Annual Update Quality Improvement Plan 2013

Executive Summary
On an annual basis the Quality Improvement Plan is reviewed and updated to reflect priorities in providing quality care in a safe environment to all patients. The purpose of the Crouse Hospital Quality Improvement Plan is to provide a framework for a collaboratively planned, systematic and organization-wide approach to improving patient care and organizational performance. It is designed to provide an integrated and comprehensive program that will monitor, assess and improve the quality of patient care delivered at this facility.

This is a thirty page document with the following key changes:

- Deleted “QI Knowledge System” as a data source page 9
- Stated that annual “QI Summit” is in essence the ISO Required Annual Management Review page. 10
- Added “hospital acquired conditions” to …we will continue to examine ways to decrease… page 10
- Included updated version of Crouse PI structure for 2013 page 21
- Deleted “Peripheral Vascular Interventional Council” from QI Plan page 28
- Updated 2013 Reporting Structure for PCIC- page 29

Quality Improvement Plan 2013

Endorsed by Senior Management: January 17, 2013

Endorsed by Patient Care Improvement Council: January 17, 2013

Endorsed by Medical Staff Executive Committee: February 5, 2013

Endorsed by Quality Improvement Committee of the Board: February 7, 2013

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The Quality Improvement Plan

Crouse Mission Statement

To provide the best in patient care and to promote community health.

Our Vision

Crouse Hospital's vision is to be to be a leading healthcare provider in Central New York by:

Service excellence
Anticipating and exceeding expectations of all we serve: our patients and their families, providers, employees, students, volunteers and other partners.

Dynamic work environment
Fostering an environment where all are valued and respected, and passion and opportunities for professional growth are encouraged.

Building on centers of clinical and organizational excellence
Doing the right thing by focusing on evidence-based patient- and family-centered care, a commitment to safety, the importance of learning and our mission, vision and values.

Innovation and collaboration
Building/fostering partnerships to enhance care, meet community need and anticipate the demands of a dynamic healthcare environment.

Financial and resource stewardship
Keeping Crouse strong through the responsible use of financial and human resources.

Our Values

Community ... working together
Respect ... honor, dignity and trust
Open and honest communication
Undivided commitment to quality
Service to our patients, physicians and ourselves
Excellence through innovation and creativity

Our aim is to be **"Simply the Best"; which simply and clearly** describes our commitment as a Hospital team to patient and employee safety, clinical and operational excellence, customer service excellence and efficiency excellence.

Our Guiding Beliefs

The following beliefs guide our performance improvement and outcome management interventions and strategies. They focus on our philosophical understanding that we are here to serve four distinct but interrelated customer groups: community, employee, patient and physician.

- We are here to serve our community by providing high quality patient care and emphasizing health promotion and wellness activities.
- Being responsive to the needs of our patients, families, community, physicians, employees and students ensure our fulfillment of our Mission.
- The delivery and continuous improvement of high quality patient care is our greatest commitment. We strive to provide high quality care at a reasonable cost and will add new technologies, treatments and preventive programs where appropriate and feasible. A sound financial base is of utmost importance in meeting our goals.
- Since high quality care can only be delivered through a quality medical staff and hospital staff, the needs of the physicians and employees are of great concern.
- The Crouse Hospital healthcare team consists of well-qualified physicians, professional nursing and technical staff, support staff and volunteers. The hospital recognizes their loyalty and needs and is committed to providing fair policies, programs and employee compensation. “Employer of Choice” is a commitment that goes beyond the words. It is our commitment to all who work at Crouse Hospital to be the best organization possible.
- We have a responsibility to educate current and future health practitioners, including nursing, medical and allied health professionals. We encourage and support research activities whenever possible and will continue our working relationships with the SUNY Health Science Center at Syracuse.
- Management will actively participate in a leadership role among the community’s healthcare providers, working with them to provide a strong healthcare system for the community and to avoid costly duplication of services. Competition stimulates and challenges us to grow. We will work hard at being successful and remaining the premier hospital in Central New York.

Executive Summary

The Crouse Hospital Quality Improvement Plan provides a framework upon which an integrated and comprehensive program to monitor, assess and improve the quality of patient care delivered at Crouse can be built. This plan supports the organizational mission to provide high quality care at a reasonable cost and to continuously improve our performance. Our core values include a commitment to clinical excellence, service excellence and the fostering of a team approach to delivering care and services.

Crouse uses an approach to improving clinical and service quality that includes five key processes: definition, measurement, analysis , improvement and control. Important patient care and service processes and outcomes are measured through the use of quality indicators and data collection techniques. Analysis of the collected data is accomplished through statistically valid techniques to determine levels of performance and quantify variation in processes and outcomes. Where there is an identified opportunity for improvement, the decision to act will depend upon a prioritization process that considers factors such as the impact on patient care and outcomes, customer satisfaction, relevance to the mission and strategic plan, and the extent to which the improvement is required by oversight or regulatory entities. When an opportunity for improvement is prioritized for action, the PDSA methodology is employed to make the improvement. Within PDSA is the six sigma DMAIC model; a set of tools outlined in five chronological phases: Define, Measure, Analyze, Improve and Control. In addition to the PDSA and DMAIC approach, lean healthcare principles will be applied throughout the process redesign.

The performance improvement council infra-structure supports Crouse's commitment to quality and the core values of clinical excellence, service excellence and teamwork. The committees and councils within the structure are multidisciplinary and include representatives from the medical staff, the hospital staff. There are four types of quality improvement councils:

- The **Oversight council** is responsible for the establishment and implementation of the overall Quality Improvement Plan.
- **Coordinating council** is responsible for supporting the functional and service line Councils through leadership, barrier removal, prioritization and allocation of resources.
- **Peer review committees** exist to review individual cases that require a determination pertaining to the standard of care delivered.
- The **functional and service line performance improvement councils** measure, assess and improve the quality of care and delivery of services throughout the organization.
- The Clinical Advisory Group is a team of physicians, nursing professionals, and quality experts that advises the Hospital leadership and the QI teams. They serve as a think tank, as well as a way in which physician engagement can be nurtured through physician leadership.

Results of process or quality improvement initiatives are communicated as appropriate throughout the organization in an effort to share ideas, gain understanding of relevant processes, encourage collaboration, instill CQI into the organizational culture and to stimulate creative and innovative improvement initiatives. The staff is encouraged to participate by offering improvement suggestions formally or informally and through participation on teams and Councils.

The objectives, scope, organization and effectiveness of the Quality Improvement Program are evaluated annually and revised as necessary.

2013 Quality Improvement Plan

PURPOSE

The purpose of the Crouse Hospital Quality Improvement Plan is to provide a framework for a collaboratively planned, systematic and organization-wide approach to improving organizational performance. It is designed to provide an integrated and comprehensive program that will monitor, assess and improve the quality of patient care delivered at this facility.

OUR COMMITMENT TO QUALITY

The core of the Crouse Quality Improvement Program is that it addresses quality in all areas and at all levels throughout the organization. For Crouse Hospital to succeed in the rapidly changing and increasingly competitive healthcare environment in this region, we make the commitment to:

- Compete on the basis of excellence in clinical outcomes, customer satisfaction and value
- Use a collaborative approach to improving the quality of services that includes the clinical and administrative leadership, the staff at all levels, patients and members of the hospital family and the community
- Demonstrate public accountability by implementing improvement initiatives that meet the expectations of our patients, regulatory and oversight bodies and other customers
- Maintain or improve the quality of care and services while exercising fiscal responsibility to maintain a strong financial foundation
- Focus improvement efforts on systems and processes rather than people or departments, while maintaining an effective mechanism to identify and correct sentinel events
- Provide the tools and resources necessary to foster an environment where quality improvement is a driving force within the organization.

OUR CORE QI OPERATING TENETS

In support of the Hospital's Mission, Vision and Values, the quality improvement processes and infrastructure is to promote the active engagement and application of the MVV. In addition there are four core operating tenets the QI program aims to apply:

Clinical excellence: We continuously strive to improve clinical outcomes for the patients we serve.

Service excellence: We strive to respond to our internal and external customer's needs in a timely, efficient and professional manner.

Teamwork: We work together as a team to efficiently complete our tasks, striving to eliminate barriers between departments, services, disciplines and job classifications. We will provide improvement teams with the tools and resources necessary to systematically

identify, prioritize, measure, and act upon opportunities for improvement.

Employee & Patient Safety

We promote an environment that fosters safe use of equipment, work processes and the administration of medications in order to ensure safety to our patients and employees
.

QUALITY GOALS AND OBJECTIVES

The following are the goals and objectives of the Quality Improvement Plan:

1) Continually evolve a structure that efficiently and effectively promotes performance improvement throughout the organization.
2) Integrate the improvement efforts of the medical staff, hospital administration, and the hospital staff into a collaborative quality improvement model.
3) Plan and prioritize improvement efforts based on input from our customers, clinical leaders, current research and our own experience over time.
4) Align quality improvement efforts with the organization's mission, vision and values.
5) Use performance measures and quality indicators to evaluate statistically clinical and organizational performance, processes and outcomes. Measures include safety measures, clinical measures, financial efficiency measures and service measures.
6) Maintain a "facts-driven" QI program that systematically monitors important processes and outcomes at the aggregate level while supporting a rigorous sentinel event program that captures events that require root cause analysis, peer review or other corrective action.
7) Develop and adhere to processes that assure compliance with all regulatory and oversight agencies.
8) Provide education, support, consultation and guidance to administration and clinical staff in their monitoring, evaluation and improvement processes.
9) Utilize a systematic approach to performance improvement that prioritizes improvement initiatives.
10) Collaborate with our physician partners to develop mechanisms for monitoring and improving the quality of patient care and organizational functions across the emerging Crouse delivery system.
11) Monitor the effectiveness of the QI program and make revisions as necessary.

PROGRAM METHODOLOGY

Crouse Hospital uses an approach to clinical and service quality improvement that is consistent with scientific principles (PDSA). Our approach has five key processes:

Definition

Measurement of organizational and patient care processes with data collected through quality indicators.

Analysis, assessment and reassessment of the data.

Improvement of care and organizational processes based on the analysis of data.

Control

Crouse Hospital's Quality Improvement Program is based upon data collection and analysis to assess organizational performance in the quality of clinical patient care, the efficiency and effectiveness of the delivery systems and the level of customer service provided during the delivery of those services. Data collection will occur at many levels throughout the organization and on a variety of important functions, but the following organization-wide functions are identified as most important to the delivery of patient care services and achieving desired patient outcomes:

Patient Focused-Functions

- Patient Rights
- Provision of Patient Care, Treatment and Services
- Medication Management
- Surveillance, Prevention and Control of Infections

Organizational Functions

- Improving Organizational Performance
- Leadership
- Management of Environment of Care
- Management of Human Resources
- Management of Information
- Medical Staff

Quality Indicators

Indicators are developed to measure and monitor the performance and stability of processes used in delivering patient care services and the associated outcomes. Indicators measure both processes and outcomes in an objective fashion, based on current knowledge and clinical experience, and may include clinical standards or other applicable professional guidelines. Special attention shall be given to the development of indicators for those processes and/or outcomes which are high risk, high volume, tend to be problem prone, and/or offer opportunities for improvement. The goal of indicator development, data collection and analysis is to quantify the level of performance and stability of processes, to identify areas for performance improvement and to determine if performance improvement initiatives have met their goals.

Quality indicators are established with a hospital-wide (Family of Measures) view, as well as at each performance improvement council, service-line and department level. Panels of indicators are developed at various levels throughout the organization that contain measures of the quality of patient care, the efficiency and effectiveness of the processes used to provide that care and the level of customer service provided internally and/or externally to our customers. Using a panel of indicators to measure these three important dimensions of the delivery system provides a mechanism to gauge the effect improvement efforts in one dimension have on the other two.

In support of the above, the Family of Measures (FOMs) (Appendix A) provide the governing Board, Senior Management, Directors, Managers/Supervisors, Staff, the Medical Staff Executive Committee, the Patient Care Improvement Council, and all performance improvement councils an effective, high level view of the overall performance of the Hospital:

See Appendix A for a complete listing of the Family of Measures.

Data Sources

Data used in the assessment of organizational performance and the quality of care is collected from several sources, including generic occurrence screening, patient events and internal occurrence reports, safety program review, the risk management program, Council minutes, patient/family surveys or the complaint log, employee input, departmental logs, medical records, hospital information systems, financial data/DRG reports, customer service activities, internal databases, and external monitoring reports.

Assessment

Crouse Hospital uses statistically valid, aggregated data to determine causes of process and outcome variation. The assessment of process and outcomes data may include comparing performance to available reference databases, to clinical practice guidelines or practice parameters, to the performance of similar organizations and benchmarks, to the stated objectives of performance for that process, to the expectations of our patients, staff or physicians, to our own performance over time, or to the accreditation or regulatory standards promulgated by oversight agencies. The assessment process is used to identify and prioritize opportunities for improvement. Patterns, trends and opportunities for improvement are identified at both the organizational and at the

department or service level. Data collected through the QI program is analyzed, presented, prioritized and acted upon at several multi disciplinary and interdepartmental forums.

Setting Improvement Opportunities

- The impact on patient safety, care and outcomes
- The impact on customer satisfaction
- The scope and extent of the process in question
- Its relevance to the hospital's mission and strategic plan
- High risk, problem prone process, or one where variation has historically been a problem
- The extent to which the process improvement is a requirement of regulatory or oversight bodies
- Available resources

When the monitoring and statistical analysis of quality indicators reveal that there is an opportunity for process improvement, the decision to act will depend on:Each operational service and coordinating performance improvement council identifies and defines the appropriate performance improvement opportunities within their purview. The Patient Care Improvement Council approves the annual performance improvement goals for the prospective PI councils.

The annual Quality Improvement Summit (also referred to as Annual Management Review) will provide direction and prioritization for high level improvement initiatives. The hospital will continue to focus attention on collaboration with outside agencies to improve the overall delivery of care to all patients. There will also be efforts paid in prioritizing opportunities for improved performance through the examination of relationship between patient demographics, length of stay, and costs in relation to complications. We will continue to examine ways to decrease unplanned readmissions and preventable hospital acquired conditions and complications.

Continued attention will be paid to performance indicators through third party payers and the overall reduction of "never events".

Performance Improvement Model: PDSA

When opportunities for improvement are identified through data collection and analysis, and are subsequently prioritized for action, the PDSA methodology is used to make the improvement. This approach includes the following steps:

Plan an intervention that responds to the analysis of the data
Do a pilot of the intervention
Study the effectiveness of the pilot
Act on the results of the intervention and repeat the PDSA cycle as necessary

- Members from all organizational levels integrate their knowledge and expertise in a collaborative environment.
- Members of one department/service learn how their processes affect other departments or services.

- Educates the entire staff in the quality improvement process and the use of CQI tools and techniques, including statistical process control, and helps ingrain the use of this body of knowledge into the organizational culture.
- Within PDSA is the Six Sigma DMAIC model; a set of tools outlined in five chronological phases:
- **D**efine: Develop a clear project charter that identifies processes to be improved that are relevant to customer needs and that will provide significant benefits to the hospital.
- **M**easure: Determine the baseline and target performance of the process, define key input and output variables and validate the measurement system.
- **A**nalyze: Use data to find the root cause of the problem; to understand and quantify their effect on process performance.
- **I**mprove: Identify process improvements to optimize process outputs and reduce variation.
- **C**ontrol: Document, monitor and assign accountability for sustaining gains made by the process improvements.

The DMAIC approach when combined with PDSA ensures that a standardized approach to process improvement is followed and that the voice of the customer is reflected within the process improvement.

In addition to the PDSA and DMAIC approach, lean healthcare principles will be applied throughout the process redesign. Lean Healthcare includes tools such as:

- Identify and Eliminate Waste:
    1. Overproduction (making extra/unnecessary copies)
    2. Waiting (Equipment, signatures)
    3. Motion (searching for charts/medication
    4. Transport (constantly moving equipment from one place and back)
    5. Over processing (Ordering more test then what is required)
    6. Inventory (Excessive office supplies, medication in excess of usage)
    7. Errors (Redraws, wrong patient, medication errors)

- 5S
    1. Sorting (when in doubt move it out)
    2. Set – items in order (a place for everything and everything in its place)
    3. Shine (clean is lean)
    4. Standardize (reduce variation through standardization)
    5. Sustain through education and communication

These are two tools of many that will focus attention on non value added activities that increase cost and reduce patient satisfaction.

Performance improvement initiatives are conducted at the lowest practical organizational level of involvement and include interdepartmental or multi-disciplinary representation in most instances. This team approach to quality improvement serves several important purposes: Quality improvement teams will establish quality, cost or service targets as appropriate for the improved or redesigned process, establish time

frames for completion and work with leadership to allocate resources for project completion. Opportunities for process improvement identified at the unit, department, or service level, which do not involve other areas, are acted upon using systematic process improvement techniques within the department. Departmental initiatives are prioritized based upon the process's relevance to the department's mission, impact upon patient safety and care or other department-specific factors.

QUALITY IMPROVEMENT STRUCTURE

The structure used to support the quality improvement program reflects Crouse Hospital's commitment to quality and the core values of clinical excellence, service excellence and teamwork. Members of our committees, councils and teams represent diverse departments, services and disciplines throughout the organization. There is a bias for action at each council, committee or team level. The use of the PDSA methodology allows organizational leadership to have confidence in the results of team efforts without imposing layers of bureaucratic checks and balances that may stifle team activity.

- **Oversight** entities are responsible for ensuring that the quality improvement plan is approved and implemented throughout the organization.
- **Coordinating** council supports the functional and service line Councils through leadership, barrier removal, prioritization and allocation of resources.
- **Peer review** entities review individual cases that emerge through the Quality Improvement program that require a determination pertaining to the standard of care delivered. Proceedings of these committees are protected from discovery under 2805m of the New York State Public Health Law.
- **Functional/Service line** councils measure, assess and improve the quality of care and delivery services throughout the organization. These groups function largely as self-directed work teams within the overall framework of the Quality Improvement Plan.

There are four types of Quality or Performance Improvement councils/committees:

See Appendices B & C for the table of organization and descriptions of important committees/councils in the Quality Improvement Structure.

CORRECTIVE ACTIONS-reference Crouse policy (ISO 9001)

In keeping with the goal of achieving organizational excellence by improving existing processes, the primary focus of the Crouse Quality Improvement Program has shifted over time from scrutinizing individual performance to examining the performance of the organization's systems and processes. With that in mind, the following actions may be recommended in the resolution of identified problems:

- Process modification, redesign, or re-engineering
- Implementation of new or revised services, policies, or procedures
- Development of educational programs
- Equipment or facility changes
- Staffing or skill mix changes

- Counseling of individuals
- Modification/limitation or removal of clinical privileges
- Enhanced communication

COMMUNICATION OF RESULTS

Results of process improvement initiatives will be communicated as appropriate throughout the organization in an effort to share ideas, gain a better understanding of relevant processes, encourage collaboration, instill concepts of continuous improvement into the organizational culture, and to stimulate creative and innovative improvement initiatives. The findings, conclusions, recommendations, actions and results of interdepartmental or multi-disciplinary process improvement teams should be reviewed at relevant hospital and departmental meetings.

The Patient Care Improvement Council will receive reports from the councils a minimum of two times per year unless immediate assistance is required in the removal of barriers for improvement. Minutes recording quality improvement activities from any source shall clearly reflect problem identification, corrective action, resolution and follow-up monitoring.

The Quality Improvement Committee of the Board and the Medical Staff Executive Committee will receive, at each of their meetings, an executive summary of the PI Councils' activities and indicators.

STAFF INVOLVEMENT IN PERFORMANCE IMPROVEMENT

Employees at all levels are encouraged to participate in performance and quality improvement activities as appropriate and necessary. Also, staffs are encouraged to participate by offering suggestions and recommendations for quality improvement projects through their involvement in event reviews, performance improvement initiatives, departmental meetings, and other formal and informal means. Staff participating on committees/councils or teams will be provided just-in-time training in the methods and techniques of the adopted improvement methodology (FOCUS-PDSA).

PATIENT AND EMPLOYEE SAFETY

Patient and employee safety are to be a part of all work and clinical performance improvement initiatives. The hospital's patient and employee safety program includes:

- Critical Event Review Process
- Root Cause Analysis Process
- Failure Mode Effects Analysis Process
- Occurrence Reporting Process and Analysis, including NYPORTS
- Safety Performance Improvement Council
- Standards and Review Committee
- PI Infrastructure

Each performance improvement council and hospital department is responsible to review, assess, identify, improve and monitor key patient safety opportunities (including the goals and recommendations set forth by the Joint Commission's National Patient Safety Goals, Agency for Healthcare Research and Quality, and the Institute for Healthcare Improvement) within their realm of responsibility. The Safety Performance Improvement Council provides hospital-wide leadership and coordination to ensure a system's approach for the hospital's patient and employee safety program/efforts.

Patient and employee safety concerns with improvement strategies and results will be communicated to the hospital's Quality Improvement Committee of the Board through the PI infrastructure.

ROLE OF RISK MANAGEMENT

Risk management activities, aimed at loss control activities, are one component of an integrated Quality Improvement Program. The Risk Management Department works in collaboration with the QI Department and the Office of Medical Staff Administration to:

1. assemble information related to negative healthcare outcomes and incidents resulting in injury

2. report the implementation of risk reduction strategies including safety management activities to protect the financial assets of the hospital.

Patterns and trends identified through the measurement and assessment of quality improvement data are reported to the Risk Manager for review from a risk management perspective. Likewise, any patterns or trends of significance identified through the tracking of risk management data are reported to the QI Department.

An annual report providing a synopsis of actions undertaken by Risk Management is submitted to the Quality Improvement Committee of the Board.

CONFIDENTIALITY

In accordance with Subsection 3 of 6527 of the Education Law and 2805(m) of the Public Health Law no proceeding, documentation, records, or Council action related to the performance of medical review, participation in a medical and dental malpractice program, incident reporting or investigation for renewing professional privileges and association shall be subject to disclosure under Article 31 of the civil practice law and rules. Furthermore, no person in attendance at such meetings shall be compelled to testify as to what transpired.

Based on these provisions, the hospital is afforded protection for the confidentiality of information that is directed through the Quality Improvement Program. However, statements made by any person in attendance of such Council meetings and, who is party to an action or proceeding of the subject reviewed, are subject to disclosure in accordance with Section 6527 Education Law and 2805(m) of the Public Health Law. Therefore, quotes and statements by persons in attendance at such meetings shall not be included in minutes.

Access to patient or practitioner specific information is strictly controlled with access afforded only to members of administration, departmental directors, clinical service chiefs and Council chairpersons upon approval of the Chief Medical Officer when specific information is needed to facilitate decisions. Reports and minutes containing this type of specific information are retained in a secure area. All patients will be identified by case number and physicians identification by physician number.

Conflict of Interest

No physician shall be responsible for reviewing his or her own care. When only one physician in a specialty or sub-specialty is on the medical staff, practice will be reviewed within the expertise of the department. If practice is not within the expertise of the department in question, provisions will be made to have cases evaluated by an outside expert in the same medical specialty. This outside review will be arranged when deemed appropriate by the Chief Medical Officer after consultation with the appropriate Chiefs of Clinical Service and/or members of the Peer Review Committee.

ANNUAL PROGRAM EVALUATION objectives, scope, organization and effectiveness of the Crouse Hospital Quality Improvement Program will be evaluated at least annually and revised as necessary. Emphasis will be placed on areas monitored and evaluated, problems/opportunities for improvement identified and acted upon, success of actions taken and improvements made in patient care.

Acknowledgment and Endorsement

Derrick Suehs, Chief Quality Officer	Date
Anthony Scalzo, MD Co-Chair PCIC	Date
Ann Sedore, RN Co-Chair PCIC	Date
Paul Kronenberg, MD Chief Executive Officer	Date
Michael Duffy, MD, President of the Medical Staff	Date
Robert Miron, Chair-Board QI Committee	Date
Chair Crouse Hospital Board	Date

Appendix A: FAMILY OF MEASURES

2012Family of Measures		Important Functions					Dimension of Performance			
Indicator	Frequency	Vision1	Vision 2	Vision 3	Vision 4	Vision 5	Clinical	Service	Safety	Efficiency
SERVICE										
HCAHPS Questions- All Patient Experience (VBP)	Monthly	√					√	√	√	√
Patient Satisfaction: Return without hesitation (Strongly Agree) ED & Prompt Care	Monthly	√					√	√	√	√
Patient Satisfaction: Return without hesitation (Strongly Agree: Inpatient	Monthly	√					√	√	√	√
Patient Satisfaction: Return without hesitation (Strongly Agree) Outpatient Surgery	Monthly	√					√	√	√	√
Patient Satisfaction: Return without hesitation (Strongly Agree) Cardiac Care	Monthly	√					√	√	√	√
Patient Satisfaction: Return without hesitation (Strongly Agree) Radiology	Monthly	√					√	√	√	√
Patient Satisfaction: Return without hesitation (Strongly Agree) KFMC	Monthly	√					√	√	√	√
Patient Satisfaction: Would Recommend without hesitation (Strongly Agree) ED and Prompt Care	Monthly	√					√	√	√	√
Patient Satisfaction: Would Recommend without hesitation (Strongly Agree) Inpatient	Monthly	√					√	√	√	√
Patient Satisfaction: Would Recommend without hesitation	Monthly	√					√	√	√	√

2012Family of Measures		**Important Functions**					**Dimension of Performance**			
Indicator	Frequency	Vision1	Vision 2	Vision 3	Vision 4	Vision 5	Clinical	Service	Safety	Efficiency
(Strongly Agree) Outpatient Surgery										
Patient Satisfaction: Would Recommend without hesitation (Strongly Agree) Cardiac Care	Monthly	√					√	√	√	√
Patient Satisfaction: Would Recommend without hesitation (Strongly Agree) Radiology	Monthly	√					√	√	√	√
Patient Satisfaction: Would Recommend without hesitation (Strongly Agree) KFMC	Monthly	√					√	√	√	√

2012Family of Measures		**Important Functions**					**Dimension of Performance**			
Indicator	Frequency	Vision1	Vision 2	Vision 3	Vision 4	Vision 5	Clinical	Service	Safety	Efficiency
SAFETY										
Patient Falls per 1000 Pt Days	Monthly	√					√		√	√
Staff Lost Work Day Injuries	Monthly		√				√	√	√	√
Med Errors per 1000 Pt Days	Monthly	√				√		√	√	
Overall Absenteeism Rate	Monthly		√					√	√	√
Rookie Departure Rate	Monthly		√					√	√	√
Overall Vacancy Rate	Monthly		√					√	√	√
Overall Staff Termination Rate	Monthly		√					√	√	√
CLINICAL										
Inpatient Mortalities	Monthly	√					√		√	
Restraints	Monthly	√					√		√	√
Nosocomial Resistant Organisms	Monthly	√					√		√	
Central Line Infections	Monthly	√					√		√	
Case Mix Index	Monthly	√					√	√	√	√
Unplanned Readmissions within 30 Days (Adult Medical & Surgical)	Monthly	√			√	√	√		√	√

2012Family of Measures		**Important Functions**					**Dimension of Performance**			
Indicator	Frequency	Vision1	Vision 2	Vision 3	Vision 4	Vision 5	Clinical	Service	Safety	Efficiency
3M PPC UTI, Stroke, Pressure Ulcer, Transfusion/hemorrhage, PE	Monthly	√			√	√	√		√	√
Root Cause Analyses		√		√	√	√		√	√	√
Reportable NYPORTS		√		√	√	√		√	√	√
Wound Infection Knees/Colons NYS DOH	Monthly	√		√	√	√		√	√	√
JCAHO CORE MEASURES										
Acute Myocardial Infarction	Monthly			√			√		√	√
Congestive Heart Failure	Monthly			√			√		√	√
Community Acquired Pneumonia	Monthly			√			√		√	√
Surgical Infection Prevention	Monthly			√			√		√	√
EFFICIENCY										
Cost per Case	Monthly	√			√	√	√	√	√	√
Overall Length of Stay	Monthly	√			√	√	√	√	√	√
Average Medicine Length of Stay	Monthly	√			√	√	√	√	√	√
Average Surgery Length of Stay	Monthly	√			√	√	√	√	√	√

2012Family of Measures		**Important Functions**					**Dimension of Performance**			
Indicator	Frequency	Vision1	Vision 2	Vision 3	Vision 4	Vision 5	Clinical	Service	Safety	Efficiency
Total Admissions	Bi-Weekly					√		√	√	√
Average Daily Census	Bi-Weekly					√		√		√
Total FTEs per Adjusted Occupied Bed	Bi-Weekly		√			√	√		√	√
Gross Revenue	Bi-Weekly					√		√	√	√
Net Patient Revenue	Bi-Weekly					√		√	√	√
Wait Time in ED >6 hours	Monthly	√					√	√	√	√
Total Number ED Diversion Hours	Monthly	√			√		√	√	√	√

Vision Statements:

Service excellence

Anticipating and exceeding expectations of all we serve: our patients and their families, providers, employees, students, volunteers and other partners.

Dynamic work environment

Fostering an environment where all are valued and respected, and passion and opportunities for professional growth are encouraged.

Building on centers of clinical and organizational excellence

Doing the right thing by focusing on evidence-based patient- and family-centered care, a commitment to safety, the importance of learning and our mission, vision and values.

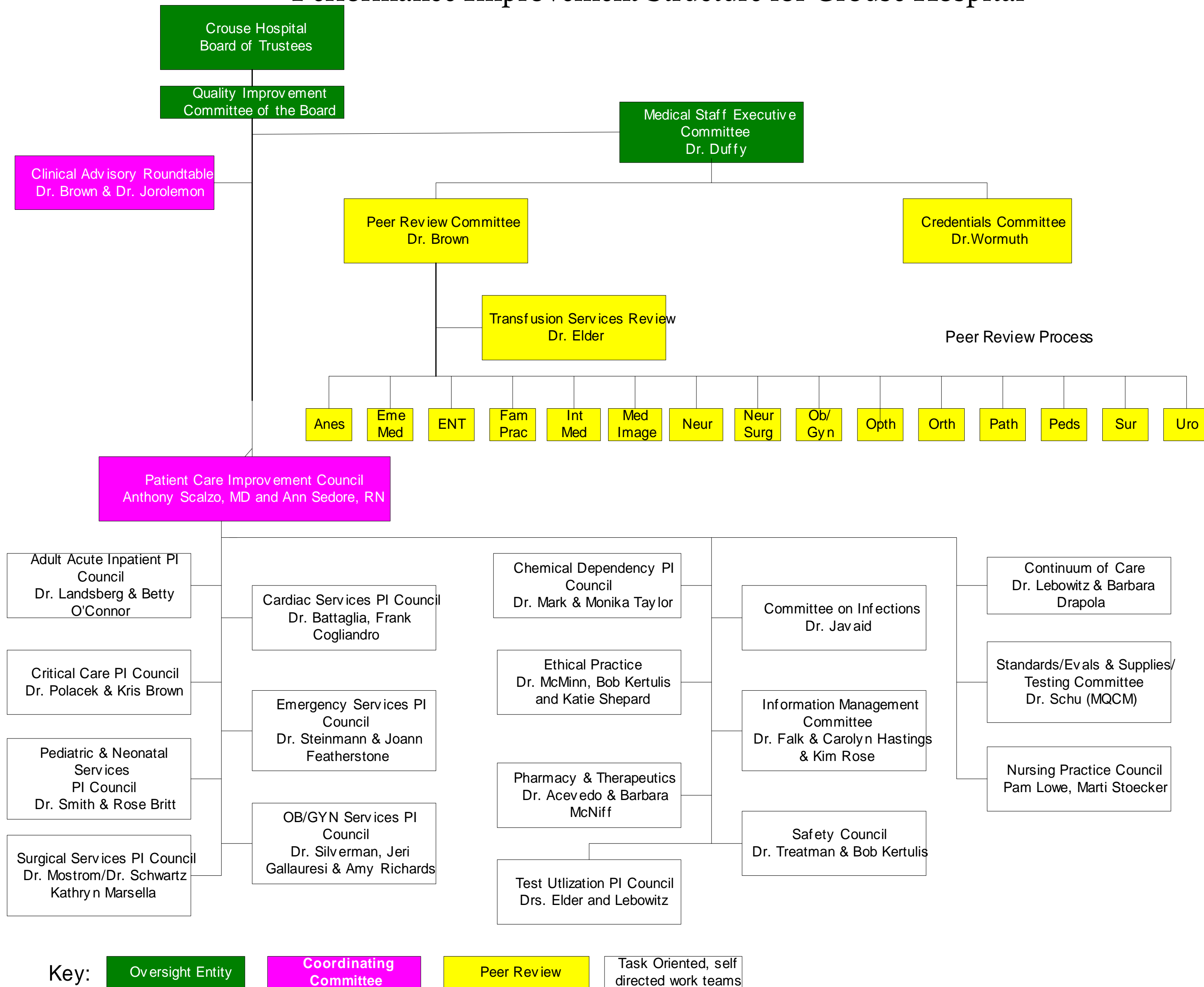
Innovation and collaboration

Building/fostering partnerships to enhance care, meet community need and anticipate the demands of a dynamic healthcare environment.

Financial and resource stewardship

Keeping Crouse strong through the responsible use of financial and human resources.

Performance Improvement Structure for Crouse Hospital



Updated January 16, 2013

APPENDIX C: COUNCIL SUMMARIES

Key Quality Improvement Oversight Councils and their related functions:

OVERSIGHT BODY	ROLE/RESPONSIBILITY	REPORTS TO
Crouse Hospital Board of Trustees Chair: Community leader elected by the Board	Overall accountability for the quality of care provided by Crouse Hospital	External oversight entities and the community
Quality Improvement Committee of the Board Chair: Member of the Crouse Hospital Board of Trustees	To oversee the Quality Improvement program for the Board of Trustees. The committee will accomplish this function through: • Review of reports from Committees within the QI structure on actions taken to improve the quality of care provided by the hospital and medical staff. • Review of reports received from external sources related to the quality of service or patient care provided at Crouse and the follow up actions taken as a result of this monitoring. • Review of reports from the Risk Management and Safety Programs. • The review of data, reports, profiles or information from any organizational source in order to monitor and report on the quality of patient care provided at Crouse to the Hospital Board of Trustees.	Crouse Hospital Board of Trustees
Medical Staff Executive Committee Chair: President of the Crouse Medical Staff	The full committee charge for the Medical Staff Executive Committee is outlined in the Bylaws, Rules and Regulations of the Crouse Medical Staff. Those responsibilities that relate to the quality improvement function can be summarized as follows: • Recommend to the Board of Trustees medical staff appointments, reappointments and changes in category. • Provide medical staff oversight for the QI review activities of the medical staff departments and the committees of the medical staff.	Crouse Hospital Board of Trustees

OVERSIGHT BODY	ROLE/RESPONSIBILITY	REPORTS TO
	• Act upon recommendations from the Medical Care Evaluation Committee, or such other committees as appropriate when questions are raised about the quality of care provided by a staff member. • Review medical staff compliance with standards and regulations imposed through Crouse's participation with the JCAHO, through state or federal agencies or other entities as required.	

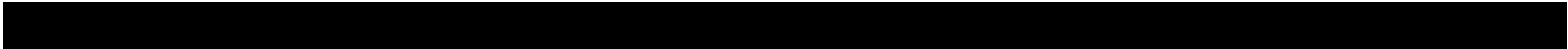
The following Coordinating Council is the clearinghouse for the coordination of all quality and performance improvement activities within the organization.

COORDINATING COUNCIL	ROLE/RESPONSIBILITY	REPORTS TO
Patient Care Improvement Council Co-Chairs: Vice President of the Medical Staff & Chief Nursing Officer	Systematically monitor and improve processes and outcomes associated with the environment of care (safety), infection control, patient's right and organizational ethics, information management, human resource management, the use of medications and regulatory and accreditation compliance. • Measure and improve processes and outcomes associated with the delivery of patient care at Crouse Health • Support the multi disciplinary patient care performance improvement councils through the provision leadership, prioritization, barrier removal and allocation of resources for improvement initiatives • Establish accountability and completion time lines for patient care improvement projects prioritized for action • Provide coordination among patient care improvement councils to eliminate duplication of effort or conflicting goals • Approve and support service line performance improvement councils' annual performance improvement plans.	Medical Staff Exec Committee, QI Committee of the Board

The following medical staff peer review entities are established according to the Constitution and Bylaws of the Medical Staff of Crouse Hospital.

PEER REVIEW BODY	ROLE/RESPONSIBILITY	REPORTS TO
Crouse Hospital Peer Review Committee Chair: Chief Surgical or Medical Quality Officer	Subcommittee of the Medical Staff Executive Committee, as needed. Review all clinical issues where different committee or department chiefs have made conflicting standard of care determinations addressing the same peer review incident. The committee may chose to review patient care or clinical issues referred from the QI department or gleaned from other committee minutes. The committee shall recommend the policies outlining the information to be included in the QI files and coordinate medical staff investigations, including those initiated from inquiries from outside supervisory agencies.	Medical Staff Executive Committee & QI Committee of the Board
Credentials Committee Chair: Senior past president of the medical staff	Investigate the credentials of all applicants and re-applicants for membership on the medical or affiliate staff, review their privileges and make recommendations as to their approval. Make recommendations as to additional privileges for current members of the medical or affiliate staff Investigate anything pertaining to the conduct and practice of the members of the medical staff as referred to it by the Medical Staff Executive Committee.	Medical Staff Executive Committee
Transfusion Services PI Council Chair: Medical Director of Laboratory Services	Establish and implement annual performance improvement plan. Monitor and improve processes and outcomes associated with the use of blood and blood products, including: • Ordering practices • Processes for distribution, handling and dispensing of blood and blood	Peer Review Committee & Patient Care Improvement Council

PEER REVIEW BODY	ROLE/RESPONSIBILITY	REPORTS TO
	components • Administration of blood and blood components • Monitoring blood and blood components effect on patients • Review of all transfusion reactions	



Each of the functional or service line committees/councils listed in this table is responsible for a particular function or the processes and outcomes related to the delivery of services within a service line. Each committee/council is co-chaired by a physician and an administrative member. Where there are more than one key medical staff departments involved in a particular service line (Surgical services include both surgeons and anesthesiologists) a Vice Chair will be appointed. The Vice Chair and Physician Co-Chair will rotate their positions every two years. The Councils are interdisciplinary, as appropriate to the function overseen. Reports are submitted to the appropriate coordinating council on at least a quarterly basis, and each is assigned a liaison from the respective coordinating council to facilitate rapid barrier removal, decision making and clear communication.

Each council/committee develops their own objectives, indicators and measures specific for their service or functions and includes measures of patient safety, clinical quality, cost efficiency and customer service, as appropriate to the function overseen.

FUNCTIONAL or SERVICE-LINE COUNCIL	ROLE/RESPONSIBILITY	REPORTS TO
Continuum of Care Council Co-Chairs: Active Credentialed Member of Medical Staff and Director, Care Coordination	Establish and maintain a Utilization Management Program in a continuous effort to improve the quality of care and services the hospital provides. Develop Standards of Care and written criteria to be utilized in determining the medical necessity of hospital admissions, continued stays and appropriate levels of care. Establish and maintain a mechanism for the review of quality of care issues identified during concurrent review. Analyze patterns of utilization of resources and conduct focused studies and/or	Patient Care Improvement Council

FUNCTIONAL or SERVICE-LINE COUNCIL	ROLE/RESPONSIBILITY	REPORTS TO
	reviews as indicated. Analyze financial and utilization data and trends identifying opportunities and implementing actions for improvement. Increase hospital growth by decreasing the average length of stay optimizing resources and minimizing system delays. Optimize hospital reimbursement through the accurate classification of patient status and level of care assignment. Maintain a proactive denial management program to ensuring appropriate reimbursement for services delivered. Establish and implement annual performance improvement plan.	
Critical Care PI Council Co-Chairs: Medical Director of ICU and Critical Care Nurse Manager	Multi-disciplinary council charged with the measurement, assessment and improvement of processes and outcomes associated with the care provided in the Adult Critical Care Units.	Patient Care Improvement Council
Surgical Services PI Council Co-Chairs: Chief, Dept of Surgery and Surgical Services Manager Vice-Chair: Chief, Dept of Anesthesia	Multi disciplinary council charged with the measurement, assessment and improvement of processes and outcomes associated with the care provided by the inpatient and outpatient Surgical Services. In addition, this council is responsible for the oversight of events surrounding the trauma program. Establish and implement annual performance improvement plan.	Patient Care Improvement Council
Pediatric Services PI Council Co-Chairs: Chief, Dept of Pediatrics and Pediatrics Unit Manager	Multi disciplinary council charged with the measurement, assessment and improvement of processes and outcomes associated with the care provided by the Pediatric and Neonatal Services Establish and implement annual performance improvement plan.	Patient Care Improvement Council
Obstetrics & Gynecology Services PI Council Co-Chairs: Chief, Dept of OB	Multi disciplinary council charged with the measurement, assessment and improvement of processes and outcomes associated with the care provided to the	Patient Care Improvement

FUNCTIONAL or SERVICE-LINE COUNCIL	ROLE/RESPONSIBILITY	REPORTS TO
and WSC nurse managers	patients seeking care under obstetrics and gynecology services. Establish and implement annual performance improvement plan.	Council
Adult Acute Inpatient PI Council Co-Chairs: Chief, Dept of Medicine and Nurse Manager from an Inpatient Med/Surg Unit	Multi disciplinary council charged with the measurement, assessment and improvement of processes and outcomes associated with the care provided by the Adult Acute Inpatient Units. Establish and implement annual performance improvement plan.	Patient Care Improvement Council
Emergency Services PI Council Co-Chairs: Medical Director and Nurse Manager of Emergency Services	Multi disciplinary council charged with the measurement, assessment and improvement of processes and outcomes associated with the care provided by the Emergency Services. Establish and implement annual performance improvement plan.	Patient Care Improvement Council
Cardiac Care PI Council Co-Chairs: Medical Director of Cardiology and Managers of Cardiology Services (Cath Lab and 4N)	Multi-disciplinary council charged with the measurement, assessment and improvement of processes and outcomes associated with the care provided by Cardiology Services. Establish and implement annual performance improvement plan.	Patient Care Improvement Council
Nursing Practice Council Chair: Senior Registered Professional Nurse	To oversee and ensure the appropriateness and standardization of Professional Nursing Practice across the Continuum of Care. Special attention will be paid to • Patient Care Issues • Nursing Practice Standards • Patient Tracking • Regulatory Compliance	Patient Care Improvement Council

FUNCTIONAL or SERVICE-LINE COUNCIL	ROLE/RESPONSIBILITY	REPORTS TO
Safety PI Council Chair: Medical Director, Employee Health and Director of Risk Management	Monitor, asses and improve the processes around the environment of care, including: Patient Safety, Employee and Visitor Safety, Security, Hazardous waste and materials, Emergency preparedness, Life safety, Medical equipment, Utility systems, and coordinate staff orientation and continuous education on the above functions. Establish and implement annual performance improvement plan.	Patient Care Improvement Council
Council on Infections Chair: Medical Director, Infection Prevention	Establish and implement annual performance improvement plan. Key functions include: • Conduct an effective surveillance program for the organization • Identify and reduce the risks of infection for patients, visitors and staff • Analyze infection control data for patterns, trends and rates of infection • Establish risk reduction or prevention strategies • Establish effective infection control mechanisms • Reports, when appropriate, information about infections internally and to public health agencies	Patient Care Improvement Council
Compliance & Ethical Practices PI Council Co-Chairs: Active Member of the Crouse Medical Staff and a Hospital Director/Manager and/or Director of Risk Management	Multi-disciplinary council charged with measurement, assessment and improvement of process and outcomes associated with continual compliance and ethical practices Role/Responsibility Establish and implement annual performance improvement plan. Monitor and improve processes and outcomes associated with… • Maintaining HIPAA Compliance in all areas • Ensuring appropriate Information Access • Documenting/Conducting Security Watches • Reviewing Excluded Providers every 30 days • Organ/Tissue Program • Advanced Directives • Palliative Medicine Consult Data	Patient Care Improvement Council

FUNCTIONAL or SERVICE-LINE COUNCIL	ROLE/RESPONSIBILITY	REPORTS TO
Information Management PI Council Co-Chairs: Active Member of Crouse Medical Staff, Director of Health Information Management & Director of Information Technology	Establish and implement annual performance improvement plan. Monitor and improve processes and outcomes associated with: • Information confidentiality, security and integrity • Medical records management and completion • Information management education • Timeliness and accuracy of data • Patient specific data and information • Discharge and transfer summary information • Medical record documentation requirements Internal information system selection upgrades, implementation and training	Patient Care Improvement Council
Chemical Dependency Performance Improvement (PI) Council Co-Chairs: Medical Director and Director of the Chemical Dependency Treatment Services	Multi disciplinary council charged with the measurement, assessment and improvement of processes and outcomes associated with the care provided in the Chemical Dependency Treatment Services. Establish and implement annual performance improvement plan	Patient Care Improvement Council
Pharmacy and Therapeutics Council Co-Chairs: Active Member of the Crouse Medical Staff and the Director of the Pharmacy	Establish and implement annual performance improvement plan. Monitor and improve processes and outcomes associated with: • Approving and maintaining the formulary • Adverse drug reactions • Medication errors • Preparing and dispensing medications • administration of medications • Monitoring of effects of medication on patients	Patient Care Improvement Council
Test Utilization PI Council Co –Chairs: Active Member of the Medical Staff and a Hospital/Director/Manager	Multi-disciplinary council charged with reducing redundant utilization of testing. Successful implementation of process changes will result in increased safety and patient satisfaction and decreased costs associated with duplicating work. Establish and implement annual performance improvement plan.	Patient Care Improvement Council

FOM	Council	Analyst	Co-Chairs	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
Carey	Continuum of Care	Carey	Lebowitz, Drapola	xx						xx					
	Transfusion Srv PIC	Sigona	Elder, Garritano	xx						xx					
	Test Utilization	Learned	Elder, Garritano	xx						xx					
Dawson	Cardiac Services	Sigona	Battaglia, Cogliandro		xx						xx				
	Chemical Dependency	LeFever	Mark, Taylor, Vincent		xx						xx				
	Council on Infections	Dawson	Javaid		xx						xx				
Johnson	Adult Acute Care	Dawson	Landsberg, O'Connor			xx						xx			
	Clinical Advisory Group	Johnson	Brown, Jorolemon			xx						xx			
	Information Management	Sigona	Falk, Hastings & Rose			xx						xx			
Learned	Obstetrics & Gynecology	Carey	Silverman, Richards, Gallauresi				xx						xx		
	Critical Care	Learned	Polacek, Brown				xx						xx		
	Nursing Practice Council	Dawson	Lowe, Stoecker				xx						xx		
LeFever	Surgical Services	Johnson	Mostrom, Schwartz, Marsella					xx						xx	
	Safety Council	LeFever	Treatman, Kertulis					xx						xx	
	Emergency Services	Learned	Steinmann ,Featherstone					xx						xx	
Sigona	Ethics/Corporate Comp	Dawson	McMinn, Kertulis, Shepard						xx						xx
	Pharmacy & Therapeutics	Learned	Acevedo, McNiff						xx						xx
	Pediatric Services	Carey	Smith, Britt						xx						xx

PCIC meets the third Thursday of every month from 0700-0830 in the Boardroom