

ADVENTIST BEHAVIORAL HEALTH POLICY/PROCEDURE

<p>TITLE: Performance Improvement Plan</p> <p>THE JOINT COMMISSION STANDARD: PI.01.01.01 to PI.04.01.01: The organization collects data to monitor its performance</p>	<p>DEPARTMENT: Leadership</p> <p>POLICY NUMBER: LD-38</p> <p>DATE ISSUED: September 2000</p> <p>DATE REVIEWED/REVISED: 01/01, 11/01, 11/02, 01/03, 01/04, 01/05, 02/06, 05/08, 12/10, 07/11, 02/13, 9/13</p>
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POLICY

It is Adventist Behavioral Health policy to engage personnel (medical staff, staff, volunteers, and contract team members) in ongoing monitoring, evaluation and improvement of the quality, appropriateness and safety of the care and services provided to our residents, patients and clients.

PURPOSE

The Performance Improvement Program is designed to provide a coordinated, objective and systematic approach to system-wide as well as entity specific performance improvement activities. The Program uses an integrated and collaborative approach to increase the probability of desired quality and safety outcomes by assessing and improving governance, managerial, clinical and support processes that most affect outcomes.

The program supports AHC’s vision: “AHC will be a high performance integrator of wellness, disease management, and health care services, delivering superior health outcomes, extraordinary patient experience and exceptional value to those we serve.” Primary to meeting the vision is to meet the mission: “We demonstrate God’s care by improving the health of people and communities through a ministry of physical, mental, and spiritual healing.” The values of respect, integrity, service, excellence and stewardship drive ABH’s ability to meet its critical success factors, mission and vision. The program reflects continuous improvement support of AHC’s Quality and Safety vision: “We are the safest place to receive care and deliver superior clinical outcomes.”

SCOPE

The Performance Improvement Program provides the structure and mechanisms for measurement, assessment, analysis and improvement of patient care processes and outcomes at both a system-wide and entity specific level. The program covers all residential treatment, hospital and community based services provided by ABH.

GOALS

The goal of the Performance Improvement Program is to assure continuous and incremental performance improvement in the delivery of quality health care that is efficient, cost effective

and consistent with the facilities' strategic initiatives. The program promotes an organization-wide commitment to continually meet and/or exceed best practice in the delivery of health care and services.

The program emphasizes ongoing assessment of various dimensions of performance including (1) surveillance of health care delivery involving the qualifications and performance of those managing and delivering the services; (2) outcomes of care and service delivery; and, (3) availability and utilization of support resources, facilities, staff, equipment, and environment to assure efficiency, cost effectiveness and accountability for both professional and paraprofessional staff.

OBJECTIVES

1. To provide an effective, planned, systematic mechanism to design, measure, assess, and improve the performance of the system.
2. To enhance, maintain and continually improve the quality of care through identification, use, analysis and measurement of best practices related to patient care and safety.
3. To facilitate a proactive approach toward continuous quality improvement activities by evaluating actions taken to assure that desired results are achieved and sustained.
4. To promote communication and reporting of quality improvement activities across the behavioral health system's leadership, medical staff, the governing body, and staff.
5. To ensure patient safety, prevent untoward occurrences and reduce liability through systematic monitoring of the treatment environment.

Organization wide quality assessment and improvement activities include utilization management, management of information, medication management, patient safety, risk management, research, quality control and infection control, surveillance and reporting. Assessment findings are communicated to the ABH Governing Board, Behavioral Health Quality and Safety Committee and entity specific Medical Executive Committees, Performance Improvement, Patient Safety and leadership councils at least quarterly.

LEADERSHIP ROLE:

Leaders play a central role in fostering improvements. Adventist Behavioral Health Systems' leaders include the Governing Board, President, Assistant Vice President/COOs, AVP Quality and Patient Safety, and Medical Directors. Each entities senior leadership, medical service directors, department managers, unit managers, and members of medical staff leadership lead their respective entity's performance improvement initiatives.

ABH leadership adopted the Performance Improvement Program to clearly define how all levels of the system will address improvement issues. The Program includes planning the process of improvement; setting priorities for the scope and focus of measurement; establishing the problem-solving methodology unique to the organization; systematically measuring and assessing performance; setting priorities for improvement; reviewing utilization information to help prioritize use and management of limited resources; implementing improvement activities based on assessment conclusions: and, maintaining or improving achieved improvements.

PERFORMANCE IMPROVEMENT PROGRAM:

1. Establishes a planned, systematic, system-wide approach wherein data are collected on high priority/high risk processes and other required areas in order to monitor the stability of existing processes, identify opportunities for improvement, identify changes that lead to improvement and/or sustain improvement.
2. Considers performance monitoring data, benchmarking data, scientific and technological advances in the design of new services and/or the redesign of existing processes, functions, or services (internal and contracted).
3. Collects data to monitor processes that involve high risk or vulnerable populations, especially those that may result in sentinel events.
4. Systematically aggregates and analyzes data over time using appropriate statistical techniques and translates that data into meaningful information.
5. Sets priorities for improving systems and processes to promote positive outcomes.
6. Intensively analyzes undesirable patterns or trends in performance, selects high risk processes and utilizes statistical analysis (such as failure mode effect analysis) to proactively reduce risk, and performs root cause analyses when sentinel events and near misses occur.
7. Determines actions needed to minimize risk of effects on populations served, such as redesigning processes and underlying systems.
8. Assesses the effectiveness of actions taken to promote performance improvement and sustains the improvement.
9. Provides a mechanism for assessing the clinical competence of individuals providing patient care.
10. Communicates performance improvement activities to the Governing Board, system leadership, medical staff, staff, and community.
11. Establishes a mechanism to assure one level of patient care.
12. Ensures compliance with regulatory and accrediting agencies.
13. Monitors utilization to evaluate the appropriateness of admissions, length of stay, discharge practices, use of medical resources, and other factors related to utilization of hospital and physician services.
14. Reviews and approves a written utilization review plan for the hospital.

ORGANIZATION:

1. Governing Board

The Governing Board has the ultimate responsibility for establishing quality patient care. This authority is delegated to the Behavioral Health Quality and Safety Committee which provides oversight. Leadership and Medical Staff develop methods for monitoring the delivery of patient care.

2. Behavioral Health Quality and Safety Committee

The Behavioral Health Quality and Safety Committee (BHQS) provides oversight for quality and patient safety across the behavioral health system. The committee promotes communication, collaboration and alignment of AHC and behavioral health quality improvement initiatives across the behavioral health continuum. ABHQS membership is comprised of medical, nursing, quality and risk management leadership from each entities' PI Council and at least one Governing Board member.

3. Performance Improvement Council (PIC)

Entities establish PICs to oversee their performance improvement activities and to promote service excellence through effective management of resources and systems. Specific duties include:

- A. Meets at least ten times annually and reports to the Governing Board at least quarterly.
- B. Serves as a forum for performance improvement, risk management and patient safety.
- C. Coordinates and integrates all performance improvement activities throughout the facility.
- D. Reviews measures of performance, both process and outcomes, for patient care and organizational functions.
- E. Identifies processes for improvement.
- F. Prioritizes opportunities for improvement in order of importance considering those that affect a larger percentage of patients, place patients at risk or are problem prone.
- G. Charters cross-functional teams and monitors team progress.
- H. Monitors process performance on an ongoing basis.
- I. Identifies negative patterns or trends by using internal and external sources (i.e. incident data base, root cause analyses, JCAHO's Sentinel Event Alerts).
- J. Reviews department indicators for compliance with established thresholds.
- K. Serves as a forum for discussion of interdisciplinary problems, determining the priority with which hospital-wide problems shall be evaluated and assigning task forces to address interdepartmental process issues when necessary.
- L. Integrates strategic, business, and operating plans.
- M. Oversees pathway development and implementation.
- N. Reviews and determines that each medical record, or a representative sample of the records, is complete and consistent, and reflects the diagnosis, results of the diagnostic tests, therapy rendered, condition and progress of the patient, and condition of the patient at discharge.
- O. PIC Membership
 - Medical Director (Co-chair)
 - Director of Performance Improvement and Risk Management (Co-Chair)
 - President or Vice-President, Chief Operating Officer
 - Service and/or Assistant Medical Director (as assigned)
 - Chief Nursing Officer or Director of Nursing
 - Program Directors
 - Human Resources Director
 - Local Integrity Officer
 - Patient Advocate
 - Performance Improvement Manager and Analyst

4. Medical Executive Committee

The Medical Executive Committee reviews and approves, through receipt of minutes and summary reports, as defined in the Medical Staff Bylaws, all recommendations and actions that pertain to the Medical Staff.

- A. The Medical Director serves as a link between the Medical Staff and senior leadership regarding performance improvement activities.
- B. Coordinates the quality review and performance improvement activities of the clinical departments, including, but not limited to (i) important aspects of care, efficiency and appropriateness of care provided specific to patients' conditions; (ii) timeliness of interventions, (iii) effectiveness and continuity of care, (iv) consistency and standard of care rendered within and among the different units/departments, and (v) the manner in which care is provided to patients to reduce patient exposure to risk.
- C. Reviews all patient care evaluation data and efforts by medical review committees to comply with the System's performance review program, and make appropriate recommendations for corrective action.
- D. Receives and reviews reports related to credentialing, risk management and patient safety, pharmacy and therapeutics, infection control, utilization review and other medical related functions.
- E. Ensures that prospective and retrospective studies are appropriately integrated into the performance improvement program.
- F. Reviews all PRO citations and/or quality letters received by ABH regarding proper documentation to evidence appropriate care and/or follow-up regarding quality of care issues raised by the State review body.
- G. Documents the effectiveness of the overall performance improvement program as it relates to the medical staff.
- H. Integrates risk management and patient safety findings into ongoing performance improvement and quality monitoring processes.

5. Senior Leadership

- A. Provides an administrative level of leadership that assures participation in the Program by hospital staff members.
- B. Takes action on problems identified as relating to hospital policies and procedures.
- C. Allocates adequate resources for assessing and improving patient care and organizational functions.

6. Departments

- A. Each department/unit manager is responsible for conducting performance improvement activities. Their responsibilities include: Develop and evaluate annually, performance improvement initiatives based on the ABH performance improvement plan.
- B. Establishes criteria for measuring and reporting of departmental processes that are intended to define optimal quality standards. For each dimension of performance of quality identified in the plan, key indicators will be measured periodically against established thresholds. For those indicators not meeting established thresholds, action plans will be initiated by the appropriate department heads.
- C. Monitors follow-up assessment activities to ensure that corrective actions are effective.
- D. Provides year-end listing of accomplishments achieved in an established format.
- E. Refers problems that may be hospital-wide or interdepartmental to the PIC for recommendations.

7. Cross-functional Process Action Teams:

1. Are officially organized and charged by the PIC to improve a given process.
2. Are composed of between 5 – 10 members who represent departments which impact or are impacted by the named process.
3. Have established objectives and are usually time limited in nature.
4. Follow a structured approach to problem solving as described below.
5. Report regularly to PIC on progress.

Prioritization of processes to be improved include:

- High volume issue.
- High risk or problem prone issue – such as suicide assessments and prevention
- Associated with patient rights.
- Patient assessment.
- Patient/family education – such as community resources, medication education
- Coordination/continuum of care.
- Leadership.
- Management of information.
- Environmental of care.
- Enhance the quality of care or services.
- Enhance customer satisfaction.
- Reduce cost and waste
- Enhance market share.
- Enhance staff and physician loyalty.

PROCESS IMPROVEMENT MODEL:

The hospital uses the Plan-Do-Check-Act in combination with other process improvement methodologies such as Lean and Six Sigma to improve processes. Process improvements using the PDCA methodology are achieved through the following steps:

1. Identify the process to improve.
2. Organize a team to improve the process.
3. Understand and analyze the process.
4. Identify the recommended improvements.
5. Plan the improvements.
6. Implement the improvement.
7. Check the results.
8. Act so as to sustain or improve the process.

“Lean Six Sigma is a fact-based, data-driven philosophy of quality improvement that values defect prevention over defect detection. It drives customer satisfaction and bottom-line results by reducing variation and waste.” When using the Lean Six Sigma D.M.A.I.C. methodology, variations and defects are reduced through the following steps:

1. define,
2. measure
3. analyze

4. improve
5. control

APPROACH:

The Performance Improvement Program strives to improve care through the collection of data which is used to measure performance of existing processes, identify opportunities for improvements in processes, identify the need to design new processes, determine the effectiveness of the process improvement, and improve upon or sustain performance improvement. Performance measures focus on:

- A. Process and outcomes.
- B. Ongoing monitoring using generic screens.
- C. High risk, high volume, and/or problem prone processes including:
- D. Medication management.
- E. Timeliness, completion and quality of medical records.
- F. Use of seclusion and restraints
- G. Behavior management and treatment.
- H. The Joint Commission (TJC) initiatives, such as National Patient Safety Goals and program specific Priority Focus Areas.
- I. Patient safety and risk management
- J. Hospital Based Inpatient Psychiatric Services, a TJC core measure set.
- K. Event tracking system reports.
- L. Infection control reports.
- M. Utilization Management findings.
- N. Environment of Care reports.
- O. Needs, expectations and feedback of patients, physicians, team members and community.
- P. Analysis of and response to complaints, surveys, assessments and inspections performed by external accreditation, licensing, regulatory and reimbursement agencies.
- Q. Comparison of organizational performance overtime and with other sources of data.

EDUCATION:

All team members receive at least a one-hour Performance Improvement awareness presentation. Leaders, department managers, and supervisors receive at least 3 hours of awareness training. When a team is chartered and throughout the team process, process improvement training is provided by the Director of Performance Improvement and designees. Medical Staff PI awareness occurs through MEC presentations, team membership, and written articles.

COMMUNICATION OF PI RESULTS:

- A. Information on PI results and team activities are communicated through a variety of ways including articles in Prism, postings throughout the facility and discussion in employee meetings.
- B. Performance Action Team results are reported at BHQS and entity PIC, MEC and/or staff meetings.

- C. Communication (storyboards, graphs, and print media) is displayed throughout the hospital.
- D. Recognition and Reward programs may recognize team participation and results.
- E. Entity PICs share information with their respective MEC, Governing Board and/or community oversight council.

CONFIDENTIALITY:

Due to the sensitive nature of all data, reports, and minutes generated under the PI Program, confidentiality will be protected by all staff regardless of the level of their participation. All references to patients and physicians will be made by patient number and or initial and physician code.

CONFLICT OF INTEREST:

No health care provider or other individual involved in quality assessment and performance improvement activities shall be allowed to review any case in which he/she is professionally involved. In the event of known conflict of interest, the individual should excuse themselves from participating in the process.

Reference:

The Joint Commission, Hospital and Behavioral Health Care Accreditation Standards, Leadership, Performance Improvement, and Sentinel Event Chapters. 2013.

ANNUAL EVALUATION

The ABH Performance Improvement Program will be reviewed annually to ensure that the structure and functions of the program achieve the major goals and objectives as defined. The Performance Improvement Plan will also be reviewed to ensure compliance with the standards established by TJC and to ensure consistency with major policy actions initiated by the ABH Governing Board and BHQS.

ABHS, AVP, Quality and Patient Safety

Date

ABH Medical Director

Date

ABHS President

Date

ABH Governing Board

Date