ST. ELIZABETH HEALTHCARE
EDGEWOOD/COVINGTON/HOSPICE
PERFORMANCE IMPROVEMENT PLAN

2025

Original Approval:	**November 3, 1986**
Last Reviewed/Revised/Approved:	**November 1, 2017**
	October 24, 2018
	December 3, 2019
	February 16, 2021
	December 19, 2021
	December 1st, 2022
	February 4th , 2023
	February 7th, 2024
	February 5th, 2025

Table of Contents

PURPOSE

As St. Elizabeth Healthcare continues its journey to excellence to deliver comprehensive and compassionate care to those we serve, we strive to become a high reliability organization that focuses on what is valuable to our patients and their families. St. Elizabeth Healthcare's PI plan describes the performance improvement processes and the organization to help carry out the vision for the communities that we serve.

The PI Plan is aligned and driven by the Mission Statement, Vision, Values and Strategic Plan of the healthcare system.

Mission Statement - "As a Catholic healthcare ministry, we provide comprehensive and compassionate care that improves the health of the people we serve".

Vision - "St. Elizabeth will lead the communities we serve to become one of the healthiest in America".

Values - ICARE **I**nnovation, **C**ollaboration, **A**ccountability, **R**espect and **E**xcellence

The PI Plan focuses on continuous process improvement throughout the healthcare system to accelerate the cultural transformation of improving healthcare delivery through transparently monitoring performance metrics, promoting lean thinking, providing leadership development, and conducting process improvement initiatives.

The purpose of the plan is to provide a road map to the system that ensures St. Elizabeth is providing evidence-based high-quality care that eliminates waste and meets the customer expectations. The PI Plan includes the goals, structure, and objectives to align quality improvement activities across the system. It also defines organizational responsibilities, program scope, and priorities. Finally, the plan describes the data governance of key metrics for ongoing monitoring and evaluation of healthcare services and processes.

PROGRAM GOALS

Strategic Quality Goals

- Highest quality care in the region
- Leading in Patient Experience
- Centers for Medicaid and Medicare Services (CMS) 5-star status
- Achieve top 25%tile performance in Readmissions and Mortality as part of the CMS 5-star program

PI Impact Goals

As outlined by the Institute of Medicine (IOM), St. Elizabeth's goals are to improve quality and safety through the pursuit of the following aims:

- **Safe**: avoiding injuries to patients from the care that is intended to help them.
- **Timely**: reducing waits and sometimes harmful delays for both those who receive and those who give care.
- **Effective**: providing services based on scientific knowledge to all who could benefit.
- **Efficient**: avoiding waste of equipment, supplies, ideas and energy.

- **Equitable**: providing care that does not vary in quality because of personal characteristics such as gender, ethnicity, geographic location, and socioeconomic status.
- **Patient-centered:** providing care that is respectful of and responsive to individual patient preferences, needs and values and ensuring that patient values guide all clinical decisions.

PI Capacity Goals

To establish and sustain quality management structures and methods that:

- Identify opportunities for improvement
- Prioritize performance improvement projects
- Build capability to use a system-wide PI methodology
- Drive measurable and sustainable improvements
- Track and trend patient care and organizational outcomes

To achieve these goals, all SEH associates will need to participate in systematic quality improvement efforts which focus on patient care delivery and support processes that promote optimal patient outcomes.

AUTHORITY

The Board of Trustees shall have the ultimate authority and responsibility for establishing, maintaining, and supporting a comprehensive and integrated Quality Improvement program. This includes an annual review of the Performance Improvement plan. The Board of Trustees shall delegate the responsibility for administering the program to the Quality Improvement Committee (QIC), the Chief Quality Officer, VP of Quality Operations, Chief Medical Officer, Chief Nursing Executive, and Medical Staff leaders. The Board of Trustees has delegated the authority for overseeing the effectiveness of the quality program to the Quality and Patient Care Committee (QPCC) of the Board of Trustees. The QPCC of the Board of Trustees serves as the link between the QI program and the Board of Trustees and shall report to the Board on the effectiveness of the QI program.

PROGRAM SCOPE

The scope surrounding the PI Program at St. Elizabeth Healthcare is evolving to ensure comprehensive oversite of quality outcomes that address external regulatory requirements as well as internal strategic goals. The scope for PI is driven and altered by the expectations and demands of our customers. The PI activities of St. Elizabeth are coordinated across inpatient and ambulatory settings. The organization of these PI activities centers on the flow of patient care in which interrelated processes occur across multiple departments. However, PI activities may also focus on departmental processes.

The scope of the PI program involves personnel, patients, functions, required regulatory measures, and key quality indicators.

1. **Personnel**
   St. Elizabeth Healthcare believes every associate, physician, vendor and contractors have an implicit responsibility to quality patient-centered care. Whether involved in direct patient care or indirect

support services, each person contributes to quality patient outcomes. Cooperation, initiative, and effort from all personnel are required to obtain and sustain quality patient outcomes.

Personnel required to participate in PI initiatives, whether departmentally or house-wide, will be provided sufficient time. PI activities may include committee involvement, data management activities, education, and other activities.

2. Patients

PI activities will be conducted systematically with a focus on the patients and families in the acute hospital and ambulatory setting. PI activities will be prioritized towards high volume, high risk or problem prone issues/groups. When reasonably possible, 100% of a patient group will be monitored to obtain the appropriate data. The Joint Commission sampling requirements will be followed when not possible to monitor 100%.

3. Functions that are monitored include but are not limited to:

~ Patient Rights and Organizational Ethics
~ Provision of Care, Treatment and Services (Patient Assessment, Education, Continuum)
~ Patient Safety
~ Patient Experience/Satisfaction
~ Mortality
~ Readmissions
~ Length of Stay
~ Medication Management
~ Infection Surveillance/Prevention/Control
~ Management of the Environment of Care
~ Staffing to demand
~ Leadership Practices
~ Management of Information
~ Quality Improvement Initiatives
~ Behavior Management Procedures

4. Processes and Outcomes for Regulatory Requirements

(Rates are used to measure processes/outcomes whenever possible. *Requires Intensive Assessment)

PI Activities and Review require mandatory measurement of:

✓ **Focus Indicators (Important Processes & Outcomes/High Risk Populations) Including:**

- The Joint Commission, CMS and other participating registries for accreditation/certification purposes including Core Measures.
- Significant departures from established clinical standards/ patterns (see Peer Review Policy).
- Efficiency of clinical practice patterns.
- Significant departure from results provided by other organizations.
- Identified waste.

✓ **Medication Management**

- Medication Use:
- Significant Medication Variances
- All Serious Adverse Drug Events

Near Misses

- ✓ **Anesthesia, Operative, Invasive & Non-Invasive Procedures That May Place the Patient at Risk.**
  - Operative & other procedures that may place patients at risk.
  - Pre- and post-operative major discrepancies
  - Frozen Section versus Final Path Diagnosis
  - Sedation Adverse Events

- ✓ **Blood & Blood Components**
  - Use of blood and blood components
  - All confirmed transfusion reactions

- ✓ **Outcomes Related to Resuscitation**
  - Code Blue
  - Rapid Response

- ✓ **Medical Assessment & Treatment of Patients**
  - Pain Management

- ✓ **Autopsy information**
  - Discrepancies from Ante-Mortem Diagnosis
  - Permission for Autopsy

- ✓ **Participation in measuring, assessing, and improving**
  - Patient/Family Education
  - Coordination of care with other practitioners and hospital personnel
  - Accurate, timely and legible completion of patient medical records

- ✓ **Perceptions of care, treatment and services/HCAHPS**

- ✓ **Cardiology/Cardiac Surgery Process and Outcome**

Organization wide Interdisciplinary PI include measurement and evaluation of:

- ~ Management of information (including Medical Record Review)
- ~ Safety/Security
- ~ Equipment Management
- ~ Utilities Management
- ~ Life Safety Management
- ~ Utilization Management
- ~ Infection Control
- ~ Research as Applicable
- ~ Patient Safety Activities
- ~ Patient/family needs, perception of risks to patients and suggestions for improving patient safety.
- ~ Hazardous Materials/Waste
- ~ Emergency Preparedness
- ~ Risk Management Activities

PI projects and prioritization including measurement and evaluation of:

- ~ Interdisciplinary PI Projects and Team Projects
- ~ Department Specific Activities
- ~ Quality Control Activities

Key Quality Indicators

Key indicators will be identified by Health System Leaders. Key indicators may be those required by accrediting, review, licensure, or other outside organizations. Indicators may also be identified internally for opportunities for improvement activities. Key indicators as follows:

Core Measure Sets are:

- ~ Selected based upon; high volume DRGS, high risk or patient populations prone to problems in the past
- ~ Reported to the various committees including the Board of Trustees.
- ~ Analyzed on a quarterly basis by Quality Management Department, Core Measures Committees, Admin Council members and the Board of Trustees.

- ✓ **Severe Sepsis/Septic shock**
- ✓ **Stroke Accreditation and Certification Measures**
- ✓ **Outpatient CMS Quality Measures (OQR)**
- ✓ **Prenatal Care**
- ✓ **National Best Practice Quality Performance as measured by:**
  - o American College of Cardiology and the National Cardiovascular Data Registry for CathPCI LAAO, TAVR, and ICD
  - o American Heart Association Get With the Guidelines for Heart Failure, Atrial Fibrillation, Coronary Artery Disease and Stroke
  - o Society of Thoracic Surgeon CABG and Thoracic Care.
  - o ELSO ECMO Registry
  - o Intermacs LVAD Registry
- ✓ **Patient Safety Indicators**
- ✓ **Infection Control including Hand Hygiene**
- ✓ **Patient Experience Indicators**
  - Inpatient
  - Outpatient
  - ED
  - Outpatient Ambulatory Surgery
  - Oncology
- ✓ **Readmissions**
- ✓ **Clinical Documentation Improvement (CDI)**
- ✓ **National Database of Nursing Quality Indicators (NDNQI) Measures**
  - Falls
  - Pressure Injury Prevalence (including device-related)
  - Nurse Satisfaction
  - Turnover
  - Skill Mix
  - Nursing Hours/Patient Day
  - Restraints
  - Catheter Associated UTI
  - Ventilator Associated Pneumonia

- Central Line Associated Bloodstream Infections
- Peripheral IV Site Infiltrations (Neonatal)
- Pain Assessment (Neonatal)
- Pain-impairing function
- Physical/Sexual Assault (Psychiatry)
- Clostridium difficile (CDIFF)
- Methicillin-resistant Staphylococcus aureus (MRSA)
- Venous thromboembolism (VTE)
- Ambulatory surgical center (ASC) patient burns
- Adverse outcomes of care (wrong site, side, patient, procedure, implant, or device)
- Return to acute care
- HbA1c target levels
- Extravasation rate
- Door-to-balloon time
- Antibiotic stewardship
- Delay in treatment
- Telehealth appropriate disposition
    -

✓ **Pain Assessment and Management**
✓ **Quality Improvement Project Initiatives Key Outcome and Process Measures**
✓ **Medical Staff Peer Review Performance Improvement (PI) Activities include the following objectives:**
- To provide a data-driven system for identifying variances related to individual physicians and care. This program should coordinate its findings with the reappointment process for physicians.
- Improve evidence-based patient care by reducing variation and waste.
- Meet the Joint Commission requirements for Ongoing Professional Practice Evaluation (OPPE) and Focused Professional Practice Evaluation (FPPE) at each respective facility.

ORGANIZATION AND RESPONSIBILITY

The PI Plan establishes the organization and responsibilities for enacting improvements and reporting information to the Quality Improvement Committee (QIC) and the Board of Trustees. To facilitate the objectives of the program, the following individuals, departments, and committees have the responsibility to foster an approach to quality that develops professional ideals for ongoing improvement.

1. Leadership of the Quality Division

The Vice President of Quality Operations leads the quality division. The Quality Division includes the following departments: Quality Management, Quality Improvement, Patient Safety/Accreditation/Infection Control, Clinical Documentation Improvement and Patient Experience. This division is responsible for establishing and administering the Health System's PI plan.

2. Quality Management Department

The Quality Management Department is responsible for the overall quality data strategy and quality data governance throughout the healthcare system. Activities include analyzing, coordinating, and communicating quality information throughout the healthcare system. The Quality Management Department also assists and

supports all Medical Staff and Health System Departments in developing appropriate indicators/reports related to departmental, interdisciplinary or organization wide projects. A member of the Quality Management Department sits on Medical Staff and Health System committees as indicated. The department is responsible for: monitoring Medical Staff quality and utilization indicators, supporting and/or participating in interdisciplinary teams and collection of data for benchmarking studies. The Quality Management Department also is responsible for responding to and assisting the needs of organization wide studies required by regulatory agencies (e.g., Medication Variances,) or instituted by management or other departments (e.g., Gainsharing indicators, Med Record review).

3. Quality Improvement Department

The Quality Improvement Department facilitates strategic quality initiatives and helps establish sustainment of continuous improvement efforts. Quality Improvement projects follow and promote a system wide methodology. A key objective for this department is a transformation that includes knowledge transfer to the supported areas. This department also helps to establish and teach basic and advanced process improvement concepts, techniques, and tools to department managers and frontline staff.

4. Patient Safety / Infection Control / Accreditation

Patient Safety and Infection Control provide surveillance of safety and infection prevention standards and report findings to department leadership. Department spearheads root cause analysis of identified safety events to mitigate future occurrences. They provide coaching and consultation to leaders and staff on industry best practices to minimize harm and prevent infection. Also, this team coordinates external agency surveys and certifications.

5. Patient Experience

Patient Experience monitors the survey process of our patients and their satisfaction with their experience in our system. They report results and identify opportunities for the system and departmental improvement. The Patient Experience department also helps address patient complaints. They provide coaching and consultation on industry best practices to leaders and staff to improve the experience of patients and their families.

6. Health System Leaders

The leaders of St. Elizabeth Healthcare are responsible for implementing and maintaining the PI Program in their respective divisions, departments or units. Monitoring and reporting on interdisciplinary issues are the leader's responsibility and are completed within the appropriate time frames. Leaders use pre-established, objective process criteria to assess the effectiveness of their contributions to PI and improved patient safety through: PI study results/action planning reports, patient satisfaction studies, utilization studies, profitability, market share and benchmarking projects.

7. Medical Staff

Medical Staff members are integrated into the PI Activities through their department activities and through organization wide studies and committees. Medical Staff leaders prioritize, assess, identify opportunities to improve, and implement action planning. Leaders of the Medical Staff communicate findings, conclusions, recommendations, and actions taken to improve organization wide performance to their departments and through various committees such as the Quality Improvement Committee and Medical Executive Committee.

8. Nursing

The nursing division coordinates a comprehensive PI Program that includes nationally nurse sensitive indicators and unit-based measures.

A. Nursing Leaders

The Sr. Vice President/CNE is responsible for implementing and maintaining the PI program in the nursing department. Program management is assigned to the Nursing Clinical Support Services Manager.

B. Clinical Performance Improvement Council (CPIC)

The CPIC is responsible for receiving, coordinating and disseminating quality information conducted in nursing departments. The council is comprised of the chairs of the nursing divisional committees. The council is chaired by a professional staff nurse selected from the council membership. The council is advised by the Nursing Clinical Support Services Manager or designee. The CPIC supports all divisional nursing performance work, discusses organizational performance trends, shares nursing-specific quality outcomes and recommends action. Performance Improvement priorities are established on an annual basis. Performance improvement education is provided to council members and to nursing staff throughout the organization.

C. Nursing Divisional Performance Improvement Committees

The Nursing Divisional Performance Improvement Committees are responsible for ensuring that the quality program is consistent for the division. The committee is comprised of Managers and/or staff nurses from their unit. Ad hoc membership includes Infection Control, Patient Safety and Accreditation, and an Information System Application Coordinator. The committees are chaired by a professional staff nurse selected from the committee membership. The committees are advised by the Director, Nursing Quality & Performance Improvement (or designee). The Nursing Divisional Performance Improvement Committee shares unit Performance Improvement trends, consistency of data collection and fall out criteria, as well as sharing best practices. (see appendix E)

D. Unit-Based Performance Improvement

Unit based design teams/councils serve as the forum for staff participation in the quality program at the nursing unit/department level. Quality control measures and unit specific performance related to CMS/TJC Core Measures and HCAHPS are the responsibility of the individual unit based teams and managers. Nurse-sensitive quality indicators and unit specific quality studies are reported to the CPIC.

9. Quality Improvement Teams

The primary function of each QI project team is to improve organizational performance by measuring, analyzing, and improving the systems used to deliver care and/or services and report findings and improvement plans to appropriate quality committees. Each project team composition will be guided by the nature of the topic, and includes front line staff, clinical and/ or non-clinical that is closest to the process being studied. The Quality Improvement Department will provide PI methodology, facilitation, and change management support. Teams report their progress to Executive Sponsors and MD champions on regular basis and present results to the Quality Improvement Committee for review as appropriate.

10. Clinical Documentation Improvement (CDI) & Coding

The CDI department's role is to help ensure that all clinical documentation is accurate and complete. This role is important because provider documentation must give an accurate picture of how sick the patient is, the level of resources needed to care for the patient, and their risk of mortality.

11. Other Organization-wide Departments involved in the PI Program

Other organization-wide committees that address quality include: Medical Executive Committee, Risk Management, Service Lines, HAC committee, Nursing Excellence, CDI and Care Coordination. These committees work through their individual leaders that have been designated to review their issues. Coordination among quality committees is represented in the Quality Committees Infrastructure chart in the Appendix A.

12. Quality Improvement Committee (QIC)

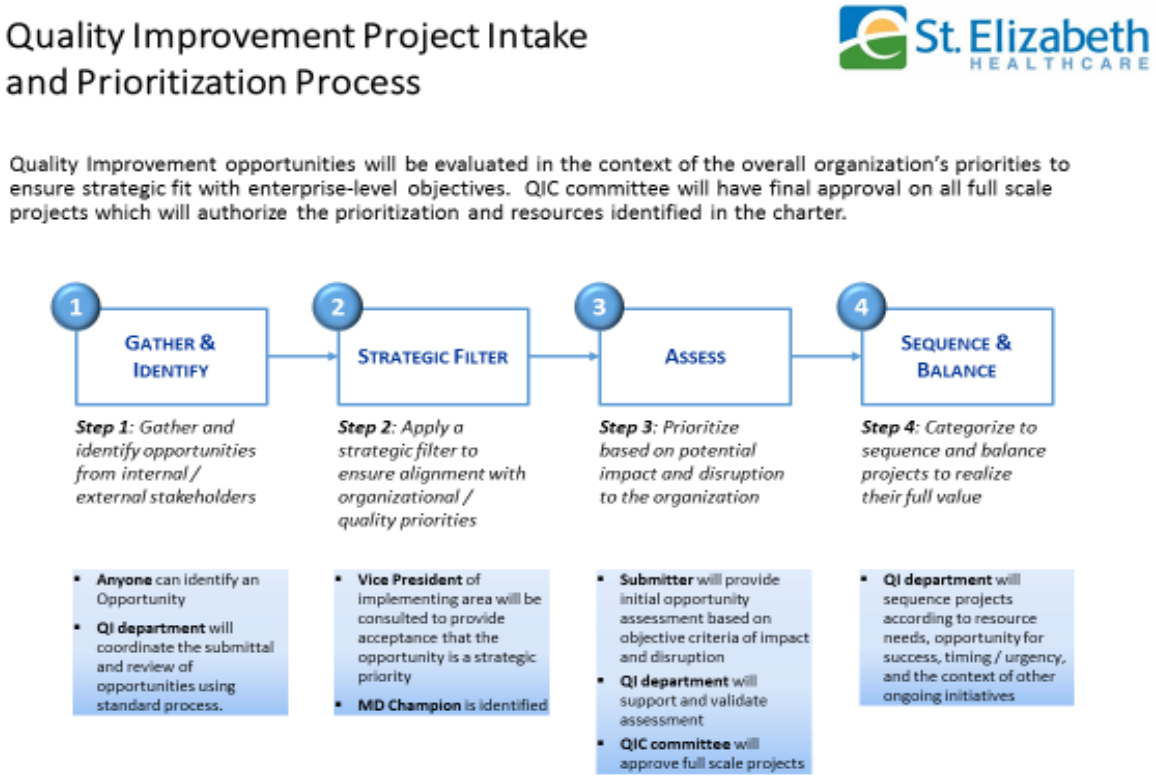
The Quality Improvement Committee coordinates and prioritizes performance improvement activities. The Committee is designed to provide Health System and Medical Staff leadership and management support/direction for improvement activities. The Quality Improvement Committee is composed of Physician Leaders, Administration Representatives, and Department Heads. This Committee reviews and evaluates proposed PI projects. The Committee is interdisciplinary and problem solving in nature. The Committee is chaired by the president-elect of the Medical Staff. As problems or opportunities to improve care are identified, representatives from other departments may be asked to attend the Quality Improvement Committee meetings. With input from the appropriate people and departments, the members of the Quality Improvement Committee will assist in setting priorities by viewing the organization's overall goals, analyzing the availability of resources to address the improvement opportunities, and consider the organization wide effect of changes in process and outcome. The Quality Improvement Committee members (Appendix B) meet monthly, unless otherwise noted.

13. Quality and Patient Care Committee of the Board of Trustees (QPCC)

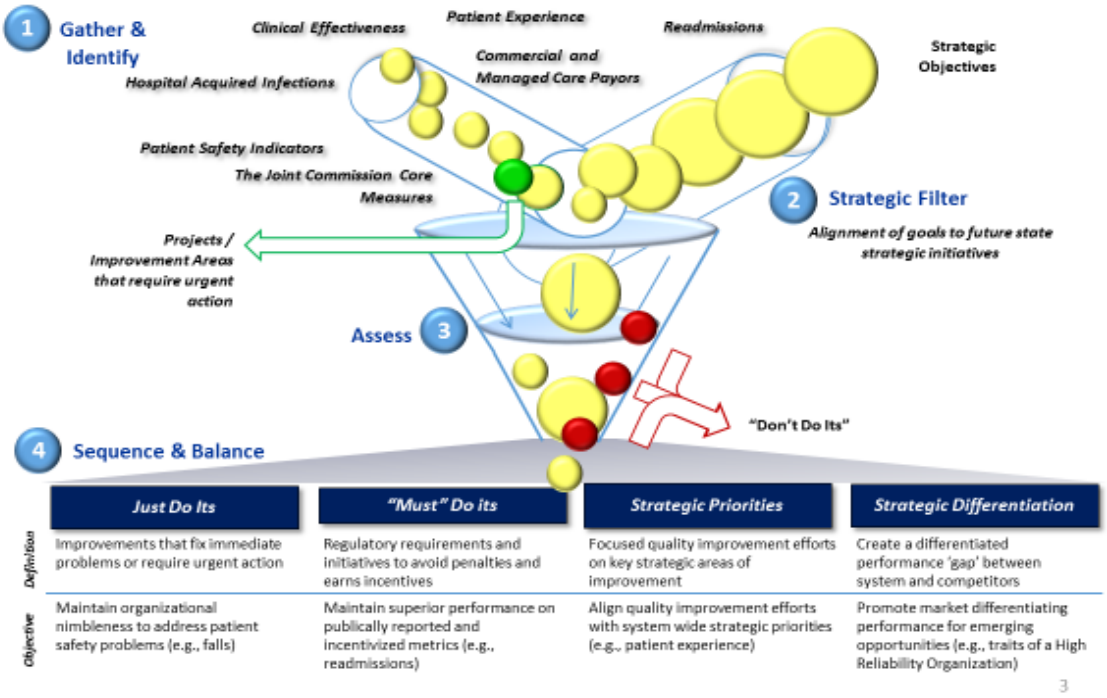
The Quality and Patient Care Committee reviews quality, safety, risk, patient experience, patient safety, infection control and utilization reports for the system. Quality improvement activities and recommendations for policies regarding patient care matters are reported to the Board.

PRIORITY SETTING

Annually and throughout the year St. Elizabeth Healthcare will address and set system priorities for PI initiatives. Projects are initiated through a thorough review of system level data and leader requests. These projects are then vetted through Senior leadership to ensure they relate to a significant issue and/or align to a strategic initiative. Next, prioritization of major QI initiatives occurs through QIC after assessing the total impact and level of disruption. Finally, the project is scheduled to be conducted using the most appropriate method by the QI department. The work plan for FY25 to help achieve our system's quality goals is listed in Appendix D.



Systematic Prioritization Process



3

Quality Improvement Project Application - Scoring

Key: Mandatory Field

Instructions	Please assess the potential Impact and Disruption of your proposed initiative in the yellow boxes based on the definitions provided. Please comment on the reason for your assessment in the space provided.

	Domain	1 (Low)	2	3	4	5 (High)	Applicant Score	Comments
Impact	Patient Impact	*Initiative focus is not patient-centric (emphasis on other improvements) - < 50 pts/yr affected*	*... > 50-200pt/yr*	*Success will improve either patient safety / outcomes or patient experience - 200 -600 patients affected*	*... 600-900 pts/yr*	*Initiative introduces an innovative approach to the patient experience and addresses a widespread issue or opportunity - >900 patients affected*		
	Workflow	*Implementation will not impact clinical / administrative workflow*	*...*	*Success will moderately improve workflow*	*...*	*Success will produce a measurable, significant impact to workflow, increasing efficiency and reducing time requirements*		
	Strategic Differentiation	*The initiative does not lend itself to external communication of success*	*...*	*The initiative may improve St. Elizabeth's image or credentials in less-prominent publications (e.g., may help CMS 5 Star achievement, helps other rankings)*	*...*	*Success can be clearly illustrated to the community and/or build prominent credentials to use as a differentiating factor from other hospitals (e.g., critical to CMS 5 Star achievement, new service line)*		
	CMS 5 Star Impact	*No impact to CMS 5 Star*	*...*	*May help CMS 5 Star achievement (intended to add to Strategic Differentiation)*	*...*	*Critical to help CMS 5 Star achievement (intended to add to Strategic Differentiation)*		
	Financial	*The initiative is unlikely to improve St. Elizabeth's financial position - low to no financial impact*	*... >$50k*	*The initiative may improve St. Elizabeth's financial position, but is unlikely to make a major impact - Medium Oppty >$100k*	*... >$500k*	*The initiative will result in significant savings for St. Elizabeth through process standardization, reduced costs, P4P improvement, etc. - excess of $1M*		
	Total Impact Score						0	

Quality Improvement Project Types

	Full-Scale Projects (MWE)	Fast-Track Projects (RIE)
Resources	▪ Spans multiple groups or teams in the organization	▪ Limited to one group or team in the organization
Impact	▪ Expected to impact multiple areas (e.g., departments, disciplines, offices)	▪ Limited to one department, office, and function
Oversight	▪ Requires improvement team guidance throughout the project application and implementation	▪ Requires minimal to no guidance from improvement team
Data Reporting	▪ Report to Improvement Team regularly on progress via PDSA form	▪ Track data at the local level and report outcomes at the end of a project
Application & Prioritization	▪ Submit full project application with scoring for prioritization	▪ Submit fast-track application with scoring for alignment with strategic goals
Project Inventory	▪ Include project application, progress reports, and outcomes as case studies and reference for future projects	▪ Include project application and outcomes report as reference for future projects

MWE – Multi Week Event RIE – Rapid Improvement Event

Departmental PI Priorities

Department and Unit PI Initiatives will assess priority using the following criteria for scoring on the St. Elizabeth Department PI Summary form:

1. The degree to which the opportunity reflects St. Elizabeth Healthcare's Mission, Vision, Values, Priorities and Goals.
2. The resources required to pursue the improvement opportunity.
3. Whether the opportunity is or affects a mandated/required organizational study.
4. Whether the improvement opportunity addresses a high volume, high risk or problem prone process.
5. The degree to which the opportunity reflects our patient's/family's perceptions and staff views with respect to their needs and expectations.
6. Whether the opportunity pertains to a high impact clinical/technical service.
7. Whether the opportunity pertains to Patient Safety, Safety, Infection Control, Risk Management, Utilization Mgt. or Quality Control concerns.
8. Whether the opportunity addresses utilization issues such as a high-cost function or process, or whether the opportunity promises significant cost savings.

PRIORITIZATION: (*Check those that apply)*	
• **Clinical Technical Quality**	
• **Resource Utilization/Costs**	
• **Patient/Family/Employee Satisfaction**	
• **Mission, Vision, Values Related**	
• **Patient Safety**	
• **High Volume/Risk/Problem Prone**	
• **External Benchmark/Publicly Reported**	
• **Customer Required (i.e. JCAHO)**	
*** 7 - 8 checks = high priority** *** 5 - 6 checks = moderate priority** *** 3 - 4 checks = low priority** *** 0 - 2 checks = not a priority**	

Prioritization should formally occur annually for departments and units when departmental PI projects are being reviewed. Prioritizing should occur at any time when issues arise that require either designated teams or a natural workgroup to monitor the process by involved department and leader of those departments. When issues require more complex or inter-department review, the Quality Improvement Committee will accept referred issues for priority setting. PI activities should be sensitive to emerging needs such as those identified through unanticipated adverse occurrences, regulatory changes, patient/staff needs, etc. Re-prioritization may need to occur considering new issues.

FOCUS PDSA

The designated improvement approach at SEH is **FOCUS PDSA.** The QI department uses this methodology when facilitating QI projects that have been approved by the Quality Improvement Committee. This is a proven process improvement methodology with established deliverables. The FOCUS acronym means:

Find a process or identify a problem that needs improvement.

Organize a team that understands or works with the process or problem.

Clarify knowledge of the process can help to ensure there's agreement on what the real issues are. Every person who walks through the process or experiences the problem sees things from a little different perspective making it important to clarify the knowledge from every perspective.

Understand the process variations and root causes.

Select solution(s) to test.

The **PDSA** process then convenes for the selected solutions to test. A Simplified PDSA form shown below is in place for use by QI teams:

PDSA

St. Elizabeth HEALTHCARE

Team: _____ *Initiative:* _____

What is the objective of the test / briefly describe the test

Description:

PLAN

(Plan for change or test: who, what, when, where)

#	What	Who	When

What do you predict will happen?

Measures *How will you know that the change is an improvement?*

DO

Test the Changes / Was the test carried out as planned? / Record data and observations / What did you observe that was not part of the plan?

STUDY

Did the results match your predictions? / Compare the result of the test to previous performance / What did you learn?

ACT

Decide to Adopt, Adapt, or Abandon (Check One) Describe what modifications for next test or steps for implementation are required)

Adapt *(Improve the change and continue testi* Adopt *(Select changes to implement larger scal* **Abandon** *(Discard this change)*

Active QI projects will be monitored by the Quality Improvement Department and progress reported to the Quality Improvement Committee and The Quality and Patient Care Committee of the Board. Project performance is reported beyond project handoff, typically for a period of 12 months, and there is accountability to sustaining improvement through process governance. A structure for process governance must be determined with each project handoff.

Department and unit specific QI Studies may alternatively use the PI Summary Form to facilitate implementation of the PDSA cycle for departmental quality improvement initiatives.

PERFORMANCE IMPROVEMENT (PI) SUMMARY

REPORTING DEPARTMENT:		CAMPUS:	

PLAN (Complete all Sections)

1)	CATEGORY *(check those that apply)*	
	Emergency Management	
	Environment of Care	
	Human Resources	
	Infection Prevention and Control	
	Information Management	
	Leadership	
	Life Safety	
	Medication Management	
	Patient Safety & National Pt. Safety Goals	
	Provision of Care, Treatment and Services	
	Record of Care, Treatment and Services	
	Rights & Responsibilities of the Individual	

2)	TOPIC
	What subject have you selected?
	Why did you choose this subject?
	What do you hope to accomplish?

3)	PRIORITIZATION: (*Check those that apply)*		
	Clinical Technical Quality		
	Resource Utilization/Costs		
	Patient/Family/Employee Satisfaction		
	Mission, Vision, Values Related		
	Patient Safety		
	High Volume/Risk/Problem Prone		
	External Benchmark/Publicly Reported		
	Customer Required (i.e. JCAHO)		
	* 7-8 Checks =	High Priority	
	* 5-6 Checks =	Moderate Priority	
	* 3-4 Checks =	Low Priority	
	* 0-2 Checks =	Not a Priority	

4)	Sample Size		*Sample Size Required(info only)*	
	1st Q		< 30 --------	100% Review
	2nd Q		30-100------	30 Cases
	3rd Q		101-500-----	50 Cases
	4th Q		> 500-------	70 Cases

5)	DATA			
	Data Source			
	Fall Out Criteria			
	Baseline data prior to implementation of change(new studies only)			
	Data Point #1:		Data Point #2	

6)	Participating Departments:

7)	Project Leader:

DO (Document your measures/indicators below)	GOAL	1st QUARTER			2nd QUARTER			3rd QUARTER			4th QUARTER			Average Year-End Results
		N	D	%	N	D	%	N	D	%	N	D	%	
Outcome Measure(s)				#DIV/0!			#DIV/0!			#DIV/0!			#DIV/0!	#DIV/0!
				#DIV/0!			#DIV/0!			#DIV/0!			#DIV/0!	#DIV/0!
				#DIV/0!			#DIV/0!			#DIV/0!			#DIV/0!	#DIV/0!
				#DIV/0!			#DIV/0!			#DIV/0!			#DIV/0!	#DIV/0!
Compliance Measure(s)				#DIV/0!			#DIV/0!			#DIV/0!			#DIV/0!	#DIV/0!
				#DIV/0!			#DIV/0!			#DIV/0!			#DIV/0!	#DIV/0!
				#DIV/0!			#DIV/0!			#DIV/0!			#DIV/0!	#DIV/0!
				#DIV/0!			#DIV/0!			#DIV/0!			#DIV/0!	#DIV/0!
				#DIV/0!			#DIV/0!			#DIV/0!			#DIV/0!	#DIV/0!
				#DIV/0!			#DIV/0!			#DIV/0!			#DIV/0!	#DIV/0!
				#DIV/0!			#DIV/0!			#DIV/0!			#DIV/0!	#DIV/0!
				#DIV/0!			#DIV/0!			#DIV/0!			#DIV/0!	#DIV/0!
				#DIV/0!			#DIV/0!			#DIV/0!			#DIV/0!	#DIV/0!
				#DIV/0!			#DIV/0!			#DIV/0!			#DIV/0!	#DIV/0!
				#DIV/0!			#DIV/0!			#DIV/0!			#DIV/0!	#DIV/0!
				#DIV/0!			#DIV/0!			#DIV/0!			#DIV/0!	#DIV/0!
				#DIV/0!			#DIV/0!			#DIV/0!			#DIV/0!	#DIV/0!
				#DIV/0!			#DIV/0!			#DIV/0!			#DIV/0!	#DIV/0!
				#DIV/0!			#DIV/0!			#DIV/0!			#DIV/0!	#DIV/0!

DIRECTIONS:

1. Monitor continuously, calculating quarterly results on an ongoing basis.
2. Develop specific action plans based upon quarterly results.
3. Monitor effects of action planning continuously, altering if needed to ensure improvement.
4. Scores ideally should increase quarterly as the year progresses.
5. Year-end goals noted based upon best practices, benchmarks, standards, literature or internal goals.
6. Completion of this form ensures completion of PDSA Cycle.
7. Complete run chart for at least one indicator and graph it across time.
8. Continue to monitor until process is stable; after achieving goal, monitor another two quarters within next 9 months, then complete focused follow-up studies as indicated to ensure stability.

PERFORMANCE IMPROVEMENT (PI) SUMMARY - STUDY/ACTION PLAN

STUDY/ANALYSIS (Complete your interpretation and evaluation of the numerical results)

1st QUARTER	2nd QUARTER	3rd QUARTER	4th QUARTER

ACTION (Complete step by step actions to improve performance)

1st QUARTER STEPS	WHO	DATE	2nd QUARTER STEPS	WHO	DATE
3rd QUARTER STEPS	**WHO**	**DATE**	**4th QUARTER STEPS**	**WHO**	**DATE**

PDSA CYCLE

The **PDSA** - **P**lan, **D**o, **S**tudy, **A**ct Cycle (also called the Shewhart Cycle) is the testing and implementation phase of our performance improvement model. This cycle is widely used because of its logic, simplicity, and continuous nature.

1. **PLAN** Design the Process/Actions. An operational plan for implementing the chosen action should be created. Planning involves determining what action will be taken, what associates need to participate, a timeline, what indicators will be developed, and how the processes and outcomes of the monitor will be measured and assessed. Predict what you think will happen from the action. Research and utilization of Best Practices is strongly recommended for all PI Studies. Improvement activities may also be used to design new processes as well as improve existing processes.

2. **DO** Carry out the action. This is best done on a small scale at first for a short period of time. Collect data on indicators from the "plan" stage. Record your observations including any problems or unexpected findings. Monitors may include indicators that provide data related to patient expectations.

3. **STUDY** Analyze the Data**.** The data collected during the monitoring period should be analyzed. This analysis seeks to answer this question: **Was the improvement action entirely successful, partially successful or not successful in achieving the desired outcomes?** The analysis determines the degree of success, and then compares the results to desired performance targets and to baseline results from prior data collection periods. Several tools within EXCEL are available as well as other statistical software to determine trends and tests of significance.

4. **ACT** Improve and Sustain the Performance**.** Action plans will be developed based upon the analysis of the data. If the study is not successful, the cycle repeats. Once actions have been shown to be successful, they are made a part of standard operating procedures.

    A. When assessment of data indicates an opportunity to improve, corrective actions should be **adopted** and if possible, spread to similar areas.
    B. When measurement indicates lower effectiveness, may require **amendment** of the actions.
    C. Should evaluation of results show no progress or value to continue, the actions can be **abandoned**.

PI PROGRAM FRAMEWORK

A principal goal of the PI plan is to provide a working framework on which quality improvement can manifest across our system. Performance data should be trended across time, establishing baseline rates or thresholds. To achieve our goals, leaders set expectations, develop/review/ revise plans and manage the measurement and assessment of quality processes. Leaders define and support the organization-wide approach to PI (FOCUS PDSA) and collaborate to ensure issues are addressed throughout the Health System.

The PDSA Cycle should continue for the identified issue(s) until the issue is resolved. When pre-determined levels of care are reached, the ongoing improvement plan must emphasize maintaining the gain and striving for stability.

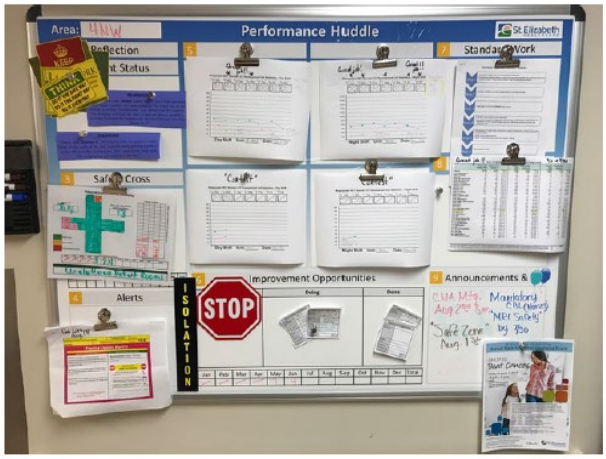
Units/departments should design and/or be involved in a minimum of one PI project each year. If interdisciplinary issues are involved, it is expected that appropriate collaboration and input is solicited. General PI activities of leaders include the following:

1. Prioritize opportunities for improvement using data and information to guide decisions and to understand variation in the performance of processes supporting safety and quality. Measure the quality of care including high risk and error prone processes through a planned, systematic, ongoing process.
2. Set measurable objectives/expectations for improving hospital performance and improving patient safety. Benchmarks/Goals can be set using past internal data, literature, or comparative data.
3. Draw conclusions based upon findings and develop action plans to maintain stability and/or improve patient outcomes and processes. Evidence-based best practices are identified that reduce variations in performance.
4. Implement actions to improve patient outcomes, eliminate waste and align the hospital with physicians and other providers across the care continuum. The projects may include development and implementation of Care Maps/ Protocols and Clinical Pathways, Order Sets or Best Practices.
5. Monitor results of action plans and adjust plans as necessary.
6. Attend PI Education to educate themselves in Performance Improvement Methods and Techniques.
7. Provide time and resources for staff to participate in PI and improve patient safety. Educate their staff in the theory and techniques required to participate in PI and Patient Safety Processes.
8. Establish information systems and data management processes for ongoing PI and patient safety initiatives.

Quality Improvement Approaches:

- Huddles – The daily huddle is a foundational structure in moving our culture forward to a continuous improvement organization. Frontline staff and their leaders meet daily to discuss performance issues affecting their areas. The daily huddle has several key objectives: Provide time for daily communication with an emphasis on safety and improvement, review daily metrics that can be directly impacted by front line staff, and generation of improvement opportunities to reduce waste and error. Huddle efforts are aligned with organizational goals and are facilitated by the department leaders. The improvements generated usually are 'just do its'.

Example Huddle Board



- Department Specific projects – An issue identified by the department or area that is within the area's own control. Department leaders assign group of associates to resolve and use the FOCUS PDSA

methodology to address. Project is facilitated by a leader or associate within the area and results are shared with area manager and director.

- Rapid Improvement WorkOuts™ – An issue with defined scope identified in the division and the division leadership desires facilitation between multiple areas to resolve. A trained facilitator within the division or a Quality Consultant is used to organize a rapid improvement event with a team of front-line associates to recommend solution and action steps to department and division leaders for approval.

- Multi-department/System QI teams – A complex issue rises to the facility or system level that is reviewed and approved by the Quality Improvement Committee (QIC). A QI team is organized and conducts a systematic process review using the FOCUS PDSA methodology to address. The team meets over multiple weeks to develop solutions for approval by an Executive Sponsor and as needed by the QIC.

The Director of Quality Improvement can be consulted to assist in identifying the proper approach as needed.

COMMUNICATION

1. All members of the Board, The Quality Improvement Committee and Administrative Council have direct access to the Quality Executive Dashboard containing key quality measures.
2. Service line quality dashboards are regularly reviewed by Service line leaders and the Quality Improvement Committee.
3. Reports of data collected, actions taken and results of the effectiveness of those actions other than anticipated legal claims are reported quarterly to the Clinical Performance Improvement Council (CPIC). Additionally, performance improvement reports are submitted from each nursing unit/department Manager to their responsible Director, VP, and the Sr. VP/CNE.
4. A quality update is provided bi-weekly at Administrative Council meetings.
5. A quality report is presented at every monthly system management meeting. Key quality metrics, awards, QI initiative updates and other quality information is shared. Managers are responsible to share this information with their staff.
6. The Quality Improvement Committee meets monthly and publishes a newsletter that is emailed to all staff.
7. The "Connections" emails (a weekly hospital publication) that goes to all staff, frequently contains quality related articles at St. Elizabeth.
8. The St. Elizabeth website, https://www.stelizabeth.com/about/quality-reporting, contains information on quality that is available to the staff, physicians and the community.
9. PI quality committees, QI initiative committees, and other adhoc meetings all provide opportunities for PI communication.
10. Other forms of communication include: QI gallery walks, education that occurs onsite (i.e. annual stroke symposium), and emails for special topics.

Quality Management helpline is available to leaders or staff with any questions. The Quality Reporting SharePoint site is available to all SEH employees and houses all reports published by Quality Management. https://stelizabethhealthcare.sharepoint.com/sites/QMReportPortal/

EDUCATION

PI Education gives managers and front-line associates at St. Elizabeth the strategies and tools they need to participate in PI at all levels. The curriculum follows a development path to raise staff awareness and skills in a progressive manner. Key building blocks of knowledge educational activities are:

Daily Management: Routine methods to improve processes including huddles, visual management, 5S, standard work, mistake proofing and reducing waste

Sponsored Improvement Events: QIC or Administrative approved events such as QI teams in either formal Multi-week or Rapid cycle events, as well as attendance at quality training events.

Leadership Standard Work: Routine protocols of leaders such as establish alignment of priorities, review results, sponsor projects, round on patients, recognize staff, validate processes and sustain improvements.

The quality training curriculum focuses on leader and staff development and includes:

Core	Training Modules
Daily Management	QI 100 Intro to Lean – During St. E Day Orientation (waste reduction, standard work)
	QI 200 Daily Management Systems / huddles (Huddles, Safety, Metrics, OFI, Leading, Auditing)
	QI 250 Journey to Excellence (JTE) for Leaders – CBL
	QI 300 Applied LEAN for managers (Metrics, Huddles, 5S, Visual mgmt., Manager Std Work...)
Sponsored Improvement Events	QI 400 A3 Problem Solving (Problem statement, Value Stream/Process Mapping, RCA, Solution, PDSA)
	QI 450 Lean Fundamental Skills for teams (Value Stream Mapping, Focus PDSA, std work, A3, simulation)
	QI 500 Advanced PI for Clinicians *
	QI 600 Workout Practitioner Training (Workout problem solving / Facilitator)
Leadership Standard Work	QI 700 Leadership Alignment
	QI 710 Sustain Planning for Leadership
	QI 720 Leadership Gemba : Intentional Rounding
	QI 730 Financial Impact Reporting & Calculators

- A CBL on leadership practices – "QI 250 Journey to Excellence for Leaders" is also available to help onboard new leaders to evidence-based leadership practices that support our goal of improvement and high reliability.
- Real time training occurs from quality division staff as needed.

QUALITY DATA MANAGEMENT

St. Elizabeth Healthcare will continue to leverage technology to:

- Ensure data quality (complete and accurate).
- Identify and recommend quality data standards and definitions.
- Build quality data literacy (training and education).
- Maximizing data utilization (data driven culture).
- Automate quality data collection and reporting.
- Enhance and create reports that meet customer requirements, are visually appealing and user friendly, and provide statistical analysis as needed.
- Meet quality regulatory requirements.

Key data sources used for data collection and benchmarking:

- Epic
- PRC
- The MIDAS Comparative Data Base
- Centers for Medicare and Medicaid Services Databases
- The Joint Commission
- American College of Cardiology Database
- Society of Thoracic Surgeons Database
- American Heart Associate Get with the Guidelines Databases
- Anthem Quality Project
- Ohio and Kentucky Hospital Association Databases
- CDC's National Healthcare Safety Network (NHSN) Database

Guidelines for selecting quality indicators, collecting and analyzing data:

1. Indicators can be collected from a mix of outcomes and processes.
   A. Indicators can be outcome driven related to clinical practice and patient care. (e.g., complications, infection rates)
   B. Indicators can be process focused, striving to improve the processes that lead to outcomes of patient care.
   C. Indicators can address the quality and stability of existing function and opportunities to improve.
   D. Indicators can address the design and evaluation of new processes and functions.
   E. Indicators should demonstrate that when change is made, outcomes and processes improve.
2. Interdisciplinary monitoring and evaluation of issues is required, when other disciplines may be impacted by a PI project.
3. Departments or divisions with similar units or divisions should consider utilizing identical indicators when possible, for benchmarking purposes. (Identification of the provision of the same level of care.)
4. Department specific projects may be conducted to improve performance at the individual department level.
5. Benchmarking, Patient Safety, Required Measure Sets (The Joint Commission/CMS Core Measures) and Key Quality Indicators should be considered when evaluating opportunities for improvement.
6. Medical Staff Departments with similar patient types should consider utilizing identical indicators when possible for benchmarking purposes. Medical Staff should also be involved in monitoring the Joint Commission functions and multidisciplinary teams.

7. The Quality Management Department monitors the Medical Staff Quality following Annual Indicator approval by Medical Staff and Medical Staff Leaders. Indicators will be distributed to the Medical Staff each January in order that they can be advised of current criteria.
8. Data should be collected both as part of routine monitoring and for high priority issues. Data related to routine monitoring activities is collected continuously and aggregated at least quarterly. Aggregate results are provided per indicator by Medical Staff and Health System departments/projects. High priority issues may require more frequent data aggregation such as monthly or even weekly. Data may be sampled for studies. Sampling Strategies: A sample should represent the entire population of cases. Define your population carefully (e.g., DRG__; all surgical patients, etc.). Be sure to randomly select cases across the quarter (or month). For example: first 5 and last 5 cases each month; first 10 patients with last name beginning with letter A; use table of Random Samples.
9. Trending of aggregate results is continuous, as improvement activities attempt to reach a pre-determined level of care (a goal, a benchmark, a national standard, etc.). Maintaining the gain each quarter in quality scores and then subsequently demonstrating improvement in that score is desired.
10. Assessment of data should be systematic and statistically correct while considering comparative data. Comparisons with and participation in external databases will be utilized by St. Elizabeth Healthcare as appropriate. When aggregate results indicate a specific high priority problem or undesirable variations, a more intensive assessment is required. When assessment findings are relevant to an individual's performance, 100% of such cases should be reviewed as indicted for a specified time frame.

To ensure timely, readily available quality data to leaders an electronic Executive Quality Dashboard is available and continuously updated. This quality dashboard is available to The Board of Directors, Administrative Council, Senior leaders and other managers.

See appendix C. for key metric data governance.

PROGRAM EVALUATION

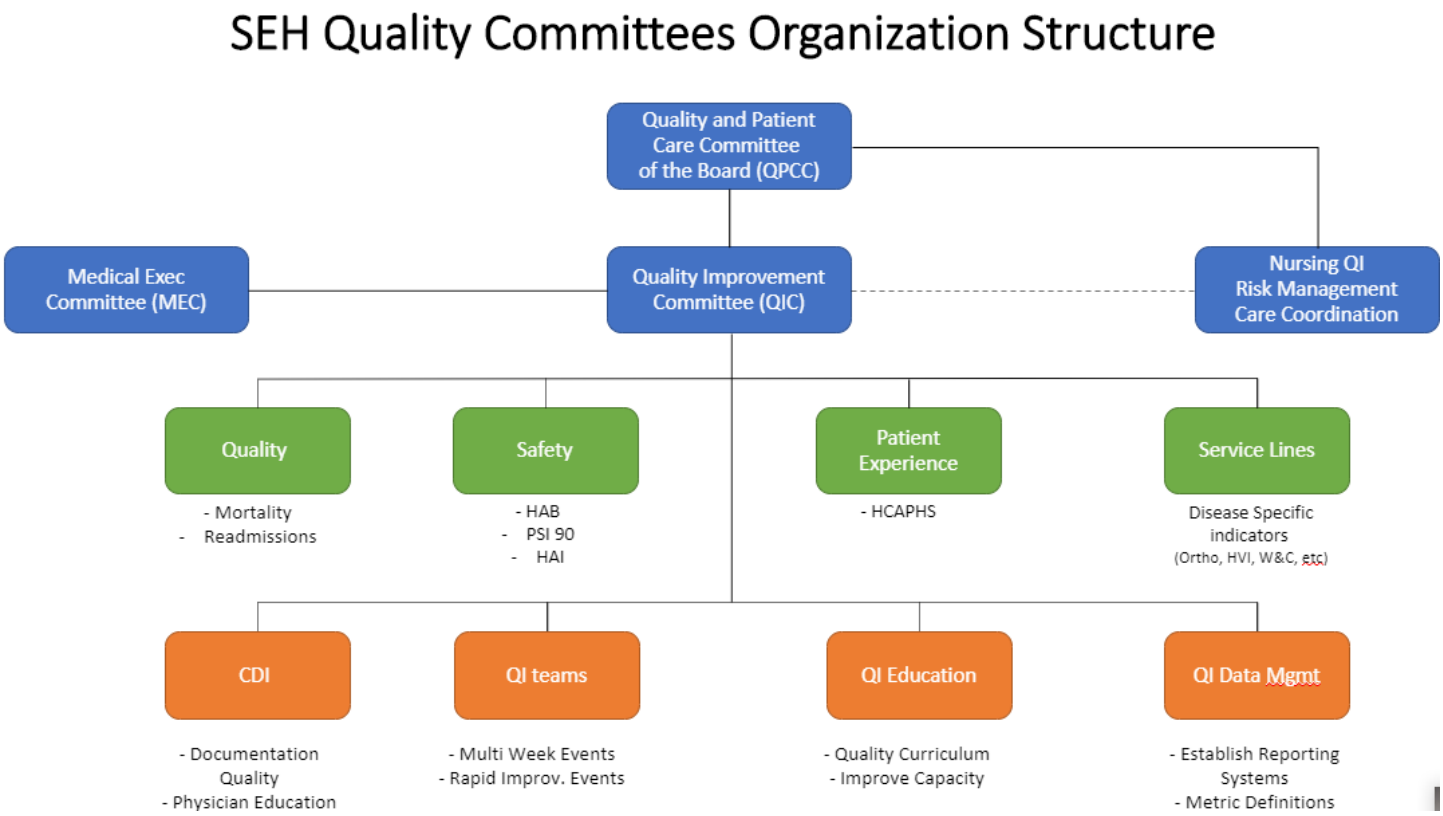
On an annual basis, the Quality Improvement Committee (QIC) shall evaluate the Medical Center's quality improvement activities, based on goals and objectives as stated in this plan. In addition, measurable goals and objectives to be achieved shall be documented for each year and used as part of the evaluation of the effectiveness of the program. The organization-wide PI Plan is to be reviewed annually and revised as

necessary. Annual approval is obtained by the QIC, Medical Staff Executive Committee, and the Quality and Patient Care Committee (QPCC) of the Board of Trustees.

CONFIDENTIALITY

All information, reports, statements or other data used in the course of the quality improvement process shall be considered privileged and strictly confidential in their entirety and such materials shall be used only for the evaluation and improvement of organizational processes and quality patient care. Such materials are not available for review by any individual outside of the quality improvement structure.

APPENDIX A. SEH QUALITY COMMITTEES INFRASTRUCTURE



APPENDIX B. QUALITY IMPROVEMENT COMMITTEE MEMBERS

- **2025 Composition**: *The Quality Improvement Committee is composed of the following membership (which will be reviewed and evaluated on an annual basis):*

Title	Name (Current)
Board and Medical Staff Representatives	
Medical Staff President	Dr. Chaitanya Mandapakala
Medical Staff President-Elect	Dr. Perry Poteet
CMO (SEH)	Dr. LaRoy Kendall
Quality Committee of the Board Representative	Dr. Michael Jones
Department of Surgery Chair	Dr. Balaji Kalyanaraman
Surgery Medical Director	Dr. Kevin Schuler
Department of Medicine Chair	Dr. Ephese Moise
Critical Care	Dr. Hani Murad
Medicine Rep at Large	Dr. Alex Schmitt
Exec Medical Director Care Transitions	Dr. Chanti Flanagan
SEP Quality Representative	Dr. Mark Kolar
SEPN Quality Chair	Dr. Linda Hermiller
Family Practice Faculty	Dr. Karl Schmitt

Title	Name (Current)
Administration	
Chief Physician Quality officer	Dr. Brown
Chief Clinical Officer	Dr. James Horn
Chief Operating Officer	Vera Hall
Vice President, Quality Operations	Jim McCarville
CEO/President SEP	Dr. Heidi Murley
Chief Medical Informatics Officer	Dr. Barry Wendt
SVP/Oncology Services	Kathy Jennings
Chief Nursing Executive Chief Nursing Officers	Laurie Conkright, Angela Roberts, Christy Miller Karen Tucker
Quality Organization Leaders	
Director of Pt Safety, Infection Control, &Acc	Christina Castelli-Bische
Direct of Quality Management	Clark Wheeler
Director of Quality Improvement	Bill Harrington
Director of Patient Experience	Julie Smalley

The Quality Improvement Committee will be supported with marketing / communications expertise as necessary to maximize effectiveness of messaging across the organization.

Summary of Committee Responsibilities

The responsibilities of the committee are as follows:

- *Coordinating and synthesizing the vision for quality across inpatient and outpatient care at St. Elizabeth Healthcare*
- *Keeping apprised of current quality innovation and research to proactively identify focus areas*
- *Defining quality metrics to measure the overall health of the system*
- *Prioritizing quality improvement goals, projects, and initiatives*
- *Reviewing specific areas with lagging quality performance and corresponding root cause analyses to identify strategies to address these issues*
- *Providing recognition for improved performance in previously identified quality focus areas*
- *Facilitating quality collaboration across inpatient and outpatient quality efforts*
- *Establishing and/or providing approval for new quality-related committees and workgroups*
- *Acting as quality champions to be accountable for the communication of quality initiatives to and obtaining input from the broader Medical Staff*

APPENDIX C. KEY QUALITY MEASURE GOVERNANCE

Domain	Metric	Source System	Reporting System
Mortality	Death rate among heart attack patients (AMI)	Midas	Enterprise Quality Dashboard
	Death rate for coronary artery bypass graft (CABG)	Midas	Enterprise Quality Dashboard
	Death rate for chronic obstructive pulmonary disease (COPD)	Midas	Enterprise Quality Dashboard
	Death rate for heart failure patients (HF)	Midas	Enterprise Quality Dashboard
	Death rate for pneumonia patients	Midas	Enterprise Quality Dashboard
	Death rate for stroke patients	Midas	Enterprise Quality Dashboard
	Proxy Measure- Acute Care Risk Adjusted Mortality O/E Ratio	Midas	Enterprise Quality Dashboard
	Deaths among patients with serious treatable complications after surgery (PSI 04)	Midas	Future Qlik DB
Safety of Care	Central line associated bloodstream infections (CLABSI) Rate	NHSN	Excel
	Central line associated bloodstream infections (CLABSI) SIR	NHSN	Excel
	Catheter associated urinary tract infections (CAUTI) Rate	NHSN	Excel
	Catheter associated urinary tract infections (CAUTI) SIR	NHSN	Excel
	Surgical site infections for colon surgery (Colon SSI) Rate	NHSN	Excel
	Surgical site infections for colon surgery (Colon SSI) SIR	NHSN	Excel
	Surgical site infections from abdominal hysterectomy (SSI Hyst) Rate	Epic	Enterprise Quality Dashboard
	Surgical site infections from abdominal hysterectomy (SSI Hyst) SIR	Epic	Enterprise Quality Dashboard
	Methicillin resistant staphylococcus aureus (MRSA) blood lab identified events (bloodstream infections) Rate	Epic	Enterprise Quality Dashboard
	Methicillin resistant staphylococcus aureus (MRSA) blood lab identified events (bloodstream infections) SIR	Epic	Enterprise Quality Dashboard
	Clostridium difficilie (C.Diff) laboratory identified events (intestinal infections) Rate	Epic	Enterprise Quality Dashboard
	Clostridium difficilie (C.Diff) laboratory identified events (intestinal infections) Rate SIR	Epic	Enterprise Quality Dashboard
	Rate of complications of hip/knee replacement patients	Midas	Enterprise Quality Dashboard

Domain	Metric	Source System	Reporting System
	Serious complications (PSI 90)	Midas	Enterprise Quality Dashboard
Readmission	Hospital return days for AMI patients (excess days in acute care)	Midas	Excel
	Rate of unplanned readmission for CABG surgery patients	Midas	Enterprise Quality Dashboard
	Rate of unplanned readmissions for COPD patients	Midas	Enterprise Quality Dashboard
	Hospital return days for HF patients	Midas	Excel
	Rate of unplanned readmissions after hip/knee surgery	Midas	Enterprise Quality Dashboard
	Proxy Measure- Acute Care Readmission Risk Adjusted Readmissions O/E v.3.0	Midas	Enterprise Quality Dashboard
	Hospital return days for pneumonia patients	Midas	Excel
	Rate of unplanned readmissions after discharge from hospital (Hospital Wide Readmissions HWR)	Midas	Enterprise Quality Dashboard
Patient Experience	Patients who reported that their nurses communicated well	Press Ganey	Enterprise Quality Dashboard
	Patients who reported that their doctors communicated well	Press Ganey	Enterprise Quality Dashboard
	Patients who reported that they received help as soon as they wanted	Press Ganey	Enterprise Quality Dashboard
	Patients who reported that staff explained about medicines before giving it to them	Press Ganey	Enterprise Quality Dashboard
	Patients who reported that their room and bathroom were clean	Press Ganey	Enterprise Quality Dashboard
	Patients who reported that the area around their room was quiet at night	Press Ganey	Enterprise Quality Dashboard
	Patients who reported that they were given information about what to do during their recovery at home	Press Ganey	Enterprise Quality Dashboard
	Patients who understood their care when they left the hospital	Press Ganey	Enterprise Quality Dashboard
	Patients who gave their hospital a rating on a scale from 0 (lowest) to 10 (highest)	Press Ganey	Enterprise Quality Dashboard
	Patients who would recommend the hospital to their friends and family	Press Ganey	Enterprise Quality Dashboard

APPENDIX D. FY 2025 WORK PLAN

Project	Description	Physician Champion	Executive Sponsor	Division
Strategy & Impact Plan				
Clinical Documentation Accuracy	To increase the accuracy of documentation for the diagnoses having the most discrepancies through ModusOne CDxI Implementation	Dr. Fry	Dr. Brown / Jim McCarville	Quality and Hospitalists
Age-Friendly Care Improvement	To advance our improvements in care delivery for our patients 65+ to meet the CMS Age Friendly Hospital Measure.	Dr. Pavlou / Dr. Flanagan	Amy Thompson / Rhonda Eviston	Nursing
Baldrige Self-Assessment 2025	To discover and prioritize opportunities to grow excellence through assessment using the Malcolm Baldrige Award Criteria	N/A	SVP / EVP on JTE Steering Committee	All
Avoidable ED Admissions	To reduce avoidable admissions from the ED	Dr. Wolff / Dr. Flanagan	Missy Miles	Emergency Services
2025 Readmissions Reduction	Scope TBD, will focus on most significant remaining opportunity, which appears to be readmissions from SNF	Dr. Flanagan	Dr. Brown	Care Management
Oncology No-Show Appointments (Potential Project)	Scope TBD, related to reducing patients not attending appointments	TBD	Kris Karwisch	Oncology
Stepdown Care Improvement (Potential Project)	Scope TBD, related to reducing patient load in ICU that could be served in a stepdown unit once designed (awaiting pre-project demand analysis)	Dr. Durrani / Dr. Murad	Dr. Schuler / Donna Parsons	Nursing
Patient Handoff (Potential Project)	Implement I-PASS patient handoff process or equivalent as this was identified as an opportunity in a Safety Culture survey	Dr. Brown	TBD (Laurie Conkright?)	Nursing
Build Capacity				
Work-Out™ Training	4 Divisional Work-Out™ Projects	Dr. Brown	Facilitator VPs	Quality
Associate Training	6 Applied Lean Classes 6 Standard Problem Solving with A3 1 Work-Out™ Facilitator training 2 QI team training simulation	Dr. Brown	Jim McCarville	Quality

APPENDIX E. NURSING PERFORMANCE IMPROVEMENT PROGRAM STRUCTURE