

APPENDIX 6



Maturity Matrix 2014

Criteria Definitions

- Level 1 – Does not yet meet policy requirements, but shows evidence of making progress toward establishing key program elements.
- Level 2 – Meets requirements for the Quality Management and Patient Safety Programs set forth in statewide policy.
- Level 3 – Exceeds minimum program requirements. Staff actively participate in improvement processes, and are creating a culture of continuous learning and improvement.

*Institutions must satisfy all criteria within a level to achieve that level (if not all criteria is satisfied, the institution defaults to the next level below).

Institutions not meeting all Level I criteria default to "Level 0".

Institution Performance Improvement Work Plan			
Subcategory	Level 1 Criteria	Level 2 Criteria	Level 3 Criteria
Updates	<ul style="list-style-type: none"> • Quality Management Committee (QMC) updates the plan at least annually, adopting new improvement priorities as appropriate. • QMC has submitted an update on the status of initiatives to headquarters Quality Management Section and the Regional Health Care Executives at least once in the past 12 months. 	<ul style="list-style-type: none"> • Quality Management Committee (QMC) updates the plan at least quarterly, adopting new improvement priorities as appropriate. • QMC has submitted an update on the status of initiatives to headquarters Quality Management Section and the Regional Health Care Executives within the past three months. 	<ul style="list-style-type: none"> • Quality Management Committee (QMC) updates the plan at least quarterly, adopting new improvement priorities as appropriate. • QMC has submitted an update on the status of initiatives to headquarters Quality Management Section and the Regional Health Care Executives within the past three months. The update includes an accurate and detailed status of initiatives, performance objectives, and data trends to date.
Plan Content	<ul style="list-style-type: none"> • Plan includes priority improvement areas, relevant and measurable performance objectives, and improvement strategies. • Plan contains less than 50% of High Priority Improvement Areas for institution. • Plan may not reference all major improvement projects occurring at the institution (other corrective actions plans/ improvement projects are managed in separate documents). 	<ul style="list-style-type: none"> • Plan includes priority improvement areas, relevant and measurable performance objectives, and improvement strategies. • Plan contains 50-75% of High Priority Improvement Areas for institution. • Plan covers all major improvement projects occurring at institution. 	<ul style="list-style-type: none"> • Plan includes priority improvement areas, relevant and measurable performance objectives, and improvement strategies. • Plan contains 85% or more of High Priority Improvement Areas for institution. • Plan covers all major improvement projects occurring at institution.
Communication with and Engagement of Staff	<ul style="list-style-type: none"> • QMC has been disseminated the plan to health care staff at least once in the past year. 	<ul style="list-style-type: none"> • QMC disseminates an updated plan at least quarterly, so that all health care staff have current information about the status of improvement projects. 	<ul style="list-style-type: none"> • QMC disseminates an updated plan at least quarterly to all health care staff. The plan and updates are posted in a centralized location where health care staff can easily access it. • Staff can articulate at least some of the current priorities and how their work contributes to improvements.



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Evaluating Overall Operations and Performance

<i>Subcategory</i>	<i>Level 1 Criteria</i>	<i>Level 2 Criteria</i>	<i>Level 3 Criteria</i>
Review of Performance Data	<ul style="list-style-type: none"> The QMC reviews progress toward Improvement Plan objectives at least monthly, using reports such as the Health Care Services Dashboard. 	<ul style="list-style-type: none"> The QMC reviews progress toward Improvement Plan objectives at least monthly, using reports such as the Health Care Services Dashboard. The QMC reviews system surveillance data at least quarterly to identify improvement opportunities, including health care incident /adverse event data. The QMC identifies strengths and weaknesses in the institution’s implementation of the Primary Care Model. 	<ul style="list-style-type: none"> The QMC reviews progress toward Improvement Plan objectives at least monthly, using reports such as the Health Care Services Dashboard. The QMC reviews system surveillance data at least quarterly to identify improvement opportunities, including health care incident/adverse event data. The QMC identifies strengths and weaknesses in the institution’s implementation of the Primary Care Model. The QMC compares performance with other institutions and organizations outside the CDCR.
Usable Formats	<ul style="list-style-type: none"> Data are provided “as is” in standardized formats (e.g., Institution Scorecard). 	<ul style="list-style-type: none"> Data are provided in a variety of formats, particularly using graphics, depending on the needs of the audience and to promote positive behavior change, including at unit level (e.g., by clinic, care team, patient, housing unit, staff person, etc.). Numbers in the population/sample/sub-sample are large enough to say whether differences or changes have meaningful significance. <ul style="list-style-type: none"> Data used in analyses have denominators greater or equal to 30. Data are trended over time to identify levels of performance, patterns, trends, and variations. <ul style="list-style-type: none"> Statistically significant findings are noted, as well as findings with insufficient power. 	<ul style="list-style-type: none"> Data are provided in a variety of formats, particularly using graphics, depending on the needs of the audience and to promote positive behavior change, including at unit level (e.g., by clinic, care team, patient, housing unit, staff person, etc.). Numbers in the population/sample/sub-sample are large enough to say whether meaningful differences or changes are significant. <ul style="list-style-type: none"> Data analyses use the entire population or samples of greater than or equal to 30 are selected using random sampling or systematic sampling (every kth person). Data are trended over time to identify levels of performance, patterns, trends, and variations. <ul style="list-style-type: none"> Statistically significant findings are noted, as well as findings with insufficient power. Data are annotated to show events that may have affected the findings (e.g., marked to show when an intervention started and ended).
Communication with and Engagement of Staff	<ul style="list-style-type: none"> The QMC disseminates data to health care staff at least monthly. 	<ul style="list-style-type: none"> The QMC disseminates data to health care staff at least monthly and managers and supervisors highlight important changes in performance at discipline-specific or unit-level staff meetings and other appropriate forums. 	<ul style="list-style-type: none"> The QMC disseminates data to health care staff at least monthly and managers and supervisors highlight important changes in performance at discipline-specific or unit-level staff meetings and other appropriate forums.



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			<ul style="list-style-type: none"> Managers and supervisors are trained in using data to investigate problems and test solutions. Managers, supervisors, & line staff use data in their day-to-day work to investigate problems and test solutions.
Data Validation	<ul style="list-style-type: none"> Staff conducting statewide audits apply standardized methods for data collection, in accordance with statewide policies, procedures, and written instructions. 	<ul style="list-style-type: none"> Staff conducting statewide audits apply standardized methods for data collection, in accordance with statewide policies, procedures, and written instructions. Staff collecting / analyzing data are appropriately trained. When the institution receives notice that data is unreliable, leaders take effective action to improve accuracy. 	<ul style="list-style-type: none"> Staff apply standardized methods for data collection, in accordance with statewide policies, procedures, and written instructions. Staff collecting / analyzing data are appropriately trained. When the institution receives notice that data is unreliable, leaders take effective action to improve accuracy. The QMC periodically tests data reliability through cross-checking against an independent data source, chart reviews, redundant analysis with an independent reviewer, and other techniques.

Improvement Projects

Subcategory	Level 1 Criteria	Level 2 Criteria	Level 3 Criteria
Project Management	<ul style="list-style-type: none"> Each improvement project has an assigned oversight committee and project lead. 	<ul style="list-style-type: none"> Each improvement project has an assigned oversight committee and project lead. Improvement projects provide regular, documented project updates (at least quarterly) to the oversight committee. Oversight committees take action when projects are not making progress. 	<ul style="list-style-type: none"> Each improvement project has an assigned oversight committee and project lead. Improvement activities are documented in a work plan, which divides activities into individual tasks with assigned staff and deadlines. Project teams provide regular, documented project updates (at least quarterly) to the oversight committee. Oversight committees take action when projects are not making progress.
Improvement Models and Techniques	<ul style="list-style-type: none"> All improvement projects: <ul style="list-style-type: none"> Are supported by staff of multiple disciplines who have day-to-day knowledge of the health care processes involved. Include executive sponsors who have received training in their project role. 	<ul style="list-style-type: none"> All improvement projects: <ul style="list-style-type: none"> Are supported by staff of multiple disciplines who have day-to-day knowledge of the health care processes involved. Include executive sponsors who have received training in their project role. Establish clear and measurable 	<ul style="list-style-type: none"> All improvement projects: <ul style="list-style-type: none"> Are supported by staff of multiple disciplines who have day-to-day knowledge of the health care processes involved. Include executive sponsors who have received training in their project role.



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	<ul style="list-style-type: none"> ○ Establish clear and measurable objectives. 	<ul style="list-style-type: none"> ○ objectives. ○ Take steps to sustain improvements when an initiative has proven successful, such as codifying new processes in a local operating procedure or documenting new roles in duty statements or desk manuals. ● Improvement projects use one or more of nationally-recognized improvement models or techniques referenced in policy. 	<ul style="list-style-type: none"> ○ Establish clear and measurable objectives. ○ Take steps to sustain improvements when an initiative has proven successful, such as codifying new processes in a local operating procedure or documenting new roles in duty statements or desk manuals. ● Project teams use a range of nationally-recognized improvement models or techniques referenced in policy. ● Project background, goals, activities, and results are well documented.
Best Practices	<ul style="list-style-type: none"> ● Improvement teams research best practices when developing interventions. 	<ul style="list-style-type: none"> ● Improvement teams research best practices when developing interventions. ● The QMC and other institution staff use performance data to identify best practices at other institutions and contact other institutions to gather input about potential changes that might be adopted. ● Institution staff know where to find the Best Practice resource page on Lifeline. 	<ul style="list-style-type: none"> ● Improvement teams research best practices when developing interventions. ● The QMC and other institution staff use performance data to identify best practices at other institutions and contact other institutions to gather input about potential changes that might be adopted. ● Institution staff know where to find the Best Practice resource page on Lifeline. ● The QMC and other institution use performance data at the clinic or staff-person level to identify best practices within the institution. ● Best practices are documented and submitted to headquarters.

Quality Management Support Unit

<i>Subcategory</i>	<i>Level 1 Criteria</i>	<i>Level 2 Criteria</i>	<i>Level 3 Criteria</i>
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<p>Quality Management Support Unit</p>	<ul style="list-style-type: none"> • The institution has implemented the QMSU model as described in the statewide memorandum of 7/3/2014. • The QMSU members: <ul style="list-style-type: none"> ○ Meet at least weekly. ○ Specialize by discipline. ○ Have completed initial orientation at headquarters (QM/Patient Safety Academy). 	<ul style="list-style-type: none"> • The institution has implemented the QMSU model as described in the statewide memorandum of 7/3/2014. • The QMSU members: <ul style="list-style-type: none"> ○ Meet at least weekly. ○ Specialize by QM or Patient Safety project, skill set, or expertise. ○ Work together on projects and cross-cover as appropriate (especially Health Program Specialist staff). ○ Have completed initial orientation (QM/Patient Safety Academy) and at least one advance topic training in the past year. ○ Participate in improvement teams. 	<ul style="list-style-type: none"> • The institution has implemented the QMSU model as described in the statewide memorandum of 7/3/2014. • The QMSU members: <ul style="list-style-type: none"> ○ Communicate with each other daily (and may share office space). ○ Specialize by QM or Patient Safety project, skill set, or expertise. ○ Work together on projects and cross-cover as appropriate (especially Health Program Specialist staff). ○ Have completed initial orientation (QM/Patient Safety Academy) and at least one advance topic training in the past year. ○ Provide formal training and hands-on coaching in basic QM/Patient Safety topics to institution staff at least quarterly. ○ Facilitate development / updates of institution Improvement Plan. ○ Work with clinical executives/managers to plan and manage major improvement projects. ○ Participate in/facilitate improvement teams. ○ Are recognized resources for information on the QM/Patient Safety Program and tools.
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Institution Improvement Committees

<i>Subcategory</i>	<i>Level 1 Criteria</i>	<i>Level 2 Criteria</i>	<i>Level 3 Criteria</i>
<p>Roles and Responsibilities</p>	<ul style="list-style-type: none"> • Committee members know which projects and performance metrics fall under their purview. 	<ul style="list-style-type: none"> • Committee members know which projects and performance metrics fall under their purview. <ul style="list-style-type: none"> ○ The scope of each committee is defined in writing and posted in a centralized location easily accessible to staff. 	<ul style="list-style-type: none"> • Committee members know which projects and performance metrics fall under their purview. <ul style="list-style-type: none"> ○ The scope of each committee is defined in writing and posted in a centralized location easily accessible to staff.



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		<ul style="list-style-type: none"> ○ The documented scope for each committee includes which performance metrics the committee is responsible for monitoring over time. • Expectations for Committee Chairs, workgroup/Quality Improvement Team (QIT) leads, and committee support staff are defined in writing and posted in a location easily accessible to staff. 	<ul style="list-style-type: none"> ○ The documented scope for each committee includes which performance metrics the committee is responsible for monitoring over time. • Expectations for Committee Chairs, workgroup/Quality Improvement Team (QIT) leads, and committee support staff are defined in writing and posted in a location easily accessible to staff. • Committee Chairs, workgroup/Quality Improvement Team (QIT) leads, and committee support staff receive formal training at least quarterly on their respective roles in the quality management committee structure. • The QMC provides Committee Chairs, workgroup/QIT leads, and committee support staff with feedback on their performance at least quarterly.
<p>Documentation of Committee Activity</p>	<ul style="list-style-type: none"> • Agendas and minutes are prepared for each committee meeting. 	<ul style="list-style-type: none"> • Agendas and minutes are prepared for each committee meeting. • Agendas, minutes, and committee reports are documented in standardized templates. • Agendas are provided at least 3 business days in advance for all committee, workgroup, and QIT meetings. • Minutes are provided for all meetings and posted in a centralized location for access by appropriate staff. • Committees, workgroups, and QITs provide written reports summarizing their activities and performance data for review by oversight committees. 	<ul style="list-style-type: none"> • Agendas and minutes are prepared for each committee meeting. • Agendas, minutes, and committee reports are documented in standardized templates. • Agendas are provided at least 3 business days in advance for all committee, workgroup, and QIT meetings. • Minutes are provided for all meetings and posted in a centralized location for access by appropriate staff. • Committees, workgroups, and QITs managing an improvement project complete a charter or similar document describing the background, purpose, and scope of the improvement project. • Committees, workgroups, and QITs provide written reports summarizing their activities and performance data for review by oversight committees. • Action items are tracked in a centralized database easily accessible to appropriate staff.



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Communication and Coordination	<ul style="list-style-type: none"> Reporting between standing committees occurs on a regular basis, per a documented schedule. 	<ul style="list-style-type: none"> Reporting between standing committees occurs on a regular basis, per a documented schedule. Committees collaborate on improvement projects that cross committee scope / domain. 	<ul style="list-style-type: none"> Reporting between standing committees occurs on a regular basis, per a documented schedule. Committees collaborate on improvement projects that cross committee scope / domain. Assigned staff review committee action items for overlap between projects and alert appropriate committee members. Information about ongoing improvement projects is shared with all health care staff at least quarterly.
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Patient Safety

<i>Subcategory</i>	<i>Level 1 Criteria</i>	<i>Level 2 Criteria</i>	<i>Level 3 Criteria</i>
Patient Safety Culture	<ul style="list-style-type: none"> At least 50% of institution staff participated in the most recent Safety Patient Culture Survey. Institution achieved an average score of 60% or higher on the most recent Patient Safety Culture Survey. 	<ul style="list-style-type: none"> At least 50% of institution staff participated in the most recent Safety Patient Culture Survey. Institution achieved an average score of 65% or higher on the most recent Patient Safety Culture Survey. 	<ul style="list-style-type: none"> At least 50% of institution staff participated in the most recent Safety Patient Culture Survey. Institution achieved an average score of 75% or higher on the most recent Patient Safety Culture Survey. When an adverse event occurs, institution executives and managers use a statewide Health Care Incident Decision Algorithm to determine appropriate response to the event.
Identifying and Addressing Risks to Patients	<ul style="list-style-type: none"> Health care staff are trained upon initial hiring and on an ongoing basis in the importance of identifying and reporting risks to patients, including how to use the health incident reporting system. Health care staff report all adverse events within 24 hours. The institution completes all root cause analyses (RCAs) assigned by the Adverse / Sentinel Event Committee using the standardized statewide procedure (RCA Tool Kit). 	<ul style="list-style-type: none"> Health care staff are trained upon initial hiring and on an ongoing basis in the importance of identifying and reporting risks to patients, including how to use the health incident reporting system. Health care staff report all adverse events within 24 hours and also report near misses. The institution completes all root cause analyses (RCAs) assigned by the Adverse / Sentinel Event Committee using the standardized statewide procedure (RCA Tool Kit). RCAs meet the criteria for a thorough and credible RCA and are completed within 45 days. After RCAs are completed, the institution monitors performance indicators for at least four months to ensure that the patient risk has been effectively resolved. 	<ul style="list-style-type: none"> Health care staff are trained upon initial hiring and on an ongoing basis in the importance of identifying and reporting risks to patients, including how to use the health incident reporting system. Health care staff report all adverse events within 24 hours and also report near misses. The institution completes all root cause analyses (RCAs) assigned by the Adverse / Sentinel Event Committee using the standardized statewide procedure (RCA Tool Kit). RCAs meet the criteria for a thorough and credible RCA and are completed within 45 days. After RCAs are completed, the institution monitors performance indicators for at least four months to ensure that the patient risk has been effectively resolved. The institution uses proactive methods to



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			<p>identify potential risks to patients, including Failure Mode and Effects Analysis and other system surveillance (e.g., performance reports, patient registries, and the Dashboard).</p>
<p>Safety-Related Communication</p>	<ul style="list-style-type: none"> Health care staff know where to find the statewide Web site for Patient Safety Program resources. 	<ul style="list-style-type: none"> Health care staff know where to find the statewide Web site for Patient Safety Program resources. The findings from root cause analysis (with all confidential information redacted) are disseminated to health care staff, along with information about current effects to address patient safety problems. 	<ul style="list-style-type: none"> Health care staff know where to find the statewide Web site for Patient Safety Program resources. The findings from root cause analysis (with all confidential information redacted) are disseminated to health care staff, along with information about current effects to address patient safety problems. Statewide Patient Safety Stories and Alerts are circulated to staff and discussed in staff meetings. The institution encourages staff to share concerns about patient safety in staff meetings and other regular forums and includes line staff in creating solutions.