



**Erlanger Health System**

**Performance Improvement Plan  
2013 - 2014**

**Approved by Joint Conference and Accreditation Committee of the Board – 10/9/12**

**Approved by Quality Oversight Committee – 9/11/12**

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## **Organizational Mission, Vision, & Strategic Imperatives**

### **Mission:**

Deliver excellence in medical care to improve the health status of our region, while providing vital services to those in need and training to health professions through affiliation with academic partners.

### **Vision:**

Erlanger will lead as a comprehensive provider of acute care and ambulatory health services, offering a “system of care” that delivers value in terms of quality, cost effectiveness, customer service, teaching and research – directed at improving the health of our community and region

### **Erlanger Strategic Imperatives**

1. Deliver exceptional care, every time
2. Be transparent, value and promote our outcomes, quality & patient safety
3. Align our culture and organizational structure with our strategy
4. Collaborate with physicians to achieve our vision; strengthen our education & training programs and position Erlanger as the region’s academic health system
5. Enhance our leadership position at the local and regional levels with existing and new services
6. Optimize our system of inpatient and ambulatory care to advance the integration of services, achieving benchmark productivity, customer satisfaction and quality to strengthen financial performance
7. Collaborate with community and academic partners to improve the health status of the community

## PI Program Goals

### Goal

The goal of the Erlanger Health System (EHS) Performance Improvement Plan is to maintain an organization-wide performance improvement program based on a systematic approach to prioritizing, assessing, designing, implementing and sustaining improvements in both clinical and operational processes and outcomes.

### Principles for Performance Improvement

1. To measurably improve our delivery of **safe, effective, patient-centered, timely, efficient, and equitable** patient care.
2. To ensure that our approach to performance improvement is team-based, multidisciplinary, and interdepartmental.
3. To ensure that key process and outcome measures are tracked, communicated, assessed, and acted upon when needed.
4. To establish appropriate organizational structures for performance improvement and to clearly delineate roles and responsibilities.
5. To effectively engage and support physicians and other clinicians in improvement activities.
6. To effectively engage senior leadership and the board in quality, safety & service improvement activities (new in FY13)
7. To ensure that a consistent approach for performance improvement is followed by Erlanger Health System.

## **Transparency & External Data Sharing**

**Core Measure Reporting:** Core Measures are quality, safety or service metrics that are required or recommended to be reported to either CMS or TJC. The data is currently abstracted by Erlanger, and reported through an outside vendor. The current Core Measures reported to CMS and/or The Joint Commission are: Acute Myocardial Infarction, Congestive Heart Failure and Community-Acquired Pneumonia, Inpatient and Outpatient Surgical Care Improvement, ED Turnaround Time, Global Immunization, Children’s Asthma, Inpatient Psych, Stroke, VTE, and Perinatal Care.

**HospitalCompare:** CMS posts each hospital’s performance on Core Measures, and has developed additional administrative metrics that are created based on billing data that CMS has, and do not require any action on the hospital’s part. Some examples of administrative data include 30 day readmission rates, 30 day mortality rates, complication rates, patient safety indicators, inpatient quality indicators, hospital acquired conditions, and Medical Imaging utilization rates. Patient Satisfaction is also measured and reported as HCAHPS scores.

**Meaningful Use:** CMS has initiated a program that encourages hospitals to automate the collection of quality related statistics. Over time, the Core Measures will be automated instead of manually abstracted, and feedback will be closer to ‘real time’. Stroke, VTE, and ED Turnaround metrics are being initiated as Meaningful Use measures at this time.

**Value Based Purchasing:** CMS has initiated a ‘pay for performance’ program that includes administrative data, patient surveys (HCAHPS), Core Measures, and Meaningful Use metrics, and there are financial incentives to improve our performance as compared to other hospitals.

**LeapFrog Quality Reporting:** EHS voluntarily reports on LeapFrog indicators.

**IHI:** Erlanger voluntarily reports on IHI process and outcome indicators for several key IHI initiatives.

**THA:** We share data in statewide initiatives sponsored by the Tennessee Center for Patient Safety.

**Daily Pride:** Current Performance on Key Quality Metrics will be published monthly in the Daily Pride

Many other organizations obtain CMS billing data and other sources to formulate reports that are compared with other hospitals and published in public forums. Two examples are “U.S. News and World Report” and “Consumer Reports”.

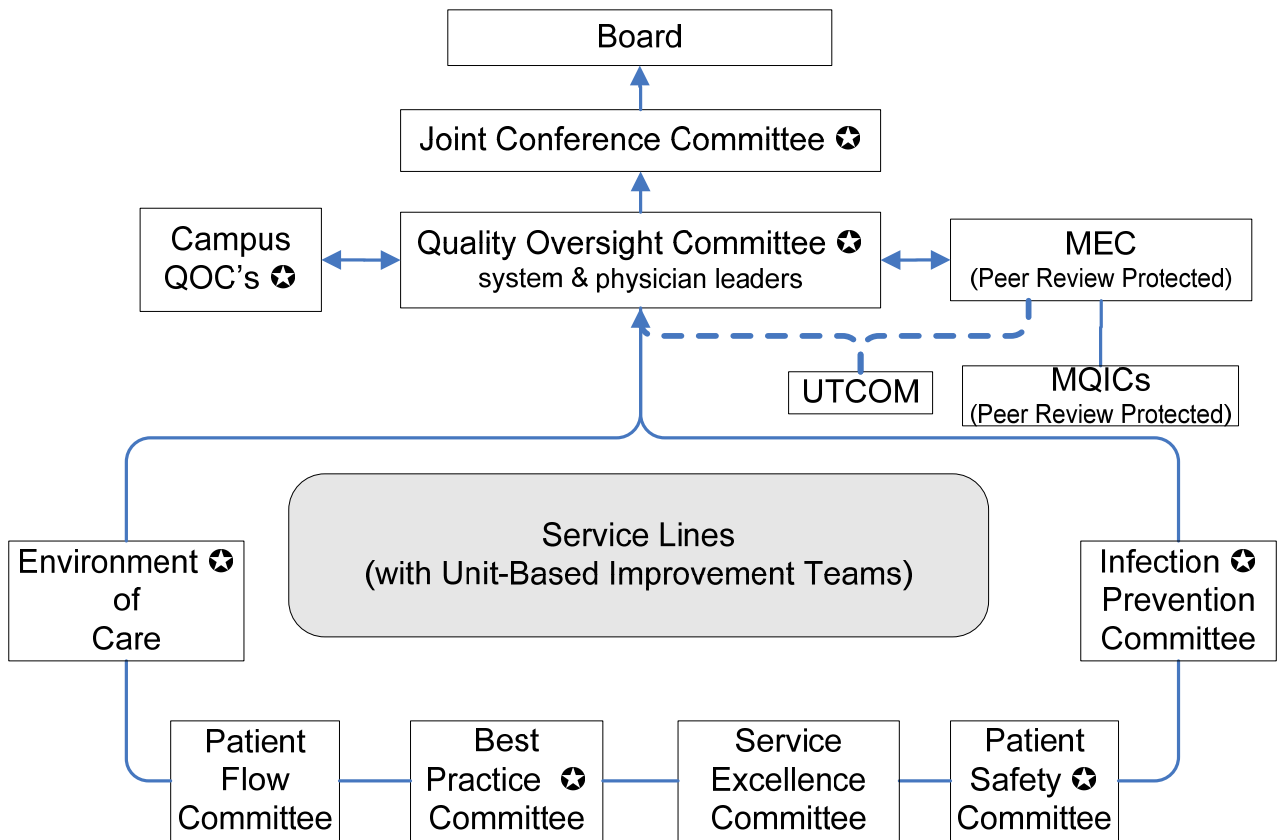
## Framework, Priorities and Methodology

### Framework

The ultimate responsibility for a comprehensive and integrated performance improvement plan rests with the organization’s leaders, deriving their authority from the Board of Trustees. In order to achieve performance improvement goals, the leadership has developed an organizational framework for implementing the Performance Improvement Plan. A diagram of this framework is provided:



### Performance Improvement Structure (December 2013)



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This design facilitates interaction between all organizational levels and encourages multidisciplinary efforts to maximize performance improvement. Key components of this framework are described below:

#### 1. Joint Conference Committee

The Joint Conference Committee is the subcommittee of the Board of Trustees where quality, safety, and service process and outcomes data are discussed. The Joint Conference Committee receives regular reports from the Quality Oversight Committee.

**2. Quality Oversight Committee (QOC)**

QOC is the quality steering committee for EHS consisting of physician leaders and members of hospital's executive leadership team. QOC evaluates Erlanger Health System's overall performance improvement program for its comprehensiveness, integration, effectiveness, and cost efficiency and revises the Performance Improvement Plan as needed. The QOC is also responsible for oversight of accreditation and regulatory standard compliance.

**3. Medical Executive Committee (MEC)**

The MEC oversees all medical staff-related issues with formal oversight of peer review concerns, physician effectiveness, and credentialing. The Medical Executive Committee must review and endorse recommendations from clinical process improvement activities having a direct and significant impact on patient care.

**4. Medical Quality Improvement Committees (MQICs)**

MQICs are established for each of the recognized departments of the Medical Staff and are staffed by the Clinical QI Department. Members are designated by the Chief of Staff and appointed by the MEC. The Chairmen of the MQICs periodically report to the MEC on peer review matters, and other matters of clinical quality significance. The Chairmen may, when requested by the Chief of Staff, report to the QOC on specific issues.

**5. University of Tennessee College of Medicine (UTCOM)**

The UTCOM Dean, faculty, and residents participate in the Erlanger Quality Improvement System, and are members of the Quality Oversight Committee and the Medical Executive Committee.

**6. Campus Quality Oversight Committees**

TCT, and the Community Health Centers have 'campus quality committees' that review and analyze outcomes and process data related to patient safety, patient flow, patient satisfaction, and the implementation of best practices on their campuses. Our goal is to establish campus QOCs for Erlanger East and Erlanger North in FY 2014, and for Physician Office Practices. Campus quality committees report to the QOC.

**7. Service Lines**

Service Lines focus on activities that have business and service interests in common, such as the Cardiology Service Line. Each Service Line also has a set of administrative and quality metrics by which their success is measured are reported on Service Line Scorecards. Specific hospital units, depending on the type of patients they serve, are assigned to one of the Service Lines. The Service Line leaders therefore take responsibility for quality, safety and service on each unit. Unit-based improvement teams take local ownership of quality, safety and service within each unit which also has a scorecard. The success of the EHS PI Plan depends on the success of each unit. Therefore, Service Lines are the front-line bedside champions for improving patient safety, quality, and overall patient and family experience.

**8. Environment of Care**

The Environment of Care Committee promotes a safe, functional, and supportive environment within the hospital so that quality and safety are preserved. The environment of care is made up of three basic elements:

- The building or space, including how it is arranged and special features that protect patients,

visitors, and staff

- Equipment used to support patient care or to safely operate the building or space
- People, including those who work within the hospital, patients, and anyone else who enters the environment, all of whom have a role in minimizing risks.

## **9. Infection Prevention**

The Infection Prevention Committee assumes responsibility for determining best practices needed to protect patients and staff from hospital acquired infections. They also establish metrics for reliability in following the implemented processes and in measuring outcomes. The Infection Prevention Committee has also taken on the responsibility of establishing and monitoring best practices for antibiotic stewardship

## **10. Patient Safety Steering Committee**

The focus of the Patient Safety Steering Committee is to prevent patient harm. The Patient Safety Steering Committee reviews and analyzes relative outcomes and process data, then recommends specific actions or projects to address key safety issues.

## **11. Best Practice Steering Committee**

The focus of the Best Practice Steering Committee is to implement best treatment practices for known disease processes. The Best Practice Steering Committee identifies nationally defined best clinical practices, reviews and analyzes outcomes data and process data related to the implementation of those best clinical practices, and works with appropriate groups (such as PCC Teams or the Nurse Practice Council) to oversee the successful implementation of changes.

## **12. Governance Service Excellence Steering Committee**

The focus of the Service Excellence Steering Committee is to enhance the patient and family experience of care throughout Erlanger Health System. The Service Excellence Steering Committee identifies nationally and internally defined best practices designed to improve the perception of service quality for patients and their support system.

## **13. Patient Flow Steering Committee**

The focus of the Patient Flow Steering Committee is to assure efficient movement of patients through the system of care by identifying nationally and internally defined best practices designed to remove barriers to flow.

## **PI Project Selection and Prioritization Process**

### **Priorities**

Erlanger has a top-down and bottom-up approach to project selection. Individual units or departments select projects based on potential for next harm to patients. Projects which are identified within the EHS Strategic Plan, affect other departments and/or include stakeholders from other hospital departments will be chartered and monitored by the QOC. Projects will have an executive champion as needed from the executive team to assist with removing barriers, monitoring progress, and reporting to QOC.

EHS collects data on important processes and outcomes related to patient care and organizational functions. The purpose is to establish priorities for measurement, to collect data, and to appoint improvement teams when appropriate. In setting priorities EHS' leadership considers the following:

- First Priority - Opportunities to measurably improve our delivery of safe, timely, effective, efficient, equitable, & patient-centered care
- Second Priority - EHS' Strategic Imperatives and Operational Objectives
- Third Priority – Focus on externally published metrics that are consistent with Erlanger's organizational goals (new in FY13)

The QOC prioritize organization-wide improvement initiatives by considering at a minimum the following factors:

- Overall impact on the areas listed above;
- Potential for breakthrough improvement, and
- Availability of resources in light of other initiatives.

These priorities are regularly reviewed and modified. In addition, the priorities are modified when an immediate need arises due to unforeseen circumstances or events.



## **PI Methodology**

Erlanger's basic approach to Performance Improvement is to use a specifically identified method to: identify problems; involve knowledge workers and leaders in the solution process; make sure that the changes are well-planned; and make sure that the implementation of change actually addresses the problem. The specific method used for improvement depends on the situation. These methods can be used independently or in conjunction with each other, as described below.

### **Training on PI Tools**

Training for tools and approaches are generally best accomplished on a just-in-time basis, and are associated with a particular project or task. As a project develops, the training needs for the project are intentionally considered and are included as part of the project. People that facilitate projects may be provided with additional formal training about the available tools and tool selection.

### **Lean**

Lean is set of tools whose goal is to establish a “practice that considers the expenditure of resources for any goal other than the creation of value for the end customer to be wasteful, and thus a target for elimination. Working from the perspective of the customer who consumes a product or service, ‘value’ is defined as any action or process that a customer would be willing to pay for” (September 2012, “Lean Manufacturing” on Wikipedia).

Some of the key tools of Lean include:

- Rapid Improvement Project (Kaizen) – a way of managing projects where resources are allocated so that the majority of the work of a project is done within a one to two week period, including process design, implementation, and follow-up planning. This is a key tool to achieve Breakthrough Improvement.
- Value Stream Mapping – detailed documentation of processes in flowchart form, with consideration for external factors and process variations. Commonly, the design phase of a Rapid Improvement Project includes either developing or validating the existing process (‘ismap’), then assessing waste improvement opportunities and process redesign ideas, and developing the new recommended process (‘shouldmap’)
- Waste Identification – an intentional review of work to assess for the 8 specific types of wastes that can occur in healthcare (Toussaint, John and Gerard, Roger, “On the Mend: Revolutionizing Healthcare to Save Lives and Transform the Industry”, 2010, Lean Enterprise Institute)
- 5S – Organizing the work environment to be effective and efficient
- Defect Huddle (Kanban) – A process for immediate response to defects, focused on two key factors: a response to problems that could result from the defect, and changes required to avoid future occurrences of the defect.
- Standard Work – detailed documentation that addresses common situations and the ‘standardized’ actions and responses.
- A3 - a single-page project status communication tool that is commonly used in Lean environments. It is intended to be used to prioritize activity, and to share information about the project to people that are not directly involved in the project, in order to improve the quality of feedback and support. The A3 is a living document, so it should reviewed and updated regularly throughout the course of the project.

## **Breakthrough Improvement**

Breakthrough Improvement is a strategy for methodically focusing on key organizational initiatives, that was initially developed by the Institute for Healthcare Improvement (see <http://www.ihl.org/IHI/Results/WhitePapers/TheBreakthroughSeriesIHIIsCollaborativeModelforAchieving+BreakthroughImprovement.htm> for more information). Erlanger's implementation of Breakthrough Improvement includes the following key concepts:

- Identification of a key outcome System Measure that is tracked and shared with all levels of the organization
- Assigning the Breakthrough Improvement initiative to a specific, accountable executive leader
- Specifically linking the Breakthrough Improvement initiative to Strategic Imperatives in the organization
- Identification of Key Drivers that are measurable processes that would impact System Measure.
- Forming interdisciplinary teams focused on the Key Drivers, with the authority and responsibility of implementing change. Six Sigma and/or FOCUS-PDCA can be valuable methods to identify the actions and solutions that best address the Key Drivers.
- Using data driven improvement to identify and implement small scale tests of change based on the PDCA cycle described below

## **Six Sigma (DMAIC):**

At a very high level, Six Sigma is a methodology that gives people at all levels of the organization the skills and shared way of thinking to systematically drive out waste by improving activities, connections and workflows. Building on the Six Sigma concept of reducing error and deviation from expected results, Six Sigma provides a toolkit that helps identify errors, delays, costs of poor quality, etc. Although it started in manufacturing, Six Sigma can be applied to any business workflow—including healthcare. It is now used across multiple industries.

**Define the problem**

**Measure the outcomes**

**Analyze the Inputs**

**Improve the process**

**Control to validate changes are still in place, and that improvements are recognized and sustained.**

## **FOCUS-PDCA**

FOCUS-PDCA is a simplified approach to standardizing performance improvement, and is very appropriate for basic improvement initiatives. Many of the tools used in FOCUS-PDCA are also contained in the Six Sigma “toolkit”, including Control Charts, Run Charts, Pareto Diagrams, etc.

**Find a process to improve**

**Organize an effort for improvement**

**Clarify current knowledge of the process**

**Understand reasons for variation within the process, and measure the process**

**Select a strategy for improvement based on the Clarified knowledge & Understood variations**

**Plan the improvement**

**Do the testing of the action**

**Check to determine the effect of the action**

**Act on implementing the action on a wide scale**

## Specific Improvement Initiatives and Goals for FY 14

### Preliminary

Desired Direction	Metric		
	Description	Stat	
Service Excellence ↑	HCAHPS % of Available Points Earned (Using FFY15 rules)	46%	Nat'l Avg
		27%	FY12 Actual
		36%	FY13 Actual
	Internal Standard	60%	FY14 Stretch
	Natl Avg + 1%	47%	FY14 Target
	Best of last 2 years	36%	FY14 Threshold
Hand Hygiene ↑	% of Observations with appropriate hand hygiene	78.6%	FY12 Actual
		84.6%	FY13 Actual
	Internal Standard	93.0%	FY14 Stretch
	Internal Standard	90.0%	FY14 Target
	Internal Standard	87.0%	FY14 Threshold
Catheter Associated Urinary Tract Infection (CAUTI) ↓	CAUTI per 1,000 Urinary Catheter Days	1.60	Nat'l Avg
		4.14	FY12 Actual
		5.39	FY13 Actual
	Natl Avg	1.60	FY14 Stretch
	Middle between Threshold & Stretch	2.87	FY14 Target
	Best of last 2 years	4.14	FY14 Threshold
Central Line Associated Bloodstream Infection (CLABSI) ↓	ICU CLABSI per 1,000 Central Line Days	1.24	Nat'l Avg
		1.62	FY12 Actual
		2.00	FY13 Actual
	Natl Avg	1.24	FY14 Stretch
	Middle between Threshold & Stretch	1.43	FY14 Target
	Best of last 2 years	1.62	FY14 Threshold
Early-Term Elective Deliveries (ETED) ↓	% of Deliveries at 37 wks to 38w6d without documented justification	32.9%	FY12 Actual
		26.1%	FY13 Actual
	Leapfrog Level 4	5.0%	FY14 Stretch
	Leapfrog Level 3	10.0%	FY14 Target
	Leapfrog Level 2	15.0%	FY14 Threshold
SCIP Appropriate Intervention Rate ↓	Includes Inpatient and Outpatient SCIP Measures	98.4%	Nat'l Avg
		97.0%	FY12 Actual
		97.8%	FY13 Actual
	50% Reduction in Fallouts	98.9%	FY14 Stretch
	25% Reduction in Fallouts	98.4%	FY14 Target
	Same as FY13	97.8%	FY14 Threshold
CABG - Extubation within 6 Hours Post-Op ↓	Metrics Pending Collaboration with HeartSource		Nat'l Avg
			FY12 Actual
			FY13 Actual
			FY14 Stretch
			FY14 Target
			FY14 Threshold