UPMC ST. MARGARET
&
UPMC ST. MARGARET
HARMAR OUTPATIENT CENTER

Performance Improvement Plan
2012
1. PURPOSE
The purpose of this plan is to provide a framework for promoting performance improvement at UPMC St. Margaret and UPMC St. Margaret Harmar Outpatient Center. Performance Improvement shall entail quality patient care and overall organizational performance and reduction of risks to our patients. Through the support and involvement of the Board of Directors, Medical Staff, Administration, and UPMC St. Margaret and UPMC St. Margaret Harmar Outpatient Center personnel, the culture will promote an environment based on collaboration and mutual respect, support innovation, excellent data management, performance improvement, proactive risk assessment, and commitment to customer satisfaction and patient safety. The plan is coordinated to participate in the UPMC Health System strategic initiatives and is based on UPMC St. Margaret and UPMC St. Margaret Harmar Outpatient Center’s mission, values, and vision.

2. MISSION STATEMENT
The mission of UPMC St. Margaret and UPMC St. Margaret Harmar Outpatient Center is to provide the right care, every time, ensuring the highest level of quality care and patient satisfaction.

4. VALUES
UPMC St. Margaret and UPMC St. Margaret Harmar Outpatient Center are guided by the following values:

Compassion
UPMC St. Margaret and UPMC St. Margaret Harmar Outpatient Center will uphold the highest standards of customer service by providing an environment that is kind, caring, compassionate, and patient centered.

Academics
UPMC St. Margaret and UPMC St. Margaret Harmar Outpatient Center will attract the best qualified medical and support staff using a multi-disciplinary approach to patient care in collaboration with the University of Pittsburgh Medical Center, community resources, and patients’ families, resulting in specialized medical care supported by evidence based research and education.

Respect
UPMC St. Margaret and UPMC St. Margaret Harmar Outpatient Center respect the diversity of all individuals regardless of race, religion, and cultural background; we are committed to providing access to high quality and cost-effective care.

Empathy
UPMC St. Margaret and UPMC St. Margaret Harmar Outpatient Center understand and respect the specific needs of each patient and family, which results in an individualized plan of care.

Safety
UPMC St. Margaret and UPMC St. Margaret Harmar Outpatient Center provide the highest quality care to ensure a safe environment for each patient. We are leaders in quality care. We measure, report, and monitor our quality outcomes and revise protocols and/or procedures to improve the safety and quality of the patients’ environment of care.

3. VISION STATEMENT
For all patients to have “The Ultimate Patient Experience.”

The key factors to our success will be:

- To develop effective partnerships and governance with physicians and others, based on mutual trust and shared objectives
- To invest in our employees through education, recognition, clear work expectations and effective performance evaluation
To anticipate and respond to the health care needs and expectations of the patients in our community

To produce both traditional and innovative health care services that are cost effective and measurable in outcome.

To improve financial strength through effective resource management and increased revenue opportunities

5. DEFINITION OF QUALITY

UPMC St. Margaret and UPMC St. Margaret Harmar Outpatient Center believe that quality is providing “the right care,” at the right time, the right way, every time. Quality is the desire of every person at every level to do it perfectly the first time. It is patient-centered care without errors, defects and rework.

6. GOALS AND OBJECTIVES

The fundamental goal of performance improvement at UPMC St. Margaret and UPMC St. Margaret Harmar Outpatient Center is to continuously improve patient safety and the quality of all patient care and other services.

The Performance Improvement Program will be a systematic, organization-wide process for planning, designing, measuring, assessing, and improving performance and sustaining achieved improvement to improve patient outcomes and ensure patient safety. The approach to improving performance, creating a supportive and nurturing atmosphere and empowering participants will be fostered by the following essential processes:

- Developing a planning mechanism incorporating baseline data from external and internal sources and input from organization leaders that will result in performance measurement, analysis, improvement, and patient safety.
- Emphasizing design needs associated with new and existing services, patient care delivery, work flows and support systems, which will minimize medical error and increase satisfaction on the part of patient and their families, physicians and staff.
- Monitoring performance by developing appropriate measures and comparing with internal and external benchmarks, thereby identifying trends in care.
- Analyzing current performance by assessment of data collected and identifying opportunities for improvement.
- Focusing on improving performance in all of its dimensions and sustaining improved performance.
- Promoting communication, dialogue and informational exchange across the facility with regard to findings, analyses, conclusions, recommendations, actions and evaluations pertaining to performance improvement.
- Striving to establish collaborative relationships with diverse agencies, corporations and foundations for the purpose of promoting the general health and welfare of the community served.
- Proactively identifying improvements in patient care processes to enhance patient safety.

7. STRATEGIC INITIATIVES

- Partner with the Board, Medical Staff, Administrative Leadership to enhance and foster a culture which promotes patient and employee safety, quality, and satisfaction.
- Improve clinical, quality, and, safety performance.
- Enhance computer applications/technology for staff efficiency and patient safety.
- Improve community health through community based initiatives.
- Improve and sustain program goals and objectives related to P4P Initiatives and VBP.
- Improve and sustain Patient Satisfaction scores/targets.
- Strive for Magnet Redesignation
- Enhance communications throughout the entire organization providing information to patients, families, physician, and staff on programs and services.
- Continuously monitor and implement process/programs to improve patient throughput
- Enhance clinical practice through research and evidenced based practice.
8. **ORGANIZATION FRAMEWORK**

- **Board of Directors**
  The Boards of Directors of UPMC St. Margaret and UPMC St. Margaret Harmar Outpatient Center have the ultimate responsibility for performance improvement. To fulfill the commitment of performance improvement, the boards delegate the responsibility for developing, implementing, and maintaining performance improvement activities to administration, management, medical staff and employees. The boards recognize 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 boards provide direction for the organization’s improvement activities. Membership on the Quality Patient Care Committee and reports from the Committee provide the boards with a means of evaluating the organization’s effectiveness in improving quality.

- **Medical Staff Executive Committee**
  The Medical Staff Executive Committee is chaired by the Past President of the Medical Staff, and is comprised of the chair of each Medical Staff department, physician leaders and Hospital Administrative Staff. This body is responsible for the medical policies of UPMC St. Margaret and UPMC St. Margaret Harmar Outpatient Center, and makes recommendations to the Boards, as necessary. The Medical Staff Executive Committee reviews data that impact quality and safety improvement efforts from the Quality Patient Care Committee, Safety Committee, Medical Staff Quality Review Committee, the Critical Care Committee, the Pharmacy and Therapeutics Committee, the Infection Control Committee, the Surgical Review Committee and the Transfusion Committee.

- **Medical Staff Quality Review (MSQR), Critical Care, Pharmacy and Therapeutics (P&T), Infection Control Committee, Surgical Review Committee, and Transfusion Committee**
  These bodies are standing committees of the Medical Staff. These committees have representation from Medical Staff departments, Administration and clinical departments, and are concerned with issues, and reports that impact quality and safety improvement initiatives related to:
  
  - Patient care processes
  - Quality and appropriateness and outcomes of care provided by clinical areas and medical staff

- **Quality Patient Care Committee**
  This is a multi-disciplinary committee chaired by the Director of Medical Services. It oversees the quality improvement activities of all departments. The committee responsibilities include the following:
  
  - To oversee the implementation of and to monitor beneficial quality initiatives and quality measurements
  - To assess the provision of patient care and promotion of performance improvement
  - To assess resource needs for continued quality of patient care and programmatic development
  - To assure compliance with the standards of the Joint Commission and other regulatory agencies relevant to patient care
  - To review reports from other committees charged with matters of quality of care and patient safety
  - To review published quality reports and other national data as well as published literature from local and national media, journals, etc.
  - To provide a forum for the discussion of matters of Hospital policy and practice, especially those pertaining to patient care, and to provide for liaison among the Board, the Medical Staff, and Administration
  - To keep the Boards of Directors and the Membership informed as to problems, changes or trends in the healthcare field that could materially affect the quality of patient care services or operations of the Hospital

  The Quality Patient Care Committee shall meet at least quarterly. Minutes of each meeting will be recorded and provided to the Committee and the Board.

- **Management**
  Management is responsible for ongoing performance improvement activities in their service areas as well as supporting system wide multidisciplinary teams. Many of these activities interface with various departments, medical staff, and the community. It is critical that the managers foster an environment of collaboration with
both internal and external customers.

- **Role of Employees**
  The role of the individual employee is critical to the success of a performance improvement initiative. Quality is everyone’s responsibility. All employees must believe that every process can be improved and feel empowered to fix and prevent problems, as well as contribute to improvement efforts. Any employee, medical staff member or volunteer may make a suggestion for a Performance Improvement Team.

- **Patient Safety Committee**
  The Patient Safety Committee includes departments and components of UPMC St. Margaret and UPMC St. Margaret Harmar Outpatient Center. All areas participate in the program though the reporting of near misses and actual medical health care events. This committee will recommend the processes chosen for proactive risk assessments based on literature, errors and near miss events, sentinel event alerts, and the national patient safety goals. This committee also oversees the provision of education to employees, contractors, and volunteers about the reporting and reducing of health care errors. The Patient Safety Committee will facilitate and oversee the implementation of the national patient safety goals at UPMC St. Margaret and UPMC St. Margaret Harmar Outpatient Center. The Patient Safety Committee reports their actions and recommendations to the Quality Patient Care Committee and to the Board of Directors.

- **Performance Improvement Teams**
  Teams are cross-functional and multidisciplinary in nature. Teams will be prioritized based on the strategic initiatives of the organization, with regard to high risk, high volume and urgency. Performance Improvement teams report their findings and recommendations to key stakeholders for approval. Performance Improvement teams establish specific, measurable goals for identified initiatives. A facilitator will be assigned when necessary.

- **Framework for Performance Improvement Activities**
  All teams and improvement efforts will utilize the FOCUS – PDCA methodology for their activities. All teams are educated in this process at the time of their kickoff and all managers have received formalized training in using the FOCUS – PDCA model.

9. **SCOPE OF PERFORMANCE IMPROVEMENT ACTIVITIES**
   The Performance Improvement Program includes the monitoring and evaluation of the interdisciplinary activities of the medical staff, nursing staff, ancillary clinical staff and support services. Performance Improvement findings are used for the evaluation of providers with clinical privileges (during reappointment, request for new or additional privileges and performance evaluation) and to evaluate the performance of employees who are not subject to the Medical Staff credentialing process.

- **Medical Staff**
  The on-going performance improvement process of the medical staff includes the services provided by the following departments:
  - Anesthesiology
  - Emergency Medicine
  - Family Practice and Pediatrics
  - Medicine
  - Orthopedic Surgery
  - Pathology
  - Radiological and Diagnostic Imaging
  - Surgery

- **Hospital and Outpatient Services**
  The performance improvement processes of Hospital/Outpatient services include all departments/Program Lines and Process Improvement Initiatives.

- **Quality Control**
  Quality control functions are carried out in patient and non-patient care departments where lack of control measures would cause a negative impact on patient care (i.e. laboratory calibration instruments, radiology...
quality control measurements)

- **Peer Review Process**
  Medical Staff activities specifically those related to Blood Usage, Operative and Invasive procedures, Mortality, Unplanned Readmission, Medication Usage, Sentinel Events, Timeliness and pertinence of clinical documentation are monitored and findings which suggest that issues relating to practitioner performance might exist are subject to the peer review process.

  Peer review process is triggered by variations in performance seen during criteria based reviews conducted on Medical Staff activities. The findings from these reviews are then submitted for further review by peers on relevant committees, or departments and then communicated to the physician for his/her comments and finally communicated to the responsible Medical Staff official for deliberation, adjustment of concern levels and resolution.

  To further facilitate the peer review process, this material is placed in the confidential files of the practitioner so that it is readily available to the Department Chairman for final determinations and consideration at the time of reappointment.

10. **CONFIDENTIALITY**
All activities set forth in this plan including any information collected by any Medical Staff Committee, Administrative Committee or Hospital department 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. Confidentiality of patient and provider will be maintained by assigning numbers to those involved in corrective/disciplinary actions involving privileges of a member of the Medical Staff shall be in accordance with the Medical Staff Bylaws and Board Policy on Medical Staff Appointment and Clinical Privileges.

11. **IMPROVING ORGANIZATIONAL PERFORMANCE**
The FOCUS-PDCA methodology is the UPMC St. Margaret approach to organizational performance improvement. The model for continuous improvement, FOCUS-PDCA, was originally defined by the Hospital Corporation of America. It provides a common language for interventional strategies and an orderly sequence for implementing the cycle of continuous improvement.

**FOCUS**
- Find a process to improve
- Organize a team that knows the process
- Clarify current knowledge of the process
- Understand the causes of process variation and impact on compatibility
- Select the change

**PDCA**
- Plan
- Do
- Check
- Act

A. **FOCUS**

1. **Find a process to improve**
   - prioritize based on customers
   - define the problem
   - state the aim

2. **Organize a team that know the process**
   - identify the team members with the fundamental knowledge of the process
   - identify senior leaders to support the team and remove the barriers to success
• assign roles and responsibilities
• write a mission statement and identify the aims to accomplish
• know customers (expectations/needs)

3. Clarify current knowledge of the process
• document the current process
• review the literature
• review the practice of others
• identify potential root causes
• identify key quality findings to measure
• develop data retrieval tools
• measure key quality findings
• establish baseline data

4. Understand causes of process variations and impact or comparability
• measure the results
• stabilize the process
• identify and reduce the variation
• eliminate inappropriate variation
• prepare to compare “apples to apples”

5. Select the change
• prioritize opportunities to improve
• select the improvement

B. PDCA

1. Plan
• a change aimed at improvement
• state the plan/intervention
• create evidence based recommendations from literature, consensus or expertise

2. Do
• implement the change on a small scale; pilot

3. Check
• check the results
• analyze the data for process improvement and customer service
• lessons learned

4. Act
• revise and standardize the changes

• Incorporating Staff Recommendations
Staff views and recommendations are sought through staff surveys, staff meetings, and with leaders through nominal group studies. Multidisciplinary teams consisting of front line staff conduct process improvement activity. Brainstorming is used to clarify the current process and select the process(es) to improve. The teams prioritize the processes to improve and develop the action plan. Changes are made to the improvement plan based upon the findings, group discussion and suggestions from the Performance Improvement Team.

• Education and Training
To facilitate the development of operational expertise, communication skills, knowledge and competency related to Process Improvement fundamentals and safety; education and training programs are made available and provided in the form of:
orientation programs for new staff
performance improvement education programs and workshops
focus programs for managers and leaders

- Improving Upon Performance Improvement
  As a result of the assessment process associated with the review of indicator data, evaluations can be made regarding current levels of performance and whether specific improvement opportunities exist which should be designated as priorities. The type and cause of variation are presented by using statistical tools and method in the reporting format. Intense analysis of the data by drilling down to arrive at the root cause of variations is used to identify changes that need to be implemented.

- Performance Improvement Priorities
  Performance improvement priorities are determined annually. Priority consideration is given to:
  - The vision, key strategic planning initiatives
  - Key stakeholder feedback
  - High volume activities
  - High risk activities or processes which place patients at risk if not performed well, if performed when not indicated or if not performed when indicated
  - Problem prone activities
  - High cost activities
  - Sentinel/near miss events or sentinel event alerts
  - System initiatives
  - High organizational impact
  - Critical steps in a least one high-risk process will be measured and analyzed on an ongoing basis
  - Patient Safety issues
  - National Patient Safety Goals

Because UPMC St. Margaret and UPMC St. Margaret Harmar Outpatient Center are sensitive to the ever changing needs of the organization, priorities may be changed or re-prioritized due to:
  - Identified needs from data collection and analysis
  - Unanticipated adverse occurrences affecting patients
  - Changing regulatory requirements
  - Significant needs of patients and/or staff
  - Processes identified as error prone or high risk regarding patient safety
  - Criteria to institute a proactive risk assessment (i.e., sentinel alerts, information in professional journals)
  - Changes in the environment of care
  - Changes in the community

- Sustaining Improvement
  Once performance improvement priorities are identified, appropriate resources and changes needed in a process are implemented either on a pilot basis or across the organization. Performance measures are then selected to determine the effectiveness of the change and whether the improved results are sustained.

12. Designing New and Modified Processes/Functions/Services
  UPMC St. Margaret and UPMC St. Margaret Harmar Outpatient Center design and modify processes, functions, and services with quality and safety in mind. When designing or modifying a new process the following steps are taken:
  - An expert within the organization is assigned the responsibility of developing the new process.
  - Key individuals, who will own the process when it is completed, are assigned to a design team led by the expert.
  - The design team develops or modifies the process utilizing information from the following concepts:
    - It is consistent with our mission, vision, values, goals, objectives and strategic plans
It meets the needs of individuals served, staff and others
It is clinically sound and current
It is consistent with sound business practices
It incorporates available information from within the organization and from other organizations about potential risks to patients, including the occurrence of sentinel events, in order to minimize risks to patients affected by the new or redesigned process, function or service
It includes analysis and/or pilot testing to determine whether the proposed design/redesign is an improvement
It incorporates the results of performance improvement activities
It incorporates the consideration of patient safety issues

- Performance expectations are established, measured, and monitored. These measures may be developed internally or may be selected from an external system or source. The measures are selected utilizing the following criteria:
  - They can identify the events it was intended to identify
  - They have a documented numerator and denominator or description of the population to which it is applicable
  - They have defined data elements and allowable values
  - They can detect changes in performance over time
  - They allow for comparison over time within the organization and between other entities
  - The data to be collected is available
  - Results can be reported in a way this is useful to the organization and other interested stakeholders

13. PROACTIVE RISK ASSESSMENTS
- At least one high-risk process will be selected for risk assessment and hazard analysis. Selection will in part be based on information published by The Joint Commission that identifies the most frequently occurring types of sentinel event:
  - The process is assessed to identify steps that may cause undesirable variations, or “failure modes”
  - For each identified failure mode, the possible effects, including the seriousness of the effects on the patient are identified
  - Potential risk points in the process will be closely analyzed including decision points and patient’s moving from one level of care to another through the continuum of care
  - For the effects on the patient that are determined to be “critical”, a root cause analysis is conducted to determine why the effect may occur
  - The process will then be redesigned to reduce the risk of these failure modes occurring or to protect the patient from the effects of the failure modes
  - The redesigned process will be tested and then implemented. Performance measures will be developed to measure the effectiveness of the new process
  - Strategies for maintaining the effectiveness of the redesigned process over time will be implemented

- Risk assessments are conducted to proactively evaluate the impact of buildings, grounds, equipment, occupants, and internal physical systems on patient and public safety.

- Ongoing hazard surveillance rounds including Safety Surveillance Rounds, Security Rounds, and departmental monitoring are conducted to provide a comprehensive ongoing surveillance program.

- The Safety Officer and Environmental Safety Committee review trends and incidents related to the Safety Management Plan. The Environmental Safety Committee provides guidance to all departments regarding safety issues. These trends and incidents are identified from incident report forms, Safety Surveillance Rounds, Security Rounds, and department questions.

14. DATA COLLECTION
UPMC St. Margaret and UPMC St. Margaret Harmar Outpatient Center choose processes and outcomes to monitor based on the mission and scope of care and services provided and populations served.
Data that the organizations consider for the purpose of monitoring performance include, but is not limited to, the following:

- National Database of Nursing Quality Indicators (NDNQI)
- Performance measures related to accreditation and other requirements
- Risk management
- Utilization management
- Quality control (i.e., Lab, Radiology, etc.)
- Patient, family, and staff opinions, needs, perceptions of risks to patients, and suggestions for improving patient safety
- The effectiveness of pain management
- Staff willingness to report medical/health care errors
- Outcomes of processes or services
- Autopsy results
- Performance measures from acceptable data bases
- Customer demographics and diagnoses
- Financial data
- Infection control surveillance and reporting
- Research data
- Performance data identified within The Joint Commission standards or identified by other regulatory bodies
- Needs, expectations and satisfaction of individuals and organizations served, including:
  - Their specific needs and expectations
  - Their perceptions of how well the organization meets these needs and expectations
  - How the organization can improve
  - How the organization can improve patient safety
- Measurement to determine the effectiveness of our patient safety goals implementation programs
- Organ Procurement

The organizations also collect data to monitor the performance of processes that involve risks or may result in a sentinel event. As appropriate, performance measures will be identified for the following processes:

- Medication Management
- Operative and other procedures, such as radiotherapy, CT scans, MRI, that place patients at risk
- Use of blood and blood components
- Restraint use
- Care or services provided to high-risk populations
- Outcomes related to resuscitation
- Staffing effectiveness

In addition, the following clinical and administrative data are aggregated and analyzed to support patient care and operations:

- Pharmacy transactions as required by law and to control and account for all drugs
- Information about hazards and safety practices used to identify safety management issues addressed by the organization
- Records of radio-nuclides and radiopharmaceuticals, including the radio-nuclide’s identity, the date administered, and disposal
- Records of required reporting to authorities
- Performance measures of processes and outcomes
- Summaries of performance improvement actions and actions to reduce risks to patients

15. AGGREGATION AND ANALYSIS OF DATA

UPMC St. Margaret and UPMC St. Margaret Harmar Outpatient Center believe that excellent data management and assessment are essential to an effective performance improvement initiative. All performance improvement teams and activities must be data driven and outcome based. The analysis process includes comparing data within our organization, with other comparable organizations, with standards, and with best practices. Data are aggregated and analyzed within a time frame appropriate to the process or area of study. Data will also be
analyzed to identify system changes that will help to improve patient safety.

Data are analyzed in many ways including:

- Using appropriate performance improvement problem solving tools
- Making internal comparisons of its performance of processes and outcomes over time
- Comparing performance data about its processes with information from up-to-date sources
- Comparing performance data about its processes and outcomes to other hospitals and reference databases

Intensive analysis is completed for:

- Levels of performance, patterns or trends that vary significantly and undesirably from what was expected
- Performance varies significantly and undesirably from the performance of other organizations
- Performance varies significantly and undesirably from recognized standards
- When a sentinel event has occurred
- When a variation has occurred in the performance of processes that affect patient safety
- Hazardous conditions which would place patients at risk
- When undesirable variation occurs, which may change priorities.

The following events will automatically result in an intense analysis:

- Confirmed transfusion reactions
- Serious drug events
- Significant medication errors and
- Major discrepancies between pre and post op diagnoses
- Adverse events related to use of sedation or anesthesia
- Staffing Effectiveness Issues
- Deaths associated with Hospital Acquired Infections
- A Sentinel event

16. PLAN APPROVAL

Representatives of Administration, the Medical Staff, and the Boards of Directors have approved this plan. Any amendments to this program may be made as needed and shall be approved by these parties.

UPMC ST. MARGARET and
UPMC ST. MARGARET HARMAR OUTPATIENT CENTER
PERFORMANCE IMPROVEMENT PLAN

Approved by the Quality Patient Care Committee

__________________________
John T. Wisneski, Jr., M.D.
Director of Medical Services

Date:

Approved by Administration

__________________________
Teresa Petrick
President & CEO

Date:
Approved by UPMC St. Margaret Board of Directors

____________________________
Neil Y. VanHorn
Chairman

Date:

Approved by UPMC St. Margaret Harmar Outpatient Center
Board of Directors

____________________________
Neil Y. VanHorn
Chairman

Date: