

UTHCPC PERFORMANCE IMPROVEMENT PLAN 2011-2012

PURPOSE

The purpose of the University of Texas-Houston Harris County Psychiatric Center (UTHCPC) Performance Improvement Plan is to provide a leadership driven framework and an organizational structure to:

- A. achieve the mission and strategic goals of the UTHCPC
- B. integrate the hospital Performance Improvement (PI) activities into a comprehensive interdisciplinary program
- C. ensure that the Governing Body, Medical Staff and professional staff demonstrate a consistent endeavor to deliver safe, effective, optimal patient care
- D. ensure quality services in an environment of minimal risk

MISSION: Where are we now?

The UTHCPC is dedicated to excellence and leadership in the provision of patient care and the growing need for treatment of persons with mental illness residing in Harris County. UTHCPC has the unique additional missions of the University of Texas-Houston Health Science Center (UT-HHSC) which includes conducting research into the cause and treatment of mental illness, educating professionals in the care of the mentally ill, and providing the resources and knowledge of our staff to the local community. To achieve this mission requires an ongoing effort by all individuals to continually improve systems, processes, individual and organizational performance to ensure the delivery of the best care possible to meet and exceed (when appropriate) customer expectations,

VISION: Where do we want to be?

The UTHCPC will be a premier psychiatric provider in the delivery of treatment, education, and research. UTHCPC faculty and staff will promote clinical excellence and innovative policies in conjunction with the total mental health community and the people of Harris County.

VALUES

“We Care”

Working as a team to provide quality care in a safe environment
Excellence in the service of care

Culturally competent staff
Accountability in our commitment to excellence
Respect and compassion
Ethical and fair treatment for all

GOAL of PERFORMANCE IMPROVEMENT PLAN

In keeping with its mission, the UTHCPC has developed a Performance Improvement Plan committed to the continuous designing, monitoring performance, analyzing data, and improving and sustaining organizational performance. The hospital mission supports an environment where performance improvement efforts are an integral component of daily functioning.

OBJECTIVES of the PERFORMANCE IMPROVEMENT PLAN: How do we get there?

- Support the organization's mission and strategic plan;

Last Revision October 2007

Review Date 08/28/09

Revised October 2010

Reviewed August 2011

- Systematically plan, monitor performance, analyze current performance, and improve and sustain improvements of processes and outcomes of patient care through interdisciplinary teams, clinical service and department activities and peer review;
- Provide a mechanism for establishing/resetting organization-wide PI priorities;
- Address internal and external customer's needs and expectations;
- Promote interdepartmental and interdisciplinary communication with a scientific approach to problem solving;
- Facilitate dissemination, discussion and understanding of clinical and management data among medical staff and hospital staff members;
- Develop performance measures consistent with the organizational strategic plan;
- Integrate organizational performance improvement activities;
- Measure the organization's key outcomes, activities, and processes to support safety, improvement, innovation, and learning;
- Provide a mechanism by which medical staff and hospital staff members are educated in PI principles and processes;
- Develop an environment that encourages and empowers staff to identify and address issues through the PI process;
- Support compliance with accreditation standards and regulatory agency requirements.

GOVERNANCE & LEADERSHIP

The Hospital/Governing Body Liaison Committee is responsible and accountable for the quality of all services delivered by UTHCPC. The Hospital/Governing Body Liaison Committee's authority and accountability is delegated to the Chief Administrator and the medical staff for developing, implementing, and maintaining a viable performance improvement program. The Governing Body receives a quarterly Performance Improvement Report.

The Executive Director of UTHCPC is responsible for providing the necessary leadership, education, guidance, and support within the limits of resources available to maintain an ongoing program of performance improvement.

The Medical Staff of UTHCPC, under the direction of the Medical Director/Chief of Staff, is responsible for taking a leadership role in processes that are the primary responsibility of physicians and actively participate in organization-wide performance improvement activities.

MEDICAL STAFF EXECUTIVE COMMITTEE

Oversight and approval of the PI Plan is further delegated by the Executive Director to the Medical Staff Executive Committee, which has responsibilities for oversight of the quality of medical care, rendered to UTHCPC patients. The Medical Staff shares responsibility with the UTHCPC Executive Director and Administration for developing and reviewing clinically appropriate policies and recommending standards for other UTHCPC staff whose conduct directly influences the quality of patient care.

The Medical Staff Executive Committee is responsible for:

- Assisting and participating in the development, implementation, and evaluation of ongoing performance improvement program;
- Selecting and reviewing clinical indicators and criteria for use in peer review and in evaluating patient care quality;

Last Revision October 2007

Review Date 08/28/09

Revised October 2010

Reviewed August 2011

- Participating in and providing support to interdisciplinary performance improvement teams to foster integration, input, and problem solving at all levels of the organization;
- Reviewing and providing input and feedback to departments and services;
- Recommending clinical privileges; and
- Recommending medical staff for appointment and reappointment

Additionally, each Medical Staff committee is responsible for ongoing monitoring of quality activities under that committee's purview. The Medical Staff Executive Committee also requires each clinical service and clinical program to participate in the PI Program.

The elected and appointed leaders of the Medical Staff and clinical services are responsible for:

- Taking leadership roles in improving processes where the clinical process is the primary responsibility of physicians;
- Ensuring that the medical staff participates in the planning, monitoring, analyzing and improving of patient care processes;
- Ensuring that when measurement findings are relevant to an individual's performance, the medical staff determines their use in peer review or ongoing evaluations of licensed independent practitioner's competence;
- Ensuring that the findings, conclusions, recommendations, and actions taken to improve organizational performance are communicated to appropriate medical staff members.

PERFORMANCE IMPROVEMENT COMMITTEE (PIC)

The Performance Improvement Committee has been established as an oversight committee to provide leadership and guidance for improving the organization's performance.

The Performance Improvement Committee has responsibilities for:

1. Oversight and establishing/resetting priorities for the Hospital's comprehensive, interdisciplinary Performance Improvement program;
2. Development of an environment that encourages and empowers staff to identify and address issues through the PI process;
3. Empowerment of committees to identify opportunities, design performance improvement activities and resolve issues;
4. Assurance of compliance with accreditation standards and regulatory agency requirements;
5. Reporting to the Hospital/Governing Body Liaison Committee on performance improvement initiative, goals, and significant issues;
6. Establishing organization-wide PI measures that are strategically aligned;
7. Assessing resource utilization and provide oversight to the Utilization Review service; and
8. Chartering PI Teams if needed and providing oversight.
9. Reviewing and providing oversight for sentinel event root cause analyses.

Performance Improvement committee shall consist of the following members: Chief Administrator, Executive Director, Medical Director, Chief Nursing Officer, Director of Performance Improvement, and President of the Medical Staff. The PIC reports to the Hospital/Governing Body Liaison Committee.

The PIC has delegated responsibilities for coordination, integration, and ongoing monitoring of the organization's performance to improve and sustain quality of patient care processes and care to the Performance Improvement Coordinating Council (PICC).

Last Revision October 2007

Review Date 08/28/09

Revised October 2010

Reviewed August 2011

PERFORMANCE IMPROVEMENT COORDINATING COUNCIL (PICC)

The PI Coordinating Council has been established as organization-wide committee to synthesize and coordinate PI activities of the Medical Staff and Hospital. As such, UTHCPC leadership and Medical Staff have assigned primary responsibility for recommending, implementing, and monitoring of PI activities to the PI Coordinating Council. The PI Coordinating Council reviews and integrates PI efforts across the organization. The PI Coordinating Council ensures that activities throughout the organization are consistent with the priorities established by leadership. The PI Coordinating Council systematically reviews reports from quality related UTHCPC committees, The Joint Commission teams and PI Teams to identify key areas of opportunities. The PI Coordinating Council identifies specific high volume, high risk and problem prone aspects of care, instructing the appropriate committee or committees to prioritize their efforts accordingly. Intradepartmental performance improvement activities are shared with the PI Coordinating Council through the Performance Improvement support staff to assure coordination of efforts. At the end of the fiscal year, Performance Improvement support staff with the assistance of the departments will summarize and communicate the efforts of each department and clinical service, including those efforts that were effective and those that were not. This annual reporting mechanism facilitates communication among departments, informs the organization's leadership of planned and completed PI activities, and shares recommendations and improvement successes throughout the organization.

The PI Coordinating Council is responsible for:

1. Monitoring quality-related functions including PI and policy development;
2. Reviewing reports and the intensive analyses from committees and others relating to organization-wide measures and making recommendations for effective correction actions for operational and quality of care issues;
3. Referring issues to appropriate PI teams, clinical services, departments or committees;
4. Facilitating dissemination, discussion and understanding of performance improvement data;
5. Educating Medical Staff and Hospital leadership, management and employees in PI principles and processes;
6. Coordinating and integrating the various quality and organizational performance activities and measurements throughout the organization;
7. Obtaining input for problem-identification from committee's representatives, department heads or representatives, administrative reports including incident reports, survey findings from professional organizations such as The Joint Commission, departmental quality assessment reports, and Physician Quality Improvement;
8. Reviewing department and clinical service PI reports and making recommendations for effective corrective actions;
9. Evaluating applications and make recommendations for chartering PI Teams and providing ongoing oversight to PI Teams;
10. Evaluating the PI program annually and making recommendations for organization-wide PI indicators,
11. Evaluating ORYX data and making recommendations regarding opportunities for improvements; and
12. Identifying opportunities where interdisciplinary approaches are needed to efficiently and efficaciously resolve problems.

Last Revision October 2007

Review Date 08/28/09

Revised October 2010

Reviewed August 2011

Membership of the Performance Improvement Coordinating Council includes representatives from all departments (direct and indirect patient care). Contract Services providing direct patient care or services affecting the health and safety of patients are also included in the on-going monitoring activities and as appropriate, the PI team process, and other designated representatives as needed. The Medical Staff may also be requested to serve as a member of a PI team. The PI Committee appoints membership for a one-year term.

PERFORMANCE IMPROVEMENT SUPPORT STRUCTURE

The PI department staff provides support to the PI Committee and PI Coordinating Council for coordinating, organizing, aggregating, and reporting aggregate information to the PI Committee, Medical Staff, Hospital Committees, departments, and clinical programs.

Performance Improvement activities throughout the organization are also dependent upon the management of information function. This function is performed in an interdisciplinary collaborative approach throughout the facility. As the management of information is a function that is comprehensive, impacting all services within the facility, the review of this function is performed as a collaborative process when medical staff and departmental performance improvement activities are conducted. Outcomes are reflected in the specific departments and hospital wide through the auspices of the Performance Improvement Committee's review and analysis of performance improvement data.

PERFORMANCE IMPROVEMENT STRUCTURE AND INFORMATION FLOW

The reporting structure for the PI processes at UTHCPC is illustrated in Diagram 1. It shows the integration of the Medical Staff and Hospital committees, departments, and clinical programs in the PI structure. (See Diagram 1.)

Performance Improvement information flows according to the structure. Departments and program specific Performance Improvement information is reported to PI Coordinating Council through departmental/committee PICC representatives.

Reporting consists of systematic communication of information and the feedback related to the surveillance, review of data, and the improvements of specific processes and outcomes. Each designated measure is reported according to an established ongoing schedule and in a consistent written format to the PI Coordinating Council.

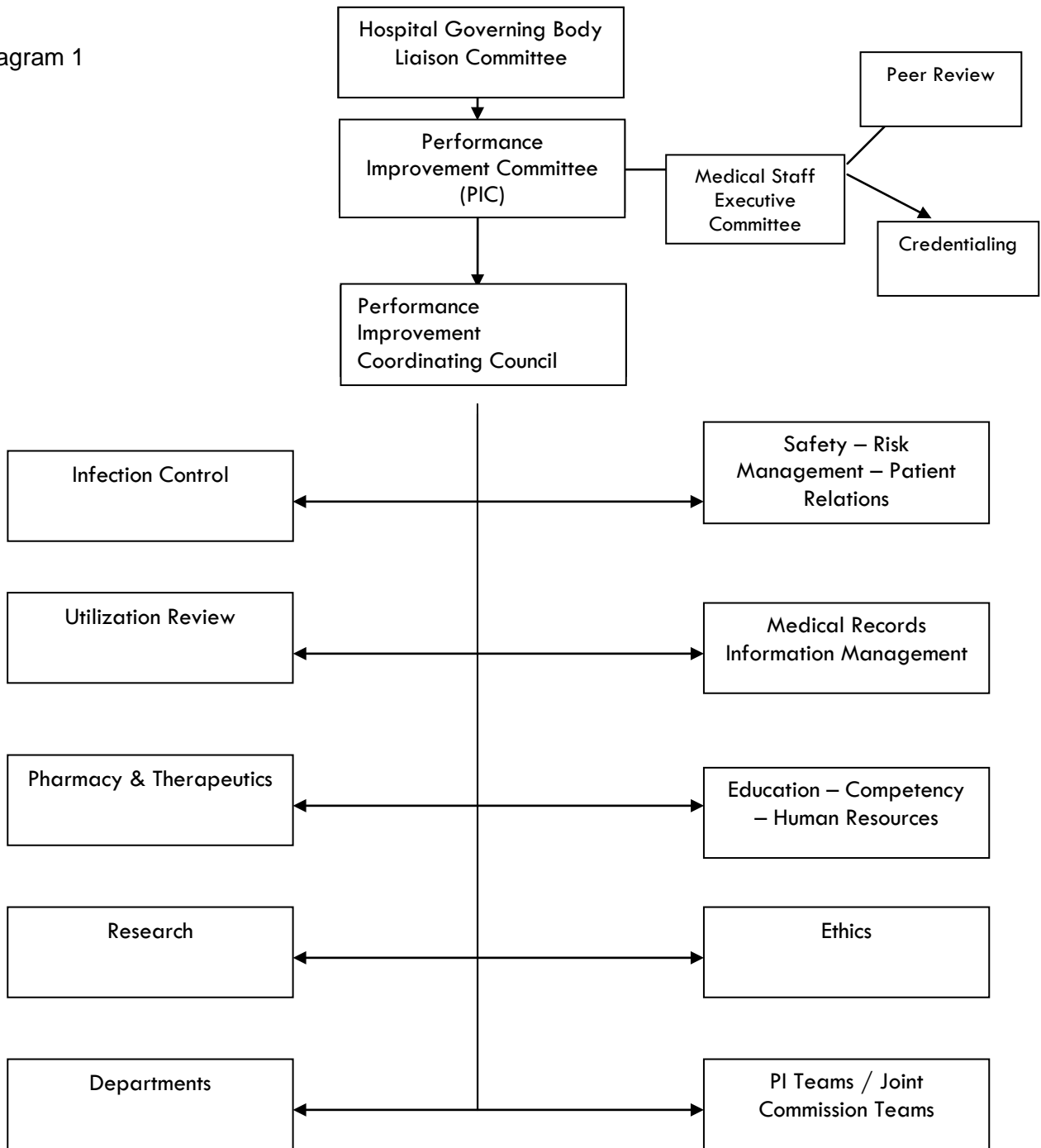
Last Revision October 2007

Review Date 08/28/09

Revised October 2010

Reviewed August 2011

Diagram 1



PERFORMANCE IMPROVEMENT PRINCIPLES

UTHCPC has adopted the concept of Continuous Quality Improvement (CQI) as reflected in the vision statement. The principles of CQI reflect a concept of working continuously to better meet customer needs and exceed their expectations.

The principles of CQI are:

- **Customer Focus:**
Knowledge and understanding of internal and external customer needs and expectations;
- **Process View of Work:** Analysis of processes for redesign and variance reduction using a scientific approach;
- **Innovation:**
Seeking new and different ways to meet customer needs and exceed expectations;
- **Measurement:**
Management through knowledge, decisions are based on knowledge confirmed with facts and data driven by an understanding of variation:
- **Organizational Involvement:**
All members have mutual respect for the dignity, knowledge, and potential contributions of others. Everyone is engaged in improving the processes in which they work.

PERFORMANCE IMPROVEMENT METHODOLOGY

UTHCPC's approach to PI is based upon The Joint Commission cycle for improving performance: design, monitoring performance through data collection, analyzing performance, and improving and sustaining improved performance. The monitoring and evaluation methodology selection is the FOCUS-PDCA process (® HCA, Nashville, Tenn.)

The steps are:

Find a process to improve

The first step is to find opportunities for improvements. This often requires baseline data collection to determine whether a problem actually exists. Data may come from variances from established standards/thresholds, patient or physician complaints, risk management issues, aggregate outcome measures/benchmarking, satisfaction questionnaires, clinical department meetings, staff meetings, hospital or medical staff department meetings, and quality monitoring activities. Prior to data collection, processes are evaluated to determine the following:

1. Purpose
2. Data sources
3. Detail of data collection
4. Data collection method
5. Appropriateness of sampling (at least 5 percent or 30 cases, whichever is larger)
6. Frequency of data collection.

Organize a team when necessary that is familiar the process

- Sometimes, initial actions are taken to reduce or improve these problem variations. However, these initial actions may require greater assistance from other disciplines or people to improve the problem.
- Teams provide employees an opportunity to take an active part in improving work processes and the products and services provided.

Last Revision October 2007

Review Date 08/28/09

Revised October 2010

Reviewed August 2011

- If the problem is interdisciplinary, team members are selected from most or all of the areas involved.

Consider an interdisciplinary team when the process is complex; there is a potential for reduction of rework: there is an opportunity for improvement of product or service to achieve greater alignment between customer requirements and supplier capabilities.

- Employees from all levels are encouraged to participate
- Teams will provide appropriate reports of PI activity to the PICC.
- Reports are to be submitted for review when the opportunity for improvement is selected and within 90 days of when the team has completed the improvement cycle (FOCUS-PDCA).
- The final report will include an analysis; conclusions, actions taken and results of actions related to performance improvement activities. Forms for planning, recording and documenting Performance improvement activities are found on the F: info\forms. **Clarify current knowledge of the process**
- Once a problem (opportunity for improvement) has been defined, theories of causes are formed and evaluated by the team.

Understand sources of process variation

- This is done using various PI tools (Pareto charts, run charts, control charts, flow charting, root cause analysis, cause and effect diagram, histogram, scatter diagram, etc) and generally involves the collection of data that supports the causes of the problem.

Question?	PI Tool
How much variation do we have and what kind (special or common cause) of variation? Is the process stable? Is our process changing over time?	Run chart or Control chart
What are we trying to accomplish? Which variables out of the many are occurring the most? What are the few vital areas we should focus on?	Pareto charts
How does the process work now at the detail level, what are the variables	Detailed flow chart
What is the root cause?	Root cause analysis
What are the many variables affecting this outcome? What are the root causes	Cause and effect diagram (fishbone)
How this one variable is distributed (what is the spread of LOS, Cost, etc. In our population?)	Histogram
Is variable 'A' possibly related to variable "B"?	Scatter Diagram

Select the process improvement

Where are we in the process and where do we want to be?

Last Revision October 2007

Review Date 08/28/09

Revised October 2010

Reviewed August 2011

- When a need or opportunity to establish new services, extend product lines, occupy a new facility, or significantly change existing functions or processes, the following factors will be considered:
 - The process will be consistent with the hospital's mission, vision, values, and strategic goals.
 - The needs and expectations of patients, staff, medical staff and others will be considered in the design of the process.
 - Clinically sound and up-to-date scientific, professional, and other sources of information will be considered in the design or redesign of processes.
 - The process will be consistent with sound business practices.
 - Baseline performance expectations will be established to guide measurement and assessment activities (such as use of reference databases, best practice examples and community standards).
 - During the process of data collection and evaluation, areas that can be improved are identified and prioritized.

Plan the improvement and continued data collection

During the planning step, the causes of variation are prioritized, solutions are designed, an implementation strategy is developed and indicators to measure the effectiveness of the improvement are created.

Indicators are derived from valid sources and supported by available clinical, operational or performance improvement literature.

Do Improvement, data collection and analysis

- Implementation strategies are outlined in an action plan that identifies the plan for improvement, the persons responsible, the target dates for implementation, identification of any dependencies (required for implementation) and any comments related to the actual implementation.
- Incorporate the plan into the department policy or standards if applicable
- Distribute the new policy or standard to all key individuals
- Educate staff, management, and Medical Staff on changes.

Check and study the results through data collection to analyze the plan

- As action plans are implemented, indicators identified in the plan are monitored and tracked so that actual performance improvement occurs.
- Ongoing tracking of indicators insures stability of the process.

Act to hold the gain and to continue to improve the process.

- When performance improvement is not sustained, the FOCUS_PDCA cycle continues as the new process and causes of variation are re-assessed.

UTHCPC Characteristics of Good Data Projects

- It originates with a problem
- It ends with a conclusion
- It is logical
- The process is based on valid and reliable data and metrics
- It is orderly

Last Revision October 2007

Review Date 08/28/09

Revised October 2010

Reviewed August 2011

- It is supported by literature and experiential knowledge
- It displays appropriate statistical tools
- The interpretation of data leads to further refined questions and a new cycle of inquiry.

PERFORMANCE IMPROVEMENT PRIORITIES

The criteria used to prioritize opportunities for improvement include, but are not limited to:

- Mission/Vision/Values
- Strategic plan goals/objectives
- Joint Commission Priority Focus Areas (PFAs)
- PI priorities
- Quality of care
- Clinical Outcomes
- Processes of Care
- Safety
- Customer Satisfaction
- Resource Management
- Continuum of care
- High risk
- Problem prone
- Regulatory requirements
- Sentinel Event Alerts / Sentinel Event
- Failure Mode Effect Analysis (Proactive risk assessments)
- The Joint Commission National Patient Safety Goals
- Root Cause Analysis

Based upon these criteria, the PI priorities for FY 11-12 are

1. Elopements
2. Seclusions
3. Medication Errors reaching the patient
4. Patient Injuries resulting in transfer to a medical facility
5. Patient Satisfaction with Activities Provided
6. Employee Satisfaction

Performance Improvement priorities and activities may be reprioritized based on significant organizational performance findings or changes in regulatory requirements, patient population, environment of care, and expectations and needs of patients, staff, or the community. The PI Committee may reset priorities.

PERFORMANCE IMPROVEMENT MEASURES

Performance measures for processes that are known to jeopardize the safety of the individuals served or associated with sentinel events will be routinely monitored. At a minimum performance measures related to the following processes, as appropriate to the care and services provided are monitored with the approval, and at the suggested frequency of the Performance Improvement Committee:

- Performance data identified in various chapters of the Comprehensive Accreditation Manual For Hospital
- Symptom improvement scales

Last Revision October 2007

Review Date 08/28/09

Revised October 2010

Reviewed August 2011

- Management of hazardous conditions (including identification and resolutions, as appropriate, of hazardous conditions)
- Medication use (including significant medication errors and adverse drug reactions).
- Seclusion / Restraint
- Care or services provided to high-risk populations
- Staffing effectiveness
- The appropriateness and effectiveness of pain management
- Recommendations for achievement of The National Patient Safety Goals
- Patient Flow
- Continuum of Care
- Peer review activities
- The PI Committee with recommendations from the PI Coordinating Council has established organizational performance improvement measurements that operationalize the PI priorities and include the priority processes and patient populations, regulatory and accrediting agency requirements. The Joint Commission standards are included in the planning and designing of measurement activities.

UTHCPC participates in data collection for the following state/national studies

- Behavioral Health Concepts Incorporated (PSAT) (Patient Satisfaction Tool)
 - NASMHPD Research Institute Behavioral Healthcare Performance Measurement System
- UTHCPC has maintained the following ORYX Measurements FY 10-11.

- Screening of Risk Of Violence, Substance Use Disorder, Trauma and Patient Strengths Completed
- Hours of Restraint Use
- Hours of Seclusion Use
- Clients discharged on multiple anti-psychotics without a clinically adequate rationale
- Discharge summary and aftercare Recommendations are sent to the Next Level of Care Provider Upon Discharge

PERFORMANCE IMPROVEMENT EDUCATION

PI Coordinating Council assures that medical staff, hospital leadership, and hospital employees receive training in PI methods and tools. PI information is included in the UTHCPC employee orientation program and is a component of the annual mandatory educational requirements. Furthermore, the Performance Improvement Department provides educational opportunities to ensure that all employees and the Medical Staff are aware of the interdisciplinary PI activities currently underway and that each is aware of the opportunities and resources available to support their PI efforts.

The following matrix identifies the framework for PI education:

GROUPS	PI PLAN	METHOD AND TOOLS	APPLICATION	RESPONSIBILITIES
Governing Body	X			X
Med. Staff Executive Committee	X	X	X	X

Last Revision October 2007

Review Date 08/28/09

Revised October 2010

Reviewed August 2011

PI Committee	X	X	X	X
---------------------	----------	----------	----------	----------

GROUPS	PI PLAN	METHOD AND TOOLS	APPLICATION	RESPONSIBILITIES
PI Coordinating Managers	X	X	X	X
Team members	X	X	X	X
Physicians	X	X	X	X
Staff Members & Individuals	X	X		X

CONFIDENTIALITY

Confidentiality is essential to the PI process. Deliberations of the PI Committee, PI Coordinating Council, Medical Staff Executive Committee and other Medical Staff committees and teams where PI issues are discussed are protected from outside review. Additionally, names of specific individuals (patients, physicians, staff, etc.) are withheld from all reports. Performance improvement data and reports are maintained in locked files.

EVALUATION

The effectiveness of the PI Plan is evaluated by the PI Coordinating Council and reported annually to the Governing Body, Medical Staff Executive Committee and PI Committee. This evaluation is based on comparisons of annual goals and objectives with program activities and achievements.

Last Revision October 2007

Review Date 08/28/09

Revised October 2010

Reviewed August 2011