PERFORMANCE IMPROVEMENT PLAN

FY 2019

PENINSULA REGIONAL MEDICAL CENTER
PERFORMANCE IMPROVEMENT PLAN

I. PENINSULA REGIONAL MEDICAL CENTER MISSION

Improve the Health of the Communities We Serve

II. CORPORATE VALUES

- Respect
- Service
- Honesty
- Safety
- Accountability
- Compassion

III. PERFORMANCE IMPROVEMENT MISSION

The mission is to facilitate performance improvement by setting direction and providing resources for quality, safety, and service initiatives in the organization.

IV. COMMITMENT TO QUALITY

We count on each other to:

- Contribute to the continuous improvement of his or her own work on a daily basis.
- Participate in Performance Improvement Teams and other quality improvement activities.
- Foster an environment of participation, teamwork and professional growth.
- Be attentive to the "Voice of the Customer".
- Adhere to our corporate values.
- Endeavor to improve the quality and safety of and service to our patients and the care environment

V. OBJECTIVES:

1) Determine improvement and safety priorities and assign accountabilities
2) Review appropriate organizational outcome data aligned with the PRMC/PRMG strategic plan and goals. Focused metrics for FY 2019 include:
    a. Maryland Hospital Acquired Condition rates
    b. Potentially Avoidable Utilization: 30-day Readmissions & Prevention Quality Indicators (PQI)
    c. HCAHPS/CGCAHPS

d. Employee & Provider Engagement
e. Flow: LOS, cycle time metrics, efficiency of care

3) Review and prioritize project charters and assign to appropriate project leads/teams.
4) Receive reports on the outcomes or results of priority decisions
5) Assure compliance with the Joint Commission/CMS, Department of Health and other accreditation requirements

VI. ACCOUNTABILITY:

A. Ultimate responsibility for the organizational improvement activities will be vested in the Peninsula Regional Medical Center Board of Trustees (Board). The Board gives full support and commitment by providing for resources and support systems related to patient care, patient safety and engagement and organizational performance. Performance Improvement activity, with support from the Medical Executive Committee and Executive Operations Team, will be reported to the Quality Oversight Committee of the Board of Trustees.

B. The Executive Operations Team has been delegated by the Board of Trustees to directly monitor the hospital-wide initiatives, to coordinate the resolution of any identified opportunities to improve the delivery of health care and to recommend action(s) to the Board of Trustees, President of the Medical Staff and/or President of the Medical Center, as necessary, and to assure compliance with improvement activities. The Executive Operations Team will meet at least quarterly and document the activity findings.

C. Medical Staff and Hospital Leadership are directly accountable for the ongoing monitoring, evaluation and improvement activities which include:
- identification of scope of care and key processes
- use of objective measurable indicators that reflect current knowledge and clinical/technical expertise
- ongoing collection and/or screening of data and information
- improving quality of patient care and work systems and resolving identified problems through actions taken as appropriate
- utilizing robust process improvement methodologies to create breakthrough change that is sustained by strong change management techniques

VII. COMPOSITION OF EXECUTIVE OPERATIONS TEAM

Executive Vice President/COO of the Medical Center
Vice President, Medical Affairs/Chief Medical Officer
Vice President of Patient Care Services/Chief Nursing Officer
Vice President, Population Health
Vice President, Ambulatory Services
Vice President, People Department
Chief Financial Officer
PRMG CEO/COO

VIII. SCOPE

Shall include at least the following:

A. Medical Staff

1. OPPE and FPPE

Ongoing Professional Practice Evaluation (OPPE) and Focused Professional Practice Evaluation (FPPE) are processes for monitoring and evaluation of current competency for practitioners with granted privileges. Multiple sources of information and performance data are used for these evaluations, including:

(a) Review of individual patient care cases
(b) Review of compliance with rules of the Medical Staff
(c) Review of compliance with Hospital and Medical Staff policies
(d) Review of clinical standards with the use of rates in comparison with established benchmarks
(e) Review of operative and other procedures that may place patients at risk
(f) Review of drug usage
(g) Review of medical record documentation and completion
(h) Review of blood transfusion usage
(i) Review of pharmacy, nutrition and therapeutic interventions
(j) Review of risk management issues
(k) Review of peer review determinations

The Department/Division Chiefs will use this information to establish processes to monitor, evaluate and improve the appropriateness of patient care and the clinical performance of all individuals with clinical privileges. Results of these evaluations will be reviewed and shared with the practitioner in accordance with the OPPE/FPPE policy.

2. Clinical Operational Effectiveness

Aggregate performance data will be evaluated for opportunities to improve the overall Medical Staff/Hospital clinical quality, efficiency and medical necessity of the care provided to patients. Leaders of departments, divisions, and service lines will evaluate data from service lines, practitioner groups, and clinical patient care units and develop plans for patient care improvement and for optimization of appropriate resource utilization.

B. Hospital Departments - with patient care responsibilities

1. Ongoing monitoring and evaluation of the quality, safety, service and appropriateness of patient care:
   a) Patient Care Services (Nursing, Rehab & Respiratory Medicine)
   b) Population Health and Patient Care Management
   c) Behavioral Health Services
   d) Pharmaceutical Services
   e) Surgical & Anesthesia Services
   f) Ambulatory Care Services
   g) Imaging Services
   h) Food & Nutrition Services
   i) Medical Laboratory Services & Pathology
   j) Cancer Center Services
   k) Cardiothoracic Services
   l) Peninsula Regional Medical Group
   m) Women's and Children's Health

2. Support Services: provide key operational support processes to the patient care departments related to quality, safety, service and appropriateness of care.
   a) Infection Prevention
   b) Risk Management
   c) Environment of Care Committee
   d) Environmental Services/Transport
   e) Finance
   f) Patient Access
   g) Volunteer Services
   h) Pastoral Care
   i) Information Management
   j) People Department
   k) Organizational Effectiveness
   l) Planning
   m) Materials Management
   n) Facilities Management / Protection Services
   o) Business Intelligence and Clinical Analytics

IX. PERFORMANCE IMPROVEMENT PROCESS AND METHODS

A. Priorities for performance improvement are established based on the strategic directions of the medical center, the important functions and processes that support these directions, and required external focus and regulatory areas such as CMS, The National Patient Safety Goals, Institute of Medicine and clinical core measures. Performance improvement integrates quality assessment and improvement, risk management, resource management, accreditation and credentialing/privileging.

B. Performance improvement is accomplished through a systematic and ongoing approach (Appendix B) designed to:
   - Identify important functions, processes and outcomes;
   - Prioritize problems and/or process/outcome measurement based on impact, applicability, (high volume, high risk, problem prone, relationship to strategic directions), requirements (quality control, important functions, relationship to elements

of performance), and history;
- Use objective, explicit, and measurable key performance indicators and criteria;
- Establish meaningful control plans which trigger further evaluation or intensive assessment;
- Collect, aggregate, and analyze data;
- Assess patterns, trends, and unusual events using both internal and external comparisons, standards, and best practices; initiate intensive assessment as indicated;
- Develop and implement strategies for improving care or resolving problems;
- Evaluate effectiveness of actions taken; and
- Maintain accurate records of all activities
- Ensure organization-wide adherence to the National Patient Safety Goals (Appendix A)

C. Performance Improvement Team Formation and Training: (see appendix C)

1. The Executive Staff of the Medical Center is responsible for supporting improvement teams at the organizational level and ensuring resources are available. Organization level project charters are presented and obtain executive approval within the appropriate reporting structure. Teams may be chartered for cross-functional, multi-department improvement efforts, or to assist in the design of new organizational processes. The team charter will define the business case/problem statement, scope of the project, milestone timelines, team membership, goals and deliverables, and any constraints.
2. Local level project charters will be presented at departmental Core Team meetings and approved by the divisional Director.

3. All project teams will follow a standardized problem solving method that incorporates the aspects listed below:

Define: Statement of the opportunity for improvement showing current state, the voice of the customer, business case, problem statement, scope of the project, and anticipated goals and deliverables.

Measure: What data is needed, what is the best way to measure, is the data accurate. Data management, sources, and access should be determined and reported to the appropriate approval authority.

Analyze: Data driven analysis of process performance. Establish measurable baselines if not currently available. Identify most influential factors.

Improve: Generate solutions and develop implementation plans. Test the solutions for effectiveness.

Control: Evaluate and measure impact of changes. Create and implement a control and communication plan. Identify process owner and measurement intervals for managing process control. Identify additional improvement opportunities.

Teams receive "Just-in-time" training on team process, dynamics and the DMAIC process from their assigned facilitator. Team leaders receive training in meeting management and performance improvement tools as needed. Teams will be supported by Lean/Six Sigma trained personnel within Organizational Effectiveness

and/or throughout the organization.

D. Team Report Out Structure

To provide consistency in project reporting, teams are asked to report out in the following manner:

1. New Project Proposals:
    a. Project Charter with a focus on business case, problem statement, scope of the project, milestone timeline, and goals/deliverables.
    b. Baseline data (if it exists) to support the project charter
    c. Anticipated resource needs (team members, PI support, anticipated length of project time) to complete the project
2. Ongoing Project Reports:
    a. Review of Project Charter
    b. Which phase of the improvement process the project is currently in and significant information/results to share as a result of the completed phase(s). (See Section C.2 above.)
    c. Significant data as relevant by phase of project
    d. Barriers to project completion and/or resource needs
3. Project Completion Report Outs
    a. Current State post – project
    b. Metrics pre and post (improvement noted)
    c. Process owner ongoing metrics, control plan and responsible department(s) to sustain results

E. Organizational Outcome Reports

The following organizational outcome measures will be regularly reported to the Executive Operations Team and other quality councils as needed by designated metric owners. In addition, project teams assigned to the improvement of those metrics will report as per the Team Report out structure above.

1. Infections Rates (QBR specific along with any other organizational target)
2. PAU: PQI/Readmissions
3. MHACS
4. Patient Engagement via HCAHPS/CGCAHPS
5. Employee Engagement
6. Provider Engagement
7. Cycle Time Metrics from Key Value Streams to include length of stay, ED efficiency
8. Mortality

For organizational level projects, Executive Operation team members will determine if any additional actions or follow up must be made based on the information provided in the reports. For local/departmental projects, Service Line and/or Department Directors will make this determination.

X. REPORT AND FOLLOW UP

A. The Executive Operations Team shall have authority to direct department/ services/committees to present interim reports on a timely basis and a final report when the identified problem(s) is resolved.

B. Pertinent information obtained through generic, informational and clinical screens is reported to appropriate Medical Staff, Administrative and Service-based committees.

C. Regular reports of the Executive Operations Performance Improvement Team Reports and Medical Executive Committee activities are made via minutes distributed to the Quality Oversight Committee and the Board of Trustees.
D. Medical Staff Peer Review is reported through the Medical Staff Departments to the Executive Committee of the Medical Staff and by the President of the Medical Staff to the Board of Trustees.
E. Minutes of the Executive Operations Performance Improvement Team reports are also distributed to Medical Executive Committee. They consider these reports, take action as indicated and make recommendations back to the Executive Operations Team.
F. Local/Departmental Projects will report out via the Core Team Structure and to the Director sponsor of the project.

XI. INFORMATION SOURCES THAT INFORM PROJECT SELECTION - include, but are not limited to the following:

A. Concurrent and retrospective review of the medical record
B. Incident reports
C. Patient questionnaires and satisfaction surveys
D. Morbidity/mortality review
E. Medical Staff Committee minutes
F. Written referrals from hospital and/or medical staff committees/departments
G. Clinical/generic screening activities
H. External regulator/accrediting agencies written survey reports
I. Teams utilizing Lean Six Sigma/DMAIC process
J. Internal and external databases

XII. CONFIDENTIALITY OF INFORMATION

All patient, provider and hospital data shall be treated as strictly confidential. Confidentiality is maintained through limited access to data by qualified individuals. The minutes and other work documents of the Executive Operations Team and any appointed subcommittee, and all other medical staff committees formed to evaluate and improve the quality of health care are deemed "Medical Review Committee" materials per Article 34, Section 134A of the Maryland Code and as such are not subject to discovery.

All members shall maintain the confidentiality of information coming to their knowledge through the work of the Performance Improvement activities.

XII. REAPPRAISAL/MEASUREMENT

A. A record shall be prepared and maintained by each department and clinical service of the opportunities identified and solved which have an impact on the improvement of patient care and safety.
B. A list of the improvements in patient care which result from the hospital-wide activities shall be prepared annually.
C. The organization shall annually assess the improvements in patient care and safety resulting from the various quality review activities.
D. The Performance Improvement Plan shall be reviewed annually and revised as necessary; approved by the Medical Executive Committee of the Medical Staff, the Quality Oversight Committee, and the Board of Trustees.

APPROVALS

Chairman, Medical Executive Committee Date

Chairman, Quality Oversight Committee Date

President/CEO of Hospital Date

Chairman of the Board of Trustees Date

Revised: 6/94, 8/95, 11/96, 7/97, 7/98, 2/2000, 6/2001, 7/2002, 10/2003, 3/2005, 6/2006; 1/2007; 5/2008; 3/2009; 2/2011; 2/2012; 1/2013; 1/2014; 4/2014; 2/2015, 2/2016, 1/2017, 6/2018

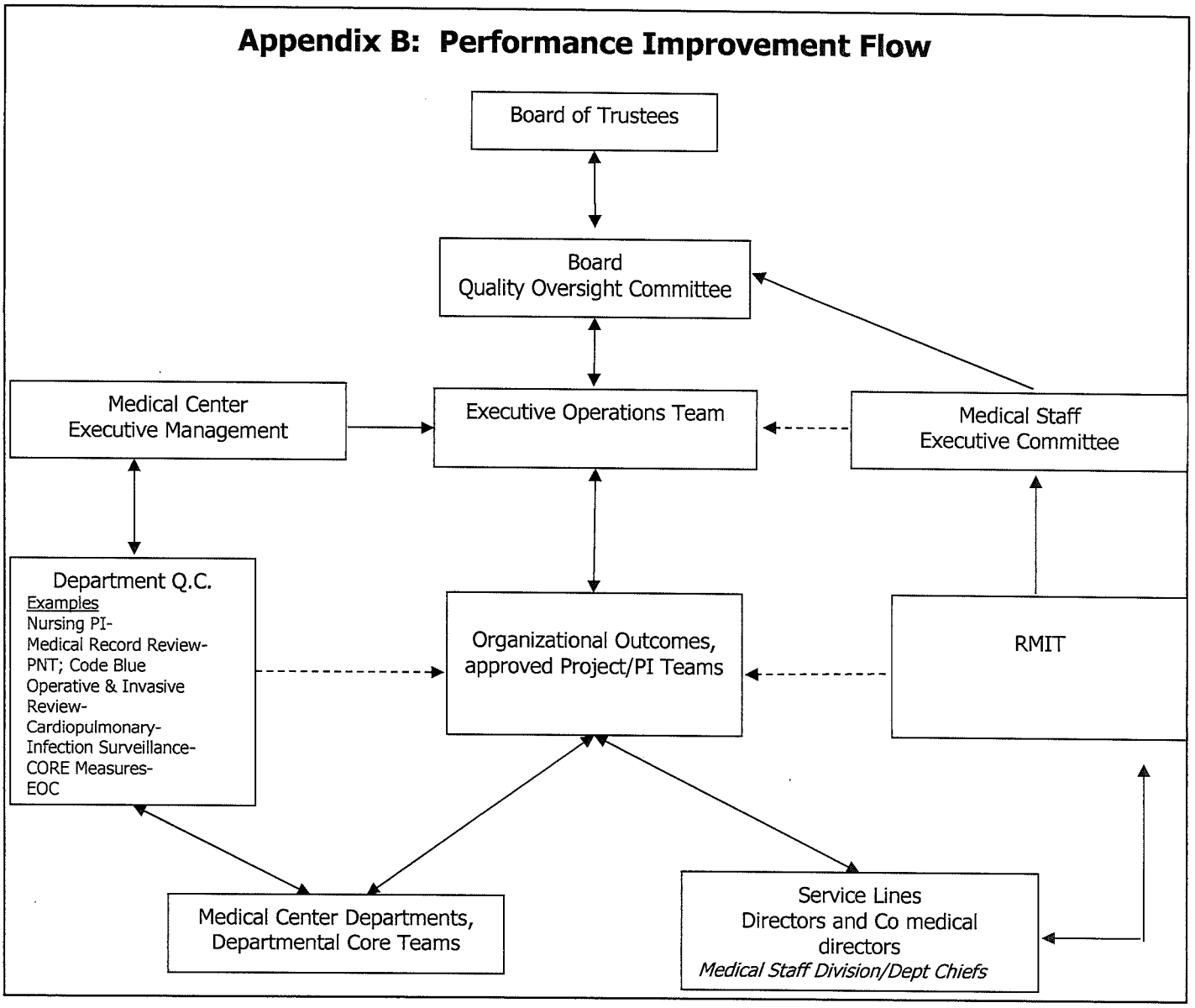
2018 Hospital National Patient Safety Goals

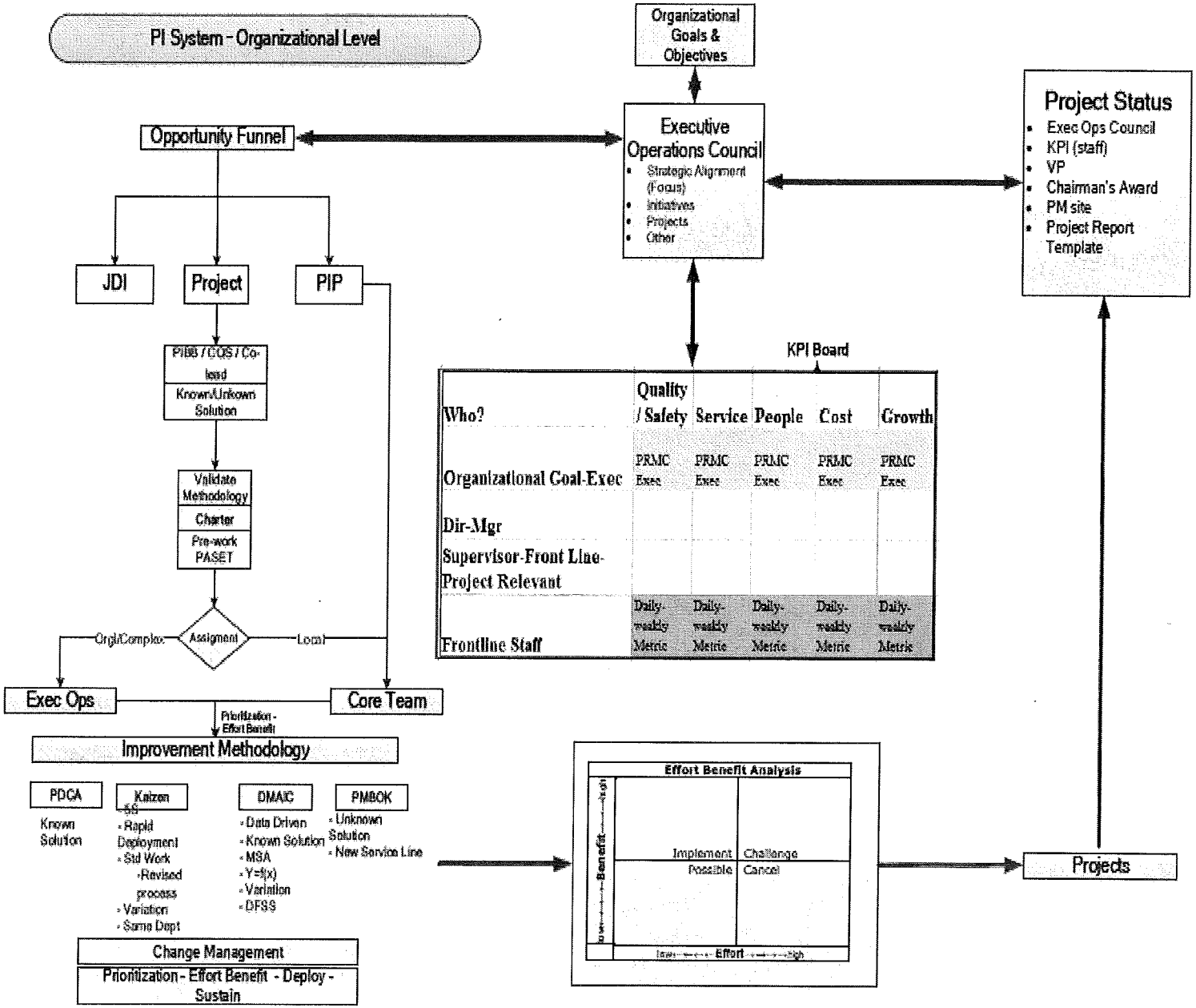
The purpose of the National Patient Safety Goals is to improve patient safety. The goals focus on problems in health care safety and how to solve them.

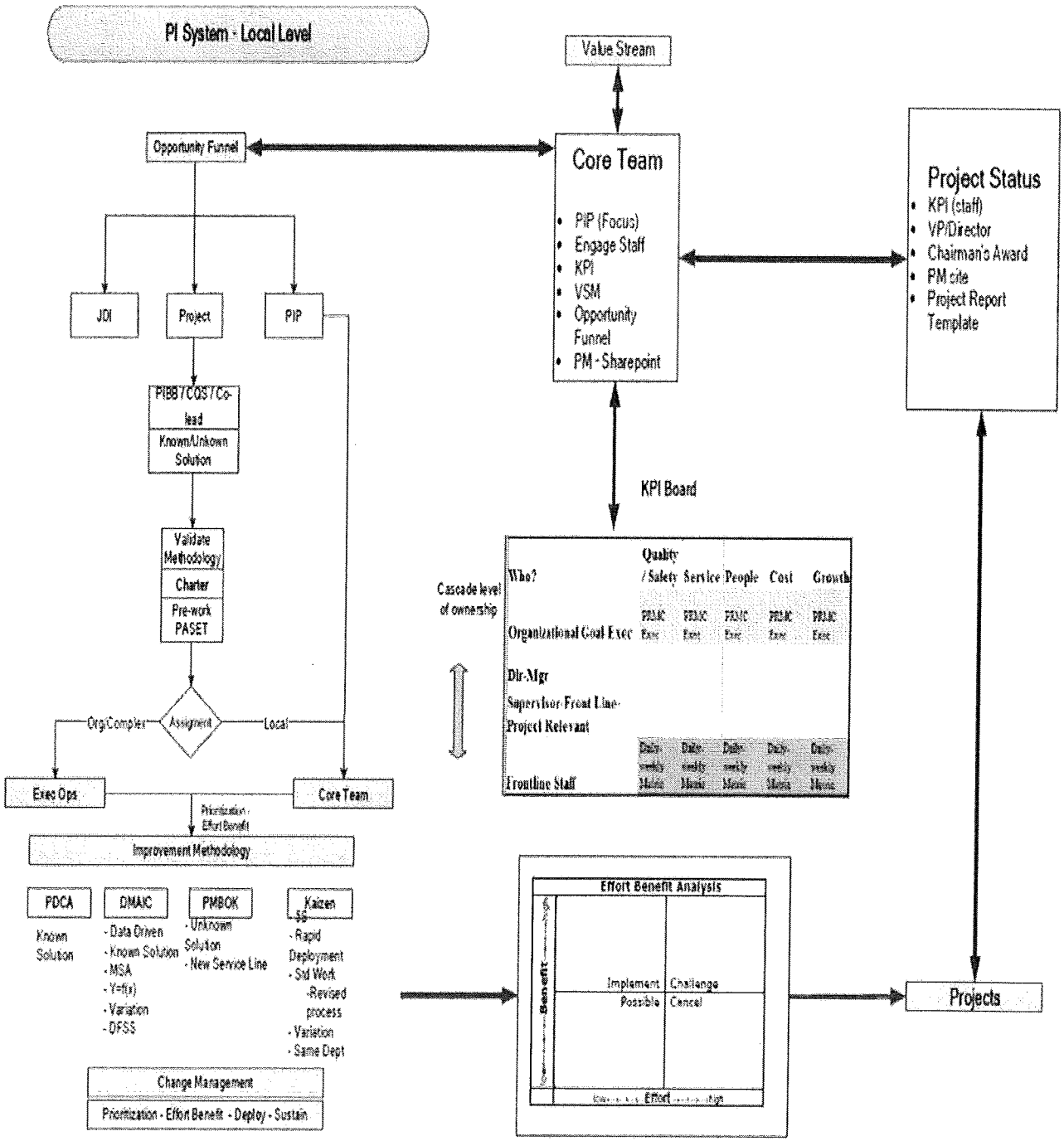
Identify patients correctly	
NPSG.01.01.01	Use at least two ways to identify patients. For example, use the patient's name and date of birth. This is done to make sure that each patient gets the correct medicine and treatment.
NPSG.01.03.01	Make sure that the correct patient gets the correct blood when they get a blood transfusion.
Improve staff communication	
NPSG.02.03.01	Get important test results to the right staff person on time.
Use medicines safely	
NPSG.03.04.01	Before a procedure, label medicines that are not labeled. For example, medicines in syringes, cups and basins. Do this in the area where medicines and supplies are set up.
NPSG.03.05.01	Take extra care with patients who take medicines to thin their blood.
NPSG.03.06.01	Record and pass along correct information about a patient's medicines. Find out what medicines the patient is taking. Compare those medicines to new medicines given to the patient. Make sure the patient knows which medicines to take when they are at home. Tell the patient it is important to bring their up-to-date list of medicines every time they visit a doctor.
Use alarms safely	
NPSG.06.01.01	Make improvements to ensure that alarms on medical equipment are heard and responded to on time.
Prevent infection	
NPSG.07.01.01	Use the hand cleaning guidelines from the Centers for Disease Control and Prevention or the World Health Organization. Set goals for improving hand cleaning. Use the goals to improve hand cleaning.
NPSG.07.03.01	Use proven guidelines to prevent infections that are difficult to treat.
NPSG.07.04.01	Use proven guidelines to prevent infection of the blood from central lines.
NPSG.07.05.01	Use proven guidelines to prevent infection after surgery.
NPSG.07.06.01	Use proven guidelines to prevent infections of the urinary tract that are caused by catheters.
Identify patient safety risks	
NPSG.15.01.01	Find out which patients are most likely to try to commit suicide.
Prevent mistakes in surgery	
UP.01.01.01	Make sure that the correct surgery is done on the correct patient and at the correct place on the patient's body.
UP.01.02.01	Mark the correct place on the patient's body where the surgery is to be done.
UP.01.03.01	Pause before the surgery to make sure that a mistake is not being made.

The Joint Commission
Accreditation
Hospital

Appendix B: Performance Improvement Flow




PI System - Organizational Level
Organizational Goals & Objectives
Executive Operations Council
Strategic Alignment (Focus)
Initiatives
Projects
Other
Project Status
Exec Ops Council
KPI (staff)
VP
Chairman's Award
PM site
Project Report Template
Opportunity Funnel
JDI
Project
PIP
PIBB / COS / Co-lead
Known/Unkown Solution
Validate Methodology
Charter
Pre-work PASET
Assigment
Org/Complex
Local
KPI Board
Who?
Quality / Safety
Service
People
Cost
Growth
Organizational Goal-Exec
PRMC Exec
Dir-Mgr
Supervisor-Front Line-Project Relevant
Frontline Staff
Daily-weekly Metric
Exec Ops
Core Team
Prioritization - Effort Benefit
Improvement Methodology
PDCA
Known Solution
Kaizen
5S
- Rapid Deployment
- Std Work
-Revised process
- Variation
- Same Dept
DMAIC
- Data Driven
- Known Solution
- MSA
- Y=f(x)
- Variation
- DFSS
PMBOK
- Unknown Solution
- New Service Line
Change Management
Prioritization - Effort Benefit - Deploy - Sustain
Effort Benefit Analysis
Benefit
Implement
Challenge
Possible
Cancel
Effort
Projects


PI System - Local Level
Value Stream
Opportunity Funnel
Core Team
PIP (Focus)
Engage Staff
KPI
VSM
Opportunity Funnel
PM - Sharepoint
Project Status
KPI (staff)
VP/Director
Chairman's Award
PM cite
Project Report Template
JDI
Project
PIP
PIBB/COST/Co-lead
Known/Unkown Solution
Validate Methodology
Charter
Pre-work
PASET
KPI Board
Cascade level of ownership
Who?
Quality /Safety
Service
People
Cost
Growth
Organizational Goal Exec
Dir-Mgr
Supervisor-Front Line-Project Relevant
Frontline Staff
Org/Complex
Assignment
Local
Exec Ops
Core Team
Prioritization - Effort Benefit
Improvement Methodology
PDCA
Known Solution
DMAIC
- Data Driven
- Known Solution
- MSA
- Y=f(x)
- Variation
- DFSS
PMBOK
- Unknown Solution
- New Service Line
Kaizen
- Rapid Deployment
- Std Work
-Revised process
- Variation
- Same Dept
Change Management
Prioritization - Effort Benefit - Deploy - Sustain
Effort Benefit Analysis
Benefit
Implement
Challenge
Possible
Cancel
Effort
Projects