State of Tennessee
Health Facilities Commission
502 Deaderick Street, Andrew Jackson Building, 9th Floor, Nashville, TN 37243
www.tn.gov/hsda Phone: 615-741-2364 hsda.staff@tn.gov

QUALITY MEASURE REPORT

Reporting Periods:

Date Report Submitted: _____

QM (Current) Reporting Period: ***Beginning Date*** _____ ***End Date*** _____

Report Year: ☐ Year One ☐ Year Two ☐ Year Three or More (Specify Year) _____

Name of Certificate of Need Project

Certificate of Need (CON) Number: _____

Original CON Project Name: _____

Current Name: _____

Approved/Original Certificate of Need (CON) Name: _____

Date of Project Approval: _____ **Date of Project Completion** _____

Project Description (*Below – Box will Expand/Wrap*)

Quality Measure Report Preparer Information

_____ _____
Name **Title**

_____
Relation to CON Holder

_____ _____
Email Address **Phone Number**

CREDENTIALING

	Number	Type	Status	Most Recent Issue Date	Expiration Date	Last Survey Date
Licensure						
HFC/Licensure						
MHSAS						
DIDDS						
Certification						
Medicare						
TennCare/ Medicaid						
Other – Specify						
Accreditation**						
AAAASF						
ACHC						
ACR						
ACRO						
ASTRO						
CARF						
CCAC						
CHAP						
DNV						
HFAP						
NCI						
NCQA						
TJC						
URAC						
Other - Specify						

***Acronyms for above:*

AAAASF – American Association for Accreditation Ambulatory Surgery Facilities
ACHC – Accreditation Commission for Health Care
ACR – American College of Radiology
ACRO – American College of Radiation Oncology
ASTRO – American Society for Radiation Oncology
CARF – Commission on Accreditation of Rehabilitation Facilities
CCAC – Continuing Care Accreditation Commission
CHAP – Community Health Accreditation Partner
DNV – Det Norske Veritas Healthcare's National Integrated Accreditation for Healthcare Organizations
HFAP – Health Facilities Accreditation Program
NCI – National Cancer Institute
NCQA – National Committee for Quality Assurance
TJC - The Joint Commission
URAC - Utilization Review Accreditation Commission

Briefly describe below items in the above table and any other related issues of concern pertaining to licensure, certification, or accreditation. (**Documentation should include copies of any or all of the following: provider license and last survey conducted by licensing agency, extension approval documentation, CMS certification notices that apply, and accrediting organization approval notice and/or accreditation award.*)
(*Below – Box will Expand/Wrap***)**

Surveys

	Actions? (Yes or No)	If yes, Date of Action	Compliance Achieved? (yes or no)	Date Compliance Achieved
Licensure				
Suspension of Admissions				
Civil Monetary Penalties				
Suspension of License				
Revocation of License				
Other – Specify				
Certification				
Medicare Suspension Notice				
Medicaid/TennCare Suspension Notice				
Medicare Decertification Notice				
Medicaid/TennCare Decertification Notice				
Corporate Integrity Agreement				
Other – Specify				
Accreditation				
Accreditation Revocation				
Accreditation Denial				
Other - Specify				

Describe below the nature and scope of identified non-compliance actions. (*Documentation should include any or all of the following: survey reports and related provider plans of correction pertaining to licensure and/or complaint investigation surveys with licensing agency notice of acceptance, CMS notices that apply, and accrediting organization survey findings.*)
(*Below – Box will Expand/Wrap***)**

Discuss below the nature and scope of any staffing related findings identified in the surveys.
(*Below – Box will Expand/Wrap***)**

Performance and Quality Assessments

Describe below your plan for data reporting (including data on patient re-admission to hospitals), quality improvement, customer satisfaction measurement, and process monitoring system.
(*Below – Box will Expand/Wrap***)**

When did your self-assessment process/program begin?
(*Below – Box will Expand/Wrap***)**

If available, please provide a comparison of your organization's performance to state and/or national quality measure/metrics using information available from CMS/Medicare (e.g. Medicare Compare) and/or other appropriate accrediting sources, such as the Joint Commission or other CMS recognized accrediting organizations.
(*Below – Box will Expand/Wrap***)**

When did your external assessment process/program begin?
(*Below – Box will Expand/Wrap***)**

Project Only Utilization Data

Specify Unit of Measure: _____

Current Year Utilization: _____

Total Facility* Only Utilization Data

Specify Unit of Measure: _____

Current Year Utilization: _____

Payor Source	Current Year - Project Only		Current Year - Total Facility*	
	Gross Operating Revenue	% of Total	Gross Operating Revenue	% of Total
Medicare/Medicare Managed Care				
TennCare/Medicaid				
Commercial/Other Managed Care				
Self-Pay				
Other (Specify)_____				
Total		100%		100%
Charity Care				

**If applicable*

Position Classification	Project Only FTEs	Total Facility FTEs
A. Direct Patient Care Positions		
Position 1		
Position 2		
Position 3		
Position 4		
Position 5		
Position 6		
Position 7		
Position "etc." – Insert additional rows if needed		
Total Direct Patient Care Positions		
B. Contractual Staff		
Total Staff *(A+B)*		

Please briefly describe what actions, if necessary, during the Quality Measure reporting period were taken to improve the staffing and/or ensure that patient needs were met.
(*Below – Box will Expand/Wrap***)**