UHCCR 1

Office of the President
December 14, 2015

Members, University Health Care Committee of the Board of Trustees:

UK HEALTHCARE FY2016 QUALITY, SAFETY, AND PATIENT EXPERIENCE PLAN

Recommendation: that the University Health Care Committee approve the UK HealthCare FY2016 Quality, Safety, and Patient Experience Plan, attached hereto as Exhibit I, in accordance with applicable law.

Background: Pursuant to University of Kentucky Governing Regulation II.E.i(1)(a), the University Health Care Committee "serves as the governing body and governing authority to manage and operate the University Hospitals in accordance with the Conditions of Participation promulgated by the Centers for Medicare and Medicaid Services and with the law and regulations governing the operations and services of hospitals in the Commonwealth of Kentucky."

In 42 CFR Part 482, the Centers for Medicare and Medicaid Services ("CMS") set out the conditions for a hospital to participate in the Medicare Program. As part of the conditions for participation, CMS requires in 42 CFR 482.21 that the participating hospital develop, implement, and maintain an effective, ongoing, hospital-wide, data-driven quality assessment and performance improvement program. The UK HealthCare FY2016 Quality, Safety, and Patient Experience Plan sets out such program for the University's hospitals and clinical activities for FY 2016.

This Plan has been developed and approved by the necessary and appropriate officials as documented on page 1 of the attached Exhibit I.

Action taken: ☑ Approved ❑ Disapproved ❑ Other _____

EXHBIT I

UK HealthCare FY2016 Quality, Safety, and Patient Experience Plan

The FY2016 Quality, Safety and Experience Plan demonstrates the commitment of UK HealthCare to the people of the Commonwealth of Kentucky and beyond; to provide high quality, high value, safe, efficient and patient-centered care to each and every patient.

On behalf of all members of the UK HealthCare family, we endorse this plan:

Chief Clinical Operations Officer: _____
Robert H. Cofield, MHA, DrPH

President, Medical Staff: _____
Andrew Bernard, MD

Chief Medical Officer: _____
Bernard Boulanger, MD, MBA

Associate VP of Finance: _____
Craig Collins, MBA

Chief Information Officer: _____
Cecilia Page, DNP, RN

Chief of Ambulatory Services: _____
Marc Randall, MD

Chief Administrative Officer: _____
Ann Smith, MPA

Chief Nurse Executive: _____
Colleen H. Swartz DNP, MBA, RN

Chief Transformation & Learning Officer: _____
Mark V. Williams, MD

11/4/15

Thank you to the following individuals for assistance in preparing this plan:

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UK HealthCare – FY2016 Quality, Safety, and Patient Experience Plan

I. INTRODUCTION

Our highest priority at University of Kentucky HealthCare (UKHC) is high quality, safe, patient-centered care. UKHC has a longstanding commitment to excellence in patient care, teaching and research. We integrate this excellence into our patient safety and quality of care efforts in every aspect of UKHC's day-to-day operations and care delivery. Investing in quality improvement and the implementation of best practices, the UK OptimalCare© approach, allows us to achieve the best possible patient outcomes. The FY2016 Quality and Safety Plan reflects the organization's values of providing coordinated patient-centered care and focuses on continuous improvements in the areas of quality and safety, patient experience, access and efficiency. Ultimately, our plan will increase the value of the care we deliver to our patients.

In addition to ensuring compliance with The Joint Commission (TJC) Standards and our enterprise policies and bylaws, the UKHC Quality and Safety Plan is built on the following guiding principles:

- *Patient centered care*: Involve patients and family in care design and decision-making that meets their needs and preferences.
- *A just, non-punitive culture of safety*: Promote blame-free incident reporting with focus on correcting the underlying systematic design or system malfunctions.
- *Support and empower interprofessional teams to drive improvement*: Provide care teams with goal-defined responsibilities and support them with dedicated staff and resources, data collection and analysis, and monitoring.
- *Comprehensive quality surveillance, measurement and reporting*: Systems approach that fosters active employee and caregiver engagement.
- *Transparency and communication*: Provide easily accessible, valid, meaningful information with open communication with leadership, clinicians, managers, frontline staff, patients and the general public about our clinical performance.
- *Staff empowerment and innovation*: Create an environment and provide resources that foster problem solving and breakthrough change to enhance quality and safety.

The strategies outlined in this plan are intended to facilitate the best service to our patients and the best clinical outcomes, in accordance with evidence-based research. The Quality and Safety Plan affirms UKHC's commitment to quality, safety and patient experience and will assist in the promotion, coordination and leadership of quality and safety priorities throughout the organization.

UKHC Mission

UK HealthCare is committed to the pillars of academic health care – research, education and clinical care. Dedicated to the health of the people of Kentucky and surrounding regions, we will provide the most advanced patient care and serve as an information resource. We will strengthen local health care and improve the delivery system of the Commonwealth by partnering with community hospitals and

physicians. We will support the university's education and research needs by offering cutting edge services on par with the nation's very best providers.

UKHC Vision

Become a top academic medical center serving Kentucky and beyond that strives to:

- Provide a broad range of advanced subspecialty care so that Kentuckians need not travel outside Kentucky for medical care.
- Become a clinical destination serving Kentucky and beyond for select highly specialized services.
- Support rural health care, collaborating closely with community providers to enable residents to receive appropriate health care in their local communities.
- Mature collaborative relationships into a well-integrated health delivery system that can respond to a changing health care environment and provide high-quality, cost-efficient health care.
- Support the research and teaching missions of the university.

Monitoring Metrics

Nationally recognized performance metrics and benchmarks are utilized in order to help position UK HealthCare as a national leader in quality, safety and performance improvement. The University Healthsystem Consortium (UHC) is used as the primary source of comparison by UKHC.

The hospital first collects data on the required items as defined by The Joint Commission (TJC), Centers for Medicare and Medicaid Services (CMS) and other regulatory bodies. This monitoring includes, but is not limited to, the following. The performance and information are shared through weekly, monthly, and quarterly Quality and Safety meetings and bi-weekly Patient Safety Committee meetings. The weekly and monthly scorecards are available to all staff (via the Quality Monitoring & Reporting SharePoint site).

Measures	**Monitoring Frequency**
1. Mortality (both observed and expected mortality rates)	Raw numbers monitored weekly Observed/Expected (O/E) received monthly
2. Patient safety indicators	Weekly
3. Hospital acquired infections	Weekly
4. Access to care (new patient visit lag)	Monthly
5. Length of stay (both observed and expected rates)	O/E received monthly
6. Same hospital readmissions	Weekly
7. Patient experience (inpatient and ambulatory)	Weekly
8. Engagement (staff and physicians)	Annually thorough Engagement Survey
9. Sentinel events	Weekly (reported monthly)
10. Nursing sensitive indicators (IV infiltrates, restraints, assaults, pressure ulcers and falls)	Weekly

II. Setting the Quality and Safety Agenda

The leaders of UK HealthCare, in collaboration with the Medical Staff Committees and the University Health Care Committee (a subcommittee of the University of Kentucky Board of Trustees), set the priorities for quality monitoring, safety and performance improvement annually. These priorities are embodied in the **UK HealthCare Enterprise Goals**, which are discussed and approved by the UK Board of Trustees University Health Care Committee annually. By codifying these goals, the governing body sets the agenda for patient care and quality improvement at UK HealthCare each year. The fiscal year 2016 annual Enterprise goals have the following objectives:

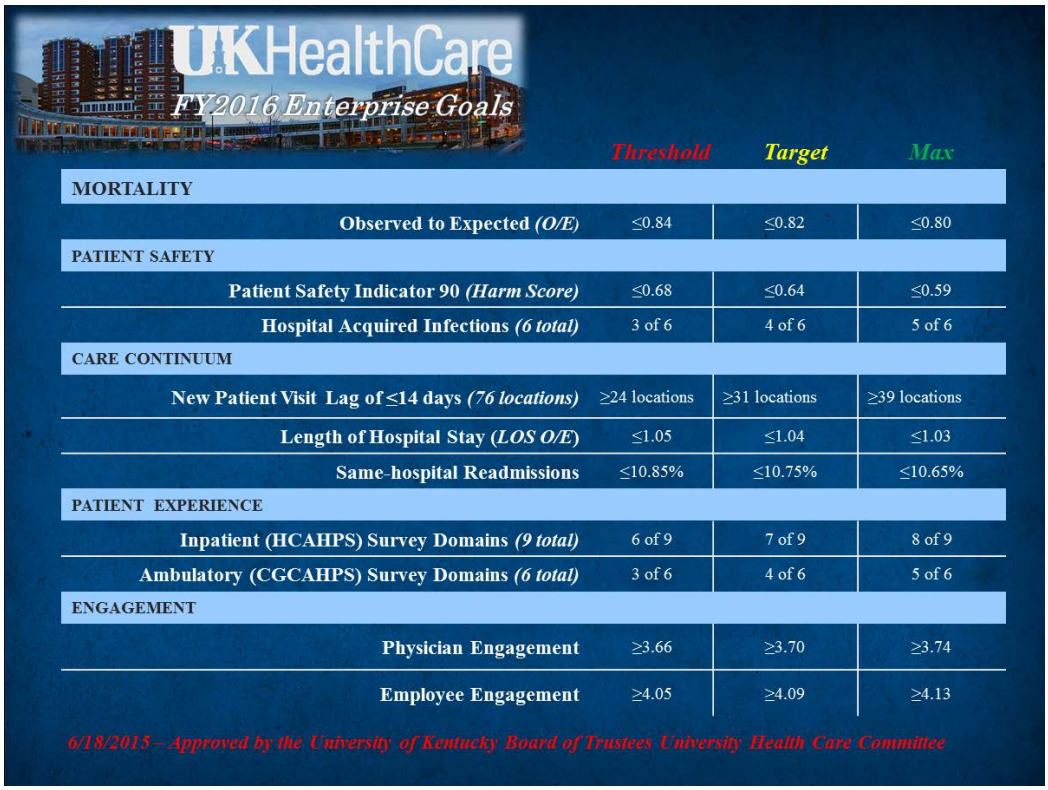


Figure 1: FY16 Enterprise Goals - approved by the University of Kentucky Board of Trustees University Health Care Committee on June 18, 2015

The iterative process to develop the enterprise goals each year includes input from many individuals and groups within UK HealthCare and local experts/teams in each domain. The goal building process sets the focus for quality improvement, harm prevention and reduction, access and efficiency initiatives, patient experience and engagement for the coming fiscal year. Goals are developed based, in part, on the UHC top performer model, which is a robust and tested framework. All metrics are validated by external agencies (such as UHC, CMS, and TJC) and the definition and source is clearly documented. In order to be selected by UK HealthCare as a measure of performance, historical performance data must

be available and the measurement tool must be reliable. The previous calendar year's performance is generally used as the internal benchmark.

To gain alignment of effort and resource allocation and to focus our quality improvement work, the UK HealthCare deploys **Cascading of Enterprise Goals** throughout the organization, by a variety of methods, to gain alignment on quality improvement efforts (figure 2).

Figure 2 – FY16 Cascading of Enterprise Patient Care Goals

The cascading process is a translation or application of the strategic level goals to and more specific goals that can be understood by organizational units such as departments, teams and individuals.

We consider the cascading of our Enterprise Goals to be a performance management system aimed at achieving and sustaining organizational alignment throughout the clinical enterprise of University of Kentucky HealthCare. We use cascading of enterprise goals as a quality strategy execution system.

Additionally, we have incorporated **patient-centered care** as a foundation for our 2020 Strategic Plan, which also includes a strong focus on value-based care (See Figure 3). This strategic plan provides a 5-year guide for UK HealthCare as it navigates changing times in the health care industry. Hundreds of UK HealthCare faculty and staff participated in the plan's development, which represents the collective wisdom of our very talented community. With a foundation of **patient-centered care**, the plan emphasizes that where our culture needs to change – we must change to deliver a more connected and

personalized experience for our patients. It will guide all of us at UK HealthCare to our goal of delivering the safest, high quality, efficient and accessible care.

UK HealthCare Strategy 2020

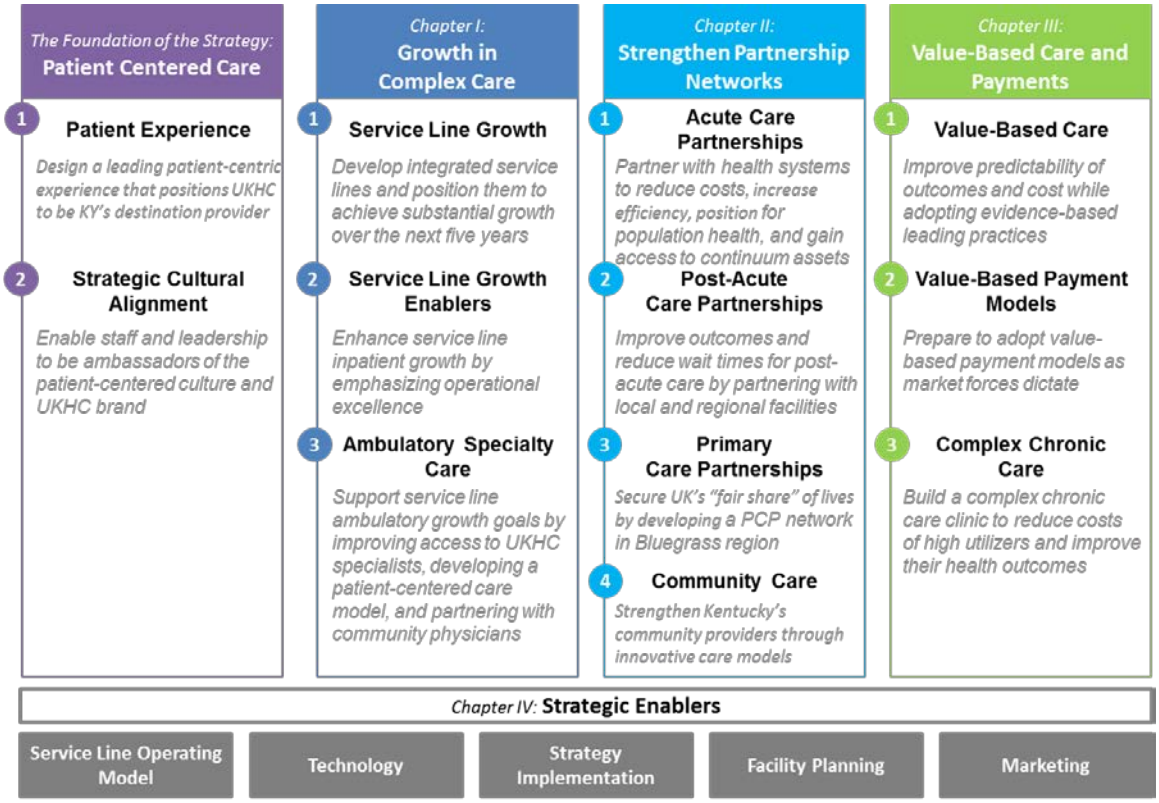


Figure 3: UK HealthCare Strategy 2020

III. Governance

Our governance structure is aimed at ensuring accountability, two-way information sharing, and transparent reporting of performance and oversight for the quality improvement efforts at UK HealthCare. This performance monitoring starts at the patient level with performance being reported up through the enterprise and ultimately to the governing body, the University Health Care Committee. Figure 4 shows the main elements of the reporting structure at UK HealthCare. All reporting relationships are bidirectional with information flowing up to the governing body and down the structure ultimately to impact the bedside clinicians and patients. The UK HealthCare Quality & Safety Committee and the Medical Staff Operating Subcommittee receive monthly reports from many other committees and departments within the enterprise (Figures 5 and 6). This reporting structure allows oversight of all quality, safety and performance initiatives within the enterprise.

The medical staff is structured through the medical staff operating subcommittees at Chandler and Good Samaritan hospitals with an overall enterprise medical staff executive committee. The Medical Staff Executive Committee (MSEC) provides oversight and support to the medical staff committees, oversees medical staff by-law functions, credentialing processes, and reviews contracts for outside clinical services. The Medical Staff Operating Subcommittees also meet monthly and review the progress by multiple teams and committees throughout the enterprise. These committees and teams are outlined in the medical staff by-laws and include: Pharmacy and Therapeutics, Infection Control, Quality and Safety, Graduate Medical Education, Transfusion, Operating Room, Transplantation Service, Ethics, ICU (Critical Care), Diagnostic Imaging and Testing, Cancer, Nutrition, Anatomic Pathology. While there is some duplication in reporting to the MSEC, the intent of committees reporting at this meeting is to assure that the medical staff has information and authority over the appropriate clinical operation of the facility. The President of the Medical Staff and CMO have the leadership responsibility to bring issues from these venues to the governing body.

The Board of Trustees of the University of Kentucky establishes, maintains, supports, and exercises oversight of the quality, safety and performance activities that occur within the enterprise. The Board of Trustees fulfills its responsibilities related to these metrics through the governing body, the University Health Care Committee.

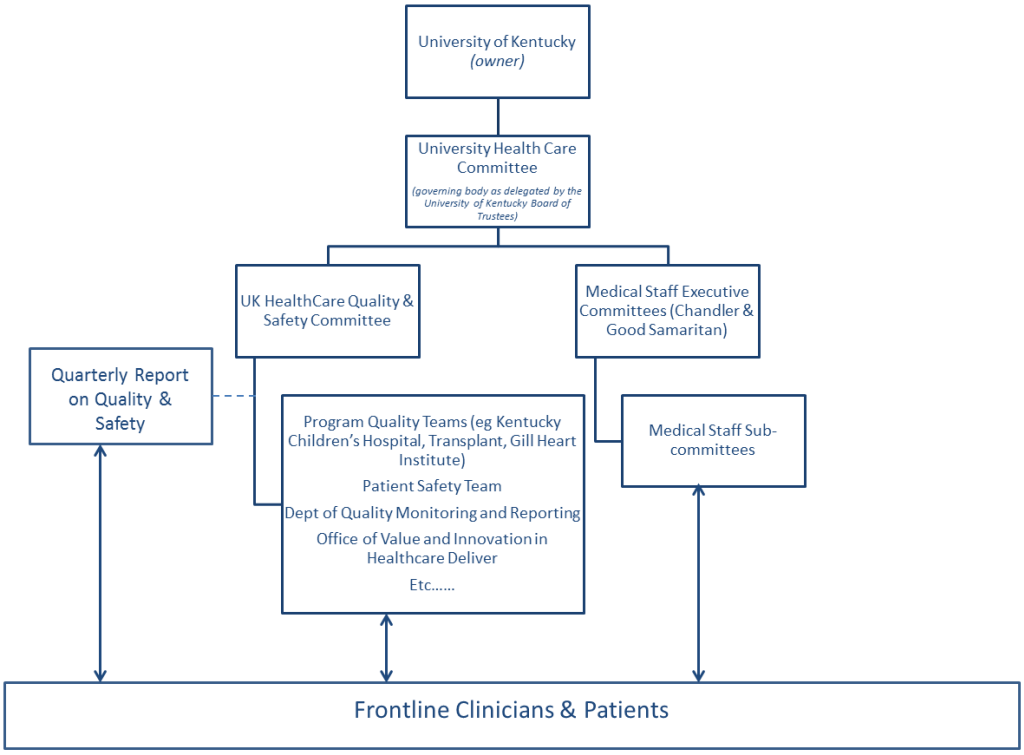


Figure 4: Reporting Structure

Figure 5: Quality & Safety Committee Reporting Structure and Scheduled Agenda Items

Figure 6: Medical Staff Operating Subcommittee Reporting Structure

IV. Program Overview

UK HealthCare places great emphasis on the continuous monitoring of quality, safety and performance improvement initiatives throughout the enterprise. This monitoring includes a weekly, monthly and quarterly venue to discuss outcomes in order to assure that UK HealthCare is delivering optimal care in a timely fashion.

The Weekly Patient Care Huddle is an intense and thorough review of the patient care provided each week. This group meets weekly on Thursdays for a huddle to discuss performance on the enterprise goals and other metrics that roll up into these metrics; any safety events occurring during the prior week are also identified and (often) discussed. This meeting is attended by all levels of clinicians and staff, including the Chief Medical Officer (CMO), Chief Nurse Executive and Chief Administrative Officer. The goal of this huddle is to engage all those present in the ongoing initiatives and to create an open dialog to discuss any concerns related to quality and safety.

Monthly, we take time to reflect on our performance results on enterprise metrics by holding the **UK HealthCare Quality and Safety Committee** meeting. This meeting is chaired by the CMO and attendance at this meeting includes members of the senior leadership team as well as leaders throughout the enterprise. This ensures that the performance on each of the key metrics is transparent throughout the enterprise, and performance improvement plans are discussed. Also, committees, programs and service lines throughout the enterprise report to this committee on a rotating basis to ensure that all initiatives throughout the enterprise are being monitored and supported as necessary (See Figure 5). In addition to the main scorecard used for this monthly meeting, there is a supplemental scorecard with additional quality and safety data. Shortly after this meeting ends, the enterprise scorecard is widely circulated and posted transparently on the UK Healthcare Employee Web site (Care Web).

The monthly review and evaluation also includes a summary report on the performance of the health system on those measures sensitive to the practice of nursing. The metrics are reported in context of the entire report, but also carved out and presented as needed for Magnet designation. The nursing strategic plan provides the structure to direct and provide a firm foundation for nursing practice expression. The nursing strategic plan for FY 15-16 is provided in Appendix 1.

After each quarter ends, a Quarterly Report on Quality and Safety meeting occurs to review enterprise performance on initiatives and their associated metrics. Other agenda items for this meeting include the report out by teams who are working diligently on quality, safety and performance improvement initiatives and awards that recognize teams and individuals who have made significant contributions to the enterprise. These awards include the Great Catch award for those who identify patient safety concerns, the Top Performer award for those who are performing exceptional care to patients, the Rising Star award for teams that have demonstrated improved performance and the Home Run Service award for those who are making a significant impact on the patient experience. Importantly, the UK Executive Vice President for Health Affairs or his designee chairs this meeting. It is open to all at UK HealthCare and routinely the auditorium is packed with approximately 300 people who learn and share.

Senior leaders are present and they provide clear direction and support so the organization continues moving forward with a clear purpose. Meeting results and slides are posted transparently on the internal website for reference so even those unable to attend the quarterly meeting learn and become aware of UKHC's current state and progress in quality and safety.

It is highly important that the performance and priorities for the organization are communicated to all staff within the enterprise. Information reaches staff through a variety of channels, including but not limited to:

- Bulletin boards in their work areas
- Regular staff and department meetings
- E-mail (In the Loop, Change Delivered, Weekly Update)
- Web Site – Care Web
- Ad-Hoc Meetings
- Medical Director meetings
- Medical Department meetings
- Town hall leadership meetings
- Regular leadership meetings
- Quarterly nursing staff meetings
- Nursing Leader meetings

V. BUILDING A CULTURE OF SAFETY

A safety culture is also a learning culture – organizations learn from their safety data, undertake needed actions, and make substantial system changes in an effort to ultimately prevent injuries and save lives. Literature and our own experiences document that harm to patients can be reduced or eliminated and our goal is always zero harm. An organization's culture is reflected by what it does - its practices, procedures, and processes - rather than in what it claims to espouse or believe. At UKHC, we strive for a culture of safety by ensuring it is:

1) **Informed** - leaders understand the technical, organizational, environmental, and human factors that impact error
2) **Just** - trust pervades the organization so people report safety concerns and errors and know what constitutes unsafe practice
3) **Values** reporting - staff and leaders know the importance of accurate data and reward reporting of errors and near misses
4) **Flexible** - responsibility for addressing immediate safety situations is given to front-line experts

Proactive Risk Identification and Process for Mitigating the Risk Factors

UKHC collects safety event information using the National Patient Safety Goals (NPSGs) by The Joint Commission, standards of practice of professional organizations and federal guidelines provided by CMS and other regulatory agencies. The information includes actual or potential occurrences involving inpatients, outpatients, employees and visitors. Information is provided from all employees and medical staff through **completion of incident reports**, which is an open online system and reporting can be anonymous.

All reporting data are used to track and trend processes and outcomes or initiate activities that address process, system, protocol or equipment events. Opportunities for improvement regarding patient safety issues are prioritized according to level of severity, frequency of the occurrence, potential for harm to the patient, employee or visitor and potential for liability (Failure Mode Effect Analysis – FMEA). Weekly review of information is performed by Office for Value and Innovation in Healthcare Delivery (OVIHD), in collaboration with UKHC Risk Management, to direct the administrative and medical staffs' attention to areas of clinical care representing significant sources of actual or potential risk. Types of medical / health care errors included in data analysis are:

- ***Harm***
  - ***9: Death***—Dead at time of assessment.
  - ***8: Severe permanent harm***—Severe lifelong bodily or psychological injury or disfigurement that interferes significantly with functional ability or quality of life. Prognosis at time of assessment.
  - ***7: Permanent harm***—Lifelong bodily or psychological injury or increased susceptibility to disease. Prognosis at time of assessment.
  - ***6: Temporary harm***—Bodily or psychological injury, but likely not permanent. Prognosis at time of assessment.

- ***Reached the Patient***
  - ***5: Additional treatment***—Injury limited to additional intervention during admission or encounter and/or increased length of stay, but no other injury. Treatment since discovery and/or expected in future as a direct result of event.
  - ***4: Emotional distress or inconvenience***—Event reached patient; mild and transient anxiety or pain or physical discomfort, but without the need for additional treatment other than monitoring (such as by observation; physical examination; laboratory testing, including phlebotomy; and/or imaging studies). Distress/inconvenience since discovery and/or expected in future as a direct result of event.
  - ***3: No harm evident, physical or otherwise***—Event reached patient, but no harm was evident.
- ***Near Miss***
  - ***2: Near miss (requires selection of one of the following)***
    - Fail-safe designed into the process and/or a safeguard worked effectively
    - Practitioner or staff who made the error noticed and recovered from the error (avoiding any possibility of it reaching the patient)
    - Spontaneous action by a practitioner or staff member (other than person making the error) prevented the event from reaching the patient
    - Action by the patient or patient's family member prevented the event from reaching the patient
    - Other
    - Unknown
  - ***1: Unsafe condition***

Sentinel Events are tracked by the Accreditation and Risk Management departments. The accreditation department works with the CMO office to assure that we have a clear and up to date list of issues considered to be a sentinel event. All sentinel events are reviewed and reported out at the monthly Quality & Safety Committee Meetings to facilitate oversight at the Senior Executive level of the enterprise.

We have a hospital wide interdisciplinary response mechanism to all the sentinel event alerts. To address any patient safety issue related to sentinel event alerts, we immediately construct an interdisciplinary team to formulate the risk reduction strategy and follow up through an action plan. The Comprehensive Accreditation Manual (CAMH) states the TJC expectations of the appropriate response to a sentinel event, which includes conducting a timely, thorough, and credible root cause analysis; developing an action plan designed to implement improvements to reduce risk; implementing the improvements; and monitoring the effectiveness of those improvements. UKHC SWARM includes comprehensive systematic analysis and an action plan, so it meets TJC standards for investigation and analysis of adverse and sentinel events. SWARMing is the UK HealthCare's standard approach to all sentinel events, with some supplementation (e.g., event-related documents), as reporting of an RCA for a sentinel event.

Investigation, Analysis, and Reporting – RCAs and SWARMing

UKHC developed a novel rapid approach to root cause analysis (RCA)—called "SWARMing"—with the goal of establishing a consistent approach with centralized support to investigate and analyze adverse or undesirable events.* This process occurs without unnecessary delay after an event, undertakes thoughtful analysis by an interdisciplinary team, and encourages reporting of adverse events by frontline staff.

Any personnel at UKHC can call for a SWARM. Most often the SWARM process begins when staff complete an incident report regarding an event. A patient safety analyst at OVIHD, in collaboration with Risk Management, reviews the report or a known adverse event, and makes the decision of conducting either a rapid RCA or a full SWARM. If a SWARM is determined to be the best approach, the report is reviewed by a department administrator and the clinical risk manager who rapidly conduct a preliminary investigation to document the basics of "what happened" and "who was involved" with a timeline to allow a SWARM to be scheduled as soon as possible. In some cases of specific concern, SWARMs are performed immediately after the event.

Commonly, participants include those directly involved in the event aiming to be inclusive, so attendees might range from a ward clerk to the chair of surgery. The SWARM process consist of 5 key steps:

(1) Introductory explanation of the process;
(2) Introduction of everyone in the room;
(3) Review of the facts that prompted the SWARM;
(4) Discussion of what happened with investigation of the underlying systems factors;
(5) Conclusion with proposed focus areas for action and assignment of task leaders with specific deliverables and completion dates.

The weekly SWARM Closure report is shared broadly with system leaders to ensure transparency of responsibility of the person assigned to a task and timeliness to closure.

*Li J, Boulanger B, Norton J, Yates A, Swartz CH, Smith A, Holbrook PJ, Moore M, Latham B, Williams MV. "SWARMing" to Improve Patient Care: A Novel Approach to Root Cause Analysis. Jt Comm J Qual Patient Saf. 2015 Nov;41(11):494-3.

Legal Protections for Patient Safety Activities

Congress passed the Patient Safety and Quality Improvement Act (PSQIA) of 2005, 42 U.S.C. 299b-21 et seq. (PSQIA) to "facilitate an environment in which health care providers are able to discuss errors openly and learn from them." H.R. Rep. No. 109-197, at 9 (2005). The Act was intended to replace a "culture of blame" and punishment with a "culture of safety" that emphasizes communication and cooperation. See S. Rep. No. 108-196, at 2 (2003). Patient Safety Activities at UK HealthCare that are carried out in an effort to improve patient safety and the quality of health care delivery, including collection and analysis of Patient Safety Work Product (PSWP) and the development and dissemination of information with respect to patient safety, such as recommendations, protocols, and best practices or the use of PSWP to encourage a culture of patient safety, that are submitted to the UK HealthCare

Patient Safety Organization (PSO), are privileged and confidential to the greatest extent allowable under the PSQIA. PSWP includes incident reports, SWARM data, sentinel event analyses, and all other data and information described in the UK HealthCare Policy #A06-035 entitled "Patient Safety Evaluation System" and reported to the UK HealthCare PSO in accordance with the PSO Service Agreement.

Integrating Ambulatory Patient Safety

We recognize that the type of events that occur in a dynamic, ever changing outpatient setting require a different analysis and approach than those that occur in a more controlled hospital environment and established the Ambulatory Patient Safety team. The team is responsible for development of the communication plans and educational materials that focus on changing the culture and increasing the number of ambulatory submissions. This team also analyzes all events and identifies opportunities for unit level SWARMs. This structure provides leadership insight on what is taking place within the ambulatory system that needs to be changed/modified to create a safer environment for patients/visitors/staff. In addition to continuously educating staff on the value of incident reporting, the FY2016 focus includes developing an ambulatory Patient Safety Deputy program to leverage local expertise in the management and oversight in each clinical area for rapid response to an emergency (the first 10 minutes) while paramedics are in transit.

Performance and Measure of Success

Providing periodic (monthly, quarterly, etc.) report on specific sets of indicators is a routine essential of the Quality and Safety Plan. All Patient Safety Indicators for National Patient Safety Goals are observed effectively and continuously in all patient care areas at UKHC monthly. The monitoring and analysis of Patient Safety Indicators are based on multiple patient safety programs, such as National Patient Safety Goals by the Joint Commission, AHRQ Patient Safety Indicators, and CMS hospital acquired infections/conditions.

The Patient Safety (PS) and Infection Prevention and Control (IPAC) department at OVIHD constructs the monthly patient safety report through direct observation of practice, concurrent medical record review, retrospective chart review, etc. The data collection and analysis is conducted at an interdisciplinary level and organizational patient safety reporting is constructed and communicated via OVIHD.

The following are some of the metrics monitored by the IPAC department at OVIHD.

- VAP
- CLABSI
- CAUTI
- MRSA/MDRO
- SSI
- Hand Hygiene
- Outbreaks of infectious disease

The following are some of the NPSG metrics monitored by the PS department in OVIHD.

- Improve accuracy of patient identification
- Effective Communication re: Critical Values
- Safe use of Medications re: correct labeling of medications/solution in procedural areas, Anticoagulant therapy mismanagement and Medication Reconciliation
- Reduce harm associated with clinical alarms systems
- Reduce risk of health-care associated infections
- Identification of inherent risks in the population-suicide, patient needs for appropriate treatment and education in the prevention of suicide for patient and his/her family
- Universal Protocol

Patient Safety Educational Activities – Translating Research into Practices

The educational and/or promotional events emphasize research evidence, best practices, medical error reduction, and specific job-related aspects of patient safety. Ongoing in-service and other educational programs emphasize specific job-related aspects of patient safety. As appropriate, training activities incorporate methods of team training to foster interdisciplinary, collaborative approach to the delivery of patient care and reinforces the need and way to report medical errors. The OVIHD initiates the relevant plans (e.g., World Thrombosis Day) and conducts educational activities in coordination with other educational efforts undertaken at UKHC.

VI. PERFORMANCE/QUALITY IMPROVEMENT

The Office for Value and Innovation in Healthcare Delivery (OVIHD, Appendix 2 – OVIHD Org Chart) serves as the resource for all quality improvement and patient safety projects. The Performance Improvement (PI) department at OVIHD uses a systematic approach to support and guide improvement teams at UK HealthCare by applying Lean principles, problem solving, and change management process and tools. The health system operation engineers, analysts, and quality improvement specialists have specific expertise in improvement methodologies, and support UKHC's priority organizational initiatives. The team has expertise in numerous Quality Improvement tools, including, but not limited to: Patient Flow, FOCUS-PDSA, Engagement, Lean, Six Sigma, Process Design, FMEA, Reflective Learning, and Statistical Process Control. This team supports cross-organizational priorities and teams who are engaged in improvement. Educational programs are offered to enable capacity building and bring performance/quality improvement to life within teams at all levels. The strength of encouraging teams to own their quality improvement processes is that change and improvement become real to them and imbedded in their daily activities, rather than housed in a single overseeing department.

Lean Thinking Principles

Lean in healthcare is "an organization's cultural commitment to applying the scientific method to designing, performing, and continuously improving the work delivered by teams of people, leading to measurably better value for patients and other stakeholders." The leadership at UKHC understands that in order for lean principles to take root, leaders must first work to create an organizational culture that is receptive to lean thinking. We use the six principles of Lean to help implementing this approach to improving care (http://www.mayoclinicproceedings.org/article/S0025-6196%2812%2900938-X/fulltext).

1. Lean is an *attitude of continuous improvement*. Lean involves a culture of continuous improvement in which leaders are always raising the bar to drive value.
2. Lean is *value-creating*. The ultimate goal of Lean is to improve value.
3. Lean is *unity of purpose*. Lean can unify teams around a shared goal.
4. Lean is *respect for the people who do the work*. Healthcare leaders need to empower front-line workers to drive improvement.
5. Lean is *visual*. Visual tracking provides easy access to data and serves as a place for communicating concerns and new ideas.
6. Lean is *flexible regimentation*. In a Lean approach, workers need to identify root causes of problems and change standards to optimize processes.

Through partnership with the UK College of Engineering Lean Systems Program, which is a collaboration between UK and Toyota, the UK Center for Health Services Research developed the UKHC Lean Model (Appendix 3). The UKHC Lean Model video has been distributed to UKHC enterprise and is available at https://chsr.med.uky.edu/chsr-uk-healthcare-lean-model

Health IT Performance Improvement

Following the premise that the health IT, when fully integrated into health care delivery organizations, facilitates substantial improvements in health care quality and safety, we continue to embark on the deployment and optimization of information technology as a critical infrastructure to our program. Our belief in health IT supports the ONC (Office of National Coordinator) objective to use health IT to make care safer and to continuously improve the safety of health IT (ONC, 2013). Monitoring occurs through utilization of previously mentioned incident reports, SWARMS, and aggregating and analyzing data on key processes such as medication errors, computerized provider order entry (CPOE) compliance, and clinical decision support alerting to prevent adverse events.

Through the organizational quest for meaningful use of the EHR, we have adopted a focus on usability of deployed systems to enhance the user experience with IT and ensure the systems perform safely in the clinical environment. The continuous improvement in the use of Health IT is critical to ensure the complex system is designed, tested and used correctly and safely. We utilize usability testing and evaluation prior to deployment of designed solutions.

Adherence to the federal mandate for meaningful use (MU) has been a key focus and will continue as such in our deployment, monitoring and evaluation of Health IT. Achieving MU Stage 2 in FY 2015 is the foundation for the organization priorities in strategies to meet MU Stage 3. The new regulations released in October 2015 for MU Stage 3 will provide the roadmap for quality initiatives related to Health IT.

UKHC CQI Storyboard

To help teams analyze specific breakdowns in care and discover their underlying causes to develop targeted solutions that solve these complex problems, the OVIHD PI team developed the UKHC CQI Storyboard (Appendix 4) – The FOCUS-PDSA Model. The FOCUS-PDSA quality improvement process can strategically guide team's efforts to narrow down, collect data, and select and organize a team for the problem area chosen. It also guides team through all the remaining steps of the quality improvement process. The checklist is based upon the FOCUS-PDSA cycles of QI.

Find a Process or Problem to Improve

- Align with organizational goals
- Recognize the role of stakeholders/customers in prioritizing potential process improvements
- Identify the known gap between knowledge and practice
- Collect data to understand scope of the problem and possible reasons for it
- Write a good problem statement

Organize a Team to Improve the Process

- Identify key players in a process and organize a multidisciplinary team
- Identify the team leader/process owner
- Determine the goal statement for improvement
- Develop agreed upon ground rules

Clarify Current Knowledge of the Process

- Understand how the current process works
- Flow chart the actual process
- Identify customers and suppliers in the process
- Recognize the importance of performance indicators.
- Set up a measurement process and collect data. Be innovative.

Understand Sources or Causes of Process Variation

- Analyze data using analytical tools
- Understand the capacity for variation in the system
- Brainstorm all possible ideas and causes for problem
- Identify causes of variation in the system

Select the Improvement or Intervention

- Look for ways to limit variation in the process
- Evaluate alternatives for potential effectiveness and feasibility
- Learn what has worked at other organizations (copy)
- Identify what improvements or interventions will be made in the process
- Remember that solution doesn't have to be perfect the first time

Plan How to Implement the Improvement and Test the Changes

- Obtain buy-in from key stakeholders, leadership, and frontline staff.
- Identify key people to assist with implementation
- Make predictions and identify ways to counteract resistance to change
- Develop a communication plan.
- Develop a plan to include who, what, where, and when

Do Implement the Plan

- Implement the improvement in small test of change (pilot)
- Collect data before, during, and after the pilot
- Record any unexpected events and other observations
- Begin analyzing the data.
- Pilot again with changes, OR roll out system-wide

Study the Results of the Implementation

- Analyze data on how well the process is being implemented
- Analyze data to determine if the desired outcomes are being achieved
- Succinctly summarize the findings of the small-scale tests.
- Determine if/when modifications to the solution are needed.

Act to Hold the Gain and Continue Improvement

- Develop implementation strategy across organization
- Develop a monitoring schedule to measure gains over time.
- Keep it on some meeting agenda at least annually
- Establish ongoing education plan
- Determine how processes can be improved further

VII. PATIENT AND STAFF ENGAGEMENT

The Office of Patient Experience (OPE), working in collaboration with Office for Value and Innovation in Healthcare Delivery (OVIHD), serves as the content experts and champions of Patient and Family Centered Care (PFCC) improvements and projects. The OPE uses a systematic approach to consult and guide improvement teams at UK HealthCare by applying best practices, facilitation, problem solving, and change management process and tools. The team has expertise in numerous patient and staff experience improvement topics, including, but not limited to: Analysis of Patient Satisfaction and Employee and Physician Engagement, Education and Training, Leadership Development, Complaint Resolution, Pastoral Care and Volunteer Services.

The following metrics are some of the metrics monitored by the OPE:

- Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS)
- Clinician and Group Consumer Assessment of Healthcare Providers and Systems (CG CAHPS)
- Additional patient experience surveys for other areas not captured in CAHPS surveys
- Employee and Physician Engagement
- Grievance compliance in accordance with CMS guidelines

The goal of the OPE is to guide the integration of PFCC into all aspects of the planning, delivery, and evaluation of health care at UKHC, which is grounded in mutually beneficial partnerships among health care providers, patients and families.

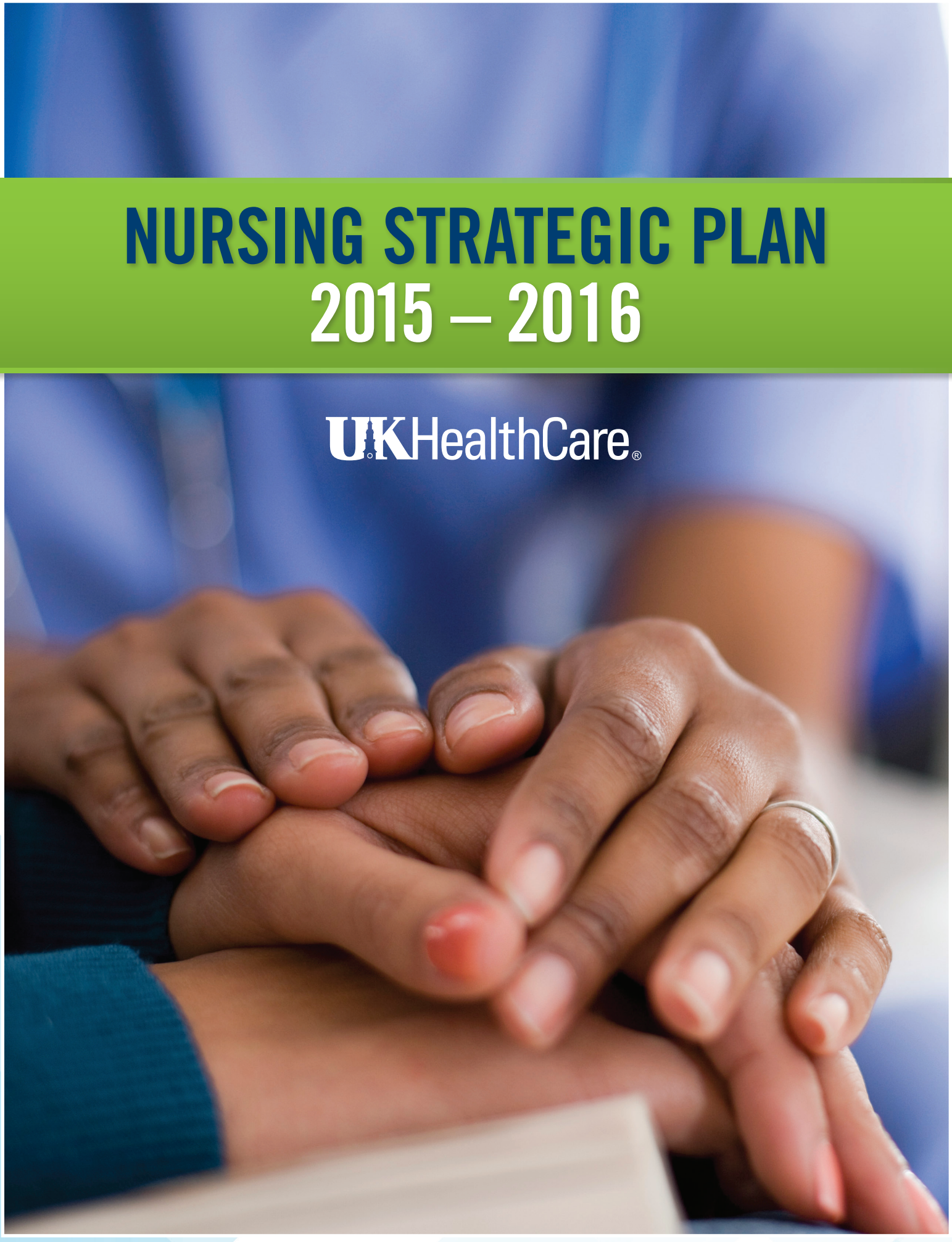
VIII. CLOSING

The Quality and Safety Plan is designed to align, support and promote the UKHC's mission, vision and values. The plan is not a standalone document - it is supported by other documents and tools including the strategic plan, the balanced scorecard and numerous educational and research opportunities. The plan provides guidance for identifying priorities and measures of our achievements in service quality, care outcomes and risk mitigation. We are attempting to do everything possible to ensure that our organization is a national leader in patient safety and quality, one that does not subject our patients to unintended harm and that delivers best practice care to all our patients. This plan will be reviewed on an annual basis to ensure continued alignment with the vision, mission and strategic directions of UKHC.

Appendix 1 – UKHC Nursing Strategic Plan 2015 - 2016

NURSING STRATEGIC PLAN 2015 – 2016

UKHealthCare®

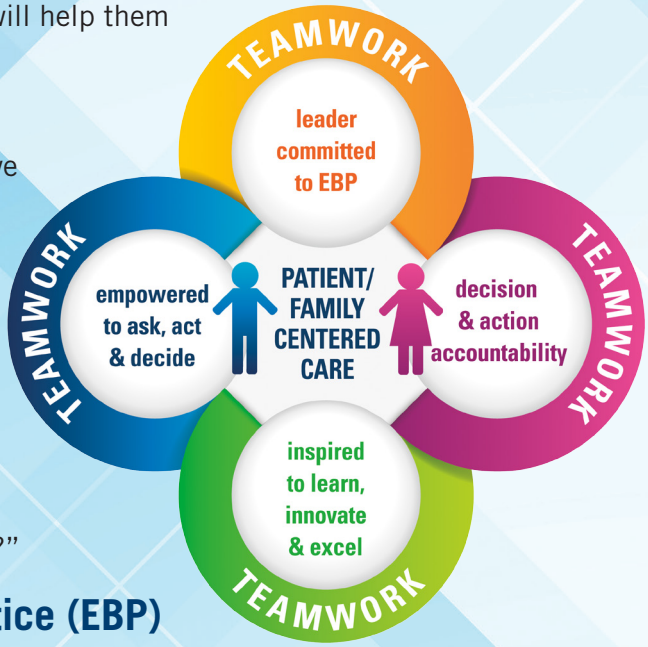


Professional Practice Model Implementation Guide

I believe patient/family-centered care is our core element

We show our belief in patient- and family-centered care by:

- Telling our patients what care we are providing and why it will help them
- Explaining their medications
- Involving our patients and their families in Bedside Shift Report (BSR)
- Ensuring our patients are safe by monitoring Nurse Sensitive Indicators (NSIs) using BCMA
- Getting to know our patients and their needs



I am accountable for decisions and actions

We own our nursing practice by:

- Holding ourselves and each other accountable
- Knowing and owning our patient data
- Being on a Shared Governance Council or taking identified projects to a council
- Asking ourselves "how can we improve the care we provide?"

I am a leader committed to Evidence-Based Practice (EBP)

I am a leader when:

- I am at the bedside caring for my patients and their families
- I coordinate the care of my patients
- I collaborate with the clinical nurse specialist and others to make changes in nursing care based on the evidence

I am empowered to ask, act and decide

I ask, act and decide when:

- I work with the patient on their goals of care
- I "stop the line" to advocate for our patients and their families
- I am able to escalate concerns to the appropriate team member
- I work to clarify the goals of care with the health care team

I am inspired to learn, innovate and excel

I learn, innovate and excel when I:

- Interact and develop a therapeutic relationship with my patients and their families
- Actively seek opportunities to develop professionally
- Achieve a national certification
- Achieve Nursing Professional Advancement level
- Join/maintain membership in a professional organization
- Pursue advancement of my degree
- Participate in community initiatives
- Precept new staff and students
- Attend a conference related to my clinical area
- Conduct a poster presentation, author a journal article or make a podium presentation.

COLLABORATING FOR PATIENT-CENTERED CARE

Our nursing strategic plan is a living document that provides the foundation and the direction for all levels of nursing at UK HealthCare. The strategic plan includes identified objectives that provide nursing with a long-term vision, tactics that focus our daily work, and targets with frequency measures to provide a system of accountability. To ensure that our strategic plan is relevant and timely, input is collected from nursing leadership and our nursing council chairs. Meaning is created when tactics are put into action, targets are met and improved patient outcomes are observed. Our nursing strategic plan serves as a road map to align efforts so that our collective movement positively impacts patient- and family-centered care, as well as the environment of care.

UK HealthCare® and UK College of Nursing leaders encourage interaction at all levels of nursing practice. Ensuring:

- Patient-centered care model
- Evidence-based practice
- Professional development
- Advanced practice in specialty care

Nursing leaders from UK HealthCare and the College of Nursing include, left to right, Colleen Swartz, chief nurse executive; Kathleen Kopser, associate chief nurse executive; Robyn Cheung, director of professional practice and innovation; Terry Lennie, associate dean for PhD studies; Patricia B. Howard, executive associate dean for academic operations and partnerships; Julie Hudson, perioperative services administrator; Patricia Burkhart, associate dean for undergraduate studies; Kathy Isaacs, director of nursing professional development; Gwen Moreland, assistant chief nurse executive; Patty Hughes, assistant chief nurse executive; Thomas Kelly, associate dean for research; Brandy Mathews, assistant chief nurse executive; and Janie Heath. (Not pictured, Lacey Buckler, assistant chief nurse executive)

2016 UK HEALTHCARE NURSING STRATEGIC PLAN

	QUALITY AND SAFETY: EMPIRICAL QUALITY OUTCOMES	PATIENT & STAFF EXPERIENCE: EXEMPLARY PROFESSIONAL PRACTICE
	Create a culture where we use data to support decision making, drive evidence-based practice (EBP), prevent patient harm and optimize patient outcomes at the point of care	**Improve the UK HealthCare experience to support patient- and family-centered care and staff engagement**
Tactics	1. Communicate accuracy, accessibility and timeliness of the daily rounding report (DRR) to all inpatient nurses and leaders by October 1, 2015 2. Re-survey the Patient Care Managers (PCMs) and Clinical Nurse Specialists (CNSs) monthly (progressing to quarterly) to solicit ongoing feedback/data collection re: utility/ satisfaction with the daily rounding report (DRR) and unit-specific scorecard (USS) 3. Examine the unit-specific scorecard (USS) with the same rigor as the daily rounding report (DRR) 4. Integration/coordination of work to the accountable steering teams for Nurse Sensitive Indicators (NSIs), Venous Thromboembolisms (VTEs), Sepsis and hospital-based psychiatric measures 5. Continue working with AllScripts to populate the 'Nursing Data Mart' 6. Continue to monitor and improve accuracy and reliability of the daily rounding report (DRR) 7. Collaborate with Impact Team to reduce the burden of documentation of quality measures 8. Design structures to promote best practices across the care continuum to include collaboration with Clinical Quality Specialists (CQSs) and Clinical Nurse Specialists (CNSs) 9. Patient Care Managers (PCMs) provide real time, individualized feedback to staff regarding clinical quality measures through the use of the daily rounding report (DRR)	1. Evaluate Mastery Simulation pilot project and determine if appropriate for enterprisewide implementation; evaluate inclusion of bedside shift report (BSR) as a mastery simulation skill 2. Continue to focus on patient experience packet (revise in January 2016) and include other areas (procedural, Kentucky Children's Hospital and Spanish); goal to engage patients and families as members of the health care team in an effective discharge planning process. 3. Provide oversight for patient call-back team and recommend an enterprisewide operational implementation plan 4. Educate staff on the enhanced role of patients and families in decision making. Review and revise patient experience web-based training (WBT) to include patient and family involvement 5. Will audit the bedside shift report (BSR) and Patient Experience Packet utilization
Nursing Tactics	1. Implement and document components of Nurse Sensitive Indicators (NSIs)/ quality bundles 2. Ask, act and decide about the impact of nursing care in prevention of patient harm 3. Incorporate unit-specific quality data in service line shared governance councils	1. Organize the delivery of information to both patients and families from the interdisciplinary care team (during rounds at the bedside, care conferences, consultations, phone calls) • Purposeful hourly rounding • Bedside Shift Report (BSR) • Utilizing AIDET in our communications (A=Acknowledge; I=Introduce; D=Duration; E=Explanation; T=Thank You) • Integration of Patient Experience Packet into workflow 2. Provide frequent updates to the patient when procedural or care delivery delays occur.
Outcomes	1. Patient Care Managers (PCMs) and Clinical Nurse Specialists (CNSs) will utilize the daily rounding report to inform their work flow and support clinical staff 2. PCM/CNS satisfaction due to the use of the daily rounding report and unit specific scorecard will improve from baseline survey and over time 3. Will see 90% compliance with process measures for Nurse Sensitive Indicator (NSI) bundles 4. All UK HealthCare nursing units will exceed 50th percentile with positive movement toward 25th percentile on all NSIs using the National Database of Nursing Quality Indicators (NDNQI) and UHC database	1. Project survey 2. Metrics consistent with enterprise goals 3. Discharge and care transitions domain 4. Complete staff education 5. Pilot results; draft of Operational Plan 6. Quarterly session update in spring 7. Include 2 patients on the team by Spring 2016
Measurement Frequency	1. Monthly monitoring with a progression to quarterly measurements of use and satisfaction of Patient Care Managers (PCMs) and Clinical Nurse Specialists (CNSs) with daily rounding report (DRR) and unit-specific scorecard (USS) 2. Monitoring through the UK HealthCare enterprise monthly Quality Close	1. Weekly stoplight report monitoring 2. Monthly HCAHPS, CG-CAHPS, NSI and Press Ganey reports
Team Members	Kathy Stephenson*, Suzanne Springate*, Carla Teasdale, Ben Nichols, Robyn Cheung, Amanda Green, Lacey Buckler, Jill Blake, Leah Perkins, Lisa Butcher, Sarah Gabbard, Sarah Lester, Daniel Cotter, Brandy Mathews *Denotes team lead	Judy Poe*, Lisa Thornsberry*, Bridget Shepherd, Richard Zerbee, Gwen Moreland, Patty Hughes, Angie Lang, Leah Perkins, Patient Name TBD

2016 UK HEALTHCARE NURSING STRATEGIC PLAN

	PATIENT & STAFF EXPERIENCE: EXEMPLARY PROFESSIONAL PRACTICE	PATIENT & STAFF EXPERIENCE: EXEMPLARY PROFESSIONAL PRACTICE
	Improved experience for staff: Continued work in implementing Healthy Work Environment (HWE) strategies	**Optimizing our service delivery - supply chain management and pharmacy**
Tactics	1. Ensure skilled communication teams are implemented in all service lines 2. Team members will facilitate development of skilled communication teams as needed 3. Each service line will report on team actions quarterly 4. Develop algorithms and disseminate information for: • Zero Tolerance policy • 'Stop the line' with escalation to include communication strategies 5. Ensure communication to the bedside nurse on the Healthy Work Environment (HWE) • Chief Nurse Executive (CNE) communication • Embed in unit weekly notes and CNE Nursing Updates • Engage bedside nurses as staff champions of the Healthy Work Environment (HWE)/ skilled communication 6. Bedside nurses added to Staff Experience team 7. Involve Magnet Champions and unit-based councils to ensure unit involvement	1. Enterprise roll-out of linen initiative to include: EVS tent cards alerting our staff/patients/families of the program, development of staff education, bed cover integrated into current process. 2. Expansion of 'Big Blue Goes Green' program to include: • Can recycling program education • Protected health information (PHI) education for staff, patients and families 3. Continued pharmacy efficiency efforts: • Meds to beds program • Meds to patient drawer • Meds to PYXIS 4. Standardized supply chain management communication plan to also include a standard logo 5. Continued evaluation of isolation gown usage to include considerations around reusable versus disposable gowns 6. Ongoing supply room management to include process for monitoring: • Expiration dates • Nursing evidence-based practice products • High-dollar/high-usage items • Quarterly reviews of supply rooms • Redundancy with the frequently called items not regularly stocked
Nursing Tactics	1. Take active role in decisions at the bedside using skilled communication techniques 2. Use of skilled phone communication by stating the unit and your name 3. Use proper chain of command with new medical staff to support their learning 4. Use of SBAR to facilitate skilled, accurate, safe patient handoffs 5. Active use of bedside shift reporting (BSR) to promote communication of care 6. Promote the use of teach back in interactions to ensure understanding	1. Will take an active role in educating our patients' and their families about our 'linen and go-green initiatives'. 2. Will be mindful of enterprise recycling efforts 3. Will be mindful of protected health information (PHI) and will educate our patients and families on how to protect their own PHI 4. Will be a good steward of resources 5. Follow up with identified patient allergies for accurate prescription of medications
Outcomes	1. Monitor Press Ganey/National Database of Nursing Quality Indicator (NDNQI) scores to measure effectiveness 2. Continue to improve the employee engagement workforce commitment score to 4.05	1. Reduction in our linen pounds per patient day as well as a reduction in water consumption 2. Staff knowledge around linen, 'go-green' and supply chain initiatives 3. Improved medication delivery to nursing units and patients 4. Improved staff satisfaction around having the 'materials I need to do my job' 5. Reduction in calls to Materials Management by UK HealthCare staff
Measurement Frequency	3. Annual Press Ganey Survey 4. Annual NDNQI Survey	1. Update list of current council officers annually 2. Survey staff using the "Conditions of Work Effectiveness Questionnaire-I" 3. Will repeat the annual congress 4. Newsletter to be released at least twice per year
Team Members	Lisa Fryman*, Patti Howard*, Shelly Marino, Phillip Eaton, Amberlee Fay, DeeDee McCallie, Kim Wilson, Jessica Porter	Sherri Dotson, Lorra Miracle, Julie Deverges*, Julie Blackburn*, Becky Garvin, Philip Almeter, Joe Caban, Audrey Yates

2016 UK HEALTHCARE NURSING STRATEGIC PLAN

	PATIENT & STAFF EXPERIENCE: EXEMPLARY PROFESSIONAL PRACTICE	MANAGEMENT STRATEGY: TRANSFORMATIONAL LEADERSHIP
	Empowerment of nursing staff through continuing to integrate the principles of shared governance (SG) and professional practice models into the nursing culture at UK HealthCare	**Growth management**
Tactics	1. Continue to share the success of our councils through the Shared Governance (SG) newsletter and Annual Congress 2. Invest in strategies to educate staff in their understanding of the Professional Practice Model (PPM) and how it aligns to their daily practice; Session at nursing quarterly session 3. Seek opportunities for further development of Shared Governance at UK HealthCare; Use Employee Engagement comment themes to drive future endeavors 4. Integrate Shared Governance (SG) in Behavioral Health across the enterprise 5. Consider opportunities/challenges in incorporating Ambulatory Services in the Shared Governance structure – adapting to service line operating model 6. Consider the logistics of moving toward an interdisciplinary model of Shared Governance to support the service lines	1. Re-energize the UK HealthCare Enterprise Throughput Team 2. Establish a process for managing outpatient same day admits (OPDAs) through a service-line specific approach 3. Move Pulmonary/Medicine service line to Pavilion A 9/10 and repurpose 5th and 6th floors in Pavilion H 4. Continue to meet our interfacility transfer requests 5. Continued growth of the UK HealthCare Good Samaritan Hospital census
Nursing Tactics	1. Actively participate in the Shared Governance process by serving on a council or sharing with service line or enterprisewide councils initiatives to improve the provision of care. 2. Proactively seek the evidence to support changes in practice or to support current practice. 3. Assume accountability for nursing practice and the ability to have input into the decisions that affect the work at the bedside. 4. Have the ability to speak to the Professional Practice Model (PPM) and the graphic model and how it is displayed in our everyday practice	1. Meet timing standards for transfers into the UK HealthCare enterprise 2. Give report when beds are ready; receive report when called; follow operation pull guidelines 3. Submit discharge order immediately upon patients departure 4. Staff input on care model variation including skill mix
Outcomes	1. Review National Database of Nursing Quality Indicators (NDNQI) and Employee Engagement survey results around questions related to PPM tenets 2. Visibility of SG/PPM in literature, websites and units 3. Query staff regarding understanding of PPM	1. Team will address variations to established monthly benchmarks via capacity dashboard 2. All outpatient same-day admissions will be cohorted in their service line on a daily basis 3. A. Successful move to Pavilion A and reoccupancy of Pavilion H beds; B. 90% or greater cohorting of Medicine patients 4. Accept 80% or greater of all interfacility transfers 5. Establish a report for analysis of appropriate transfers to GSH that will include patients considered and utilization of GSH capacity.
Measurement Frequency	1. Update list of current council officers annually 2. Survey staff using the "Conditions of Work Effectiveness Questionnaire-I" 3. Will repeat the annual congress 4. Newsletter to be released at least twice per year	1. Re-energize the existing Throughput Team of clinicians and support staff and engage this team in scrutinizing our performance in moving patients through the enterprise. This will be done through monthly review and analysis of established benchmarks and quick response to erosions in performance. 2. Daily measurement of flow effectiveness through PACU holds and PACU ICU boarding with reporting up through OR Executive Team if smoothing of, or modifications to OR schedule needs to occur 3. All Medicine patients and Medicine ICU patients will move by established move date. All Pavilion H beds will be reopened by established backfill date 4. Monitor with daily Lost Transfer report from Capacity Command Center and benchmark year over year with monthly transfer report 5. GSH growth will be monitored through monthly report used to analyze successful optimization of available capacity (number of red occurrences, ADC and over/under triage of patients, etc.)
Team Members	Robyn Cheung*, Kathy Isaacs, Becky Garvin, Shannon Haynes, Tanna McKinney	Tish Haney*, Kathy Semones, Lisa Counts, Julie Hudson, Pam Lane, Kathleen Kopser

2016 UK HEALTHCARE NURSING STRATEGIC PLAN

	MANAGEMENT STRATEGY: NEW KNOWLEDGE, INNOVATION AND IMPROVEMENTS	MANAGEMENT STRATEGY: EXEMPLARY STRATEGIC PROFESSIONAL PRACTICE
	Leveraging technology to promote innovative solutions to evidence-based care and communications	**Interprofessional strategic maturation**
Tactics	1. Develop innovative solutions to enhance communications: • Among providers and nurses: Design the communication flow utilizing innovative technology; Implement Phase I of the unified communications strategy to coordinate provider/nursing communications and demonstrate improved efficiencies. • Among nurses and patients: Enhance the integration of KRAMES within the EMR platform(s); Identify linkages to the patient portal for nurse-driven patient education 2. Extend paperless initiative: A. Implement electronic documentation within procedural areas and other identified paper locations. B. Complete the BCMA roll-out extended into FY16 for all patient care areas. C. Hardwire evidence-based practice and resources within the EMR (CPG's, other references). D. Prioritize and complete identified device integration gaps and CRRT. E. Hardwire usability review in all designs impacting nursing documentation through the IMPACT demand management program. 3. Technological solutions for transitions of care • Evaluate the ability to pull in the EMS documentation, run sheets, into the UKHC EMR. • Implement utilization of the CCDA (Continuity of Care Document Architecture) as a modality for data sharing to transferring facilities. • Complete the implementation and evaluate effectiveness of the software product, care management. 4.Develop a program for monitoring patient safety from technology error surveillance • Incorporate FMEA process in support of the alarm management strategy • Develop a baseline monitoring system for errors related to IT and report within the nursing dashboard framework • Collect data from errors and implement continuous improvement activities based on trends.	1. Mature/improve collegial relationship with physician partners by participating in service line model, continued work with BOOST, coordination of interdisciplinary performance goals into annual performance evaluation (PE) process, interdisciplinary rounding 2. Mutualistic relationship with the University of Kentucky College of Nursing 3. Support evidence-based practice (EBP) collaboration through education and clinical practice 4. Showcase the collaborative work of the college and UK HealthCare 5. Continue to leverage resources between the college and UK HealthCare 6. Collaborate best practice to support the educational needs of both facilities 7. Monitor and develop nursing shortage strategies to address issues and explore solutions with the University of Kentucky College of Nursing 8. Support an Inclusive Care Environment and a diverse workforce 9. Certification goal: • 75 RNs will achieve a national certification in FY'16 10. Timeline goal for achieving 80/20 by 2020 • January 2015-December 2015 (BSN within 5 years) • January 2016-December 2016 (BSN within 4 years) • January 2017-December 2017 (BSN within 3 years) • January 2018-December 2018 (BSN required) 11. Leader/staff professional development goals annually
Nursing Tactics	1.Nursing communication and patient safety improved between shifts with the consistent use of hand-off reports	1. Assume an active role in interdisciplinary rounding 2. Use skilled communication to build relationships with physician partners 3. Proactive use of plain language and teach back when providing care and supporting self-care 4. Contribute to an evidence-based practice (EBP) environment/generate clinical inquiry 5. Actively seek opportunities to promote professional growth 6. Attend offerings on inclusive care environments and diversity trainings to enhance practice and professional relationships 7. Precept new staff/students 8. Achieve and/or maintain a national certification 9. Attend professional development sessions/classes/conferences 10. Pursue an advanced degree in nursing
Outcomes	1. Each and every patient will have one (1) clinical practice guideline (CPG) documented per admission with the admission assessment 2. Improve communication between team members 3. Unit councils will be engaged in design processes	1. Monitor effectiveness of interdisciplinary rounding, skilled communication and shared governance EBP by way of the following: • HCAHPS • NDNQI • Press Ganey Employee Engagement survey • Conditions for Work Effectiveness Questionnaire (CWEQ) 2. Monitor attendance at educational sessions 3. Monitor attendance at preceptor workshop 4. Monitor achievement of national certification 5. Monitor levels of education by way of payroll report and RN profile
Measurement Frequency	1. Conduct point prevalence this year for use of clinical practice guidelines (CPGs) 2. Electronic ticket to ride every patient every time 3. Employee engagement survey will show improved perception of communication between care teams in the next cycle 4. Unit councils will report out monthly regarding technology changes and user interface effectiveness	1. Ongoing and annually 2. Ongoing 3. Ongoing 4. Every 3 months 5. Annually
Team Members	Carla Teasdale*, Patti Howard, Lisa Thornsberry, Philip Eaton, Jill Blake	Kathy Isaacs*, Colleen Swartz, Janie Heath

2016 UK HEALTHCARE NURSING STRATEGIC PLAN

MANAGEMENT STRATEGY: STRUCTURAL EMPOWERMENT

Building a collaborative network to ensure safe patient transitions

Tactics

1. Improve care delivery and expand acute care capacity by moving patients to more appropriate settings (SNF, LTACH, IRF, home health, hospice, palliative care, etc) as quickly as health status warrants and evident by reduction in 30-day all cause readmission rates. Achieving national CMS rates for 3 of 5 MS-DRGs.
2. Developing an integrated post-acute care network across Kentucky for UKHC patients leading to improved outcomes and efficiency indicated by a LOS Index to 1.0 or less.
3. Identify and complete preferred partnership agreements with top 10 post-acute care providers by October 2015 and complete agreements with top 25 by January 2016.
4. Develop a multidisciplinary team to enhance care transition processes associated with inpatient to ambulatory setting, assuring accurate & adequate communication between the settings and patient understanding of scheduled follow-up. Refine care transitions through partnership via the Kentucky Appalachian Transition Services (KATS).

Nursing Tactics

1. Utilization of teach-back; understanding of follow-up appointments prior to discharge; teaching to patient/family when to return to the hospital v. MD/clinic
2. Patient/Family Services- conduct initial discharge screenings within 24 hours of admission; Implement social service screening to identify social needs/requirements/ hurdles to discharge.
3. Providing patients with a choice and recognition of the preferred provider list
4. RN will review the discharge instruction form with the patient before discharge

Outcomes

1. Achieve faster intake of appropriate patients
2. Preference for patient transfer as a preferred partner; Statement of work developed to create networks resulting in seamless experience across the care continuum.
3. SNFs receive support from UK HealthCare to meet the requirements of the partnership
4. UK HealthCare identified by partners as being committed to communication, education and clinical care of patients, improving delivery systems by partnering with key entities for optimal patient outcomes.
5. 100% of patients will have medical record documentation of follow-up appointments/ testing as appropriate. A minimum of 90% will complete follow up as scheduled.

Measurement Frequency

Monthly Enterprise Reporting:

1. UHC length of stay (LOS) reports
2. UHC opportunity days associated with patient transitions to preferred partners
3. Readmission rates (30-day all-cause) per Centers for Medicare and Medicaid Services
4. Medical record documentation quarterly review per the number of patients completing follow-up appointments/testing as scheduled upon acute care discharge.

Team Members

Penny Gilbert*, Janet Cole, Lisa Thornsberry, Lynn Gentry, Amanda Green, Colleen Swartz

Nursing Strategic Plan Implementation Guide

QUALITY AND SAFETY

- **IMPLEMENT** Nurse Sensitive Indicator (NSI) / other quality bundles and ensure accurate documentation
- **ASK, ACT and DECIDE** about the impact of nursing care in prevention of patient harm
- **UNDERSTAND** NSIs and quality bundles as they relate to my work unit
- Use data to **IMPROVE** my practice
- **INCORPORATE** unit-specific quality data in service line shared governance councils
- **CONDUCT** Bedside Shift Report (BSR) and safe patient handoffs/transitions in care
- **ROUND** with a purpose

STAFF AND PATIENT EXPERIENCE

- **USE** AIDET
- **PARTICIPATE** in shared governance and decisions on my unit
- **RECOGNIZE** peers who do a great job
- **ASSIST** with hiring decisions for my team
- **ENSURE** patient and family voice heard in care decisions
- **DEVELOP SKILLED COMMUNICATION** for the interprofessional dialogue
- **ROUND** with a purpose
- **INVOLVE** patient and/or family in Bedside Shift Report (BSR)

PRACTICE OF NURSING

- **INDIVIDUALIZE** patient plan of care using the foundation of our professional practice model (PPM)
- **PURSUE OPPORTUNITIES** to increase my knowledge
- **ACTIVELY PARTICIPATE** in the shared governance process by serving on a council or sharing with service line or enterprisewide councils initiatives to improve the provision of care
- **PROACTIVELY SEEK THE EVIDENCE** to support changes in practice
- **ASSUME ACCOUNTABILITY** for my nursing practice
- **HAVE** input into the decisions that affect my work
- **INTEGRATE THE PROFESSIONAL PRACTICE MODEL INTO MY DAILY PRACTICE**

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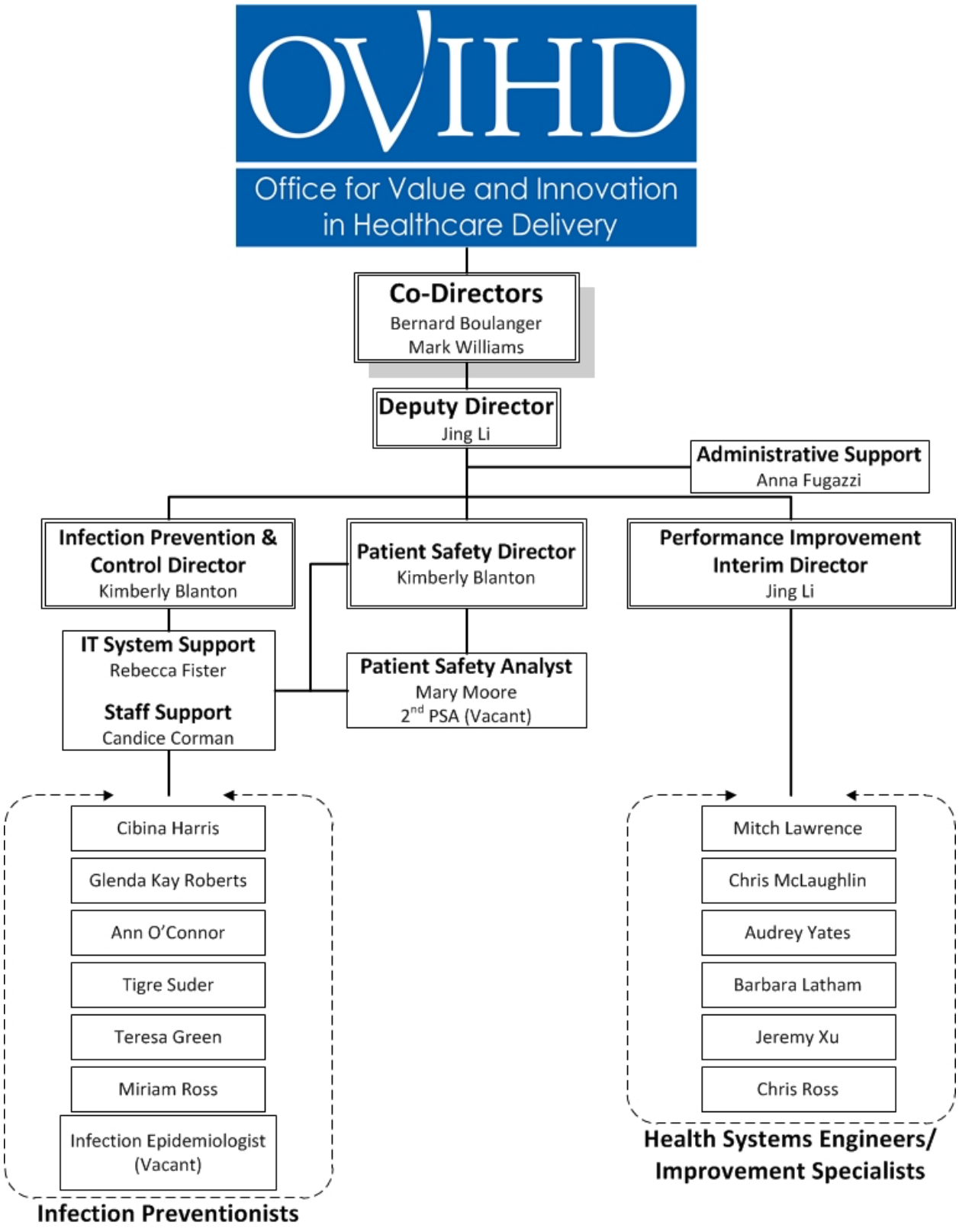
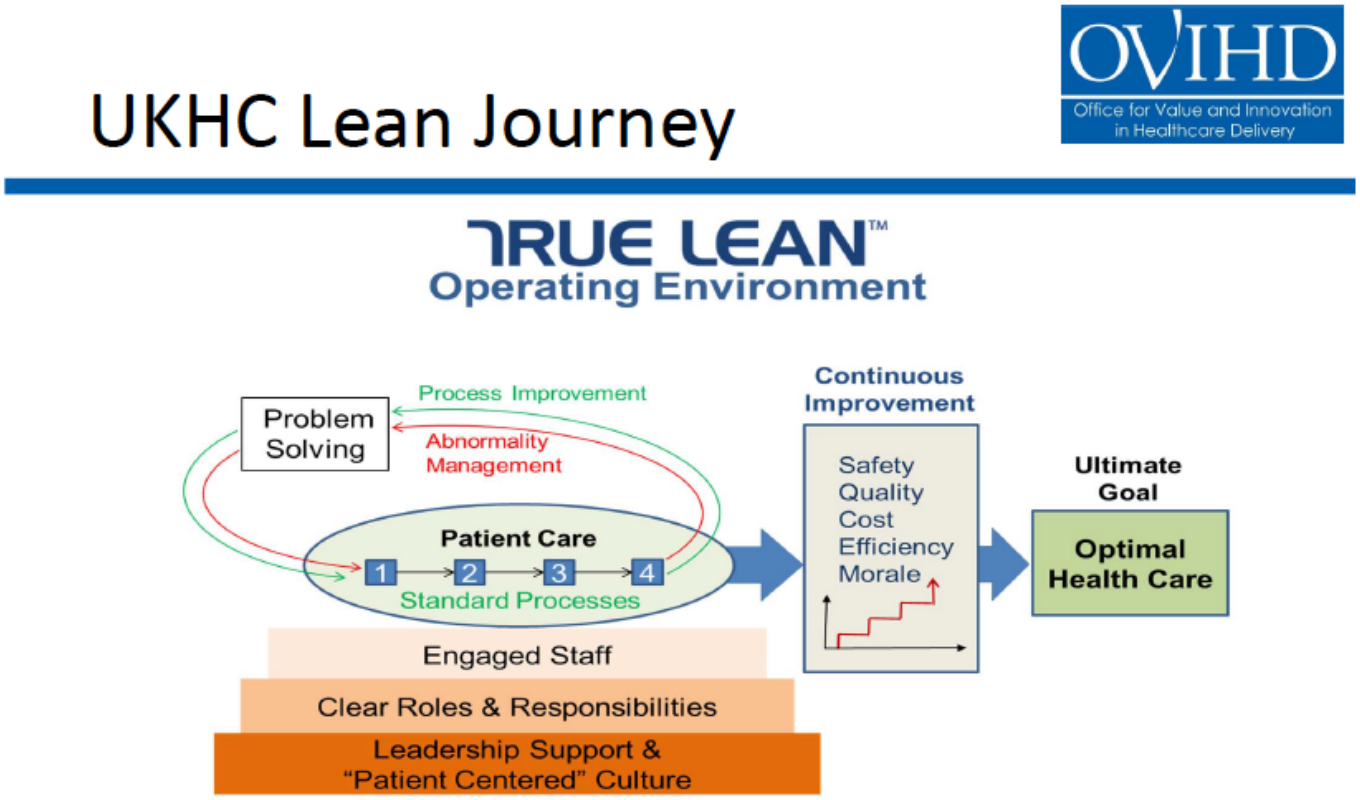
UKHealthCare®

ukhealthcare.uky.edu/nursing

Appendix 2 – OVIHD Org Chart



Appendix 3 – UK HealthCare Lean Model



https://chsr.med.uky.edu/chsr-uk-healthcare-lean-model

Appendix 4 – UKHC CQI Storyboard

TITLE:
EXECUTIVE SPONSOR:
FRONT LINE LEADERS:

OVIHD Office for Value and Innovation in Healthcare Delivery

CQI Storyboard

(Continuous Quality Improvement)

UK HealthCare

FIND a Process to Improve

- ❑ Identify a problem and understand how solving would align with UKHC Enterprise Goals
- ❑ Collect and analyze data to understand scope of problem
- ❑ Display the gap between standard and current situation
- ❑ Observe the process through the eyes of the patient and/or staff
- ❑ Write a problem statement describing the impact on care provided at UKHC

Available OVIHD Tools

- Observations
- Data
- Staff/Patient Surveys
- Scoping Document
- Prioritization Matrix
- FMEA

ORGANIZE a Team

- ❑ List project owner responsible for ensuring project completion
- ❑ List key team members essential for the interdisciplinary team
- ❑ List the team member who is responsible for collecting, analyzing, and displaying data
- ❑ Set-up and schedule standing meetings

Available OVIHD Tools

- Team Member List
- Meeting Agenda
- Timeline

CLARIFY Current Knowledge

- ❑ Complete observations and identify waste
- ❑ Define current state process map
- ❑ Analyze data to verify the problem is clearly identified
- ❑ Create SMART (specific, measurable, achievable, relevant, time-bound) goals using STEEEP principles (safe, timely, effective, efficient, equitable, and patient-centered)

Available OVIHD Tools

- Waste Identification
- Current State Process Map
- Pareto
- Process Measurement and Data Collection
- Spaghetti Diagram
- Time Studies
- SMART Goals Template

UNDERSTAND Root Causes

- ❑ Brainstorm all possible causes of the identified problem
- ❑ Complete observations to eliminate causes that are not true
- ❑ Continue to narrow down the list and identify causes for variation in the process

Available OVIHD Tools

- Fishbone Diagram
- Affinity Diagram
- 5 Whys

SELECT the Improvement

- ❑ Brainstorm change ideas for eliminating root causes
- ❑ Complete observations to verify effectiveness, feasibility, and sustainability of change ideas
- ❑ Contact similar areas or organizations to see what has worked
- ❑ Identify what improvements will be made in the process
- ❑ Remember the solution does not have to be perfect the first time

Available OVIHD Tools

- Brainstorming (Learning Circle)

PLAN the Improvement

- ❑ Obtain buy-in from key stakeholders, leadership, and frontline staff on change ideas
- ❑ Create future state process map
- ❑ Make predictions and identify ways to counteract resistance to change
- ❑ Create communication action plan and project timeline describing how the team will move forward including who, what, where, and when
- ❑ Finalize SMART goals

Available OVIHD Tools

- Communication Plan
- Future State Process Map
- FMEA

DO the Improvement

- ❑ Pilot the improvement with a small cycle of change
- ❑ Observe the process through the eyes of the patient and staff
- ❑ Collect data before, during, and after the pilot
- ❑ Analyze the results
- ❑ Document any unexpected events and other observations
- ❑ Make any system adjustments to improve data outcome
- ❑ Pilot again with changes if needed
- ❑ Document standardized work

Available OVIHD Tools

- 5S
- Revisions to Future State Process Map
- Observations
- Standardized Work

STUDY the Results

- ❑ Collect data before, during, and after system-side implementation and analyze
- ❑ Analyze data to determine if the team achieved SMART goals
- ❑ Complete observation of compliance of change idea including speaking with frontline staff and patients
- ❑ Document the findings of the pilot and system-wide implementation
- ❑ Determine if/when modification to the change idea is needed

Available OVIHD Tools

- Data Analysis
- Pre/Post Data Comparison
- Run Chart
- Observations
- Compliance

ACT and Determine Next Steps

- ❑ Develop implementation strategy across areas impacted by change idea
- ❑ Develop a monitoring schedule to measure if SMART goal is continually being sustained
- ❑ If SMART goal is not met, evaluate process to determine if it needs to be refined or if a new FOCUS-PDSA necessary
- ❑ Establish ongoing education plan to keep stakeholders informed
- ❑ Document obstacles and lessons learned encountered throughout the process
- ❑ Continually challenge the team on how the process can be improved further

Available OVIHD Tools

- Sustainability Plan
- Observations
- Lessons Learned
- Action Items List
- Visual Management
- Dashboard
- Run Chart

FY16 Enterprise Goals

6/1/2015

UKHealthCare

FY2016 Enterprise Goals

Draft 6/1/15

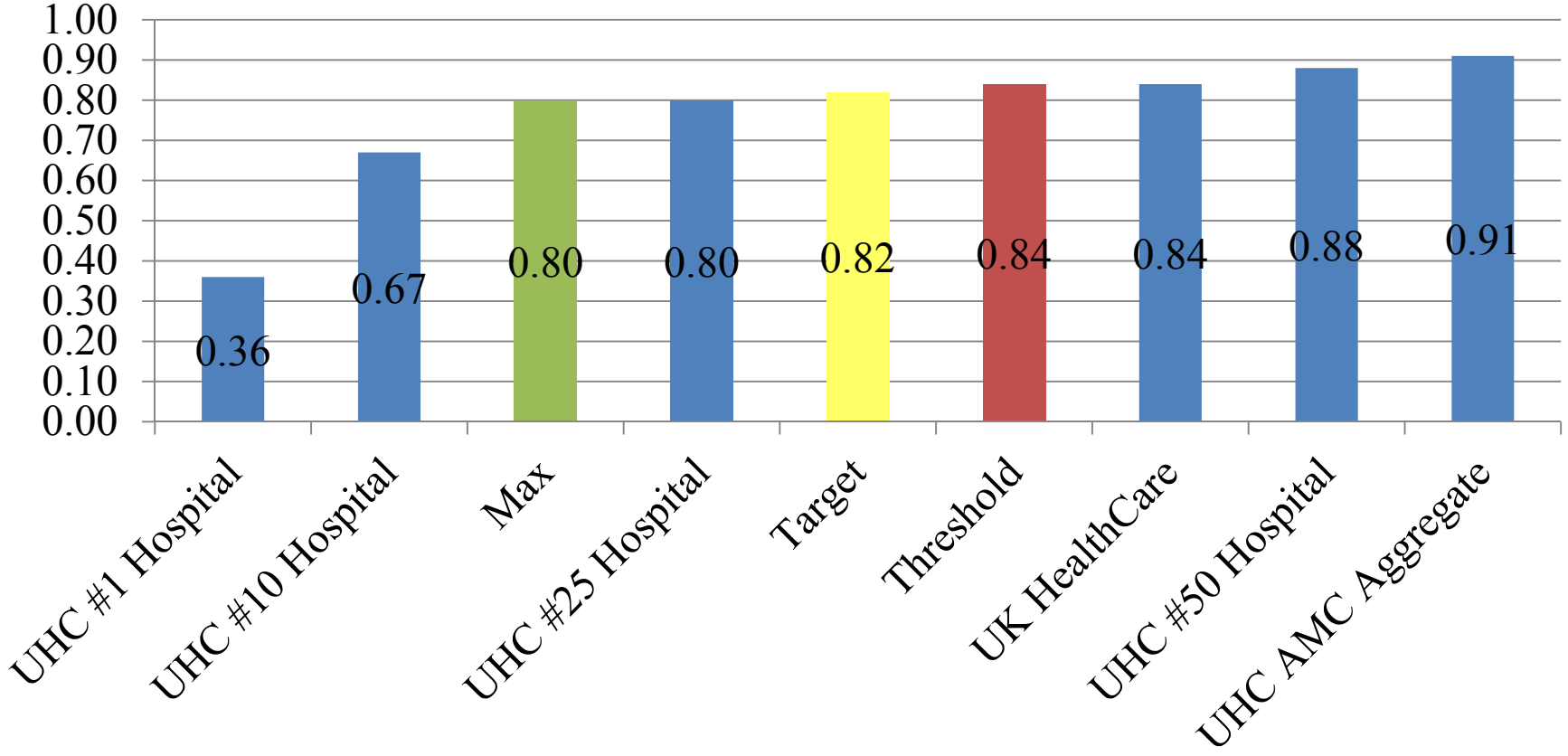
	Threshold	Target	Max	Current Performance CY 2014
MORTALITY				
Observed to Expected *(O/E)*	≤0.84	≤0.82	≤0.80	0.84
PATIENT SAFETY				
Patient Safety Indicator 90 *(Harm Score)*	≤0.68	≤0.64	≤0.59	0.60
Hospital Acquired Infections *(6 total)*	3 of 6	4 of 6	5 of 6	4 of 6
CARE CONTINUUM				
New Patient Visit Lag of ≤14 days *(76 locations)*	≥24 locations	≥31 locations	≥39 locations	24 locations (FY15 YTD)
Length of Hospital Stay (*LOS O/E*)	≤1.05	≤1.04	≤1.03	1.10
Same-hospital Readmissions	≤10.85%	≤10.75%	≤10.65%	10.85%
PATIENT EXPERIENCE				
Inpatient (HCAHPS) Survey Domains *(9 total)*	6 of 9	7 of 9	8 of 9	7 of 9
Ambulatory (CGCAHPS) Survey Domains *(6 total)*	3 of 6	4 of 6	5 of 6	3 of 6
ENGAGEMENT				
Physician Engagement	≥3.66	≥3.70	≥3.74	3.66 (2015 survey)
Employee Engagement	≥4.05	≥4.09	≥4.13	4.05 (2015 survey)

Guidelines

- The UHC "top performer" model is our framework. This framework is robust and tested.
- All metrics must have historical performance data available.
- The metrics chosen should be validated by other agencies such as UHC, CMS, TJC, or NQF.
- The previous Calendar Year is used as the benchmark period (unless otherwise stated).
- The metric definition and source must be documented clearly.

MORTALITY

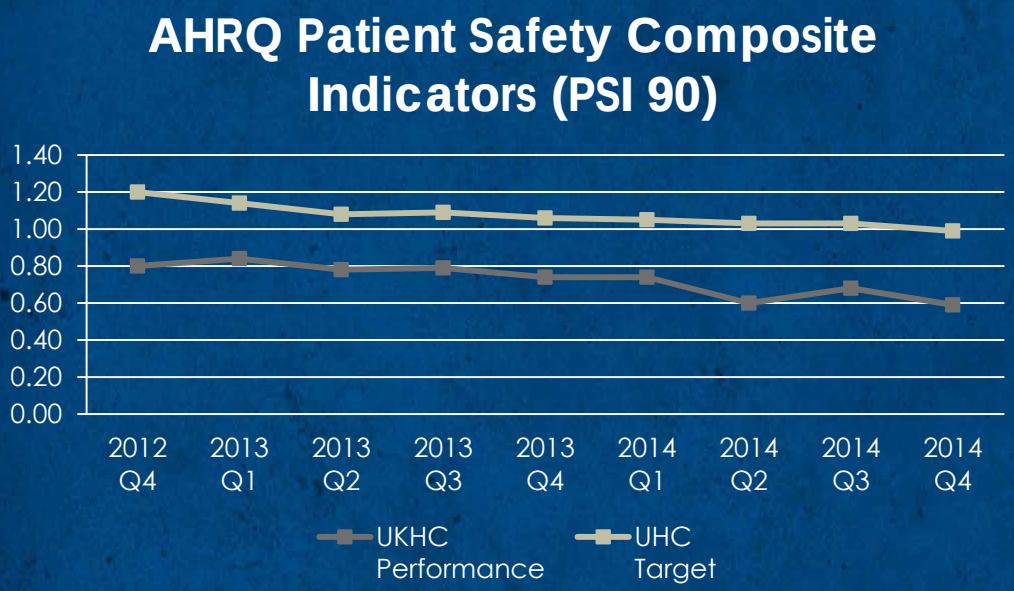
Mortality Performance (O/E)
2014 Risk Model for CY 2014



Threshold – 0.84 **Target – 0.82** **Max – 0.80**

PATIENT SAFETY

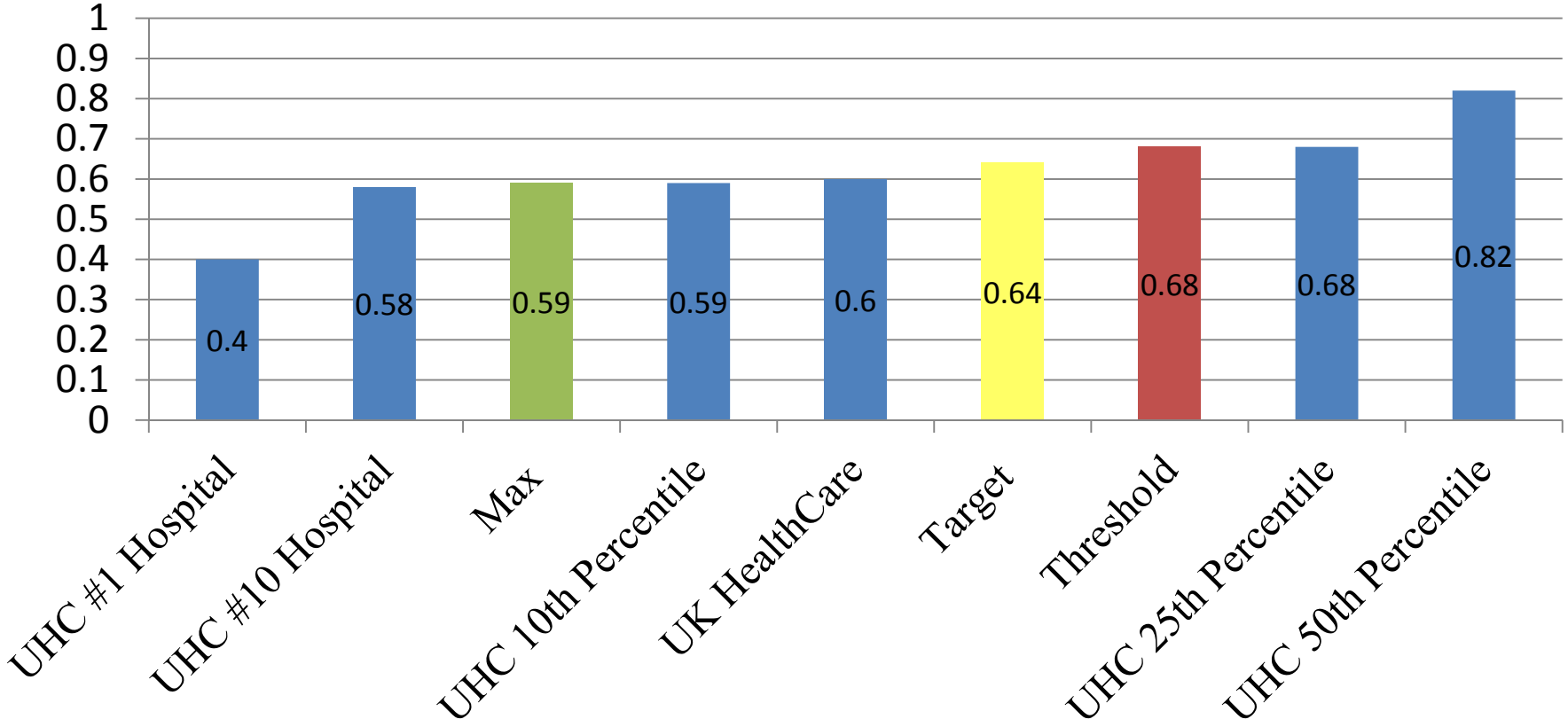
Patient Safety Indicator 90 Benchmarking



Patient Safety Indicators Included in PSI 90

- Pressure Ulcer
- Iatrogenic Pneumothorax
- Central Venous Catheter-Related Bloodstream Infection
- Postop Hip Fracture
- Postop PE or DVT
- Postop Sepsis
- Postop Wound Dehiscence
- Accidental Puncture or Laceration

Patient Safety Indicator 90 Performance
CY 2014



Threshold – 0.68 Target – 0.64 Max – 0.59

***Performance will be based on most recent rolling year performance**

Hospital Acquired Infections

- Catheter Associated Urinary Tract Infection (CAUTI)
- Central Line Associated Blood Stream Infection (CLABSI)
- Methicillin Resistant Staphylococcus Aureus with Bacteremia (MRSA)
- Clostridium Difficile (C. Diff)
- Surgical Site Infections (SSI)
  - Abdominal Hysterectomy
  - Colon

HEALTHCARE ASSOCIATED INFECTIONS PROGRESS

NATIONAL

HEALTHCARE-ASSOCIATED INFECTION (HAI) DATA give healthcare facilities and public health agencies knowledge to design, implement, and evaluate HAI prevention efforts.

Learn how your hospital is performing: www.medicare.gov/hospitalcompare
For additional information:

- 2013 HAI Progress Report: www.cdc.gov/hai/progress-report/
- NHSN: www.cdc.gov/nhsn
- Preventing HAIs: www.cdc.gov/hai

LEGEND

↓ 2013 Nat'l SIR is significantly lower (better) than comparison group

↑ or ↓ Change in 2013 Nat'l SIR compared to group in column header is not statistically significant

↑ 2013 Nat'l SIR is significantly higher (worse) than comparison group in

HAI TYPE	# OF U.S. HOSPITALS THAT REPORTED DATA TO CDC'S NHSN, 2013+	2013 NAT'L SIR vs. 2012 Nat'l SIR‡	2013 NAT'L SIR vs. Nat'l Baseline‡	2013 NAT'L SIR
CLABSI Nat'l Baseline: 2008	3,578	↓ 4%	↓ 46%	0.54
CAUTI Nat'l Baseline: 2009	3,640	↑ 3%	↑ 6%	1.06
SSI, Abdominal Hysterectomy Nat'l Baseline: 2008	3,182	↓ 4%	↓ 14%	0.86
SSI, Colon Surgery Nat'l Baseline: 2008	3,348	↑ 14%	↓ 8%	0.92
MRSA Bacteremia Nat'l Baseline: 2011	3,827	↓ 5%	↓ 8%	0.92
C. difficile Infections Nat'l Baseline: 2011	3,924	↓ 6%	↓ 10%	0.90

+The number of hospitals reporting for each HAI type may differ because some hospitals do not use central lines or urinary catheters, or do not perform colon or abdominal hysterectomy surgeries.
‡The 2012 Nat'l SIRs can be found in the data tables of this report.
‡Nat'l baseline time period varies by infection type. See first column of this table for specifics.

WHAT DOES THE STANDARDIZED INFECTION RATIO (SIR) MEAN?

IF THE NATIONAL SIR IS:

MORE THAN 1	There was an increase in the number of infections reported in the nation in 2013 compared to the national baseline.
1	There were about the same number of infections reported in the nation in 2013 compared to the national baseline.
LESS THAN 1	There was a decrease in the number of infections reported in the nation in 2013 compared to the national baseline.

THIS REPORT IS BASED ON 2013 DATA, PUBLISHED JANUARY 2015

Hospital Acquired Infection Performance CY 2014

Metric	UK HealthCare Performance (Raw Number)	UK HealthCare SIR	Target-Based on CDC National SIR for 2013
CAUTI	185	1.65	1.06
CLABSI	68	0.41	0.54
MRSA	48	2.17	0.92
C. Diff	178	0.78	0.90
SSI: Abdominal Hysterectomy	4	0.61	0.86
SSI: Colon	13	0.51	0.92

Threshold – 3 out of 6 Target – 4 out of 6 Max – 5 out of 6

***Performance will be based on most recent rolling year performance**

CARE CONTINUUM

New Patient Visit Lag Performance FY15 YTD

- Goal set at ≤ 14 calendar days between date of request and date of appointment
- 76 locations included
- Appointment types measured – New OB, New Patient, New Patient Spanish, Diagnosis Specific New
- Excludes appointments booked/documented after the date of service
- Current performance

≤ 14 Days	15-29 Days	≥30 Days
24 locations	22 locations	31 locations

Threshold – 24 locations **Target – 31 locations** **Max – 39 locations**

NEW PATIENT VISIT LAG PERFORMANCE
FY15 YTD – CLINICS MEETING TARGET

Location	July	August	September	October	November	December	January	February	March	FY - YTD Average
Sleep Center	3	2	2	3	5	5	3	3	2	3
Sports Rehabilitation	7	7	5	6	7	8	5	5	7	6
MCC-Multidisciplinary Oncology-Head-Neck	7	7	6	7	7	9	6	7	7	7
Georgetown Ob/Gyn	9	6	5	8	6	7	9	6	9	7
Pediatric Infectious Disease	7	7	6	5	6	13	7	6	11	7
Orthopaedic Surgery - Sports Medicine	11	8	7	6	8	10	8	7	6	8
June Buchanan	6	6	8	7	6	8	9	7	13	8
NFV-Family and Community Med	6	10	6	8	8	8	7	10	10	8
Adolescent Medicine	7	12	8	8	14	11	6	8	8	9
Pediatric Pulmonary	9	11	9	9	8	10	8	9	9	9
Transplant Clinic - Heart Medicine	11	12	6	8	8	12	15	10	10	10
MCC-Multidisciplinary Oncology-Surgery	8	8	12	8	10	11	8	7	23	10
Surgery Peds	10	17	9	8	13	7	8	13	11	10
Cardiothoracic	8	12	9	12	11	13	5	13	6	11
MCC-Multidisciplinary Oncology-GU-Surg	21	13	8	12	11	11	10	8	9	11
Ob/Gyn Oncology	10	11	10	11	16	12	9	11	11	11
MCC-Multidisciplinary Oncology-Hem-Med	10	12	11	13	11	10	12	9	13	11
Surgery Plastic	12	10	11	10	15	11	16	12	13	12
Orthopaedic Surgery - Trauma	14	13	11	10	9	11	14	14	16	12
Family Care Center	12	14	14	16	11	13	10	14	14	13
Polk Dalton Ob/Gyn	13	12	15	14	15	16	14	13	12	14
Gastroenterology - General	19	16	14	15	12	14	11	11	12	14
Surgery General - Oncology (Gold)	16	13	15	12	10	16	14	11	17	14
Pediatric Nephrology	28	17	11	13	11	12	9	12	16	14

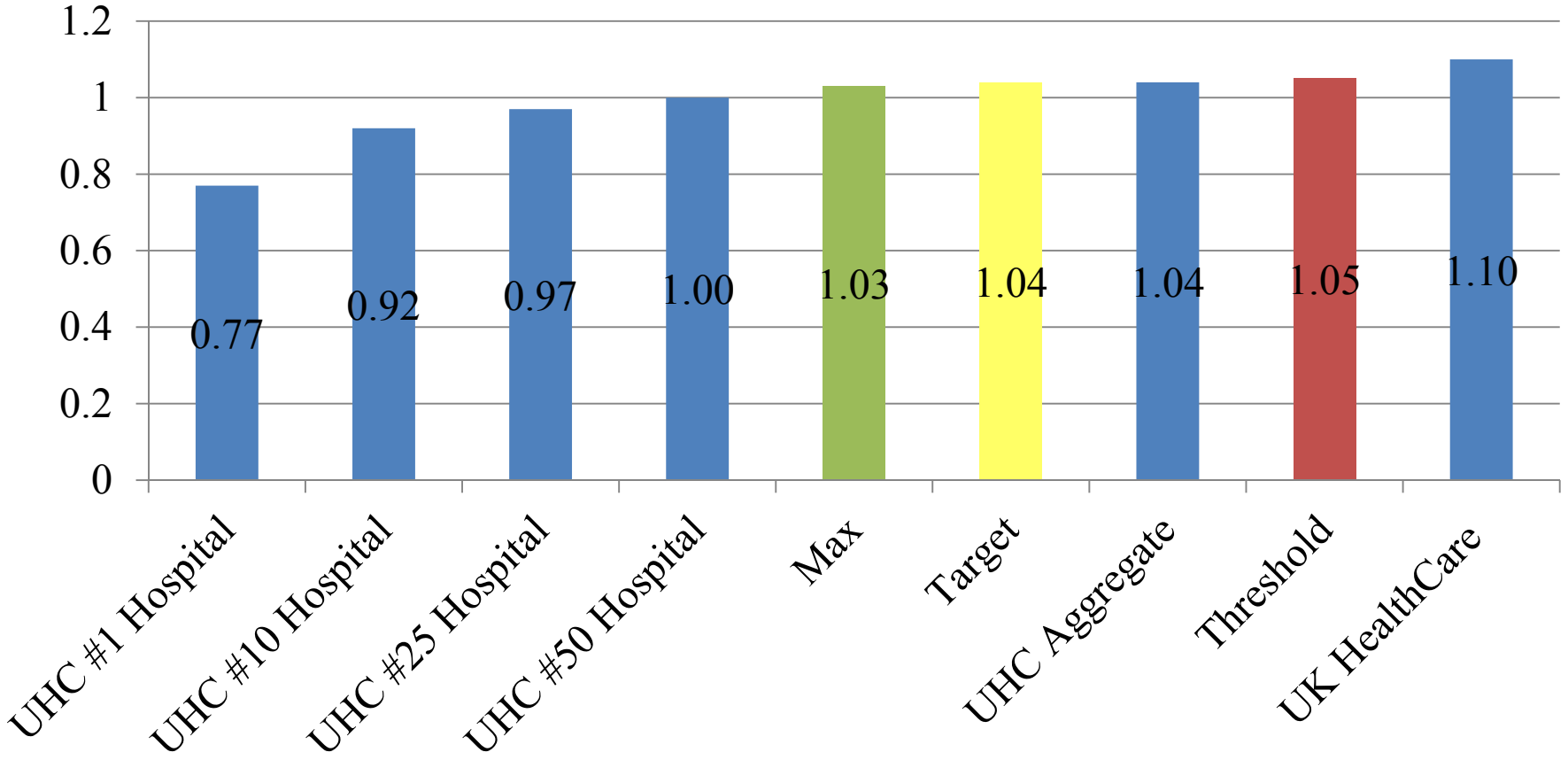
New Patient Visit Lag Performance
FY15 YTD – Clinics Not Meeting Target
Lag of 15-30 days

Location	July	August	September	October	November	December	January	February	March	FY - YTD Average
Internal Medicine - Peds	17	15	16	18	9	15	19	6	11	15
Transplant Clinic - Liver Surgery	15	13	9	11	16	19	15	15	20	15
Orthopaedic Surgery - Reconstructive	16	16	13	11	13	18	15	17	20	15
Interventional Pain	17	12	12	14	12	15	14	12	26	15
Transplant Clinic - Liver Medicine	1	10	3	10	16	19	15	15	21	16
Orthopaedic Surgery - Pediatrics	15	18	18	18	17	14	14	16	16	16
Pediatric Hematology Oncology	12	14	10	11	17	20	15	20	21	16
Gastroenterology - Lower	17	17	30	14	15	21	14	13	14	17
Ophthalmology - Cornea	16	25	14	14	17	19	18	21	17	18
Allergy and Immunology	16	14	17	12	19	19	17	25	23	18
CBCC - Surgery	15	28	14	10	24	18	17	31	20	19
Surgery General - Vascular (Red)	17	17	15	14	15	18	18	23	34	19
Psychiatry-Adult	22	33	26	19	17	21	21	7	8	19
Internal Medicine - Orange	18	25	N/A	N/A	16	N/A	N/A	8	29	20
Ophthalmology - Retina	20	15	22	18	16	22	23	19	21	20
Pediatric Cardiology	16	17	21	24	28	31	24	29	31	24
Rheumatology	26	24	25	24	26	27	23	22	23	24
Transplant Clinic - Kidney Surgery	39	32	28	21	19	23	14	24	34	27
Markey Hematology Program	32	30	29	21	34	27	25	23	27	27
Pediatric Endocrinology	54	37	32	45	26	31	26	22	16	28
Surgery General - Trauma (Blue)	22	25	23	25	31	26	29	40	41	29
Neurosurgery	21	25	25	28	36	27	33	42	42	30
CBCC - Medicine	18	19	24	25	39	33	40	35	41	30

New Patient Visit Lag Performance
FY15 YTD – Clinics Not Meeting Target
Lag ≥31 days

Location	July	August	September	October	November	December	January	February	March	FY - YTD Average
Cardiology	27	30	27	22	31	34	32	39	37	31
Otolaryngology	27	28	29	27	30	27	35	38	41	31
Pulmonary	40	36	36	40	31	24	25	28	28	32
Pediatric Rheumatology	18	19	24	17	32	37	24	33	57	32
Gastroenterology - Liver	46	41	36	36	36	27	22	24	27	33
Orthopaedic Surgery - Hand	34	27	29	34	29	35	31	48	40	34
Ob/Gyn - General	32	36	32	32	40	39	34	34	39	35
Surgery General - GI (Green)	35	35	39	33	35	36	26	48	33	36
South Primary Care*	54	64	27	40	42	33	40	37	4	38
Physical Medicine And Rehab	32	31	33	42	37	42	51	53	46	41
Ophthalmology - Pediatrics	39	46	48	44	46	45	36	29	35	41
Family Medicine - Yellow	38	50	44	34	30	45	37	37	46	41
Family Medicine - Blue	37	47	46	46	48	42	39	36	34	41
Infectious Disease	37	34	32	34	48	51	42	42	51	42
Family Medicine - Green	45	40	52	36	54	40	46	25	52	44
Family Medicine - Purple	51	42	47	49	38	35	41	33	48	44
Orthopaedic Surgery - Spine	39	37	45	45	46	60	51	23	54	46
Family Medicine - Red	50	49	48	49	42	47	45	34	53	47
Nephrology	33	40	50	41	53	65	59	51	53	48
Surgery Urology	46	44	49	59	63	46	42	40	46	48
Ophthalmology - General	50	48	54	56	61	59	51	50	48	53
Polk Dalton Primary Care	57	53	48	52	54	50	56	47	58	53
Georgetown Family Medicine	41	35	39	54	55	57	67	73	81	55
Endocrinology	46	43	39	45	70	62	60	67	69	56
Neurology Child	78	73	83	65	86	67	46	54	48	62
Internal Medicine - Green	42	77	68	46	90	98	91	42	26	64
Women's Health	85	76	97	35	20	35	34	43	22	71
Internal Medicine - Blue	61	75	72	53	90	78	109	81	95	76
Neurology Adult	81	96	104	39	79	108	102	112	98	86
Pediatric Gastroenterology	62	59	64	70	68	53	53	96	158	86

Length of Stay Performance(O/E)
2014 Risk Model for CY 2014



Threshold – 1.05 Target – 1.04 Max – 1.03

Length of Stay Budgeting Analysis for FY16

FY 2016 ALOS Budget Target

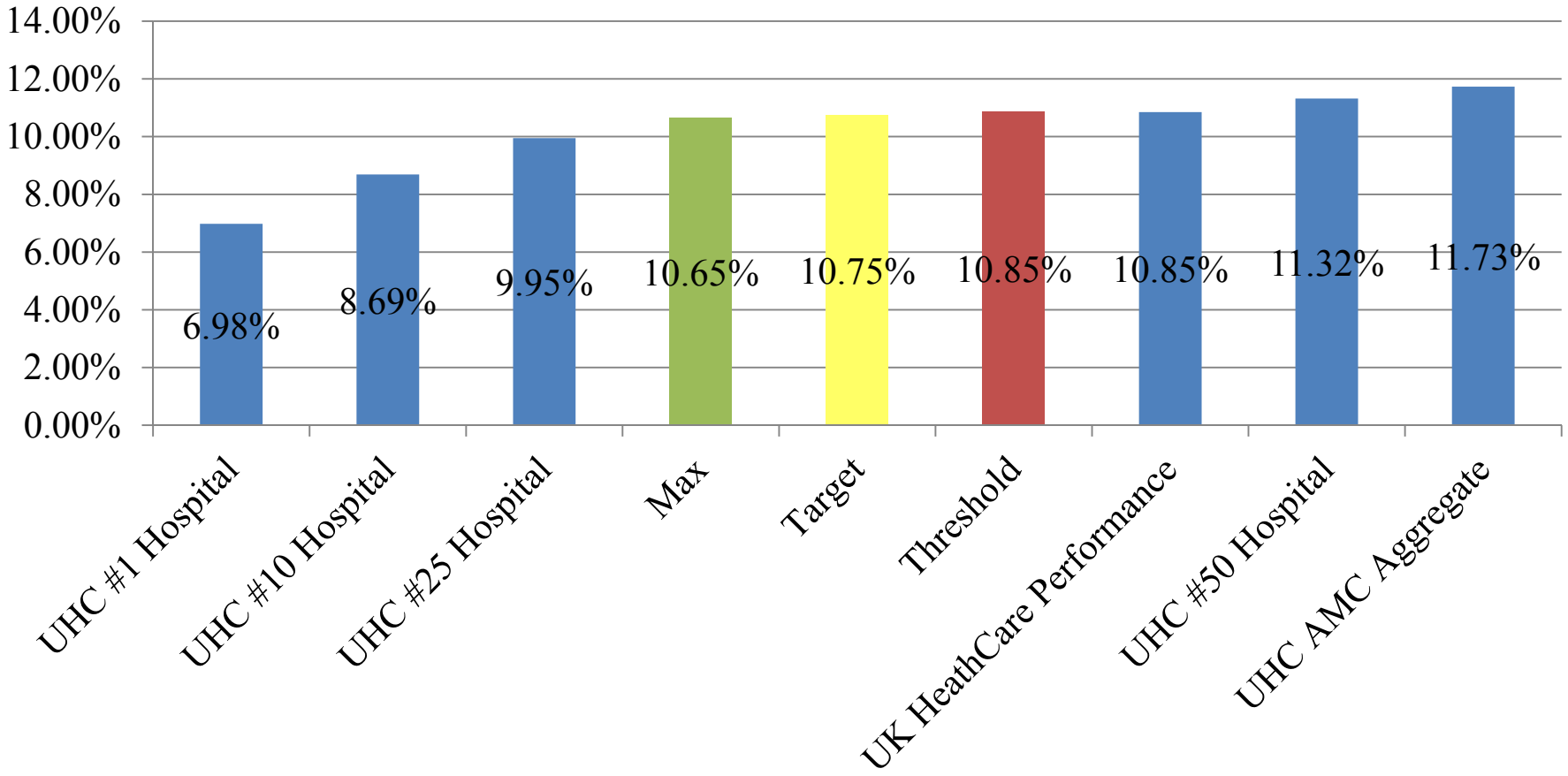
5/11

Peds/Adult	(All)
Enc - Discharge Status_Desc	(All)

Enc - UK Admit Service_Desc	Encounters	Actual Patient Days	UHC Expected LOS	Index	Opp Days	ADC Opportunity	Bed Capacity Created	ALOS	Exp ALOS
TRAUMA SURGERY (BLUE)	2,059	18,027	15,389	1.17	2,638	10.9		8.76	7.47
MEDICINE TEAM 3	1,837	12,158	9,710	1.25	2,448	10.1		6.62	5.29
INTERNAL MEDICINE 4	1,181	10,420	8,438	1.23	1,982	8.2		8.82	7.14
PED NEONATOLOGY	508	13,258	12,311	1.08	947	3.9		26.10	24.23
PUL ICU TEAM 1	252	3,343	2,441	1.37	902	3.7		13.27	9.68
OBSTETRICS	1,430	5,235	4,399	1.19	836	3.4		3.66	3.08
INTERNAL MEDICINE 3	283	2,647	1,863	1.42	784	3.2		9.35	6.58
TRANSPLANT CARDIAC	86	1,469	778	1.89	691	2.8		17.08	9.04
COMMUNITY/ INTERNAL MED	255	1,964	1,341	1.46	623	2.6		7.70	5.26
GI/ENDO SURGERY (GREEN)	515	3,760	3,138	1.20	622	2.6		7.30	6.09
HEMATOLOGY ONCOLOGY	341	4,631	4,025	1.15	606	2.5		13.58	11.80
PUL ICU TEAM 2	262	3,149	2,545	1.24	604	2.5		12.02	9.72
CARDIO-THORACIC SURGERY	712	6,322	5,788	1.09	534	2.2		8.88	8.13
CCU CARDIOLOGY	372	2,911	2,408	1.21	503	2.1		7.83	6.47
CARDIOLOGY	367	2,750	2,290	1.20	460	1.9		7.49	6.24
INTERNAL MEDICINE 1	323	2,660	2,266	1.17	394	1.6		8.24	7.02
PUL ICU TEAM 3	143	1,621	1,270	1.28	351	1.4		11.34	8.88
TRANSPLANT LIVER	161	1,497	1,179	1.27	318	1.3		9.30	7.33
PULMONARY	135	1,910	1,609	1.19	301	1.2		14.15	11.92
COMMUNITY INT MED TEAM 2	108	774	501	1.55	273	1.1		7.17	4.63
INTERNAL MEDICINE 2	319	2,541	2,297	1.11	244	1.0		7.97	7.20
SURGICAL SPEC	173	1,015	838	1.21	177	0.7		5.87	4.84
MEDICINE TEAM 1	146	947	788	1.20	159	0.7		6.49	5.40
TRANSPLANT RENAL	100	687	561	1.23	126	0.5		6.87	5.61
INTERNAL MEDICINE 5	201	1,364	1,243	1.10	121	0.5		6.79	6.18
UROLOGY	395	1,514	1,398	1.08	116	0.5		3.83	3.54
INTERNAL MEDICINE 7	247	1,850	1,736	1.07	114	0.5		7.49	7.03
ORTHO RECONSTRUCTION	732	2,800	2,687	1.04	113	0.5		3.83	3.67
VASCULAR SURGERY (RED)	355	2,606	2,506	1.04	100	0.4		7.34	7.06
Total	**25,557**	**168,198**	**153,308**	**1.10**	**14,890**	**61.3**		**6.58**	**6.00**

Target 1.08 Index	**25,557**	**165,573**	**153,308**	**1.080**	**12,265**	**50.5**	**10.8**	**6.48**	**6.00**
Target 1.07 Index	**25,557**	**163,917**	**153,308**	**1.069**	**10,609**	**43.7**	**17.6**	**6.41**	**6.00**
Target 1.06 Index	**25,557**	**162,506**	**153,308**	**1.060**	**9,198**	**37.9**	**23.4**	**6.36**	**6.00**
Target 1.05 Index	**25,557**	**160,973**	**153,308**	**1.050**	**7,665**	**31.5**	**29.7**	**6.30**	**6.00**
Budget Target	**25,557**	**160,813**	**153,308**	**1.049**	**7,505**	**30.9**	**30.4**	**6.29**	**6.00**
Target 1.04 Index	**25,557**	**159,440**	**153,308**	**1.040**	**6,132**	**25.2**	**36.0**	**6.24**	**6.00**
Target 1.03 Index	**25,557**	**157,846**	**153,308**	**1.030**	**4,538**	**18.7**	**42.6**	**6.18**	**6.00**
Target 1.02 Index	**25,557**	**156,374**	**153,308**	**1.020**	**3,066**	**12.6**	**48.7**	**6.12**	**6.00**
Target 1.01 Index	**25,557**	**154,841**	**153,308**	**1.010**	**1,533**	**6.3**	**55.0**	**6.06**	**6.00**
Target 1.00 Index	**25,557**	**153,308**	**153,308**	**1.000**	-	-	**61.3**	**6.00**	**6.00**

Same Hospital Readmissions
CY2014 Performance



Threshold – 10.85% Target – 10.75% Max – 10.65%

PATIENT EXPERIENCE

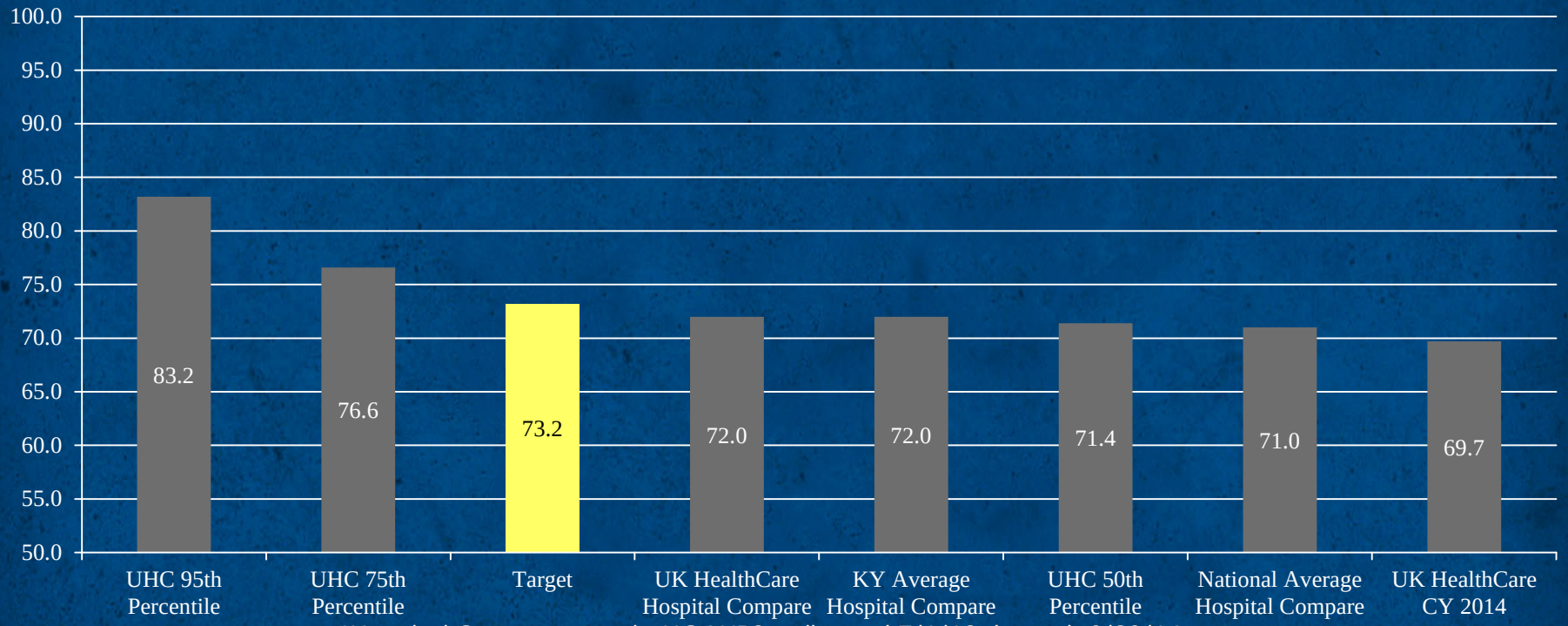
HCAHPS Current Performance
CY 2014

Domain	Current Performance	Target – Based on 60th Percentile
Rate 9/10	69.7	73.2
Communication with Nurses	80.8	79.9
Responsiveness	68.8	64.9
Communication with Doctors	80.9	81.5
Hospital Environment	65.9	65.4
Pain	72.6	71.6
Communication with Meds	67.0	64.2
Discharge	88.5	87.7
Care Transitions	56.7	55.5

Threshold – 6 out of 9 Target – 7 out of 9 Max – 8 out of 9

Rate the Hospital (Responses Answering 9-10) CY 2014

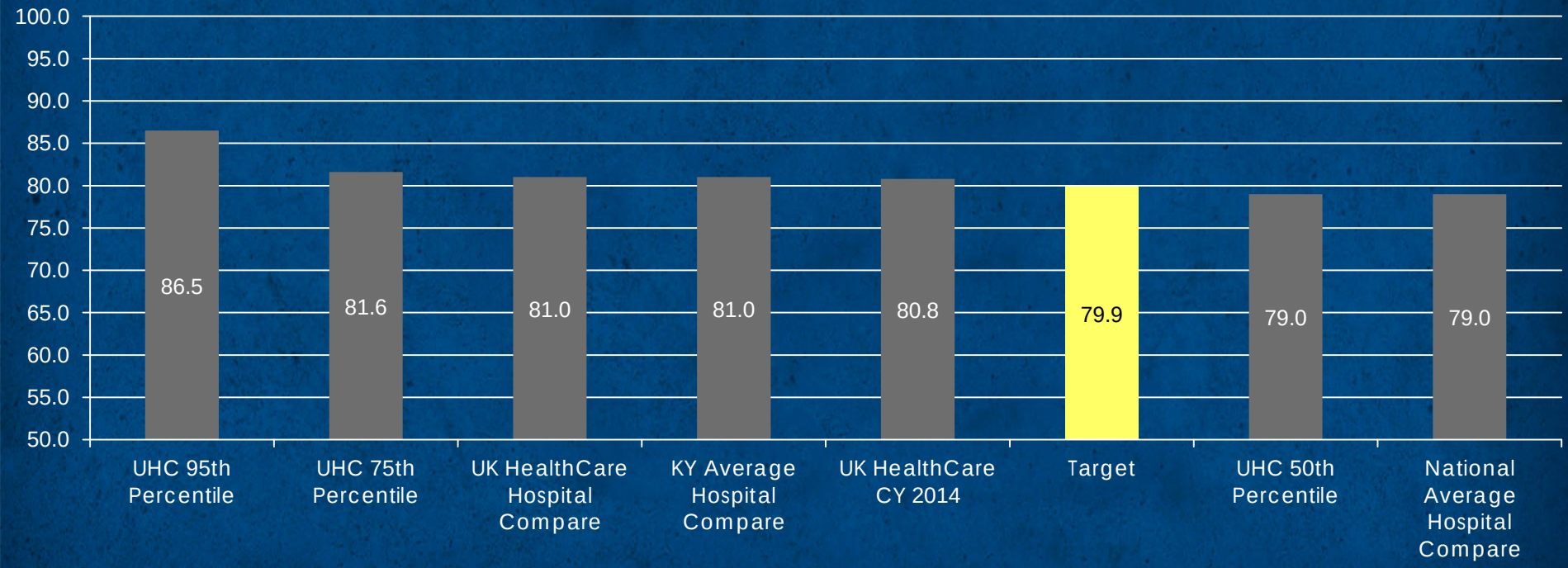
Using any number from 0 to 10, where 0 is the worst hospital possible and 10 is the best hospital possible, what number would you use to rate this hospital during your stay?



*Hospital Compare results HCAHPS collected 7/1/13 through 6/30/14

Communication with Nurses (Responses Answering Always) CY 2014

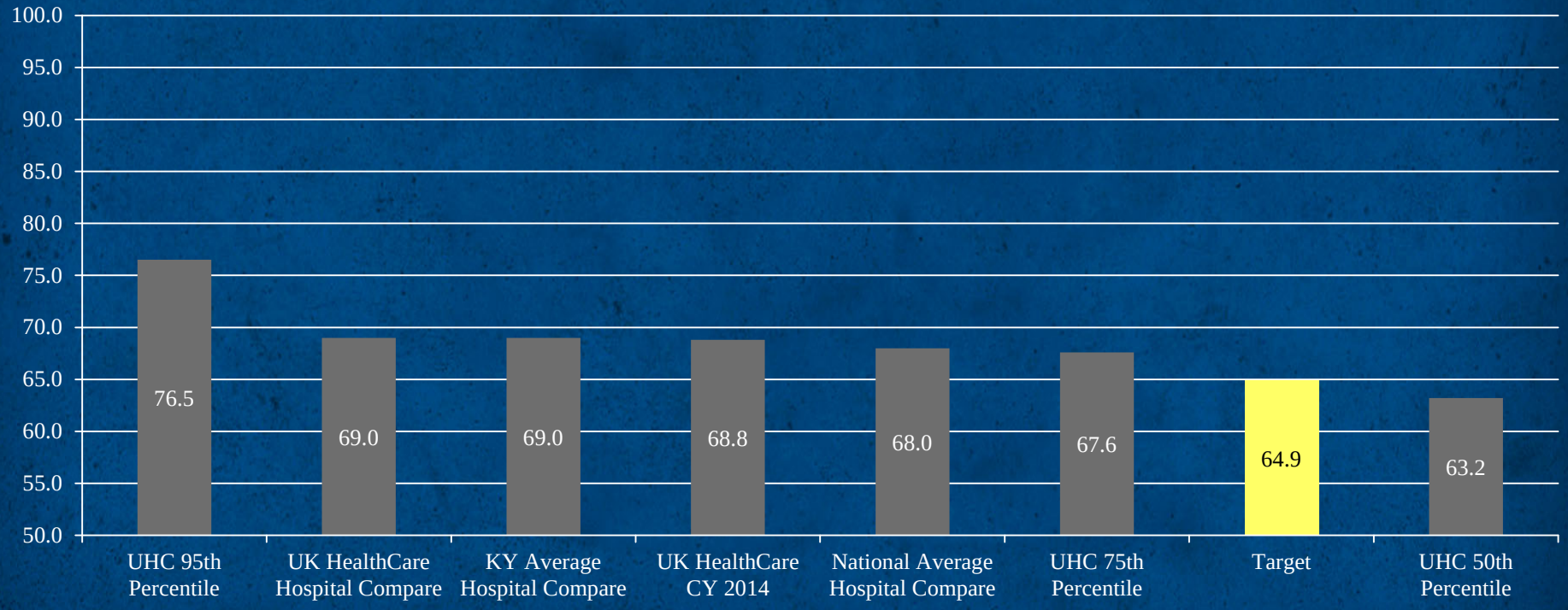
During this hospital stay, how often did nurses treat you with courtesy and respect?
During this hospital stay, how often did nurses listen carefully to you?
During this hospital stay, how often did nurses explain things in a way you could understand?



*Hospital Compare results HCAHPS collected 7/1/13 through 6/30/14

Responsiveness (Reponses Answering Always) CY 2014

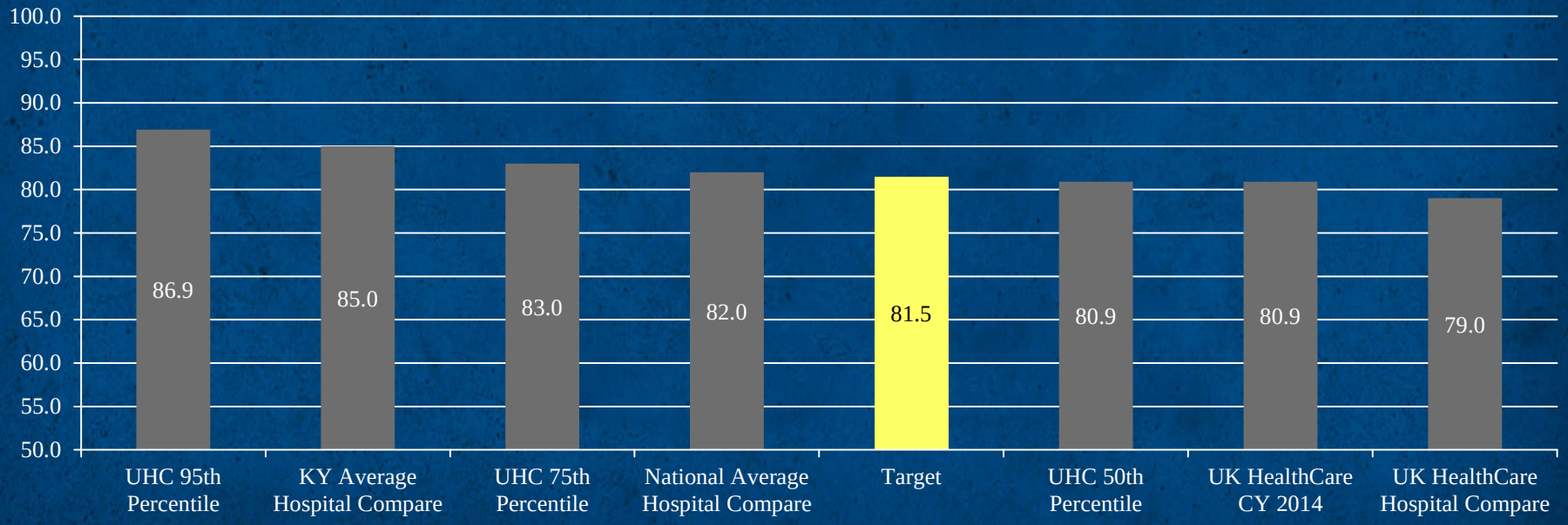
During this hospital stay, after you pressed the call button, how often did you get help as soon as you wanted it?
How often did you get help in getting to the bathroom or in using a bedpan as soon as you wanted it?



*Hospital Compare results HCAHPS collected 7/1/13 through 6/30/14

Communication with Doctors (Responses Answering Always) CY 2014

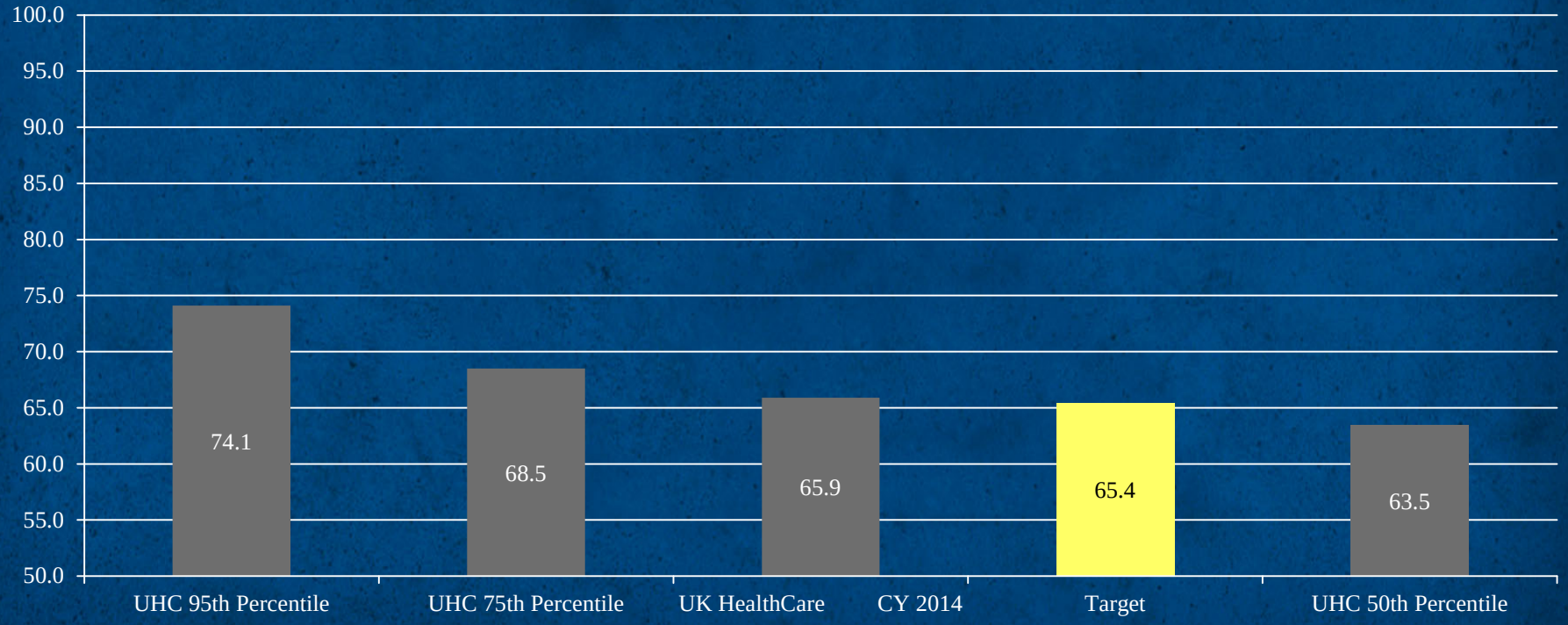
During this hospital stay, how often did doctors treat you with courtesy and respect?
During this hospital stay, how often did doctors listen carefully to you?
During this hospital stay, how often did doctors explain things in a way you could understand?



*Hospital Compare results HCAHPS collected 7/1/13 through 6/30/14

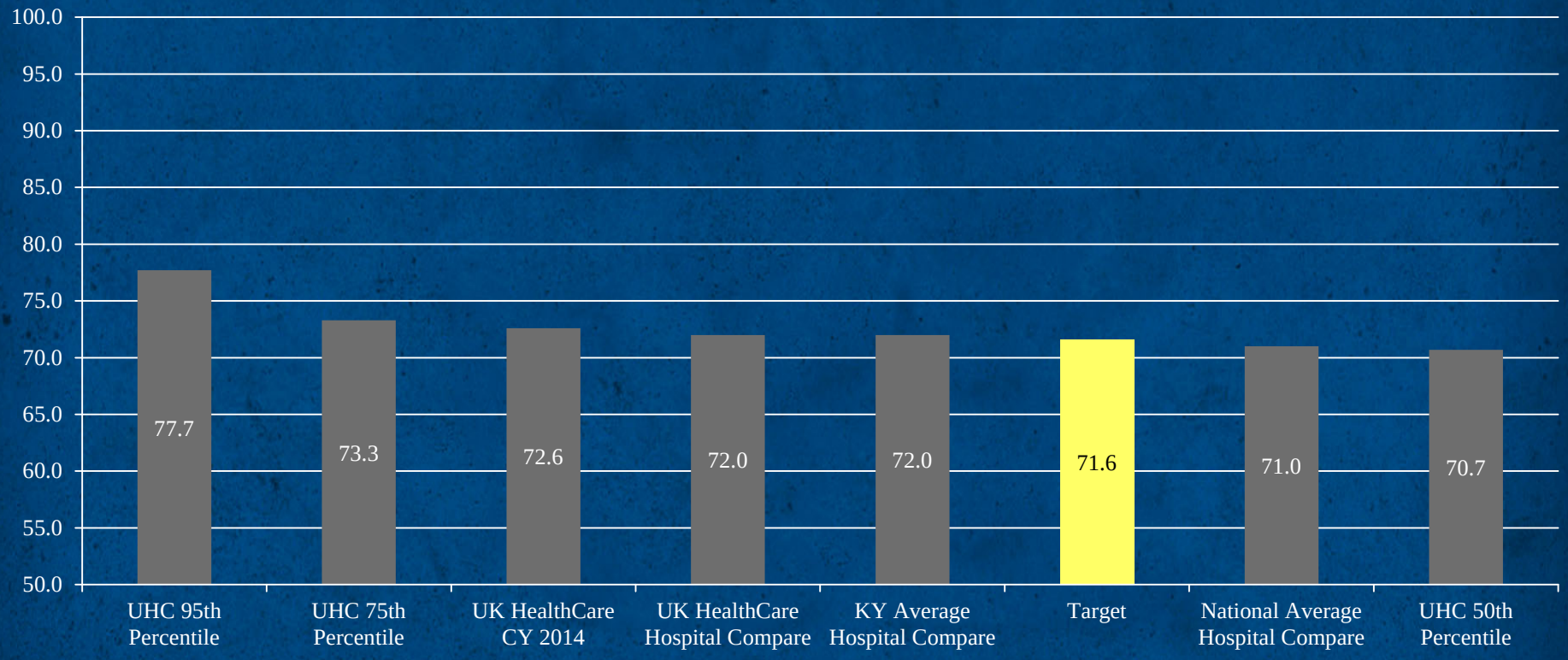
Hospital Environment (Responses Answering Always)
CY 2014

During this hospital stay, how often were your room and bathroom kept clean?
During this hospital stay, how often was the area around your room quiet at night?



Pain (Responses Answering Always) CY 2014

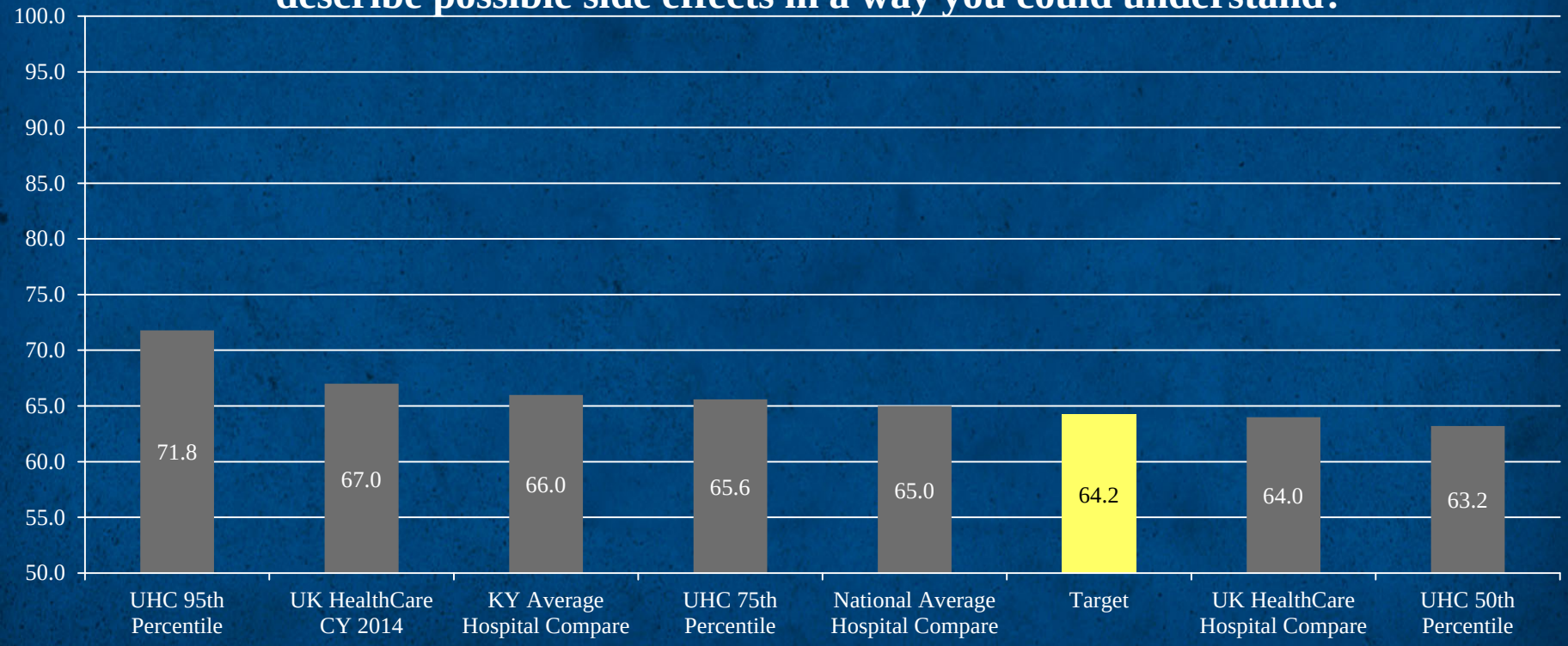
During this hospital stay, how often was your pain well controlled? During this hospital stay, how often did staff do everything they could to help you with your pain?



*Hospital Compare results HCAHPS collected 7/1/13 through 6/30/14

Communication with Meds (Responses Answering Always) CY 2014

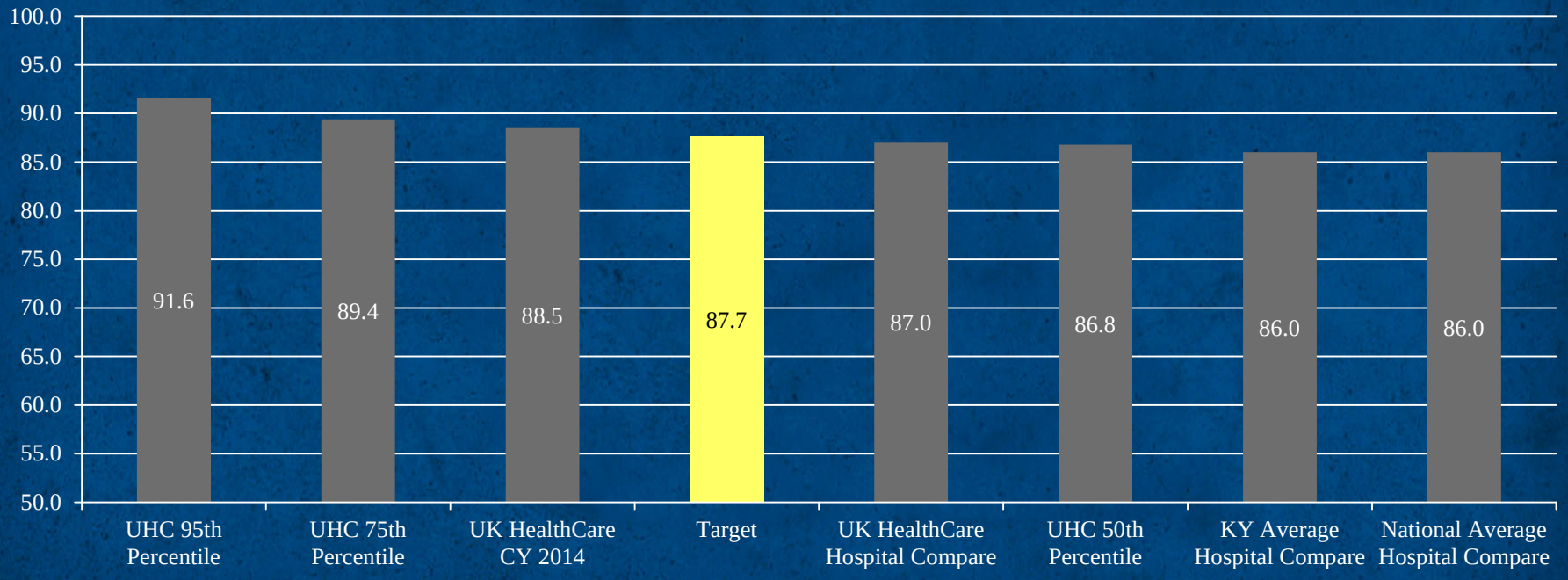
Before giving you any new medicine, how often did hospital staff tell you what the medicine was for?
Before giving you any new medicine, how often did hospital staff describe possible side effects in a way you could understand?



*Hospital Compare results HCAHPS collected 7/1/13 through 6/30/14

Discharge (Responses Answering Always) CY 2014

During this hospital stay, did doctors, nurses or other hospital staff talk with you about whether you would have the help you needed when you left the hospital?
During this hospital stay, did you get information in writing about what symptoms or health pr

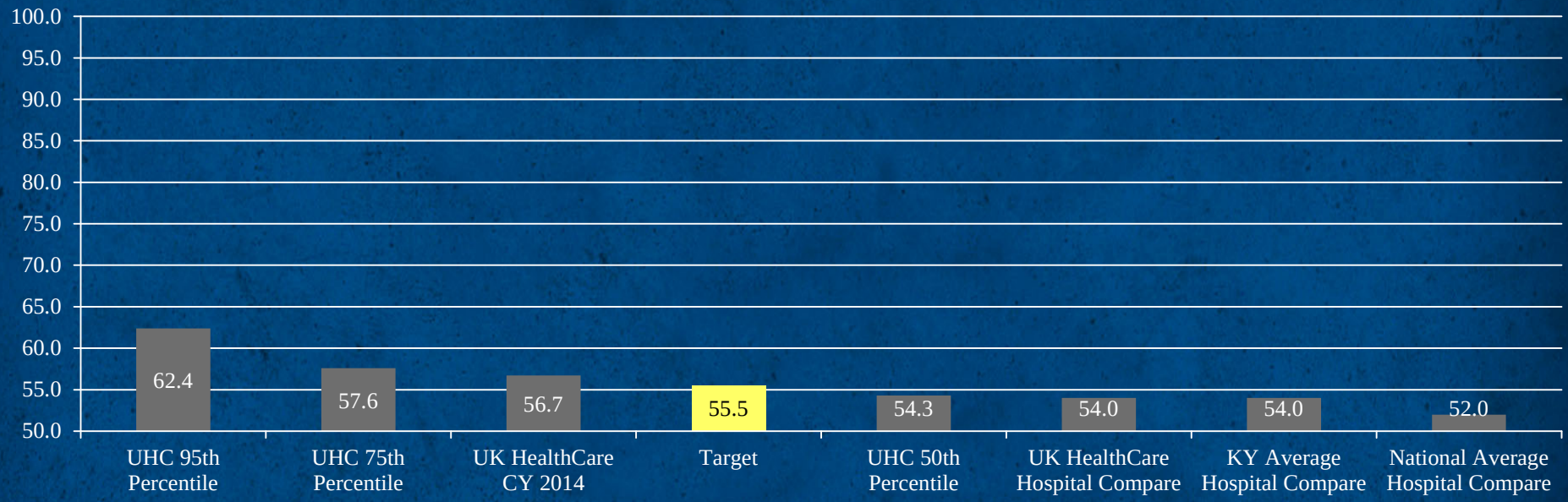


*Hospital Compare results HCAHPS collected 7/1/13 through 6/30/14

Care Transitions (Responses Answering Always) CY 2014

During this hospital stay, staff took my preferences and those of my family or caregiver into account in deciding what my health care needs would be when I left.

When I left the hospital, I had a good understanding of the things I was responsible for in ma



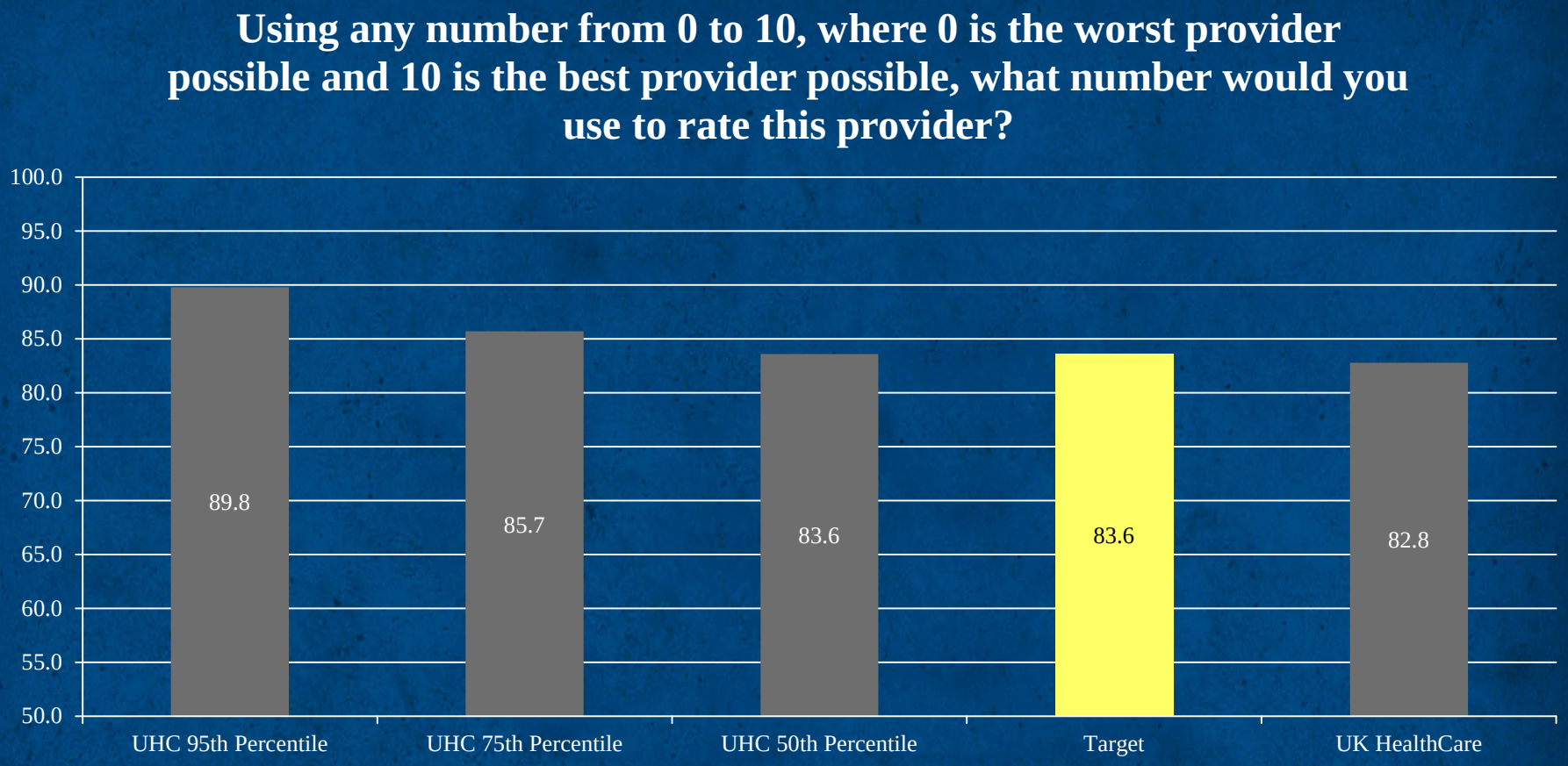
*Hospital Compare results HCAHPS collected 7/1/13 through 6/30/14

CG-CAHPS Current Performance CY 2014

Domain	Current Performance	Target – Based on 50th Percentile
Rate the Provider	82.8	83.6
Access to Care	59.1	56.2
Test Results	75.4	74.5
Physician Communication	90.4	91.2
Office Staff Quality	91.0	91.0
Willingness to Recommend	89.2	90.3

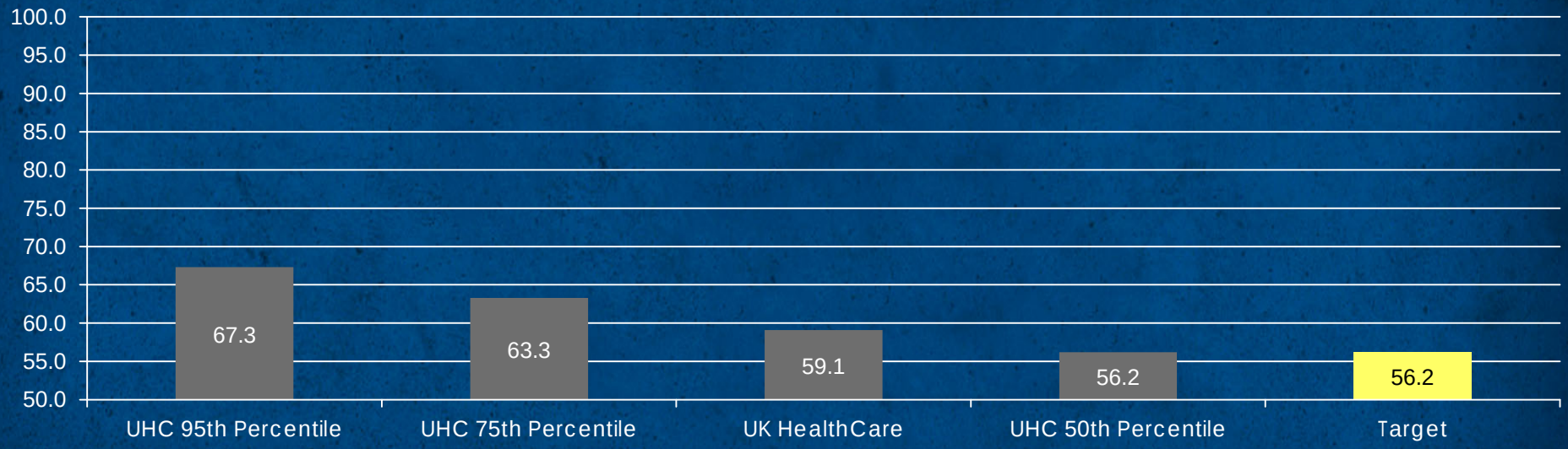
Threshold – 3 out of 6 Target – 4 out of 6 Max – 5 out of 6

Rate the Provider (Responses Answering 9-10) CY 2014



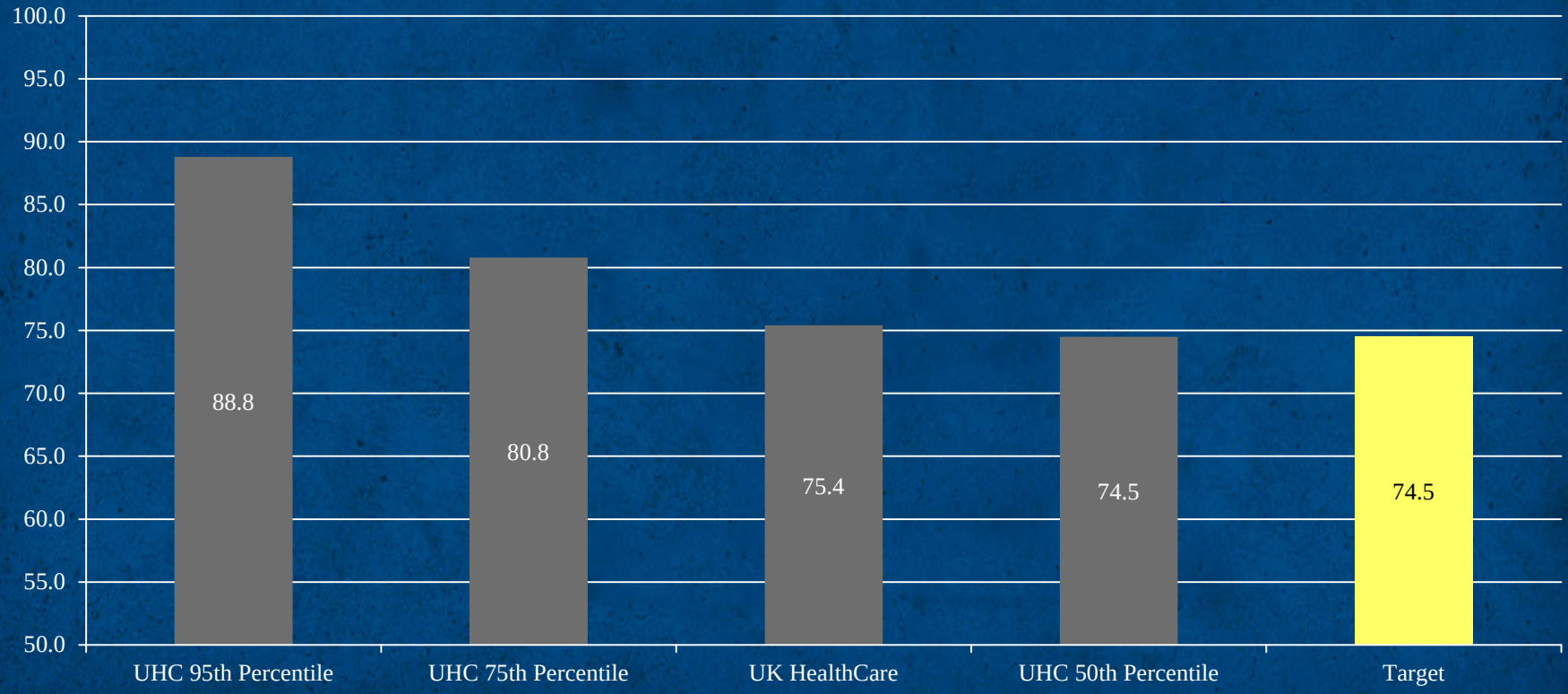
Access to Care (Responses Answering Always) CY 2014

In the last 12 months, when you phoned this provider's office to gen at appointment for care you needed right away, how often did you get an appointment as soon as you needed?
In the last 12 months, when you made an appointment for a check-up or routine ca



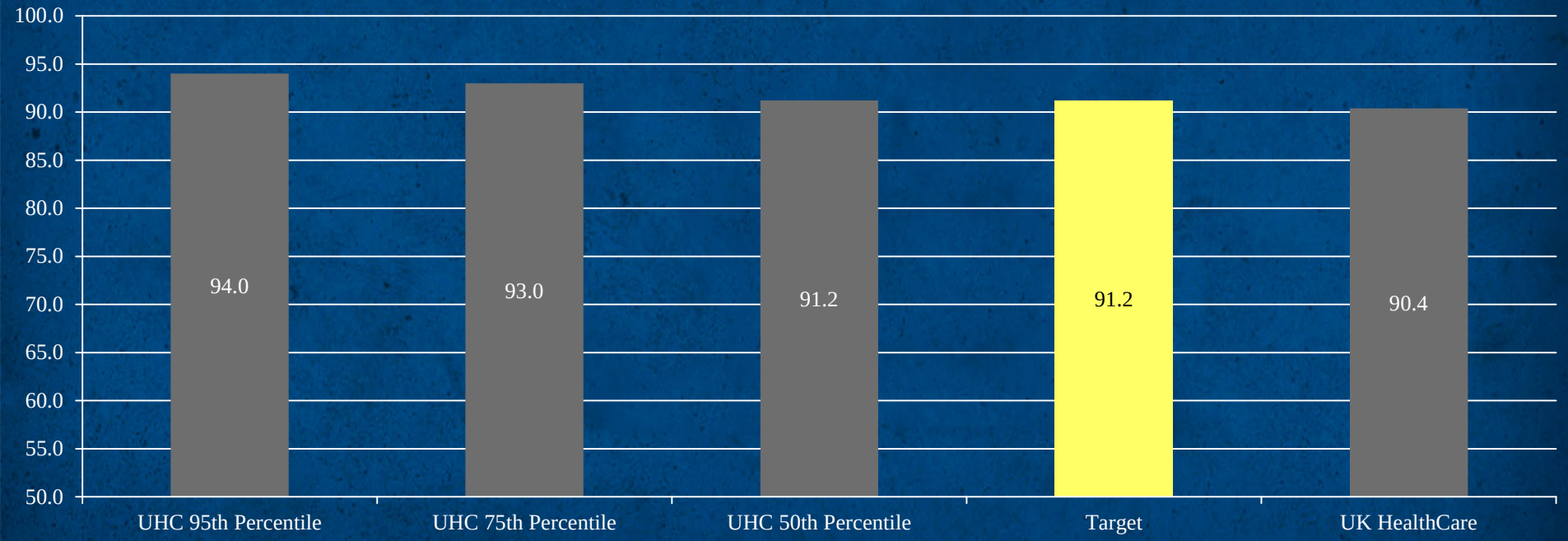
Test Results (Responses Answering Yes) CY 2014

Did someone from this provider's office follow up to give you those results (blood test, x-ray, or other test)?



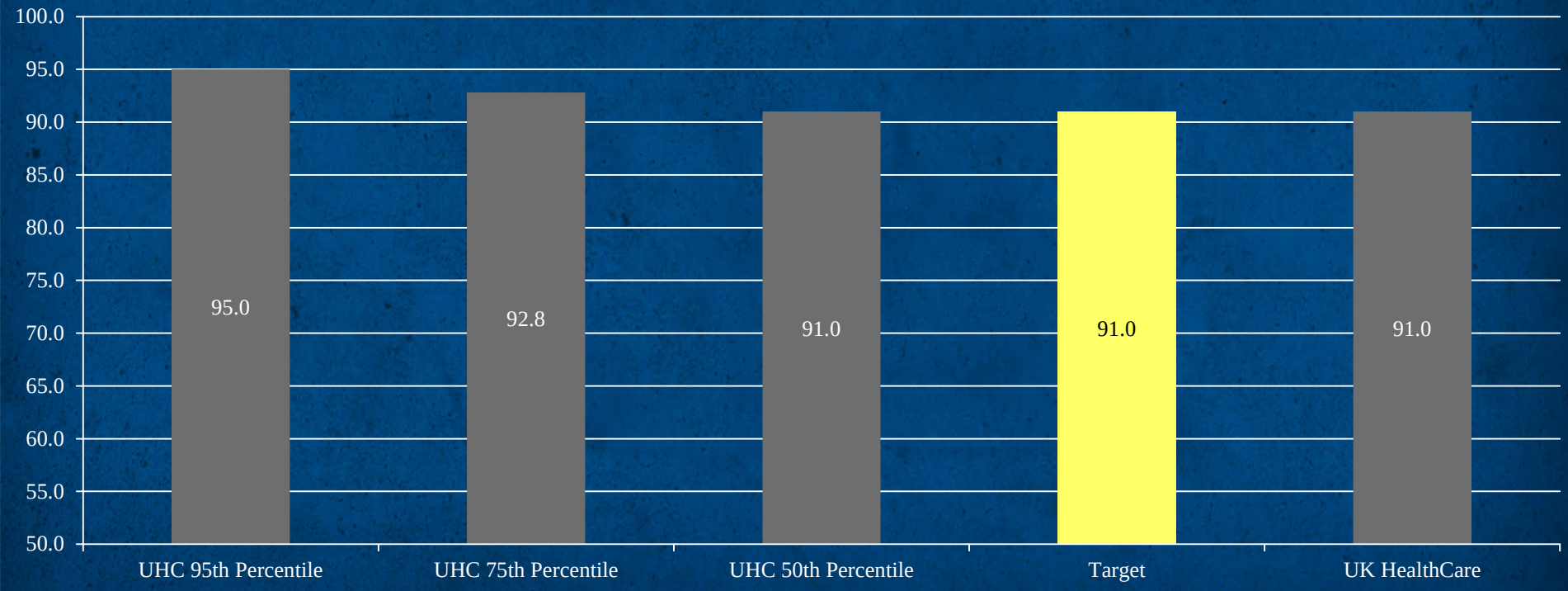
Physician Communication (Responses Answering Definitely)
CY 2014

During your most recent visit, did this provider explain things in a way that was easy to understand?
During your most recent visit, did this provider listen carefully to you?
During your most recent visit, did this provider give you easy to understand info

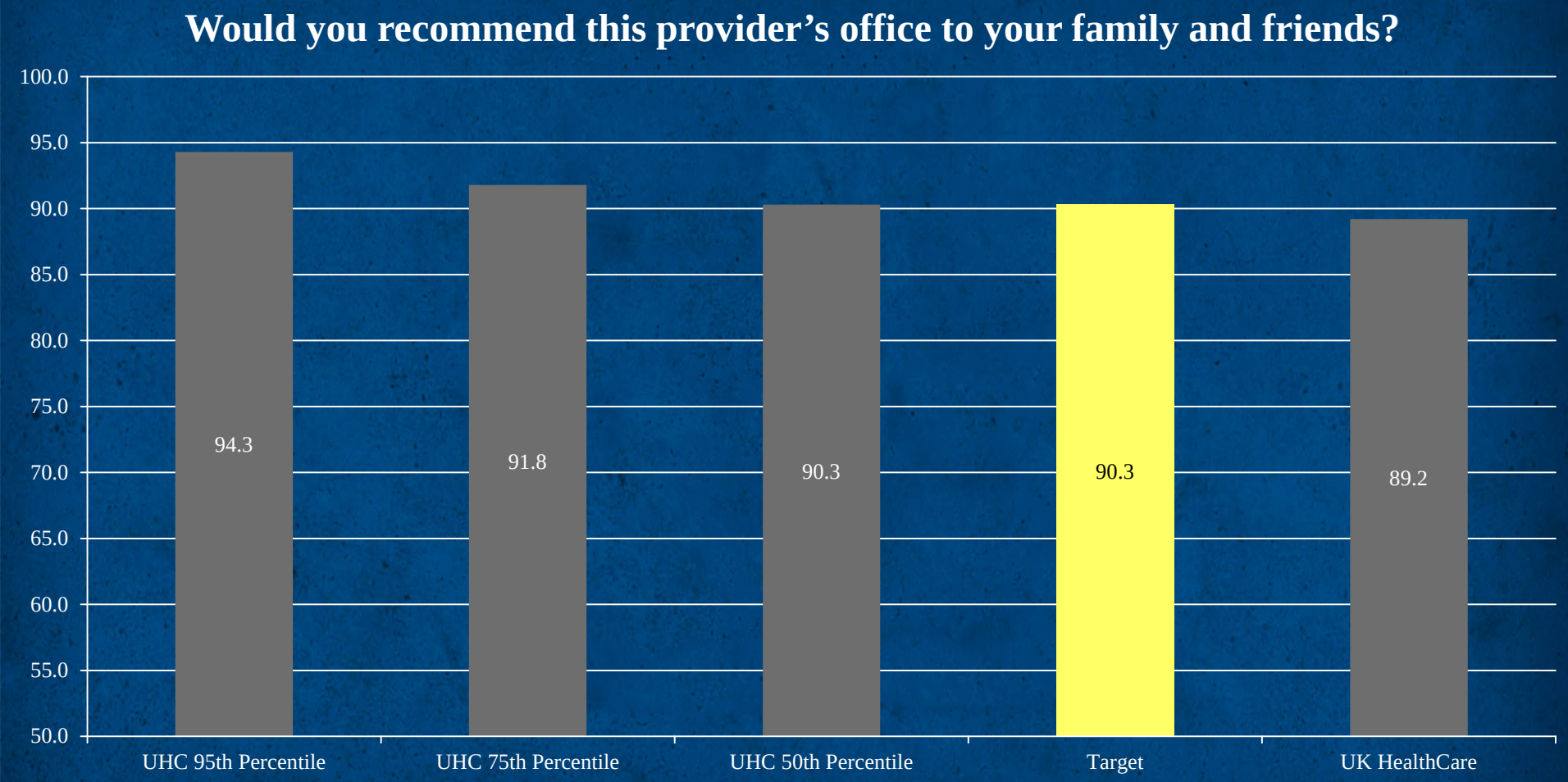


Office Staff Quality (Responses Answering Definitely)
CY 2014

During your most recent visit, were clerks and receptionists at this provider's office as helpful as you thought they should be?
During your most recent visit, did clerks and receptionists at this provider's office treat you with courtesy and respect?



Willingness to Recommend (Responses Answering Definitely) CY 2014



ENGAGEMENT

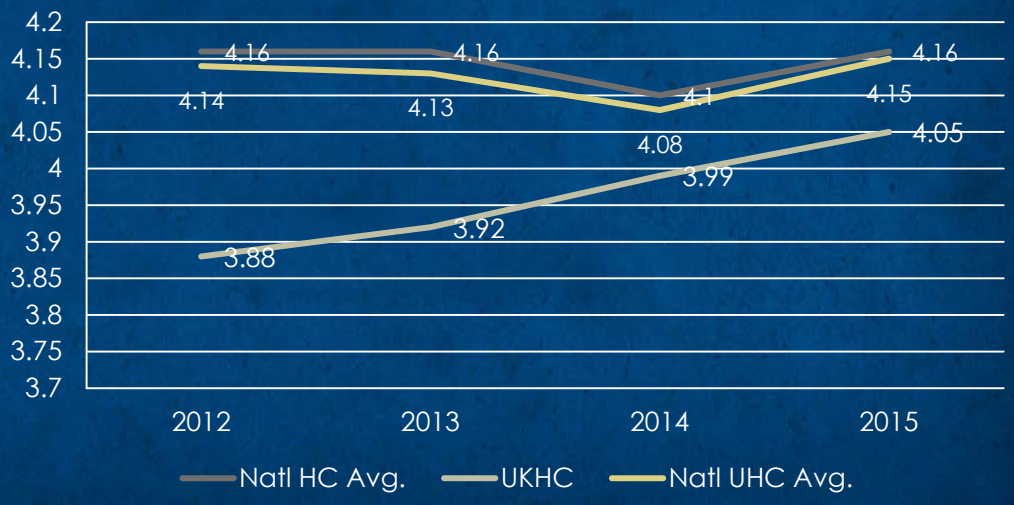
Employee Engagement 2015 Performance

- Based upon results of survey conducted in March 2015
- Employees surveyed include
  - Corporate
  - Chandler Hospital
  - Ambulatory
  - College of Medicine
  - Kentucky Children's Hospital
  - Central Kentucky Management Services
  - Good Samaritan Hospital

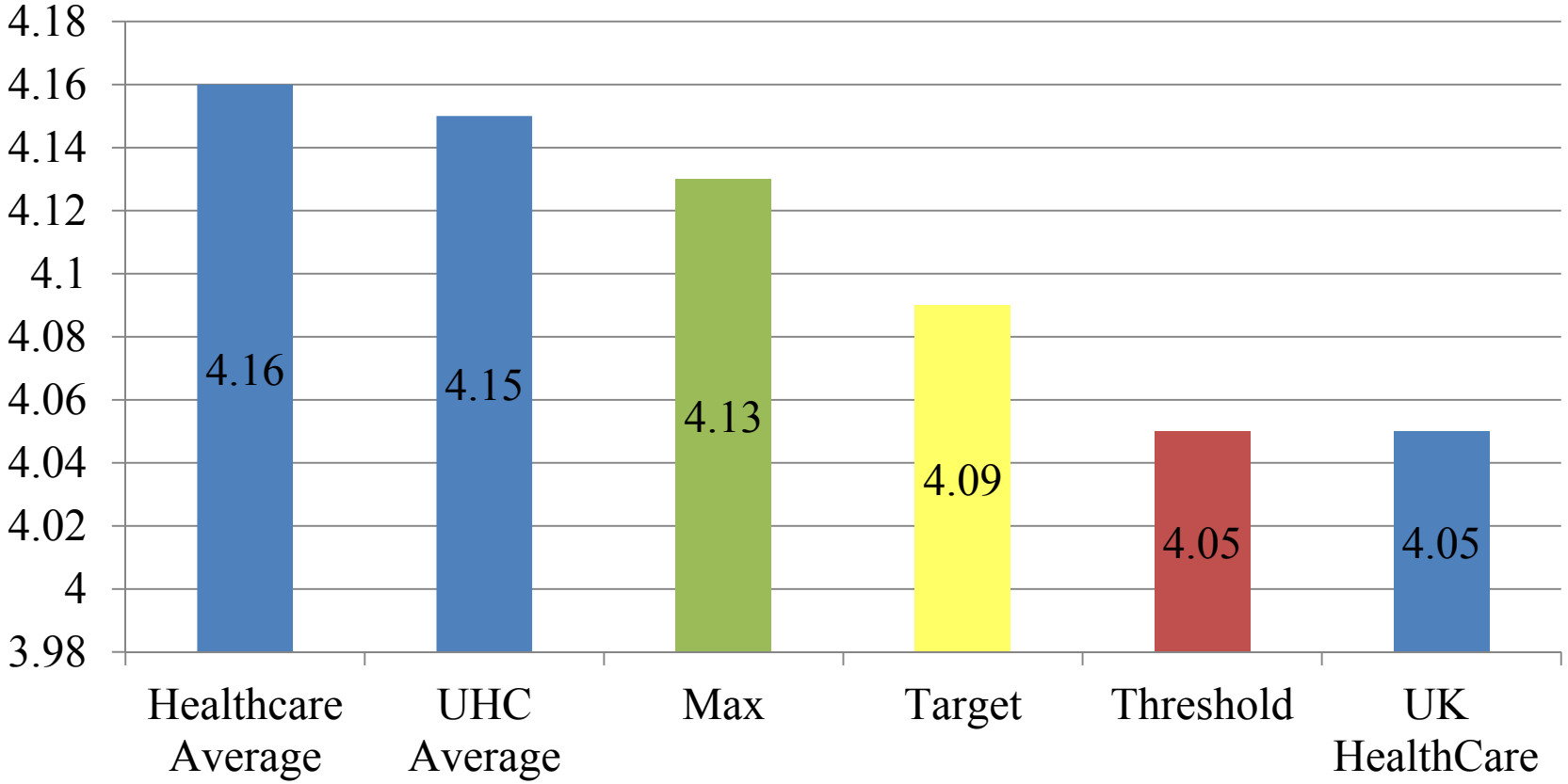
Engagement Items

1. I am proud to tell people I work for this organization.
2. I would recommend this organization to family and friends who need care.
3. I would like to be working at this organization three years from now.
4. I would stay with this organization if offered a similar job elsewhere.
5. I would recommend this organization as a good place to work.
6. Overall, I am a satisfied employee.

Employee Engagement Indicator



Employee Engagement
2015 Performance

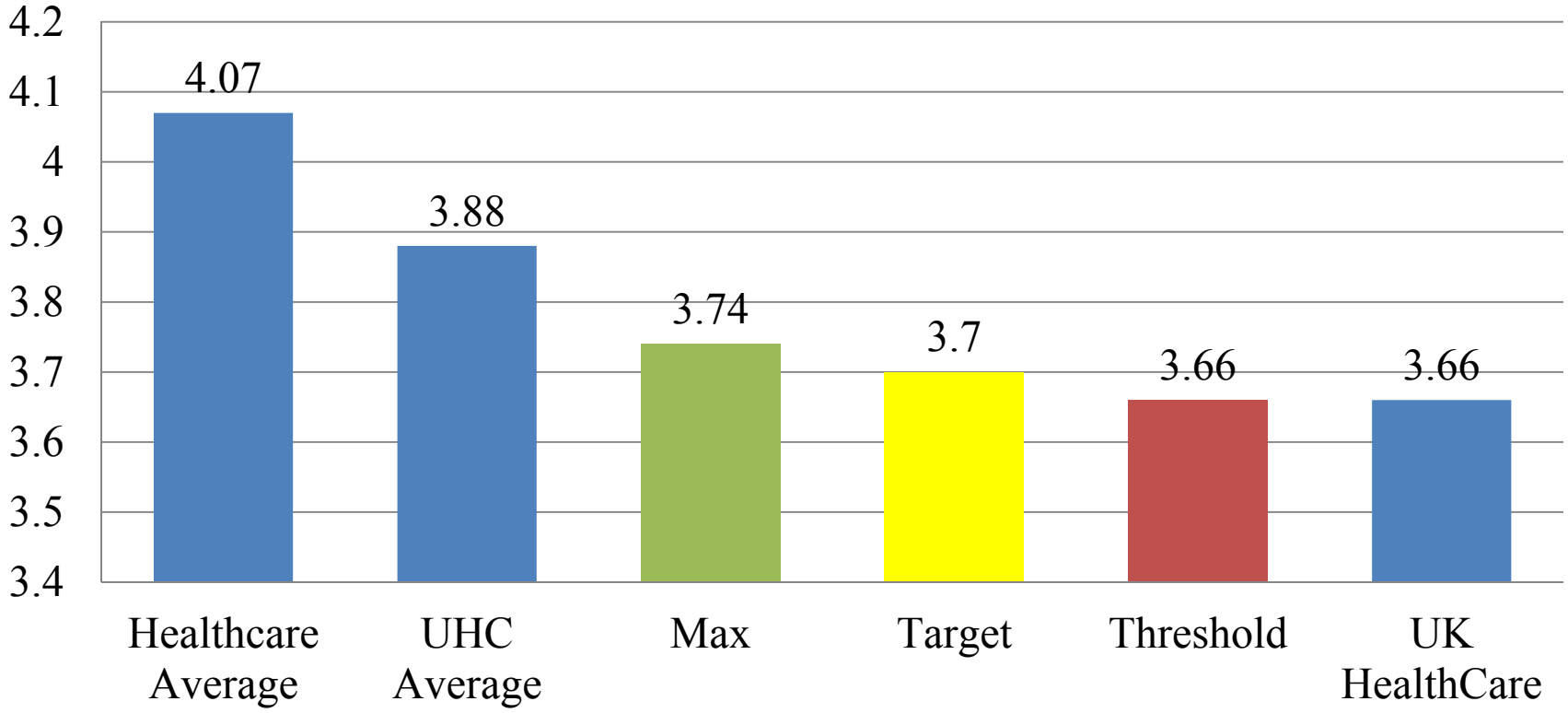


Threshold – 4.05 Target – 4.09 Max – 4.13

Physician Engagement
2015 Performance

- Based upon results of survey conducted March 2015
- Physicians surveyed include faculty clinical physicians only
- Engagement Items
  1. I would recommend this hospital to family and friends who need care.
  2. I would stay with this hospital if offered a similar position elsewhere.
  3. I am proud to tell people I am affiliated with this hospital.
  4. I would recommend this hospital to other physicians and medical staff as a good place to practice medicine.
  5. If I am practicing medicine three years from now, I am confident that I will be working with this hospital.
  6. Overall, I am satisfied working with this hospital.

Physician Engagement
2015 Performance



Threshold – 3.66 Target – 3.7 Max – 3.74

POTENTIAL METRICS FOR INCLUSION

Mortality

Metric	Where Is This Included?	Penalty for Low Performance?
Mortality	VBP, UHC Q&A Study, Hospital Compare	Yes

Patient Experience

Metric	Where Is It Included?	Penalty for Low Performance?
HCAHPS - Communication with Nurses	VBP, UHC Q&A Study, Hospital Compare	Yes
HCAHPS - Communication with Doctors	VBP, UHC Q&A Study, Hospital Compare	Yes
HCAHPS - Responsiveness of Staff	VBP, UHC Q&A Study, Hospital Compare	Yes
HCAHPS - Pain Management	VBP, UHC Q&A Study, Hospital Compare	Yes
HCAHPS - Communication About Medications	VBP, UHC Q&A Study, Hospital Compare	Yes
HCAHPS - Cleanliness and Quietness	VBP, UHC Q&A Study, Hospital Compare	Yes
HCAHPS - Discharge Information	VBP, UHC Q&A Study, Hospital Compare	Yes
HCAHPS - Overall Rating of Hospital	VBP, UHC Q&A Study, Hospital Compare	Yes
HCAHPS - Care Transitions	UHC Q&A Study, Hospital Compare	No
CG-CAHPS - Rate the Provider	UHC Q&A Study	No
CG-CAHPS - Access to Care	UHC Q&A Study	No
CG-CAHPS - Test Results	UHC Q&A Study	No
CG-CAHPS - Physician Communication	UHC Q&A Study	No
CG-CAHPS - Office Staff Quality	UHC Q&A Study	No
CG-CAHPS - Willingness to Recommend	UHC Q&A Study	No

Best Practices

Metric	Where Is It Included?	Penalty for Low Performance?
Influenza Immunization	VBP, CMS, TJC, Hospital Compare	Yes
VTE Core Measures	UHC Q&A Study, ,CMS, TJC, Hospital Compare	No
Stroke Core Measures	UHC Q&A Study, CMS, TJC, Hospital Compare	No
Children's Asthma	TJC, CMS, Hospital Compare	No
Perinatal Care Core Measures	TJC, CMS, Hospital Compare	No
Tobacco Use Core Measures	TJC	No
Healthcare Personnel Influenza Immunization	Hospital Compare	No
PQRS Measures	Hospital Compare, CMS	Yes

Care Continuum

Metric	Where Is It Included?	Penalty for Low Performance?
Percent of New Patient Visits (Ambulatory)	UHC Q&A Study	No
New Patient Visit Schedule Lag (Ambulatory)	UHC Q&A Study	No
Encounters Per Physician Per Session	UHC Q&A Study	No
Percent of ED Patients That Have 4+ ED Visits in Last 12 Months	UHC Q&A Study	No
Encounters Per Room Per Day	UHC Q&A Study	No
ED Length of Stay – Treat & Release	UHC Q&A Study, CMS, Hospital Compare	No
ED Length of Stay – Admitted Patients	UHC Q&A Study, CMS, Hospital Compare	No
Readmissions	Readmissions Reduction Program, UHC Q&A Study, Hospital Compare	Yes
ED Admit Time to Departure	UHC Q&A Study, CMS, Hospital Compare	No
LOS	UHC Q&A Study	No

Patient Safety

Metric	Where Is This Included?	Penalty for Low Performance?
PSI 90 Composite Measure	HAC Program, VBP, Hospital Compare	Yes
CLABSI	HAC Program, VBP, UHC Q&A Study, Hospital Compare	Yes
CAUTI	HAC Program, VBP, UHC Q&A Study, Hospital Compare	Yes
SSI – Colon Surgeries	HAC Program, VBP, UHC Q&A Study, Hospital Compare	Yes
SSI – Abdominal Hysterectomies	HAC Program, VBP, UHC Q&A Study, Hospital Compare	Yes
MRSA	HAC Program (coming in FY17), Hospital Compare	Yes
CDI	HAC Program (coming in FY17), UHC Q&A Study, Hospital Compare	Yes
PSI – 03 Pressure Ulcer	UHC Q&A Study	No
PSI – 06 Iatrogenic Pneumothorax	UHC Q&A Study, Hospital Compare	No
PSI – 09 Hemorrhage & Hematoma	UHC Q&A Study	No
PSI – 11 Post-Op Respiratory Failure	UHC Q&A Study	No
PSI – 13 Post-Op Sepsis	UHC Q&A Study	No
PSI – 12 Post-Op DVT/PE	Hospital Compare	No
PSI – 14 Post-Op Wound Dehiscence	Hospital Compare	No
PSI – 15 Accidental Puncture & Laceration	Hospital Compare	No

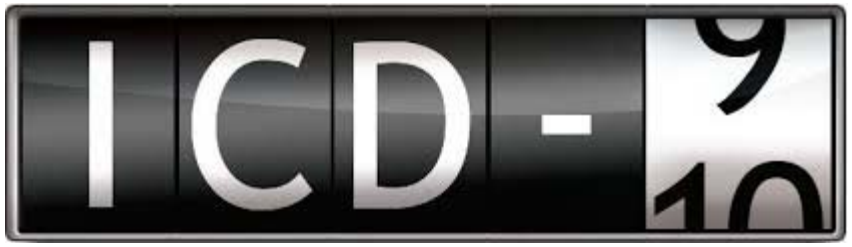
Engagement

Metric	Where Is This Included?	Penalty for Low Performance?
Employee Engagement		No
Physician Engagement		No

SUPPLEMENTAL
DATA USED IN GOAL SETTING

ICD-10

- ICD-10 is scheduled to start in October 2015
- This will be taken into consideration with goal setting



Mortality Benchmarking

UHC Clinical Outcomes Report (Risk-Adjusted Mortality)

Print Date: Wednesday, April 15, 2015
Data Extract Date: Thursday, March 12, 2015

University of Kentucky Hospital/University of KY - Good Samaritan Hospital Roll Up

Oct - Dec 2014 (Q4)

Total Inpatient

Definition - Total Inpatient
The mortality O/E ratio for all inpatients excluding bad data, nonviable neonates, and records with a null expected mortality. This includes cases in the service lines not displayed individually on the report. The target is the UHC 25th percentile.

	Relative Performance	Denom (Cases)	Obs/Exp Ratio	UHC Median	Rank
Current Quarter		9,539	0.79	0.89	30/122
Recent Year		37,666	0.83	0.91	34/124

	Current Quarter	Last Quarter	Recent Year
Cases (denom.)	9,539	9,851	37,666
Observed Deaths	257	287	1,080
Expected Deaths	323.07	325.99	1,285.77
Observed Mortality (%)	2.69	2.91	2.87
Expected Mortality (%)	3.39	3.31	3.41
Observed/Expected Ratio	0.79	0.88	0.83

Data Source: UHC CDB
Related Report: VIP

Benchmarks:			Percentiles:				
	Compare Group (n)	Percentile	10th	25th	50th	75th	90th
Current Quarter	UHC Primary Population (119)	24	0.68	0.80	0.89	1.00	1.15
Recent Yr	UHC Primary Population (121)	27	0.71	0.83	0.91	1.01	1.12

Recent Year Five Base MS-DRGs with Highest Excess Deaths (>=25 cases):		Cases	O/E Ratio	Excess Deaths
Base MS-DRG 294	SEPTICEMIA W/O MV 96+ HRS	1,111	1.05	7.19
Base MS-DRG 288	POSTOP/POST TRAUMAT INFEC W/ OR PROC	103	4.18	3.80
Base MS-DRG 73	RESP SYS DX W/ VENT < 96 HRS	198	1.09	3.57
Base MS-DRG 275	COAGUL DIS	67	3.19	3.44
Base MS-DRG 208	ENDOC DIS	54	3.60	2.89

Recent Year UHC Top-10 Mortality O/E in Total Inpatient	Mort O/E	Cases	LOS O/E	Readmit Rate
MAYOCLINIC_AZ	0.35	13,039	0.77	14.09
NYU	0.53	38,361	0.96	7.03
MAYOCLINIC_FL	0.58	12,302	0.81	13.48
EMORY	0.59	24,523	1.04	12.67
DENHEALTH	0.61	23,672	1.03	8.47
BEAUMONT-ROYALOAK	0.62	61,936	0.99	11.79
OHIOSTATE	0.64	49,367	0.97	10.88
CHRISTIANACARE	0.65	58,208	1.01	10.29
LIFESPAN_MIRIAM	0.65	16,419	0.86	12.65
EMORY_MIDTOWN	0.67	24,670	1.11	8.48

UHC Comparison Data

UK HealthCare Enterprise						
	CY 2014		FY 2015 (July-Feb)			
	2013 Risk Model	2014 Risk Model	2013 Risk Model	2014 Risk Model	Top Performers CY 2014, 2013 RM	Top Performers CY 2014, 2014 RM
LOS	1.09	1.10	1.09	1.10	#1: Mayo Clinic Arizona (0.77)	#1: Mayo Clinic Arizona (0.77)
All AMCs (aggregate)	1.03	1.04	1.02	1.04	#10: IU Health (Ball Memorial) (0.92)	#10: #10: IU Health (Ball Memorial) (0.92)
Rankings	96/128*	96/128*	100/128*	100/128*	#25: Louisville (0.96)	#25: Louisville (0.97)
					#50: Georgia Regents (0.99)	#50: Georgia Regents (1.00)
Mortality	0.78	0.84	0.80	0.86	#1: Mayo Clinic Arizona (0.33)	#1: Mayo Clinic Arizona (0.36)
All AMCs (aggregate)	0.85	0.91	0.84	0.90	#10: Emory Midtown (0.63)	#10: Emory Midtown (0.67)
Rankings	36/128*	36/128*	51/128*	53/128*	#25: Wisconsin (0.74)	#25: Iowa (0.80)
					#50: John Hopkins Bayview (0.81)	#50: UH Case (0.88)
Readmissions	10.85%	10.85%	10.89%	10.89%	#1: Nevada (6.98%)	#1: Nevada (6.98%)
All AMCs (aggregate)	11.73%	11.73%	11.57%	11.57%	#10: AHS Overlook (8.69%)	#10: AHS Overlook (8.69%)
Rankings	42/128*	42/128*	44/128*	44/128*	#25: Saint Luke's KC (9.95%)	#25: Saint Luke's KC (9.95%)
					#50: Brigham (Partner's) (11.32%)	#50: Brigham (Partner's) (11.32%)
***Rankings are not official from UHC, only serving as close estimates**						

Patient Safety Indicator 90 Benchmarking

UHC Quality and Safety Management Report

Print Date: Tuesday, April 14, 2015

University of Kentucky Hospital/University of KY - Good Samaritan Hospital Roll Up

Oct - Dec 2014 (Q4)

AHRQ Patient Safety Composite Indicators - PSI90 AHRQ Patient Safety Quality Indicator Composite

Summary Definitions

AHRQ

Definition: This is a weighted average of reliability-adjusted ratios (RARs) for selected patient safety indicators, with each RAR weighted with NQF-selected weights. Composite = [indicator 1 RAR x weight] + [indicator 2 RAR x weight] +...+ [indicator N x weight]. The indicator RARs are a weighted average of the risk-adjusted ratios and the reference population ratios. The RAR weights are determined empirically by AHRQ. RAR = [riskadjusted ratio x weight] + [reference population ratio x (1-weight)]. Indicator RARs are computed for the following: PSI 3 Pressure Ulcer; PSI 6 Iatrogenic Pneumothorax; PSI 7 Central Venous Catheter-Related Bloodstream Infections; PSI 8 Postop Hip Fracture; PSI 12 Postop PE or DVT; PSI 13 Postop Sepsis; PSI 14 Postop Wound Dehiscence; PSI 15 Accidental Puncture or Laceration.

Numerator: Numerator.

Denominator: Denominator.

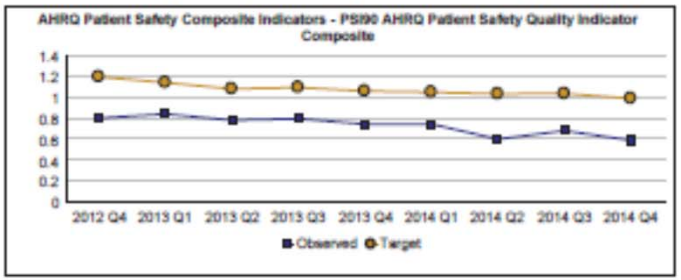
Target: UHC 75th percentile

See Also: http://www.qualityindicators.ahrq.gov

Oct - Dec 2014 (Q4)

	Relative Performance	Denom (n)	Observed	Target	Rank
Current Quarter	⊙		0.59	0.99	9/126

UHC Population	Value	10th	25th	50th	75th	90th	Mean
Observed	0.59	0.53	0.70	0.84	0.99	1.26	0.87



Jan 2014 - Dec 2014 (recent year)

	Relative Performance	Denom (n)	Observed	Target	Rank
Recent Year	⊙		0.60	1.03	16/128

UHC Population	Value	10th	25th	50th	75th	90th	Mean
Observed	0.60	0.59	0.68	0.82	1.03	1.31	0.89

Recent Year UHC Top 10 in This Metric	Cases	O/E	Observed
UPHS-PRESMEDCTR			0.40
MICHIGAN			0.46
IOWA			0.49
UTAH			0.49
RUSH			0.51
UCLA-RONALD_REAGAN			0.53
KANSAS			0.53
UPHS-HUP			0.57
IU_HEALTH-BALL_MEM			0.57
PARTNERS-MASSGEN			0.58

⊘ No Data Available ● Substantially Worse than Target ◒ Worse than Target ⊙⊙ Better than Target ⊙ Meets Target ! Interpret with Caution (less than 25 cases)

IPAC Scorecard – FY2015

Patient Safety: Hospital Acquired Infections

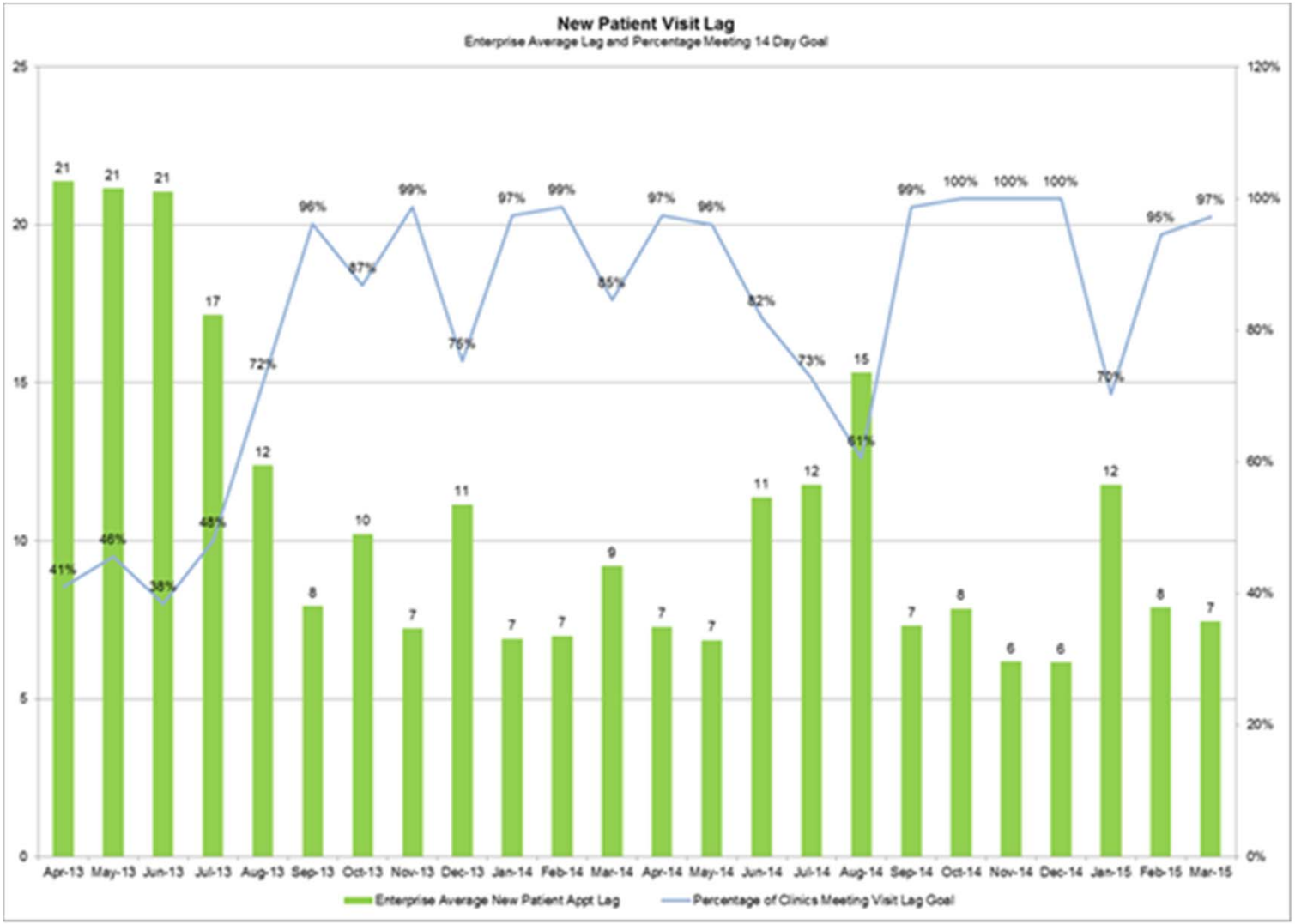
FY 15 Targets for HAIs (6 total)	2 of 6		3 of 6		4 of 6				**Month Overall Score: 3/6		
INDICATOR	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Target	YTD	YTD vs Goal
CAUTI	14	15	11	9	10	20	9	2	205	90	
CAUTI Rate	*3.4*	*3.5*	*2.6*	*2.1*	*2.2*	*4.9*	*2.2*	*0.5*	*4.2*	*2.7*	
CLABSI	7	3	3	5	3	7	4	8	113	40	
CLABSI Rate	*1.0*	*0.4*	*0.4*	*0.7*	*0.4*	*1.0*	*0.6*	*1.2*	*1.5*	*1.5*	
MRSA w/ Bacteremia	5	1	3	9	5	3	4	4	39	34	
MRSA w/ Bacteremia Rate	*0.2*	*0.0*	*0.2*	*0.4*	*0.3*	*0.1*	*0.2*	*0.2*	*0.2*	*0.2*	
C. Difficile	14	20	11	8	19	24	26	17	137	139	
C. Difficile Rate	*7.6*	*11.0*	*6.2*	*4.4*	*11.0*	*12.9*	*13.0*	*9.4*	*6.8*	*9.5*	
VAE	0	0	0	0	0	1	0	0		1	
VAE Rate	*0.0*	*0.0*	*0.0*	*0.0*	*0.0*	*0.5*	*0.0*	*0.0*		*0.1*	
*Surgical Site Infections: **Always 30 days behind*											
SSI: Abdominal Hysterectomy	0	1	0	1	0	*0*	*Data not available*	*Data not available*	13	2	
SSI: Colon	0	1	3	2	2	*2*	*Data not available*	*Data not available*	9	10	

Hospital Acquired Infection Performance CY 2014

Metric	UK HealthCare Performance (Raw Number)	UK HealthCare SIR	Target-Based on CDC National SIR for 2013	Target-Based on UHC 50th Percentile
CAUTI	185	1.65	1.06	1.27
CLABSI	68	0.41	0.54	0.45
MRSA	48	2.17	0.92	Not available
C. Diff	178	0.78	0.90	0.99
SSI: Abdominal Hysterectomy	4	0.61	0.86	1.15 (Only 1 SSI Rate)
SSI: Colon	13	0.51	0.92	1.15 (Only 1 SSI Rate)

Threshold – 3 out of 6 Target – 4 out of 6 Max – 5 out of 6

Patient Access Performance



HCAHPS

Composite of the following –Make Goal the **Top Box** reflective of the most current percentile ranking:

Option 1: 50/60/70 for all
Option 2: 60/70/80 for all

		Option 3: see below
1. Rate 9/10	FYTD 46 tile	50/60/70
2. Communication with Nurses	FYTD 62 tile	60/70/80
3. Communication with Doctors	FYTD 51 tile	50/60/70
4. Hospital Environment	FYTD 65 tile	70/75/80
5. Pain	FYTD 59 tile	50/60/70
6. Communication with Meds	FYTD 78 tile	70/75/80
7. Discharge	FYTD 74 tile	70/75/80
8. Care Transitions	FYTD 64 tile	60/70/80
9. Responsiveness	FYTD 80 tile	75/80/90

Threshold	6 of 9
Target	7 of 9
Max	8 of 9

CG-CAHPS

Composite of the following–Make Goal the Top Box reflective of the most current percentile ranking:

Option 1: 50/60/70 for all

		Option 2: see below	
1. Rate the Provider	FYTD 39 tile	40/50/60	
2. Access to Care	FYTD 52 tile	50/60/70	
3. Test Results	FYTD 49 tile	50/60/70	
4. Physician Communication	FYTD 30 tile	30/40/50	
5. Office Staff Quality	FYTD 52 tile	50/60/70	
6. Willingness to Recommend	FYTD 32 tile	30/40/50	(This seems more appropriate in an Ambulatory setting?)

Note: FY17 – we should have data on the new Nursing Domain but not for FY16

Threshold	3 of 6
Target	4 of 6
Max	5 of 6