GUIDELINES FOR FILING SEMI-ANNUAL AND ANNUAL REPORTS

Guidelines for Semi-Annual Report

The Patient Care Assessment Coordinator's (PCA) Semi-Annual Report to the health care facility's governing body must be prepared every six months, consistent with the attached Reporting Schedule. Once a year, the PCA Coordinator's PCA Program Annual Report (required by 243 CMR 3.11(4)) is to be included with one of the Semi-Annual Reports. See the schedule for details.

The Semi-Annual Report is required by 243 CMR 3.07(3)(g). It must be submitted to your health care facility's governing body (its Board of Trustees or Board of Directors, for example), with a copy submitted to the *Quality and Patient Safety Division, Board of Registration in Medicine, 200 Harvard Mill Square, Suite 330, Wakefield, MA 01880,* not later than 30 days after the end of the applicable six-month period. The guidelines were developed under authority of G. L. c. 112, § 5I, 243 CMR 3.07(3)(g) and 243 CMR 3.07(3)(k).

Semi-Annual Reports should evidence diligent effort on the part of the PCA Coordinator to apprise the governing body of the operation of the facility's qualified Patient Care Assessment program. A recommended format for the Semi-Annual Report is on pages 3 and 5 of this document.

Major incidents, as defined in 243 CMR 3.08, (aka Safety and Quality Review Reports) continue to be separately reportable to the Quality and Patient Safety Division on the basis of calendar quarters, with reports due within 30 days after the end of each quarter. Forms for this purpose are available on the Board's website at www.mass.gov/massmedboard, or may be obtained by contacting the QPS Division at (781) 876-8294. The Semi-Annual Report should not be used for reporting major incidents to the Board. However, the *Report of Internal Reporting and Screening Systems* section of the report -- to the extent applicable -- may include summary information on incidents reported as SQRs.

The recommended format for the Semi-Annual Report is attached.

Guidelines for Annual Report

While there is no recommended format for the Annual Report, there are six elements that must be included. They are as follows [243 CMR 3.11(4)]:

1. A summary analysis of patient complaints and their disposition.
In this summary, you should discuss the number and types of complaints patients have made to your facility and the system through which your facility addresses complaints. Please also summarize respective resolutions of complaints received.

2. The names of all full licensees (physicians only) who have terminated their relationship with the health care facility.

Please list any physician who has terminated his/her relationship with your facility during the reporting period. (This is a regulatory requirement. The QPS Division does not share this information with other Board Divisions. Nor does the QPS Division use this information to evaluate your facility's PCA Program.)

3. Any amendments to the Patient Care Assessment Plan and any proposed amendments thereto, pursuant to 243 CMR 3.03(1).

If you have amended your PCA plan during the reporting period, please submit those amendments with your annual report. Please also include proposed amendments. (If you submit your entire PCA plan, please highlight proposed and actual amendments. If there have been no amendments, do not submit an additional copy of your plan; simply indicate that there have been no changes.)

4. The number of major incident reports (Safety and Quality Reviews) filed pursuant to 243 CMR 3.08.

In your report, please indicate the number of major incident reports submitted to the Board during the past twelve months. (You do not need to include descriptions or copies of previously submitted reports.)

5. The written instructions for the Patient Care Assessment Plan, pursuant to 243 CMR 3.06(3).

If there have been no changes in your facility's instructions during the past twelve months, it is not necessary to resubmit them. Merely indicate in your report that there have been no changes.

6. Summary information on the handling of impaired physicians.

In this summary, please discuss your facility's mechanism for addressing reports of physician impairment internally, or through referral to one or more external entities.

If you have any questions about these guidelines or Semi-Annual and Annual Reporting in general, please contact the QPS Division at (781) 876-8294.

FORMAT FOR SEMI-ANNUAL REPORT

Name of Facility: _____

For Six Months Ended: _____

To: Board of Trustees/Governing Body

From: Patient Care Assessment Coordinator

Date: _____

cc: Quality and Patient Safety Division, MA Board of Registration in Medicine

I/we have completed this report to the extent applicable, and have or will have forwarded a copy to the Board of Registration in Medicine QPS Division within 30 days after the end of the six-month period identified above.

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Major Tasks Completed

This section should contain a description of the major quality improvement initiatives undertaken during the reporting time period. Examples of "major tasks" that should be described in this section include: successful completion of accreditation surveys; implementation of patient safety initiatives (e.g. initiatives undertaken in accordance with Joint Commission recommendations); major system-wide changes (e.g. implementation of computer based order entry system), or the findings of an internal task force.

Report of Internal Reporting and Screening Systems

This section of the report should include data on Focused Occurrence Reporting Criteria and Focused Occurrence Screening Criteria. This data should be reported with a numerator and denominator, and contain a rate and a benchmark. The section should also include the following:

- An analysis of the data. Analysis should also include a description of the facility's findings and conclusions, based on an aggregate look at the over all performance against the benchmark used (external or internal).
- If a trend is identified in analysis, the following information should be provided: description of the trend and causative factors; a description on any actions recommended or implemented; and follow-up taken or planned by the facility to evaluate the effectiveness of the actions recommended or implemented. If no patterns and trends were identified as a result of data analysis, this should be stated in the report.
- A graph or bar chart should <u>always</u> be accompanied by analysis, findings, trends and actions, as described above.

Actions recommended or taken as a result of review of a single event or "near miss" may also be reported in this section. (The facility does not need to include information already reported in SQRs, unless it desires to do so for the purpose of reporting to its governing body.)

The facility should select occurrence reporting criteria that will identify serious unexpected patient outcomes. Screening criteria should be effective in identifying those adverse or potentially

adverse occurrences that might otherwise be missed. The QPS Division also encourages facilities to collect, analyze and report on “near miss” data.

The following are examples of events identified through focused occurrence screening and reporting: medication events; HAI data (SCIP/VAP/CLBSI/C-diff/MRSA/CAUTI); falls, pressure ulcers and other events that might meet “Serious Reportable Event” criteria; unexpected deaths; unexpected returns to the OR; birth trauma injury to neonate; ICU readmissions; unplanned ICU transfers; equipment malfunction; and IV infiltrates.

General Recommendations

This section should include changes that are being taken to address the structure and quality of the facility’s PCA Program. The source of the changes should be identified (e.g. analysis of internal incident reporting data, peer review activities, outside regulatory agencies). This section should report on other activities, such as medical staff and employee training. This section also should contain a description of any changes made to reporting and occurrence screening criteria.

A. Recommendations for changes in the PCA program. The source of these recommendations should be identified (e.g., analysis of the internal incident reporting system, peer review activities, other regulatory agencies).
B. Other patient care program information (e.g., describe employee training and other educational activity, including that relating to medical staff).
C. Changes in focused occurrence reporting and occurrence screening criteria.

Submitted by: _____

Name and title: _____

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Commonwealth of Massachusetts
Board of Registration in Medicine
Quality and Patient Safety Division

Semi-Annual And Annual Reporting Schedule

Health Care Facility Type	Period for Semi-Annual Report #1	Period for Annual Report	Period for Semi-Annual Report #2
Mental Health Clinics	July 1st to December 31st **Due January 30th**	January 1st to December 31st Due January 30th ∇	January 1st to June 30th **Due July 30th**
HMO's	N/A	January 1st to December 31st **Due January 30th ∇**	N/A
Licensed Clinics, Infirmaries	September 1st to February 28th **Due March 30th**	March 1st to February 28th **Due March 30th ∇**	March 1st to August 31st **Due September 30th**
Hospitals w/OB	September 1st to February 28th **Due March 30th**	March 1st to February 28th **Due March 30th ∇**	March 1st to August 31st **Due September 30th**
All Teaching Hospitals	September 1st to February 28th **Due March 30th**	March 1st to February 28th **Due March 30th ∇**	March 1st to August 31st **Due September 30th**
All Other Hospitals	November 1st to April 30th **Due May 30th**	May 1st to April 30th **Due May 30th ∇**	May 1st to October 31st **Due November 30th**
MRI Centers	September 1st to February 28th **Due March 30th**	March 1st to February 28th **Due March 30th ∇**	March 1st to August 31st **Due September 30th**

∇ ***Of the Following Period***