Developing a Performance Improvement Process in a Critical Access Hospital (CAH)

Beatrice Community Hospital and Health Center

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Overview

State the quality issue you worked on:

Increasingly organizations are seeking better ways to improve the quality of patient care by improving outcomes through performance improvement initiatives. Over the past 18 months Beatrice Community Hospital and Health Center (BCHHC) Board of Directors and members of the Leadership Council have taken action on the development of a performance improvement program. The Board of Directors set to achieve BCHHCs Vision in becoming the health care provider of choice, providing access to needed services, and taking a leadership role in the health care delivery system. BCHHC is dedicated to providing compassionate health care to the community and to achieving excellence through its commitment to quality. The Chief Executive Officer (CEO) and the Board of Directors at BCHHC recognized continuous evolvement had to occur to bring the organization in alignment with its strategic imperatives. Evaluating current processes for measuring improvement was necessary in becoming an information-driven hospital. Outcome measurement needed to occur organization-wide with goals easily identifiable and patient focused. As part of BCHHC's mission to provide quality care for improved patient outcomes, the quest for excellence began with the development of a performance improvement process to produce quality outcomes.

Describe how you identified the issue:

As a critical access hospital (CAH) and accredited by the Joint Commission, BCHHC has been accustomed to meeting requirements for reporting measures and outcomes. Historically, data on core measures, non-core measures, and internal data indicators were collected by individual departments and submitted to the Director of

Nursing (DON). This lengthy list of indicators was displayed on Excel spreadsheets consisting of eleven pages with an emphasis on numbers that were often incomplete. The bulky spreadsheets were difficult to read and did not provide a clear assessment of what was actually happening with processes within the organization. Since the process for reporting measures was not user friendly managers and Directors were not able to easily identify gaps in processes or patient care delivery systems. The degree of accountability for improving reportable measures was left to a few people and not shared within the organization. The cultural orientation was to comply with accrediting guidelines and to correct problems rather than prevent them thus resulting in fragmented organizational interests. The Board of Directors realized there was a need for change in measuring and reporting outcomes, not just clinically, but financially, and in all departments of the hospital.

During the process of change the Board of Directors at BCHHC created a Chief Nursing Officer (CNO) position. The CNO would augment the leadership team with input at the operational level of the organization. The CNO responsibilities include a focus on performance, enhanced teamwork, and improved communications. One key goal for the CNO position is to develop continuous quality improvement priorities and establish a performance improvement scorecard. With previous Performance Improvement (PI) experience, the CNO began to execute quality initiatives.

Describe the importance this issue has for the organization and patients:

Consumers of health care services expect quality service. The challenge for health care organizations is to meet this demand and provide quality care with quality outcomes. The need for a performance information process is essential to tracking

programming goals and treatment in the patient planning process and to monitor changes and development of programs over time. Clinical, financial, and organizational performance data is vital information to improving healthcare outcomes. With the development of the performance improvement process there will be less risk for harm to the patient, increased patient/employee satisfaction, and improved patient outcomes. Since BCHHC is the only hospital within a 35 mile radius it is important to the community, employees, and the patients served within the hospital that performance improvement is at the forefront of the organization's strategic plan.

Methods

Describe the intervention approach implemented (the process you used):

Initially, the role of the governing board was established and included frequent review of the performance improvement plan, defining processes to improve quality, data collection and process evaluation, clarity of the board's responsibilities and accountabilities, and immediate adjustment of design failures. Design success was monitored routinely and adjusted as necessary. The Board of Directors established a Board Quality Committee consisting of medical staff, board members, and members of the Leadership Council. With the Board of Directors as its oversight, the Board Quality Committee is the reporting board for the performance improvement program. The responsibilities of the Board Quality Committee include the following:

- Recommend policies and procedures that enable the medical staff to process medical staff applications and reappointments and that expedite the board's decision with respect to granting clinical privileges.

- Monitor the performance of the medical staff in carrying out its responsibilities for evaluating and improving patient care.
- Monitor the performance of all hospital programs in developing and implementing quality improvement responsibilities and review to assure that the organization remains nationally accredited and locally respected for its quality of care.
- Review periodic trend reports that reflect the overall performance of the hospital in providing quality care in a customer-focused, cost-effective manner.
- Ensure that the quality services and their quantification is a hospital-wide expectation of all operating units.
- Ensure that all operating programs develop a specific plan for implementing the concept of continuous quality improvement through individual and team initiative. This includes implementation, evaluation, and oversight processes within the appropriate medical/administrative/governance structures.

With full support from the governing board of the hospital, including the newly formed Board Quality Committee, the CNO began a collaborative approach with directors/managers, direct care staff, and other employees to become involved with the process of performance improvement. Directors/managers were accountable for their departmental performance. The process for change was initiated and the organizational assessment for readiness to change completed. The clinical areas became the model for implementation of the reporting tools from a spreadsheet based format to a Dashboard system.

There are approximately 30 departments within BCHHC. The objective in the performance improvement plan was to initiate the dashboard reporting process in each department beginning with the clinical areas. All core and non-core measures would be included on the dashboard scorecard. Additional data indicators for process improvement were included as well. The BCHHC Dashboard system also included reporting from the organization as a whole.

With the introduction of the Dashboard reporting system, a framework for process improvement also occurred. The model for testing process change at BCHHC is the FOCUS-PDSA (IHI, 2002) (Appendix A). The FOCUS-PDSA model is a rapid cycle method to improve processes for ongoing improvement. With determination to implement this model as a standard for process improvement, BCHHC began to educate staff on the use of the framework in performance improvement. Multidisciplinary and interdisciplinary teams were created to begin work on performance improvement initiatives as identified in the strategic imperatives.

Throughout the development and implementation of the performance improvement process, senior leaders within the organization continued to support and evaluate the plan for organization-wide improvement. Periodic updates on the progress of the performance improvement program were provided to the Board of Directors, Leadership Council, and Board Quality Committee. In accordance with the organization's commitment to achieving excellence through providing quality service to the community, patients, and staff, the decision was made to employ a Performance Improvement (PI) Manager. The PI Manager would oversee all performance improvement activities within each department of the hospital and provide education, resources, and support in ongoing

process improvement. In addition, the PI manager would focus on program development, establish new policies and procedures for the PI process, and report all Dashboards to the Board Quality Committee (see Appendix B).

Results

With the introduction of the PI Manager, additional changes occurred within BCHHC. The Dashboard forms for reporting data indicators on quality measures were revised and standardized. Currently, the Dashboard system includes the following reporting forms:

- Data Sheet-records data indicators, the source of the data, the method used for calculating the data, and the benchmark source and purpose for collection of the data. This is submitted annually to the PI Manager.
- Departmental and Organizational Detailed Scorecards-Presents quarterly color percentages of calculated totals for each data indicator (blue=exceeds expectation, green= meets expectations, and red=below expectations). Thresholds for achieving benchmark goals and any comments regarding the calculations are reported on this form. Submitted quarterly to the PI Manager.
- Departmental and Organizational Dashboard- Reflects color dashboard as previously described in a visual display. Data indicators in red (below expectations) are easily identified. Red indicators on this form require the presentation of a RDAAR Report. This report is submitted to the Board Quality committee for review.
- RDAAR (Reason/Rationale, Data, Analysis, Action, Recommended Action) Report- Generated when a red indicator is on the departmental or organizational

dashboard. The reason and/or rationale for the red indicator must be given. A data analysis of the indicator with a run or control chart is required. An Action Plan is provided on the report from the responsible committee or Director/Manager. The Action Plan is reviewed and approved or disapproved by the Board Quality Committee. Other recommended actions are obtained from the Board Quality Committee on this report. Follow-up action is required by the next quarter for evaluation by committee members.

As the performance improvement process has progressed with the standardization of the Dashboard system there have been other successes as well. The most measurable success in the previous 12 months is going from approximately 25% of the departments reporting data indicators on the Dashboard system to over 90% of the hospital entities reporting on Dashboards. This includes the long-term care center, outpatient clinics, Patient Safety Committee, and the Patient Care Committee. Previously, nursing administration reported 0% of the National Nursing Quality Indicators and now are reporting nine of these indicators. Other evidence of improved performance includes improved patient satisfaction scores, increased employee satisfaction, and an increased network of interdisciplinary and multidisciplinary teams.

Lessons Learned

One of the greatest barriers in developing a performance improvement process for reporting was staff resistance to change the process. Converting to the Dashboard system also took longer than first anticipated. Challenges were in developing managerial ownership of the data collection process, understanding the use of a matrix-based system, and identifying applicable benchmarks for quality indicators. Every department manager

within BCHHC is now accountable for the reliability of their data collection and reporting of their indicators on the Dashboard.

The sustainability of this process improvement is quite good. With a governing board committed to quality patient care, a culture that is accepting change, and dedicated staff focused on improving performance, there is little chance for failure. The Dashboard system is in place with a FOCUS-PDSA model for modifying processes as needed. Over time, improved outcomes in patient care will provide the evidence base for sustainability.

As BCHHC prepares for a new health information system (HIS) there will be greater access to retrieving data. The Dashboard system should easily transfer into a HIS and decrease the need to manually extrapolate data from medical records. As the Dashboard process accumulates data, the HIS will be helpful in tracking trends and populating fields of the Dashboard forms. The Dashboard is a system that is versatile and can be utilized manually and electronically.

Conclusion

Throughout the development of a performance improvement process the focus of the program has been and is on the key stakeholders. The path to quality and improving patient care and services is becoming increasingly well traveled. The culture of the organization has changed from reactive to a proactive force and the stakeholders are driving the change. A spirit of collaboration and team building has been embraced and will continue to evolve as does the quest for excellence in performance improvement at BCHHC.

References

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IHI quality improvement resources: A model for accelerating improvement: Setting aims: Forming the team: Establishing measures. (2002). *Resources*. Retrieved August 15, 2002, from Institute for Healthcare Improvement Web site: http://www.ihi.org/resources/qi/qi2aims.asp

Appendix A - FOCUS-PDSA Framework

FOCUS-PDSA

F Find a process to improve
O Organize a team that knows the process
C Clarify current knowledge of the process
U Understand sources of process variation
S Select the process improvement
P Plan the improvement
D Do the improvement
S Check the results
A Act to hold the gain

Finding a process to improve derives from numerous sources;

- Strategic initiatives
- Key processes, and
- Results of measurements
- Define customer and key quality characteristics
- Write opportunity statement

Organizing

- Gather people who know the process
- Authority needed to change the process
- Set ground rules for the group
- Timeline planned

Clarifying

- Flow chart actual steps of the process
- Search for the best method
- If appropriate, implement it
- Assure the "right" team members for planning and implementing the process

Understanding

- Key quality characteristic must be measured and analyzed
- Process is stabilized

- Improvement may need to be narrowed or focused
- Root causes of any problems identified
- Clarify with cause and effect diagrams

Select

- Select an improvement from list of potential actions
- Evaluate the actions for effectiveness and feasibility
- Prioritize the list and select the improvement

PLAN

- Find a process to improve
- Organize to improve it
- Clarify knowledge
- Understand variation
- Select an improvement

DO

- Implement the plan
- Document barriers to the change tested
- Begin analysis of the data

STUDY

- Complete data analysis
- Evaluate the results
- Did the process change result in the expected effect?

ACT

- Standardize improvement or,
- Start over with new PDSA

Appendix B-Timeline for Performance Improvement Process Development

January 2006-Board members, CEO, and MD's attend Governance Institute meeting.

November 2006 -Interim CNO introduced to Board of Directors by the CEO, Fiduciary responsibility for quality of care recognized by Board members.

February 2007- Board members, CEO, and MD's attend Governance Institute meeting.

March 2007-Interim CNO hired by BCHHC.

June 2007-The Board Quality Committee and its charter are approved by the Board of Directors.

July 2007-CNO begins ongoing education of departmental managers on Performance Improvement tools and Dashboard data collection process.

October 2008- Data collection begins using Dashboard process for FY 2008.

January 2008-CNO presents Dashboard data for fourth quarter of FY 2007 to the Board Quality Committee.

May 2008- Board members, CEO, and MD's attend Governance Institute meeting.

June 2008- Performance Improvement Manager hired by BCHHC.

July-August 2008- Performance Improvement Manager meets with every department manager to review Dashboard process and reporting elements.

September 2008-Dashboard reporting forms standardized for organization-wide reporting of data indicators.