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| --- | --- | --- | --- | --- | --- | --- |
| Problem Statement:  \_\_\_\_% Currently meeting goal (updated monthly) | | | | | | Facility Name:  Facility Provider Number:  Person completing report:  Date:  I have reviewed this action plan  (Medical Director Signature)  (Administrator Signature) |
| Goal for Improvement: | | | | | |
| Date Required-Needed Resources: | | | | | |
| Root Causes-Barriers: | | | | | |
| Actions Already in Place: | | | | | |
| **Action Plan Implementation Steps** | **Team Members** (Note responsible member) | **Start Date** | **Estimated Completion Date** | **Checkpoint Dates** | **Date Completed** | **Comments**  (Status, outcomes, disposition, etc.) |
|  |  |  |  |  |  |  |