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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.) |
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