Hospice of Rutherford County
Policies and Procedures

Category: Risk Management     Code: RM 001A
Subject: Performance Improvement Plan     Page: 1 of 8
Policy Date: 03/05/03     Revised: 07/06, 11/08
Approved: Date:

Policy:

Hospice of Rutherford County’s performance improvement plan is designed to monitor, evaluate and improve the quality, appropriateness and outcomes of care, treatment and services by:

- Planning, designing, measuring, assessing, and improving new or revised processes of patient care and service
- Identifying opportunities through continuous assessment of systems and processes of care using a collaborative, interdisciplinary focus
- Implementing solutions and actions which will bring about desired change
- Facilitating a positive patient outcome
- Maintaining a safe environment for staff, patients and visitors
- Reporting information to the Board of Directors they need to fulfill their responsibility for the quality of patient care and safety
- Meeting state and federal regulatory guidelines and accreditation standards for quality assurance and performance improvement.

The Performance Improvement Plan, established by the management of Hospice and the interdisciplinary Performance Improvement Committee with the support and approval of the Board of Directors provides the mechanism to monitor patient care, treatment and services with the goal of identifying and resolving any processes, functions and services that may adversely impact patient care, treatment and services.

The primary goal of the Performance Improvement Plan is to continuously and systematically improve patient care, treatment and services. To achieve this goal, Hospice’s performance improvement activities shall be interdisciplinary, collaborative and organization-wide, including services provided under contractual agreement. Process design shall focus on the:

- organization’s mission
- needs of those served, staff and others
- use of clinically sound, current data
- use of sound business practices
- use of results of performance improvement, patient safety and risk reduction activities
Procedures

I. Scope of Activities

The Performance Improvement Plan is designed to assess and improve the quality of care provided and safety practices throughout Hospice. The plan shall include monitoring and evaluation of: (1) patient care provided directly and by arrangement and (2) organizational activities provided. The Plan will encompass:

1. Ethics, Rights and Responsibilities
2. Provision of Care, Treatment and Services
3. Medication Management
4. Surveillance, Prevention and Control of Infection
5. Improving Organizational Performance
6. Leadership
7. Management of the Environment of Care
8. Management of Human Resources
9. Management of Information

The focus of performance improvement activities includes but is not limited to:

- **Persons served:** (patient, caregiver, community bereavement client, referring physician, etc.)
- **Services:** (nursing, social work, personal care, counseling, medical, volunteer, therapy, etc.)
- **Clinical Activities:** (observation and assessment, coordination of care, referrals, medication administration, wound care, catheter care, teaching activities, counseling, etc.)
- **Disciplines:** (physician, nurse, hospice aide, social worker, chaplain, counselor, volunteer, etc.)
- **Contract services:** (therapy, oxygen, durable medical equipment, patient transportation, etc.)
- **Levels of care:** (routine home care, respite, in-patient care, continuous home care)
- **Site of care:** (home, skilled nursing and assisted living facilities, Hospice House, hospital, etc.)

II. Organization:

A. **Board of Directors**

1. The Board of Directors is responsible for the quality of patient care.

2. The Board requires staff, through the Executive Director and the interdisciplinary Performance Improvement Committee, to implement and report on activities and mechanisms for monitoring, assessing and evaluating patient safety practices and quality of patient care, for identifying and resolving problems and for identifying opportunities to improve patient care, service and performance throughout the organization.

3. The Board, through the Executive Director, provides resources and support systems for the performance improvement functions and risk management functions related to patient care, treatment and services, and safety.
4. The Board, through the Executive Director, assigns staff to be responsible for the Performance Improvement Plan (PIP) and projects.

B. Executive Director

The Executive Director assigns and supervises the Compliance Officer.

C. Compliance Officer

1. The Compliance Officer is responsible for: (a.) coordination and implementation of the annual PIP Plan and on-going projects and (b.) collection, management, and report of data, projects and outcomes.

2. The Compliance Officer reports directly to the Executive Director and coordinates the activities of the Professional Advisory Committee and the Performance Improvement Committee.

3. The Compliance Officer is responsible for employee education regarding responsibility and involvement in performance improvement activities and the PIP Plan.

D. Performance Improvement Committee

1. The Performance Improvement Committee is responsible for the identification and resolution of problems and for identifying opportunities to improve patient care, service and performance throughout the organization. Methodology includes:

   • Study processes to identify steps in process where there is, or may be, undesirable variation.
   • Identify possible effects and severity of effects on patients, clients, community and employees.
   • For most critical effects, conduct root cause analysis.
   • Redesign the process and/or systems to minimize risks or protect patients from effects of undesirable variation.
   • Test and implement redesigned process.
   • Identify and implement measures of effectiveness of redesigned process.
   • Implement a strategy for maintaining the effectiveness of redesigned process over time.

2. The PI Committee may serve as the Performance Improvement Team or may appoint a team to plan and implement a specific improvement project. The Team will be composed of employees who are familiar with the concern being investigated, and may include clinical and/or administrative staff and/or volunteers. The Performance Improvement Team will report all results in the form of minutes to the Compliance Officer.

   The PI Committee shall ensure that ongoing monitoring includes: (a) at least one important aspect related to service provided and (2) one related to an administrative aspect of function or service
III. Methodology

A. Hospice uses the **Plan, Do, Study, Act** Model of Improvement

**PDSA**

**Goals**

What are we trying to accomplish? (**AIM**)

How will we know that a change is an improvement? (**MEASURE**)

What changes can we make that will result in an improvement? (**CHANGE**)

---

**PLAN THE IMPROVEMENT**

**ACT TO MAINTAIN THE GAIN**

**DO THE IMPROVEMENT**

**STUDY THE RESULTS**

---

**PLAN:**

Objective and valid performance measures are identified for monitoring and assessing processes and outcomes of care including those affecting a large percentage of patients, and/or place patients at serious risk if not performed well, or performed when not indicated, or not performed when indicated; and/or have been or likely to be problem prone.

Performance measures are based on current knowledge and clinical experience and are structured to represent interdisciplinary processes as appropriate.

Data will be collected from internal sources and external sources. The following data sources may be used in the development of performance measures:

- Staff opinions and needs
- Staff perceptions of risks to patients and suggestions for improvement
- Outcomes of processes or services, including incident reports
- Performance measures from approved internal and external databases
- Infection control surveillance and reporting
- Patient and caregiver perceptions of care (satisfaction surveys)
- Risk management
- Utilization review
- Patient demographics and diagnoses

Performance measures for processes that are known to risk safety of patients or associated with sentinel events will be routinely monitored. Performance measures related to the following processes are monitored with approval and at the suggested frequency of the PI Committee.

- Data from incident reports and worker’s compensation claims
- Known problem prone processes
- Medication use, including adverse reactions/errors
- Sentinel events
- Timeliness of assessments and evaluation of services
- Appropriateness of treatment
- Patient plan of care and goals
- Assessment of treatment outcomes
- Patient/caregiver/representative education
- Infection control practices
- Staff in-service education and training
- Patient/caregiver, attending physician and staff satisfaction
- Appropriateness, timeliness and effectiveness of pain and symptom management
- Care provided to high-risk populations
- Appropriateness, timeliness and adequacy of documentation
- Medication management
- Staffing effectiveness

Benchmarks or thresholds that trigger further assessment and evaluation are established. Undesirable patterns or trends in performance are analyzed. Further analysis may be conducted when the levels of performance, patterns or trends vary significantly from those expected.

**DO**

Collect data to determine:
- Stability of existing processes
- Level of performance of existing processes
- Priorities for improvement of existing processes

Design of possible new processes

**STUDY**

Assess care when benchmarks or thresholds are reached in order to identify opportunities to improve performance or resolve problems.
ACT

Take action to correct identified problems or improve performance. Evaluate effectiveness of actions taken and document improvement in care. Communicate results of monitoring, assessment and evaluation process throughout the organization.

B. Information Management

Performance improvement activities are dependent on the management of information. The goals of information management are to: (1.) improve effective communication, patient care and safety, governance, management and support services and (2) assure accurate, timely, complete and legible medical records.

Information is obtained, managed and used to improve individual and organizational performance. Review of this function is performed in an interdisciplinary and collaborative manner. Activities of the Performance Improvement Committee, including data, review and analysis, are reflected throughout the organization.

IV. Professional Advisory Committee

A. The Professional Advisory Committee (PAC) is an advisory committee to the Board of Directors, Executive Director and the Performance Improvement Committee. The PAC meets quarterly to advise the organization regarding scope of services, clinical services, coordination of services and program evaluation.

B. PAC activities focus on quality assurance, performance improvement, utilization review and risk management activities. The PAC reviews the quarterly Quality Improvement Summary, quarterly QAPI Snapshot, Performance Improvement Plan and the on-going activities of the Performance Improvement Committee, and the Annual Evaluation of Hospice of Rutherford County.

C. The PAC serves as liaison with other health care professionals and organizations in the community.

D. The Executive Director appoints the PAC, whose members are part of the community’s healthcare system and represent services provided by Hospice. Members include but are not limited to:

<table>
<thead>
<tr>
<th>Hospice</th>
<th>Community</th>
</tr>
</thead>
<tbody>
<tr>
<td>Board Member</td>
<td>Pharmacist</td>
</tr>
<tr>
<td>Executive Director</td>
<td>Nurse</td>
</tr>
<tr>
<td>Director of Clinical Services</td>
<td>Social Worker</td>
</tr>
<tr>
<td>Compliance Officer</td>
<td></td>
</tr>
<tr>
<td>Physician</td>
<td></td>
</tr>
</tbody>
</table>
V. Communication and Integration of Information:

A. The findings, conclusions, recommendations and actions taken to improve performance and the results of actions taken are documented and reported through established channels.

B. Results of the outcomes of performance improvement activities and patient safety activities are reported to the Compliance Officer and the Performance Improvement Committee on a monthly/quarterly basis as designated.

C. The Performance Improvement Committee will submit a monthly report of its activities to the Executive Director and the Director of Clinical Services.

D. The Performance Improvement Committee will provide the Board of Directors with a report of organization-wide performance improvement activities at least quarterly.

E. Documentation and reports will include:
   - Findings from monitoring activities
   - Conclusions about opportunities for improvement
   - Recommendations concerning potential actions
   - Actions taken to bring about change
   - Outcome of action’s effectiveness (follow-up monitoring to determine lasting effectiveness)

VI. Utilization Review

A quarterly utilization review of clinical records will be performed to determine adequacy of the plan of care and the appropriateness and effectiveness of care, treatment and services. The effectiveness of clinical forms and documentation will be evaluated and revised as necessary. At a minimum, 10% of active patient records and 5% of bereavement records are reviewed quarterly. Utilization review activities are summarized by the Compliance Officer and reported to management and the Professional Advisory Committee quarterly.

VII. Annual Program Evaluation

Hospice will complete an annual program evaluation to include a review of patient care, services and business operations. Individuals and organizations which interact with Hospice in patient care activities will be encouraged to participate in the evaluation. The evaluation will include but is not limited to:

- The effectiveness of the Performance Improvement Plan;
- The effectiveness, quality and appropriateness of all program services provided to patients, clients and the community, including services provided under contract;
- The effectiveness of administration and fiscal operations;
- Utilization of staff, and
- Review and revision of policies, procedures and forms used by Hospice.
Hospice obtains reactions from patients, representatives, families, caregivers, facilities, contract providers, physicians and other persons involved in the provision of care. Feedback from persons served as stated in satisfaction surveys, is used by the Board, management, Performance Improvement Committee and employees to improve performance and planning of care, treatment and services. 

See Policy RM 001D: Use of Satisfaction Surveys.

The Compliance Officer is responsible for completion of the evaluation, which shall be completed within 60 days of Hospice’s fiscal year end. After review and approval by the PAC, the evaluation is presented by the Executive Director to the Board of Directors.

VII. Confidentiality

All information related to performance improvement activities in accordance with this plan is confidential. Confidential information may include but is not limited to: staff committee meetings, Performance Improvement reports, electronic data gathering and reporting, medical record reviews and incident reports. Some information may be disseminated on a “need to know basis” as required by agencies such as federal review agencies, regulatory bodies or any other organization with a proven “need to know” as approved by the Executive Director and/or the Board of Directors.

Hospice of Rutherford County
Performance Improvement Plan Approval

ADOPTION:

The Performance Improvement Plan has been reviewed, approved and adopted by the Board of Directors and by the Administration as attested to by the signatures below:

________________________________________  ________ ____________________  
Board of Directors                                    Date

_________________________________________  ________ ____________________  
Executive Director                                   Date

_________________________________________  ________ ____________________  
Medical Director                                     Date

_________________________________________  ________ ____________________  
Performance Improvement Committee, Chairperson       Date