Rome Memorial Hospital & Residential Healthcare Facility's
2019-2020 Performance Improvement (PI) Plan Quality Goals

1. DEVELOP, IMPLEMENT AND MAINTAIN AN EFFECTIVE, ONGOING, HOSPITAL-WIDE, DATA DRIVEN QUALITY ASSESSMENT AND PERFORMANCE IMPROVEMENT (PI) PROGRAM TO ACHIEVE ZERO HARM.

For the 2019-2020 PI period, focused patient safety related initiatives are as follows:

CRITICAL TEST RESULTS MANAGEMENT (CTRM)

Rationale: Critical test results management (CTRM) is the process of communicating important imaging findings for immediate or future action, as defined in Policy *ADM-016 Reporting Critical Results, Tests, and Values*. To augment compliance and auditing capabilities of the current manual critical tests results reporting process, Rome Memorial Hospital has implemented a dedicated closed loop electronic CTRM system through which providers receive notifications of diagnostic radiology findings. To date, provider usage of the results portion of the tool has been incompletely adopted, making it difficult to standardize the hospital's response to critical test results.

Goal(s):
1. 100% of providers within the Greater Rome Affiliates umbrella will utilize the dedicated closed loop electronic CTRM system
2. 100% of new providers within the Greater Rome Affiliates umbrella will be set up with the necessary application and associated training during their medical staff onboarding process
3. 95 % of level red alerts will be reported by radiologist within 30 minutes of test completion
4. 95 % of level red alerts will be acknowledged within 60 minutes of notification
5. 95 % of level orange alerts will be acknowledged within 3 hours of notification

Strategies:
- Enhancement of provider onboarding training to stress the importance of CTRM and the associated obligations of each provider
- Elicit feedback from users to assist in determining education/training needs and identifying potential process improvement opportunities
- Delivery of CTRM compliance results at the practice/department level with accompanying messages/guidance/strategies for ongoing or improved outcomes
- Data will be reviewed at the Performance Improvement Committee on a bi-monthly basis as well as at the monthly Radiology Department meeting

Frequency of data collection:
- Practice/provider level data will be collected on a monthly basis

SEPSIS RESPONSE PROCESS

Rationale: While RMH has improved consistently in our adherence to the sepsis treatment bundles adopted by CMS and NYS over the past several years, we are capable of even greater results. Sepsis is a medical emergency and thus reliant on timely diagnosis and prompt treatment. The link between pperformance improvement efforts for sepsis and improved patient outcomes has been well established. To that end, New York is one of several states with mandated sepsis reporting, and effective in 2018, sepsis response and outcomes were incorporated into the CMS **Hospital Compare** quality ratings report.

Goal(s):
1. Achieve no less than the 75th percentile for NYS and CMS sepsis outcomes measures for sepsis-bundle adherence

2. Achieve no less than the 75th percentile for CMS reported Sepsis mortality rate

Strategies:
- Reconvene monthly multidisciplinary Sepsis workgroup
- Disseminate timely outcomes data to front-line staff
- Move to concurrent analysis of sepsis bundle adherence as opposed to current retrospective review
- Respond to all bundle element failures with support of department leadership
- Track and trend sepsis mortality cases

Frequency of data collection:
- Compile internal sepsis bundle adherence monthly
- Case abstraction submitted to CMS (through Press Ganey) and NYS (IPRO) quarterly
- Mortality reviews as needed based on abstraction outcomes

FALLS REDUCTION AND MANAGEMENT PROGRAM

Rationale: Fall prevention requires the active engagement of a multidisciplinary team of individuals involved in caring for the patient, an organizational culture of safety and support for operational practices that promote teamwork and communication. A falls reduction and management program must also recognize and balance the importance of patient mobility and the need to minimize restraint utilization.

Goal(s):
1. Decrease inpatient fall occurrences to 2.3/1000patient days. This is based on the New York State Partnership for Patients (NYSPFP) benchmark. This compares us to 138 other facilities.

Strategies:
- Set an expectation for completion of unit-based post fall huddles for all falls and audit for compliance
- Conduct weekly fall QAPI meetings with risk management, unit leaders (when fall occurs on their unit), and the director of professional development
- Reinforce and monitor the established functional mobility program for adherence and desired outcomes.

Frequency of data collection:
- Occurrence entry into the events management system; weekly review of falls for QAPI; monthly falls data aggregated and distributed to patient safety committee; monthly data uploaded into NYSPFP system

2. MEASURE AND RESPOND TO ORGANIZATION-WIDE PATIENT SATISFACTION DATA

Rationale: Current research demonstrates a correlation between patient satisfaction and healthier outcomes. Additionally, patient satisfaction is highly correlated with patient retention. The measurement of patient satisfaction allows healthcare providers the opportunity to analyze their processes and improve their care delivery. This goal supports the triple aim model of improving the patient experience of care improving the health of populations, and reducing the per capita cost of health care. The goal also drives the standard of care delivered by health care providers by regularly utilizing evidence-based methods of improving a patient's experience.

Achieve sustained improvement in Inpatient, Emergency Department and Outpatient Ambulatory Surgery patient satisfaction survey results

Goal(s):

1. Achievement and maintenance of the 75th percentile for Hospital Inpatient and Outpatient Ambulatory Surgery CAHPS with an ultimate strategic goal of achieving the 90th percentile.
2. Achievement and maintenance of the 90th percentile in all domains for the Emergency Department patient satisfaction survey

Strategies:

- Department/Unit rounding, education, and implementation of evidence-based patient experience strategies
- Enhanced oversight by the Director of Patient Experience of internal non-CAHPS patient satisfaction surveys, inclusive of survey revisions, survey dissemination, data collection, results compilation and outcomes reporting
- Measure accountability of all patient satisfaction domains by department/service to identify areas for improvement and develop action plans where there are opportunities for improvement
- Timely dissemination of department/unit/service level patient experience data. Includes patient experience data collection of inpatient units, Emergency Department (ED) Outpatient Ambulatory Surgery, and internal patient satisfaction survey results from all other outpatient service departments.

Frequency of data collection:

- Press Ganey patient satisfaction data aggregated monthly.
- Survey comments reports available weekly for review.
- Outpatient services internal survey data aggregated quarterly, inclusive of comments reports.
- All performance improvement activities related to improving the patient experience will include measurable goals and plans for sustainability. These activities will be included in the quarterly patient experience reports sent to the BOT and PI committee.

Redesign the internal patient satisfaction survey process for outpatient service departments by Q2 2020

Goal(s):

1. Develop a consistent framework for outpatient satisfaction survey content by 4Q2019
2. Standardize the outpatient survey process by end of year 2019
3. Implement new process Q1 2020

Strategies:

- Outpatient department rounding, education, and implementation of evidence-based patient experience strategies
- Enhanced oversight by the Director of Patient Experience of internal non-CAHPS patient satisfaction surveys, inclusive of survey revisions, survey dissemination, data collection, results compilation and outcomes reporting

- Measure accountability of all patient satisfaction domains by department/service to identify areas for improvement and develop action plans where there are opportunities for improvement
- Timely dissemination of department/unit/service level patient experience data

Frequency of data collection:

- Outpatient services internal survey data aggregated quarterly, inclusive of comments reports.
- All performance improvement activities related to improving the patient experience will include measurable goals and plans for sustainability. These activities will be included in the quarterly patient experience reports sent to the BOT and PI committee.

3. STUDY AND IMPROVE SAFE MEDICATION ADMINISTRATION AND APPLICATION OF BEST PRACTICE FOR MEDICATION UTILIZATION WITHIN THE FACILITY.

For the 2019-2020 PI period, these projects will include:

INPATIENT GLYCEMIC CONTROL

Rationale: The inpatient glycemic control workgroup is focused on the incorporation of evidence-based glycemic control practices, i.e. the basal-bolus protocol, within our inpatient units. The nursing, pharmacy and hospitalist functions will continue to work together to enforce best-practice utilization of the Basal-Bolus protocol. A significant degree of progress was achieved in 2018 but there are ongoing opportunities in reducing the volume of oral antiglycemic agents (through use of basal-bolus protocol), and reducing our percentage of hyperglycemic blood glucose results >200mb/dL, and >300 mg/dL during point of care testing.

Goal(s):

1. Meet or exceed NYSPFP benchmark for hyperglycemic POCT blood glucose results for >200 and >300 mg/dL
2. Meet or exceed NYSPFP benchmark for hypoglycemic POCT blood glucose results for <40 and <70 mg/dL
3. Increase use of glycemic control protocol by 20%

Strategies:

- RPh reviews patients with insulin orders upon admission
- Provider and Pharmacy discuss Insulin Management and orders during patient stay
- Pharmacy discusses the reasoning with patient for Basal Bolus and discontinuation of oral agents during acute stay

Frequency of data collection:

- Monthly entry of POCT result numerator and denominator data into NYSPFP database

MEDICATION OCCURRENCE FOLLOW-UP AND REVIEW

Rationale: The collection and analysis of data related to medication-related hazardous conditions, near-misses, errors, and other adverse drug events has been proven to have a profound effect in the prevention of these events. Additionally, this practice strengthens the improvement process related to safe medication use.

Goal(s):

1. Zero category E or greater medication occurrences: These are medication occurrences that result in patient harm.

Strategies:

- Encourage reporting of unsafe conditions, near misses and errors that had the potential to cause harm (Category A, B, C, and D) so that processes or circumstances that have the potential to lead to errors can be assessed and mitigated before any harm reaches our patients.
- Timely review of all medication events to determine the contributing factors and reduce the risk of repeat errors
- Application of a Just Culture approach to medication errors to ensure that we are not overly punitive in our response to the error and failing to address contributing factors related to systems/process failures
- The medication reconciliation process at both admission and discharge will be reviewed in detail to identify opportunities to strengthen the process and eliminate as many potential risks to patient safety as can be controlled for

Frequency of data collection:

- Data will be collected and reviewed monthly at the departmental level and presented monthly to the Medication Safety Committee and the BOT Quality Council, inclusive of action plans for areas for improvement.

OPIOID STEWARDSHIP INITIATIVE

Rationale: There must be an organization wide commitment to applying best practice standards to the administration, prescription, and maintenance practices related to opioids. In 2018 the emergency department committed to participation in the IHA Opioid Alternative (ALTO) Project. The program is aimed at reducing the administration of opioids in New York State Emergency Departments (ED). Modeled after a similar initiative in Colorado, the ALTO takes a unique approach to pain management by administering alternatives to opioids (ALTOs) for certain conditions. Those conditions include: Musculoskeletal pain, headache, renal colic, dental pain, and abdominal pain. Additionally, our outpatient primary care practices have worked diligently to address opioid management

Goal(s):

1. Convene the appropriate members and champions across the continuum of care
2. Define the scope of the program within our institution and our ability to fully implement opioid reduction initiatives

Strategies:

- Gather baseline data related to the qualified conditions for the program and overall utilization of opioids
- Educate core fundamentals of the program to oncoming physicians and all those that come in contact with the patient and provide patient care
- Examine any secondary effects on decreased opioid utilization that could be shown through a decrease in overall opioid prescriptions
- Order sets will be created in T-system that include ALTO in the diagnosis. A physician has the option to click the order set and it offers alternative options to opioids.
- Educate core fundamentals of the program to oncoming physicians and all those that come in contact with the patient and provide patient care
- Examine any secondary effects on decreased opioid utilization that could be shown through a decrease in overall opioid prescriptions
- When a new physician is recruited, they will be directed to and educated on the cheat sheet for ALTO. Nursing will play a pivotal role in having discussions with the physician prior to prescribing an opioid and educating them if necessary on the alternatives available.

Frequency of data collection: Monthly report through IT, Quality, and the ED to determine utilization of opioids that is will be reported out to the Emergency Department (ED) Committee and filtered out by the conditions listed in the original aim of the project.

4. STRATEGICALLY AND METHODICALLY INCORPORATE JUST CULTURE PRINCIPLES AS AN EVERYDAY PART OF THE ORGANIZATIONAL CULTURE

Defined: Just Culture is the awareness by everyone throughout the organization about the inevitability of medical errors; but all errors and unintended events are reported, even when the events may not cause patient injury. A culture of safety balances learning and accountability for behavioral choices with organizational and individual values, and fosters transparency, trust and open communication: all that promote the delivery of highly reliable, safe, and quality care.

Goal(s):

1. 100% of Root Cause Analyses will include front-line staff participation
2. At least 90% of reviews of post occurrence follow-up actions will support the application of Just Culture values

Strategies:

- Develop checks and balances (i.e. monitoring and follow-up) to ensure application of Just Culture values in response to errors. No fewer than 10% of occurrence reports will be audited to determine if just culture concepts are appropriately applied during the incident investigation and follow-up process. Any trending that may be identified through these reviews will result in additional staff and leadership education.
- Conduct the Agency for Healthcare Research & Quality (AHRQ) Safety Culture Survey in 2019

Frequency of Data Collection: Data will be collected monthly to investigate the application of Just Culture practices in response to occurrences and/or incidences. To ensure application of Just Culture concepts, analysis will look at follow-up on the corrective action directed toward the unit the occurrence/incident took place.

5. BUILD A PHYSICIAN PEER SUPPORT INFRASTRUCTURE FOR MEMBERS OF THE MEDICAL STAFF THAT SUPPORTS BEST PRACTICE

Rationale: Increase physician engagement in key initiatives and committees where there is not enough interdisciplinary representation. Increase physician willingness to champion key initiatives for others to follow.

Goal(s):

1. All multidisciplinary patient safety/quality performance improvement initiatives will include at least one medical staff member on the project team to ensure that physician expertise and perspectives are present throughout the performance improvement process.
2. All multidisciplinary safety/quality performance improvement initiatives facilitated through the Quality and Performance Improvement Department will report their outcomes through an appropriate medical staff communication platform to ensure that the medical staff are included in updates related to such initiatives.

Strategies:

- Identification of physician champions appropriate to each major patient safety/quality initiative
- Ensure that providers are afforded an opportunity to give input at the outset of significant performance improvement undertakings as opposed to notification of major changes after the fact.
- Onboarding of providers will include notification of quality initiatives and an open invitation to participate in these efforts.

Frequency of Data Collection:

- Data collection will be dependent upon the individual parameters of each project, however updates should be given no less than quarterly to appropriate sources. An accounting of provider participation in significant patient safety/quality initiatives will be submitted to the MEC on a quarterly basis.

6. EVOLVE AND SUSTAIN A COMPREHENSIVE CARE TRANSITIONS MODEL FOR IMPROVED PATIENT OUTCOMES ACROSS THE CONTINUUM OF CARE

For the 2019-2020 PI period, these projects will include:

READMISSIONS REDUCTION

Rationale: Reduction of hospital wide 30-day readmissions for top diagnoses and patients with high hospital utilization. Drive population health initiatives by identifying disparate and high-risk populations that are more susceptible to being readmitted to the hospital. Improve on the safety and quality of care of RMH's patients. Improve on results that are reflected in value-based purchasing penalties vs. incentives.

Goal(s):

1. Exceed CMS and other payer specific readmissions benchmarks
2. Achieve maximum incentive payments through Excellus BCBS payer incentive program
3. Systematically reduce number of avoidable readmissions, based on internally agreed upon data sources, from quarter to quarter (since CMS data is a minimum of 12 months old)

Strategies:

- MAX NY goals aligned with 30-day readmissions reduction efforts for rapid cycle improvement process application
- Internal readmission workgroup focusing on readmissions diagnoses,-discharge planning, post-acute access to resources, and social determinants of health.
- Restructuring the care transitions process to include crucial information for patients leaving the hospital for continuity of their patient information to other healthcare services (home care, primary care, specialty care, skilled nursing)
- Identification of commonalities and patterns within our readmissions cases and development of improved data analysis to better focus our readmissions reductions efforts
- Evaluate historical readmissions data related to pneumonia, heart failure, acute myocardial infarction (AMI), chronic obstructive pulmonary disease (COPD), elective primary total hip arthroplasty and/or total knee arthroplasty (THA/TKA),
- Observation status utilization discussions
- Review of all cases in which a patient returns to the facility within 72 hours of readmission

Frequency of Data Collection: Monthly internal readmission report, inclusive of diagnosis information; review of all 72 hour returns to facility is ongoing and reported to the readmissions workgroup monthly, utilization review concerns stemming from readmission data analysis will be brought to PI Committee for discussion.

PATIENT-CENTERED LENGTH OF STAY REDUCTION INITIATIVE

Rationale: Systematically addressing the efficiency of care delivered has been linked to reductions in length of stay (LOS) and improved patient outcomes. An initiative designed to reduce LOS has the potential to lower cost and improve patient throughput, enabling the hospital the serve more patients. This will require communication and collaboration between the hospital, community providers, patients and families.

Goal(s):

1. Fewer than 10% of observation status admissions will exceed 2 midnights.
2. Reduction of LOS achievements will not negatively impact readmissions
3. Achieve and sustain an overall medical/surgical LOS of 3.5 days within 12 months

Strategies:

- Establishment of an Efficiency of Care Committee to take a patient-centered approach to LOS.

- Robust monitoring of hospitalist and non-hospitalist LOS data. Tracking by diagnosis, medical service, provider, etc. will allow the team to identify actionable trends related to length of stay.
- Systematically address, through the multidisciplinary team, the identified barriers to efficient patient care
- Case reviews discussed with the multidisciplinary team as learning opportunities
- Utilization of our events reporting system to document cases of extended LOS and their associated barriers to discharge. The data coming out of this effort will assist in efforts to identify and remove barriers that we have control over.
- Reports of workgroup progress will be provided to the PI

Frequency of Data Collection: There are a variety of data collection activities related to this initiative. Daily team review of LOS and processing of extended LOS cases within the events portal, monthly comprehensive LOS reports through finance, and any performance tracking related to barrier elimination plans. Collectively, the LOS data will be consolidated into a committee dashboard that will be presented to the Performance Improvement Committee, Quality Council, Medical Executive Committee, Hospital Executive and Leadership Teams, and the MAXNY Coalition.

7. INVENTORY QUALITY METRICS AND BENCHMARKS

Rationale: Increase transparency of information. Support current and proposed new initiatives with data and minimize any confusion on the source of data. Support cohesiveness and communication of departments by sharing information during team meetings and committees. Support patient safety initiatives throughout the hospital through consistency of data collection and reporting practices (ex. Medication Occurrences, Sepsis Workgroup, Readmissions, Falls, Complaints & Grievances and Wound Management).

Goal:

- Centralization of data and analytics in the hospital
- Performance improvement workgroup and departmental folders within will be created for the storage of department level QA information no later than Q4 2019 (except for clinical services which has a central location already)
- All multidisciplinary performance improvement initiatives will collaborate with the quality and performance improvement department to ensure that projects objectives are defined and consistent with organizational goals and priorities, resources are properly defined and appropriately allocated and that the appropriate reporting structure is in place for accountability and sustainability of results.

Strategies:

- Develop leadership skills specific to QAPI
- Relocate all data and information related to continuous preparedness, quality assurance and ongoing performance improvement in a centralized K: drive location easily accessible to leadership and other key team members
- Establish project development expectations and supportive tools to keep performance improvement initiatives moving forward and to ensure sustained results

Frequency of Data Collection: Daily, weekly, monthly, quarterly, and annually as determined by plans of corrective actions resulting from surveys, ongoing regulatory requirements, and internal performance improvement activities.