Quality Management Plan

2011

Liberty Health
Quality Management Plan

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QUALITY MANAGEMENT PLAN

I. Introduction

LibertyHealth is committed to becoming the premier organization for health services in Hudson and the surrounding counties, through the establishment of partnerships with patients, physicians, staff, volunteers and the community. The system therefore is committed to continuously improving performance in the provision of patient care and services. LibertyHealth strives to balance excellence in healthcare with responsible fiscal management, while remaining on the cutting edge of healthcare innovations. The system leadership has established the Mission, Vision, Values and a Strategic Plan to provide direction for the organization as it operates in this evolving healthcare environment.

II. Mission Statement

The mission of LibertyHealth is to enhance the lives of the residents of Jersey City and the neighboring communities, through our customer-centered commitment to the promotion of health and wellness.

III. Vision Statements

Our vision is to achieve the top 10th percentile in our pillars of excellence - Patient Safety, Clinical Quality, Satisfaction and Economic Health, with a goal of achieving top100 hospitals national recognition. Through these accomplishments, we will attract the highest level of talent to deliver quality, compassionate care, making LibertyHealth the regional provider of choice.

IV. Values Statement

LibertyHealth values are Trust, Accountability, Communication, Excellence, and Teamwork. These values serve as the basis of our actions and the measurement of our success. To fulfill our mission, we strive to exceed recognized standards of performance and foster an environment that supports honesty, respect, integrity, and collective goals. We pursue increasing competence, professionalism, loyalty and empowerment of a multi-cultural work force that allows each individual to achieve his or her greatest potential while exceeding the expectations of our patients and community.

V. Definition of Quality

Quality is defined as those activities directed toward raising the standards of performance, through improved work processes and the reduction of "variation" in outcomes, there-by increasing the consistency of performance around the standard, ensuring the best possible clinical outcomes for patients, safety and satisfaction for all customers, retention of staff and sound financial performance.

We continuously strive to improve what we do each day by working collaboratively to provide one level of quality care to all patients.

VI. Purpose

The purpose of the Quality Management Plan is to establish a coordinated, collaborative, organizational process that provides oversight as a clearing house for quality assessment and improvement throughout Liberty Health including key clinical, operational and business process improvement. The QM Plan outlines we the plan, design, analyze, improve and control patient care and services in the form of interdisciplinary committees. Criteria for prioritization are used to select the focus of our improvement activity and resources.

VII. Objectives

1. Establish Whole System Measures

   Whole System Measures are a balanced set of system-level measures that evaluate the overall quality of a health system. Whole System Measures (WSMs) align improvement work across an organization. The Institute for Healthcare Improvement developed the concept of Whole System Measures to supply health care leaders and other stakeholders with data that enable them to evaluate their health systems' performance as a whole. WSMs monitor overall performance on core dimensions of quality and also serve as inputs to strategic planning.

   The Whole System Measures are intended to focus on important system-level issues. They are limited to a small set of about 13 measures that are not disease-or condition-specific. One objective for developing the Whole System Measures was to also provide a view of performance that reflects care provided in different sites like: emergency care, inpatient, behavioral health and outpatient clinics across the continuum of care.

   Jersey City Medical Center has chosen the following Whole System Measures:

   SATISFACTION
   - 1. Overall Satisfaction Rating: Percent Who Would be Likely to Recommend (inpatient)
   - 2. Employee Turnover Rate

   PATIENT SAFETY
   - 3. Patient Safety Index
   - 4. IHI Defined Harm Events
   - 5. Infection Rate (overall for VAP, BSI, CAUTI)

   CLINICAL QUALITY
   - 6. Readmission Rate
   - 7. Overall Mortality Rate
   - 8. Primary C-Section Rate
   - 9. Core Measure Appropriate Care Score (Composite)

   ECONOMIC HEALTH
   - 10. Case-Mix Index
   - 11. Overall Length of Stay
   - 12. Operating Margin (before subsidies)

   Communication of WSMs throughout the organization is an important component to implementing a Whole System Measurement System. At Jersey City Medical

Center, we have created Quality Management Boards for each unit / department where we post all WSMs, department/unit specific data and PI Projects.

2. Identify a consistent, objective method of measuring, evaluating and improving important functions and key business processes that impact patient outcomes and organizational results.
3. Identify responsibilities and information flow at all levels of the organization in the management of the quality management process
4. Establish criteria to be utilized in prioritizing quality improvement activities
5. Determine a mechanism for plan review and revision
6. Automate Quality Management System to perform and track the following tasks:
    - Project submission and approval: The project submission form will be routed appropriately based on the approval requirement.
    - Project requirements: Depending on the project methodology selected (Six Sigma, PDSA, etc.), the team, may require approval specific project tools to be completed, methodologies to be adhered to, and project reviews/approvals to be obtained at specific times.
    - Project communications: At specific points within each project (the completion of a pre-determined phase or at a specific time in the project), project updates will be generated and emailed to specified users.
    - Project closure requirements: Projects will not be able to be closed unless it meet's the plan's requirements.
    - Exception reports: As project results are tracked, the application will automatically generate exception report notifications if and when metrics exceed a specified value.

VIII. Scope

Quality Management and improvement can be expressed in both financial and non-financial terms This plan addresses four types of performance improvement:

1. Health care processes and outcomes
2. Patient and stakeholder- focused
3. Financial and marketplace
4. Operational

Activities also include a coordinated interdisciplinary manner, all:

1. Clinical Departments
2. Medical Staff Committees
3. Hospital Committees
4. Hospital Departments
5. Managerial and Support Functions
6. The Community

IX. Functions

Quality Improvement activities include processes and functions that are identified as high risk, high volume, high cost and/or problem prone. In addition to the organization's mission, vision, values, and strategic plan, consideration is given to the needs and expectations of staff, patients, the community and other customers as priorities are determined. The leaders of LibertyHealth will ensure that mechanisms are in place to provide a uniform level of care to all patients with comparable healthcare needs and recognize the following as important functions of the organization:

1. Patient Rights and Organizational Ethics
2. Patient Flow - Assessment of Patients - Care of Patients- Continuum of Care
3. Education
4. Improving Organizational Performance
5. Leadership
6. Management of the environment of Care
7. Management of Human Resources
8. Management of Information
9. Surveillance, Prevention and Control of Infection

Quality Management includes activities identified through the implementation of other operational plans such as:

1. Risk Management
2. Behavioral Health
3. Trauma Program
4. Quality Peer Review
5. Case Management / Utilization Review

X. Accountability & Authority

The authority and responsibility for assuring the quality of patient care services provided by its medical staff members and other professional and support staff is vested in the Liberty Health Board of Trustees of Liberty Health Hospitals.

The organization's leaders set expectations, develop plans, and implement procedures to assess and improve the quality of the organization's management, clinical and support processes. As appropriate, the Board shall hold the medical staff and hospital administration responsible for implementing quality management efforts. The organization's leaders include members of the Board of Trustees, The Executive Administration, The Quality Assessment and Oversight Committee, The Quality Management Steering Committee and The Medical Executive Committee.

The Board will review periodic reports of findings, actions and results from Performance Improvement activities in order to assess the program's efficiency and effectiveness.

The Board of Trustees authorizes the Administration and Medical Staff to establish a Quality Management Steering Committee, Important Key Business Process and Service Line Committees, Six Sigma teams and Organizational Quality Management Program. Outcomes of the ongoing

improvement activities will be communicated through the various committees to the Quality Management Steering Committee.

The Medical Staff Executive Committee authorizes the Medical Staff Departments, The Clinical Directors, and its members to participate in the Quality Management Program.

The President / CEO of LibertyHealth authorize all hospital departments, their directors and members to participate in the Quality Management Program.

XI. Liberty Health 4 Pillars – Safety, Quality, Satisfaction and Economic Health

1. Patient Safety Pillar
   Patient Safety is the foundation of high quality health care. Patient Safety is a global category which includes both process and outcome. LibertyHealth believes that safe high quality care is achieved by taking a systems approach to creating a culture that is designed to reduce harm to patients, and a culture that approaches problems from a continuous quality Improvement perspective. This pillar sets our commitment to the prevention of errors in patient care. Errors related to patient identification, communication processes, falls, pressure ulcers, and medications are all examples under this pillar. The goals are devoted to the prevention and the elimination of near misses, adverse events and medical errors.

2. Clinical Quality Pillar
   The Clinical Quality focus is on increasing the likelihood of desired health outcomes, through congruence with current professional knowledge and evidence-based practice. At LibertyHealth we recognize that quality of care is the degree to which health services for individuals and populations meet best practice standards. If we can assure, at the very least, a safe environment for inpatients, outpatients and emergency department patients, our next most logical step is to assure outcomes which compete on a state and national level.

3. Satisfaction Pillar
   Satisfaction is one of our strategic pillars for Liberty Health. Our 5 year goal is to achieve satisfaction scores in the 90th percentile nationally for three consecutive quarters. To achieve this goal requires Liberty to meet and exceed our customer's expectations, provide excellent service and deliver superior care experiences. Success combines patient satisfaction, employee satisfaction and physician satisfaction. Under the satisfaction pillar our mission is customer loyalty. We have a Service Excellence Philosophy which states that we are committed to providing care that is respectful of and responsive to individual patient preferences. We ensure that patient's, physician's and employee's needs and expectations are fulfilled.

   a. Definition of a Customer:
      A customer is defined as a patient, family member, visitor, employee,

community member, potential future patient, customers of our competitors and/ or a LIP.

b. Satisfaction Pillar Program Structure:

A system-wide approach to service excellence builds consistency in our message to the patients, family members, visitors, physicians, employees and the public we serve.

To accomplish our mission we have established an oversight committee called The Service Excellence Steering Committee (SESC) and four sub-committees to address in-patients by domain, emergency department patients, employees and physician satisfaction and engagement. Each of these subcommittees will have a chair and relevant composition.

The Liberty Health Service Excellence Steering Committee (SESC) has oversight and responsibility for establishing priorities, setting long range and short term goals for the organization, for developing strategy based on best practice and monitoring the achievement of percentile ranks, mean scores and to evaluate the effectiveness of the overall program annually.

c. Meetings: Meetings are held 1 time per month or as needed but no less than 4 times per year.

d. Agendas / Reports: The agenda is developed monthly based on current topics and issues discussed at the prior meeting and submitted by the general committee members. The Satisfaction Oversight Steering Committee will provide quarterly reports to the PISC and the MEC. A summary of the SESC is prepared and reported to the QAIOC and to the full Board of Trustees at least annually.

e. Composition: Representatives from all Liberty facilities; Jersey City Medical Center, Meadowlands Hospital, Liberty Home Care, Behavioral Health, Ambulatory Care at Columbus Ave Clinic and Liberty Rehabilitation Institute. The committee's composition is multidisciplinary including administration, medial staff, nursing, environmental, social services, respiratory, security, food service, patient advocate, admitting, techs, aides and other employees to be determined by the committee.

f. Community Engagement: For Liberty Health community engagement is a strategic action aimed at achieving such a degree of loyalty that the patient or stakeholder advocates for our organizations healthcare service offerings. Achieving such loyalty requires a patient stakeholder-focused culture in our workforce based on a thorough understanding of our business strategy and the behaviors and preferences of our patients and stakeholders. Our stakeholders include patients, families, the community, insurers, other third-party payors, and employers, health care providers,

patient advocacy groups, Department of Health and students. We strive to balance the differing expectations of patients and stakeholder groups. We are committed to serving our community. So much so that we have included a patient formally admitted to the hospital as a participant on our PISC.

4. Economic Health Pillar
   Achieving economic health is a multifaceted objective. We can only achieve our goals in this pillar of excellence if we first drive patient safety, clinical quality and customer satisfaction. Improved volume in targeted and strategic areas is the result of deliberate attention to these factors. In the past years, significant efforts have been to reduce the cost of care, and the 2010 goals surrounding economic health reflect our need and desire to maintain these important gains, as well as seek opportunities for additional improvement, cost savings, and efficient use of resources.

XIII. Process Improvement Methodology

Liberty Health has adopted the Six Sigma DMAIC and Lean Six Sigma process improvement methodology for organization wide process improvement activity. LibertyHealth utilizes Six Sigma Project Teams to study large scale processes within the hospital, design new processes, and to make improvements. The teams are interdisciplinary and include staff members from the involved departments, the administration, and the Medical Staff as necessary. The teams identify processes or problems needing improvement and then study the process using the DMAIC methodology to improve outcomes by identifying root causes and eliminating variations. The Teams are initiated based on the priorities established by the organization and its leadership. We use criteria aligned with our strategic goals to prioritize projects for improvement.

When appropriate, for smaller scale projects, we use rapid cycle improvement methods like PDSA to find and implement solutions. Both DMAIC and PDSA include in their beginning phases, the requirement for baseline data collection or "pre-testing" activity prior to intervention. We recognize how useful rapid cycle improvement is when working on projects with a more defined scope. After implementation of an intervention we complete outcome measures or "post testing" to measure the impact of our transformational changes.

1. Project Selection includes the identification of an aspect of care or process critical to the health and safety of the patient, the quality of the services provided the satisfaction of the consumer, and the economic impact on the organization. Sources for identifying these key aspects include, but are not limited to:
   a. External benchmarks that trigger evaluation of the function, process, or care provided
   b. Variations identified through monitoring activities
   c. Adverse events and Near Misses
   d. Patient and staff recommendations

2. The Design phase requires a review of the function or process, the development of a problem statement, the determination of the type of data to be collected, and the establishment of parameters for the study. When the opportunity for improvement will significantly change existing functions or processes the following factors are considered:

a. Consistent with the Mission, Vision, Values and Strategic aims
b. Needs and expectations of the patients, staff, and others
c. Information on potential risks to patients
d. Evidence based practice and current knowledge from the literature

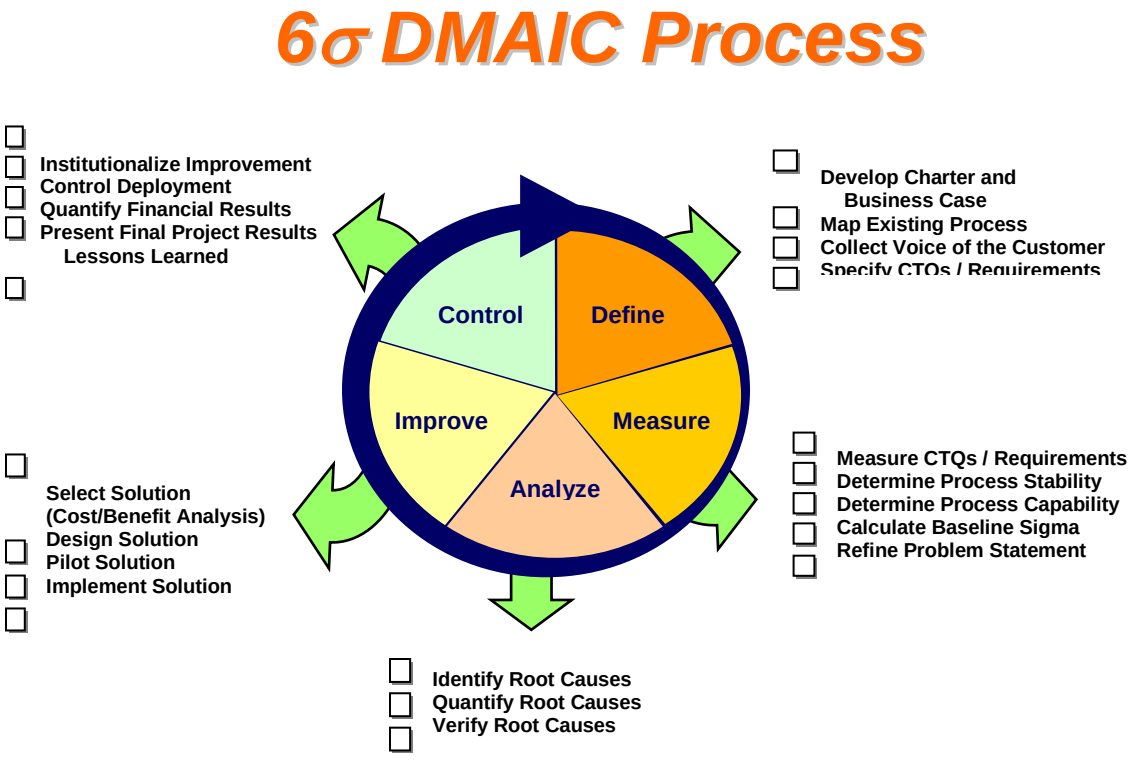
3. The Measure phase involves collecting the data deemed appropriate to determine the need for additional data and to determine a baseline

4. The Analyze phase involves the aggregation, display, presentation, and evaluation of data collected, a determination of proposed solutions to the issue based on data review, and the identification of an appropriate mechanism to implement the proposed solution including resources required for implementation

5. The Improvement phase includes communicating and implementing the potential solution to the issue and evaluating the outcome of the implemented solution for effectiveness and improvement

6. The Control Phase involves creating a control plan to sustain the improvements overtime.

7. DMAIC Methodology



DMAIC = Define, Measure, Analyze, Improve and Control

XIII. Quality Improvement Program Structure

1. Board of Trustees

The Board of Trustees is ultimately responsible for the quality of patient care and services provided, as well as the establishment and maintenance of an effective, organization-wide Quality Improvement Plan. The Board, therefore, will:

a. Review and endorse the performance Improvement Plan
b. Delegate the plan, design, and implementation to the Quality Assessment and Oversight Committee
c. Receive regular summary reports on organization-wide improvement activities including issues and concerns, actions taken, resolutions, and follow-up
d. Assess annually in the self assessment process the effectiveness of its role in the performance improvement process

2. Quality Assessment, Improvement and Oversight Committee

This committee is comprised of selected representatives of the Board of Trustees, Administration, Medical Staff and Patient Care Services Leadership. The committee functions to oversee the Performance Improvement Plan Implementation and to:

a. Reprioritize performance improvement activities as needed in response to unusual or adverse events
b. Assure that serious occurrences are reviewed and resolved with intensive risk assessment and analyses
c. Receive reports of performance improvement/monitoring activities including outcomes, trends, actions, and follow-up from hospital wide committees and departments, the medical staff, and performance improvement teams
d. Monitors hospital and medical staff compliance with performance improvement objectives and regulatory requirements

The committee meets a minimum of six (6) times per year with additional meetings called as necessary to assure that the ongoing needs of the performance improvement program are identified, addressed, and resolved. The Committee reports regularly at the Board of Trustee meetings in written form so that the governing body is kept informed of the results of performance improvement activities and has the opportunity to offer feedback, guidance, and necessary support to the program.

3. Quality Management Steering Committee

The Quality Management Steering committee establishes the framework for improving performance in the key clinical, operational and business processes of the organization utilizing a collaborative and interdisciplinary methodology. The QM Steering Committee's (QMSC) primary purpose is to: 1) provide guidance for allocation of resources to organization wide quality management activities; 2) determine direction and vision for overall quality outcomes and 3) oversee the Quality Management program development and specific activities of the hospital departments and medical staff, 4) monitor achievement of committee/ six sigma team goals and objectives, 5) ensure regulatory

compliance, 6) patient safety 7) ensure Performance Improvement is ongoing. This committee meets regularly and reports to the QAIOC and full Board a minimum of twice per year.

The QMSC committee receives proposals for launching performance improvement teams, progress reports on existing teams and initiatives and other activities to maintain sustained improvement. The committee establishes priorities for organization wide performance improvement activities designed to improve patient outcomes. Prioritization utilizes the following criteria: (Appendix 1: Prioritization Matrix)

1. Alignment with the Mission, Vision, Values, and Strategic Goals
2. High Risk, High Volume, Problem Prone
3. Impact on Patient Safety & Clinical Quality
4. Regulatory requirement or standards that must be met within a specific time frame
5. Opportunities to improve processes within each of the important functions
6. Impact on Satisfaction
7. Operational Impact
8. Benefit to the community
9. Available financial and human resources
10. Impact on Financial Health

a. Specific Responsibilities are:

1. Assessing key clinical, operational, business, organizational, departmental and inter-departmental needs for performance improvement efforts through periodic review of:
    a. Patient Safety Indicators Data
    b. CORE Measures
    c. Occurrence of Medical errors and risk reduction activity.
    d. Risk assessment of at least one high-risk process annually (FMEA)
    e. Financial performance data
    f. Departmental, administrative, or medical staff Performance Improvement monitoring data
    g. Analysis and trends of satisfaction data
    h. Direct requests from administration and Medical Staff.
    i. Analysis of strategic plan implications
    j. IHI and AHRQ data
3. Determining the need for training and education in performance improvement, including:
    a. Patient Safety
    b. Customer Service training

c. Training to support the development and management of departmental performance improvement programs
d. General employee training on performance improvement and team building
e. Training incorporated into organizational and departmental orientation programs
f. Training for Performance Improvement team leaders and facilitators
g. Six Sigma tools and techniques

3. Providing communication to departments about quality management efforts and requirements.

4. Identification of Allocation of Resource needs and recommendations to the Board of Trustees.

5. Prioritization of Improvement Activities using the prioritization tool (Appendix II)

6. Monitor all departmental, medical staff and organizational compliance with the Performance Improvement Program objectives and regulatory requirements.

7. Review the Annual Appraisal of the Risk Management Programs.

8. Review & approve the following annual plans:
   a. Performance Improvement
   b. Risk Management
   c. Utilization Management
   d. Environment of Care Plans
   e. Plan for the Provision of Patient Care Services

9. Assure regular input of Quality Improvement information to the Credentialing committee

b. Composition: The Performance Improvement Steering Council consistsof the following representation:

1) Two members of the Board of Trustees, appointed by the Chairperson of The Board of Trustees.
2) The President and Chief Executive Officer.
3) The Chairperson of the Performance Improvement Steering Committee shall be a Board of Trustees member appointed by the Chairperson of the Board of Trustees.
4) Chief Medical Officer
5) Chief Safety Officer
6) Chief Nursing Officer
7) Chief Financial Officer

8) Active Medical Staff Leaders – Chiefs of Medicine, Surgery, OB/GYN, Emergency and Cardiology
9) Director responsible for Quality and Performance Improvement
10) Vice President of Facilities
11) Vice President of Human Resources
12) Risk Manager
13) Patient Advocate
14) A Patient admitted during the past three years

c. Meetings:

The Quality Management Steering Committee:
Meets regularly, but no less than 4 times per year and maintains a permanent record of its proceedings and activities.

d. Agenda

The agenda of the Performance Improvement Steering Committee includes but is not limited to the following topics:

1. Patient Safety Report
2. Infection Control
3. Surgical Safety
4. Patient Care Services Outcomes
5. Information Management related to Patient Safety
6. Hospital Score Card
7. Human Resources Data
8. Satisfaction –Patient, Employee and Physician
9. Summary reports from Key Process Committees
   9.1.1.1. (Clinical, Business or Operational)
10. All departmental monitoring activities summary
11. Risk Management Trends
12. Medical Executive Committee Summary
13. Case Management/Utilization Review
14. Environment of Care/Safety
15. Six Sigma Teams
16. Financial Performance Data

4. Medical Executive Committee

The Medical Staff of LibertyHealth seeks to continually improve the quality of medical care provided to patients. Where a clinical process is the primary responsibility of physicians, physicians take the leadership role in improving that process utilizing the organization wide framework for improvement. These processes include but are not limited to:

1. Medical assessment and treatment of patients
2. Use of medications
3. Use of blood and blood components
4. Operative and other invasive procedures
5. Pain Management
6. Infection Control

7. Coordination of Care with other disciplines
8. Peer Review
9. Efficiency of clinical practice patterns
10. Significant departures from established patterns of clinical practice.

The Medical Staff participates in process improvement activities relating to other patient care functions such as education of patients and families, patient's rights and organizational ethics, and the completion of medical records in an accurate, timely, and legible manner. The Medical Executive Committee reviews and evaluates reports of Medical Staff Departments and Committees for opportunities to improve and areas needing further study and follow-up. The committee gives direction for that follow-up. The Medical Executive Committee receives recommendations from the Quality Assessment and Oversight Committee, based on their monitoring activities, for areas of potential improvement. The committee prioritizes and re-prioritizes improvement opportunities based on established criteria. The committee participates in the annual review of the Quality Management Plan and makes recommendations for revisions as necessary.

5. Medical Staff Departments

The Medical Staff is an integral part of the Quality Management and Improvement Process. The Medical Executive Committee governs the quality improvement activities of the Medical Staff Departments and is responsible to:

1. Make recommendations to the QMSC as to the organization of the performance assessment and improvement activities.
2. Oversee mechanisms used to conduct, monitor, and evaluate such activities.
3. Delegate to Committees the responsibility of monitoring and evaluating medical care via Interdisciplinary Teams.
4. Assure that quality review activities are consistent with hospital, state and federal accrediting and regulatory agency requirements.
5. Support participation on interdisciplinary teams based on specific patient populations.
6. Performs Peer Review to ensure that the professional medical staff, assesses the performance of individuals granted clinical privileges through the process of critical self-analysis, and that the results of such assessments are used to improve care, Patient safety and identify opportunities for improvement. (See Peer Review Policy for complete process).

6. Key Process Councils (Clinical, Business or Operational)

The purpose of the Key Process Council is examine and make recommendations for improvement in outcomes related to this important hospital function.

General Responsibilities are:

1) Cooperative interaction between and among all key process councils

2) Measure and assess compliance with identified metrics.

3) Maintain and update a resource “ebook” to Identify required data sources and location as appropriate

4) Identify areas for improvement

5) Establish priorities for recommendation to the QMSC

6) Recommend and plan improvement activities based on priorities, including objectives, related tasks, accountabilities, responsibilities, required resources (i.e., people, time, finances, support systems, etc.), and completion dates. In determining expected dates of completion, establish realistic time frames, allowing time for testing improvement strategies, approval processes, etc., and consideration of compliance time frames.

7) Implement changes. Pilot changes in select areas if appropriate to determine if the actions were effective.

8) Identify and involve staff in the change process.

9) Implement plans for improvement. After appropriate period of time measure and assess compliance with standards.

10) Identify need for and promote education.

11) Make recommendations regarding required information from related Six Sigma Teams.

13) Provide Reporting to the QMSC
- The update of all ongoing performance improvement activities, to include recommendations and follow up
- Identification of any deficiencies in fulfilling functional standards & regulatory compliance.
- Provision of remediation plans where appropriate.

7. Six Sigma Teams (SST)

Project Teams at Liberty Health are multidisciplinary teams with an identified improvement opportunity and have completed a team proposal to obtain organizational resources. SST’s use the principles and concepts of basic statistical and performance analysis tools outlined in DMAIC to improve the key processes that achieve the outcomes that meet our customer’s needs. SST’s have a defined beginning and projected end

and will be accountable to an assigned Committee. Liberty Health can have any number of SST's in progress at any point in time as defined by the Steering Committee's prioritization criteria(Appendix II) Requests for a SST's can be initiated by anyone in the organization using the PI Team Proposal form (Appendix I).

1. Six Sigma Team Membership

The Project Team Membership consists of the following:

a. Team Leader
b. A Champion (if determined necessary by the Team)
c. A Six Sigma Black Belt or Green Belt
d. Team Members are employees who have expertise, experience and direct involvement in the process being improved.

2. Role of SS Team Leader

a. Definition –Liberty Health employee who has been chosen by the Team to be responsible for the progress of a particular process improvement team.

b. Responsibilities – Consult with the Black Belt or Green Belt to determine:
   - The selection of team
   - The design and implementation of quality improvement process as authorized by the Steering Committee.
   - Training requirements and education activities necessary for the team.
   - Metrics
   - Methods of recording and communicating results.
   - Communication methodologies as approved by The PISC

c. Select as team members, employees who have expertise experience and direct involvement in the process being improved.

d. Delineate the Team Process including utilizing tools such as Clinical Pathways, Variance Records, Opportunity for Improvement Summaries, Action Plans, Process Control Charts, etc.

e. Formulate a clear, concise purpose statement and projected measurable and achievable goals for the project.

f. Coordinate and integrate activities to team members (to include logistical coordination and recording of team member meetings, data collection and follow up).

g. Submit ongoing reports to the assigned Committee as required using the Project team report summary (Appendix III)

The Role of the SS Black Belt or Green Belt

1. Definition

   A member of the Performance Improvement Department or an employee who has training and knowledge of the continuous quality improvement process, statistical analysis and team building. BBs and GBs act as impartial team members who are not involved in the operational/technical aspects of the process.

2. Responsibilities

   Act as a quality improvement process consultant to the team leader in the areas of:

   - Quality tools to be utilized.
   - Training.
   - Data collection, analysis and measurement tools.
   - Methods of recording and communicating results.
   - Problem-solving methods.
   - Sequence and content of quality improvement process elements.
   - Teamwork and interaction.

3. Act as a process consultant to team members during the implementation of the quality improvement process.

4. Monitor group interaction and quality improvement activities of the team.

5. Work with the team leader to foster good communication and team building.

Role of Team member

1. Definition

   A Liberty Health employee who has experience and expertise in the process being improved and who is directly involved in the day-to-day operation of that process.

2. Responsibilities

   Work as part of the team to utilize Performance Improvement techniques to analyze, understand, document and simplify the designated process.

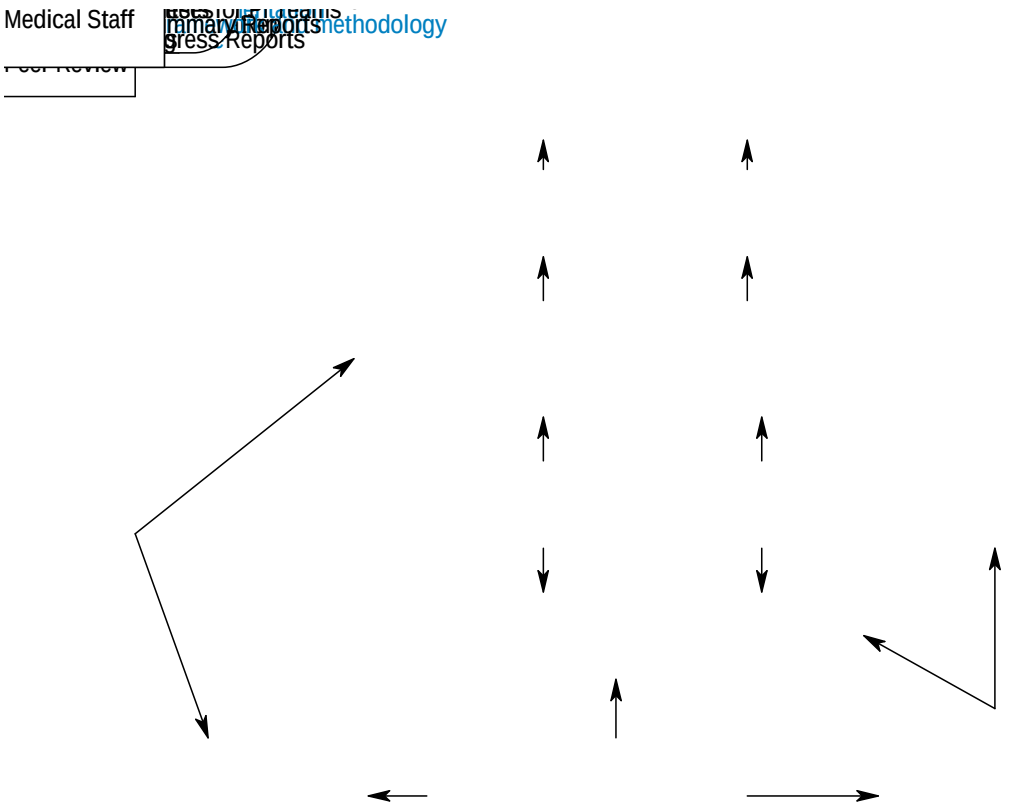
   - Attend meetings and remain until adjournment
   - Actively participate in discussion.
   - Adhere to the Ground Rules.

X. Documentation and Data Collection for Performance Improvement Activities

Each team must complete a DMAIC Project Charter (Appendix V) to be approved by the team Leader and Champion. A Power Point following the DMAIC method with a metric driven score card has been adopted as the official record to document improvement activities. It is designed around the DMAIC Model. It provides an easy to read summary of the data collection analysis, findings, action steps, and outcomes of the improvement process.

XVIII. Communication Plan

Performance Improvement relies on interactive, open communication paths freely and continuously used. In order to achieve the exchange of ideas and information required for a continuously improving organization, communication between all committee and organization groups responsible for performance improvement is expected. Formal communication paths are defined in the Performance Improvement Organizational Chart (Below). The teams, the committees and the Steering Committee, Quality Assessment and Oversight Committee and The Board participate in vertical and horizontal communication.



XIX. LibertyHealth has established the following as organization wide priorities under the organization's 4 pillars of excellence as follows:

1. PRIORITY FOCUS	2. RATIONALE
II. PATIENT SAFETY • Decrease the number of AHRQ Never Events • Decrease the number of IHI global trigger tool harm events • Decrease the number of high risk medication adverse events	High Risk, Problem Prone, Customer satisfaction, outcome on entire organization
III. QUALITY • Improve AMI, CHF, Pneumonia, SCIP, and Stroke Core Measures • Decrease overall mortality • VAP/BSI • Radiology Turn Around Time • Restraint/Seclusion Use	High Risk, Problem Prone, Customer satisfaction
IV. SATISFACTION • Improve inpatient, ED, and ambulatory patient satisfaction • ED Throughput • Improve overall employee satisfaction • Improve overall physician satisfaction	Outcome on entire organization
V. ECONOMIC HEALTH • Decrease Average Length of Stay • Insurance Denials	Outcome on entire organization

The priorities may be reprioritized periodically in response to sentinel events or events identified through Performance Improvement monitoring and evaluation, changing regulatory requirements, patient/staff needs, changes in the patient population, environment of care, or in the community.

The committee meets monthly, and at additional times as necessary, to assure organizational accountability in the successful conduct of the performance improvement program. Committee reports are provided to the Quality Assessment and Oversight Committee.

XX. Staff Participation in Performance Improvement:

Staff participation on six sigma teams is essential. The front line employees with the most knowledge of the actual day-to-day workings of the processes are essential to process examination. Every employee is encouraged to participate in PI activities. These activities can be interdepartmental or on multidisciplinary teams. Employees are provided education on Performance Improvement and Patient Safety in hospital orientation, departmental orientation, and departmental meetings and in ongoing educational programs. PI expectations shall be incorporated into the job descriptions and performance evaluations.

XXI. Program Coordination

The Performance Improvement Program will be supported by the Performance Improvement Department under the supervision of the Senior Vice President of Safety and Quality.

The Performance Improvement/Quality Department will be responsible for supporting the Performance Improvement activities through consultation, facilitation, education, and collaboration to include:

1. Individual case driven and global issue driven reviews of risk, utilization and quality issues within the hospital. This department makes referrals of individual patient care issues to Department Chairpersons or their designee, for review and comment.
2. Provision of central clearinghouse services for all Performance Improvement issues and record keeping for the Performance Improvement Steering Committee.
3. Coordination of hospital-wide and departmental monitoring and committee activity for the purpose of reporting to the Steering Committee.
4. Assisting the Medical Staff Committees in fulfilling the meeting requirements of the Medical Staff By-Laws.
5. Assisting the Important Function Councils/Panels/Teams in fulfilling their role.
6. Active participation in the Patient Safety and Performance Improvement Steering Committee.

XXII. Plan Evaluation

The Performance Improvement Plan will be reviewed annually and revised as necessary. The review assesses at a minimum:

A. Areas for improvement were identified, acted upon, and improvement demonstrated.
B. The written plan accurately reflects the evolving process
C. Performance Improvement is documented and communicated in an organized manner
D. The effectiveness and appropriateness of the Performance Improvement Plan and activities

XXIII. Confidentiality Statement

All data and information collected and maintained by the Performance Improvement Department, as well as proceedings, reports, and records from any review body shall be confidential. All data and information is strictly used for Peer Review. No data or information shall be released for any purpose.

Performance Improvement Plan
Appendix List
2011

Appendix	Title
I	Project Team Proposal
II	PI Initiative Prioritization Tool
III	PI Team Summary
IV	Score Cards for Reporting Data
V	DMAIC Project Charter

Appendix I

PI TEAM PROPOSAL

DATE: _____ VULNERABLE PROCESS: _____

NAME OF PERSON COMPLETING FORM: _____

SERVICE/ DEPT: _____ PHONE: _____

Please complete all requested information. Attach any supporting documents. If you have any questions regarding the proposal process, contact Performance Improvement Department, Ext. 71- 2934 or 70-3255

The team addresses the Liberty Pillar: (Please Circle)

1. Briefly describe the performance improvement you would like studied by a Team (Define):

_____

_____

_____

2. List the departments/services that should be represented in this Team, including medical staff (Define):

_____

_____

3. Check immediate financial resources needed: ❑ People ❑ Materials ❑ Finances ❑ Other Describe:

_____

_____

4. Do you anticipate a cost savings? ❑ YES ❑ NO If yes, describe and quantify how this will be achieved. Show your methods and calculations. Attach supporting documents:

_____

5. How long do you anticipate the project taking to complete? Can you give a brief timeline.

_____

_____

6. List recommendations to monitor and evaluate the success and improvement (Measure)

_____

_____

Please return to the PI Office.

Appendix II

2010 SIX SIGMA

Performance Improvement Initiative Prioritization Tool

Performance Improvement Opportunity: _____ DATE SUBMITTED:_____

This document will be used by the PISC to assist with **prioritizing** SIX SIGMA improvement initiatives. The advisability of the project will be considered utilizing but not limited to the weight determined by this tool.

IMPACT ON PATIENT SAFETY & CLINICAL QUALITY:

10= Prevent Mortality
4 = Prevent Morbidity
4 = Prevent Infection
4 = Addresses one of the CORE Measures
4 = Addresses Leapfrog Safe Practices or IHI Initiative
3 = Pain Management
3 = Post Surgical Status
3 = Correct use of blood and blood components
2 = Improve timeliness of providing care
2 = Reduce duration of patient stay (LOS)
0 = No impact on patient care outcomes

IMPACT ON SATISFACTION (Employee, Physician and/or Patient):

5 = High impact on retaining customers and attracting new ones
5 = High impact on employee or physician satisfaction
5 = High impact on attracting new physicians to Liberty

ECONOMIC HEALTH (Business Case):

7 = Media Attention
5 = $1,000,000 or more per year
3 = $500,000 or more per year
2 = $ 250,000 or more per year
2 = Reduce the cost of poor quality
1 = Intangible in $'s but financial impact in increased Productivity

FULFILL THE 2010 JOINT COMMISSION NATIONAL PATIENT SAFETY GOALS

5 = Accuracy of patient identification
5 = Improve communication among caregivers (Handoff & Read back)
5 = Improve the use of medication management
5 = Surgical Outcomes
5 = Improve Patient Management on Anti-Coagulation Therapy
5 = Involves Patient in Care as a Patient Safety Strategy
5 = Improve Infection Control Practices
5 = Reduce Falls

OPERATIONAL IMPACT

2 = High Volume
2 = High Risk
2 = Problem Prone / Chronic
2 = Urgency

3 = Mandated by the State Department of Health/JCAHO
3 = Customer Dissatisfaction Documented
1 = Identified by Staff

MANAGEABLE SIZE

1 = Project can be completed within 6 months or less
1 = Long term benefit (benefit will repeat yearly)
1 = Likely to be a winner for the organization

MEASURABLE & OBSERVABLE

5 = Process can be measured i.e. Explained using quantifiable terms such as DPMO
5 = Project can correct a continuing problem (not a recent one time episode)

_____ = TOTAL POINTS (If < 30 points, please provide supportive rationale for Project Selection)

FOR PISC COMMITTEE USE ONLY

OVERALL IMPRESSION OF PROJECT:

FEASIBLE? ( ) YES ( ) NO MEASURABLE ( ) YES ( ) NO

Approved_____ Not Approved_____ Date_____

Assigned to: _____
COMMITTEE FOR REPORTING

Champion _____ Support Staff Assigned_____

Reappraisal Due Date_____ Approved_____ Not Approved_____

Appendix III

Project Team Form

Reason for Improvement – Linkage to Strategic Priorities	
Team Mission	
2009 Improvement Target	
Indicators	
Type of Team(clinical or operational)	
Method	
Membership	
Deliverables	
Term	
Meeting Date/Times	
Black Belt/ Green Belt	
Leader	
Secretary	

Concur: Performance Improvement Steering Committee Date:_____

_____

Joseph Scott, Chief Executive Officer

Appendix V

LIBERTYHEALTH SYSTEM
Jersey City Medical Center

Six Sigma – DMAIC Project Charter

Project Title:			
Business Case			
Problem/Opportunity Statement:			
Project Scope:			
Goal Statement:			**Best Practices**
Sponsors: **Team Members:**			**Stakeholders:**
Preliminary Plan	**Target Date**	**Actual Date**	**Estimated Cost Savings / Revenue Enhancement for 2009**
Start Date			
DEFINE			
MEASURE			
ANALYZE			**Notes**
IMPROVE			
CONTROL			
Completion Date:			

Performance Improvement Plan 2010

Signature Page

Reviewed and Approved:

Date:_____

_____
Robert E. Margulies, Esq.
Chairman, LibertyHealth Board of Trustees

_____
Joseph F. Scott, FACHE
President & Chief Executive Officer

_____
Kenneth F. Garay, MD
Chief Medical Officer