# Your Hospital
## PERFORMANCE IMPROVEMENT PLAN

## Introduction and Principles

Your Hospital is dedicated to excellence in health care for our community. We believe that a comprehensive Performance Improvement program is a primary means of meeting organizational goals and promoting the facility's mission of providing the community with an array of high quality health care services designed to meet community needs. Our aim is to insure the care provided is safe, effective, patient-centered, timely, efficient and equitable. To that end, the organization as a whole will participate in systematic Performance Improvement efforts. Our efforts will focus on areas that significantly impact critical clinical processes, clinical outcomes, key business results, facility core functions and the primary needs of patients. Individual competence, when identified as an issue in Performance Improvement, will be handled through the appropriate medical staff and human resource procedures and processes.

This framework for improving performance describes a global model for structure, process and outcomes measurement and improvement. The framework incorporates several key assumptions.

- Performance means what is done and how well it is done.
- Quality means the degree to which health services for individuals and populations increase the likelihood of desired health outcomes and are consistent with current professional knowledge (Lohr, 1990).
- Patients and others judge the quality of health care based on health outcomes and sometimes on their experiences with the care process and level of service provided.
- Patients, purchasers, regulators, and other stakeholders expect and use quantitative/explicit data and qualitative/implicit perceptions to judge quality and value of health care.

The guiding principles of the plan are:

- We will identify and focus on functions that are important to the patient and other customers.
- We will assess the facilities performance with objectives and relevant measures and defined data elements;
- We will involve all staff in Performance Improvement;
- We will pursue improvement continuously;
- We will emphasize key functions as defined by the patient experience, not by departmental structure.

- We will make determinations on quality and decisions on improvement strategies based on data.

## Program Goals

The Performance Improvement Program focuses on the measurement, assessment and improvement of performance and work processes to:

- Improve the safety of the healthcare systems and work processes
- Identify indicators of quality related to structure, process and outcomes of patient care.
- Measure clinical practice against best practices or benchmarks appropriate to critical access hospitals;
- Design or redesign care processes based on best practices
- Improve coordination and communication across patient conditions, services, and settings

## Program Objectives for 2004

The program objectives for 2004 will focus on performance improvement activities in the following areas:

- The integration of the Performance Improvement process as an integral component of problem solving and work process improvement within the facility.
- The evaluation and improvement of work processes related to managing facility resources including personnel, supply and equipment availability and use and the appropriate generation of patient charges.
- The evaluation and improvement of systems and work process involved in the provision of patient care and the improvement of patient safety
- The evaluation and improvement of patient and family satisfaction with care and service.

## Scope and Integration

The scope of the PI program is organization wide. All personnel and departments are expected to be actively involved in the program. Contract services providing direct patient care or services affecting the health and safety of patients are also included in the on-going monitoring activities and, as appropriate, the PI team process. Examples of involvement are participation on a PI team, collecting assessment data and participating in data analysis. The Medical Staff is actively involved in the quality management program through the peer review process and peer profile for appointment and re-appointment. The Medical Staff may also be requested to serve as a member of a PI team. The PI

program evaluates the quality and appropriateness of the diagnosis and treatment outcomes. The program includes:

- All patient care services and other services affecting patient health and safety;
- Nosocomial infections;
- Medication therapy;
- Quality and appropriateness of diagnosis and treatment by medical staff members including mid-level providers;
- Utilization management;
- Staff opinions and needs; and
- Patient satisfaction

## Roles and Responsibilities

The Governing Board has the ultimate responsibility for the quality of care and service provided. The Board's accountability for quality is discharged through its performance of four major responsibilities:

- Demonstrating a top-down commitment to high quality and to the organization's programs for quality management.
- Requiring that objective measures be used to gauge the quality of care and services being provided.
- Ensuring that quality management programs are in place and working effectively to monitor and improve quality.
- Appointing, reappointing and granting privileges to the Medical Staff based on documentation of current clinical and behavioral competence.

Responsibility for development and implementation of the PI program is delegated by the Governing Board to the organizations leadership. Leaders play a central role in fostering improvement through planning, educating, setting priorities, providing support, such as time and resources, and empowering staff. The organizational leadership includes the Governing Board, Medical Staff, administrative leaders, and department directors. The Board receives a quarterly report from the Performance Improvement Committee. The contents of all reports to the Governing Board contain sufficient detail and analysis to allow the Board to effectively meet its responsibility for quality oversight.

## Performance Improvement Committee (PIC)

The Governing Board delegates to the PIC the central authority for managing the PI program. The PIC is made up of the
Chief Executive Officer, the Medical Staff Director, the Assistant Administrator for Patient Care Services, the Assistant Administrator for Financial Services, the Human Resources Director, the Director of Community Relations, the Planetree

Coordinator and the Performance Improvement Coordinator. The responsibilities of the PIC include:

- Coordination and oversight of the hospital wide program.
- Provision of a framework for a planned, continuous, systematic and organization wide approach to designing, measuring, assessing and improving performance.
- Oversight of staff education and training for Performance Improvement and the facilitation of the PI process.
- Assure adequate resource allocation for the PI process and QA/PI activities throughout the organization.
- Prioritize Performance Improvement projects and commission teams.
- Identify organizational trends or opportunities for improvement projects from reports received throughout the organization. Sources of data and information include reports from infection control studies, utilization review studies, risk management reports, and corporate compliance audits.
- Request additional quality assessment studies or PI projects.
- Report to the Governing Board quarterly and annually the results of the quality activities and the PI process including the financial impact of the projects and program.
- Integrating PI efforts with daily work activities.

## Membership in the Rural Montana Healthcare Performance Improvement Network

The facility has elected to join the Rural Montana Healthcare Performance Improvement Network in an effort to provide support to the facility for the Performance Improvement program. The Network provides an opportunity to work with other Critical Access Hospital to identify appropriate measures of quality for Critical Access Hospitals, provide a mechanism to meet licensure and certification requirements for outside quality review, outside peer review and to establish best practices for Critical Access Hospitals. Upon request the QIN will assist the facility in the development of studies to evaluate facility structures, processes and outcomes. All data gathered by and for the QIN is for the purpose of assessing and improving quality, and for educational purposes and as such, is confidential and privileged information.

## Departmental Responsibilities

Each department is responsible for assessing and improving quality within the department. To accomplish this each department will develop a departmental dashboard report that monitors important department work process and departmental services. Content for departmental dashboard reports focuses on

areas of high risk, high volume or problem prone components of care. The ongoing monitoring of the departmental dashboards includes the analysis of the data to insure work process remain in control. Identification of opportunities for improvement activities or activities to improve patient safety will result in the use of either a "quick fix" process or a request to commission a PI team.

## Performance Improvement Coordinator

The primary responsibilities of the PI coordinator include coordination of the implementation of this plan, providing support for the department managers and the PI teams as a resource person, support and coordination for training throughout the organization as it relates to quality issues, generate a "dashboard" report of quality measures for the PIC, the governing board and medical staff. Specific qualifications and performance standards are described in the job description.

## Medical Staff

The Medical Staff participation focuses on peer review and the review of data related to:

- Drug use review
- Infection control studies
- Blood use review
- Mortality review
- Medical record timeliness
- Outcome studies
- Internal and outside peer review activities

## Approaches and Methodologies

The PI program is a framework for organizing a planned and systematic approach to the measurement, assessment and performance improvement activities related to the important functions with the organization. The components of this program include:

- A **quick fix process** to be used for identified problems, which do not require a comprehensive approach to problem solving and solution implementation.
- **Departmental dashboard reports** are generated on a monthly basis and reported to the PIC quarterly. Each department is responsible for developing a data collection process to monitor important work processes and departmental services. Departmental benchmarks are developed for each data element.
- **Performance Improvement team** activities are those, which may be intradepartmental, or interdepartmental projects that look at the work

process of the organization related to important functions within the facility and utilize a team approach to identify opportunities to improve process flow and outcome.

- **Facility Dashboard report** is a report generated for the Governing Board, the PIC and the Medical Staff that provides data about utilization of services, statistical information about important hospital functions and processes. The content included in this report will be revised as needed to meet the quality monitoring needs of the Governing Board.
- **Outside quality review process** is provided by the Performance Improvement Network's benchmarking project using data is collected by the hospital staff and reported to the PIN for inclusion in the aggregate database. Reports are returned to the facility on a quarterly basis for evaluation and identification of opportunities for improvement.

Data is collected on the following types of measures or indicators:

- **Structure**: measures describing the organization, it's structure, services, provider demographics and traits.
- **Process** – measures that describe the goal directed interrelated series of events, actions, mechanisms or steps related to providing care and service.
- **Outcomes** – measures that describe the results of the performance or nonperformance of a process or processes.

## The PI process we use is PDCA.

**P – plan the improvement project**

- Identify the process to be improved
- Appoint the project team

- Provide just in time training
- Identify customers and their expectations, translate customer expectations for services into expectations for work processes
- Create a flow chart of the current process
- Develop indicators to identify the extent to which customer expectations are being met and the cost of poor quality.
- Plan data collection and remaining steps

**D – do data collection**

- Collect and organize data
- Distinguish between common and special cause variation in order to select the appropriate type of improvement actions.

**C- check the effectiveness of the actions**

- Document the results from the actions
- Evaluate the extent to which the actions caused improvements or problems.

**A – act to improve the action, hold the gains, and continue the process**

- Continuously improve the actions and monitor results
- Institutionalize the actions to hold the gains – develop written procedures for the new process

Continue the process

## Communication

The Performance Improvement Committee provides oversight and functions as the central clearing house for quality data and information collected throughout the facility. The PIC tracks, trends and aggregates data from all sources to prepare reports for the governing board and the medical staff.

## Confidentiality of Information

Appropriate safeguards have been established to restrict access to highly sensitive and confidential Performance Improvement information, which is protected against disclosure and discoverability through Montana State law.

## Annual Evaluation

Each year the PIC will evaluate the organization's success in achieving the goals and annual objectives of the Performance Improvement Program. The annual report will be a summary of the year's activities including the role of leadership in the program, the results of the Medical Staff activities, and a review of the quality assessment, quick fix and PI activities related to each objective established for the year. An assessment of the overall effectiveness of the plan and the program will be made by the PIC and forwarded to the Governing Board with recommendations for improvement.

**PI Plan Approval:**

_________________________________________ __________
Governing Board Date

_________________________________________ ___________
Medical Staff Date

_________________________________________ ____________
Chief Executive Officer Date