Hennepin Healthcare System	
Title: 2026 – 2027 Performance Improvement Plan	**Plan #** 001983
Policy Sponsor: Vice President of Performance Improvement and Safety	
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PURPOSE

It is the goal of the Hennepin Healthcare System Board, Hennepin County Board, and employees to continuously improve the safety and quality of patient care and services provided.

Hennepin Healthcare System's (HHS) approach to Performance Improvement is a system wide framework that has strategic and operational direction from leadership and includes improvement activities initiated by front line team members. Performance improvement activities are collaborative, interdisciplinary and in support of HHS' mission, vision, values, strategic directions, and regulatory requirements.

The Performance Improvement plan defines performance improvement priorities, roles, responsibilities, and framework to ensure an environment of continuous performance improvement.

PERFORMANCE IMPROVEMENT PRIORITIES

Leadership selects performance improvement priorities based on what is most critical for success from the perspective of patients, community, employees, and other key stakeholders, and includes a review of applicable performance measures, including dimensions of health equity data, known, and identified best practices, the need to meet regulatory requirements and done in a manner that supports alignment with organizational goals and the strategic plan. Leadership is accountable for achieving these results.

HHS' strategic plan defines areas of focused improvement. Within these focal areas, improvement initiatives are selected, prioritized, and completed on an annual basis, and as new needs are identified.

QUALITY DEFINITION and PRINCIPLES

The definition of Quality used by the Hennepin Healthcare System is to provide Safe, Timely, Effective, Efficient, Equitable and Patient-Centered Care (STEEEP). This is achieved through a system wide focus on the continuous analysis and improvement of the STEEEP performance aims as identified by the Institute of Medicine:

Safe: Patients should not be harmed by the care intended to help them.

Timely: Unnecessary waits and harmful delays should be reduced.

Effective: Care should be based on sound scientific knowledge.
Efficient: Care shouldn't be wasteful.
Equitable: Care shouldn't vary in quality because of patient characteristics; and
Patient-Centered: Care should be responsive to individual preferences, needs, and values.

Performance improvement is supported by a culture of continuously measuring, assessing, and initiating changes to improve outcomes. HHS employs the following principles in its approach to performance improvement:

A. Senior Leadership and Board of Directors Commitment:
1. Dedication to safety and the elimination of harm.
2. Dedication to continuous improvement demonstrated by involvement where the work happens (daily operations).
3. Develop clear business goals and objectives to set the direction of the organization.
4. Make available all necessary resources to meet these goals and objectives.
5. Coach leaders to develop people and solve problems.
6. Utilize strategy deployment for breakthrough initiatives and ongoing operational improvements.
7. Helping frontline team members see the line of sight from their day-to-day work to the strategic objectives of the organization.

B. Patient and Customer Focus: Knowledge and understanding of internal and external customer needs and expectations.

C. Continuous: Measurement and improvement are ongoing. Needs are anticipated.

D. Process Improvement: Analysis of processes for redesign and variance reduction using scientific methods. Employees use data and direct observations to identify and reduce waste in our processes.

E. Just Culture: Focus on performance improvement, not punishment. A transparent culture of openness that supports reporting of actual or potential events thereby creating an accounting, which forms the basis of improvement and/or learning.

F. Involvement: Employees are actively engaged, from the front lines through leadership, in improving the processes in which they work. All members have mutual respect for the dignity, knowledge, and potential contributions of others.

G. Health Equity: The organization is committed to partnering with our entire community, both internal and external, in achieving their fullest health potential by actively eliminating barriers due to racism, or any other consequence of social position or socially influenced circumstances.

H. Data Analysis: Reviewing data by different patient segments is critical to analyzing patient data and target improvement efforts. This approach supports value-based care, allows focused interventions, provides a means to evaluate effectiveness of a strategy and is necessary to assure improved healthcare outcomes for all patients.

ORGANIZATIONAL STRUCTURE

This integrated structure is based and/or integrated with the following:

A. The HHS Management System is integrated with the improvement model. This structure provides a framework to help leaders manage or "run" their business, develop people to solve problems and improve overall performance. It uses visual tools, places a strong focus on processes (not just results) and integrates improvement into daily work.

B. Uses standard improvement tools and methodology.

C. Incorporates key elements of systems thinking to ensure organizational alignment, agility, and management by fact.

D. Ensures leadership participation at the appropriate level and optimal use of resources.

E. Ensures strategic alignment and appropriate review of organizational indicators.

F. Establishes clear lines of accountability, responsibility and authority for decision making and results through a formal chartering process.

G. Fosters interdisciplinary rather than representative membership.

H. Bases resource allocation on organizational priorities.

I. Promotes system wide improvement capacity and competency.

J. Reviews outcomes on an annual basis to evaluate past performance and revise direction, as appropriate. Ensure committees are data driven.

K. Ensures transparent, two-way organizational flow of communication regarding priorities, progress, and outcomes.

L. Ensures spread of performance outcomes and best practices.

M. Embraces excellence, celebrates success, and fosters a culture of improvement and learning.

The structure is based on interlocking layers of accountability or levels including the HHS Board of Directors (and its committees), Quality and Safety Management Committee and its subcommittees, the Medical Executive Committee and their subcommittees and the Executive Leadership Team. This includes oversight of the annual plan initiatives, ad hoc organizational improvement projects, and operational improvement via departmental and program activities.

I. <u>Quality and Safety Management Committee</u>

The Quality and Safety Management Committee (QSMC) provides balanced leadership and oversight of operations across the system to exceed the expectations of our internal and external customers through the provision of Safe, Timely, Effective, Efficient, Equitable and Patient-Centered Care and Service (STEEEP).

The QSMC indicators reflect the STEEEP performance dimensions to promote value, which includes financial stewardship, to the ultimate customer, patients. This is achieved through a system-wide review of key performance indicators that cascade through the system that supports standardized problem-solving efforts and resource allocation towards "running the business" and "improving the business" in a transparent fashion.

This committee will identify opportunities for improved performance which could be necessary at the system or local level. Performance improvement areas will be prioritized

and could be addressed via the Annual Plan objectives, improvement initiatives or teams, or Kaizen events.

II. QSMC/MEC Subcommittees:

A. These subcommittees are ongoing groups of organizational and medical staff employees delegated to analyze, report, and act on regulatory standards and/or defined key performance indicators (e.g., employee safety, or infection prevention, etc.) as delegated by the QSMC or MEC.
B. These committees are driven by written charters with defined elements.

III. Departments and Programs:

A. Department and Program leaders are responsible for the development and implementation of annual improvement goals that are aligned with the organizational annual plan. Excellence Councils may exist within departments and serve to guide staff participation in relevant performance improvement initiatives.
B. Clinical Departments report progress on improvement initiatives via the area's visual management board and as requested.

IV. Ad Hoc Performance Improvement (PI) Teams:

A. Ad hoc PI teams are organizational groups assigned to improve a prioritized strategic or sanctioned performance initiative. These teams are resourced and required to report progress on a periodic basis.
B. PI teams are required to follow the defined organizational improvement process. They are time-limited and with a clear scope and deliverables outlined using a team charter document.

All quality committees undergo an initial chartering process that includes a comprehensive charter document and annual committee evaluation. Recommended charter elements include Purpose, Scope, Objectives, Measures of Success, Decision Making Authority, Reporting Relationships, Communication Expectations, Meeting Frequency, Membership, and Roles and Responsibilities.

ROLES and RESPONSIBILITIES

I. Governance

A. Hennepin County Board of Commissioners

The parent body for Hennepin Healthcare System Inc. and has ultimate responsibility for the Hennepin County Medical Center mission.

B. Hennepin Healthcare System (HHS) Board

The HHS Board is the governing body responsible for guiding Hennepin Healthcare System.

C. HHS Board Quality, Safety, Audit and Compliance Committee (QSAC)

1. A subcommittee of the HHS Board that shall assist the Board in oversight of overall quality and safety within HHS.
2. The objectives of the QSAC include but are not limited to the following:
    a Quality and safety of the Patient Care and services

b Safety of the Environment of care for all, including patients, employees and visitors,
c Effectiveness of the processes used to ensure quality and safety regarding patient care and services

3. Make recommendations to the Board based upon deliberation within the committee's scope of assignment.

II. Senior Leadership

Quality and Safety Management Committee

The QSMC ensures organizational excellence across the system, including clinical and non-clinical work processes and level of service provided to internal and external customers, in order to assess the key quality, safety and service indicators for the system, including but not limited to: Patient satisfaction, patient safety, employee and organizational safety, workforce planning, regulatory compliance, the flow of patients, equipment and information, interdisciplinary subcommittees, departments and sanctioned ad hoc improvement groups.

1. Establish annual team goals specifying areas of focus.
2. Prioritize and provide oversight and resources for designated performance improvement initiatives in areas of clinical and non-clinical support services.
3. Approve charters and selected indicators for reporting subcommittees.
4. Review, revise and submit recommendations for the following to the Board Quality, Safety, Audit and Compliance Committee on an annual basis:
   a. Organizational Performance Improvement Plan
   b. Organizational Patient Safety
   c. Environmental Health and Safety Management Plans.
5. Identify and monitor key performance indicators (KPIs) and when needed, take corrective action regarding negative variances and opportunities for improvement.
6. Assess and act on summary reports and corrective action plans from designated areas with regard to negative variances and opportunities for improvement.
7. Prioritize and provide resources for designated improvement initiatives.
8. Provide support to clinical and service areas within scope by reducing barriers to achieve success and/or sanctioning ad hoc improvement teams.
9. Ensure transparent, consistent communication to relevant stakeholders regarding improvement findings and progress.
10. Provide oversight for organizational reporting and recognition related to improvement initiatives.

A. Medical Executive Committee (MEC)

1. The Medical Executive Committee is the policy-making body for the medical staff, consistent with the Bylaws, medical staff rules and regulations, and subject to the approval of the governing body. This includes receiving monthly performance improvement reports and acting on those matters that pertain to the medical staff professional function and practice.
2. The MEC is populated by chairs of departments and other members of the medical staff and is chaired by the President of Medical Affairs It has an indirect reporting relationship to the QSMC and collaborates with the QSMC regarding PI activities.

3. Duties of the MEC are to:
    a. Act as the policy-making body for the medical staff as a whole
    b. Act on behalf of the medical staff between meetings
    c. Act on applications to the medical staff on the recommendations of the Credentials Committee
    d. Receive and act on committee reports
    e. Act on those matters brought before it by the Chief Medical Officer, President of Medical Affairs, members of the Medical Staff, CEO or Governing Body which pertain to the professional function of the HHS, and which require broad policy decisions.

B. Subcommittees of QSMC and MEC

1. Medical Staff Quality Committee (MSQC): Peer Review

The MSQC ensures that the hospital, through the activities of its medical staff, assesses the performance of individuals granted clinical privileges and uses the results of such assessments to improve patient care. The MSQC reports to the Medical Executive Committee and has an indirect reporting relationship with QSMC as it relates to system issues identified within its review activities.

2. Credentials Committee

The Credentials Committee provides recommendations to the Medical Executive Committee for credentialing and privileging of physicians and other practitioners providing healthcare services to patients at the Medical Center.

3. Regulatory Steering Committee (RSC)

The RSC provides leadership and oversight to ensure the organization is in continuous compliance with applicable accreditation and certification regulatory standards. The steering committee supports continuous regulatory readiness by ensuring that new requirements are identified, existing standards are monitored and identified findings are corrected in a timely manner. The RSC also ensures that processes are in place to monitor and submit accurate and timely state and federal publicly reported quality measures.

4. Environmental Health and Safety Committee (EHSC)

The EHSC provides leadership and oversight to ensure a safe, secure and effective environment for patients, employees, volunteers and visitors. This committee continuously works to ensure resources and processes are in place to mitigate and/or reduce environmental and safety hazards and maintain organizational compliance with appropriate regulatory standards. It maintains the required management plans of Hazardous Waste, Medical Equipment, Safety, Security, Utilities and Workplace Violence Prevention.

5. Clinical Safety Practices Committee

The Clinical Safety Practices Committee provides leadership and oversight to patient safety with the goal of achieving continuous improvement of prioritized patient safety initiatives. The Clinical Safety Practices Committee is directly accountable to the QSMC and/or its subcommittees.

6. **Medical Group Quality and Safety Committee**: The MGQSC establishes and monitors quality and safety standards and metrics (for the medical staff) and provides advisement to quality and safety improvements, patient experience and risk management activities.

7. **Hospital Quality Committee:** The purpose of this committee is to review performance for key outcomes across acute care (critical care, emergency department, and med/surg), discuss active work, and communicate actions needed to improve and sustain outcomes.

8. **Ambulatory Quality Committee:** The ACQC provides expertise and leadership to improve quality outcomes and care through coordination and monitoring of performance initiatives across ambulatory care settings in alignment with health system strategic priorities.
9. **Responsible AI in Healthcare Committee:** This committee was established to ensure responsible and ethical use of artificial intelligence (AI) technologies within the organization by overseeing the development, implementation, and ongoing governance of AI initiatives, applications, and projects to promote patient safety, data privacy, and equitable healthcare outcomes.
10. **Trauma Quality Programs:** These committees provide oversight and direction for the Level 1 Adult and Pediatric Trauma program and is foundational for success and continued state and national verification by the American College of Surgeons Committee on Trauma. In addition, the program provides oversight and direction for the adult and pediatric burn program and is foundational for success and continued state and national verification by the American Burn Association.
11. **Jail Health Oversight Committee:** The Jail Health Services (JHS) Quality Committee ensures the delivery of high-quality healthcare services within the jail setting. The committee monitors and evaluates key quality and safety indicators affecting the incarcerated population, identifying opportunities for improvement and enhancing care standards.
12. **Culturally and Linguistically Appropriate Service (CLAS) Committee:** The CLAS Committee provides leadership and oversight of processes, procedures, and initiatives designed to achieve the organization's CLAS program goals as a key function in providing exceptional patient care.
13. **Home Care QAPI:** Accountable to review and meet program specific CMS and Joint Commission standards and create an annual plan that reflect the complexity of the homecare services, focuses on improving outcomes, demonstrates improvement in performance measures and uses data to monitor the overall effectiveness, safety and quality of care and services provided.
14. **Surgical Services Quality and Safety Committee**: Multidisciplinary team that oversees the quality, safety and improvement efforts surrounding all aspects of surgical services.

C. Departments, Programs and Ad Hoc Improvement teams

Department and Program leaders are responsible for achieving a value driven system of care within their areas of responsibility. This includes the development and implementation of annual improvement goals that are aligned with the organizational annual plan, implementing care models that coordinate across the continuum of care, establishing and/or maintaining standards of care that drive clinical, functional, and financial outcomes in ways that improve the patient/family experience and promote employee engagement. Excellence Councils within departments guide team member's

participation in relevant performance improvement initiatives. Improvement initiatives conducted by the Excellence Councils are approved by the area leadership. Clinical Departments report progress via their visual management system and may be asked to provide written reports as needed.

Ad hoc Improvement Teams

These teams conduct organizational performance improvement initiatives as sanctioned by the QSMC or its subcommittees. They receive support from assigned resources and report progress to the QSMC or its subcommittee, as appropriate.

QUALITY SUPPORT PROCESSES and FUNCTIONS

A. Performance Measurement and Improvement (PM&I)

This department supports organizational performance improvement by providing data, tools, skills and expertise needed to assess and improve processes, outcomes, patient safety, customer service and continual survey readiness.

B. Measurement and Analysis:

1. Quality and Performance Improvement Data Team (QPID), Patient Safety, Accreditation, Health Information Management, Analytics Center of Excellence (ACE) Informatics, Information Technology and Financial Services provide data needs and analysis that supports a data driven approach to performance improvement.
2. Information sources for monitoring performance and improvement activities include an integrated quality system, electronic health record, stand-alone internal systems and external systems. External data systems allow us to analyze and compare data regionally and nationally with similar institutions and established benchmarks.
3. Data is used to establish baseline performance, monitor ongoing performance and outcomes; determine whether changes in process have met expectations and if improvements have been maintained. Responsibility for performance measures is established when measures are identified. Whenever possible, control charts, run charts, line graphs or other statistical tools will be used in reporting data.

C. Process Improvement Methodology

HHS has four major elements used in the process improvement methodology. This framework is used as appropriate to the size of the problem and improvement needed.

1. **Four Major Elements in the HHS Model for Improvement are:**
   Step 1: Evaluate and Plan opportunity (Do I have a Problem?)
   Step 2: Problem Solving (Do I know the Root-Cause?)
   Step 3: Control and Sustain Results (Have I confirmed Cause and Effect?)
   Step 4: Consider Spread throughout the system (Have I confirmed the countermeasures?)
2. Improvement work is done using many supporting tools such as:
   a. Rapid Process Improvement Workshops
   b. Value Stream Mapping
   c. 3P Design Events
   d. Failure Mode Effects Analysis

3. The “Hennepin Management System” is based in quality assessment/ improvement science and principles, provides a framework to help leaders manage their business, and develops people to solve problems and improve performance. It uses visual tools, places a strong focus on processes, not only results, and integrates improvement into daily work. This system includes a daily Tiered Huddle system to ensure adequate resources are in place, problem-solving of issues and a mechanism for two-way communication.
4. PDSA - This process is used to safely conduct a test of change using scientific methods. Plan the trial of change, run the trial (Do), Study the results, and then adjust before next steps (Act).
5. 4 Step Problem Solving - used for problem solving, steps define the issue, history and background, current state, root cause, future state, countermeasures, and action plan and follow up.
6. Project Management – used for implementation when a solution is identified or to spread best practices across the enterprise.

D. Performance Improvement Education

As needs are determined, the Performance Measurement and Improvement Department in conjunction with Organizational Development and Learning and other key stakeholders, plan for performance improvement and patient safety learning opportunities.

E. Prioritization

The selection of improvement initiatives is based upon multiple sources of input, including, but not limited to, the HHS Strategic Plan, recommendations from subcommittees, Medical Staff Quality, various survey results, Community Needs Assessments, local Excellence Councils, and other organizational monitoring activities. Any requested improvement initiatives that are strategic in nature, organization-wide, and/or multidisciplinary, are reviewed and approved using defined criteria. The criteria include, but are not limited to, alignment to strategic goals, the impact on safety/quality and the patient experience, initiative scope, regulatory implications, financial impact, and availability of resources.

F. Communication

Each committee and group within the quality structure is encouraged to identify any key messages for organizational communication. Messages include, but are not limited to, key decisions, balanced scorecard results, progress reports, required education, and celebrations of success. Messages and updates are posted in a variety of manners including the intranet where they are accessible to all. With the goal to increase information and transparency, committee charters and membership will be made available for viewing on the organization’s intranet.

G. Confidentiality

Confidentiality is maintained based on full respect of the patient, employee, and medical staff rights to privacy. Performance improvement activities and information are protected in accordance with Minnesota Statutes § 145.61-66.

H. Evaluation

To ensure progress and consistency with organization policies, practices and strategic plan priorities, the plan is continuously evaluated. The results of these reviews are used for ongoing planning.

Endorsed By the:
HHS Quality and Safety Management Committee
HHS Board Quality, Safety, Audit and Compliance Committee

Presented to/Approved by:
Hennepin Healthcare System Board