UPMC Passavant
POLICY MANUAL

SUBJECT: Quality Plan 2017
DATE: July 2016

PURPOSE/OBJECTIVES: To continuously improve the quality healthcare we provide in our community through monitoring performance to promote best practice and support the “right” improvement activity by incorporating these strategic priorities:

**MISSION:**
To enhance the health of the communities we serve through clinical and service excellence.

**VISION:**
To be the health care provider of choice; putting our patients, health plan members, employees, and community at the center of everything we do and creating a model that ensures that every patient gets the right care.

**VALUES:**
Communication
Accountability
Responsibility and Integrity
Empathy
Safety/Quality

**FY 2017 STRATEGIC PILLARS**

- Strive to create a safe, fair culture that focuses on the elimination of all preventable harm and death.
- Support a work environment that assures employee engagement and caregiver satisfaction.
- Continuously establish and drive patient and member quality outcomes at the lowest costs through the application of focused rigorous improvement efforts.
- Engage patient’s, families and members in managing their healthcare and assure they have best care experience possible.
QUALITY DEFINED:
Quality at UPMC Passavant is defined as:

- A combination of successful medical, service and cost outcomes.
- Care and services that are safe, effective, efficient, patient-centered, timely and equitable.

UPMC Passavant has developed and implemented a Quality Structure (below) comprised of multiple performance improvement teams. Each team has an assigned Physician and Registered Nurse champions. These teams have the ability to make their own decisions regarding quality process improvement care initiatives, and utilize the Quality Oversight Council to report initiative progress, seek guidance and feedback, and to assist with addressing barriers.

Overview of the UPMC Passavant Quality Structure:
Performance Improvement Teams are invited to present at the Quality Oversight Council (QOC). QOC reports up through the Quality Patient Care Committee (QPCC). Information provided is then summarized and shared with the Board of Directors at the Passavant quarterly Board meetings.

Description:
**Performance Improvement Teams**: Performance improvement teams are multidisciplinary in nature. Teams prioritize improvement processes, develop action plans, analyze data, and act upon the findings for performance improvement. Performance Improvement teams establish specific, measurable goals.
for identified initiatives. Their progress, especially as it impacts other services in the Hospital, are reported at the Quality Oversight Council, as appropriate

**Quality Oversight Council (QOC):** This council is comprised of executive leaders, physicians, nursing, operations and a community member. The council is scheduled to meet eight times per year (with the exception on the same month of QPCC) and is chaired by Tom Schauble, MD. Project leaders from the performance improvement teams are invited to present updates, as well as barriers and challenges seeking council feedback. The responsibilities of the QOC are:

- Communicate directives of Quality Patient Care Committee, Medical Executive Committee & Board of Directors
- Report outcomes, information to Quality Patient Care Committee
- Identify opportunities for performance improvement and needed resources
- Review current process and outcome measurements
- Report clinical, operational and patient satisfaction outcomes
- Annual review of System Quality goals and strategic initiatives
- Prioritization of Performance improvement activities

**Quality Patient Care Committee (QPCC):** Quarterly meeting of Professional Staff as defined in Medical Staff Bylaws and includes representatives of the Board of Directors, Professional Staff, Executive Management, Medical Executive Committee, Quality, Nursing and hospital staff. It is co-chaired by the immediate Past President of the Medical Staff, Steve Harris, MD and a Board Representative, Dan Sullivan, MD. This committee’s responsibilities are:

- Oversight in the development, implementation and monitoring of services and processes for clinical as well as non-clinical indicators of quality service
- Assess needed resources through reports of other hospital committees, including ad hoc reports, service lines and guides the prioritization of performance improvement activity
- Promote regulatory compliance
- Review publicly reported quality reports such as Medicare’s Hospital Compare, and Pennsylvania Health Care Cost Containment Council (PHC4)
- Provide an opportunity for discussion of hospital policies and practices especially those pertaining to patient care.
- Provision of comments and feedback to individual units/departments presenting their Process Improvement activities.
- Oversite of Quality Dashboards to provide Board Members a visual report on issues, trends, and constantly changing requirements in health care that affect hospital activities

**Board of Directors:** The Board of Directors of UPMC Passavant Hospital, chaired by Richard Hamilton, has the ultimate responsibility for performance improvement. To fulfill the commitment of performance improvement, the board delegates the responsibility for developing, implementing, and maintaining performance activities to administration, management, medical staff and employees. The board recognizes that performance improvement is a continuous process, and will provide the necessary resources to carry out this philosophy. Through the development of strategic initiatives, the board provides direction for the organization’s improvement activities. Membership on the Quality Patient Care Committee and reports from the Committee provide the board with a means of evaluating the organization’s effectiveness in improving quality.

**Medical Executive Committee:** The Medical Executive Committee is chaired by Steven Jones, MD. The MEC is comprised of the Chairs for the departments and the Executive Management Group (EMG). They are responsible to assure participation of the Professional Staff in Hospital performance improvement activities. The committee reviews and trends quality indicators for patient
care services, safety and patient satisfaction on a monthly basis and is provided upon request an update on associated process improvement activities. The MEC then makes recommendations as appropriate to various committees and departments when there are significant departures from established and expected clinical practice patterns.

PERFORMANCE IMPROVEMENT APPROACH:
FOCUS-PDSA: PI model utilized by the Institute for Healthcare Improvement (IHI) and the chosen methodology for our facility. It provides a common framework for performance improvement projects and the implementation of continuous process improvement.

- Find a problem
- Organize a team of people who understand the process
- Clarify the issues
- Uncover the Root Cause
- Start the PI process
  - Plan the improvement
  - Do the improvement
  - Study to see if you got the results you expected
  - Act by rolling it out to other areas, discard the idea or begin another PDSA

Incorporating Staff Recommendations: Staff views and recommendations are sought through various committees, staff surveys, leadership visibility rounds, town-hall meetings, breakfast/lunch with the President, or suggestion boxes.

Quality Fairs: In support of an environment for performance improvement, the Quality Fair is one method to showcase initiatives, share ideas, foster interdisciplinary collaboration, and provide education. All staff are encouraged to participate annually utilizing the FOCUS PDSA methodology. Judging criteria are applied to projects submitted and multiple awards are presented based on submission.

Education and Training: To facilitate the development of operational expertise, communication skills, knowledge and competency relating to core performance improvement fundamentals, the following education and training programs are available:
- Orientation programs for new staff
- Performance improvement education programs and workshops

Data Transparency:
UPMC Passavant is committed to data transparency with all staff. Through our Passavant eNet data portal locally, staff can access data such as Core Measure, Pay for Performance, Nursing Sensitive Indicators, Human Resource and Infection Control data. Data from these measures is reflected in the dashboards.

Dashboards: Monthly Hospital, Quarterly Hospital, Operational Departments and Nursing Unit Based Dashboards with QI Opportunity for each are utilized to track and trend process and outcome measures which are critical to the Quality Program. Variances are discussed openly with hospital leadership as well as frontline staff. Magnet Dashboard displays 8 quarters of data for nursing
sensitive indicators (Pressure Ulcers Stage II or greater, Falls with Injury as well as CAUTI & CLABSI infections).

**Nurse’s Station:** informational portal located on the eNet with access to all staff. Nursing sensitive indicators (NDNQI), quality dashboards, Infection Control data and informational materials such as the Communicator and Nursing Insights are posted for all staff to review. This “one stop shop” leads the bedside care giver to important clinical as well as procedural information.

**Internal and External Performance Data:**
Comparative data may be used to base levels of performance. Internal data may be provided by databases including, but not limited to, Cognos, Crimson, and eQuality Check. External reference databases may include Get with the Guidelines, Society for Thoracic Surgery, Center for Medicare and Medicaid Services (CMS), Pennsylvania Health Care Cost Containment Council (PHC4), Quality Insights of Pennsylvania (QIP), The Joint Commission (TJC), Center for Disease Control (CDC), National Healthcare Safety Network (NHSN), Pennsylvania Safety Authority (PSA), Patient Safety Reporting System (PSRS), National Database of Nursing Quality Indicators (NDNQI), Crimson, American College of Surgeons National Surgical Quality Improvement Program (ACS NSQIP)

**SCOPE OF PERFORMANCE IMPROVEMENT ACTIVITIES:**
Quality and continuous Performance Improvement is a cornerstone of our healthcare system as well as our hospitals and as such our activity represents a high priority in promoting patient safety as well as effective and efficient provision of care.

1. Guides performance management and improvement in daily provision of care
2. Guided by analysis of trends and evidence of practice as well as proactive approaches to providing “benchmark” care to our patients
3. Guides Pay-for-Performance opportunities that are available to the hospital
4. Provides timely updates for our performance activity to internal bodies as well as our system, state, federal and regulatory bodies
5. Oversees quality indicators that promote best practice performance of key activities of care
6. Quality nurses respond in a timely manner to issues identified through:
   a. IIER process
   b. RCA
   c. FMEA
   d. Clinical Quality Reviews
   e. Patient Safety & Risk Committee
   f. Other committees or services that recognize performance improvement activity
   g. Patient Complaint and Grievance Process
   h. Routine trending and analysis of ongoing issues
7. Promotes Unit or Department based Quality Monitoring and PI activity by responsible leaders
   a. Encourages staff to identify areas for improvement and areas for monitoring
   b. Uses the FOCUS-PDCA model to promote rapid cycle improvement
   c. Encourage use of the hospital monthly and Quarterly Dashboards where process and outcome measures are tracked and trended. A PI Dashboard displays areas below target where focused PI activity is directed.
   d. Nursing Unit Based Dashboards where staff can review their quality measures.
   e. Discuss PI regularly at their staff meetings
f. Our staff participate in interdisciplinary PI activity, examples include-
   i. Falls Reduction
   ii. Reduction of Hospital Acquired Pressure Ulcers
   iii. Medication Event Review Team
   iv. Reduction of Hospital Acquired Catheter Associate Urinary Tract Infections
   v. Nursing/Pharmacy PI Team
   vi. Readmission Reduction
   vii. Patient Experience
   viii. Improving compliance with VTE prophylaxis
   ix. Reduction of Surgical Site Infections
   x. Sepsis

g. Our leaders establish expectations regarding performance improvement activity by department level.

8. Supports Ongoing Professional Practice Evaluation (OPPE) to meet TJC requirements
9. Utilize Crimson data to provide analytics of physician practices and outcomes
10. Collects, aggregates and displays data in an organized manner to guide our leadership in making data driven decisions
11. Collects aggregates and utilizes Get with the Guideline on Condition A & Cs to improve outcomes.
12. Collects aggregates and utilizes Get with the Guideline on Stroke to improve outcomes.
13. Provide New Hire orientation to Quality Plan as well as the patient experience
14. Utilizes Press Ganey/HCAHPS data to improve the patient experience
15. Reports to the Quality Oversight Committee, Quality Patient Care Committee and the Board
   a. Quality reports are standing agenda item at Quarterly Board Meetings
16. Works collaborative with UPMC Wolff Center to address system initiatives
17. Promotes transparency in our process and outcomes of care through the use of
   a. Performance Measurement Dashboard
   b. Web-based tools for aggregate data display on individual performance indicators
   c. Indicators defined by source, data definition and benchmarks.
   d. Data Stewards are responsible to address concerns and create action plans to address opportunities
   e. Historical data will provide information on progress
   f. Indicators will be linked to regulatory requirements for display
18. Hospital leadership utilizes this data to monitor individual performance indicators
19. Oversee that monitoring and analysis are completed on the following:
   a. Unexpected mortalities, readmissions to the hospital within 30 days of discharge, autopsies, ongoing chart review for identified areas of concern/opportunity.
   b. Confirmed transfusion reactions and major discrepancies between pre-op and post-op diagnosis, including pathologic, through the Tissue & Transfusion Committee
   c. Review/ log all mortalities where restraint used within the last 24 hrs.
   d. Serious adverse drug events and serious medication errors through the Medication Event Review Team and Patient Safety & Risk Committees
   e. Staffing effectiveness through trending & analysis of information identified in RCAs for unusual events
   f. Outcomes of NDNQI data displayed on Nursing Dashboards
   g. Medication events reviewed by the Medication Event Review Team (MERT) and reported to Patient Risk and Safety Committee
   h. Moderate Sedation event reviewed by the Moderate Sedation Event Review Team (MSERT)
   i. Falls through the Falls/ Fall associated injury Prevention Team (F/FAPT)
j. Support the monitoring of compliance with Core Measures. In alliance with CMS Value Based Purchasing, Hospital Acquired Conditions (HAC) and Patient Safety Indicators (PSI) and Inpatient (IQR) & Outpatient (HOP) Quality Indicators are tracked and trended with a focus on process improvement.

k. Risk Review Committee meets monthly to review reported events. This group is comprised of Senior Executives, Clinical Directors, DCOI, and Quality/Risk staff.

l. Grievance Committee meets biweekly to complete reviews of patient/ family grievances. This committee is comprised of Senior Executives, Medical Director of the Emergency Department, Clinical Directors, Risk/Quality and Medical Staff Services leaders.

**PEER REVIEW PROCESS:**

Medical staff activities such as blood utilization, operative and invasive procedures, mortality, unplanned readmissions and sentinel events are monitored. The six recommended Joint Commission competency areas are monitored electronically through Crimson for the OPPE On-going Physician Practice Evaluation:

- Interpersonal/Communication skills
- Practice Based Learning and Improvement
- Professionalism
- System based practice
- Medical /clinical knowledge
- Patient Care – specialty specific metrics

Findings that may suggest issues relating to practitioner performance are subject to the peer review process (OPPE/FPPE) according to Medical Staff Bylaws and Policies.

A Professional Practice Evaluation Committee (PPEC) is in place for the purpose of:

1. Defining the Medical Staff expectations for patient care and safety through patient care protocols and guidelines
2. Establishing and updating triggers for professional practice evaluation
3. Effectively, efficiently, and fairly evaluate care being provided by practitioners
4. Provide constructive feedback, education and performance improvement assistance to practitioners regarding the quality, appropriateness, and safety of the care they provide

**CONFIDENTIALITY:**

All activities set forth in this plan including any information collected by any Medical Staff Committee, administrative committee, organization committee, or departments in order to evaluate the quality of patient care is considered a part of the Hospital and Medical Staff Peer Review Process and thus, is private and confidential. This includes: all minutes, reports, worksheets and other records, which are to be maintained in physically secure areas. Such materials are to be held in strictest confidence and are to be carefully safeguarded against unauthorized disclosure. Corrective/disciplinary actions involving privileges of a member of the Medical Staff shall be in accordance with the Medical Staff By-laws and Board policy on Medical Staff appointment and clinical privileges.
DEFINITIONS:

**Benchmark:** Target or goal of Performance Improvement (PI) activity

**UPMC Wolff Center:** University of Pittsburgh Medical Center’s corporate PI group who supports system hospitals by sharing best practices, collaborative activity and education on innovative ideas.

**Contracted Services:** Services that reach patients which are provided by caregivers who are not University of Pittsburgh Medical Center employees are considered contracted and as such the Department Director where this service is provided will be required to provide indicators of quality service.

**Inpatient & Outpatient Core Measures:** The Joint Commission/Medicare’s nationally recognized indicators for quality of care for populations at risk.

**Monitor:** Assessment of an indicator that is looked at and scrutinized to ensure quality performance. Clear data definition/ collection guidelines promote consistent results to support analysis of information over time.

**Medicare:** Largest payer of healthcare services, this government agency’s mission is to assure health care security for beneficiaries and in the area of quality to
- Improve quality of care and health outcomes for the beneficiaries of CMS programs
- Protect beneficiaries from substandard or unnecessary care
- Core Measures, same as for TJC, see [www.HospitalCompare.gov](http://www.HospitalCompare.gov)

**National Nursing Database for Quality Indicators:** The National Database of Nursing Quality Indicators® (NDNQI) is a proprietary database of the Press Ganey Associates, Inc. The database collects and evaluates unit-specific nurse-sensitive data from acute care hospitals. Participating facilities receive unit-level comparative data reports to use for quality improvement purposes. They also offer an RN Survey which allows comparison of how our nurses perceive the quality of care at our hospital compares to other facilities.

**Pennsylvania Department of Health:** DOH’s mission is to promote healthy lifestyles, prevent injury and disease, and to assure the safe delivery of quality healthcare for all Commonwealth citizens.
- Conducts Occupancy Survey when structural changes in the facility are made
- Conducts Complaint Investigation, responding to citizen complaints
- Conducts Licensure Survey every 2 years to assess compliance with standards of care and Department of Health Regulations

**Pennsylvania Healthcare Cost Containment Council (PHC4):** An independent state agency formed under Pennsylvania statute (Act 89, as amended by Act 14) to address rapidly growing healthcare costs
- Provides comparative information about the most efficient and effective healthcare providers to individual consumers and group purchasers of health services
- Monitors Cardiac Surgery for Open Heart and reports quarterly
- May add additional public reporting (ex. Spinal Fusion)
The Joint Commission: Organization whose mission is to continuously improve the safety and quality of care provided to the public through the provision of healthcare accreditation and related services that support performance improvement in healthcare organizations.

- National Patient Safety Goals to address trends identified by previous events
- Unannounced visits approximately every 3 yrs to assess compliance with standards
- Sentinel Event Alerts reporting system to communicate the latest identified safety events
- Core Measures as demonstrated on: www.jcaho.com/quality check

CROSS INDEX TO OTHER POLICIES:

Patient Safety Plan UPMC Passavant 04.060

POLICY AVAILABILITY:

The official UPMC Passavant Policy Manual is available via the intranet via the UPMC Passavant eNet Data Portal at http://psvnt-ws1/appreportcentral/ under policies.

Signature_______________________________

SIGNED:  David Martin, President/CEO UPMC Passavant