QUALITY IMPROVEMENT PLAN

The purpose of the quality improvement efforts at Mitchell County Hospital Health Systems is to ensure the delivery of the best care possible for patients. This is accomplished by assessing patient care and other support processes in a systematic, ongoing manner in order to identify improvement opportunities and act on them in a timely manner. The plan has as its aim the improvement of key governance, managerial, clinical and support processes that are most important to the health and safety of the patients served.

The quality improvement plan is designed to integrate the pursuit of Mitchell County Hospital Health Systems' mission with the understanding that excellence in clinical outcomes must be achieved with appropriate allocation of resources.

OBJECTIVES:

A To increase the probability of desired patient outcomes, including patient and physician satisfaction, by improving those governance, managerial, clinical and support processes that affect those outcomes.

B To establish priorities for the investigation and resolution of issues and problems by focusing on those processes with the greatest potential impact on patient care outcomes and patient satisfaction.

C To assure that employees who participate in patient care are trained in assessing and improving the processes that contributes to improved patient outcomes.

D To help individuals improve the processes in which they are involved and yet address serious problems involving deficits in knowledge and skill.

E To coordinate medical staff quality improvement activities with those of the organization and integrate efforts when appropriate-specifically medical staff activities relative to utilization review, infection control, medication usage, operative and invasive procedures, blood usage, and risk management. Collaborative efforts are not limited in these areas, however, and are encouraged for all clinical and other quality improvement processes.

AUTHORITY AND ACCOUNTABILITY

The Board of Directors of Mitchell County Hospital Health Systems is responsible for establishing, maintaining and supporting an ongoing quality improvement program. This responsibility is carried out by hospital administration, the medical staff, nursing and hospital support services. The organization's leaders set expectations, develop plan, and implement procedures to assess and improve the quality of the organization's governance, management, clinical and support processes. The organization's leaders include members of the Board of Directors, Administrator, Department Managers and the Executive Committee of the medical staff. The Board will review periodic reports of findings, actions and results from quality activities in order to assess the program's efficiency and effectiveness.

SCOPE OF QUALITY ACTIVITY:

All services and departments shall participate in quality improvement efforts. The leaders noted above are responsible for guidance of organization-wide quality improvement efforts. Quality activities center around two major categories: activities that improve care and their associated support processes.

ORGANIZATION:

A Quality improvement activity:

1 The guidance for overall hospital-wide quality improvement activities is provided by the organization leaders. Their responsibilities include:

a Lead the quality initiative.
b Set priorities for organization wide quality improvement activities.
c Allocate adequate resources for assessment and improvement.
d Assure the staff has the appropriate training available for quality improvement.
e Report activities to the Board of Directors via the Director of Quality/Risk Management.

2 The Director of Quality/Risk Management serves as a resource person and coordinator for information that crosses departments, committees and individuals, hospital-wide quality activity, and for reports to the Board of Directors.

3 Ongoing measurement activities will be functional in the following areas:

a Sentinel events
b Drug usage evaluation function
c Surgical case review/operative, invasive, and non-invasive procedure function.
d Blood usage review function
e Utilization review function
f Risk management
g Quality control review:
Dietary
Laboratory
Radiology/nuclear medicine
h Patient assessment function
i Patient education function
j Human resource function
k Leadership function
l Continuum of care function
m Infection control function
n Mortality review/autopsy results
o Patient surveys
p Safety/environmental care
q Patient rights function
r Departmental CQI

4 Improvement studies shall be based on:

a Relationship to the hospital's mission, vision, values and organizational plans
b Significant sentinel events
c Significant adverse drug reactions
d Significant blood transfusion reactions

e Variations from the norm
f Major discrepancies
g Desire to improve existing processes.
h Significant utilization review issues
i Risk management monitoring
j Safety issues

Whenever possible, benchmark information will be used in analysis of data.

5 Organized Continuous Quality Improvement teams and the functions they are responsible for are:
   a ICES TEAM – Management of Environment of Care Surveillance; Prevention and Control of Infections.
   b COMPLIANCE TEAM – Organization & Management of Fraud & Abuse Policies and Procedures.
   c PATIENT TREATMENT/CARE TEAM – This team consists of multi-disciplinary members. Care of Patient (use of blood and blood components; operative & other invasive procedures; use of medications) and Trauma Review Committee.
   d PMT- Performance Management Team: Role of this team is the overall coordination of all performance and quality initiatives, benchmarks, and departmental plans.
   e PEP Teams- (Performance Excellence Program) Six teams with roles divided to oversee Leadership, Strategic Planning, Focus on Patients Other Customers and Markets, Measurement Analysis & Knowledge Management, Workforce Focus, and Process Management.

Individual departments will be responsible for monitoring activities relative to their respective areas.

6 The quarterly report by the Director of Quality/Risk management to the hospital's Board of Directors will include:
   An overview of results of relevant monitoring and improvement activities including balanced score card.
   An overview of risk management/peer review statistic results quarterly.

B Interdisciplinary quality activities:
The following interdisciplinary quality improvement functions shall be performed by the medical staff and interdisciplinary members from the hospital staff:

1 Drug usage evaluations function will be accomplished by monitor and evaluate the key processes of prescribing and ordering, preparing and dispensing, administration, monitoring patient response and adverse drug reactions involved in medication usage. Drug usage review is responsible for the development and maintenance of the drug formulary as well as approval of policies and procedures related to the selection, distribution, handling, use and administration of drugs and diagnostic testing materials. Disciplines involved in this function are: medical staff, nursing staff (from acute care, surgery, LTCU, and Special Care Unit); laboratory; administration and the pharmacist. Reports of the findings will be presented at least quarterly to the medical staff.

2 Surgical case/operative and invasive and non-invasive procedure review will be accomplished to help assure that the surgery performed in the hospital is justified and of high quality and will measure the quality of the key processes of pre-operative evaluation, intraoperative care,

post-operative recovery room care, post-operative care and follow-up. Elements in the review will include:

a The review of indications for procedures based on predetermined criteria;
b The review of pre-operative, post-operative and pathological diagnosis for significant differences.
c Process review is accomplished thru 100% screening (high volume, high risk, problem prone/tissue, non-tissue/invasive, non-invasive).
d Disciplines routinely involved in this review are the medical staff, anesthesia services, operating room nursing staff, acute care nursing staff and quality/risk management.
e Monitoring is ongoing and is reported at least quarterly to the medical staff.

3 Blood usage review is ongoing and reported at least quarterly. The review measures the key processes of indications/assessment, distribution/handling/dispensing, administration, monitoring the effects and all identified or suspected blood transfusion reactions. Also monitored is the ratio of units crossed to given and number of units typed and screened by service and ordering practices of physicians.

a Disciplines routinely involved in this review are the medical staff, laboratory staff, nursing staff, and quality/risk management. Other disciplines are involved in the review dependent on the blood products being reviewed.

4 Trauma Performance Improvement Review Committee functions as a multidisciplinary peer review committee functioning under the auspices of the Medical Staff. The purpose of the committee is to evaluate the care of the trauma patient from a clinical and systems perspective and to perform interdisciplinary implementation of improvement strategies. It is responsible for establishing objective criteria for identifying issues for review and determining compliance with standards of care. The committee will systematically monitor/analyze data, and improve patient outcomes through improvement opportunities. Recommendations and action plans with associated re-evaluation will be when areas needing improvement are determined. Members include Trauma Medical Directorr, surgeon, Trauma Manager, liaisons from anesthesia, surgery, emergency medicine, radiology, lab, director of nursing, nurse managers, and pharmacist. Additional attendees are invited ad hoc. The committee meets monthly no less than 10 times a year annually with a 50"% attendance requirement of peer review representatives.

a. The Trauma Committee will submit a quarterly report to the Medical Staff.

b. Data collection and documentation on all patients is achieved through the Trauma Registry. Information for Trauma Performance Improvement (PI) and Quality Improvement (QI) process are collected concurrently and retrospectively; specifically source of issues, problems, data and referrals includes but is not limited to as:

- Trauma Registry
- ER Logbook
- Trauma Manager/Registrar
- Daily Rounds
- Referrals from staff departments involved in the care of the trauma patient
- Hospital PI committees

c. Process for Monitoring Compliance

1. Standards of Care: All trauma patients will be reviewed on a daily basis for development of complications or any deviations from the standard of care. Patients' names and their physician's names and the nature of the incident will be logged and secured in the Trauma Manager's office.

2. Death Reviews: Trauma patient deaths are reviewed as they relate to trauma care and trauma system issues.

3. Audit Filters/Indicators: Audit filters/indicators are defined by the American College of Surgeons (ACS) and/or the trauma programs are monitored.

- Complications are provider related issues that occur in trauma patient care and are recorded into the hospital Trauma Registry. The Trauma committee will review complications from injury or treatment that significantly affect patient outcome. The Trauma committee will make appropriate referrals and recommendations. All complications will be reported on a quarterly basis and monitored for trend analysis
- Systems issues are all identified issues that are not provider related and reviewed by the Trauma Committee.

d. Review Process will be monitored continuously by utilizing the audit filters as defined by the regional and state trauma system, American College of Surgeons Committee on Trauma, and the Trauma Performance Improvement Committee. Those cases or systems issues identified will be reviewed by the Trauma Manager and the Trauma Medical Director for determination of further action.

Levels of Review:

- First Level: The Trauma Manager will do the initial case review. If the first level of review is completed, affirming that clinical care is appropriate and no provider or systems issues are identified, the case does not require a second level review or formal committee review **or** after review of all pertinent information the trauma coordinator may determine that the issue should be addressed by the Trauma Medical Director.

- Second Level: The second level review can be done by the Trauma Manager and the Trauma Medical Director. A case in which a second level review is required is when issues in clinical care, provider or systems issues are evident that require the Trauma Director's expertise and judgment. Further investigation, implementation action without formal referral to a peer review or system committee, or decide to send it to the appropriate PI committee or to a hospital department for further investigation/peer review committee and ask for follow-up.

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- Third Level: The Trauma Manager and Trauma Medical Director will perform an initial case review in preparation for the Committee meeting identifying all individual issues to be discussed. The issue is then formally reviewed by the Trauma Performance Improvement Committee. Individual practitioners involved in the patient care will be invited to attend for additional information and input. Determination of Judgment will be made by the Trauma Performance Improvement Committee using an established criteria.

e. Determination of Judgment: The committee will render a judgment regarding appropriateness of the issue and every mortality being reviewed. Each issue will be placed into a category as follows:

- Non-preventable: An event or complication that is sequel of a procedure, disease, illness or injury for which reasonable and appropriate preventable steps had been taken. (Closed)

- Possibly Preventable: An event or complication that is a sequel of a procedure, disease, illness or injury that has the potential to be prevented or substantially improved. (Refer to Risk Management)

- Preventable: An event or complication that is sequel of a procedure, disease, illness or injury that could have been prevented or substantially improved. (Refer to Risk Management)

All possible preventable and preventable complications will be forwarded to Risk Management for further review on hospital variance form. Trauma service forms are not to be forwarded to Risk Management and are not a part of the medical record.

The Trauma Performance Improvement committee may make one of the following recommendations for corrective action in each case:

- Change in existing policy and/or procedure
- Require physician to seek professional education
- Individual counseling by the Trauma Medical Director
- Removal of physician from trauma call responsibilities

f. Documentation of Analysis and Evaluation for trauma QI issues will be tracked on the "Trauma Case Review Worksheet/PI Tracking," "Performance Improvement Form", and/or the Trauma Registry. These methods track all aspects of the case review including a summary of the clinical care, identified issues, reference to discussion/minutes from the Trauma Review Committee(s) judgment, recommendations, actions, and loop closure.

g. Referral Process for Investigation or Review of cases for further investigation by the first and second level of review or a judgment/rating determination by the Trauma Performance Improvement Committee may be referred to the appropriate hospital department by appointed liaisons, committee or department managers for review. The PI committee and/or the Trauma Medical Director/Trauma Manager will then review the response of the referral for follow-up planning.

i. Trauma PI Committee Structure: The committee will function as a multidisciplinary peer review committee function under the Care of the Patient committee and the Medical Staff committee. The purpose of the committee is to evaluate the care of the trauma patient

from a clinical and systems perspective and to perform interdisciplinary implementation of improvement strategies. It is responsible for establishing objective criteria for identifying issues for review and determining compliance with standards of care. The committee will systematically monitor/analyze data, and improve patient outcomes through improvement opportunities. Recommendations and action plans with associated re-evaluation will be made when areas needing improvement are determined. Membership includes all trauma surgeons, Trauma Medical Director, Trauma Manager, general surgeon, liaisons from surgery, anesthesia, emergency medicine, radiology, and laboratory departments. Other members include the director of nursing, nurse managers, and other additional invited ad hoc attendees.

The Trauma Performance Improvement Committee will submit a report to the Medical Staff meeting quarterly and no less than 10 times a year annually with a 50% attendance requirement of peer review representatives.

j. Corrective Action Planning: The Trauma Medical Director/Trauma Manager oversees all corrective action planning and the institution of actions. Structured plans may be created by any of the Trauma PI members or committees in an effort to improve sub-optimal performance identified through the PI process. The goal is to create forward momentum to demonstrate outcome change to subsequent loop closure. Examples of corrective actions are:

- Organization of PI teams
- Education
- Referral to peer group
- Trending
- Focused Audit
- Protocols/Practice Management Guidelines
- Counseling
- Removal from trauma call privileges
- External Review
- Enhancement of resources or methods of communication

k. Confidentiality Protection for all PI activities and related documents will be considered confidential and protected as specified in K.S.A. 65-4915 and 65-4923 as sited in the Medical Staff Bylaws, Mitchell County Hospital Health Systems policies, and HIPAA. All PI will be handled as confidential and for review only. Whenever feasible, generic identifiers for patients and care providers shall be utilized. No PI information will be a part of the medical record. All paper PI documents and electronic information will be kept in a secure location with limited, controlled access. Any copies distributed at meetings will be counted and collected at the close of the meeting.

l. Loop Closure and Re-evaluation issues will be subject to Level 1, 2, or 3 reviews which may result in the formation of an action plan. In order to "close the PI loop," the outcome of the corrective plan will be monitored for the expected change and re-evaluation process demonstrates a measure of performance or change at an acceptable level. "Acceptable level" may be determined by frequency tracking, benchmarking, and variance analysis as decided by the Trauma Medical Director, Trauma Manager, and/or

m. PI committee. Loop closure will be reported to the Trauma PI committee and determination made regarding periodic or continuous monitoring.

n. Integration into MCHHS Performance Improvement Process is done through a multidisciplinary and multi-departmental approach to review the quality of care across all departments and divisions. The Trauma PI program will report through the Care of the

Patient committee, Medical Staff, Risk Management committee, and Performance Improvement teams.

6 The infection control committee is a multidisciplinary committee which meets at least quarterly to oversee the effectiveness of the hospital-wide program for the surveillance, prevention, and control of infection. The committee approves the type and scope of surveillance activities and approves actions to prevent or control infection, based on an evaluation of the surveillance reports. Committee membership includes at least representatives from the medical staff, nursing, administration, laboratory, pharmacist, quality/risk management, and the infection control practitioner. Activities of the Infection Control Committee are reported to the ICES team and then subsequently to the medical staff. The Committee reviews and approves all policies and procedures of the program at least every two years

a. The utilization review function is to oversee utilization review activities. The Utilization Review Plan which describes the program and governs its operations is approved by the medical staff, Administrator and Board of Directors.

b. The medical staff actively participates in risk management activities related to the clinical aspects of patient care and safety. Risk management monitoring indicators are included in quality improvement indicators/screens and all variances undergo medical staff peer review. Risk management reports/minutes are included at the medical staff Executive Committee meetings at least quarterly.

c. Any person may provide information to the medical staff about the conduct, performance or competency of its members. Such information shall be confirmed to acts, demeanor, or conduct reasonable likely to be:

i. Detrimental to patient safety or to the delivery of quality patient care within the hospital;
ii. Unethical;
iii. Contrary to the medical staff bylaws, rules and regulations;
iv. Below applicable professional standards.

Information provided will be reviewed and evaluated through the physician peer review process with appropriate input from other disciplines involved.

d. Reporting: Written reports of the findings, conclusions, recommendation and actions will be maintained for all quality improvement activities and be reported to the medical staff and Board of Directors.
e. Data Sources: Sources of data for all quality improvement activities shall include, but will not be limited to the following:

Medical records, morbidity/mortality review findings, pertinent risk management findings, QI activities, financial data, claims, utilization review findings, data obtained from staff interviews and observation, patient surveys or complaints, log books, data from third party payers, PRO's fiscal intermediaries or private agencies, committee and department minutes and special studies.

f. Retention of data and reports: all formal minutes and reports will be kept permanently. Quality improvement worksheets will be retained for a period of three years.

g. Outside providers: The Chief Executive Officer is responsible for assuring that a planned, systematic process for monitoring and evaluation is implemented for services provided by contracts or outside providers.

h. Confidentiality: Due to the highly confidential nature of clinical information reviewed in the quality improvement program, all necessary precautions will be taken to protect individuals and the organization.

i. To ensure the confidentiality of the program, the following will be observed:

1. Names of individuals shall be withheld from all study/review report forms.

2. All individuals shall be identified by alpha and/or number codes.

3. Code lists for individuals shall be maintained by the director of quality/risk management.

4. Medical record numbers used in reviews shall be confidential and available only to those persons actively participating in QI reviews.

5. All minutes of risk management/peer review activities will be maintained in locked files by the director of quality/risk management.

6. Access to medical staff peer review files shall be for the sole purpose of credentialing activities and subject to the requirement that confidentiality be maintained. Access shall be limited to the credentials committee, chief executive officer and the director of quality/risk Management.

7. Information being utilized in the course of an investigation shall remain in a separate peer review file during the course of the investigation and until the outcome of the investigation is resolved.

i. The Quality Improvement program will be evaluated at least once a year.

QUALITY IMPROVEMENT PROCESS MODEL:

A The approved approach to continuous quality improvement is the FOCUS model.

STEPS OF THE FOCUS MODEL:

1) FIND or identify problem or opportunity to improve:

Why work in this project?
What are the boundaries?
Who are the stakeholders of this process?
Is this process too complex given our level of knowledge?

2) ORGANIZE a team or group who are involved with the process:
   Who is the team leader or process owner?
   Does the team represent all levels of the organizations?
   Who is the facilitator who will guide the team?
   What resources are needed by the team?
   Does the team have a roadmap?

3) CLARIFY the knowledge of the process:
   What is the process flow?
   What obvious flaws can be corrected?
   Reach agreement on consistent application of the process.
   Who are the suppliers/customers of the process?
   What are their requirements and how are they measured?

4) UNDERSTAND the process variation and capability:
   Specify <u>which</u> of the processes will be improved at this time:
      Plot the customer requirements on a run chart.
      Investigate and control special causes.
      Establish limits of common cause variation.
      Assess process capability.

5) SELECT implementation strategies for continuous improvement/solution (list the strategies.)