WHITING FORENSIC HOSPITAL

PERFORMANCE IMPROVEMENT (PI) PLAN

2018

Approved by Governing Body: April 4, 2018

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WHITING FORENSIC HOSPITAL
PERFORMANCE IMPROVEMENT PLAN

I. Introduction

As a facility of the Department of Mental Health and Addiction Services (DMHAS), the Whiting Forensic Hospital (WFH) has implemented the requirements established by the Commissioner who as the Governing Authority of the Department has issued Policy Statement No. 72 wherein each hospital is to improve its performance in a systemic, cooperative and continuous manner; is to establish a facility-specific Governing Body; and is to assure a hospital-wide collaborative approach in pursuing quality in its patient care responsibilities.

II. Statement of Purpose

To establish organizational responsibilities and processes by which the Governing Body, Medical Staff, and Disciplines achieve and maintain high quality care, support services and patient safety at WFH.

The Performance Improvement Plan sets forth the functional framework for monitoring and improving processes, outcomes and safety in a planned and systematic manner that supports the mission of the hospital. The plan targets the improvement of key governance, managerial, clinical and support processes that contribute to improved patient outcomes and the safety and satisfaction of both patients and staff. It is designed to integrate the pursuit of WFH's mission with the understanding that excellence in clinical outcomes must be achieved with the appropriate allocation of resources.

Improvement in performance is geared toward reducing the risk of adverse event occurrence and ensuring the best use of hospital resources in the delivery of services. Consequently, the hospital's primary objective is to support staff in improving processes for which they are accountable and to assure that staff has adequate knowledge, skill, training, and resources to address problems that may arise.

III. Goals

The goals of the Performance Improvement Plan include the following:

- Ensure a planned, systematic and hospital-wide approach to performance improvement and patient safety, focusing on outcomes of treatment, care and services.
- Ensure that individuals, divisions, disciplines and departments representing the scope of care and services across the hospital work collaboratively to plan and implement improvement activities.
- Incorporate feedback and findings from root cause analyses, administrative reviews and culture of safety surveys into performance improvement activities to effectively reduce factors that contribute to unanticipated adverse events

and/or outcomes.

- Evaluate performance improvement, patient safety, risk management and incident data and analysis to identify changes that will improve patient safety and quality of care, treatment and services.
- Ensure changes made to improve processes or outcomes are evaluated and appropriate actions are taken when planned improvements are not achieved or sustained.
- Identify policy and procedure, staff education and other system vulnerabilities impacting safety and quality of care and recommend corrective actions.
- Address internal and external customers' needs and expectations.
- Promote open communication among disciplines within a culture that encourages innovation, creativity and change.

IV. Authority and Accountability

The Governing Body of WFH has the final authority and responsibility for the assurance of a flexible, comprehensive and integrated performance improvement program. In meeting this responsibility, the Governing Body ensures the provision of appropriate resources to assist in review functions, mechanisms for systematically monitoring and evaluating the quality, safety, and appropriateness of patient care and information management processes that provide timely access to data and support performance improvement and safety improvement activities.

The Governing Body delegates authority and accountability for the operation of the Performance Improvement Program as relates to the hospital's culture of safety, risk management processes and various safety issues, including, but not limited to, the use of high risk interventions and any identified environmental risks. The Governing Body delegates authority and accountability for oversight of investigations of incidents of abuse, neglect and exploitation of patients that allegedly involve hospital staff misconduct to the Investigation Review committee. The Governing Body delegates authority and accountability for oversight of the quality, appropriateness and integration of services in providing patient care to the Clinical Management Committee.

The Governing Body shall be provided information on the hospital's Performance Improvement Program through periodic performance improvement reports from the Director of Accreditation, Regulatory Compliance and Performance Improvement..

V. Scope of Activities

Performance improvement priorities are established by identifying important aspects of care which affect a large percentage of patients, which are likely to be problem prone and/or which are likely to place patients at risk if not performed well, not performed when indicated or performed when not indicated. The analysis of process and outcome data forms the basis for objectively evaluating

the hospital's priorities. Additional factors that affect prioritized initiatives include accreditation and/or regulatory requirements (e.g., The Joint Commission, state licensing authority, state statutes, and federal regulations) best practices (use of practice guidelines, evidence based medicine and clinical standards), DMHAS mandates, changing needs of the community, patients and staff, and changes in the environment of care. The CEO, the Governing Body and the Medical Staff actively seek feedback from "customers", including patients, families, hospital staff and supporting agencies, as performance improvement priorities are set.

Performance indicators relate to standards of care in important functions of treatment delivery, including the following:

Patient Focused Functions

1) Rights and Responsibilities (RI)
2) Provision of Care, Treatment & Services (PC)
3) Record of Care, Treatment & Services (RC)
4) Medication Management (MM)
5) Infection Prevention & Control (IC)
6) National Patient Safety Goals (NPSG)

Organization Focused Functions

7) Performance Improvement (PI)
8) Leadership (LD)
9) Environment of Care (EC)
10) Emergency Management (EM)
11) Life Safety (LS)
12) Human Resources (HR)
13) Information Management (IM)

Structures with Functions

14) Medical Staff (MS)
15) Nursing (NR)

Performance indicators are objective, measurable, and include definitions of both a numerator and a denominator. Baseline measures and/or thresholds are identified, as is the sample size, frequency of review and data collection methodology.

Performance indicators are reviewed within the divisions, disciplines or department, with summary analysis provided to the Governing Body and/or the assigned Governing Body committee(s). This summary analysis identifies any variances in performance, corrective action plans developed, including the necessary corrective action step(s); anticipated outcome(s); person(s) responsible and the time frame in which each action step must occur, the effectiveness of corrective actions, and any modifications made as warranted to

ensure the effectiveness of interventions on improving and sustaining the quality and safety of care and services..

The Governing Body monitors processes and practices by utilizing data and information from various sources. Such data sets include, but are not limited to, risk management triggers and thresholds; restraint and seclusion use; incident management data, medication events and adverse drug reactions. Ddisciplines examine the timeliness and completion of medical records, as well as clinical pertinence reviews, treatment planning processes, discharge planning processes, and patient involvement in the treatment process. Clinically related information is also reviewed, including admissions and discharges, length of stay, and readmission rates.

The hospital utilizes NASMHPD Research Institute for benchmarking specific ORYX comparative data as well as benchmarking and reporting the required Hospital-Based Inpatient Psychiatric Services Core Measure Set indicators to The Joint Commission. Hospital-Based Inpatient Psychiatric Services (HBIPS) Core Measure Set data are reviewed quarterly by the Governing Body.

VI. Description of the Plan

WFH's Performance Improvement Plan details the hospital-wide, multidisciplinary monitoring of important functions and processes. This includes a model for improvement that will be followed by all divisions, departments, and disciplines in the organization.

Division/Department/Discipline Plans

Each unit and discipline reviews and tracks key indicators as approved by the Governing Body. The Medical Staff advises the Governing Body in determining hospital priorities and provide oversight in monitoring various processes.

The ongoing monitoring and evaluation activities of the Medical Staff are reviewed monthly at meetings of the Medical Staff through reports of its committees including Infection Prevention, Medical Records, Pharmacy, Nutrition and Therapeutics, and Credentialing and Privileging.

Data on identified indicators is collected and analyzed. In order to most effectively interpret results, data will be evaluated utilizing statistical process control techniques whenever possible. The results will be compared internally over time and may also be compared to external benchmarking data as available or appropriate.

A schedule is identified for all division, department and discipline Performance Improvement activities that require reporting to the appropriate committee or review group as defined by the Governing Body.

Evaluation of monitoring activities occurs within each unit,, discipline, or committee. Unit Directors, , Discipline Directors, and/or Committee Chairs are

responsible for addressing identified problems, developing corrective action plans, including the necessary corrective action step(s) identified to address factors contributing to the problem; anticipated outcome(s); person(s) responsible and the time frame in which each action step must occur, disseminating action plans to all parties responsible for their implementation, monitoring the implementation and effectiveness of corrective actions and modifying corrective action plans as warranted. The Whiting forensic hospital – Corrective Action Plan template (Appendix B) is the standardized format used for corrective action plans.

Results from each unit and discipline performance improvement findings are communicated to staff in the respective area.

Critical to achieving positive patient outcomes and safe, quality patient care, is the communication of performance improvement outcomes and identified opportunities for improvement. It is expected that feedback is elicited from, and provided to, all of the patient care units.

Resources from the Performance Improvement Department are available to the units and disciplines to facilitate the coordination of performance improvement activities and to serve as a resource in identifying and defining indicators, establishing baselines and thresholds, performing data analysis, identifying patterns and trends and integrating improvement methodology in addressing issues that impact the safety and quality of care to patients.

The Performance Improvement Department works collaboratively with the Governing Body to identify performance improvement findings that reflect a need for continuing education or training or change in operations, and evaluates patient satisfaction data making recommendations related to improving patient perception of care and safety.

The Performance Improvement Department assists programs/units in identifying performance improvement objectives, developing methods to monitor and evaluate important aspects of patient care and evaluating the results of monitoring activities.

VII. Role of the Hospital Committees

As part of the strategic planning process, the Performance Improvement Plan at WFH is a collaborative effort of the Medical Staff and the Governing Body performed through their respective Committees. Each committee has specific responsibility relating to the Standards of Practice of the various disciplines and standards relative to hospital operations adopted by the Governing Body. Standards of Practice are outlined in the Medical Staff Bylaws as well as in the credentialing plan of the Medical Staff. The hospital through its participation in certification and accreditation programs adopts those aspects of the life-safety codes, public health codes, statutory responsibilities of professional disciplines

and their specific codes of ethics which impact both its clinical and administrative operations.

The role of the Governing Body committees and Medical Staff committees is to monitor and evaluate *Standards of Practice and Clinical Effectiveness* as they impact performance improvement functions. Key to these committees is the use of aggregate data to inform decision-making processes, which supports and enhances the Governing Body's role in communicating issues and addressing opportunities for improvement throughout the hospital.

VIII. Performance Improvement Methodology

To effectively monitor and evaluate the quality, appropriateness and safety of patient care in a planned and systematic manner, "Plan, Design, Measure, Assess and Improve" (PDMAI) has been selected for the hospital's methodology for conducting performance improvement projects. This methodology is used for monitoring and evaluating initiatives undertaken by the Medical Staff, divisions, disciplines, departments and committees. Division Directors, Discipline Directors, Department Heads and Committee Chairs are responsible for ensuring that this process is implemented. Projects are specific in scope and purpose and are time limited. The activities of each performance improvement project team are documented on the Improving Organization Performance Planning Document (see Appendix A).

The principles of performance improvement methodology described below pertain to all performance improvement activities, although the application of these principles will vary depending on the particular type of activity. Activities may be directed at quality control, performance monitoring and/or performance improvement, and include The Joint Commission required performance measures, priority issues identified by the hospital and performance improvement projects.

The PDMAI (plan, design, measure, assess and improve) approach utilized in improving organizational performance is as follows:

A. Planning

1) Hospital leadership establishes a planned, systematic and hospital-wide approach to performance improvement, focusing on outcomes of treatment, care and services.

2) Hospital leaders set priorities for performance improvement and ensure that the disciplines representing the scope of care and services across the hospital work collaboratively to plan and implement improvement activities.

3) Performance improvement activities are planned to effectively reduce factors that contribute to unanticipated adverse events and/ or outcomes.

B. Designing

1) Activities identify data sources, including frequency and duration of data collection.

2) Activities identify the persons responsible for data collection and persons responsible for summary analysis.

3) Activities identify where summarized data analysis will be reported to.

C. Measuring Performance

1) The hospital collects data to monitor its performance.

2) Data are collected on selected key indicators, including:

- Restraint use;
- Seclusion use;
- Medical Emergencies;
- Patient Perceptions of care, treatment and services;
- Staff Opinions;
- Medication Management;
- Services to High Risk Patients;
- Utilization Review;
- Medical Records;
- Environment of Care;
- Staff Competence;
- Infection Prevention;
- Behavioral Management;
- Risk Management; and
- Patient Safety

3) Indicators are measured by focusing on nine important dimensions of performance that strongly affect patient outcomes and resource use:

- ***Efficacy*** or accomplishment of the described outcome.
- ***Appropriateness*** or ***relevance*** to the patient's clinical needs.
- ***Availability*** – Appropriate care is available to meet the patient's needs.
- ***Timeliness*** – Care is provided to the patient at the most beneficial or necessary time.
- ***Effectiveness*** – Care is provided in a correct manner, given the current state of knowledge.
- ***Continuity*** – Coordination of services provided with respect to other services and providers, and other organization outcomes.

- ***Safety*** – Risk of an intervention and risk in the care environment are reduced for the patient and others.
- ***Efficiency*** – Relationships between outcomes (results of care) and resources used to deliver care.
- ***Respect and Caring*** – Degree to which the patient is involved in his/her own care decisions and to which staff provides care with sensitivity and respect for the patient's needs, expectations, and individual differences, including multicultural issues.

D. Assessing Current Performance

1) The hospital uses a systematic process to aggregate and analyze data in order to provide information on the following:

   - Current level of performance;
   - Stability of processes; and
   - Emerging patterns or trends

2) Data are aggregated at the frequency specified in the Performance Improvement Plan Indicator Description.

3) Various quality and/or statistical tools and techniques are used to analyze and display data, including:

   - Pareto Charts;
   - Flow Charts;
   - Cause and Effect Diagrams;
   - Histograms;
   - Scatter Diagrams;
   - Run Charts; and
   - Control Charts

4) Data are analyzed and compared internally over time and externally through ORYX data and the HBIPS Core Measure Set.

5) Comparative data are used to determine if there is excessive variability or unacceptable levels of performance.

6) Analysis is performed when data comparisons indicate that levels of performance, patterns or trends vary substantially from those expected.

7) Data are tracked with sufficient particularity to identify trends by division, units, work shifts, individual staff and/or patients in regard to protection from harm, provision of treatment, care and services and outcomes being achieved.

8) Analysis is performed for all of the following:

- Serious adverse drug events;
- Significant medication errors; and
- Critical incidents and Sentinel Events (Root Cause Analysis)

E. Improving Performance

1) The hospital uses the information from data analysis to identify and implement changes that will improve the quality of care, treatment and services.

2) The hospital identifies and implements changes that will reduce the risk of Sentinel Events.

3) The hospital uses the information from data analysis to identify changes that will improve patient safety.

4) The hospital ensures that corrective action plans are developed, disseminated to all parties responsible for implementation, monitored for appropriate implementation and effectiveness and modified as warranted.

5) The hospital ensures that all corrective action plans include:

a.) contributing factors to the identified problem;
b.) anticipated outcomes/measures of effectiveness
c.) action steps/risk reduction strategies
d.) person(s) responsible; and
e.) completion date for each action step

6) Changes made to improve processes or outcomes are evaluated to ensure they achieve the expected results.

7) Appropriate actions are taken when planned improvements are not achieved or sustained.

8) The hospital selects one high-risk process at a minimum of every 18 months, and conducts a Failure Mode and Effects Analysis to identify and reduce risks to patients. This analysis includes:

a) Describing the chosen process using a flowchart;
b) Identifying potential failure modes of the process;
c) Identifying possible effects that identified failure modes could have on patients and the seriousness of the possible effects.
d) Prioritizing the failure modes for corrective actions;
e) Determining causes of the prioritized failure modes;
f) Redesigning the process and/or underlying systems to minimize the risk of the effects on patients;
g) Testing and implementing the redesigned process; and
h) Monitoring the effectiveness of the redesigned process.

Recommendations for improvement can be made as a result of the assessment of division, department, or discipline specific data, as a result of aggregate data review, including ORYX and HBIPS core measure set indicators, or based on feedback from patients, employees, committees, or other stakeholders. Actions to resolve problems or improve processes may be initiated by division, department, and/or discipline leadership, the Operations Group or physicians responsible for specific processes and systems in the hospital.

Another approach to process improvement may be through the initiation of a Performance Improvement Team. Performance Improvement Teams will be chartered by the Governing Body on the recommendation of the Medical Staff or based on requests from staff. Performance Improvement Teams will follow standardized models for facilitation of groups and process redesign with the assistance of a Performance Improvement Manager as facilitator.

IX. Communication of the Plan

Performance improvement necessitates an interactive, open communication process, which is continuously utilized. In order to achieve the exchange of ideas and information required for a continuously improving organization, communication between all committees and organizational groups responsible for performance improvement is expected.

Communication includes reports of activity, change in direction or philosophy, assessment activities, and guidance for performance activity and improvement. Other information is communicated as necessary.

X. Education and Training

WFH recognizes the important role that training and education plays in performance improvement efforts. The Governing Body, Medical Staff, and Performance Improvement Staff work together to identify competency-based learning needs and develop training and education programs that will facilitate implementation of the Performance Improvement Plan.

XI. Confidentiality

Data and information collected through the performance improvement process concerning patients and providers can be of a sensitive nature. Much of this information is protected under state laws regarding peer review. While WFH is committed to protecting and preserving the confidentiality due our patients, our employees, and our Medical Staff, this must be balanced with the goal of transparency in the fulfillment of our mission and interactions with various stakeholders in terms of sharing aggregate, de-identified data and information.

XII. Adoption

Adoption of the plan follows approval by a two-thirds vote of the Governing Body.

XIII. Annual Evaluation

Each unit and discipline evaluates their performance improvement activities on an annual basis. Elements of this review include:

a) The outcomes of performance improvement activities and the ongoing appropriateness of current performance indicators.
b) The identification of the need for any educational events that may be conducted as a result of the analysis of the outcomes of performance improvement activities.
c) The identification of the need for any proposed changes to the division, department, or discipline Performance Improvement Program.

The objectives, scope, organization and effectiveness of the hospital's overall Performance Improvement Plan are evaluated annually, and revised as necessary.

Appendix A:

IMPROVING ORGANIZATION PERFORMANCE DOCUMENT

Whiting Forensic Hospital
Performance Improvement Plan

Date		Service	Whiting ☐ Dutcher ☐	Unit/Department	

A. DESIGN:

1. Rationale for Project:

2. Objective:

3. List of interdisciplinary staff participants and titles:

B. MEASUREMENT

1. Identify data to be collected:

2. Identify Data Sources used for benchmarking (include frequency and duration of data collection):

3. List the QI tools used to focus the data review:

4. Person(s) responsible for data collection:

5. Persons responsible for summary data analysis:

6. Summarized data analysis reported to:

C. IMPROVEMENT

1. Describe the actions to be taken (include whether hospital-wide action of pilot project is to be implemented):

2. Persons responsible for implementation of actions:

3. Planned performance measures (indicators):

4. Measurable goals:

5. Results (actual performance compared to desired performance)/ Conclusions of summarized data analysis (which may include current level of performance stability of current process, areas needing improvement):

6. If improvements are effective, identify plan to conduct ongoing measurement and assessment to verify that improvements are maintained (include timeframes):

7. If improvements are ineffective, identify the plan to redesign, plan, test and implement new actions:

Appendix B:

CORRECTIVE ACTION PLAN TEMPLATE

WHITING FORENSIC HOSPITAL - CORRECTIVE ACTION PLAN (CAP) Date of Event/Problem**: _____**Date of Plan: _____

Person/Entity responsible for CAP, including dissemination and tracking implementation/effectiveness (Owner):_____ Plan disseminated: ☐ yes ☐ no

Problem Description	**Contributing Factors/Root Causes**	**Anticipated Outcomes/Measures of Effectiveness** (these should be aligned with action steps and clearly remedy original problems)	**Action Step/Risk Reduction Strategy** (these should be aligned with outcomes***; only put one action per row in this table***)	**Person(s) Responsible**	**Completion Date** (for each action step)	**Actions Implemented Fully?**	**Timely Implementation?** (actions occurred according to completion date)	**Status of Outcomes** (Actions resulted in desired outcomes)
						☐ yes ☐ no If "no," explain, modifying plan as necessary with new or revised action steps	☐ yes ☐ no If "no," explain, modifying plan as necessary with revised completion dates:	☐ yes **CLOSED** ☐ no **OPEN** If "no," explain, modifying plan as necessary with new or revised outcomes and/or action steps
						☐ yes ☐ no If "no," explain, modifying plan as necessary with new or revised action steps	☐ yes ☐ no If "no," explain, modifying plan as necessary with revised completion dates:	☐ yes **CLOSED** ☐ no **OPEN** If "no," explain, modifying plan as necessary with new or revised outcomes and/or action steps

CAP modified on (include all dates): _____ CAP completed on: _____ Owner Signature/Date: _____

Governing Body Approval: Thursday, June 9, 2011