination of root causes for current performance
- evaluation of performance improvement strategies and design
- formulation and improvement of standards of care, standards of practice and performance standards, and
- prioritization of performance improvement activities.

The frame or reference for interpreting the collected data will be:

- individual patient progress from admission to discharge and post discharge
- internal trends and comparisons over time
- comparison of Hospitals within Select Medical, and
- comparison with external organizations/benchmarks nationally.

This includes:

- Participation in the Patient Safety and Healthcare Personnel Safety components of the National Healthcare Safety Network (NHSN), and
- Completion and submission of the CMS LTCH CARE Data Set Assessment for all patients at admission and discharge.

Conclusions about the need for more intensive measurement and assessment will be drawn through data analysis and by comparison to established criteria, a single sentinel event, control limits, or essential component(s) of assessment.

D. Improvement

Improving the quality and performance of existing processes and improving outcomes are the goals of our Hospital-wide quality initiatives. As often more opportunities for improvement can be identified than can be reasonably acted upon, priorities will be defined. Once the decision is made to implement an improvement strategy or test a strategy, the relevant departments and disciplines are involved and quality measure(s) selected against which to assess the success of the actions taken. The improvement process is planned, implemented, and measured to assess the process of the improvement plan.

E. Effectiveness

Once a process has been improved and/or standardized, it will again be measured to evaluate the effectiveness of any improvements that have been made. This evaluation may trigger further improvements and initiate repeating the improvement process until the maximum amount of improvement has been realized. From that point forward, the effectiveness of the process will be measured as part of the ongoing QAPI program of the Hospital.

VII. Scientific Model for Performance Improvement

The system for improving outcomes of care and services is based on the scientific approaches and the concepts and principles of continuous improvement. The Hospital will utilize The “Cycle for Learning and Improvement,” as its scientific method. Design of the process and measurement tools will take into consideration the dimensions of performance and will utilize a standardized documentation and reporting system. (See appendix A)

VIII. Data Collection Analysis

Process measurement is based on techniques and tools of continuous improvement process and descriptive statistics.

IX. Accountability for Corrective Action

A. Each service or performance improvement team participating in the program:

1. May utilize the PDCA Fillable Worksheet to document PI activities
2. Will set priorities for improvement opportunities, focusing on those with the greatest potential impact on clinical and financial outcomes and key constituent satisfaction
3. Will be responsible for initiating and evaluating corrective action in response to findings by accrediting agencies and other regulatory agencies and third-party payors.

X. Organization and Responsibilities of the Organizational Improvement Committee

A. The Organization Improvement Committee, under the direction of the Quality Physician Program Director, or designee, coordinates and monitors the overall performance improvement program. This committee is an interdisciplinary, standing committee comprised of representatives from the following: governing board, medical staff, administrative, clinical and support services.

1. The Organization Improvement Committee will:
    a) Review all data, summaries and results from all departments and the QAPI Team
    b) Summarize findings for presentation to the Medical Executive Committee and the Governing Board
    c) Refer appropriate information to clinical/operational departments, or the QAPI Team, for discussion, action and follow-through
    d) Assist in identifying and investigating problems or opportunities for improving clinical and financial outcomes as well as key constituent satisfaction
    e) Assist in setting priorities for follow-up, evaluating and redesigning corrective actions as appropriate
    f) Identify currently acceptable processes utilizing reference data bases and recommend methods for improvement, and
    g) Oversee the annual evaluation of the QAPI program and written plan.

XI. Administrative Support

A. Leadership ensures there are qualified staff and other resources available to support the QAPI function. The Director of Quality Management will:
    1. Participate in, and provide support for data collection, measurement and assessment, systematic screening of data sources and special studies
    2. Along with the Chief Nursing Officer and Human Resources Coordinator, lead the QAPI Team in identifying issues and establishing indicators, benchmarks

and criteria to evaluate clinical and employee safety outcomes and patient satisfaction
3. Develop data collection tools and reporting formats
4. Monitor pertinent local, state and federal regulations, standards and guidelines, as well as private initiatives in performance improvement, and
5. Assist in identification of continuing education needs and other corrective actions.

XII. Exchange of Information

A. The findings of all performance improvement activities, corrective actions taken and results of those actions shall be forwarded to the appropriate staff/committees on a timely basis, according to the following schedule:
   1. Hospital-wide performance improvement activities shall be reported to the Organization Improvement Committee four times a year
   2. A summary of the findings shall be submitted to the Medical Executive Committee and Governing Board quarterly
   3. Information from monitoring and evaluation activities that pertain to more than one service, will be communicated to all Hospital staff to facilitate collaboration and participation
   4. Pertinent information from monitoring and evaluation activities or special studies shall be used in the credentialing of the Medical Staff, in the performance evaluation of Hospital staff and in the planning and procurement of appropriate continuing education offerings.

B. The Director of Quality Management/Patient Safety Officer shall coordinate collection, analysis and reporting of data.

XIII. Data Sources

Sources of data for performance improvement activities shall include but will not be limited to the following: patient care functions, Hospital operations.

XIV. Retention of Data and Reports

All minutes, reports and physician profiles will be kept for ten years per the Documentation Retention Schedule found in the Compliance policy and procedure manual.

XV. Confidentiality

The performance improvement program has been designed to comply with applicable local, state and federal governments and other regulatory or accrediting bodies. Disclosure of performance improvement information is protected.

All data, reports, and minutes are confidential and shall be respected as such by all participants in the program. Names of patients, physicians, and other health care practitioners shall be coded, as appropriate, based on the sensitivity of the information discussed, so as not to identify the individual.

Data, reports and minutes are the property of the Hospital. This information is maintained in the administrative offices. Performance improvement data, reports and minutes shall be accessible only to those participating in the program.

XVI. Annual Evaluation

The Director of Quality Management shall coordinate the annual evaluation of the program and written plan for submission to the Governing Board. The annual evaluation shall address the effectiveness of the program in improving patient care and Hospital operations, resolving problems and achieving positive clinical outcomes and patient satisfaction.

The written plan may be modified at any time with the review of the Organization Improvement Committee, and the approval of the Medical Executive Committee and the Governing Board.

2023 QAPI Calendar

FUNCTION	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
Tracers (short 3-5 each; full 1-2 each) **10 Minute Tracers:** 1. Diagnostic Imaging 2. Dialysis 3. Falls 4. Isolation Med Pass Observation 5. Med Pass Observation 6. NPSG 7. Pain 8. Rehab 9. Restraints 10. Telemetry 11. Airway Assessment 12. Dislodgement **Full Tracers:** 13. Infection Control 14. Insulin 15. Med Management 16. Pulmonary 17. Wound Care **ICARE Tracers:** 18. Call Light Response 19. Discharge Process 20. Mobility * Trace at least 1 patient that fell in your hospital **See below for more detail on tracer activity	**3*** **13** **6**	**2** **17** **8**	**12** **15** **7**	**14** **9** **18**	**15** **10** **20**	**16** **19** **7**	**13** **3*** **9**	**17** **12** **7**	**15** **11** **1**	**3*** **9** **2**	**7** **13** **15**	**12** **18** **17**
Alarm Pulse Check 1. Bed Alarm 2. Telemetry 3, Pulse Oximeter 4. Telemetry Escalation 5. Feeding Tube	Tele	Feeding Tube	Bed alarm	Tele Escalation	Feeding Tube	Pulse Oximeter	Tele	Feeding Tube	Bed Alarm	Tele Escalation	Feeding Tube	Pulse Oximeter
Quarterly Critical Thinking Scenarios (Mock RRT/Codes)		X			X			X			X	
Incident Report Review	X	X	X	X	X	X	X	X	X	X	X	X
Workplace Violence	X	X	X	X	X	X	X	X	X	X	X	X
Complaint/Grievance Review	X	X	X	X	X	X	X	X	X	X	X	X

2023 QAPI Calendar

Employee Safety 1. BBFE & Employee Injury Review 2. Employee Incident RCA Findings & Actions 3. Monthly Quartile Report 4. Discussion re: employee culture of safety 5. Ideas & Suggestions re: employee safety	X	X	X	X	X	X	X	X	X	X	X	X
Infection Control 1. HAI drilldown 2. HLD Scope Monitor 3. EVS Audit Results 4. Dialysis Audit Results	X	X	X	X	X	X	X	X	X	X	X	X
CMS Quality Reporting 1. Timeliness & completeness 2. Overrides	X	X	X	X	X	X	X	X	X	X	X	X
Survey & Regulatory Compliance Review	X	X	X	X	X	X	X	X	X	X	X	X
Vent Weaning	X	X	X	X	X	X	X	X	X	X	X	X
Mobility	X	X	X	X	X	X	X	X	X	X	X	X
Acute Care Transfers	X	X	X	X	X	X	X	X	X	X	X	X
Epic Blood Report Review	X	X	X	X	X	X	X	X	X	X	X	X
OIC Priority Matrix *Review at the first QAPI meeting following OIC*		X			X			X			X	

ADDITIONAL AGENDA ITEMS, AS NEEDED

Survey Readiness Status of Action Plans (survey, FSA etc.)	**Company-wide Initiatives**	**Pro-Active Risk Assessment (FMEA)** *This is also your PI Team*
NPSG	**RCA -** review of Action Plans	**EOC**
Nutrition QAPI	**Other Department PI indicators**	**TJC Healthcare Equity (Access to Transportation)**

** If you are in your survey window, it is recommended that you complete additional tracers each month as part of your survey preparation activities.
QAPI Team members are to complete the tracers. The DQM will ensure the team understands the intent and process for completion.
The DQM will analyze tracer findings prior to the next QAPI Team meeting and discuss with the CNO. Items requiring action will be discussed by the QAPI Team at the next QAPI meeting.

CNOs: Complete 5 Pain Management tracers/audits each quarterly.

DQMs: Complete at least 2 MSPI blood audits monthly