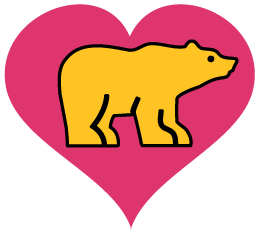

Nicklaus Children's Hospital

MIAMI CHILDREN'S HEALTH SYSTEM

# PERFORMANCE IMPROVEMENT PLAN 2017

Revised 12/26/16; Additional Revisions 2/25/2016

# PERFORMANCE IMPROVEMENT PLAN
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SECTION 1: QUALITY POLICY

**Mission Statement**

To inspire hope and promote lifelong health by providing the best care to every child

**Vision**

We will be where the children are.

Ultimately, this means being there through all stages of health and life, both physically and emotionally. To be a trusted partner to children and their families, not only in times of illness, but throughout their life journey.

**Operating Statement**

We are a passionate team using the most advanced methods to care for children and support their families

**Values and Guiding Behaviors**

## "I C.R.E.A.T.E MCHS"

**Collaboration**

- **What it means for us:** Communicating within and outside of the health system to bring the best ideas, knowledge and perspectives to the organization, the patient and the family
- **Key Characteristics:** Respectful; self-disciplined; open; transparent; approachable; flexible

**Responsibility**

- **What it means for us:** Taking ownership; acting with integrity and transparency; being reliable and dependable; consistently driving quality and safety
- **Key Characteristics:** Focused; transparent; honest; consistent

**Empowerment**

- **What it means for us:** Encouraging all employees to take initiative and make decisions in the best interests of the child and family to improve customer service and experience
- **Key Characteristics:** Trust; respect; selfless; determined; decisive

**Advocacy**

- **What it means for us:** Relentlessly supporting each other and championing the child and the family in the hospital, in the home, in the community and in health policies
- **Key Characteristics:** Positive; persistent; resourceful; problem-solver

**Transformation**

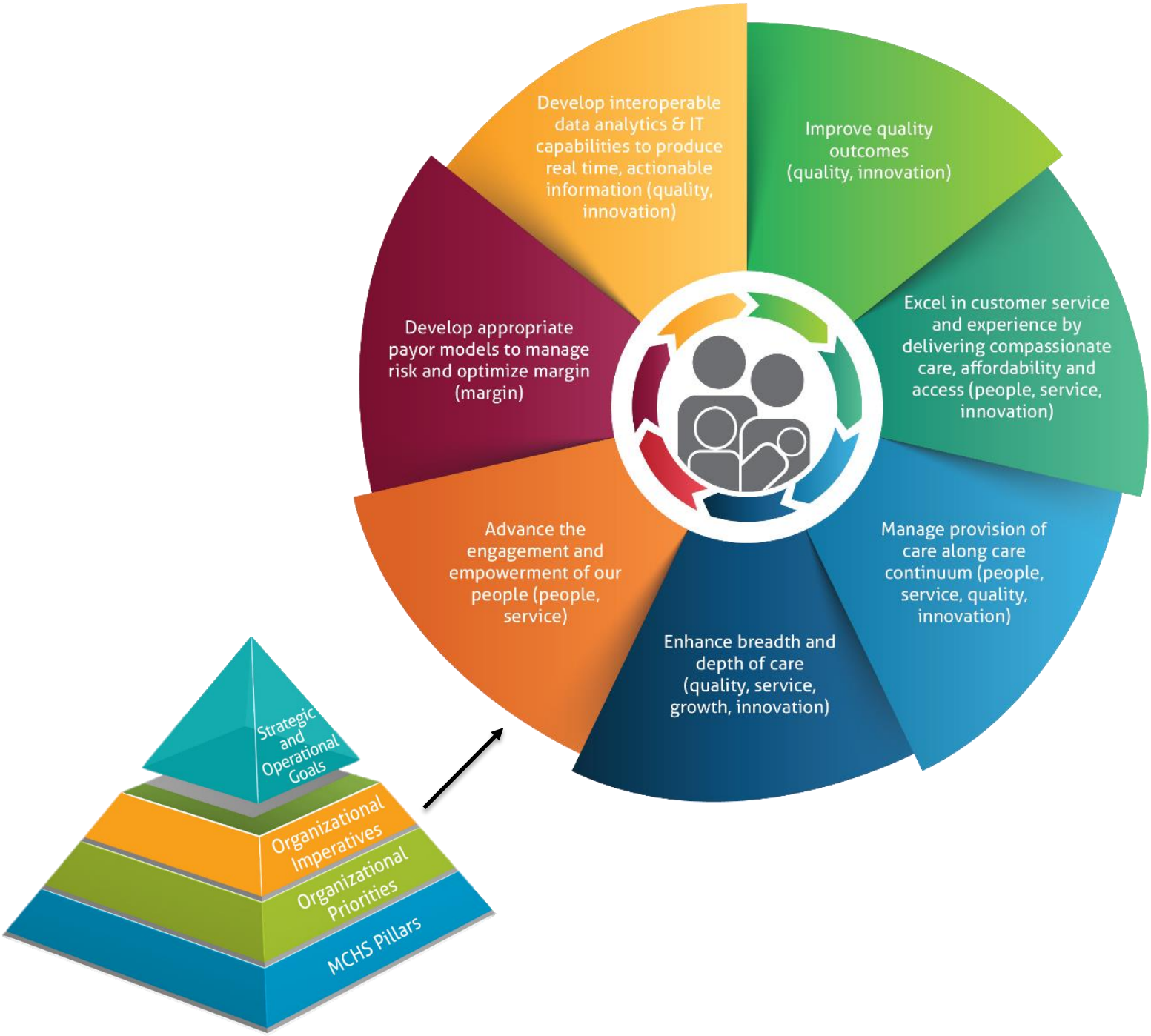
- **What it means for us:** Inspiring valuable and positive change; passionate about enhancing the motivation, morale and performance of others; constantly innovating and pushing our knowledge boundaries to improve our reach and expertise
- **Key Characteristics:** Purpose-driven; people-driven; articulate; tenacious; innovative; inspiring

**Empathy**

- **What it means for us:** Stepping into the shoes of another person, aiming to understand and respect their feelings and perspectives, and to use that understanding to guide our actions
- **Key Characteristics:** Curious; non-judgmental; humility; good listener; open; tolerant

# MCHS Strategy

Taken together the elements of MCHS's strategy comprise a unified approach to providing holistic care to patients and families in line with the vision, mission, and values of the organization.



## SECTION II: PERFORMANCE IMPROVEMENT PLAN

### A. Purpose

The mission, vision, value, strategic and service excellence statements of Nicklaus Children's Hospital guide and direct the Performance Improvement Plan and activities. The Performance Improvement (PI) Plan, in turn, promotes the hospital's mission by establishing a formal method to ensure that the hospital designs systems and processes well and systematically monitors, analyzes and improves patient outcomes and service. Performance improvement activities involve coordination and collaboration among and between departments, services, disciplines, and divisions of the hospital. Patient and family, staff, physician and external customers' needs and expectations are assessed and incorporated into performance improvement activities. The hospital's leaders and governing body set expectations, plan and manage processes to measure, assess and improve the organization's governance, management, clinical and support activities. Finally, the plan provides the framework for a collaborative approach to improve performance in a systematic, coordinated, and continuous manner to enhance patient safety and achieve optimal health outcomes.

### B. Goals

The goals of the Performance Improvement Plan are to:

- Establish and maintain a continuous, comprehensive, collaborative and effective system of measurement, assessment and improvement of patient care outcomes, service quality and safe cost-effective care;
- Promote and monitor activities that supports the identification and resolution of organizational performance improvement opportunities related to the mission, vision, and strategic plan of the hospital and to ultimately embed that philosophy into the corporate culture;
- Support hospital – leadership in setting priorities for performance improvement activities that focus on patient care, satisfaction, safety, access, processes and systems;
- Provide, encourage, support and monitor ongoing educational activities concerning performance measurement, health care systems and methods for continuous quality improvement;
- Establish mechanisms to communicate performance improvement activities throughout the organization;
- Support the Quality, Safety and Innovations' primary initiatives of:
    - Performance Improvement
    - Medical Peer Review
    - Evidence Base Medicine
    - External Collaboratives
- Support the Service Excellence Program, the Risk Management Department, the Accreditation and Regulatory Department, and the Lean Department and relevant initiatives;
  Support and monitor performance improvement activities and findings of the Patient Safety Committee and the Environment of Care (EOC) Committee.

### C. Objectives

The objectives of the Performance Improvement Plan are to:

- Provide effective communication of performance improvement activities throughout the organization through formal and informal means (i.e., committee structure, teams and task forces, written reports, bulletins and newsletters, formal and informal education and Information Technology, collaborative lead and participation, etc.);

- Utilize Lean Principles to strive for continuous quality improvement, prevention, and elimination of waste, reduction of cost of care while remaining customer-focused and –driven.
- Organize data into useful information, utilizing internal and external data sources and information sources representing “best practices” in the design of systems to improve and/or sustain optimal patient outcomes and process;
- Support a non-punitive culture to facilitate pro-active risk identification;
- Ensure pro-active use of FMECA (Failure, Mode, Effects, Criticality and Analysis) and retrospectively use the RCA (Root Cause Analysis) process for clinical high risk processes/outcomes;
- Ensure, when appropriate, that patients and family are informed about outcomes of care, including unanticipated outcomes;
- Approve and monitor patient safety initiatives recommended by the Patient Safety Committee corresponding with The Joint Commission (TJC) National Patient Safety Goals (NPSG) and recommendations and monitor the compliance with such goals;
- Provide training and education in improvement activities with emphasis on practical application and measurement of improvement;
- Present appropriate reporting of information to the Governing Body and the Medical Executive Committee in order to provide leaders with the information they need to fulfill their responsibilities in providing oversight and monitoring results of quality of patient care and safety;
- Evaluate and revise, as necessary, the objectives, scope, organization, and mechanisms for overseeing the effectiveness of the performance improvement program activities.

## SECTION III: RESPONSIBILITY FOR PERFORMANCE IMPROVEMENT

The Board of Directors of Nicklaus Children's Hospital (BOD) maintains overall responsibility for the implementation and execution of the Performance Improvement Plan. BOD monitors performance improvement activities through the BOD Quality Committee and delegates' operational responsibility and authority to the Chief Executive Officer (CEO). Administration provides adequate staffing and resources to carry out improvement activities and actively promotes a collaborative approach for evaluation of patient outcomes and service delivery and the establishment of a Performance Improvement Council to oversee implementation of the Performance Improvement Plan. The hospital's leaders, including Medical Directors, Department Chiefs, and Department Directors encourage and monitor participation in performance measurement, assessment, and improvement activities. The Quality, Safety, and Innovation Department (QSI) are responsible for coordinating the hospital-wide performance improvement activities and the reporting process to the appropriate committees.

## SECTION IV: ORGANIZATION & STRUCTURE

The organization and structure of performance improvement is designed to promote an effective system for organizational measurement, assessment, and improvement. Refer to Appendix B for more details.

**Board of Directors Quality Committee (BOD Quality)**

The Board of Directors Quality Committee (BOD Quality) is the governing body that provides the oversight and organizational direction for the institution's performance improvement activities and prioritization of these activities.

*Membership:*

Members of BOD Quality are appointed annually by the Chair of the Board of Directors. Membership includes, but is not limited to:

- Chair-elect, who must be a member of the Board of Directors
- Medical Staff Representatives, who must be members of the Board of Directors
- Medical Director for Quality
- Senior Administration Representations (i.e. CEO, Chief Nursing Officer/VP, COO)
- Quality, Safety and Innovations Administrator
- Non-medical staff Board members
- General Counsel or designee (Risk Manager)

*Meetings:*

The BOD Quality Committee meets in person at least four (4) times a year and via conference call on alternating months or as deemed necessary by the Chair of the Committee or by the Board of Directors.

*Reporting:*

The PI Council provides the BOD Quality Committee ongoing information on measures that do not meet or exceed predetermined targets, goals, or benchmark expectations. Additionally, the PI Council provides the BOD Quality with the Clinical Excellence Index (CEI, described in detail in Appendix D) Score as a standing item. The BOD Quality provides an executive summary to the Board of Directors.

*Responsibilities:*

- Review as needed, and accept or reject findings, actions and results of:
    - Measurement and improvement activities;
    - Credentials Committee and the Medical Executive Committee;
    - Sentinel Events/Code 15 or Near Misses and other pertinent Risk Management issues;
    - Environment of Care Reports/Activities;
    - Patient Satisfaction Reports/Activities;
    - Patient Safety Report/Activities;
    - New or revised regulations from DNV-GL, CMS, AHCA, or other federal and state regulations and recommendations;
- Provide recommendations for resources, services and support systems for performance improvement and organizational functions as well as Risk Management functions related to patient care and safety;
- Review and approve the Performance Improvement (PI) Plan at least annually;

- Review and approve at least annually the following Hospital Plans
    - Performance Improvement Plan
    - Provision of Care Plan
    - Environment of Care Plan (inclusive of Safety & Security Management, Fire Safety, Hazardous Materials & Waste, Medical Equipment and Utilities Management)
    - Emergency Operations Plan
    - Infection Control Plan & Risk Assessment
    - Patient Safety Plan
    - Utilization Review Plan
- Recommend organizational structure and systems modification where necessary to improve the performance measurement system.

**B. The Performance Improvement (PI) Council**

The Performance Improvement (PI) Council is the body that organizes initiates, facilitates, and monitors performance improvement activities derived from the strategic plan or direct observations and assessments and commensurate with the mission and vision statement. The PI Council also has the responsibility to oversee and approve the design and implementation of a comprehensive Safety Program as recommended by the Patient Safety Committee and the Environment of Care Committee.

At Nicklaus Children's Hospital, The Medical Director for Quality and the Administrative Director for Quality, Risk and Infection Prevention serve in collaborative roles to ensure that corrective and preventive action(s) are carried out and are measured for effectiveness.

*Membership:*

- Chaired by the Medical Director for Quality
- Medical Staff Department Chief Representatives (i.e. Pathology, ICU, ED, Surgery, Hospitalist)
- Chief Nursing Officer/VP*
- Patient Safety Officer and Chair of Patient Safety Committee (Same individual noted above = *)
- Quality, Safety, and Innovations Leadership
- Accreditation Leadership
- Utilization Management Leadership
- Medical Staff Representative(s)
- Administrative Director of Risk/Quality Management
- Infection Prevention and Control Leadership
- Risk Management Representative
- Nursing Leadership Representative(s)
- Magnet Coordinator

*Reporting:*

The PI Council provides an executive summary to the BOD Quality as well as a standing report item on the Clinical Excellence Index (CEI, described in detail in Appendix D) score and alerts the BOD Quality regarding any quality and

safety concerns identified through the Council. Documentation of non-conformities is conducted through Root Cause Analysis (RCA) and actions to correct them. Results of these RCAs is reported quarterly to the Performance Improvement Council each quarter and to the Board of Directors Quality Committee on an annual basis or as requested. Additionally, the PI Council provides an executive summary to the Medical Executive Committee.

*Meetings:*

The PI Council meets at least 10 times per year or as deemed necessary by the Chair of the Committee. See PI Reporting Calendar for 2016 (Appendix C).

*Responsibilities:*

- Annually review and approve the Hospital Plans
    - Performance Improvement Plan
    - Provision of Care Plan
    - Environment of Care Plan (inclusive of Safety & Security Management, Fire Safety, Hazardous Materials & Waste, Medical Equipment and Utilities Management)
    - Emergency Operations Plan
    - Infection Control Plan & Risk Assessment
    - Patient Safety Plan
    - Utilization Review Plan
- Prioritize performance improvement activities and/or authorize the initiation or termination of other performance improvement-related activities using the following criteria:
    - The hospital's organizational and strategic priorities;
    - Identification and assessment of treatments and services affecting the health and safety of patients for relative risks;
    - New or revised regulations from DNV-GL, CMS, AHCA, or other federal and state regulations and recommendations;
    - Results of previous performance improvement activities;
    - Unanticipated Adverse Events or Near Misses;
    - Sentinel Event Alerts;
    - Root cause analysis and FMEA findings;
    - Clinical Excellence Index Reports
    - Service Excellence Reports/Activities;
    - Environment of Care Reports/Activities;
    - Performance Improvement activities identified through Peer Review
    - Medical Staff
- Monitors and evaluates action plans derived from performance improvement activities;
- Provide an executive summary of meeting minutes to the BOD Quality and Medical Executive Committee following each PI Council meeting;
- Align and evaluate the activities that relate to the strategic plan, identified performance improvement activities and required measurements;
- Accept or reject the results and actions of measurement and improvement activities;
- Guide and assist with performance improvement actions taken by the appropriate director, committee or team;
- Provide feedback and guidance to those conducting reviews, surveillance, monitoring and reporting activities.

Expectations

- Members and participants in the Performance Improvement Council (PIC)are expected to:
- Actively participate in presentations and discussions
- Present current and accurate data
- Present data in accordance with approved standardized format ( see Appendix D- Standardized Graph Conventions)
- Submit presentations at least one week in advance of the scheduled PIC meeting

**C. Quality, Safety, and Innovation Department**

The Quality, Safety and Innovation (QSI) Department is charged to oversee and direct the implementation of the Performance Improvement (PI) Plan, support the BOD Quality and PI Council, support Medical Staff by sustaining the Peer Review process and quality improvement initiatives and to collaboratively work with the Department Directors and Teams/Task Force Leaders with development of related activities.

*Responsibilities:*

- Support the development of the Performance Improvement (PI) Plan for the organization to compliment the strategic plan, the Quality Organizational Pillar and the specifically the strategic priorities of Integration and Optimization;
- Provide training, education and information on performance measurement, assessment, and improvement to the hospital and Medical Staff as needed, particularly through the participation with national collaboratives;
- Provide consultation to Department Directors and the Medical Staff regarding the development and assessment of performance improvement activities;
- Incorporate performance improvement-related new or revised regulations, laws, statutes and standards into practice following review by BOD Quality and Medical Executive Committee;
- Provide data analysis and reports for the medical staff departments and hospital leadership;
- Review occurrences, unanticipated adverse events and unanticipated outcomes for peer review as well as refer cases to appropriate departments and committees as needed (i.e. Risk Management, Infection Control, Mortality Committee, etc.);
- Review, analyze, summarize and disseminate reports from departments, teams and any other entities involved with performance improvement measurement activities;
- Support meeting agenda, minutes, reports, and other assistance to Board of Director's Quality Committee and the PI Council;
- Support the activities of the Evidence Based Medicine Committee;
- Make recommendations for integrated performance improvement activities;
- Collaborate with the departments of Risk Management and the Medical Staff Office to collect and analyze data for Ongoing Professional Practice Evaluation (OPPE) and Focused Professional Practice Evaluation (FPPE);
- Collaborate with Health Information Management in order to identify cases requiring quality review.
- Coordinates external Quality focused surveys such as the bi-annual AHRQ Culture of Patient Safety Survey; the US News & World report Best Children's Hospital Survey, etc.

**D. Medical Administrative Directors/Department Directors**

*Responsibilities:*

- Develop and/or participate in measurement and improvement activities within the scope outlined in this plan;
- Lead and/or participate in collaborative activities, teams and task forces;
- Encourage staff to participate in intra- and inter-departmental activities;
- Assess directed department's performance using a data-driven approach and incorporate internal and external target and/or benchmarks as necessary;
- Fulfill any requirements for quality improvement activities for directed department;
- Make recommendations for performance improvement teams based on supportive data from directed department or collaborative efforts;
- Participate in peer review activities as necessary;
- Guides and oversees the implementation of performance improvement activities within the Medical Departments and Divisions.

**E. Performance Improvement Teams & Task Forces**

Performance Improvement teams and task forces are an integral part of improving care and services. Teams and task forces may be chartered based on the results of ongoing measurement and benchmarking activities or by request of Medical Staff, Administration or hospital staff.

*Responsibilities:*

- Address intradepartmental or collaborative, multidisciplinary improvement opportunities;
- Led by individuals identified through interest or direct involvement in the topic, clinical expertise and/or ability to lead the team or on the recommendation of the PI Council;
- Team or task force lead or the PI Council will initiate a Quality Blue Chip Charter;
- The PI Council delegates administrative approval of Performance Improvement teams and task forces to the Quality, Safety, and Innovation Department;
- Teams and task forces are approved according to their relationship with organizational priorities, resource availability, and/or critical impact;
- Team activities are reported to the PI Council and the BOD Quality;
- Actively participate in local, state, and national quality improvement collaboratives.

**F. Quality Sub-Committees**

The Safety Committees (i.e. Patient Safety Committee and the Environment of Care (EOC) Committee) are dedicated to the implementation and monitoring of the effectiveness of a comprehensive Safety Program.

*Membership:*

- Administration Representatives
- Quality, Safety, and Innovations Administrator or designee
- Medical and Clinical Services and Support Services Representatives
- Nursing Leadership Representative(s)
- Chief Nursing Officer or designee as appropriate
- Others as deemed appropriate by each committee's specific charter

The safety program is designed to address the safety risks our facility's environment presents to patients, staff, and visitors. The program is also designed to ensure compliance with applicable codes, regulations, and standards and to promote a culture of safety. A comprehensive annual risk assessment is performed proactively to evaluate the impact of proposed changes to new or existing areas of our facility. The safety program utilizes a variety of report forms to document patient, visitor, and staff incidents, as well as, property damage. Reports include ongoing measurement of performance, a summary of the hazards and problems identified during environmental rounds and summary reports of incidents trends and patters including the results of any root cause analysis of sentinel events. The Safety Committees identify and monitor areas requiring improvement.

The Safety Committees report the committees' findings, determinations, and actions to the Performance Improvement Council for review, as well as the results of the safety program annual evaluation. The Performance Improvement Council works jointly with the Safety Committee in order to provide for optimal patient safety practices throughout the organization. For a more detailed description of the Safety Committee, please refer to the Environment of Care Plan that is inclusive of the Safety Management Plan.

Evidence Based Medicine (EBM) Council objectives and purpose are to standardize clinical care provided at Nicklaus Children's Hospital consistent with the latest evidence based practice recommendations and established guidelines. EBM is to establish a formalized, effective, and timely process to accomplish standardization that will enable efficient and reliable care. EBM is enforced to guide and lead the content information for the implementation of the electronic medical record. The work of the Council will be guided using established library resources as it relates to standardized order sets, clinical protocols, policies, and procedures. EBM chaired by the Medical Director for Quality and is supported by the Quality, Safety, and Innovation Department.

## SECTION V: PERFORMANCE IMPROVEMENT APPROACH

Nicklaus Children's Hospital has a planned, systematic, and coordinated approach to process design and performance measurement, assessment, and improvement. The focus is on improving patient care, safety, and health outcomes through collaborative and interdisciplinary activities. Our approach includes Lean Methodology, plus internal and external target/benchmarking, Best Practices, Root Cause Analyses (RCAs), internal reviews, use of Sentinel Event Alerts and results and findings from VSM/FMECA and statistical analyses.

The hospital's leaders allocate adequate resources for measuring, assessing, and improving the hospital's performance and for improving patient safety. Leaders ensure that patient safety issues are given a high priority and addressed when processes, functions, or services are designed or redesigned.

In late 2016, the Quality, Safety & Innovation Department along with the Lean, Risk Management and Accreditation & Regulatory Departments began discussing a collaborative approach to standardize methodologies for performance improvement (quality tools, forms, trainings, data presentation, etc.). In 2017, the design and implementation of some of these methodologies will be rolled out and evaluated for effectiveness.

### A. Design and Approach

New processes are designed through the use of Lean methodology. Good process design draws upon a variety of sources for information and should:

- Be consistent with the mission, vision, and strategic plan of the hospital
- Meet the needs of individuals served, staff and others
- Incorporate the results of Performance Improvement, Patient Safety and Risk Reduction activities
- Be clinically sound and up-to-date by using current data sources and practice guidelines, etc.
- Use sound business practices
- Establish baseline performance expectations; be measureable and quantifiable
- Use internal and external sources pertaining to occurrences of medical errors and sentinel events in order to identify potential risks to patients

### B. Performance Improvement Methodologies

Nicklaus Children's Hospital utilizes the Lean Model to improve quality and efficiencies and eliminate waste, by:

- Understand who the customer is, both internal and external
- Solve the customers problem and/or demand
- Understand the values that Nicklaus Children's Hospital provides
- Manage by investigational and observational facts
- Work as a team and involve those closest to the problem
- Expand and grow the Lean knowledge
- Develop a Lean Culture and grow change agents
- Focus on Operational Process; Drive to root cause and stop the process if necessary
- Follow Kaizen Principle
- 5 Why's
- Standardization / discipline
- Sustain through customer-focused cycle time and process metrics
- Utilize Value Stream Mapping

**C. Data Collection and Sampling**

Data are systematically collected to monitor the stability of existing processes, identify opportunities for improvement, identify changes that will lead to improvement and sustain improvement. The hospital continuously collects data on relevant processes or outcomes related to patient care, safety, and organizational functions. Data is issued for both improvement priorities and continuous measurement. The measurements are collected and reported to the appropriate committees, team, or task force as outlined in Appendix C. Action plans are tracked to ensure accountability, improvement, and problem resolution.

The performance improvement measurement data is reported to the Performance Improvement Council based on the need for PI Council action, review, or recommendations regarding measurements that do not fall within appropriate range of previously designated benchmarks.

All performance improvement activities should include an adequate sample to be able to optimize the data, subsequent conclusions, and recommendations. Teams and task forces should document their sampling methodology (e.g., random, systematic, availability, population, etc.) and the rationale for their choice of the particular technique. The goal is to ensure that teams and task forces use the most relevant technique with an adequate sample size for all studies. Team leaders and task force chairpersons should maintain raw data (e.g., logs of charts reviewed, medical record numbers, dates of admission or discharge, etc.) other supporting material for validation purposes until the material is no longer needed.

**D. Aggregating and Analyzing Data**

The hospital uses a systematic process to assess collected data. The assessment process:

- Determines current level of performance as well as goals/targets/benchmarks
- Determines stability of processes
- Uses quality improvement tools
- Identifies any areas for improvement
- Assists with prioritizing
- Determines if change has been effective over time or objectives have been met
- Compares ourselves internally over time, with scientific, up-to-date data, and externally with other pediatric hospitals (benchmarking)

**E. Improve/Sustain**

The hospital uses a systematic approach to improve performance. The hospital has selected the Lean Principles for improvement activities. Lean techniques are used to eliminate waste, streamline and simplify steps, improve process efficiencies, and specify value from the customer standpoint. For performance measures that are not meeting targets or expectations, A Corrective Action/Preventive Action (CAPA) Plan may be directed to be done. (See Appendix F-CAPA). Assignment of these CAPA Plans can come from various source including but limited to PI Council, Board of Director Quality Committee, Accreditation & Regulatory, Quality, Safety & Innovation, and Senior Leadership.

**F. Use of Results and Confidentiality**

The results of the performance measurement activities are used for the following:

- To identify necessary improvements to enhance patient safety, patient care outcomes, patient/family satisfaction, and service delivery.
- To guide and direct training and educational offerings for the patient/family, hospital, nursing, resident and medical staff.
- Development/revision of policies and procedures to enhance hospital-wide systems.

All information related to organizational performance improvement activities performed by the hospital or medical staff in accordance with this plan is confidential. Records and documents created relative to performance improvement activities may not be disclosed to any person or entity except as outlined in the HIPAA Privacy Act.

Information may be disseminated as required by law and HIPAA regulations and on a "need to know" basis to agencies such as federal review agencies, National Practitioners Data Bank, or other individuals or agencies as approved by the Medical Executive Committee, Hospital Administration, and/or the Board of Directors.

**G. Goal Setting/Benchmarking and Best Practice**

An essential component of data analysis is the assessment of trends and patterns and comparison of internal data with our own past performance as well as with other organizations. When and where applicable, all performance improvement activities should employ a variety of methods to determine targets, goals, benchmarks or best practice data against which the hospital can compare its outcomes. Sources of target, benchmarking and best practice data include, but are not limited to:

- Review of the literature and external databases/references for best practice data
- Using standards from regulatory bodies, professional associations or the state and federal
- Utilizing targets and benchmarking data from selected vendors (e.g., MMP, CHA/PHIS, NHSN)

**H. Annual Plan Evaluations**

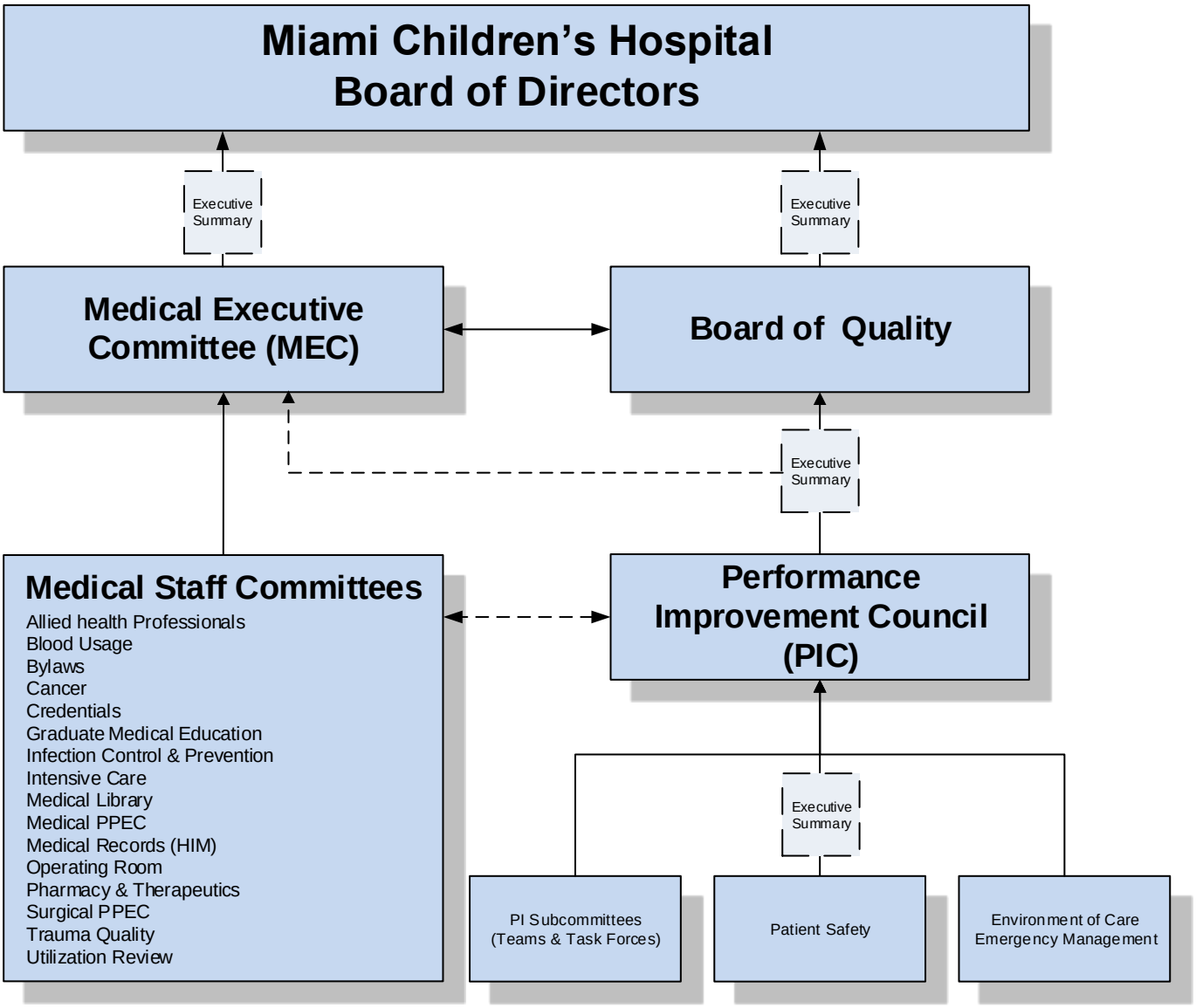
To ensure that there is an appropriate approach to the planning processes of improvement, priority setting for improvement, and systematic assessment of performance activities by the organization, the PI Plan and hospital plans will undergo an annual plan evaluation. Recommendations and revisions will be reported to the PI Council as a component of the review and approval process according to the Organization & Structure Chart depicted in Appendix A.

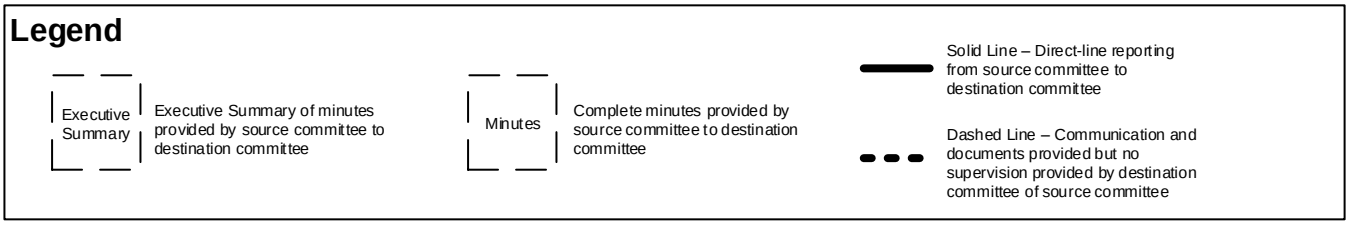
**I. Performance Measurement**

Reporting of performance measures is noted in Appendix B- Report Schedule Matrix. Performance measurement is a combination of:

- Required measurement of DNV-GL, State of Florida and other regulatory requirements
- Priorities established from our strategic goals and approved by the Performance Improvement Council and the BOD Quality Committee
- Target setting and/or Benchmarking with selected Performance Measurement Systems

**APPENDIX A: ORGANIZATION & STRUCTURE CHART**



**APPENDIX B: PERFORMANCE IMPROVEMENT REPORTING SCHEDULE 2017**

***Blue font indicates new reports to be presented**

PI Council & BOD-Quality Reporting Schedule 2017

Key: PIC = ◆ BOD-Q= ⬢

| | Reference | Reporting Frequency | Jan | Feb | Mar | Apr | May | Jun | Jul | Aug | Sep | Oct | Nov | Dec |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **Accreditation & Regulatory** | **Standing Agenda item** | 10/year | ⬢ | ◆ ⬢ | ◆ ⬢ | ◆ ⬢ | ◆ ⬢ | ◆ ⬢ | | ◆ ⬢ | ◆ ⬢ | ◆ ⬢ | ◆ ⬢ | ◆ ⬢ |
| **DNV CAPA Updates** | DNV QM.6 SR.5 | 4/year | | | ◆ ⬢ | | | ◆ ⬢ | | | ◆ ⬢ | | | ◆ ⬢ |
| **Ambulatory services**<br>• **Wait Times**<br>• **Service Excellence** | | 3/year | | | | ◆ | | | | ◆ | | | | ◆ |
| **Anesthesiology**<br>• **Sedation/Moderate Sedation**<br>• **Adverse events**<br>• **Compliance with Documentation** | DNV QM.7 SR.4 | 3/year | | | | ◆ ⬢ | | | | ◆ ⬢ | | | | ◆ ⬢ |
| **Behavior Management & Treatment**<br>• **Restraints & Seclusion** | DNV QM.7 SR.6 | 3/year | | | ◆ | | | ◆ | | | | ◆ | | |
| **Lab**<br>• **Blood Product/Transfusion Report**<br>• **Adverse Events**<br>• **Usage/waste**<br>• **Discrepant Pathology reports**<br>• **Laboratory Reports including off sites** | DNV QM.7 SR.5<br>DNV QM.7 SR.12<br>DNV QM.7 SR.16 | 3/year | | | ◆ | | | ◆ | | | | ◆ | | |
| **Bone Marrow Transplant (BMT)** | DNV QM.7 SR.3 | 2/year | | | | | | ◆ | | | | | | ◆ |
| **Cardiopulmonary Mortality / RRT / Blue Alert (GWTG)** | GWTG (Resucitation)<br>DNV QM.7 SR.16 | 3/year | | ◆ | | | ◆ | | | | | ◆ | | |
| | | 2/year | | | | | | ⬢ | | | | | ⬢ | |
| **Clinical Excellence Index** | **Standing Agenda Item**<br>DNV QM.7 SR.1-SR.16 | 10/year | ⬢ | ◆ ⬢ | ◆ ⬢ | ◆ ⬢ | ◆ ⬢ | ◆ ⬢ | | ◆ ⬢ | ◆ ⬢ | ◆ ⬢ | ◆ ⬢ | ◆ ⬢ |
| **Collaboratives/Special initiatives** | | Annually as available | | When available | | | | | | | | | | |
| **Credentialing Committee/MEC Recommendations** | **Standing Agenda Item** | Min 10/year | ⬢ | ⬢ | ⬢ | ⬢ | ⬢ | ⬢ | | ⬢ | ⬢ | ⬢ | ⬢ | ⬢ |
| **Culture of Patient Safety Survey Results (q2 two years)** | DNV QM.6 SR.5c | When available | | When available (q2 two years) | | | | | | | | | | |

PI Council & BOD-Quality Reporting Schedule 2017

Key: PIC = ◆ BOD-Q= ⬣

| | Reference | Reporting Frequency | Jan | Feb | Mar | Apr | May | Jun | Jul | Aug | Sep | Oct | Nov | Dec |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **Dietary**<br>• Assessments<br>• Documentation Compliance | DNV QM.7 SR.16 | 3/year | | ◆ | | | ◆ | | | | ◆ | | | |
| **Emergency Operations Plan** | | Annual | | | | | | | | | | | | ◆ |
| **Environment of Care Plan(s)** | | Annual | | | | | | | | | | | | ◆ |
| **Environment of Care** | DNV QM.7 SR.18 | 4/year | | | | ◆ | | ◆ | | | | ◆ | | ◆ |
| **Evidence Based Medicine Committee** | | 2/year | | | | | ◆<br>⬣ | | | | | ◆<br>⬣ | | |
| **Fall Activity Reduction Team** | DNV QM.7 SR.1 | PIC x 3 | | | | | | | | | | | | |
| **Infection Control Plan & Risk Assessment** | TJC (IC 01.03.01; IC 01.05.01) | Annual | | | ◆<br>⬣ | | | | | | | | | |
| **Infection Control Reports** | DNV QM.7 SR.8 | 4/year | | | ◆<br>⬣ | | | ◆<br>⬣ | | | ◆<br>⬣ | | | ◆<br>⬣ |
| **Lean Report** | Updates on Quality-Related Projects | 4/year | | ◆ | | | ◆ | | | ◆ | | | ◆ | |
| | | 2/year | | | | | ⬣ | | | | | | ⬣ | |
| **Medication Safety Report**<br>• **Med Errors**<br>• **Adverse Drug Events**<br>• **Antibiotic Stewardship Report** | DNV QM.7 SR.2 | 4/year | | | ◆<br>⬣ | | | ◆<br>⬣ | | | ◆<br>⬣ | | | ◆<br>⬣ |
| **Operative & Invasive Procedures**<br>• **Surgical Readmissions**<br>• **Unplanned returns to surgery**<br>• **Top procedures and associated complications report** | DNV QM.7 SR.3 | | | | | | | | | | | | | |
| **OPO-Organ Procurement Report** | | 2/year | | | | | ◆ | | | | | | ◆ | |
| | | Annual Report | | ⬣ | | | | | | | | | | |
| **Pain Task Force**<br>• **Pain Management**<br>• **CEI Indicator** | DNV QM.7 SR.7 | 3/year | | | | ◆ | | | | ◆ | | ◆ | | |
| **Patient Flow** | DNV QM.7 SR.10 | 4/year | | | ◆ | | | ◆ | | | ◆ | | | ◆ |
| • **LWBS**<br>• **OBS LOS**<br>• **Extended time for patients held in ED** | | 2/year | | | | | ⬣ | | | | | | ⬣ | |

PI Council & BOD-Quality Reporting Schedule 2017

Key: PIC = ◆ BOD-Q= ⬣

| | Reference | Reporting Frequency | Jan | Feb | Mar | Apr | | May | Jun | Jul | Aug | Sep | Oct | Nov | Dec |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **Patient Safety Committee** | DNV QM.7 SR.1 | 3/year | | | | | | ◆ | | | ◆ | | | ◆ | |
| **Patient Safety Plan** | Annual | Annual | | | | | | | | | | | | ◆ | ⬣ |
| **Performance Improvement Plan** | | Annual | | | | | | | | | | | | ◆ | ⬣ |
| **Primary Care Center (PCC)** | | 2/year | | | | | | ◆ | | | | | ◆ | | |
| **Provision for Patient Care Plan** | DNV QM.6 SR.5c | Annual | | | | | | | | | | | | ◆ | ⬣ |
| **Radiology (including off-sites)**<br>• **Wait times**<br>• **TAT**<br>• **Misreads** | DNV QM.7 SR.16 | 3/year | | ◆ | | | | ◆ | | | | ◆ | | | |
| **Rehabilitation Services**<br>• **Wait Times**<br>• **Customer Satisfaction** | DNV QM.7 SR.16 | 4/year | | ◆ | | ◆ | | | | | ◆ | | ◆ | | |
| | | 2/year | | | | ⬣ | | | | | | | ⬣ | | |
| **Report of Process Failures/Sentinel/RCA Report- Annual** | DNV QM.7 SR.1-SR.16 | Annual | | | | ⬣ | | | | | | | | | |
| **Risk Management/Safety** | **Standing Agenda Item**<br>DNV QM.7 SR.14 | | ⬣ | ⬣ | ⬣ | ⬣ | | ⬣ | ⬣ | | ⬣ | ⬣ | ⬣ | ⬣ | ⬣ |
| **Risk Management-Incident report trending/ RCA update** | DNV QM.7 SR.11 | 4/year | | | ◆<br>⬣ | | | | ◆<br>⬣ | | | ◆<br>⬣ | | | ◆<br>⬣ |
| **Service Excellence** | | 4/year | ⬣ | | ◆<br>⬣ | | | | ◆<br>⬣ | | | ◆<br>⬣ | | | ◆<br>⬣ |
| **Telehealth**<br>• **# Prescriptions written**<br>• **Compliance with documentation standards**<br>• **Documentation of recommended follow-up**<br>• **Service Excellence (customer satisfaction)** | | 2/year | | | | | | ◆ | | | | | ◆ | | |
| **Trauma** | | 3/year | | | ◆ | | | | ◆ | | | | | ◆ | |
| | | 2/year | | | | ⬣ | | | | | | ⬣ | | | |
| **Utilization Review Plan** | DNV QM.7 SR.9 | Annual | | | ◆<br>⬣ | | | | | | | | | | |

**APPENDIX C: Clinical Excellence Index**

The Clinical Excellence Index©, commonly referred to as the CEI©, was developed at Nicklaus Children's Hospital in 1998 as a means of quickly identifying progress or opportunities in key performance indicators. Though it has evolved over the years, it currently contains nine "bundles", as shown below, and is intended to be broadly applicable to quality care in a clinical health system. It is a monthly composite score, ranging from zero to 100, and is composed of 55 indicators (variable each year) clustered in 8 bundles of like measures. . Each individual indicator is scored by comparing it to either internal past performance or external benchmarks. The indicators are weighted (approximately equally) so that, when the final individual indicator scores are totaled, the maximum possible points for the CEI© is 100. The quality indicators are chosen annually by the Quality, Safety, and Innovation department and approved by the PI Council and Board of Directors Quality Committee. Indicators are determined based on strategic goals, regulatory requirements, and areas of priority for the organization.
The Clinical Excellence Specification Manual identifies and defines each measure, how it is calculated, inclusion/exclusion criteria, what are the benchmarks or targets, etc.

For Calender year ending 2016, the following were identified for modfications to the CEI:

# 2017 Executive Summary

| **REMOVE FOR 2017** | |
|---|---|
| CLABSI (Oncology only) | remove these two indicators; make new indicator by combining Oncology w/ Non-Oncology, continue to exclude Hemodialysis.<br>New indicator: CLABSI (exclude HD) |
| CLABSI (Non-Oncology) | |
| Left Without Being Seen (LWBS) – UCC | excellent performance; replaced indicator ( and LOS indicator) with "EMTALA" and "Recheck abnormal vital signs" |
| Outpatient Visit Duration – OCC | As of 1/2017, adding "Med dispensed on site" to allow pt to avoid 90" delay of going to Pharm. (able to leave UCC w/ meds in hand). No hx of LOS w/ this added process, will remove from 2017 CEI; monitor throughout 2017 to establish targets. Expect to put back on 2018 CEI. |
| Access to Care for Eval: OT/PT | Rehab unable to accurately report wait list rate;<br>adding new indicator "Education Teach Back: OT/PT/SLP |
| Access to Care for Eval: Speech/Lang Path | |
| Anti-Infective Compliance | Remove due to already doing bundle reliability |

| **NEW FOR 2017** | |
|---|---|
| CLABSI (exclude HD) | combined CLABSI Oncology and Non-Oncology , continue to exclude Hemodialysis |
| MBI – Oncology | Mucosal barrier injury lab-confirmed bloodstream infection. |
| Education Teach Back: OT/PT/SLP | new indicator for Rehab; establishing thresholds |
| Recheck abnormal vital signs – UCC | new for UCC; these replace UCC LWBS and LOS |
| EMTALA – UCC | |
| Pain Mgmt: Intervention & Reassessment – Transport | Matches other pain 21gmt. indicators |

| **CHANGED** | |
|---|---|
| Inpatient Length of Stay (Actual to Expected Ratio) | Not changing indicator, but will be eliminating extended stays. Thresholds will be determined by QSI based on new criteria Ming/Philicity will be providing.<br>Begin to monitor observations by hours. |
| Falls without Injury – Main Campus (Non-Devel.) | Exclude non-preventable falls, inline with NDNQI definition.<br>~~Possibly changing denominator from patient days (Inpt & Obs) to Adjusted patient days (includes inpts, obs, and outpatient visits main campus)~~ |
| Falls without Injury – Offsites (Non-Devel.) | Exclude non-preventable falls, inline with NDNQI definition. |
| Pressure Ulcers | Current indicator includes on stage 3 o& 4. Will now also include 'unstageable' (full-thickness pressure ulcer/injury, meaning affecting the same tissue as stage 3 or 4, but unable to stage at the moment because of specific tissue present in the wound). |

| MOVED TO DIFFERENT BUNDLE | |
|---|---|
| Parental consent | Two Transport indicators moved from "Continuum of Care" Bundle **to** "Sustainability" Bundle due to 100% compliance throughout 2016. |
| RN/Medic hand-off to receiving facility | |
| Appropriate treatment for URI | One of Clinic's indicators moved from "Continuum of Care" Bundle to "Sustainability" Bundle due to 100% compliance throughout 2016. |
| DVT & Pulmonary Emboli | Move from "Care of Critically Ill" Bundle to "Sustainability" Bundle due to -0- events since May'15. |

| CHANGES TO BE DETERMINED | |
|---|---|
| Computerized Physician Order Entry | "Meaningful Use" indicators. Data inconsistent; accurate? Action plan as result of lost points? |
| Transmit Prescriptions Electronically – Hosp. | |
| Medication Reconciliation | |
| Documentation turn-around-time | Remove these Telehealth indicators. Satisfaction indicator should only be in SEI, and documentation T-A-T is 100% compliance; low patient volume. Measures to be replaced by one determined by Dr. Biehler/Evelyn Terrell/Amanda Bolanos, possibly re: proper antibiotic use. |
| Overall satisfaction | |

| CONSIDER REMOVING | |
|---|---|
| Parental consent | Two Transport indicators moved from "Continuum of Care" Bundle **to** "Sustainability" Bundle due to 100% compliance throughout 2016; was it a good CEI measure – has always been 100%?. Or possibly remove altogether (have two other transport indicators). |
| RN/Medic hand-off to receiving facility | |

Additional measures were also identified for 2018 for collecting of baseline data and establishing thresholds during 2017

| PROPOSED ADDT'L INDICATORS FOR 2018 CEI |
|---|
| Sepsis |
| Pressure Injury Reliability Bundle (Xoana began collecting it Aug'16) |
| Outpatient Visit Duration – OCC : Removed from 2017 CEI. As of 1/2017, adding "Med dispensed on site" to allow pt to avoid 90" delay of going to Pharm. Will be able to leave UCC w/ meds in hand. No hx of LOS w/ this added process, will remove from 2017 CEI; monitor throughout 2017 to establish BM's & future targets. Expect to put back on 2018 CEI. |

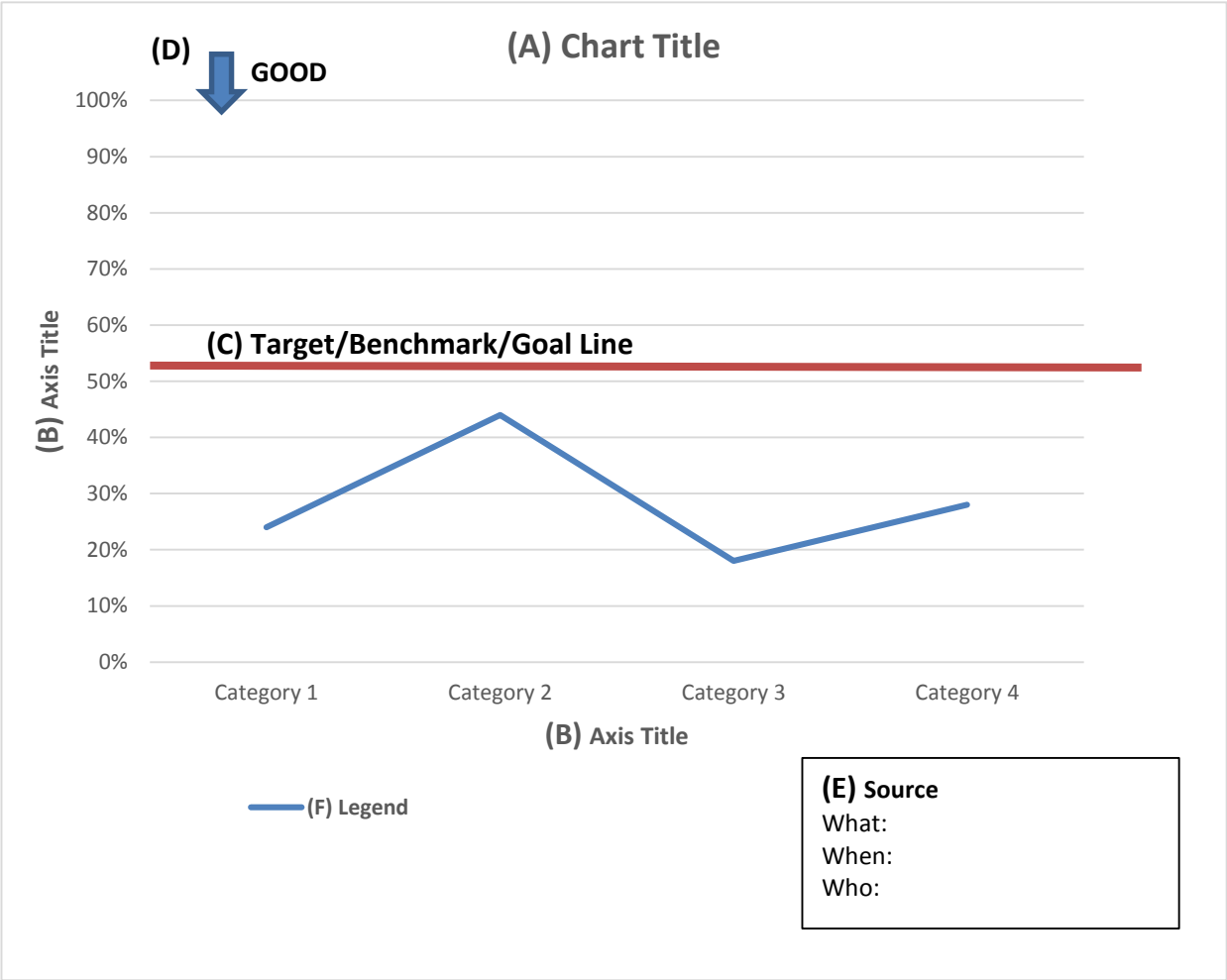
**APPENDIX D: INTERNAL COMMITTEES**

| DNV-GL Committee Alignment with QM.7 Measurement, Monitoring, Analysis | |
|---|---|
| Biomedical Ethics | SR.16 |
| Blood Usage | SR.5 |
| Bylaws | |
| Cancer | SR.16 |
| Credentials | |
| Environment of Care & Emergency Management | SR.18 |
| Infection Control | SR.8 |
| Intensive Care | SR.16 |
| Leadership Council | |
| Library | |
| Graduate Medical Education | |
| Medical Executive Committee | |
| Medical PPEC | SR.3, SR.4, SR.5, SR.12, SR.13, SR.15 |
| Medical Records | SR.17 |
| Operating Room | SR.3, SR.15 |
| Performance Improvement | See PI Plan |
| Pharmacy & Therapeutics | SR.2 |
| Psychology | SR.16 |
| Regulatory Oversight Committee | |
| Surgical PPEC | SR.3, SR.4, SR.5, SR.12, SR.13, SR.15 |
| Trauma Quality Management | SR.13, SR.16 |
| Utilization Review | SR.9, SR.16 |

**Appendix E: Standard Graph Conventions**

All graphs will have the following at a minimum:

- Graph Title (A)
- Axis Labels (B)
- Target/benchmark/goal line identified (C)
- Good arrow (up or down) (D)
- Source Box (what is the data, When was it collected, who collected it) (E)
- Legend/data box as appropriate (F)



**Appendix D: CAPA Template**

# Corrective Action/Preventive Action Plan

# (CAPA)

| | | | |
|---|---|---|---|
| **Date:** **Unit/Area:** | | | |
| **Issue/Area/Indicator to be addressed:** | | | |
| **Organizational Lead:**<br><br>**Operational Lead:** | | | |
| **Action/Prevention Steps** | **Responsible Person** | **Due date** | **Status** |
| | | | |
| | | | |
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| **Additional Notes/Special Follow Up** | | | |
| | | | |