HACKETTSTOWN REGIONAL MEDICAL CENTER
ADMINISTRATIVE POLICIES

PERFORMANCE IMPROVEMENT PLAN

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SCOPE

All employees and medical staff members of Hackettstown Regional Medical Center

PURPOSE

The Performance Improvement (PI) Plan provides a framework for the systematic, organization-wide approach to ensuring safe and quality patient care and services. It outlines the structure and methodology used to measure, assess and improve organizational performance and patient safety.

POLICY

I. The Governing Board of Directors and Hospital Leadership collaborate to determine priority areas for data collection and its associated frequency based on patient safety, customer satisfaction, clinical quality outcomes, financial performance, and regulatory compliance by focusing on the organization's values, mission and vision. This determination is demonstrated through the Governing Board of Director's annual approval of the hospital's Performance Improvement Plan and the Performance Improvement Council Reporting Calendar.

II. Hospital Leadership evaluates the effectiveness of action plans based on data and takes action if they do not achieve or sustain planned improvements. All individuals associated with HRMC are empowered to identify and act upon opportunities for improvement based on data and to work collaboratively across disciplines to deliver the best possible clinical outcomes.

III. Data reports are presented in useable formats which show trends over time and/or comparison to available external performance. Statistical tools are incorporated as appropriate.

IV. At least one Failure, Mode, & Effect Analysis [FMEA] is conducted annually to proactively analyze a high-risk process to identify and mediate risk to patient safety.

V. When designing new or modified services, policies, or procedures, the hospital ensures safety and quality of care through a focus on customer needs and involvement of staff and patients. Changes are clinically and business relevant and made based on evidence and results of PI activities. Information regarding sentinel events and potential patient risk is incorporated in the design.

VI. Performance Improvement Methodology

A. Lean: HRMC utilizes the Lean approach as its foundational performance improvement methodology. Lean is a system for the absolute elimination of waste within processes and systems. We continuously challenge processes to eliminate steps which do not add value from the standpoint of the patient.

The foundational steps for elimination of process waste are Identify, Acknowledge, Eliminate through:

- Standard Work
- User-Friendliness
- Unobstructed Throughput
- Jidoka – Making problems obvious
- Respect for People
- Kaizen – Continuous incremental improvement
- Heijunka – Optimizing flow

B. P-D-C-A is the tool used for implementing and evaluating process changes of any magnitude.

Plan action by collecting baseline data and establishing the objectives and processes necessary to deliver results in accordance with the expected output (the target or goals).

Do implement the plan, execute the process. Test the proposed change, preferably on a small scale. Collect data for analysis in the following "CHECK" and "ACT" steps.

Check or study the actual results (measured and collected in "DO" above) and compare against both the baseline performance and expected results (targets or goals from the "PLAN") to ascertain any differences. Examine the results and develop the information needed for the next step "ACT".

Act:

- If the CHECK shows that the PLAN that was implemented in DO is an improvement to the prior standard (baseline), then that becomes the new standard (baseline) process.
- If the CHECK shows that the PLAN that was implemented in DO is not an improvement, then the existing standard (baseline) process will remain in place.
- If the CHECK showed something different than expected (whether better or worse), then there is more to be learned and evaluated through future PDCA cycles.

PROCEDURE

I. Structure

A. The Governing Board of Directors:

Ensures the delivery of high quality care;
Oversees a comprehensive performance improvement program;
Provides adequate financial resources;
Reviews data reports and actions taken;
Makes responsive recommendations through the Professional Practice Committee;
Delegates authority/accountability for the PI Program to the President.

B. The Professional Practice Committee:

1. Membership:
   Representatives from Governing Board of Directors — Medical Staff President
   Medical Staff Vice-President — Medical Staff Secretary/Treasurer
   Hospital Executive Team
2. Activities:
   - Review data reports and actions taken;
   - Present findings to the Governing Board of Directors;
3. Meetings: The Committee will meet at least quarterly.

C. The President:

Oversees the PI Program;

Assures the participation of leadership and staff;
Delegates program oversight to the Performance Improvement Council.

D. Performance Improvement Council:

1. Membership:

Chair: Hospital President	Administrative Director, Quality & Safety
Chief Medical Officer	Medical Staff Vice President
Chief Operating Officer	Chief Nursing Officer
Select Departmental Leaders	Executive Director

2. Responsibilities:

a. Prioritize improvement opportunities based on the following criteria:

- Compatibility with strategic plan, mission, vision, and values;
- Criticality of impact on patient care
- Enhancement of patient safety
- Changes in the internal and external environment
- Improvement of process effectiveness (outcomes) and/or efficiency
- Implications for regulatory/accreditation compliance
- Processes which are high risk, high volume, and/or problem prone
- Impact on patient experience
- Impact on employee engagement
- Impact on financial health
- Impact on public relations

b. Based on the PI Program Communication Structure, review data and action plans from relevant committees, interdisciplinary teams, and hospital departments to determine need for support and/or resources and to ensure coordination of hospital-wide PI activity.

c. Meetings: The Council will meet at least 10 times annually.

E. The Medical Staff Executive Committee:

Supports the functions of the PI Program as identified through Departments/Chairpersons;
Assures the participation of Departments/Chairpersons and other medical staff members;
Delegates authority and accountability to the Vice President of the Medical Staff who chairs the Medical Staff PI Committee.

F. Medical Staff PI Committee:

1. Membership
   - Vice-President of the Medical Staff (Chair);
   - Four medical staff members appointed by the Medical Executive Committee;
   - Non-Voting:
     Hospital President; Administrative Director, Quality & Safety; Chief Medical Officer

2. Responsibilities:

   - Make recommendations for process-oriented medical staff PI based on data;

- Perform peer review of identified cases and provide review score based on criteria established by the medical staff policy;
- Recommend actions regarding medical staff policy/rules and/or individual practitioners to the Medical Staff Executive Committee;
- Make recommendations to the PI Council regarding opportunities for improvement to hospital processes.

G. Quality & Safety Department:

The President delegates operational oversight of the PI Program to the Administrative Director, Quality & Safety who serves as the Patient Safety Officer and the Environmental Safety Officer.

The Administrative Director, Quality & Safety directs the PI Program and coordinates monitoring of Joint Commission/CMS/NJDHSS compliance. Medical Staff OPPE/FPPE [Ongoing & Focused Professional Practice Evaluation] is directed in collaboration with the Chief Medical Officer and Vice-President of the Medical Staff. Risk Management and Infection Prevention & Control are incorporated in the PI Program.

H. Hospital Department Leader Responsibilities:

- (Quality Assurance/ Quality Control) Continuous monitoring of both service-specific and designated hospital-wide indicators for process stability. Indicators required by regulatory agencies must be included in this monitoring. Corrective action is taken for any process that performs outside of established parameters.
- Provide the Performance Improvement Council with a departmental PI report as per annually published calendar schedule;
- Provide his/her Administrative Director with updates on departmental PI activity at mutually agreed-upon intervals;
- Continuous assurance that staff is educated, updated, competent, and compliant with current best practices, including The Joint Commission standards and CMS regulation.
- Timely response to quality of care referrals and patient complaints.
- Annual updating of associated Departmental Plan of Care to include current departmental Performance Improvement Plan.

II. <u>Data Collected:</u>

- Performance improvement priorities identified by leaders;
- Hospital-acquired infections and associated preventative best practices;
- Conditions in the environment of care;
- Use of restraints;
- Effectiveness of the medication management system;
- Operative or other procedures that place patients at risk of disability or death;
- All significant discrepancies between preoperative and postoperative diagnoses, including pathologic diagnoses;
- Adverse events related to using moderate or deep sedation or anesthesia;
- The use of blood and blood components;
- All reported and confirmed transfusion reactions;
- The results of resuscitation;

- Significant medication errors;
- Significant adverse drug reactions;
- Patient perception of the safety and quality of care, treatment, or services
- Staff opinions and needs, perception of risk to individuals, suggestions for improving patient safety, and willingness to report adverse events;
- Effectiveness of fall reduction activities (assessment, interventions, education)
- Effectiveness of response to change in patient condition;
- Effectiveness of organ procurement (# of actual donors / # of eligible donors);
- Adverse event trends associated with staffing adequacy;
- Core Measure Sets as defined by CMS and Joint Commission.

III. Data Sources:

- Incident Reporting Database
- Adverse Event Analyses/RCAs
- Patient Complaints and Grievances
- Patient Satisfaction Surveys
- Staff Culture of Safety Surveys
- Internal Operational Performance Reports
- Medical Record Coding Database
- New Jersey Quality Improvement Organizations
- Joint Commission Sentinel Event Alerts;
- AHRQ Patient Safety Indicators;
- NDNQI (National Database of Nursing Quality Improvement);
- NJHA (New Jersey Hospital Association)

IV. Annual Review

The Performance Improvement Council will review and forward to the Professional Practice Committee and the Governing Board of Directors for input and approval:
The Performance Improvement Plan;
An evaluation of the previous year's Performance Improvement Program;
Annual PI Program goals and objectives;
The Performance Improvement Council Reporting Calendar.

V. Confidentiality

Data gathered through Performance Improvement activities (including risk management and peer review) is confidential. PI data will be released only to authorized persons employed by or affiliated with HRMC and agencies/institutions authorized by Administration. All peer review and risk management information is collected, evaluated and trended as part of the Peer Review and Risk Management processes established by HRMC and the Quality Improvement Act. Documents will be released only in accordance with the bylaws, rules and regulations of the Medical Staff, or as required by individual regulatory/monitoring agencies or fiscal intermediaries, according the pre-established policies and agreement of HRMC.