Performance Improvement & Safety Plan FY07

I. INTRODUCTION

The Performance Improvement and Safety Plan describes the multidisciplinary, systematic performance improvement framework developed by the University Medical Center to improve patient outcomes and reduce the risks associated with patient safety in a manner that embraces the mission of the hospital.

MISSION

The mission of UMC is to provide superior patient care, which is compassionate and cost effective, and to support and enhance the health education mission of the Medical University of Ohio. In partnership with the university, the hospitals continuously strive to develop and incorporate advancements in health care knowledge to improve the quality of patient care.

VISION

The vision for the Medical University of Ohio is to be a recognized leader in health care education. Through its hospitals, the Medical University of Ohio strives to redefine the standards of excellence in health care through quality, service and teamwork. In pursuit of this vision, UMC is committed to the values of QUALITY of the highest caliber, SERVICE beyond the expected, and TEAMWORK with individuals working together toward a common vision.

General objectives of the FY07Performance Improvement Plan are:

- To identify a framework for defining quality and performance improvement opportunities, implementing actions, and evaluating results.
- To facilitate communication, reporting, and documentation of all performance improvement and patient safety activities to staff, administration and appropriate governing members.
- To focus and coordinate the organization wide performance improvement and patient safety initiatives.
- To achieve the appropriate balance between good outcomes, excellent care and services and costs.
- To enhance effective organizational and clinical decision making
- To promote teamwork and group responsibility in identifying and implementing opportunities for improvement.
- To establish an environment that supports safety, encourages blame free reporting, addresses maintenance and improvement in patient safety issues in every department through out the facility and establishes mechanisms for the disclosure of information related to errors.

II. STRUCTURE

Key employees are responsible for the development and implementation of the Performance Improvement Plan. These individuals, the Hospital Vice President and Executive Director, the Associate Executive Director of Patient Care Services and the Director of Quality and Safety, are joined by the hospital Medical Director to fully represent the spectrum of hospital services. These individuals are supported by a structure of formal and informal committees and/or work groups where the components of the program are defined, implemented, refined and monitored. These work groups are structured around basic tenets of the hospital services, See Diagram - Appendix 2 (Equitable and patient centered care, timely care, effective care, appropriate care, safe care and efficient care). These different groups that consist of physicians, staff and management are represented via a reporting process to the Performance Improvement Council, which acts as the “oversight committee”. The Performance Improvement Council (a Medical Staff Committee comprised of physicians, administrators, and management) reports to and is supported by the Medical Staff Executive Committee which in turn reports to the Clinical Care Committee of the Board of Trustees. Refer to Organization Chart Appendix 1.

III. PERFORMANCE IMPROVEMENT PROCESS

The process for identifying performance improvement initiatives is first, to identify leadership objectives along with regulatory requirements, opportunities identified in external benchmark projects, opportunities identified through analysis of occurrence report data and opportunities identified through sentinel events or "Sentinel Event Alerts". These objectives or topics are then displayed in a matrix to better understand which areas of importance and relevance they cross, (high risk, high volume, problem prone, mission, customer satisfaction, physician satisfaction, clinical outcome, safety, regulatory). See Appendix 4. The priorities of the objectives are defined. Next, work groups or committees define the metrics (indicators, goals and benchmarks) for each topic. Data is then gathered and studied. The work groups discuss data analysis and determine what initiatives must be implemented to attain the desired outcome. Generally, implementation begins and re-measurement occurs with refinement in actions if the desired outcome is not achieved or the outcome is not maintained. Quarterly, reports are submitted to and reviewed by the Quality Department. Annually or more frequent as necessary, the performance is reviewed at the Performance Improvement Council.

IV. PERFORMANCE IMPROVEMENT MODEL

The performance improvement model developed internally and recently adopted by University Medical Centers is the "Plan, Measure, Analyze, Act and Review Quality Cycle". See Appendix 3. This cyclical model incorporates defining the opportunity, identifying the objective, collecting and measuring the data, analyzing performance and comparing with objectives, determining action steps and initiatives as appropriate based on performance, educating and re-measuring. Addressing the model on a quarterly cycle ensures complete exploration of each Performance Improvement topic.

V. CONTENT/SCOPE OF PERFORMANCE IMPROVEMENT PLAN

The Performance Improvement Plan integrates all departments within the organization. Each department links to one of the main topics defined for improvement. All departments develop annual objectives to address and support improvement of the care, treatment, service and safety outcomes that align with the University Medical Center mission. These objectives become the essence of the Performance Improvement activities organization-wide. See Appendix 6 Performance Improvement Plan Activity Grid.

The Performance Improvement topics established for Fiscal year 2006 are as follows:

Improve Access to Care
- Peri-operative Services
- Emergency Department
- Ambulatory Clinic

Improve Resource Utilization
- Reduce Length of Stay
- Reduce readmissions

Improve Patient Satisfaction
- Acute Care
- Emergency Department
- Outpatient Surgery
- Ambulatory Care
- Rehabilitation
- Behavioral Health

Reduce Infection Rates for Ventilator Associated Pneumonias, Central line bacteremias and Urinary Tract Infections
- Compliance with VAP bundle
- Compliance with Central Line Bundle
- Hand-washing surveillance/performance

Monitor Compliance with 2006 National Patient Safety Goals
- Develop and implement patient hand-off process

- Develop and implement medication reconciliation process
- Institute labeling of medications on and off the sterile field

Monitor external regulatory compliance indicators
- Core Measures
- Restraints
- Falls
- Medication Errors
- Adverse Drug Reactions
- Blood Utilization (Transfusion Reactions)
- Pain
- Safety in the environment
- Resuscitation
- Staffing effectiveness
- Organ conversion rates
- Operative/Invasive procedures
- Occurrence report trends
- Sedation Analgesia
- Seclusion
- Behavioral Management and Treatment
- Mortality and Autopsy
- Hazard Management
- Operative Diagnosis Concurrence

Unusual Changes or Events

The Performance Improvement Plan is flexible to accommodate significant services changes, structure changes, unusual events or other similar elements. Objectives and topics can be introduced at any time to be prioritized and included in the scope of the Performance Improvement Plan.

Safety

The patient safety program is integrated with all quality and performance improvement activities. It encompasses risk assessment and avoidance tactics such as choosing complex process, conducting "Failure Mode Effect Analysis" and instituting corrective activities based on the findings.

The safety program proactively institutes action plans based on findings from the "Sentinel Event Alert" documentation which is provided periodically by the Joint Commission on Accreditation of Health Care Organizations. Use of this resource for initiatives is another proactive approach to patient safety.

All occurrence reporting data are used in the safety program to track and trend or initiate activities that address process, system, protocol or equipment events. This includes near miss occurrences as well as findings from adverse events. As the entire organization reports occurrence data this component integrates all departments to the safety program.

Lastly, all developments from Root Cause Analysis activities including those from Sentinel Events are implemented and monitored through the safety program.

VI. OVERSIGHT AND SHARING OF INFORMATION

As part of the oversight process, the performance improvement initiative information flows from the work groups and committees to the Performance Improvement Council, with a selected Quality Indicator report distributed to the Medical Staff Executive Committee and ultimately to the Clinical Care Committee of the Board of Trustees. Through this process an annual review of the entire Performance Improvement and Safety Plan content and results occurs. The various duties of these oversight committees are further defined below:

1. The Board of Trustees of the Medical University of Ohio establishes, maintains, supports, and exercises oversight of the performance improvement function of UMC. The Board of Trustees fulfills its responsibilities related to the performance improvement and safety functions through the specific activities

and interactions of its Clinical Care Committee with the Hospital Administrative Services staff (HAS) and with the medical staff.

2. The Clinical Care Committee of the Board of Trustees reviews and provides feedback related to the Performance Improvement Report submitted to the committee and the Board of Trustees. The Clinical Care Committee also makes recommendations related to the provision of necessary financial resources and training to maintain and enhance the performance improvement and safety program and initiatives.

3. The Executive Committee of the Medical Staff provides oversight and support to the medical staff committees, oversees medical staff by-law functions, credentialing process, and reviews contracts for outside clinical services.

Additionally, as a mechanism to share performance improvement activities with institution staff and visitors, the following activities also take place:

- Departmental in-services on special Performance improvement topics
- Lectures and presentations to students and residents
- Articles in online communications (The Monitor) and newsletters (Pulse)
- Booth and Story Board displays in common facility areas on high emphasis topics
- An annual Performance Improvement Fair is held and is a forum to display organizational performance improvement initiatives implemented throughout the year.
- Reports of clinical data distributed to the Executive Committee of the Medical Staff, members of management and leadership teams and the Hospital Administration Staff.

VII. RESOURCES

The Quality Management Department supports and facilitates ongoing organizational performance improvement and patient safety activities. Resources within the Quality Management Department are provided to assist hospital staff and physicians with identification of appropriate data resources, retrieval of data, development and coordination of performance improvement activities and analysis of data to support and evaluate performance improvement efforts.

The primary functions of this department include:

- Monitoring regulatory standards compliance data
- Clinical data management and analysis
- Quality and performance improvement training and education
- Quality and performance improvement reporting to the Board of Trustees and to other key groups in the organization
- Coordination of internal and external databases that are used for PI projects or quality data analysis (see Appendix 5)
- Dissemination of occurrence report data to departments, Performance Improvement Council and other key groups in the organization and resolution coordination as needed;
- Occurrence report tracking and analysis
- Coordination of root cause analysis for sentinel events and other occurrences requiring intense analysis
- Coordination of Action Plans related to sentinel events or failure mode effect analysis (FMEA) projects;
- Performance improvement project initiation relative to issues found in occurrence reports;
- Process or procedure modifications related to findings from occurrence report trends and/or FMEA projects.

VIII. SUMMARY

The Performance Improvement and Safety Plan provides the framework for the University Medical Center to implement performance improvement activities. These activities improve patient outcomes and patient safety in a comprehensive, methodical and systematic manner and compliment the Hospital Plan for the Provision of Collaborative Patient Care Services.

IX. IMMUNITY/CONFIDENTIALITY CLAUSES

The Performance Improvement Council is the Medical University of Ohio's quality assurance committee as referenced in the Ohio Revised Code. Those sections of the Ohio Revised Code pertaining to immunity and confidentiality apply to the Performance Improvement Council.

A. Ohio Revised Code §2305.24

> Any information, data, reports, or records made available to a quality assurance committee or utilization committee of a hospital…shall be confidential and shall be used by the committee and the committee members only in the exercise of the proper functions of the committee.

B. Ohio Revised Code §2305.251

> No health care entity shall be liable in damages to any person for any acts, omissions, decisions, or other conduct within the scope of the functions of a peer review committee of the health care entity. No individual who is a member of or works for or on behalf of a peer review committee of a health care entity shall be liable in damages to any person for any acts, omissions, decisions, or other conduct within the scope of the functions of the peer review committee.

Adopted by the Clinical Care Committee of the Board of Trustees of the Medical University of Ohio/University Medical Center on._____.

Original Date: 9/87
Revised:
Utilization Management Plan 4/90
Quality Assessment Plan 6/90
Quality Assessment and Improvement Plan 7/92
Patient Care and Service Improvement Plan 1/93
Quality Improvement Plan 1/94
Quality Improvement Plan 1/95
Quality Improvement Plan 1/96
Quality Improvement Plan 1/97
Quality Improvement Plan 1/98
Quality Improvement Plan 1/99
Performance Improvement Plan 4/99
Performance Improvement Plan 6/99
Performance Improvement Plan 9/00
Performance Improvement Plan 3/02
Performance Improvement Plan 5/03
Performance Improvement Plan 12/04

_____
Mark Chastang
Vice President and Executive Director

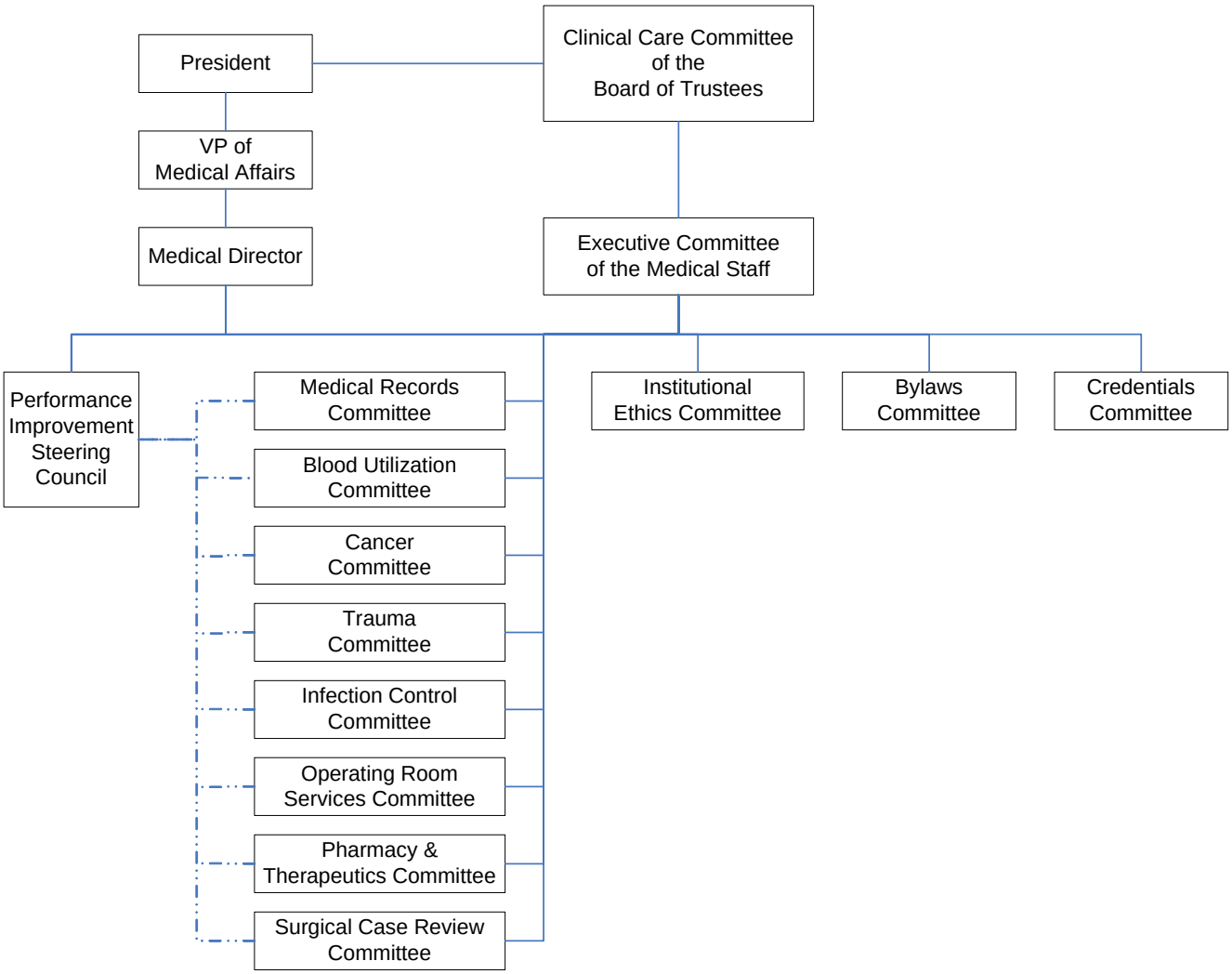
_____
Ronald McGinnis, MD
Medical Director

_____
Deepak Malhotra, MD
Chief of Staff

_____
Nancy Moody
Chairman, Clinical Care Committee

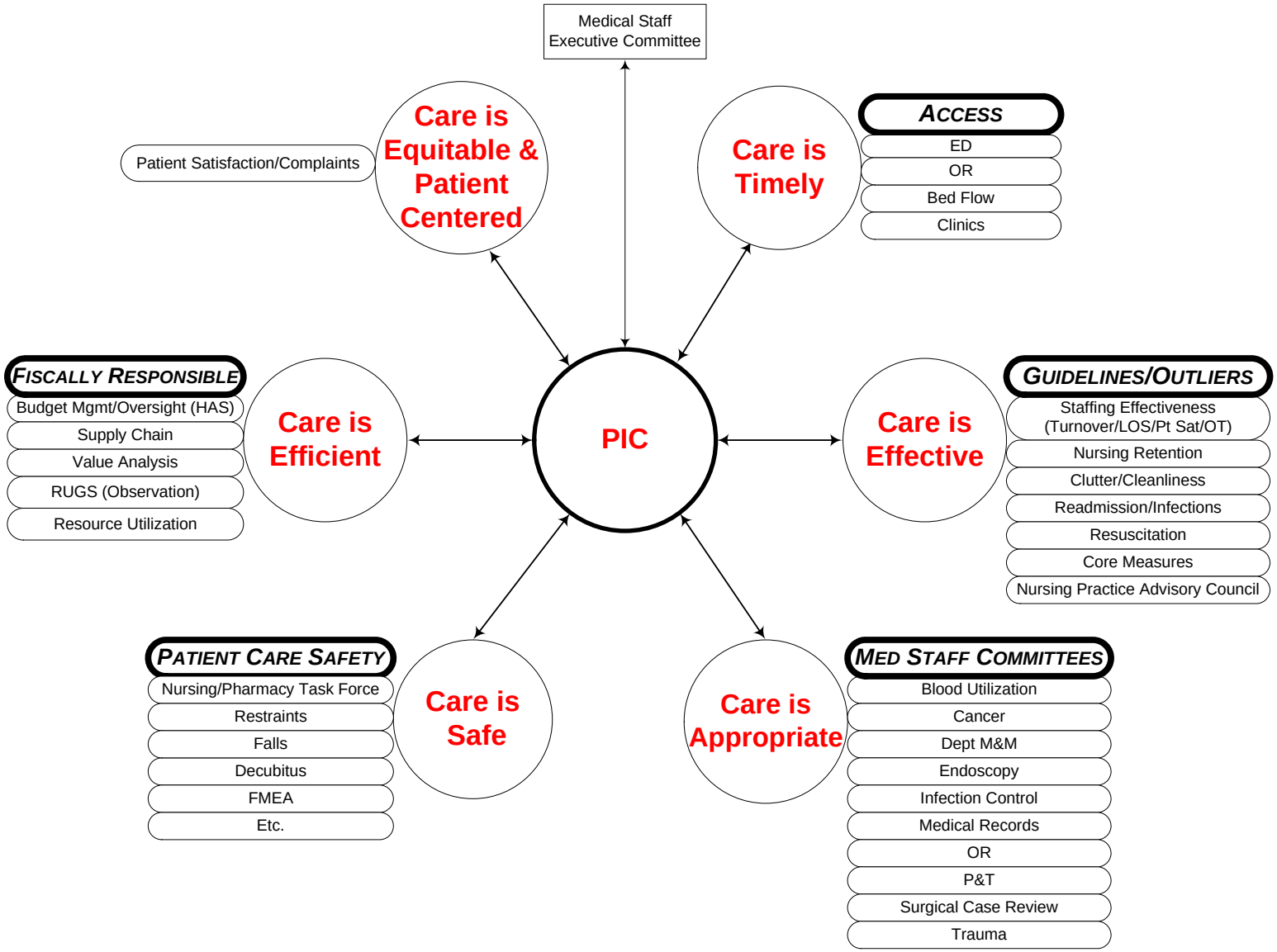
Appendix 1

Organization Framework


President
Clinical Care Committee of the Board of Trustees
VP of Medical Affairs
Medical Director
Executive Committee of the Medical Staff
Performance Improvement Steering Council
Medical Records Committee
Blood Utilization Committee
Cancer Committee
Trauma Committee
Infection Control Committee
Operating Room Services Committee
Pharmacy & Therapeutics Committee
Surgical Case Review Committee
Institutional Ethics Committee
Bylaws Committee
Credentials Committee

Appendix 2
Flow of Performance Improvement and Safety Flow of Information

PI Initiative: Care and Safety Oversight



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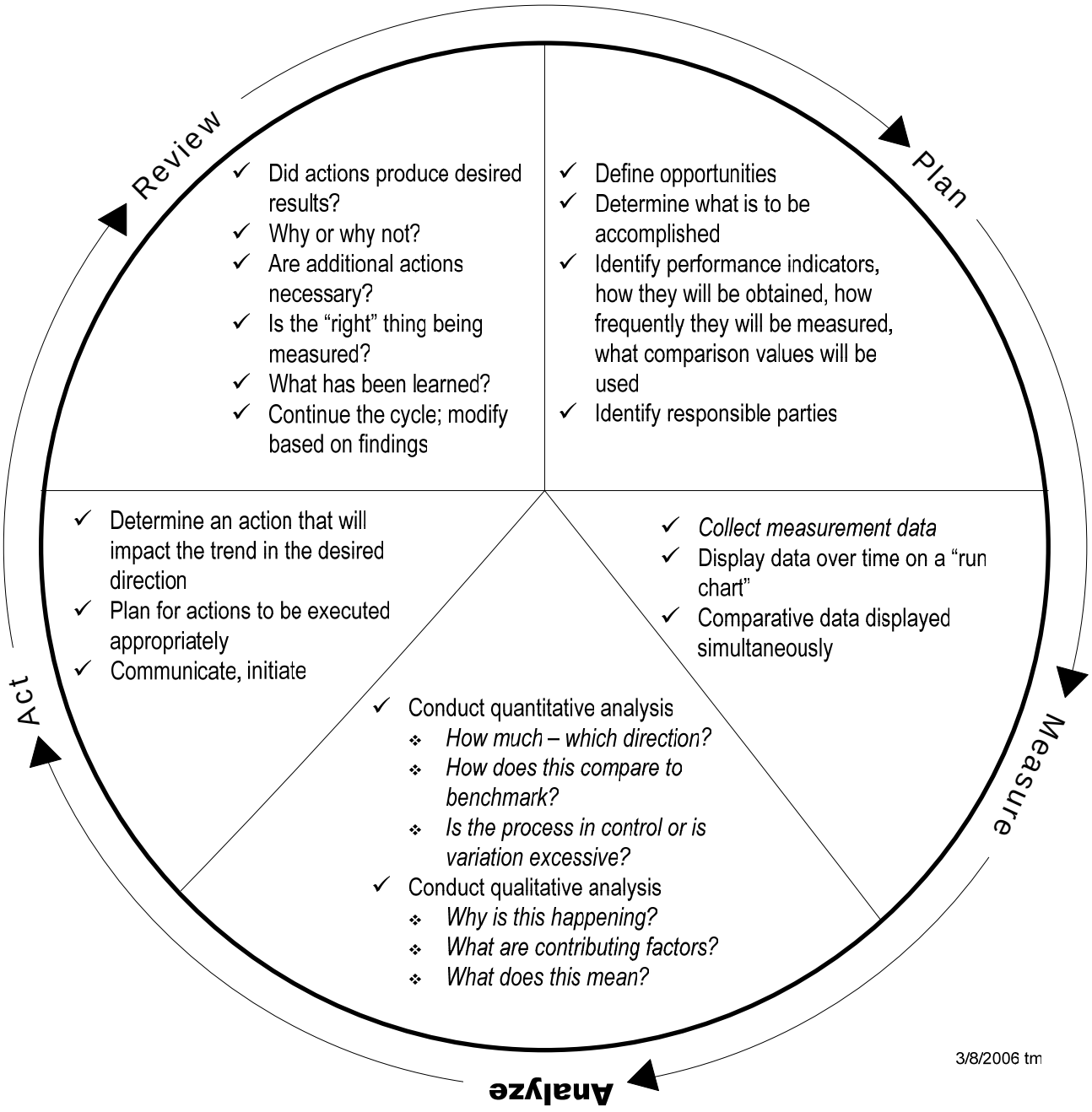
Appendix 3

Performance Improvement Model and Process

PMAAR
Performance Improvement Cycle



PERFORMANCE IMPROVEMENT QUARTERLY REPORT
THE PMAAR QUALITY CYCLE

Team/Disciplines: _____

Plan: (Define your work using priorities from the Performance Improvement Annual Plan or issues identified as impacting important outcomes of care, treatment or service. Determine what is to be accomplished, what indicators will be used, how they will be obtained, where the benchmarks and other comparative data will come from, how frequently monitoring will occur and who are the responsible parties.)

Measure: (Use existing data where possible. Indicators should reflect the issue at hand. Display the data over time, on a "run chart" and against a comparative, an internal or external goal or benchmark.)

Analyze: (Conduct quantitative and qualitative analysis. Quantitative: Which way is the experience moving - up down or static over time? Is this desirable or undesirable? Is the process in control, or does it have lots of variation? Is this special cause variation? How does the experience compare to the Goal or Benchmark. Qualitative: Why is this happening? (Consider all reasons) How do I know for sure? What are the contributing factors? What does this mean?)

Act: (Determine an action or actions that will impact the trend in the desirable direction. Invent, brainstorm, and cogitate. Plan for the actions to be carried out appropriately; communicate, assign responsibility and effective dates)

Review: (A successful intervention should cause a noticeable change in the experience within a reasonable period of time. Are the actions attaining the desired results? If yes, are additional actions needed? What will it take to sustain improvements? If no, was enough time allowed? Are additional actions necessary? Is the "right" thing being measured? Should this continue to be measured? Should another indicator be introduced? What has been learned? Continue and or modify based on how these questions have been answered)

Contact Person Completing Form: _____Dept._____

Return completed form to Quality Management, Room 2216, Dowling Hall.

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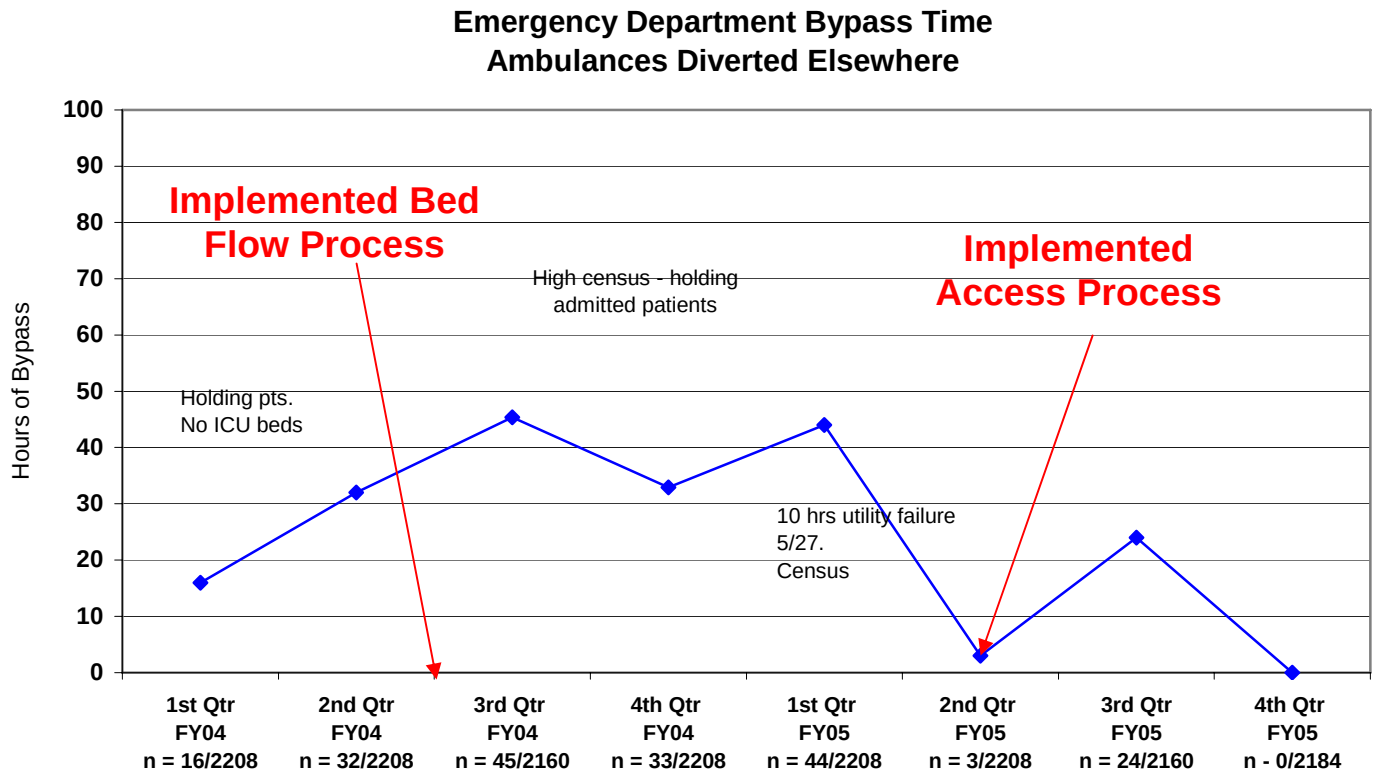
Emergency Department Bypass Time
Ambulances Diverted Elsewhere
Hours of Bypass
100
90
80
70
60
50
40
30
20
10
0
Implemented Bed Flow Process
Implemented Access Process
High census - holding admitted patients
Holding pts.
No ICU beds
10 hrs utility failure 5/27.
Census
1st Qtr FY04 n = 16/2208
2nd Qtr FY04 n = 32/2208
3rd Qtr FY04 n = 45/2160
4th Qtr FY04 n = 33/2208
1st Qtr FY05 n = 44/2208
2nd Qtr FY05 n = 3/2208
3rd Qtr FY05 n = 24/2160
4th Qtr FY05 n - 0/2184

Appendix 4

Annual Departmental and Hospital Goals

PRIORITIZATION MATRIX - FY2006

PI/Safety Goals

Opportunity	High Risk	High Volume	Problem Prone	Important to Mission	Customer Satisfaction	Staff Satisfaction	Physician Satisfaction	Clinical Outcome	Safety	Regulatory Requirement
Access to Care				✓						
Bed Flow			✓							
ED		✓	✓		✓				✓	
Lab				✓	✓					
OR	✓		✓				✓			
Radiology				✓	✓					
Customer Satisfaction Return to UMC				✓	✓					
Guidelines Utilization		✓		✓				✓	✓	
Wait Times – Ambulatory		✓	✓	✓	✓	✓	✓			
Transplant	✓		✓	✓			✓	✓		

Required PI Task Forces

Opportunity	High Risk	High Volume	Problem Prone	Important to Mission	Customer Satisfaction	Staff Satisfaction	Physician Satisfaction	Clinical Outcome	Safety	Regulatory Requirement
Resuscitation	✓							✓	✓	✓
Sedation/Analgesia	✓							✓	✓	
Pain		✓		✓	✓			✓	✓	
Resource Utilization Group				✓						✓
CORE Measures			✓	✓				✓		✓
Staffing Effectiveness			✓	✓						✓
Adverse Drug Reaction	✓		✓	✓					✓	
Organ Conversion				✓						✓

Safety Initiatives

Opportunity	High Risk	High Volume	Problem Prone	Important to Mission	Customer Satisfaction	Staff Satisfaction	Physician Satisfaction	Clinical Outcome	Safety	Regulatory Requirement
↓ med error		✓						✓	✓	
Restraint Free Environment					✓			✓	✓	✓
Reduce falls (Fall Task Force)			✓	✓	✓			✓	✓	
Universal Protocol	✓								✓	✓
Blood Utilization	✓			✓					✓	
Surgical Case Review	✓							✓	✓	
Infection Control	✓			✓				✓	✓	
National Patient Safety Goals	✓		✓	✓	✓			✓	✓	✓
Hazard Mgmt/Safety	✓		✓	✓		✓			✓	✓

Appendix 5

Internal and External Databases

	Source	Patient Population	Types of Data Elements	Available Level of Aggregation	Severity Adjustment Available
Internal Clinical Data					
HBOC Patient Management Medical Record Abstract SQL Report Writer	Hospital HBOC	Inpatient Outpatient	Pt Demographics DRG Dx/Px Codes Attending MD Proc MD Unit Info (Inaccurate) Billing Details Charges Est Reimburse Discharge Date/Disp	Patient	DRG
Financial Modeling Cost Accounting Product Management Patient Care Management	HBOC Trendstar	Inpatient Outpatient	Pt Demographics DRG Dx/Px Codes Attending MD Proc MD Unit Info Billing Details Costs Charges Est Reimburse Discharge Date/Disp	Patient	DRG
Patient Management	HBOC Outcomes Advisor	Inpatient Outpatient	Pt Demographics DRG Dx/Px Codes Attending MD Proc MD Unit Info Billing Details Costs Charges Est Reimburse Discharge Date/Disp	Patient	DRG
Patient Management	HBOC Care Manager	Inpatient Outpatient	Pt Demographics Lab Radiology Orders Unit Info	Patient	No
Infection Control	AICE	Inpatient	Patient Demographics Clinical Variables Microbiology Results Surgical Information Clinical Outcomes User Defined Fields	Patient	NNIS Class
Trauma One	Lancet	Inpatient	Patient Demographics Process of Care Details (e.g. Accident scene, transport, emergency care) Clinical Diagnostic Data (lab, x-ray) IP Dx and Px, Comp and Comorb Functional Data (self-care status) Quality Filters (41)	Patient	TISS Score Glasgow Coma Score Risk Codes
Tumor Registry		Inpatient and Outpatient Oncology			

	Source	Patient Population	Types of Data Elements	Available Level of Aggregation	Severity Adjustment Available
Financial Modeling Cost Accounting Product Management Patient Care Management	HCm	Inpatient Outpatient	Patient Demographics Physician Info (Attending, Consults) Medical History Clinical Data (vitals, lab) Dx and Px Medications Complications	Patient	DRG
Cardiothoracic Surgery	Axis PATS STS	Inpatient Outpatient (30 days post-discharge)	Pt Demographics Medical Hx Medications Clinical Data (lab) Operative Data CPB Data Post-op Complications Readmission Mortality	Patient	ASA CCS NYHA
Cardiac Catheterization	Axis PATS ACC	Inpatient Outpatient	Patient Demographics Cardiac Hx and Risk Factors Cardiac Meds Diagnostic Data (% stenosis, EF) Interventional Data with Outcome Complications	Patient	No
Heart Transplant	Axis PATS	Inpatient Outpatient Longterm follow-up on specific patient outcomes.	Pt Demographics UNOS Information Clinical Data Selected Outcomes	Patient	No
Risk Master	Dorn	Inpatient Outpatient Employees Visitors	Occurance Reports Workman's Comp Liability Claims	Patient Employee Visitor	No
Cardiac Services	MAC-based user designed. Filemaker Pro ACC	Outpatient		Patient	
OR Services	Orbit	Inpatient Outpatient		Patient	No
Renal Services	Axis PATS	Inpatient Outpatient		Patient	No
Stroke Team	Paper log.	Inpatient		Patient	No
Rehab Services	Paper log.	Inpatient		Patient	No
Liver and Pancreas Transplant Services	Axis PATS	Inpatient		Patient	No
External Clinical Data					
UHC Clinical Database	Every 3 months via IS download.	Inpatient All Payer	Mortality LOS Costs Utilization Pct Core Measures	DRG	DRGs Combination of RDRG and UCP (UHC Complication Profiler) Observed vs. Expected Outcomes (Regression Model)

	Source	Patient Population	Types of Data Elements	Available Level of Aggregation	Severity Adjustment Available
OHA Northwestern Ohio Inpatient Origin	Annual (Obtained from HCFA data and Non-Governmental Price Disclosure) "Decide"	Inpatient	Hosp Code Pt Days Pt Age, Sex, Zip, and County Admit Date/Source/Type Primary Payer DRG, RDRG, MDC Dx (Prin + 2 Sec) Px (Prin + 2 Sec) Total Charges Disch Date/Status DOB PL	ICD9 Dx/Px	RDRG
OHA Ambulatory Surgery Database	Annual (Obtained from HCFA data and Non-Governmental Price Disclosure)	Outpatient	Hosp ID PL Dx (Prin + 2) Px (Prin + 5) Pt Zip, County, Age, Sex Payer OP Charges Admit Date/Source/Type Discharge Status HCPCS Code (up to 5) APG (up to 5) MAPG Category Code	ICD9 Dx/Px	APG
UHC Benchmarking Projects	Ad hoc projects	Inpatient	Patient Demographics Extensive Clinical Data Inpatient Clinical Outcomes	Patient	No
NRC Patient Satisfaction	Quarterly	Inpatient Outpatient Clinics Outpatient Surgery Rehab Emergency Care	Overall Satisfaction Score Subscale Scores Selected Patient Demographic Data		No
Frontpath Continuous Quality Improvement Program	Annual	Inpatient	LOS Charge Mortality	Service Line	APR-DRGs
HBSI Operations Improvement	Quarterly	N/A	Departmental Hours Workload Data Costs	Department	N/A

Appendix 6
Performance Improvement Documentation

MEDICAL UNIVERSITY OF OHIO
UNIVERSITY MEDICAL CENTER

FY06 Performance Improvement Plan -- 1st Quarter Update

Area	Initiative	Indicator	Measurement	Status	Physician/ Administrative Sponsor	Project Leader
Improve Access to Care: (Patient Experience, Safety)						
PERIOPERATIVE SERVICES	Clean Case SSI Below Rate Of 1.	Surgical Site Infections	#Clean Case Infections/#Clean Cases		Norma Tomlinson Dr. Senagore	Marge McFadden Sandy Hensley
	Open Tray Sterilization Cycles in OR Below __ %	Open Tray Cycles	#Open Tray Cycles in OR/closed tray cycles in CS and OR			
	Increase Prophylactic Antibiotic Use To 100% When Indicated	Prophylactic Antibiotic Use for Selected Cases	#Cases Antibiotics Given Within One Hour Of Incision/ # Cases Indicated			
	80% On Time Starts – Inpatients 90% On Time Starts - Ambulatory	On Time Starts	# First Case On Time Starts/ # First Cases			
	Reduce Same Day Cancellations To 4% Inpatient	Same Day Cancellations	# Same Day Cancellations/ Total Cases/Month			
	Reduce Same Day Cancellations to 2% Ambulatory					
	Equipment availability	Equipment availability	# Incomplete Surgical Trays/Month			
EMERGENCY DEPARTMENT	PLWBS =or < 1%	Access patient satisfaction	# Patients Left Without Service/Total # Of Patients		Dr. Brickman	Diane Smith
	Door to treatment within 30 minutes 95%		# Pts Seen By Physician With In 30 Minutes Of Arrival To Ed/Month			
	2 hours to admit 95%		# Pts Admitted Within 2 Hours From Time Decision Made To Admit To Admission/ Total # Patients Admitted			
	2 hours to treat and release 50%		# Pts Treated And Released Within 2 Hours/ # Pts Treated And Released			
	Diversion less than 25 hours per quarter Time ED arrival to time to floor < 4 hours		# Hours ED Closed And On Diversion/Month Time ED arrival to time of floor arrival if admitted			
AMBULATORY CLINIC	Reduce days to new appointment to 5 days in selected clinics Ortho, Surv, Vasc, ENT, Neuro GIM, Family Medicine, Psych, Peds	Days to new patient appointment	# Days To New Appt By Clinic		Dr. McGinnis Marge McFadden Vickie Geha	
	Reduce Patient No Shows to 10%	No shows	# No Shows/Total Patients Scheduled			
	Reduce clinic cancellations by MD to 5%	Clinic cancellations	# MD Cancels/ # Total Patients Scheduled			
	Increase the # of new patients seen by 25%	Percentage of new pts seen	# New Pts Seen/Total Pts Seen X100			
IMPROVE RESOURCE UTILIZATION (Pt. Exp., Safety)	Decrease avoidable days to 30/month	# Avoidable days	# Avoidable Days/Month		Norma Tomlinson Dr. McGinnis	
	Reduce LOS to average of 5.0 days	Monthly LOS	Avg LOS Acute Care/Month			
	Decrease LOS to CMI Ratio to 2.5	LOS to CMI Ratio	Avg Acute Care Los/Monthly Case Mix Index			
	Decrease patients with LOS >9 days to 10.	Pts with LOS >9 days	# Pts. Los>9 Days/Month			

Area	Initiative	Indicator	Measurement	Status	Physician/ Administrative Sponsor	Project Leader
	reduce readmissions to 5%	readmissions	# Readmissions Within 3 & 7 Days/Total Admissions			
IMPROVE PATIENT SATISFACTION	Satisfaction Scores – Problems scores to be below NRC benchmark in each of the areas. Goal to be at the 90th percentile (Patient Experience) Acute Care ED OPS Ambulatory Clinics Rehab	NRC Picker data percentage of patients rating overall problem score	Patients rating overall problem scoreUMC/surveys returned		Mark Chastang	Kelly Kunz
REDUCE INFECTION RATES	VAP below rate of 5.0	SICU and MCCU Ventilator Associated pneumonias and Central line bacteremias Urinary Tract Infections	# Vap/#Ventilator Days		M. McFadden	Sandy Hensley
	Central Line Bacteremias below rate of 3		# Central Line Bacteremias/ # Central Line Days			
	UTI for ICU below NNIS of 2.25		# UTI/ Foley Catheter Days In ICU			
	UTI for med/surg below rate of 3		# UTI/Patient Days In Med/Surg/Rehab			
	UTI for Rehab below rate of 5		# UTI/Patient Days In Rehab			
	Monitor compliance with 2006 National Patient Safety Goals (Safety) 100% compliance with NPSG	Implement approach to hand off communications Kardex Compliance 90%	Number of required Kardex items updated from orders/18 x number of charts reviewed per month		Dr. McGinnis L. Oakes	Mike Allison Chad Tuckerman
		Implement process for reconciling medications across the continuum of care % Unreconciled Medications during admission	# Medications on HMR at admission but not ordered on admission and not explained /Medications on HMR upon admission			
		Label all medications on & off sterile field	# Medications Labeled In OR/# Medications Reviewed			
BEHAVIORAL HEALTH	Inpatient: 100% patient/family participation in treatment plan. Satisfaction at 95% for meets or exceeds	Patient and family participation in treatment plan customer service	# Families On ITP/ # Total Patients		Vicki Geha	Kathy Boyk Karen Price
	PHP: Decrease clinical holds to below FY 05 monthly holds.	Clinical holds	Total # Holds/Pt Days X100			
	Geri psych: 90% or better on patient satisfaction for would you recommend.	patient satisfaction	Patient Satisfaction Score/ Possible Score X100.			
External Indicators (Safety)						
CORE MEASURES	Achieve 90% compliance with all indicators Acute MI, CHF, Pneumonia	Acute MI	Smoking Cessation Advice/# Pts Who Smoked Within Previous Year.		L. Oakes	Libby Sorosiak

Area	Initiative	Indicator	Measurement	Status	Physician/ Administrative Sponsor	Project Leader
			Aspirin Administered Within 24 Hours Before Or After Arrival To Hospital/ Cases Reviewed			
			Aspirin Prescribed At Discharge/Cases Reviewed			
			Ace Inhibitors Or ARB Prescribed At Discharge For LVSD/Cases Reviewed			
			Beta Blocker Within 24 Hours After Arrival/ Cases Reviewed			
			Beta Blocker At Discharge / Cases Reviewed Inpatient Mortality Rate Compared To Expected Time From Ed Arrival To PTCA			
		CHF	Complete Set Of Discharge Instructions/ Cases Reviewed			
			Left Ventricular Function Assessment/ Cases Reviewed			
			Smoking Cessation Advice/ # Patients Who Smoked Within Previous Year.			
			Ace Inhibitors Or ARB At Discharge For Lvh/ Cases Reviewed			
		Pneumonia	Oxygenation Assessment Within 24 Hours Of Hospital Arrival /Cases Reviewed			
			Pneumococcal Screening And/Or Vaccination/ Cases Reviewed			
			Blood Cultures Drawn Before Antibiotics/ # Patients Reviewed			
			Smoking Cessation Advice/ # Patients Who Smoked Within Previous Year.			
			# Pts Received Antibiotics Within 4 Hours/Cases Reviewed			
			# Pts Who Received Antibiotics Within 8 Hours/ Cases Reviewed			
			Influenza Screen/Vaccination/ Cases Reviewed (Oct-March Only)			
SEDATION	100% free from inappropriate use of reversal agents		Sedated patients free from reversal agents/ sedation charts reviewed			Mary Ann Dimick
RESTRAINTS	Child seclusion at or below Benchmark of 2	Child Seclusion	# Child Seclusion Events/Total Pt Days X100		Vicki Geha	Kathy Benninghoff
	Adolescent seclusion at or below benchmark of 1	Adolescent Seclusion	#Adolescent Seclusion Events/Total Pt Days X100			
	Child restraint at or below benchmark of 2	Child Restraints	# Child Restraint Events/Total Pt Days X100			
	Adolescent restraint at or below benchmark of 1	Adolescent Restraints	# Adolescent Restraint Events/Total Pt Days X100			
	Geripsych restraint benchmark of 0	Geri Psych	# Geri Psych Events/ Total Pt Days X100			

Area	Initiative	Indicator	Measurement	Status	Physician/ Administrative Sponsor	Project Leader
	Med/surg restraints at or below benchmark of 3.4	Med/Surg	# Med/Surg Events/Total Pt Days X100			
			# Correct Elements Documented/Total Number Charts Reviewed X100			
	Rehab restraint at or below benchmark of 3.4	Rehab	# Rehab Restraint Hours / Pt Days Converted To Hours X100			
	ICU restraints at or below benchmark of 24.3 hours	ICUs	# ICU Restraint Hours/Pt Days Converted To Hours X100			
FALLS	Fall rate at or below benchmark: Goal for falls with moderate or greater severity injury rating below 10%	Acute Care Benchmark 3.7	# falls/ pt days x1000		Vicki Geha	Paula Shaffer
			# patient falls with moderate or greater severity rating injury/# total falls			
		Rehab Benchmark 10	# falls/ pt days x1000			
			# patient falls with moderate or greater severity rating injury/# total falls			
		Geripsych Benchmark 13.1	# falls/ pt days x1000			
			# patient falls with moderate or greater severity rating injury/# total falls			
MEDICATION ERRORS	Medication errors	Patients Receiving Narcotics And Requiring Rescue Medications	#Pts Receiving Narcotics/Pts Receiving Narcotics And Narcan			Keith Trettin
		Patients Receiving Insulin Requiring D50 Or Glucagon	# Pts Receiving Insulin / # Pts Receiving Insulin And D50 Or Glucagon			
		Severe Med Errors (E Thru I)	# Pts With Medication Occurrences In Category E Thru I/Month			
		Total Med Errors Per 10,000 Orders	Medication Errors/10,000medication Orders			
		Unapproved Abbreviations Written	# Unapproved Abbreviations Written/Month			
OPERATIVE AND OTHER INVASIVE PROCEDURES	Operative and Other Invasive Procedures 0% discrepancy between surgical pathology report and specimen/ frozen section, and no tissue specimens 100% pre/post op diagnosis agree	Surgical procedures concurrence	# Discrepancies/Specimens Reviewed		Dr. Gohara	Libby Sorosiak
			# Cases With Agreement/# Cases Reviewed			
ADVERSE DRUG REACTIONS	Adverse drug reactions					Chad Tuckerman
			# ADRs/100 Admissions			
			# ADRs/100 Patient Days			
			# Severe ADRs/100 Admissions			
			# Type C ADRs/100 Admissions			
ORGAN CONVERSION RATES	Organ Conversion Rates Conversion rate goal is 75%	Patients eligible as organ donors	# Organ Donors/# Eligible Donors		Norma	Kristen Calkins

Area	Initiative	Indicator	Measurement	Status	Physician/ Administrative Sponsor	Project Leader
BLOOD UTILIZATION	Blood utilization	Crossmatch To Transfusion Ratio	# Crossmatches Ordered/# Red Cell Units Transfused			Cindy O'Connell
		Blood Wastage	# Units Wasted/ Total # Units Transfused X100			
		Transfusion Documentation	# Transfusion Slips Correctly Completed/Total # Transfusion Slips Audited X100			
		Reactions	# Transfusion Reactions Reported/ Total # Of Transfusions X100			
PAIN	Pain assessment competed 100%	Documentation patient satisfaction pain improvement	# pain assessments completed/total number reviewed x100		Vicki Geha	
SAFETY	Annual staff survey for perception of safety Overall Problem Score below 15% Did nurses check ID band before meds, treatments, tests? Did you feel comfortable asking medical staff questions about your condition, treatment?	Staff survey related to perception of safety in the environment indicates staff feel UMC is safe environment Patient perception of safety in environment	Results of staff survey NRC Picker Tool Results for Safety Questions		Tomlinson, Chastang	Mike Allison Kelly Kunz
RESUSCITATION	100% equipment and supplies available	Evaluate codes for survival				Mary Ann Dimick
			# pts survived code for codes/ # codes			
		Evaluate equipment availability	# codes with equipment/supplies missing/#codes in acute care.			
STAFFING EFFECTIVENESS	Evaluate and develop actions plans for 100% of indicators with a moderate correlation or stronger.	4AB Correlation data between falls /med errors and HPPD and OT	# Pt falls compared to HPPD			Crystal Dixon
			# Med errors compared to HPPD			
			#Falls compared to OT			
			# Med errors compared to OT			
		MCCU correlation data between VAP/UTI and HPPD and OT	# VAP compared to HPPD			
			# VAP compared to OT			
			# UTI compared to HPPD			
			# UTI compared to OT			
OCCURRENCE REPORT TRENDS	Track 100% of occurrence reports for trends, ,	Occurrence reports by category	# occurrences/ patient days x 1000 by category	100% Tracked		Laurie Oakes