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**VIA EMAIL AND OVERNIGHT MAIL**

April 4, 2022

Mike Constantino
Senior Project Manager
Illinois Health Facilities and Services Review Board
525 West Jefferson Street, Second Floor
Springfield, Illinois 62761

**RE: #E-025-22 - West Suburban Medical Center, #E-026-22 – West Suburban Medical Center [Real Estate Only], #E-27-22 – Louis Weiss Memorial Hospital, #E-028-22 – Louis Weiss Memorial Hospital [Real Estate Only]**

Dear Mr. Constantino:

This correspondence, and the various attachments, responds to a series of additional questions regarding the captioned COE applications posed by the Health Facilities and Services Review Board (HFSRB) in the attached March 28 communication directed to me, as counsel for Pipeline Health System, LLC and certain affiliated applicant entities ("Seller") and to Juan Morado and Mark Silberman at Benesch, as counsel for AUM Global Healthcare, LLC and certain other applicant entities ("Buyer").

My response, on behalf of Seller, is attached. Please note the following:

1. Seller took responsibility for developing the responses to questions 1, 4, 5 and 7. As to the response to question 1, please note that the hospitals experienced net operating losses in most, but not in every month. Please also note that the positive financial results for each hospital in December 2020 were primarily due to receipt of federal funding pursuant to the CARES Act.

2. Buyer took responsibility for developing the responses to questions 2, 3 and 6, and will be submitting these responses under separate cover.

Thank you very much. Please do not hesitate to reach out to me with any questions or concerns, at anne.murphy@afslaw.com or (617) 9973-6246.

Very truly yours,

Anne M. Murphy

CC: April Simmons, General Counsel, HFSRB
Juan Morado and Mark Silberman, Benesch

**April 4, 2022**

**PIPELINE HEALTH SYSTEM AND RELATED SELLER APPLICANT ENTITY RESPONSES TO 3/28/2022 HFSRB STAAFF QUESTIONS (ATTACHED)**

***1. Please provide the profit and loss information for Louis Weiss Memorial Hospital and West Suburban Medical Center for each month since Pipeline assumed control.***

Please see the attached excel spreadsheet, in the format you requested, covering January 2019 to the present.

***2. Please provide the detailed plan for the turnaround of these two hospitals.***

[To be answered by Buyer]

***3. Once the purchase is completed how are you going to maintain sufficient cash flow to operate and manage these two hospitals if the seller states the two hospitals have lost money every month since 2019.***

[To be answered by Buyer]

***4. Please provide a signed quality improvement plan for West Suburban Medical Center.***

Please see the attached signed quality improvement plan for West Suburban Medical Center.

***5. Please provide an approved Financial Assistance Policy for both Hospitals.***

Please see the attached approved financial assistance policies for Weiss Memorial Hospital and West Suburban Medical Center.

***6. Are the management teams of both hospitals going to remain in place once the change of ownership occurs?***

[To be answered by Buyer]

***7. Who is the CEO of Louis Weiss Memorial Hospital?***

Irene Dumanis is the Chief Executive Officer of Louis A.Weiss Memorial Hospital. She can be reached at (773) 564-5102 or idumanis@weisshospital.com

**POLICY NAME - Financial Assistance**

**POLICY#**

**POLICY APPROVAL DATE - November 1, 2021**

**POLICY APPROVED BY:** Robert Allen
Robert Allen, Corporate CFO

**POLICY REVISED/REVIWED DATE -**

**FACILITY-Weiss Memorial Hospital**

## Scope

This policy applies to Pipeline - Weiss Memorial Hospital, LLC dba Weiss Memorial Hospital ("Hospital").

## Purpose

The policy provides direction and processes for Hospital to identify uninsured patients who qualify for financial assistance, which includes full or partial discounts for emergency or medically necessary services under Hospital's Financial Assistance policy.

## Definitions

A. **"Financial Assistance Discount"** means the discount afforded to an individual determined to be Financially Indigent in accordance with this provision of this policy.
B. **"Elective Services"** means scheduled services and certain non-emergent "walk-up" services (e.g., lab services) that are approved for a discount under the guidelines set forth in this policy.
C. **"Emergent Services"** means any service which is rendered to a patient: (1) presenting to the Emergency Department and determined to have a medical condition that without immediate medical attention would result in serious harm to the patient, whether or not the patient is admitted to Hospital or treated and released, or (2) presenting as a direct admission with a medical condition that without immediate medical attention would result in serious harm to the patient.
D. "**Medically Necessary Services**" means healthcare services that are needed to diagnose or treat an illness, injury, condition, disease or its symptoms.
**"Federal health care program"** means any plan or program that provides health benefits, whether directly, through insurance, or otherwise, which is funded directly, in whole or in part, by the United States Government, including but not limited to: Medicare, Medicaid, Managed Medicare/Medicaid, TriCare/VA/CSCHIP, Indian Health Services, Health Services for Peace Corp Volunteers, Federal Employees Health Benefit Plan, Railroad Retirement Benefits, Black Lung Program, Services Provided to Federal Prisoners and Pre-Existing Condition Plans (PCIP).
E. **"Gross Charge"** means the list price on Hospital's Charge Description Master, and represents the amount the Uninsured Patient is obligated to pay prior to any discount contemplated under this policy or the policies incorporated into this policy by reference.
F. **"Financially Indigent"** means an uninsured patient with an annual income below 200% of the Federal Poverty Level.
G. **"Health Insurance Policy"** means any Federal health care program, personal or group health policy or plan, whether fully insured or self-funded, which has as its primary purpose the reimbursement, in whole or in part, of medical services provided to a covered patient.
H. **"Income"** means the sum of the total yearly gross income.

I. **"Non-Covered Services"** means those services not covered by a patient's Health Insurance Policy. This definition includes services not covered (i) as a result of a pre-existing condition exclusion; (ii) because a patient has exhausted his or her benefits; (iii) because they are denied through a Health Insurance Policy's pre- authorization process; and (iv) services for which the patient has elected to opt out of his or her Health Insurance Policy coverage and to pay out of pocket. For purposes of a Federal health care program beneficiary, "Non-Covered Services" means only those services that are statutorily excluded from coverage. Patient co- pays and deductibles are not considered "Non-Covered Services."

J. **"Uninsured Patient"** means a patient at Hospital who has no health insurance policy in force at any time during which the patient receives treatment at Hospital.

## Policy

All uninsured patients receiving care at Hospital will be treated with respect and in a professional manner before, during and after receiving care. Hospital will provide uninsured patients with financial counseling, including assistance applying for state and federal health care programs such as Medicare and Medicaid, and for available coverage under the Affordable Care Act.

Uninsured patients who do not qualify for any state or federal health care program, and who qualify as financially indigent in accordance with the processes set forth below, will receive financial assistance discounts.

Uninsured patients who do not qualify for any state or federal health care program, and who do not quality for financial assistance discounts, may still be eligible for financial assistance. In these situations, Hospital will review all available information and make a determination on the patient's eligibility for financial assistance.

This policy applies to Hospital except to the extent it is inconsistent with any applicable state law, in which case such state law controls. State-specific procedures, including but not limited to procedures for identifying financial assistance discounts to report to appropriate agencies under applicable federal or state health care program requirements, will be documented in job aids, addenda to this policy or in separate policies. To the extent this policy is inconsistent with any applicable purchase, management, joint venture or other affiliation agreement, such agreement controls and the hospital-specific procedures will be documented in job aids, addenda to this policy, or in separate policies.

Any state-specific or facility-specific addendum to this Policy which establishes procedures or requirements that vary from those described in this Policy must be reviewed by the Hospital's
Legal Department and approved in writing by the Hospital's Chief Financial Officer for the affected facilities, or their designee.

## Procedure

A. Financial Counseling

Hospital will provide uninsured patients with financial counseling, including assistance applying for state and federal health care programs such as Medicare and Medicaid, and for available coverage under the Affordable Care Act. If uninsured patients are not eligible for governmental assistance or other coverage, the Financial Counselors will inform the patients about this policy and assist with the application process. The Financial Counselors must never indicate or suggest to uninsured patients that they will be relieved of all or a portion of the debt through financial assistance until the determination has been made that the patient is eligible for such assistance.

B. Financial Assistance Application Process

1. Presumptive Charity

The following is a listing of types of accounts where financial assistance is considered to be automatic and may be approved for financial assistance without a financial assistance application or documentation of Income:

a. Homelessness
b. Deceased with no estate
c. Mental incapacitation with on one to act on patient's behalf
d. Medicaid eligibility, but not on service date or for non-covered services

Enrollment in the following programs with low-income individuals having eligibility criteria at or below 200% of the federal poverty income guidelines:

e. Women, Infants and Children Nutritional Program (WIC)
f. Supplemental Nutritional Assistance Program (SNAP)
g. Illinois Free Lunch and Breakfast Program
h. Low Income Home Energy Assistance Program (LHEAP)
i. Enrollment in an organized community-based program providing access to medical care that assesses and documents limited low-income financial status as criteria
j. Receipt of grant assistance for medical services

In addition to the presumptive Financial Assistance criteria listed above, Hospital recognizes that a portion of the uninsured or underinsured patient population may not engage in the traditional Financial Assistance application process. If the required information is not provided by the patient, Hospital utilizes an automated predictive scoring tool to qualify patients for Financial Assistance. The tool calculates the percentage of federal poverty based on the U.S. federal poverty guidelines. These guidelines are updated and published periodically in the Federal Register. The tool provides estimates of the patient's likely socio-economic standing, as well as, the patient's household income and size.

2. Application

Uninsured Patients who do not qualify for a presumptive charity determination must complete an application and document financial need. (Attachment B – Financial Assistance Application)

Patients requesting Financial Assistance must verify the number of people in the patient's household and then determine Income (as applicable).

a. Adult Patients

In calculating the number of people in an adult patient's household, include the patient, the patient's spouse and any dependents of the patient or the patient's spouse.

b. Minor Patients

In calculating the number of people in a minor patient's household, include the patient, the patient's mother, dependents of the patient's mother, the patient's father, and dependents of the patient's father. Patients requesting Financial Assistance must verify their income and provide the documentation requested as set forth in the Assistance Application.

c. Adult Patients

For adult patients, determine the Income of the patient and other adult members of the patient's household. If and to the extent required by law, the hospital may consider other financial assets of the patient and the patient's family and the patient's or the patient's family's ability to pay, as reflected in the applicable state-specific job aid, addendum or procedure.

d. Minor Patients

For minor patients, determine the Income from the patient and the patient's legal guardians or other individuals financially responsible for the patient's care. If and to the extent required by law, the

facility may consider other financial assets of the patient and the patient's family and the patient's or the patient's family's ability to pay, as reflected in the applicable state-specific job aid, addendum or procedure.

i. Homeless Patients:
Homeless (defined as patients who do not have a primary residence or reside with family or friends) are deemed to have no income for purposes of the Hospital's calculation of Income. Documentation of Income is not required for homeless patients. To the extent that family members or others have been identified as financially responsible for the patient's care, income verification is required for such individuals in accordance with this policy in order to determine that individual's eligibility for financial assistance.

ii. Incarcerated Patients:
Incarcerated patients (Hospital personnel should attempt to verify incarceration) may be deemed to have no income for purposes of the Hospital's calculation of Income, but only if their medical expenses are not covered by the governmental entity incarcerating them (i.e., the Federal Government, the State or a County is responsible for the care) since in such event they are not uninsured patients. Income verification is still required for any other family members.

iii. Expired Patients:
Expired patients' accounts may be reviewed for probate or other responsible parties before being considered for presumptive financial assistance. Following such review, expired patients may be deemed to have no Income for purposes of the Hospital's calculation of Income. Hospital will review the patient's financial status at the time of death to ensure that a Financial Assistance adjustment is appropriate (e.g., no other guarantor appears on the patient account).

e. Documentation and Gross Monthly Family Income Verification
Income and other information may be verified through any of the following documents:

i. Wages, self-employment, unemployment compensation
ii. Social Security, Social Security Disability
iii. Veterans Pension, Veteran's Disability, Private Disability, Workers Compensation
iv. Temporary Assistance for Needy Families (TANF)
v. Retirement income
vi. Child support, alimony or other spousal support
vii. Other income

Documentation of family income can be determined from paycheck stubs, benefit statements, award letters, court orders, federal tax returns or other documentation provided by patient

In cases where the patient is unable to provide documentation verifying income, Hospital may at its sole discretion verify the patient's income in one of the following three ways:

i. The patient's written certification that the income information is true and accurate;
ii. The written certification of the hospital personnel completing the assistance application that the patient orally verified Hospital's calculation of Income Information as true and accurate, where allowed by state law; or
iii. Credit Bureau Report (including the lack thereof).

f. If the Hospital is unable to verify and document income as described in the sections above, other information to demonstrate financial need the Hospital may consider includes but is not limited to the following:
    i. The patient's employment status, credit status, and capacity for future earnings
        1. Patients who are unemployed and do not qualify for a government program
        2. Patients who have no credit established and no Bad Debt collection accounts
        3. Patients with a lack of revolving credit account(s) information
        4. Patients with a lack of revolving bank accounts(s) information
        5. Patients with delinquencies reported on open trade line accounts
    ii. The previous exhaustion of all other available resources.
    iii. Catastrophic illness.
    iv. Consultation with third-party sources to review a patient's information using predictive models that are recognized by the healthcare industry and based on public record databases, which models evaluate a patient's propensity to pay and permit the Hospital to assess whether a patient has relevant characteristics similar to patients who have historically qualified for financial assistance discounts through the formal application process.

g. Request for Additional Information
If the patient does not provide adequate documents, or the information in the provided documents is conflicting or unclear, the Hospital will contact the patient and request additional information. Except to the extent otherwise required by law, the patient's failure to provide requested information within 14 calendar days from the date of the request will result in a denial of the patient's application for financial assistance. Hospital personnel must enter a note into the Hospital computer system and any and all paperwork that was completed will be filed according to the date of the denial note. The Hospital personnel will take no further actions on the assistance application. If requested documentation is obtained prior to six months after the initial denial, all filed documentation will be retrieved and the patient will be reconsidered for Financial Assistance. If requested documentation is obtained after six months from the initial denial, the Hospital will re-verify the information provided in the initial application.

h. Classification Pending Income Verification
Except as otherwise required by applicable law, during the income verification process, while the Hospital is collecting the information necessary to determine a patient's eligibility for Financial Assistance, the patient will be treated as a self-pay patient in accordance with Hospital policies.

i. Information Falsification
Falsification of information will result in denial of the Financial Assistance Application. If, after a patient is granted financial assistance as Financially Indigent, Hospital finds material provision(s) of the Financial Assistance Application to be untrue, the financial assistance will be withdrawn and the patient's account will follow the normal collection processes.

j. Approval Process, Limits, and Exclusions
Hospital's CFO or designee must approve all Financial Assistance discounts in writing or electronically. If an application is approved, the approval applies to balances eligible for financial assistance for all dates of service within twelve months prior to the approval and for additional services provided within six months after the date of approval**.** The following services are excluded from Financial Assistance: any cosmetic procedures or services**,** patient non-compliance with payer requirements (COB/Motor Vehicle/Workers Compensation information) and other patient non-compliance determined by Hospital Also excluded are physician bills.

k. Denial of Financial Assistance
If Hospital determines that a patient does not qualify for Financial Assistance under this policy, Hospital must notify the patient of this decision in writing.

C. Applying the Discounts

1. After evaluation of an uninsured patient's application, patients who qualify as financially indigent will be afforded Financial Assistance discounts in accordance with Attachment A (Financial Assistance Sliding Scale).

2. Billing and Collection Processes

a. Financial Assistance Notices
Hospital will notify Patients and or Guarantors about the Financial Assistance Program generally by the following: Hospital will post notices regarding the availability of financial assistance to uninsured patients. These notices will be posted in visible locations throughout the Hospital such as admitting/registration, billing office and emergency department. The notices will include a contact telephone number that a patient or family member can call for more information. The following specific language complies with the notice requirements: YOU MAY BE ELIGIBLE FOR FINANCIAL ASSISTANCE UNDER THE TERMS AND CONDITIONS THE HOSPITAL OFFERS TO QUALIFIED PATIENTS. "For help with your Hospital bill or Financial Assistance, please call or ask to see our Financial Counselor or call 1-800-404-6627. Financial Assistance applications will also be available in the admitting/registration and billing areas. In addition, the Financial Assistance policy or Plain Language Summary and application is available on the hospitals website.

b. Liens on Primary Residences
Hospital will not, in dealing with patients who quality for Financial Assistance under this policy, place or foreclose liens on primary residences as a means of collecting unpaid hospital bills.

c. Interest Free, Extended Payment Plans.
Hospital will offer Uninsured Patients extended payment plans to assist in settling past due outstanding hospital bills. In addition, Hospital will not charge uninsured patients any interest under such extended payment plans.

d. Body Attachments
Hospital will not use body attachment to require that its Uninsured Patients or responsible party appear in court.

3. Reservation of Rights

a. Non-Covered Services
Hospital reserves the right to designate certain services as not subject to financial assistance under the Financial Assistance Policy.

b. No Effect on Other Hospital Policies
This policy shall not alter or modify other Hospital policies regarding efforts to obtain payments from third-party payers, patient transfers, emergency care, state-specific regulations, and state-specific requirements for statutory financial assistance classification or programs for uncompensated care.

D. All employees whose responsibilities are affected by this policy are expected to be familiar with the basic procedures and responsibilities created by this policy. Failure to comply with this policy will be subject to appropriate performance management pursuant to all applicable policies and procedures, up to and including termination. Such performance management may also include modification of compensation, including any merit or discretionary compensation awards, as allowed by applicable law.

E. References

HHS, Office of Inspector General, Guidance dated February 2, 2004, entitled "Hospital Discounts Offered to Patients Who Cannot Afford to Pay Their Hospital Bills".

Letter dated February 19, 2004, from Tommy G. Thompson, HHS Secretary, to Richard J. Davidson, President, American Hospital Association, including Questions and Answers attached thereto entitled "Questions on Charges for the Uninsured".

Federal Poverty Guidelines published by US Department of Health and Human Services from time to time.

Standards of Conduct

Quality, Compliance and Ethics Program Charter

Job Aids for State-Specific Requirements

Illinois Fair Patient Billing Act (210 ILCS 88/27)

Attachment A
Financial Assistance Sliding Scale

| | | FA DISCOUNT 100% OF CHARGES | FA DISCOUNT 90% OF CHARGES | FA DISCOUNT 80% OF CHARGES |
|---|---|---|---|---|
| # IN FAMILY / HOUSEHOLD | POVERTY GUIDELINE | UP TO 200% OF FPL | 201 – 300% OF FPL | 301 – 400% OF FPL |
| 1 | $13,590 | $27,180 | $27,315 - $40,770 | $40,905 - $54,360 |
| 2 | $18,310 | $36,620 | $36,803 - $54,930 | $55,113 - $73,240 |
| 3 | $23,030 | $46,060 | $46,290 - $69,090 | $69,320 - $92,120 |
| 4 | $27,750 | $55,500 | $55,777 - $83,250 | $83,527 - $111,000 |
| 5 | $32,470 | $64,940 | $65,264 - $97,410 | $97,734 - $129,880 |
| 6 | $37,190 | $74,380 | $74,751 - $111,570 | $111,941 - $148,760 |
| 7 | $41,910 | $83,820 | $84,239 - $125,730 | $126,149 - $167,640 |
| 8 | $46,630 | $93,260 | $93,726 - $139,890 | $140,356 - $186,520 |
| | Add $4750 each additional person | | | |

**POLICY NAME - Financial Assistance**

**POLICY#**

**POLICY APPROVAL DATE - November 1, 2021**

**POLICY APPROVED BY:** Robert Allen
Robert Allen, Corporate CFO

**POLICY REVISED/REVIWED DATE -**

**FACILITY-West Suburban Medical Center**

## Scope

This policy applies to Pipeline – West Suburban Medical Center, LLC dba West Suburban Medical Center ("Hospital").

## Purpose

The policy provides direction and processes for Hospital to identify uninsured patients who qualify for financial assistance, which includes full or partial discounts for emergency or medically necessary services under Hospital's Financial Assistance policy.

## Definitions

A. **"Financial Assistance Discount"** means the discount afforded to an individual determined to be Financially Indigent in accordance with this provision of this policy.
B. **"Elective Services"** means scheduled services and certain non-emergent "walk-up" services (e.g., lab services) that are approved for a discount under the guidelines set forth in this policy.
C. **"Emergent Services"** means any service which is rendered to a patient: (1) presenting to the Emergency Department and determined to have a medical condition that without immediate medical attention would result in serious harm to the patient, whether or not the patient is admitted to Hospital or treated and released, or (2) presenting as a direct admission with a medical condition that without immediate medical attention would result in serious harm to the patient.
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E. **"Gross Charge"** means the list price on Hospital's Charge Description Master, and represents the amount the Uninsured Patient is obligated to pay prior to any discount contemplated under this policy or the policies incorporated into this policy by reference.
F. **"Financially Indigent"** means an uninsured patient with an annual income below 200% of the Federal Poverty Level.
G. **"Health Insurance Policy"** means any Federal health care program, personal or group health policy or plan, whether fully insured or self-funded, which has as its primary purpose the reimbursement, in whole or in part, of medical services provided to a covered patient.
H. **"Income"** means the sum of the total yearly gross income.

I. **"Non-Covered Services"** means those services not covered by a patient's Health Insurance Policy. This definition includes services not covered (i) as a result of a pre-existing condition exclusion; (ii) because a patient has exhausted his or her benefits; (iii) because they are denied through a Health Insurance Policy's pre- authorization process; and (iv) services for which the patient has elected to opt out of his or her Health Insurance Policy coverage and to pay out of pocket. For purposes of a Federal health care program beneficiary, "Non-Covered Services" means only those services that are statutorily excluded from coverage. Patient co- pays and deductibles are not considered "Non-Covered Services."

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## Policy

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This policy applies to Hospital except to the extent it is inconsistent with any applicable state law, in which case such state law controls. State-specific procedures, including but not limited to procedures for identifying financial assistance discounts to report to appropriate agencies under applicable federal or state health care program requirements, will be documented in job aids, addenda to this policy or in separate policies. To the extent this policy is inconsistent with any applicable purchase, management, joint venture or other affiliation agreement, such agreement controls and the hospital-specific procedures will be documented in job aids, addenda to this policy, or in separate policies.

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Legal Department and approved in writing by the Hospital's Chief Financial Officer for the affected facilities, or their designee.

## Procedure

A. Financial Counseling

Hospital will provide uninsured patients with financial counseling, including assistance applying for state and federal health care programs such as Medicare and Medicaid, and for available coverage under the Affordable Care Act. If uninsured patients are not eligible for governmental assistance or other coverage, the Financial Counselors will inform the patients about this policy and assist with the application process. The Financial Counselors must never indicate or suggest to uninsured patients that they will be relieved of all or a portion of the debt through financial assistance until the determination has been made that the patient is eligible for such assistance.

B. Financial Assistance Application Process

1. Presumptive Charity

The following is a listing of types of accounts where financial assistance is considered to be automatic and may be approved for financial assistance without a financial assistance application or documentation of Income:

a. Homelessness
b. Deceased with no estate
c. Mental incapacitation with on one to act on patient's behalf
d. Medicaid eligibility, but not on service date or for non-covered services

Enrollment in the following programs with low-income individuals having eligibility criteria at or below 200% of the federal poverty income guidelines:

e. Women, Infants and Children Nutritional Program (WIC)
f. Supplemental Nutritional Assistance Program (SNAP)
g. Illinois Free Lunch and Breakfast Program
h. Low Income Home Energy Assistance Program (LHEAP)
i. Enrollment in an organized community-based program providing access to medical care that assesses and documents limited low-income financial status as criteria
j. Receipt of grant assistance for medical services

In addition to the presumptive Financial Assistance criteria listed above, Hospital recognizes that a portion of the uninsured or underinsured patient population may not engage in the traditional Financial Assistance application process. If the required information is not provided by the patient, Hospital utilizes an automated predictive scoring tool to qualify patients for Financial Assistance. The tool calculates the percentage of federal poverty based on the U.S. federal poverty guidelines. These guidelines are updated and published periodically in the Federal Register. The tool provides estimates of the patient's likely socio-economic standing, as well as, the patient's household income and size.

2. Application

Uninsured Patients who do not qualify for a presumptive charity determination must complete an application and document financial need. (Attachment B – Financial Assistance Application)

Patients requesting Financial Assistance must verify the number of people in the patient's household and then determine Income (as applicable).

a. Adult Patients

In calculating the number of people in an adult patient's household, include the patient, the patient's spouse and any dependents of the patient or the patient's spouse.

b. Minor Patients

In calculating the number of people in a minor patient's household, include the patient, the patient's mother, dependents of the patient's mother, the patient's father, and dependents of the patient's father. Patients requesting Financial Assistance must verify their income and provide the documentation requested as set forth in the Assistance Application.

c. Adult Patients

For adult patients, determine the Income of the patient and other adult members of the patient's household. If and to the extent required by law, the hospital may consider other financial assets of the patient and the patient's family and the patient's or the patient's family's ability to pay, as reflected in the applicable state-specific job aid, addendum or procedure.

d. Minor Patients

For minor patients, determine the Income from the patient and the patient's legal guardians or other individuals financially responsible for the patient's care. If and to the extent required by law, the

facility may consider other financial assets of the patient and the patient's family and the patient's or the patient's family's ability to pay, as reflected in the applicable state-specific job aid, addendum or procedure.

i. Homeless Patients:
Homeless (defined as patients who do not have a primary residence or reside with family or friends) are deemed to have no income for purposes of the Hospital's calculation of Income. Documentation of Income is not required for homeless patients. To the extent that family members or others have been identified as financially responsible for the patient's care, income verification is required for such individuals in accordance with this policy in order to determine that individual's eligibility for financial assistance.

ii. Incarcerated Patients:
Incarcerated patients (Hospital personnel should attempt to verify incarceration) may be deemed to have no income for purposes of the Hospital's calculation of Income, but only if their medical expenses are not covered by the governmental entity incarcerating them (i.e., the Federal Government, the State or a County is responsible for the care) since in such event they are not uninsured patients. Income verification is still required for any other family members.

iii. Expired Patients:
Expired patients' accounts may be reviewed for probate or other responsible parties before being considered for presumptive financial assistance. Following such review, expired patients may be deemed to have no Income for purposes of the Hospital's calculation of Income. Hospital will review the patient's financial status at the time of death to ensure that a Financial Assistance adjustment is appropriate (e.g., no other guarantor appears on the patient account).

e. Documentation and Gross Monthly Family Income Verification
Income and other information may be verified through any of the following documents:

i. Wages, self-employment, unemployment compensation
ii. Social Security, Social Security Disability
iii. Veterans Pension, Veteran's Disability, Private Disability, Workers Compensation
iv. Temporary Assistance for Needy Families (TANF)
v. Retirement income
vi. Child support, alimony or other spousal support
vii. Other income

Documentation of family income can be determined from paycheck stubs, benefit statements, award letters, court orders, federal tax returns or other documentation provided by patient

In cases where the patient is unable to provide documentation verifying income, Hospital may at its sole discretion verify the patient's income in one of the following three ways:

i. The patient's written certification that the income information is true and accurate;
ii. The written certification of the hospital personnel completing the assistance application that the patient orally verified Hospital's calculation of Income Information as true and accurate, where allowed by state law; or
iii. Credit Bureau Report (including the lack thereof).

f. If the Hospital is unable to verify and document income as described in the sections above, other information to demonstrate financial need the Hospital may consider includes but is not limited to the following:
    i. The patient's employment status, credit status, and capacity for future earnings
        1. Patients who are unemployed and do not qualify for a government program
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        3. Patients with a lack of revolving credit account(s) information
        4. Patients with a lack of revolving bank accounts(s) information
        5. Patients with delinquencies reported on open trade line accounts
    ii. The previous exhaustion of all other available resources.
    iii. Catastrophic illness.
    iv. Consultation with third-party sources to review a patient's information using predictive models that are recognized by the healthcare industry and based on public record databases, which models evaluate a patient's propensity to pay and permit the Hospital to assess whether a patient has relevant characteristics similar to patients who have historically qualified for financial assistance discounts through the formal application process.

g. Request for Additional Information
If the patient does not provide adequate documents, or the information in the provided documents is conflicting or unclear, the Hospital will contact the patient and request additional information. Except to the extent otherwise required by law, the patient's failure to provide requested information within 14 calendar days from the date of the request will result in a denial of the patient's application for financial assistance. Hospital personnel must enter a note into the Hospital computer system and any and all paperwork that was completed will be filed according to the date of the denial note. The Hospital personnel will take no further actions on the assistance application. If requested documentation is obtained prior to six months after the initial denial, all filed documentation will be retrieved and the patient will be reconsidered for Financial Assistance. If requested documentation is obtained after six months from the initial denial, the Hospital will re-verify the information provided in the initial application.

h. Classification Pending Income Verification
Except as otherwise required by applicable law, during the income verification process, while the Hospital is collecting the information necessary to determine a patient's eligibility for Financial Assistance, the patient will be treated as a self-pay patient in accordance with Hospital policies.

i. Information Falsification
Falsification of information will result in denial of the Financial Assistance Application. If, after a patient is granted financial assistance as Financially Indigent, Hospital finds material provision(s) of the Financial Assistance Application to be untrue, the financial assistance will be withdrawn and the patient's account will follow the normal collection processes.

j. Approval Process, Limits, and Exclusions
Hospital's CFO or designee must approve all Financial Assistance discounts in writing or electronically. If an application is approved, the approval applies to balances eligible for financial assistance for all dates of service within twelve months prior to the approval and for additional services provided within six months after the date of approval**.** The following services are excluded from Financial Assistance: any cosmetic procedures or services**,** patient non-compliance with payer requirements (COB/Motor Vehicle/Workers Compensation information) and other patient non-compliance determined by Hospital Also excluded are physician bills.

k. Denial of Financial Assistance
If Hospital determines that a patient does not qualify for Financial Assistance under this policy, Hospital must notify the patient of this decision in writing.

C. Applying the Discounts

1. After evaluation of an uninsured patient's application, patients who qualify as financially indigent will be afforded Financial Assistance discounts in accordance with Attachment A (Financial Assistance Sliding Scale).

2. Billing and Collection Processes

a. Financial Assistance Notices
Hospital will notify Patients and or Guarantors about the Financial Assistance Program generally by the following: Hospital will post notices regarding the availability of financial assistance to uninsured patients. These notices will be posted in visible locations throughout the Hospital such as admitting/registration, billing office and emergency department. The notices will include a contact telephone number that a patient or family member can call for more information. The following specific language complies with the notice requirements: YOU MAY BE ELIGIBLE FOR FINANCIAL ASSISTANCE UNDER THE TERMS AND CONDITIONS THE HOSPITAL OFFERS TO QUALIFIED PATIENTS. "For help with your Hospital bill or Financial Assistance, please call or ask to see our Financial Counselor or call 1-800-404-6627. Financial Assistance applications will also be available in the admitting/registration and billing areas. In addition, the Financial Assistance policy or Plain Language Summary and application is available on the hospitals website.

b. Liens on Primary Residences
Hospital will not, in dealing with patients who quality for Financial Assistance under this policy, place or foreclose liens on primary residences as a means of collecting unpaid hospital bills.

c. Interest Free, Extended Payment Plans.
Hospital will offer Uninsured Patients extended payment plans to assist in settling past due outstanding hospital bills. In addition, Hospital will not charge uninsured patients any interest under such extended payment plans.

d. Body Attachments
Hospital will not use body attachment to require that its Uninsured Patients or responsible party appear in court.

3. Reservation of Rights

a. Non-Covered Services
Hospital reserves the right to designate certain services as not subject to financial assistance under the Financial Assistance Policy.

b. No Effect on Other Hospital Policies
This policy shall not alter or modify other Hospital policies regarding efforts to obtain payments from third-party payers, patient transfers, emergency care, state-specific regulations, and state-specific requirements for statutory financial assistance classification or programs for uncompensated care.

D. All employees whose responsibilities are affected by this policy are expected to be familiar with the basic procedures and responsibilities created by this policy. Failure to comply with this policy will be subject to appropriate performance management pursuant to all applicable policies and procedures, up to and including termination. Such performance management may also include modification of compensation, including any merit or discretionary compensation awards, as allowed by applicable law.

E. References

HHS, Office of Inspector General, Guidance dated February 2, 2004, entitled "Hospital Discounts Offered to Patients Who Cannot Afford to Pay Their Hospital Bills".

Letter dated February 19, 2004, from Tommy G. Thompson, HHS Secretary, to Richard J. Davidson, President, American Hospital Association, including Questions and Answers attached thereto entitled "Questions on Charges for the Uninsured".

Federal Poverty Guidelines published by US Department of Health and Human Services from time to time.

Standards of Conduct

Quality, Compliance and Ethics Program Charter

Job Aids for State-Specific Requirements

Illinois Fair Patient Billing Act (210 ILCS 88/27)

Attachment A
Financial Assistance Sliding Scale

| | | FA DISCOUNT 100% OF CHARGES | FA DISCOUNT 90% OF CHARGES | FA DISCOUNT 80% OF CHARGES |
|---|---|---|---|---|
| # IN FAMILY / HOUSEHOLD | POVERTY GUIDELINE | UP TO 200% OF FPL | 201 – 300% OF FPL | 301 – 400% OF FPL |
| 1 | $13,590 | $27,180 | $27,315 - $40,770 | $40,905 - $54,360 |
| 2 | $18,310 | $36,620 | $36,803 - $54,930 | $55,113 - $73,240 |
| 3 | $23,030 | $46,060 | $46,290 - $69,090 | $69,320 - $92,120 |
| 4 | $27,750 | $55,500 | $55,777 - $83,250 | $83,527 - $111,000 |
| 5 | $32,470 | $64,940 | $65,264 - $97,410 | $97,734 - $129,880 |
| 6 | $37,190 | $74,380 | $74,751 - $111,570 | $111,941 - $148,760 |
| 7 | $41,910 | $83,820 | $84,239 - $125,730 | $126,149 - $167,640 |
| 8 | $46,630 | $93,260 | $93,726 - $139,890 | $140,356 - $186,520 |
| | Add $4750 each additional person | | | |

# WEST SUBURBAN MEDICAL CENTER
# PERFORMANCE IMPROVEMENT AND QUALITY PROGRAM PLAN
# 2021

## PURPOSE

The purpose of the West Suburban Medical Center (WSMC) Performance Improvement and Quality Program Plan is to provide a framework for monitoring patient care data and a coordinated hospital wide approach to improve organizational performance. The Performance Improvement and Quality Plan is implemented by the Quality Department under the direction of the Performance Distinction Council pursuant to the Illinois Medical Studies Act (735 ILCS 5/8-2101, et.seq.) the Illinois Hospital Licensing Act, and the Patient Safety and Quality Improvement Act of 2005. The plan provides guidance regarding organizational priorities and promotes quality assurance and improvement of patient care processes in a manner that embraces the organization's mission.

## PIPELINE MISSION/VISION/VALUES

A. ***Mission:*** To provide world-class care where you are.

B. ***Vision:*** To be the most trusted community-based healthcare network.

C. ***Values:*** Commitment to Caring and Community

a. **Passion**: Passion fuels everything we do
- We love what we do.
- We believe in healthcare that elevates people and communities.
- We seek to move healthcare from stress and burnout to passion and vibrancy.

b. **Compassion**: We care about the health and wellbeing of all our stake holders
- We believe that we can make a positive impact in people's lives, whether they are patients, families, our staff or physicians.
- Our desire to alleviate disease touches everything we do.
- We are committed to the needs of our communities.

c. **Innovation**: We work together to come up with innovative solutions
- We believe that collaboration and cross-pollination allow for innovation that others can't match.
- We are all students of healthcare and learn from each other.
- We seek to solve the toughest problems in new ways.

d. **Integrity**: We work hard because the stakes are too high not to
- We strive to be the best we can be to serve our communities' unique needs.
- We make decisions based on good data, open dialogue, and thoughtful planning.
- We have a sense of urgency and are able to adjust quickly.

e. **Resilience**: We embrace the challenges that come from serving our communities
- We believe in making bold decisions for the good of our patients and our community.
- We believe in learning from our mistakes and coming back stronger.
- We celebrate our people and the courage they bring to their work every day.

## OBJECTIVES

- Provide safe, effective, patient centered, timely, efficient, and equitable care.
- Establish and maintain an ongoing, comprehensive and objective mechanism to improve performance, clinical outcomes, and patient safety.
- Identify known, suspected or potential problems or hazards in patient care delivery, as well as opportunities for further improvement in currently acceptable care.
- Establish priorities/goals for the investigation and resolution of concerns and problems by focusing on those with the greatest potential impact on patient care outcome, patient safety, and patient satisfaction.
- Define corrective action and document resolution of known and potential problems and evidence of patient care improvement.
- Ensure coordination and integration of performance improvement activities by maintaining a Performance Improvement Committee as the focal point through which Performance Improvement and Patient Safety information will be exchanged and monitored.
- Communicate performance activities and findings to all pertinent Hospital and Administrative Staff, Medical Staff, and the Governing Board, as appropriate.
- Identify continuing education needs of clinical, administrative, and support personnel relative to Quality and Patient Safety.
- Coordinate Performance Improvement activities and findings with those of the facility's Management of the Environment, Surveillance, Prevention and Control of Infection, Information Management, Management of Human Resources, Ethics/Rights/Responsibilities, Provision of Care, Medication Management, and Leadership functions to the extent possible.
- Monitor and comply with policies, standards, regulations and laws set by the Governing Board, Medical Staff, Joint Commission, State and Federal governments and other regulating accrediting bodies.
- Enhance uniform performance of patient care processes throughout the organization.
- Provide a mechanism for integration of performance improvement activities throughout the hospital for colleagues, medical staff, leadership, volunteers and governance.

## ACCOUNTABILITY FOR PERFORMANCE IMPROVEMENT

### Governing Board

As described in the Governing Board Rules and Regulations, the Governing Board of West Suburban Medical Center bears ultimate responsibility for the performance and safety of patient care services provided by its medical, other professional and support staff. The Governing Board shall ensure an ongoing, comprehensive and objective mechanism is in place to monitor and evaluate performance, to identify and resolve documented or potential problems/hazards, and to identify further opportunities to improve patient care and safety. As appropriate, the Board shall delegate responsibility for implementing the Performance Improvement Plan to the medical staff, the CEO and hospital administration.

The Governing Board shall require, consider, and if necessary, act upon Medical Staff reports of medical care evaluation, utilization review, and other matters relating to the quality of care rendered in the Hospital.

The Governing Board shall direct that all reasonable and necessary steps be taken by the Medical Staff and Hospital Administration for meeting the Joint Commission accreditation standards and complying with applicable laws and regulations.

Other specific responsibilities with regard to performance improvement, patient care, and risk management are delineated in the Governing Board Rules and Regulations, which shall be reviewed and approved by the Governing Board.

**Medical Executive Committee (MEC)**

According to the Bylaws of the Medical Staff, the Medical Executive Committee is responsible for the quality and efficiency of patient care rendered by members of the Medical Staff and for the medical-administrative obligations of the medical staff.

The functions of the MEC with respect to quality include, but are not limited, to the following:

- Take reasonable steps to ensure professionally ethical conduct and competent clinical performance on the part of staff members, including initiating or conducting investigations and initiating and pursuing corrective action when warranted; and
- Assure active participation and involvement of the medical staff in organization-wide quality and patient safety initiatives and activities
- Receive and act on reports and recommendations from Departments, committees, and officers of the medical staff concerning the functions of evaluation and monitoring of the quality and appropriateness of care and treatment and recommend specific programs and systems to implement these functions.

**Clinical Departments**

It shall be the responsibility of the chair of the clinical Departments and specialty services, working through Departmental committees, and with the assistance of the appropriate standing committees, to design and implement effective programs: (1) to monitor and assess the quality of professional performance in each Department and service; (2) to promote quality practice in each Department and service by (a) providing education and counseling; (b) issuing letters of instruction, admonition, warning, or censure, as necessary; and (c) requiring routine monitoring when deemed appropriate by the Department or service. Other specific responsibilities with regard to performance improvement are delineated in the Medical Staff Bylaws. Refer to the Medical Staff Peer Review Policy for specific departmental responsibilities regarding focused and ongoing professional practice evaluation.

**Leadership & Support**

The leaders have the responsibility to create an environment that promotes performance improvement through the safe delivery of patient care, quality outcomes and high customer satisfaction. The leaders promote a patient safety culture of internal and external transparency, and support the Hospital's Patient Safety Program, which seeks to create a culture that values safety, disclosure of errors, and provides for a non-punitive process. Refer to the Hospital Patient Safety Program Plan for a more detailed view of the safety program. The leaders perform the following key functions:

- Adopt an approach to performance improvement, set expectations, plan, and manage processes to measure, assess, and improve the hospital's governance, management, clinical, and support activities
- Ensure that new or modified services or processes are designed well, measured, assessed, and improved systematically throughout the organization
- Establish priorities for performance improvement and safety giving priority to high-volume, high-risk, or problem-prone processes for performance improvement activities and reprioritize performance improvement activities in response to changes in the internal and external environment
- Participate in interdisciplinary and interdepartmental performance improvement and safety improvement activities in collaboration with the medical staff
- Allocate adequate resources (i.e., staff, time, and information systems) for measuring, assessing, and improving the hospital's performance and improving patient safety; and assess the adequacy of resources allocated to support these improvement activities
- Assure that staff is trained in performance improvement and safety improvement approaches and methods and receives education that focuses on safety and quality
- Continuously measure and assess the effectiveness of performance improvement and safety improvement activities, and implement improvements for these activities

### Medical Staff, Employees, and Contracted Services

- Medical staff members, hospital employees and contracted services employees maintain active participation and involvement in organization-wide quality and patient safety initiatives and activities to include participating in identifying opportunities for improvement and data collection efforts, serving on multidisciplinary teams, and implementing actions to sustain improvements.

### Performance Distinction and Quality Council

The Performance Distinction Council coordinate and monitor the overall Performance Improvement and Quality Program, to include clinical support and hospital-wide activities. The Performance Distinction Council shall:

- Request, receive and review Performance Improvement and Safety data, pertinent minutes, reports and results from relevant services, department/section or committee
- Summarize Performance Improvement findings for presentation to the Medical Executive Committee and the Governing Board through the President, Chief of Staff or designee, at least quarterly
- Refer appropriate information to individual services department/section or committee for discussion and action
- Assure active participation and involvement of appropriate interdisciplinary team members in organization-wide quality and patient safety initiatives and activities
- Assist in identifying and investigating problems or opportunities for patient safety & patient care improvement
- Assist in setting priorities for follow-up and determining appropriate corrective actions
- Monitor progress in resolving identified or potential problems/hazards & improving currently acceptable care
- Identify areas in need of further study and recommend appropriate study methods or procedures
- Oversee the annual appraisal of the Performance Improvement Program and written plan
- Review highlights of the annual appraisal of the Risk Management, Patient Safety, Infection Control, Utilization Review and Environment of Care written plans (as it relates to performance improvement and patient safety)

### Quality Management Department

The primary responsibility of the Quality Management Department is to coordinate and facilitate quality management and performance improvement throughout the hospital. While implementation and evaluation of quality improvement activities resides in each department program, the Quality Management staff serves as an internal resource for the development and evaluation of performance improvement activities. The Quality Management Department also serves as a resource for data collection, statistical analysis, and reporting functions.

## SCOPE AND ORGANIZATION

### Planning

Improving performance, clinical outcomes, and patient safety is systematic and involves a collaborative approach focused on patient and organizational functions. All services with a direct or indirect impact on patient care quality shall be reviewed under the Performance Improvement Plan. Plans for improvement should be in keeping with priorities established by hospital and medical staff leadership.

Priorities are based on the organization's mission, care, services provided and populations served. Additionally, priorities are based on the following:

- Meeting the needs of the patients, staff and others
- Resources required and/or available
- Results of performance improvement, patient safety and risk reduction activities
- Identified high risk, problem prone areas
- Information from within the organization and from other organizations about potential/actual risks to patients. (e.g., Institute for Safe Medication Practices, Joint Commission Sentinel Event Alerts)
- Accreditation and/or regulatory requirements of the Joint Commission and State

Staff input into opportunities to improve performance or patient safety will be utilized in identifying department and organization wide goals. Annually, Directors of Hospital Services will evaluate past performance and identify goals for the coming year. These goals will be prioritized by the Performance Distinction Council and submitted to the Board for approval as part of the Performance Improvement Plan.

**Exchange of Information Related to Performance**

The findings of quality review activities, the corrective actions taken and the results of those actions shall be forwarded to the appropriate committee on a timely basis, according to a set schedule.

The Performance Distinction Council shall submit a summary of the major findings of the Performance Improvement Program to the Medical Executive Committee and the Governing Board at least quarterly.

The Chief Executive Officer, President of the Medical Staff, or their designee shall keep the Governing Board informed on the status of quality review activities and trends in patient care quality and safety on a quarterly basis.

Information from improvement, monitoring and evaluation activities which pertain to more than one clinical service, department/section or committee will be shared with the affected services, departments/sections or committees, as appropriate.

All medical staff members and hospital employees shall be informed of the results of the quality review and improvement activities as it pertains to their services, department/section or committee. Results of medical staff peer review will remain within the medical staff structure and reported during a closed session of the Medical Staff Quality Committee and/or other appropriate medical staff committees.

Pertinent information from monitoring and evaluation activities or special studies shall be used in the credentialing of the medical staff, in the performance assessment of other licensed professional staff and, in the planning and procurement of appropriate continuing education offerings.

The Performance Excellence Committee shall seek to identify opportunities to coordinate patient care data collection, analysis and reporting with the organization's function of Leadership, Performance Improvement, Infection Control, Safety, Human Resources and Management of Information.

**Key Success Factors**

The following components are critical to the success of any quality and safety initiative:

- Involvement of medical, nursing and administrative leaders
- Prioritization and resource allocation by senior clinical and administrative leaders
- Education and participation of frontline service providers early in a project's development and throughout the decision making process
- Staff involvement to assist in the evaluation of objective baseline data, the establishment of measurable targets, and regular monitoring of results against those targets
- Regular updates during the process to all participants
- Recognition of individual and group achievement

**PERFORMANCE PROCESSES**

**Methodology**

West Suburban Medical Center participates in system-wide interdisciplinary monitoring of important functions. The foundation of performance improvement activities involve the use of data, design, planning, communication, implementation and ongoing monitoring of the effectiveness of improvement activities. The process to improve performance through the organization involves four steps, PDSA:

P PLAN – process of identifying projects to be worked on
D DO – analytic phase when specific elements of the problem are defined and implemented
S STUDY – evaluation of the effect of the changes made
A ACT – actions taken as a result of the evaluation of change

**Measurement**

The hospital collects data to monitor performance. Sources of data for quality review shall include, but will not be limited to, the following: medical records; monitoring activities of the medical staff and hospital departments or committees; occurrence reports and other pertinent risk management findings; Sentinel and Adverse Events; Sentinel Event Alerts ; claims, financial data; utilization review findings; patient surveys or complaints; log books (such as ER, OR); data from third-party payers, QIO, fiscal intermediaries or private agencies; committee and department minutes; and special studies.

Performance measures are structured to follow the Joint Commission dimensions of performance and are based on current evidenced-based information and clinical experience. Processes, functions, or services are designed/ redesigned well and are consistent with sound business practices. They are:

1. Consistent with the organization's mission, vision, goals, objectives, and plans;
2. Meeting the needs of individuals served, staff and others;
3. Clinically sound and current;
4. Incorporating information from within the organization and from other organizations about potential/ actual risks to patients;
5. Analyzed and pilot tested to determine that the proposed design/redesign is an improvement;
6. Incorporated into the results of performance improvement activities.

Data collection includes process, outcome, and control measures as well as improvement initiatives. Data shall be collected and reported to appropriate committees in accordance with established reporting schedules. The processes measured on an ongoing basis are based on our mission, scope of care and service provided accreditation and licensure requirements, and priorities established by leadership. Annual review of performance indicators will be documented as part of the annual evaluation. Data collection is systematic and is used to:

1. Establish a performance baseline;
2. Describe process performance or stability;
3. Describe the dimensions of performance relevant to functions, processes, and outcomes;
4. Identify areas for more focused data collection to achieve and sustain improvement.

**Analysis**

Data shall be analyzed on an ongoing basis to identify performance improvement opportunities. The assessment process compares data over time, in keeping with up to date sources (practice guidelines) and to reference databases, both internal and external to the hospital system.

When findings relevant to an individual's performance are identified, Medical Staff Leaders and Hospital Management/Administration are responsible for determining the use of the findings in the peer review process. This is accomplished in accordance with the Medical Staff Bylaws. Department/Service Directors shall act in accordance with the "Performance Evaluations" and "Education, Training and Competency of Employees" under the Human Resources policies.

West Suburban Medical Center requires an intense analysis of undesirable patterns or trends in performance when the following is identified, which includes, but is not limited to:

1. Performance varies significantly and undesirably from that of other organizations;
2. Performance varies significantly and undesirably from recognized standards;
3. When a sentinel event occurs;
4. Blood Utilization to include confirmed transfusion reactions;
5. Significant adverse drug reactions;

6. Significant medication errors, close calls, and hazardous conditions;
7. Significant discrepancies between preoperative and postoperative diagnoses, including pathologic diagnoses;
8. Significant adverse events related to using moderate or deep sedation or anesthesia;
9. Hazardous conditions;
10. Staffing effectiveness issues; and
11. ORYX core measure data that, over three or more consecutive quarters for the same measure, identify the hospital as a negative outlier.

**Improvement Model and Methodology**

Once a decision has been made to implement an improvement strategy, the organization systematically improves its performance using the Plan-Do-Study-Act (PDSA) methodology. Organization-wide Performance Improvement (PI) Teams are developed and use the PDSA model to make improvements in a specific process. Unit based PI Teams and other PDSA Teams are utilized and can form on their own to address unit-specific needs.

Decisions to act upon opportunities for improvement in care or patient safety and/or investigate concerns shall be based on opportunities identified, factors involved in measurement, required resources, and the overall mission and priorities for the organization.

Consideration is given to the expected impact or improvement on the dimension of Quality or Patient Safety. Performance expectations are set by those involved in the process. Indicators are developed and all individuals, professions, and departments involved in the process are included.

## PROACTIVE RISK ASSESSMENT

At lease every 36 months, the system selects one high-risk process and conducts a proactive risk assessment. The processes that have the most potential for affecting patient safety and reducing the risk of medical errors should be part of the criteria for selection. Once the potential process failure points are identified and analyzed, processes are redesigned to minimize the risk of harm. Newly redesigned processes are tested and implemented and monitored on an ongoing basis to ensure effectiveness.

## EDUCATION

Safety and Performance Improvement education is provided during orientation and on an ongoing basis throughout the organization. Presentations are provided to teams, committees, medical staff, individuals and leadership. Guidance is provided for proactive risk assessments Intense Analysis and Root Cause Analysis (RCA) either by training or facilitation. Just-in-time training is provided as needed.

## COMMITMENT TO COMMUNITY

West Suburban Medical Center is committed to the care of the individuals in the communities it serves. In an effort to provide the highest quality care, WSMC has initiated a number of avenues to seek and act on input from the community. The Governing Board is a major contributor of input on community perception of the hospital and its programs. The membership of the board is diverse and includes representation from local businesses, educational institutions and social organizations within the primary service area.

The hospital is also actively involved with wellness, screening, and prevention programs through the community including schools, local businesses, civic and other community organizations, utilizing them and their locales to provide health assessments and health education. Through other partnerships with local health care programs, we are able to gain feedback on services and how it might assist the various ethnic groups in the community.

It is the combination of the above programs that continuously provide us with input for improvement and community education opportunities.

## ALLOCATION OF RESOURCES

The CEO and President shall provide sufficient qualified staff, time, training, and information systems to assist the Performance Distinction & Patient Safety Committees, Medical Staff, Nursing, and Clinical Support Services in designing, implementing and maintaining effective Performance Improvement activities. The Directors/Managers of the organization shall allocate staff time to participate in performance improvement activities. Both external and internal education determined to be reflective of organizational priorities shall be supported through monies allocated for education. Budgetary planning shall include resources for effective information systems, when appropriate.

## CONFIDENTIALITY

The Performance Improvement and Quality Program of West Suburban Medical Center has been designed to comply with all applicable confidentiality and privacy laws. All data, reports, and minutes are confidential and shall be respected as such by all participants in the Performance Improvement and Quality Program. Confidential information may include, but is not limited to, the meeting minutes, electronic data gathering and reporting sentinel event and untoward event reporting, and clinical profiling. Information shall be presented so as to not identify specific Medical Staff members, patients, or other health care practitioners.

Data, reports, and minutes of the Performance Improvement program are the property of West Suburban Medical Center. This information is maintained in locked offices of the Quality Management Department and in departmental or administrative offices, as appropriate. Quality review data, reports and minutes shall be accessible only to those participating in the program. All other requests for information from the program shall be in writing stating the purpose and intent of the request, and shall be addressed to the Quality Management Department or Administration.

**WEST SUBURBAN MEDICAL CENTER**
**PERFORMANCE IMPROVEMENT AND QUALITY PROGRAM PLAN**
**2021**

Approved by:

VChristoff — 4-15-2021
Chief Quality Officer/Quality Management — Date

Barbara Mat — 4-15-2021
Chief Executive Officer — Date

Aman Abu Alab — 3-29-2022
Chair, Board of Trustees — Date

*"All information in this document and the compilation of any and all data for Performance Improvement activities at West Suburban Medical Center, in furtherance of the Medical Staff Quality Improvement Program and the initiatives of the hospital is privileged and confidential, to be used solely in the course of internal quality control, for the purpose of reducing morbidity and mortality and improving the quality of patient care at West Suburban Medical Center as provided in the Medical Studies Act, Illinois revised Statutes, Ch. 51, 8-2101, et seq.*

# WEST SUBURBAN MEDICAL CENTER
# PERFORMANCE IMPROVEMENT AND QUALITY PROGRAM PLAN
# 2022

## PURPOSE

The purpose of the West Suburban Medical Center (WSMC) Performance Improvement and Quality Program Plan is to provide a framework for monitoring patient care data and a coordinated hospital wide approach to improve organizational performance, create a culture of safety and quality, support safe decision making, and identify and respond to changes. The Performance Improvement and Quality Plan is implemented by the Quality Department under the direction of the Performance Distinction Council pursuant to the Illinois Medical Studies Act (735 ILCS 5/8-2101, et.seq.) the Illinois Hospital Licensing Act, and the Patient Safety and Quality Improvement Act of 2005. The plan provides guidance regarding organizational priorities and promotes quality assurance and improvement of patient care processes in a manner that embraces the organization's mission.

## PIPELINE MISSION/VISION/VALUES

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B. ***Vision:*** To be the most trusted community-based healthcare network.

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      - We believe in healthcare that elevates people and communities.
      - We seek to move healthcare from stress and burnout to passion and vibrancy.

   b. **Compassion**: We care about the health and wellbeing of all our stake holders
      - We believe that we can make a positive impact in people's lives, whether they are patients, families, our staff or physicians.
      - Our desire to alleviate disease touches everything we do.
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      - We believe that collaboration and cross-pollination allow for innovation that others can't match.
      - We are all students of healthcare and learn from each other.
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      - We believe in making bold decisions for the good of our patients and our community.
      - We believe in learning from our mistakes and coming back stronger.
      - We celebrate our people and the courage they bring to their work every day.

## DEFINITIONS

**Performance improvement** – The systematic process of detecting and analyzing performance problems, designing and developing interventions to address the problems, implementing the interventions, evaluating the results, and sustaining improvement.
**Sentinel event** – A patient safety event (not primarily related to the natural course of the patient's illness or underlying condition) that reaches a patient and results in death, permanent harm, or severe temporary harm. Sentinel events are a subcategory of adverse events.
**Significant adverse drug reaction (ADR)** – An adverse medication reaction experienced by an individual that required intervention to preclude or mitigate harm or that requires monitoring to confirm that it resulted in no harm to the individual.
**Significant medication error** – A medication error that reached an individual that required intervention to preclude or mitigate harm and/or that required monitoring to confirm that it resulted in no harm to the individual.

## OBJECTIVES

- To develop and implement data collection processes that support performance improvement.
- To develop and implement data analysis processes that support performance improvement.
- Establish and maintain an ongoing, comprehensive and objective mechanism to improve performance, clinical outcomes, and patient safety.
- Identify known, suspected or potential problems or hazards in patient care delivery, as well as opportunities for further improvement in currently acceptable care.
- Establish priorities/goals for the investigation and resolution of concerns and problems by focusing on those with the greatest potential impact on patient care outcome, patient safety, and patient satisfaction.
- Define corrective action and document resolution of known and potential problems and evidence of patient care improvement.
- Ensure coordination and integration of performance improvement activities by maintaining a Performance Improvement Committee (WSMC Performance Distinction Council) as the focal point through which Performance Improvement and Patient Safety information will be exchanged and monitored.
- Communicate performance activities and findings to all pertinent Hospital and Administrative Staff, Medical Staff, and the Governing Board, as appropriate.
- Identify continuing education needs of clinical, administrative, and support personnel relative to Quality and Patient Safety.
- Coordinate Performance Improvement activities and findings with those of the facility's Management of the Environment, Surveillance, Prevention and Control of Infection, Information Management, Management of Human Resources, Ethics/Rights/Responsibilities, Provision of Care, Medication Management, and Leadership functions to the extent possible.
- Monitor and comply with policies, standards, regulations and laws set by the Governing Board, Medical Staff, Joint Commission, State and Federal governments and other regulating accrediting bodies.
- Enhance uniform performance of patient care processes throughout the organization.
- Provide a mechanism for integration of performance improvement activities throughout the hospital for colleagues, medical staff, leadership, volunteers and governance.

## ACCOUNTABILITY FOR PERFORMANCE IMPROVEMENT

### Governing Board

As described in the Governing Board Rules and Regulations, the Governing Board of West Suburban Medical Center bears ultimate responsibility for the performance and safety of patient care services provided by its medical, other professional and support staff. The Governing Board shall ensure an ongoing, comprehensive and objective mechanism is in place to monitor and evaluate performance, to identify and resolve documented or potential problems/hazards, and to identify further opportunities to improve patient care and safety. As appropriate, the Board shall delegate responsibility for implementing the Performance Improvement Plan to the medical staff, the CEO and hospital administration.

The Governing Board shall require, consider, and if necessary, act upon Medical Staff reports of medical care evaluation, utilization review, and other matters relating to the quality of care rendered in the Hospital.

The Governing Board shall direct that all reasonable and necessary steps be taken by the Medical Staff and Hospital Administration for meeting the Joint Commission accreditation standards and complying with applicable laws and regulations.

Other specific responsibilities with regard to performance improvement, patient care, and risk management are delineated in the Governing Board Rules and Regulations, which shall be reviewed and approved by the Governing Board.

**Medical Executive Committee (MEC)**

According to the Bylaws of the Medical Staff, the Medical Executive Committee is responsible for the quality and efficiency of patient care rendered by members of the Medical Staff and for the medical-administrative obligations of the medical staff.

The functions of the MEC with respect to quality include, but are not limited, to the following:

- Take reasonable steps to ensure professionally ethical conduct and competent clinical performance on the part of staff members, including initiating or conducting investigations and initiating and pursuing corrective action when warranted; and
- Assure active participation and involvement of the medical staff in organization-wide quality and patient safety initiatives and activities
- Receive and act on reports and recommendations from Departments, committees, and officers of the medical staff concerning the functions of evaluation and monitoring of the quality and appropriateness of care and treatment and recommend specific programs and systems to implement these functions.

**Clinical Departments**

It shall be the responsibility of the chair of the clinical Departments and specialty services, working through Departmental committees, and with the assistance of the appropriate standing committees, to design and implement effective programs: (1) to monitor and assess the quality of professional performance in each Department and service; (2) to promote quality practice in each Department and service by (a) providing education and counseling; (b) issuing letters of instruction, admonition, warning, or censure, as necessary; and (c) requiring routine monitoring when deemed appropriate by the Department or service. Other specific responsibilities with regard to performance improvement are delineated in the Medical Staff Bylaws. Refer to the Medical Staff Peer Review Policy for specific departmental responsibilities regarding focused and ongoing professional practice evaluation.

**Leadership & Support**

The leaders have the responsibility to create an environment that promotes performance improvement through the safe delivery of patient care, quality outcomes and high customer satisfaction. The leaders promote a patient safety culture of internal and external transparency, and support the Hospital's Patient Safety Program, which seeks to create a culture that values safety, disclosure of errors, and provides for a non-punitive process. Refer to the Hospital Patient Safety Program Plan for a more detailed view of the safety program. The leaders perform the following key functions:

- Adopt an approach to performance improvement, set expectations, plan, and manage processes to measure, assess, and improve the hospital's governance, management, clinical, and support activities
- Ensure that new or modified services or processes are designed well, measured, assessed, and improved systematically throughout the organization
- Establish priorities for performance improvement and safety giving priority to high-volume, high-risk, or problem-prone processes for performance improvement activities and reprioritize performance improvement activities in response to changes in the internal and external environment

- Participate in interdisciplinary and interdepartmental performance improvement and safety improvement activities in collaboration with the medical staff
- Allocate adequate resources (i.e., staff, time, and information systems) for measuring, assessing, and improving the hospital's performance and improving patient safety; and assess the adequacy of resources allocated to support these improvement activities
- Assure that staff is trained in performance improvement and safety improvement approaches and methods and receives education that focuses on safety and quality
- Continuously measure and assess the effectiveness of performance improvement and safety improvement activities, and implement improvements for these activities

**Medical Staff, Employees, and Contracted Services**

- Medical staff members, hospital employees and contracted services employees maintain active participation and involvement in organization-wide quality and patient safety initiatives and activities to include participating in identifying opportunities for improvement and data collection efforts, serving on multidisciplinary teams, and implementing actions to sustain improvements.

**Performance Distinction and Quality Council**

The Performance Distinction Council coordinate and monitor the overall Performance Improvement and Quality Program, to include clinical support and hospital-wide activities. The Performance Distinction Council shall:

- Request, receive and review Performance Improvement and Safety data, pertinent minutes, reports and results from relevant services, department/section or committee
- Summarize Performance Improvement findings for presentation to the Medical Executive Committee and the Governing Board through the President, Chief of Staff or designee, at least quarterly
- Refer appropriate information to individual services department/section or committee for discussion and action
- Assure active participation and involvement of appropriate interdisciplinary team members in organization-wide quality and patient safety initiatives and activities
- Assist in identifying and investigating problems or opportunities for patient safety & patient care improvement
- Assist in setting priorities for follow-up and determining appropriate corrective actions
- Monitor progress in resolving identified or potential problems/hazards & improving currently acceptable care
- Identify areas in need of further study and recommend appropriate study methods or procedures
- Oversee the annual appraisal of the Performance Improvement Program and written plan
- Review highlights of the annual appraisal of the Risk Management, Patient Safety, Infection Control, Utilization Review and Environment of Care written plans (as it relates to performance improvement and patient safety)

**Quality Management Department**

The primary responsibility of the Quality Management Department is to coordinate and facilitate quality management and performance improvement throughout the hospital. While implementation and evaluation of quality improvement activities resides in each department program, the Quality Management staff serves as an internal resource for the development and evaluation of performance improvement activities. The Quality Management Department also serves as a resource for data collection, statistical analysis, and reporting functions.

## SCOPE AND ORGANIZATION

**Planning**

Improving performance, clinical outcomes, and patient safety is systematic and involves a collaborative approach focused on patient and organizational functions. All services with a direct or indirect impact on patient care quality shall be reviewed under the Performance Improvement Plan. The plan applies to all policies, procedures and processes in the hospital. Plans for improvement should be in keeping with priorities established by hospital and medical staff leadership.

Priorities are based on the organization's mission, care, services provided and populations served. Additionally, priorities are based on the following:

- Meeting the needs of the patients, staff and others
- Resources required and/or available
- Results of performance improvement, patient safety and risk reduction activities
- Identified high risk, problem prone areas
- Information from within the organization and from other organizations about potential/actual risks to patients. (e.g., Institute for Safe Medication Practices, Joint Commission Sentinel Event Alerts)
- Accreditation and/or regulatory requirements of the Joint Commission and State

Staff input into opportunities to improve performance or patient safety will be utilized in identifying department and organization wide goals. Annually, Directors of Hospital Services will evaluate past performance and identify goals for the coming year. These goals will be prioritized by the Performance Distinction Council and submitted to the Board for approval as part of the Performance Improvement Plan.

**Exchange of Information Related to Performance**

The findings of quality review activities, the corrective actions taken and the results of those actions shall be forwarded to the appropriate committee on a timely basis, according to a set schedule.

The Performance Distinction Council shall submit a summary of the major findings of the Performance Improvement Program to the Medical Executive Committee and the Governing Board at least quarterly.

The Chief Executive Officer, President of the Medical Staff, or their designee shall keep the Governing Board informed on the status of quality review activities and trends in patient care quality and safety on a quarterly basis.

Information from improvement, monitoring and evaluation activities which pertain to more than one clinical service, department/section or committee will be shared with the affected services, departments/sections or committees, as appropriate.

All medical staff members and hospital employees shall be informed of the results of the quality review and improvement activities as it pertains to their services, department/section or committee. Results of medical staff peer review will remain within the medical staff structure and reported during a closed session of the Medical Staff Quality Committee and/or other appropriate medical staff committees.

Pertinent information from monitoring and evaluation activities or special studies shall be used in the credentialing of the medical staff, in the performance assessment of other licensed professional staff and, in the planning and procurement of appropriate continuing education offerings.

The Performance Excellence Committee shall seek to identify opportunities to coordinate patient care data collection, analysis and reporting with the organization's function of Leadership, Performance Improvement, Infection Control, Safety, Human Resources and Management of Information.

**Key Success Factors**

The following components are critical to the success of any quality and safety initiative:

- Involvement of medical, nursing and administrative leaders
- Prioritization and resource allocation by senior clinical and administrative leaders
- Education and participation of frontline service providers early in a project's development and throughout the decision making process
- Staff involvement to assist in the evaluation of objective baseline data, the establishment of measurable targets, and regular monitoring of results against those targets
- Regular updates during the process to all participants
- Recognition of individual and group achievement

## PERFORMANCE PROCESSES

### Methodology

West Suburban Medical Center participates in system-wide interdisciplinary monitoring of important functions. The foundation of performance improvement activities involves the use of data, design, planning, communication, implementation and ongoing monitoring of the effectiveness of improvement activities. The process to improve performance through the organization involves four steps, PDSA:

P PLAN – process of identifying projects to be worked on
D DO – analytic phase when specific elements of the problem are defined and implemented
S STUDY – evaluation of the effect of the changes made
A ACT – actions taken as a result of the evaluation of change

### Measurement

The hospital collects data to monitor performance. Sources of data for quality review shall include, but will not be limited to, the following: electronic health records, laboratory system records, radiology system records, operating room logs, infection surveillance systems, incident reports, minutes from committee meetings, patient and staff satisfaction surveys, performance measure data, reports on mortality and autopsy data, The Joint Commission Sentinel Event Alerts, monitoring activities of the medical staff and hospital departments or committees, utilization review findings, QIO, fiscal intermediaries or private agencies, committee and department minutes; and special studies.

Performance measures are structured to follow the Joint Commission dimensions of performance and are based on current evidenced-based information and clinical experience. Processes, functions, or services are designed/ redesigned well and are consistent with sound business practices. They are:

1. Consistent with the organization's mission, vision, goals, objectives, and plans.
2. Meeting the needs of individuals served, staff and others.
3. Clinically sound and current.
4. Incorporating information from within the organization and from other organizations about potential/ actual risks to patients.
5. Analyzed and pilot tested to determine that the proposed design/redesign is an improvement.
6. Incorporated into the results of performance improvement activities.

### Data Reliability and Validity

Collected data need to be accurate, complete, and reliable. The Performance Distinction Council has established the following expectations for any data used to monitor or improve hospital performance:

- Data samples will undergo auditing.
- Data sources will be regularly checked using established procedures.
- Re-abstraction will occur on a data sample.

The Performance Distinction Council collaborates with department managers to collect data on topics in the following areas:

- Environment of care
- Infection prevention and control
- Medication management system
- Patient safety issues (for example, falls, self-harm)
- Organ procurement program, including but not limited to the organ procurement rate
- Incidents related to overexposure to radiation during diagnostic computed tomography examinations and, if applicable, provision of fluoroscopic services
- Adequacy of staffing, including nurse staffing, in relation to undesirable patterns, trends, or variations in performance

The Performance Distinction Council uses internal and external data sources to collect data. These sources are appropriate to the issue being evaluated and are defined as acceptable by this plan. PDC includes the following information when recording data:

- Data source
- Collection frequency
- Reporting frequency
- Report audience
- Responsible department(s)
- Indicators for intervention

**Analysis**

Data shall be analyzed on an ongoing basis to identify performance improvement opportunities. The assessment process compares data over time, in keeping with up-to-date sources (practice guidelines) and to reference databases, both internal and external to the hospital system.

The Performance Distinction Council does the following:

1. Uses statistical tools and techniques to analyze and display data.
2. Compares internal data over time to identify the following:
    - Levels of performance
    - Patterns or trends in performance
    - Variations in performance
3. Identifies the types of data displays preferred by the governing body and other audiences.
4. Engages the assistance of relevant departmental management and/or staff to collect and analyze data.
5. Analyzes data using methods that are appropriate to the type of data and the desired metrics, which include but are not limited to the following:
    - Comparisons
    - Benchmarks, both internal and external
    - Thresholds
6. Reports and presents data using preferred display types.
7. Reports, in writing, to leadership on issues and interventions related to adequacy of staffing, including nurse staffing. This occurs at least once a year.

Data collection includes process, outcome, and control measures as well as improvement initiatives. Data shall be collected and reported to appropriate committees in accordance with established reporting schedules. The processes measured on an ongoing basis are based on our mission, scope of care and service provided accreditation and licensure requirements, and priorities established by leadership. Annual review of performance indicators will be documented as part of the annual evaluation. Data collection is systematic and is used to:

1. Establish a performance baseline.
2. Describe process performance or stability.
3. Describe the dimensions of performance relevant to functions, processes, and outcomes;
4. Identify areas for more focused data collection to achieve and sustain improvement.

When findings relevant to an individual's performance are identified, Medical Staff Leaders and Hospital Management/Administration are responsible for determining the use of the findings in the peer review process. This is accomplished in accordance with the Medical Staff Bylaws. Department/Service Directors shall act in accordance with the "Performance Evaluations" and "Education, Training and Competency of Employees" under the Human Resources policies.

West Suburban Medical Center requires an intense analysis or root cause analysis of undesirable patterns or trends in performance when the following is identified, which includes, but is not limited to:

1. Performance varies significantly and undesirably from that of other organizations;
2. Performance varies significantly and undesirably from recognized standards;

3. When a sentinel event occurs;
4. Blood Utilization to include confirmed transfusion reactions;
5. Significant adverse drug reactions;
6. Significant medication errors, close calls, and hazardous conditions;
7. Significant discrepancies between preoperative and postoperative diagnoses, including pathologic diagnoses;
8. Significant adverse events related to using moderate or deep sedation or anesthesia;
9. Hazardous conditions;
10. Staffing effectiveness issues; and
11. ORYX core measure data that, over three or more consecutive quarters for the same measure, identify the hospital as a negative outlier.

**Improvement and Reporting**

The Performance Distinction Council does the following:

1. Collaborates with department managers, staff, and others to create and implement corrective actions to address identified areas for improvement.
2. Monitors effects of all corrective actions through additional data collection and analysis activities.
3. Identifies corrective actions that do not result in expected or sustained improvement.
4. Continues the cycle of creating, implementing, monitoring, and evaluating corrective actions.
5. Reports to leadership on the implementation and results of performance improvement activities. This occurs at least quarterly.
6. Reports incidence data on MDRO, CLABSI, and SSI to key stakeholders, including but not limited to the following:
    - Leaders
    - Licensed independent practitioners
    - Nursing staff
    - Other clinicians

Leadership does the following:

1. Reviews this plan at least annually.
2. Updates this plan to reflect any changes, including but not limited to changes in the following:
    - Strategic priorities
    - Internal or external environment (such as patient population, community health metrics, and so on)

**Improvement Model and Methodology**

Once a decision has been made to implement an improvement strategy, the organization systematically improves its performance using the Plan-Do-Study-Act (PDSA) methodology. Organization-wide Performance Improvement (PI) Teams are developed and use the PDSA model to make improvements in a specific process. Unit based PI Teams and other PDSA Teams are utilized and can form on their own to address unit-specific needs.

Decisions to act upon opportunities for improvement in care or patient safety and/or investigate concerns shall be based on opportunities identified, factors involved in measurement, required resources, and the overall mission and priorities for the organization.

Consideration is given to the expected impact or improvement on the dimension of Quality or Patient Safety. Performance expectations are set by those involved in the process. Indicators are developed and all individuals, professions, and departments involved in the process are included.

## PROACTIVE RISK ASSESSMENT

At lease every 36 months, the system selects one high-risk process and conducts a proactive risk assessment. The processes that have the most potential for affecting patient safety and reducing the risk of medical errors should be part of the criteria for selection. Once the potential process failure points are identified and analyzed, processes are

redesigned to minimize the risk of harm. Newly redesigned processes are tested and implemented and monitored on an ongoing basis to ensure effectiveness.

## EDUCATION

Safety and Performance Improvement education is provided during orientation and on an ongoing basis throughout the organization. Presentations are provided to teams, committees, medical staff, individuals and leadership. Guidance is provided for proactive risk assessments Intense Analysis and Root Cause Analysis (RCA) either by training or facilitation. Just-in-time training is provided as needed.

## COMMITMENT TO COMMUNITY

West Suburban Medical Center is committed to the care of the individuals in the communities it serves. In an effort to provide the highest quality care, WSMC has initiated a number of avenues to seek and act on input from the community. The Governing Board is a major contributor of input on community perception of the hospital and its programs. The membership of the board is diverse and includes representation from local businesses, educational institutions and social organizations within the primary service area.

The hospital is also actively involved with wellness, screening, and prevention programs through the community including schools, local businesses, civic and other community organizations, utilizing them and their locales to provide health assessments and health education. Through other partnerships with local health care programs, we are able to gain feedback on services and how it might assist the various ethnic groups in the community.

It is the combination of the above programs that continuously provide us with input for improvement and community education opportunities.

## ALLOCATION OF RESOURCES

The CEO and President shall provide sufficient qualified staff, time, training, and information systems to assist the Performance Distinction & Patient Safety Committees, Medical Staff, Nursing, and Clinical Support Services in designing, implementing and maintaining effective Performance Improvement activities. The Directors/Managers of the organization shall allocate staff time to participate in performance improvement activities. Both external and internal education determined to be reflective of organizational priorities shall be supported through monies allocated for education. Budgetary planning shall include resources for effective information systems, when appropriate.

## CONFIDENTIALITY

The Performance Improvement and Quality Program of West Suburban Medical Center has been designed to comply with all applicable confidentiality and privacy laws. All data, reports, and minutes are confidential and shall be respected as such by all participants in the Performance Improvement and Quality Program. Confidential information may include, but is not limited to, the meeting minutes, electronic data gathering and reporting sentinel event and untoward event reporting, and clinical profiling. Information shall be presented so as to not identify specific Medical Staff members, patients, or other health care practitioners.

Data, reports, and minutes of the Performance Improvement program are the property of West Suburban Medical Center. This information is maintained in locked offices of the Quality Management Department and in departmental or administrative offices, as appropriate. Quality review data, reports and minutes shall be accessible only to those participating in the program. All other requests for information from the program shall be in writing stating the purpose and intent of the request, and shall be addressed to the Quality Management Department or Administration.

**WEST SUBURBAN MEDICAL CENTER**
**PERFORMANCE IMPROVEMENT AND QUALITY PROGRAM PLAN**
**2022**

Approved by:

Chief Quality Officer/Quality Management — Date: 3-17-2022

Chief Executive Officer — Date: 3-18-2022

Chair, Governing Board — Date: 3-29-2022

**All information in this document and the compilation of any and all data for Performance Improvement activities at West Suburban Medical Center, in furtherance of the Medical Staff Quality Improvement Program and the initiatives of the hospital is privileged and confidential, to be used solely in the course of internal quality control, for the purpose of reducing morbidity and mortality and improving the quality of patient care at West Suburban Medical Center as provided in the Medical Studies Act, Illinois revised Statutes, Ch. 51, 8-2101, et seq.*

| **WSMC** | *Feb-19* | *Mar-19* | *Apr-19* | *May-19* | *Jun-19* | *Jul-19* | *Aug-19* | *Sep-19* | *Oct-19* | *Nov-19* | *Dec-19* |
|---|---|---|---|---|---|---|---|---|---|---|---|
| Net Patient Revenue | 10,757,224 | 14,016,603 | 10,042,006 | 10,226,275 | 9,876,831 | 12,670,190 | 9,248,455 | 10,503,735 | 10,218,039 | 11,208,007 | 11,276,783 |
| Other Operating Revenue | 35,115 | 26,952 | 296,245 | 91,027 | 190,259 | 51,403 | 63,388 | 236,020 | 113,492 | 139,987 | 171,430 |
| Operating Expenses | 11,520,983 | 11,799,732 | 11,667,867 | 11,662,326 | 12,720,360 | 12,104,780 | 12,083,557 | 11,920,813 | 12,905,477 | 11,001,223 | 16,614,648 |
| Non-Operating Expenses | 969,787 | 1,026,399 | 1,105,702 | 1,089,239 | 1,039,120 | 1,032,270 | 639,943 | 612,678 | 698,124 | (1,335,296) | (11,388,588) |
| **Net Income** | **(1,698,431)** | **1,217,424** | **(2,435,318)** | **(2,434,264)** | **(3,692,391)** | **(415,457)** | **(3,411,657)** | **(1,793,736)** | **(3,272,069)** | **1,682,067** | **6,222,153** |

| **WMH** | *Feb-19* | *Mar-19* | *Apr-19* | *May-19* | *Jun-19* | *Jul-19* | *Aug-19* | *Sep-19* | *Oct-19* | *Nov-19* | *Dec-19* |
|---|---|---|---|---|---|---|---|---|---|---|---|
| Net Patient Revenue | 10,570,894 | 7,080,124 | 8,837,600 | 9,204,198 | 6,575,230 | 7,892,972 | 7,674,355 | 6,679,884 | 8,420,382 | 8,264,503 | 5,582,324 |
| Other Operating Revenue | 81,983 | 66,227 | 73,356 | 76,864 | 86,837 | 87,464 | 72,508 | (17,878) | 50,790 | 49,742 | 160,156 |
| Operating Expenses | 8,992,601 | 8,750,216 | 9,015,605 | 8,922,117 | 9,893,007 | 9,074,663 | 9,016,991 | 8,213,736 | 9,551,122 | 8,444,385 | 11,365,023 |
| Non-Operating Expenses | 472,126 | 450,251 | 515,948 | 489,373 | 532,203 | 401,962 | 386,841 | 372,837 | 427,626 | (412,118) | 225,973 |
| **Net Income** | **1,188,150** | **(2,054,117)** | **(620,595)** | **(130,428)** | **(3,763,144)** | **(1,496,189)** | **(1,656,969)** | **(1,924,567)** | **(1,507,577)** | **281,978** | **(5,848,515)** |

| **WSMC** | *Jan-20* | *Feb-20* | *Mar-20* | *Apr-20* | *May-20* | *Jun-20* | *Jul-20* | *Aug-20* | *Sep-20* | *Oct-20* | *Nov-20* | *Dec-20* |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Net Patient Revenue | 11,302,998 | 9,871,394 | 9,782,599 | 8,596,093 | 11,950,471 | 13,142,533 | 10,340,866 | 10,752,151 | 10,812,933 | 9,973,613 | 13,075,389 | 10,425,195 |
| Other Operating Revenue | 189,302 | 174,975 | 175,712 | 3,538,437 | 284,332 | 169,089 | 115,752 | 549,160 | 173,411 | 124,626 | 110,001 | 17,503,520 |
| Operating Expenses | 12,148,682 | 12,702,847 | 13,520,039 | 12,137,372 | 13,827,085 | 13,316,375 | 13,376,073 | 13,150,368 | 13,078,880 | 12,113,127 | 13,661,306 | 18,431,931 |
| Non-Operating Expenses | 233,109 | 542,287 | 643,191 | 594,703 | 619,768 | (1,458,455) | 333,843 | (150,673) | 129,918 | 266,633 | 213,292 | 1,531,405 |
| **Net Income** | **(889,492)** | **(3,198,766)** | **(4,204,919)** | **(597,545)** | **(2,212,050)** | **1,453,703** | **(3,253,298)** | **(1,698,384)** | **(2,222,454)** | **(2,281,521)** | **(689,208)** | **7,965,379** |

| **WMH** | *Jan-20* | *Feb-20* | *Mar-20* | *Apr-20* | *May-20* | *Jun-20* | *Jul-20* | *Aug-20* | *Sep-20* | *Oct-20* | *Nov-20* | *Dec-20* |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Net Patient Revenue | 7,395,707 | 7,674,153 | 6,339,009 | 5,485,746 | 7,614,741 | 7,231,711 | 7,524,808 | 7,234,621 | 7,726,749 | 7,685,416 | 8,803,408 | 6,680,615 |
| Other Operating Revenue | 112,446 | 60,951 | 81,919 | 3,263,401 | 88,223 | 70,707 | 42,216 | 93,105 | 87,478 | 118,777 | 74,601 | 18,570,217 |
| Operating Expenses | 8,860,446 | 8,721,301 | 8,645,286 | 9,665,127 | 9,797,469 | 9,604,642 | 8,408,351 | 8,795,039 | 9,253,228 | 8,800,773 | 9,141,221 | 8,570,386 |
| Non-Operating Expenses | 348,026 | 277,698 | 547,061 | 330,499 | 304,134 | (1,032,913) | 266,750 | 255,117 | (49,136) | 163,542 | 160,233 | 1,112,935 |
| **Net Income** | **(1,700,319)** | **(1,263,896)** | **(2,771,420)** | **(1,246,480)** | **(2,398,640)** | **(1,269,312)** | **(1,108,076)** | **(1,722,430)** | **(1,389,865)** | **(1,160,123)** | **(423,445)** | **15,567,511** |

| **WSMC** | *Jan-21* | *Feb-21* | *Mar-21* | *Apr-21* | *May-21* | *Jun-21* | *Jul-21* | *Aug-21* | *Sep-21* | *Oct-21* | *Nov-21* | *Dec-21* |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Net Patient Revenue | 10,796,535 | 9,728,916 | 12,127,449 | 11,293,390 | 11,501,085 | 11,517,381 | 11,593,108 | 11,478,746 | 10,967,352 | 10,487,506 | 5,794,039 | 10,310,048 |
| Other Operating Revenue | 118,294 | 124,521 | 2,210,374 | 169,869 | 3,488,952 | 1,378,966 | 151,463 | 152,425 | 4,350,742 | 122,214 | (632,698) | 577,997 |
| Operating Expenses | 12,835,730 | 12,286,363 | 13,690,265 | 12,938,070 | 12,866,910 | 12,578,866 | 12,584,539 | 12,116,942 | 11,827,644 | 12,246,798 | 12,306,426 | 15,344,720 |
| Non-Operating Expenses | 208,991 | 183,630 | 197,734 | 268,213 | 191,065 | 637,119 | 217,220 | 233,335 | 205,696 | 514,639 | 288,285 | 1,249,074 |
| **Net Income** | **(2,129,892)** | **(2,616,556)** | **449,824** | **(1,743,024)** | **1,932,062** | **(319,638)** | **(1,057,188)** | **(719,106)** | **3,284,754** | **(2,151,717)** | **(7,433,370)** | **(5,705,749)** |

| **WMH** | *Jan-21* | *Feb-21* | *Mar-21* | *Apr-21* | *May-21* | *Jun-21* | *Jul-21* | *Aug-21* | *Sep-21* | *Oct-21* | *Nov-21* | *Dec-21* |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Net Patient Revenue | 7,132,421 | 7,053,029 | 8,149,288 | 7,791,127 | 7,760,280 | 7,933,045 | 7,646,416 | 7,917,768 | 8,098,687 | 8,525,876 | 4,535,968 | 7,709,737 |
| Other Operating Revenue | 53,939 | 57,932 | 996,769 | 68,851 | 272,756 | 1,228,111 | 65,312 | 101,693 | 129,234 | 105,791 | (900,218) | 38,211 |
| Operating Expenses | 8,808,901 | 8,329,907 | 9,210,657 | 8,641,950 | 8,893,919 | 8,606,915 | 8,417,973 | 8,924,874 | 9,267,967 | 9,394,432 | 9,720,001 | 6,960,594 |
| Non-Operating Expenses | 263,207 | 181,674 | 191,615 | (29,077) | 318,593 | 437,935 | 226,620 | 200,442 | 206,107 | 504,440 | 508,001 | 2,467,021 |
| **Net Income** | **(1,885,749)** | **(1,400,619)** | **(256,214)** | **(752,895)** | **(1,179,475)** | **116,306** | **(932,865)** | **(1,105,855)** | **(1,246,154)** | **(1,267,206)** | **(6,592,252)** | **(1,679,667)** |

| **WSMC** | *Jan-22* | *Feb-22* |
|---|---|---|
| Net Patient Revenue | 13,188,435 | 9,707,292 |
| Other Operating Revenue | 1,659,342 | 138,823 |
| Operating Expenses | 15,610,899 | 14,361,515 |
| Non-Operating Expenses | 281,814 | 285,478 |
| **Net Income** | **(1,044,935)** | **(4,800,878)** |

| **WMH** | *Jan-22* | *Feb-22* |
|---|---|---|
| Net Patient Revenue | 9,324,484 | 7,587,601 |
| Other Operating Revenue | 86,581 | 70,595 |
| Operating Expenses | 10,356,833 | 9,745,859 |
| Non-Operating Expenses | 286,741 | 308,294 |
| **Net Income** | **(1,232,508)** | **(2,395,957)** |