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PERFORMANCE MANAGEMENT AND PROCESS IMPROVEMENT

Chapter 3-Part 2

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QUALITY, RISK, UTILIZATION, AND PATIENT SAFETY PLANS :

- Written plans generally describe quality management / improvement, utilization review/ management, risk management, patient safety functions, and govern their operations .
- The plans may be separate or integrated. All plans should align with the organization's vision and strategic goals.
- All organization wide plans related to the provision of patient care and services must be approved by administration, the governing body, and, in hospitals, by the medical/professional staff.

Utilization Management:

- **Technique used by the payer of health care to manage costs through analysis of medical necessity and appropriateness of care including the appropriateness of:**

1. **Admission**
2. **Treatment and investigation**
3. **LOS**
4. **Discharge needs**

HIGH QUALITY + COST EFFECTIVE.

Utilization Management Plan :

- To ensure that the healthcare organization provides medically necessary at the appropriate level of care while optimizing quality outcomes and financial performance.
- To ensure effective and efficient utilization of hospital facilities and services and includes a performance improvement component. (CPGs)
- Utilization Management generally is described in writing because it is an organization-wide process with many component steps.
- To comply with local and regional healthcare delivery regulation and accreditation bodies

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Utilization Review

Inpatient	Out patient
Admission criteria	Encounter/visit
Treatment & investigation necessity (resources)	Treatment & investigation necessity (resources)
Length of stay	Accessibility of service
Transition of care	Multiple encounter / revisits
Discharge criteria	Referral
Readmission	Revisit

Utilization Problems

Under utilization	Over utilization	Misutilization
• In efficient use of resources. • Underuse of service even with evidences of medical necessity. 1. No order of ttt. 2. No investigation done 3. No care coordination (consultation) 4. No follow up	• Abuse the hospital resources without necessity. 1. Admission without necessity 2. Overuse of antibiotic 3. Increase LOS without necessity 4. Abuse for investigation	Wrongly use of hospital resource. 1. Wrong ttt.

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➢ How to prevent utilization problem?

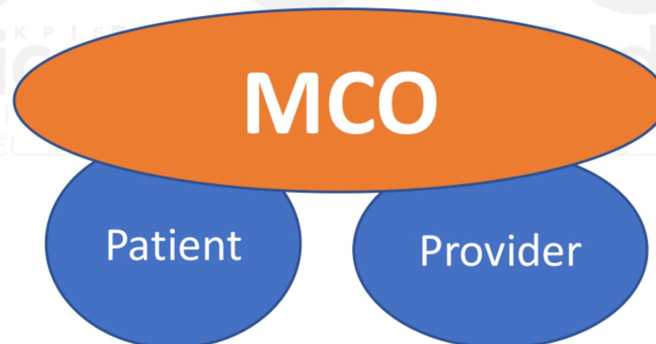
1. Pre-authorization process in MCO (managed care organization.

1. Assessment of data or cases by physician advisor , medical director with subsequent dialogue with primary care practitioners.

1. QI team activities to improve systems and processes associated with inefficient delivery of care.

Managed care Organization:

- Responsible for both **delivery** and **financing** of health care service.
- Establish links among provider, patient and payer
- Both patient and provider have an agreements with MCO:
  1. **Patient** agrees for payments of the services.
  2. **Provider** agree to accept the fees offered by MCO.



Effective Utilization management

1- Top level **commitment.**

2- Recognition that utilization management is a part. of overall quality management.

3-Knowledge of **current laws.**

4- effective UM plan.(**SMART**)

5-**Coordination** with all care levels and care management.

6- Effective **communication** and education systems.

7- Computerized databases **and information systems for tracking** UM data with comprehensive reporting capabilities.

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Care Coordination:

- It is a function that helps ensure that **patient's needs for health services** **are met** and information sharing across people ,functions
  and sites are met over time.

- Coordination **maximizes the value of service delivered to patients** by facilitating beneficial ,efficient ,safe and high quality services and improving health outcome.

- It involves **management of delivery of wellness** disease and chronic care services to both individual client **(case management)** and selected populations **(population management).**

- Care coordination assumes there is a patient care management system in place which **link patient needs to available services.**

How does Care Coordinator work?

1. Proactive care plan and follow up
2. Communication: **information availability** and shared decision making
3. Information systems: **easily accessible** by practitioner
4. **Transition/hand off** between staff.

SBAR: **Structured Communication tool designed to convey a great deal of information to be transferred accurately between HCW.**

STOP!

WHAT'S THE PROBLEM?

Errors in communication is one of the main causes of adverse events in clinical practice.

WHAT'S THE SOLUTION?

The SBAR tool helps to convey information effectively in a range of situations including handovers, referrals and when seeking senior advice.

Use of the SBAR tool during medical emergencies is recommended in the NICE Quality Standard 174.[1]

The overall goal is to improve patient safety.

Research has shown improved patient outcomes particularly when SBAR has been used over the phone.[2]

LOOK

SITUATION (WWW.Y)

- Who you are
- Where you are calling from
- Who you are speaking about
- WhY you are calling

BACKGROUND

- Age, Gender
- Presenting complaint
- Very brief summary of relevant background history

ASSESSMENT

- NEWS and key clinical findings
- Relevant tests & treatments carried out so far
- (Differential) Diagnosis
- Any specific major concern

RECOMMENDATION

- *"Can I please ask you to [help me with/advise me/review]..."*
- *"Is there anything I need to do in the meantime?"*

LEARN

REMEMBER! Ask the receiver to repeat key information to ensure understanding.[3]

The plan also needs to be communicated to the patient and/or their next of kin.

1. http://bit.ly/3auJX6F *(NICE)*
2. http://bit.ly/3auLHwJ *(BMJ)*
3. http://bit.ly/30DX5IE *(NHS Improvement)*

Our SBAR video playlist: http://bit.ly/whatisSBAR

Authors: *Sunny Jutla & Martin Wiese* ***Date:*** *27.01.2020* ***Version:*** *2.0*

* IDENTIFY SELF & SITE/ UNIT PERSON CALLING from
* IDENTIFYING INDIVIDUAL (NAME & D.O.B)
* SYMPTOM ONSET & SEVERITY

* DATE/TIME of ADMISSION
* ADMITTING DIAGNOSIS
* RELEVANT MEDICAL HISTORY
* LAB/DIAGNOSTIC RESULTS
* NOTABLE CHANGES

SITUATION

BACKGROUND

ASSESSMENT

RECOMMENDATION

* SUSPECTED UNDERLYING CAUSE or CONCERNS

* RECOMMENDATION & EXPECTATIONS
  ~ CLEAR/SPECIFIC about URGENCY of REQUEST & EXPECTED TIME FRAME

PURPOSE

* COMMUNICATION TOOL to STRUCTURE CONVERSATION about MEDICAL SITUATIONS REQUIRING IMMEDIATE ATTENTION & ACTION
  ~ REDUCES ERRORS
  ~ ENCOURAGES ASSESSMENT & DECISION-MAKING SKILLS

OSMOSIS from ELSEVIER

CASE MANAGEMENT

- It is the clinical and **administrative coordination of all phases of patient care**, where specific clinical outcomes are achieved within a time frame.
- The case management process **consists of intake and assessment**, **development of a care plan**, case **coordination**, **discharge planning**, and **quality** management.
  - Intake and assessment begins with admission to particular service.
  - A comprehensive care plan is developed after the initial assessment.
- **The plan of care should contain:**

  1-A treatment plan established by the healthcare practitioner in cooperation with the primary care provider, the patient, and family.

  2-Clearly defined, measurable short- and long-term **goals and expected outcomes** with time frames for completion.

  3-Plan and tools for **patient and family education** & case coordination and referral information.

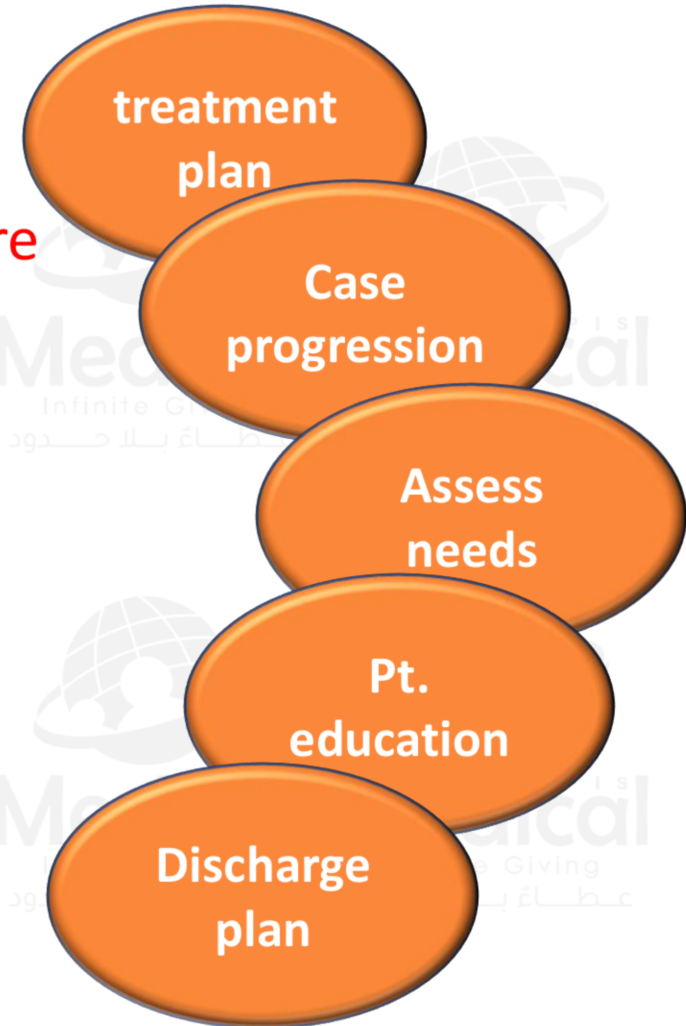
treatment plan

Measurable goal

Education

➢ Role of case manager?

1. Ensure that only **medically appropriate** and **cost** conscious care is provided to patients.
2. Maintains an **overview of the case** and helps the primary care provider maintain an objective **ongoing assessment of the patient's healthcare needs**.
3. Responsible for **ensuring continuity of care** from hospital to home, home to hospital, or hospital to subacute or long-term care facility



Community of case management = Care coordinator

1. Healthcare delivery model developed by healthcare providers for community based population of patients **with chronic conditions requiring intervention to help prevent emergency visits or hospitalization.**

2. Nurse and practitioners **home visits and follow up visits** ,communication with primary care and specialist physician.

3. It's **a team approach** involving the nurse , practitioner , hospital social services , case management based on patients needs.

4. Patients are **candidate** if they meet one or more of the following criteria:
   1)Chronic condition.
   2)Repeated hospitalization.
   3)Complex medical treatment .
   4)Absence of family.

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Care Coordinator	Case Management
Ongoing in the **community level** (prevent decline in patient health before they happen)	Triggered by **hospitalisation (**focused on safely discharging the patient
Community based (Family based)	**Patient** based
Build relationship between the team and patient care to identify the risk and prevent it.	Working to link the care team to create comprehensive care plan.

POPULATION MANAGEMENT

1. Case management rightfully focuses on the individual patient.
2. The concept of population management is a newer epidemiological focus on groups of patients with certain conditions.
3. We will focus on:
   - Disease Management
   - Demand Management programs.

Shared capitation
مبلغ ثابت بيتم الاتفاق عليه

➢ Disease management:

1. Generally refers to the management of populations of patients with high risk, high cost, high volume, high maintenance chronic disorders across the continuum of care.
2. It is intended to help patients reach better outcomes and reduce adverse impact on quality of life and healthcare costs.

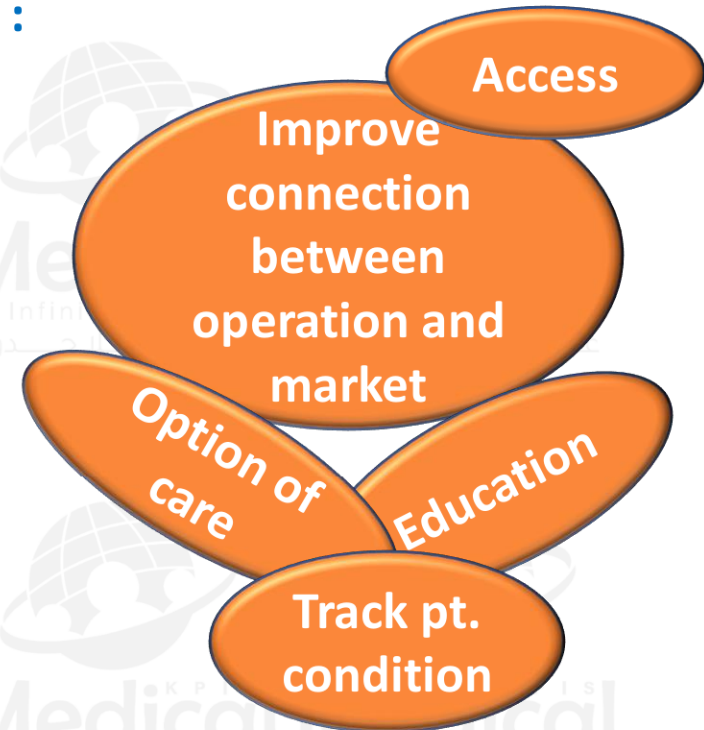
➢ Component of full service disease management program:

1. Population identification. (selection criteria)
2. CPGs
3. Plan of care (potential/proactive)
4. Risk assessment
5. Patient & family education/behavior change
6. Outcome measurement and evaluation
7. Routine reporting

Demand management:

It is the use of decision support system to influence the patients 'decisions about :

1. whether ,when , where and how to access medical services.
2. Demand management incorporates tele-service technologies ,triage.
3. The managed care organization's use of a 24-hour nurse-staffed telephone hotline to inform member/patient callers of care options and provide self management education



Components of the Demand management support system:

- Call center or hotline 24hrs.
- staffed with RNs(referral nurse) who use **protocols** or clinical algorithms approved by physicians to inform callers about care options.

1. Scheduling of physician visits.
2. Education programs.
3. Lifestyles and stress management, weight reduction , smoking cessation..

Risk Management:

- is the process of identifying, assessing and controlling **threats** to an organization's **capital** and **earnings**. These threats, or **risks**, could stem from a wide variety of sources, including financial uncertainty, legal liabilities, strategic **management** errors accidents and natural disasters.

Respond to the chance of:

1. **increasing incidence. of medical-legal issues.**
2. **control the financial costs.**
3. **diminish the emotional costs to family, society, the physician and health care insurance.**

That is why the process of Risk Management (RM) was devised.

Risk Management in a healthcare setting seeks to anticipate, respond to, control, and minimize the possibility of harm to patients, staff, visitors, and/or property loss or damage to the organization itself.

The role of the Risk Manager:

1. Identify and manage risk
2. Prevent and minimize risk of harm (Patient,Visitor,HCW)
3. Identify opportunity of improvement
4. Reduce (not eliminate financial loss).

- control liability prevent or reduce financial loss and protect the financial assets of the organization.
- Effective Risk Management Programs emphasize "harm prevention" for patients, visitors, and staff more than financial loss.
- The emphasis of QI on improving processes is a great benefit to the ongoing prevention and reduction efforts of Risk Management.

Risk

The possibility of loss or injury.

Management

The act or art of conducting or supervising something

➢ day-to-day responsibilities of the Risk Manager include:

- dealing with incident report investigations.
- patient complaints.
- litigious situations.
- adverse patient events or outcomes.
- conducting root cause analysis.
- proactively assessing risk to the organization(FMEA)

❖ Regardless of the type of healthcare organization, the Risk Management Plan should be developed by the executive and Risk Management leadership and must be approved by the organization's governing body. The plan is the road map for all risk related activities, clinical and service related, for the organization.

Traditional and Enterprise risk management

Traditional risk

- Retrospective action
- Focus on hazard
- Segmental (local approach)
- One dimensional assessment (S)
- insurable

Enterprise risk management

- proactive action
- Focus on the potentiality
- Holistic approach
- Multi dimensional assessment (S-D-O)
- Non insurable risk

Risk Management Program Components:

- **Loss prevention** and reduction (clinical and administrative components)
- **Claims** management
- **Safety/security** programs
- **Patient relations** programs
- **Contract** and **insurance** premium review
- **Employee** programs/workers compensation
- **Resource** and support system review
- **Linkage** with quality, patient safety, and utilization management

Enterprise Risk management:

- the process of identifying, assessing and controlling **threats** to an organization's capital and earnings.

- **Risk domains:**
  1. Operational
  2. Clinical & Patient Safety.
  3. Strategic.
  4. Financial.
  5. Human Capital.
  6. Legal & Regulatory.
  7. Technological.
  8. Environmental- and Infrastructure-Based Hazards

Component of ERM:

Steps:

1. Identify risk
2. Analyze risk
3. Evaluate risk
4. Treat risk
5. Monitor risk

Risk Identification:

The first step in loss prevention and reduction is the identification of risks in the organization are.

These risks can be clinical risks or non-clinical/administration risks.

The risk management program must contain processes for the identification of potential risks and implementation of steps to avoid or reduce the risk of adverse occurrences or claim and/or to prevent recurrence of the risk. When a risk with adverse impact has occurred, immediate action is required

Relationship Between FMEA and RCA

FMEA is a Pre-Problem Solving Methodology

- Opportunity to record what could go wrong before it does
- Take actions to prevent failures
- Both Predictive and Preventative

Root Cause Analysis (RCA) or Failure Analysis (FA) is a Post-Problem Solving Methodology

- Failure has already occurred and must be analyzed to prevent recurrence

RCA = Detection Cycle (Failure)

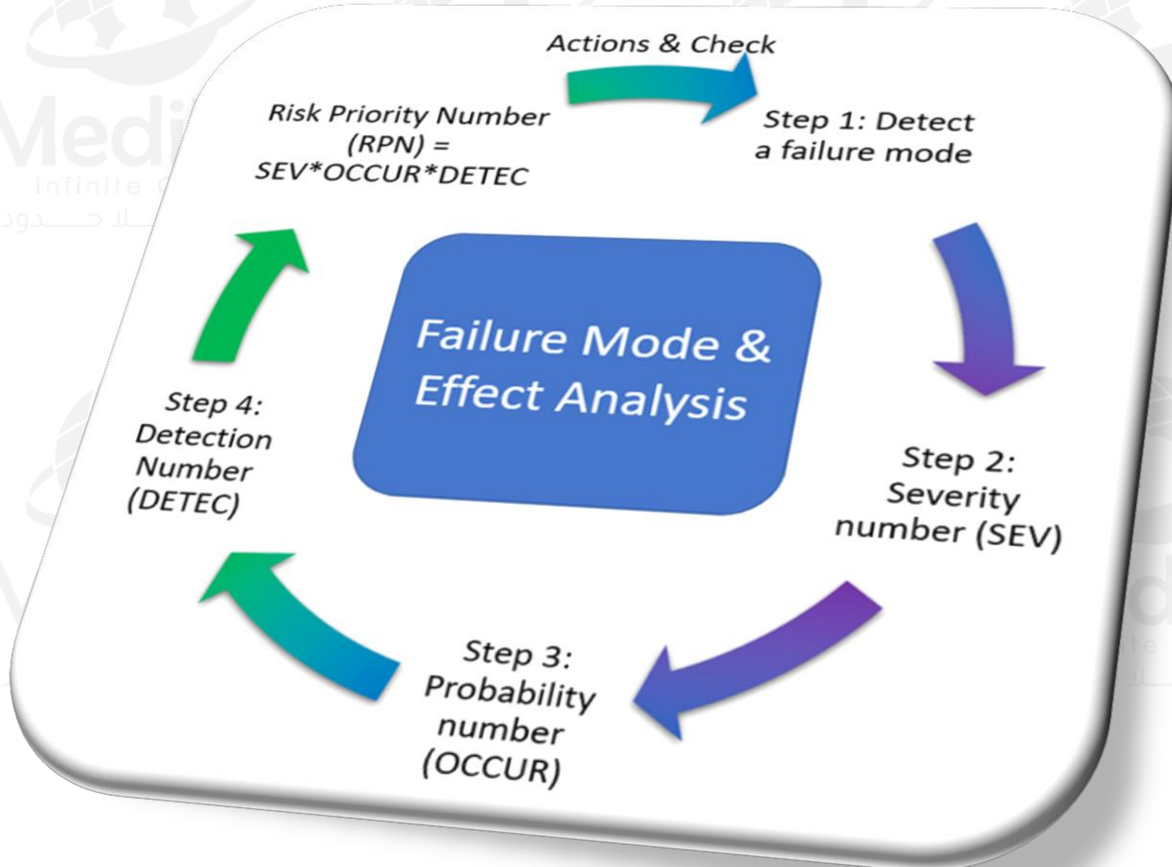
FMEA = Prevention Cycle (Failure)

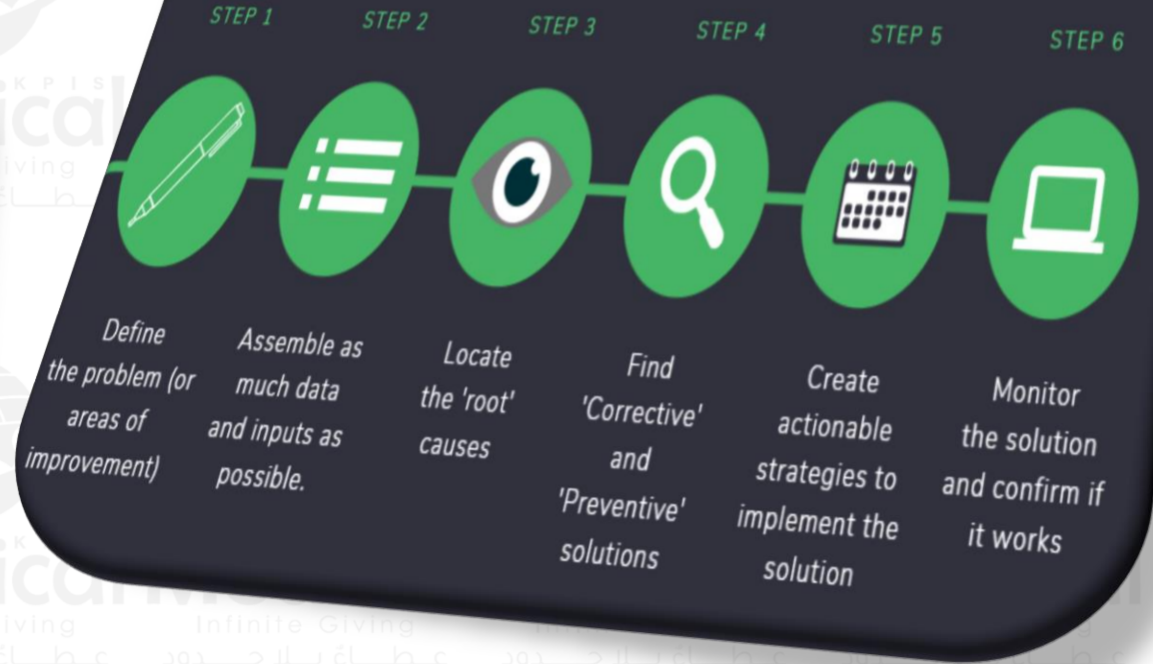
Risk (FMEA) is used as the substitute for Failure (RCA)

Risk Identification:

FMEA = Proactive

RCA = Reactive





➤ How do we identify the risk (source of risks identification.)

Continuous measurement and data collection through:

Occurrence screening – Incident report (early warning system)

External review data – patient satisfaction – physician referrals – observations – safety committee.

Review of : litigation cases in which medical records are requested or identified bylaw or literature review).

Continuous analysis of key exposure areas to identify risks:

Professional **malpractice**
General liability for **injuries to patients** , visitors
Director liability for **negligent actions** by individuals.
Environment& employee related.
Financial or contract related

➢ Example for :

Negligence

1. Lack of proper care
2. Basis on malpractice
3. Reasonable care based on a defined standard
4. Mal practice judged by peer review

Professional liability

1. Wrong diagnosis ---→ Improper TTT.
2. TTT out side field of competency (privellidge)
3. Abandonment
4. No informed consent
5. No investigation
6. No result of the test

Organization wide early warning system:

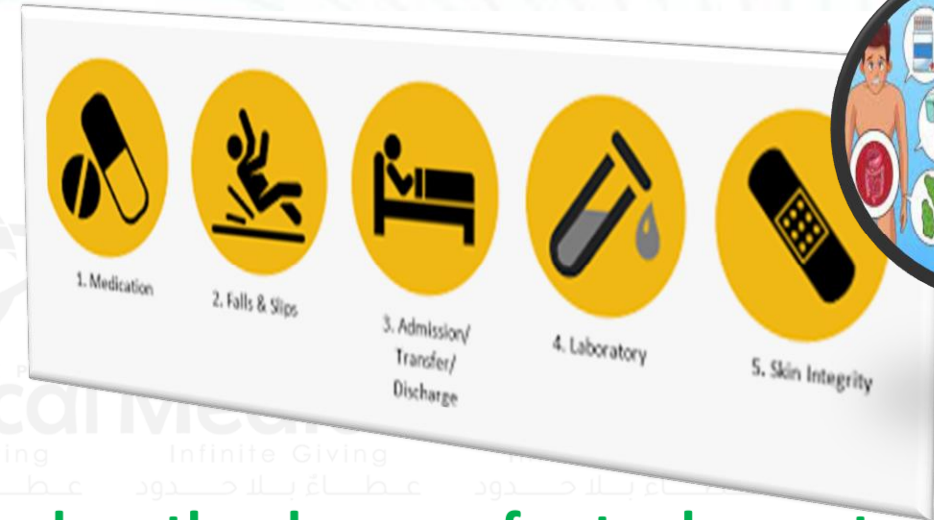
- An organization wide system to **screen** **all patients for real or potential adverse incidents, issues, and occurrences** that might result in **increased risk to the organization** or corporation and/or less than optimal quality of care.

To identify as early as possible all:

1. Adverse Events
2. Potentially compensable event.

Adverse Patient Occurrence (APO):

An unexpected, untoward event with actual or potential negative impact on the patient, or person.



Potentially Compensable Event (PCE):

An APO that might result in a lawsuit or claim based on the degree of actual or potential impact on the patient.

- In most healthcare organizations, the risk manager has been given a *list of PCEs* that the facilities insurance company wants to be notified about if they should occur.
- The insurance company then *examines* the record and makes a determination if the event truly is a potentially compensable event. If it is, then the medical record and any equipment involved in that event should be *sequestered* to prevent any alteration to the original record.

➢ In case of claim:

- The *staff* should be aware that if an adverse event occurs and there is equipment involved, it should be taken out of services and sent to the Risk manager's office. This would include any equipment, medications, syringes and supplies in use at the time of the event. If this is not accomplished at the time of the event, it is *too late to sequester* these items. If later it is determined that the event was not a PCE, these items can be discarded as appropriate, or placed back into the inventory *for use.*

- The *Risk Manager* must sign legal papers indicating this when the records are sent to attorneys during a lawsuit. If the medical records are on paper, the record of the visit where the event occurred should be copied.

The original must be placed under lock and key, usually in the Risk Management office, and the copy is placed back in medical records in case the patient comes to the facility again for patient care services.

In case of claim:

- If someone wants to add a late entry to the record, the individual should be escorted to a private room, and the escort should remain in the room after giving the individual the original record, an appropriate form to write on and a pen.
- The individual must date, time and sign the entry, as well as indicate that it is a late entry.
- The individual is not allowed to remove or cross out anything in the record
- If the medical records are ***electronic***, the Information Management department should make the record read only once the patient is discharged following the event.
- If an individual wants to add a late entry, the Risk Manager should call the Information Management department to unlock the record and then to relock it after the entry is made.

➢ In case of claim:

Equipment sequester/Isolation

Medical record kept under locked and key in RM office

Copy place back to MRD

For late entry staff should be escorted in room & sign for late entry

Not allow to remove or cross out in Medical record

EMR will be in read only mode

IHI Global Trigger Tool:

- Developed by IHI , uses consistent retrospective random review of patient records and a list of triggers to track three measures:

- **Adverse events per 1,000 patient days:**
  Total# adverse events/ Total Length Of Stay (LOS) for all records reviewed X 1,000

- **Adverse events per 100 admissions:**
  Total# adverse events/ Total records reviewed X 100

- **Percent of admissions with an adverse event:**
  Total# records with at least 1 event/ Total records reviewed X 100

Triggers

"clues" or "generic screens" to guide trained reviewers with clinical backgrounds (usually nurses) to review the information in the patient's record that may be confirmed by a physician as an adverse event

<u>Examples:</u> include any code or arrest, patient fall, transfer to higher level of care, change in surgical procedure, readmission within 30 days, and intensive care pneumonia onset.

Harm

unintended physical injury resulting from or contributed to by medical care that requires additional monitoring, treatment, or hospitalization, or that results in death

❑ Harm CATEGORIES:

- Category E: Temporary harm to the patient and required intervention
- Category F: Temporary harm to the patient and required initial/prolonged hospitalization
- Category G: Permanent patient harm
- Category H: Intervention required to sustain life
- Category I: Patient death

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Organization wide early warning system:

- **Generic screening:**
  Concurrently screen every patient hospitalization, ambulatory service or home care
  An example of 100% review process

- **Incidents reporting:**
  Notification of adverse patient occurrence & PCE

- **Patient safety data screen:**
  NAHQ survey

Risk Assessment:

- Risk analysis
- Risk Evaluation

2-Risk Analysis:

- Once potential risks are identified, they must be analyzed in order to determine their significance

- A tool that is commonly utilized when an adverse event *occurs* is a Root Cause Analysis (RCA).

- If *potential* for risk is identified, then a Failure Mode Effectiveness Analysis *FMEA* should be used to identify the risk and attempt to eliminate the risk before an adverse event occurs.

3-Risk evaluation:

- Time of risk ranking
- Process of prioritize the potential risk

RPN=S*F

1. Who will score the risk?
2. How we will calculate it?

Likelihood \ Severity	Negligible	Minor	Moderate	Major	Catastrophic
Almost certain	5	10	15	20	25
Likely	4	8	12	16	20
Possible	3	6	9	12	15
Unlikely	2	4	6	8	10
Rare	1	2	3	4	5

LimbleCMMS

The likelihood that the failure will occur.

RPN (RISK PRIORITY NUMBER) = Severity x Occurence x Detection

How severe are the effects of the failure on the system.

The chance that the failure will be detected.

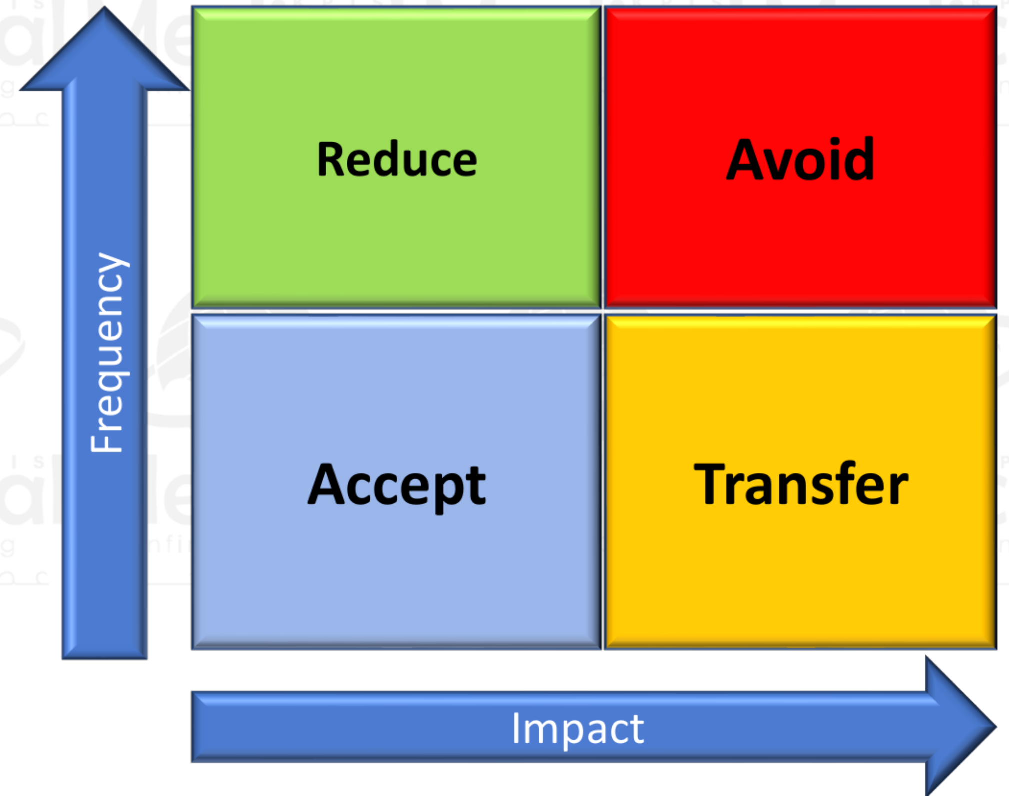
The RPN ranges from 1 (absolute best) to 1000 (absolute worst) as all 3 inputs are ranked on a scale 1 to 10.

4-Risk treat:

The process of selecting and implementing of measures to modify risk.

- There are four main risk management strategies, or risk treatment options:

1. Risk acceptance.
2. Risk transference.
3. Risk avoidance.
4. Risk reduction.



1. Risk acceptance:

A risk is accepted with no action taken to mitigate it

2.Risk transfer (shifting):

A risk is transferred via a contract to an external party who will assume the risk on an organisation's behalf.

3.Risk avoidance:

A risk is eliminated by not taking any action that would mean the risk could occur.

4.Risk reduction/prevention:

A risk becomes less severe through actions taken to prevent or minimise its impact.

Risk monitoring:

- The process of tracking and evaluating the level of residual risk

- Simply after implementing our action plan (our treatment option) again we will assess the risk score expecting decreasing the score but if it is still high we will analyse the risk again and change our strategy or our action plan to manage it.

- Risk assessment reflects the power of the frontline understanding the processes in their unit will and how it affect on the organization and reflects also system thinking for the leader in the organization.

Role of GB in ERM?

1. **Support** implementation of risk management program.
2. Establish firm **polices** to minimize risks.
3. Ensure the compliance to laws and regulations.
4. To oversee the processes supporting public reporting of adverse events.
5. Support all to **Obtain proper consent** for medical care.
6. Know and monitor the area of organizational risks(FMEA results).

Infection Prevention and Control:

The Infection Preventionist:

- Should be aware of, and prepared for, *a global outbreak* such as there was with Ebola
- Concerned with the transmission of disease and safety, the underlying function is patient/employee safety, decreased morbidity and mortality of infectious pathogens, and decreasing institutional costs relating to nosocomial infections. The primary recipient of this concern is no longer just the patient, but also the staff and visitors to the healthcare organization.
- There must be policies and processes implemented to mitigate the risk of spreading infections.
- *every member* of the organization is *charged* with prevention and containment of infections in the organization.

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Medical KPIS Infinite Giving عطاء بلا حدود

The Infection Preventionist's role:

Identify patient infections and to assure that the patient and others are doing all they can to prevent the spread of that infection.

The Infection Preventionist is also responsible for employee health in many organizations.

Ongoing review and analysis of healthcare-associated infection data (based on the organization-approved definition), risk factors and special studies for infection prevention and control.

The Infection Preventionist processes:

- Identification through cross-contamination of surveillance data and case finding
- analysis of data
- investigation of significant infections
- prevention through strategies to reduce risks and prevent infections
- control of infection prevention activities
- reporting surveillance data
- identified cases
- reporting improvements in reductions over time

➢ Goal of infection control:

Reduce risk of hospital acquired infection(nosocomial infection).

Processes involved in Infection Control program "Surveillance /control cycle"

Surveillance types:

1. **Total Surveillance EX.(infection rate)**
2. **Targeted Surveillance Ex.(CAUTI,CLABSI)**
    - This is often called 'focused' surveillance.
    - This type of surveillance is conducted to measure

the occurrence of specific infection problems, or to confirm an outbreak

The Centres for Disease Control and Prevention (CDC)

- is **the national public health institute** of the United States.
- Its main **goal** is to **protect public health and safety through the control and prevention of disease, injury, and disability.**
- The CDC **focuses** national attention on **developing and applying disease control and prevention**

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➢ The national Healthcare Safety Network:

1. **IT** is a tracking **system utilized by the CDC** to **identify infection prevention problems To utilize the information obtained for** benchmarking
2. To comply with **mandatory public reporting** state and federal mandates, and to encourage national efforts towards the elimination of healthcare acquired infections.
3. Organizations participating in this database network include **acute care hospitals, psychiatric and rehabilitation hospitals, outpatient dialysis facilities, long-term care facilities and ambulatory surgery centres**.
4. The NHSN website, provides definitions, guidelines for data collection and other information for the NHSN indicators.
5. **Data from NHSN is utilized by the CMS.**

➢ The national Healthcare Safety Network component:

➢ **Patient Safety Component:**

1. Device associated Healthcare Acquired infection
2. Surgical site infection
3. Multi drug resistance

➢ **Long term Component:**

1. MDRO
2. CAUTI

➢ **Healthcare Personnel Safety:**

1. Healthcare personnel exposure module
2. Healthcare personnel vaccination module

Environment Safety Program:

- Environment of Care Committee (EOC), sometimes called the Safety Committee, is a multidiscipline committee that is responsible for the care of the environment and the individuals that function within that environment.
- This committee includes representation from throughout the organization but specifically includes members of the Facilities staff, senior leadership, quality improvement staff, the Infection Preventionist and the Risk Manager.

➢ This committee is charged with monitoring seven areas of the organization:

1. Safety
2. Security
3. Fire Safety
4. Emergency Management
5. Hazardous Materials
6. Medical Equipment
7. Utility Management

- One of the functions of this committee is to conduct a periodic survey (often called rounding) throughout the facility on a routine basis looking to identify hazard, potential areas where risks, infections and other things can occur.

- The risks identified must be handled as soon as possible and then tracked and discussed at the EOC meetings to identify patterns, trends, and needed improvement activities.

Financial Management

1. Financial management is the study and control of money resources to meet the goals and objectives of the organization.
2. Linking the annual budget process to daily operations.
3. It is one of the most objective forms of performance measurement, particularly for the dimension of efficiency.

Financial plan (budget)

Financial Monitoring

Analysis and variance reporting

Financial plan (budget)

How the organization will allocate and use its resources?

- Basis of financial performance evaluation
- Quantitative expression
- Cost control
- Sense of financial responsibility

Financial Monitoring

Organisation monitor the annual budget to meet the financial target and strategic goals. By:

1. **Balance score card**
2. **Recognition**

Analysis and variance reporting

A management review tool to **compare** **predicted revenues** **and** **expenditures** **versus** **actual one .**

- Decisions regarding future staffing, services, supplies, and capital are made based on budget analysis.
- Financial statements :show budgeted vs. actual amounts spent **for the month, quarter, and/or year-to.date(monitored all the time)**
- **Variance reports** :**Internal** **warning systems** alerting managers and higher level management **to possible excess expenditures, inaccurate accounting**.

Cost analysis method:

Comparing/evaluating quantitatively **all costs incurred** and **benefits returned** for each proposed service or program.

Return On Investment:

Financial ratio used to calculate the benefit an investor will receive in relation to their investment cost.

Return on Investment

$$ROI = \frac{\text{Profit}}{\text{Cost of Investment}} \times 100\%$$

Profit = Current Value - Cost of Investment

The Role of the Quality/Utilization/Risk Professional in Organizational Preparation for Quality Management/Performance Improvement :

- Secure the approval, support, and commitment of all key players, which at a minimum includes the governing body, administration leaders, medical staff leaders, medical directors, nursing leaders and other clinical and support service directors/managers .

Leaders each must make a personal commitment and be willing to participate in Q/R/U management strategy development and implementation.

All others in the organization must see leadership develop a passion for Q/R/U management.

The healthcare quality professional must have the leadership skills and passion

1) to maximize the commitment of other key players

2) to identify those leaders and others who are willing to be the Q/R/U champions for the cascade of activities throughout the organization.

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Saudi Physical Therapy Association

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عطاء بلا حدود

Thanks

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