Rome Memorial Hospital & Residential Healthcare Facility's
2018-2019 Performance Improvement (PI) Plan and Quality Goals

1. MEASURE QUALITY AND PATIENT SATISFACTION FOR ALL PATIENT CARE UNITS

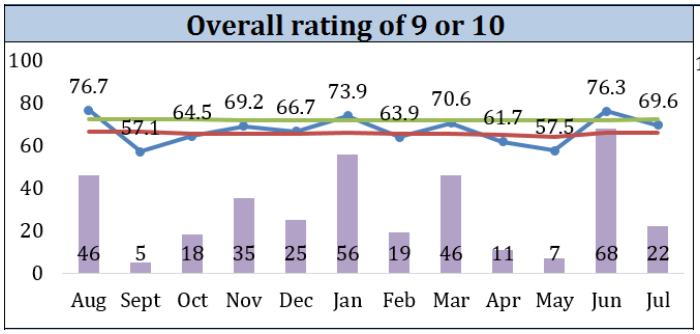
Rationale: Current research demonstrates a correlation between patient satisfaction and healthier outcomes. Additionally, patient satisfaction is highly correlated with patient retention. The measurement of patient satisfaction allows healthcare providers the opportunity to analyze their processes and improve their care delivery. This goal supports the triple aim model of improving the patient experience of care (quality and satisfaction), 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.

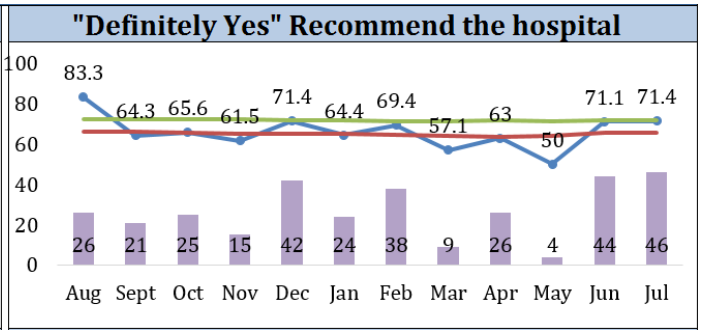
Strategies:

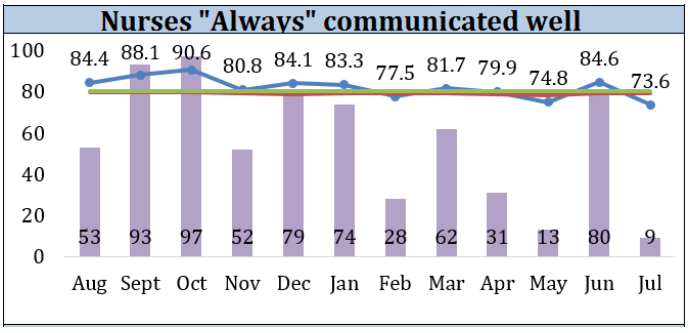
- Rounding, education, and implementation of evidence-based strategies
- Measure accountability of all patient satisfaction domains by department/service to identify areas for improvement and develop action plans where there is opportunity for improvement
- Includes data collection of inpatient units, Emergency Department (ED) and outpatient Ambulatory Surgery

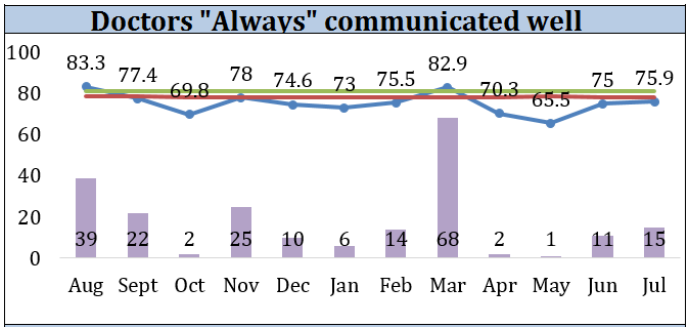
Frequency of data collection: Data will be collected and reviewed monthly at the departmental level and presented quarterly to the BOT Quality Council inclusive of action plans for areas for improvement.

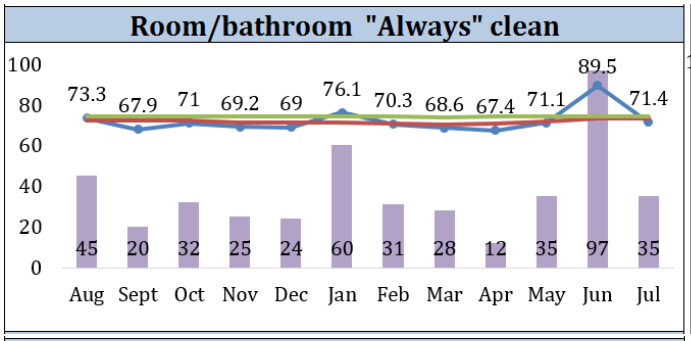
OVERALL RMH HCAHPS RESULTS (% "Always/Strongly Agree")

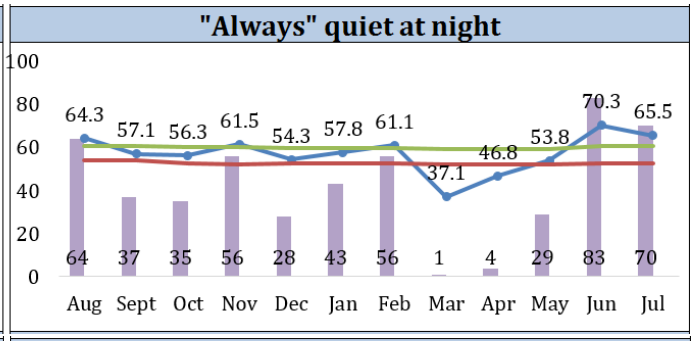


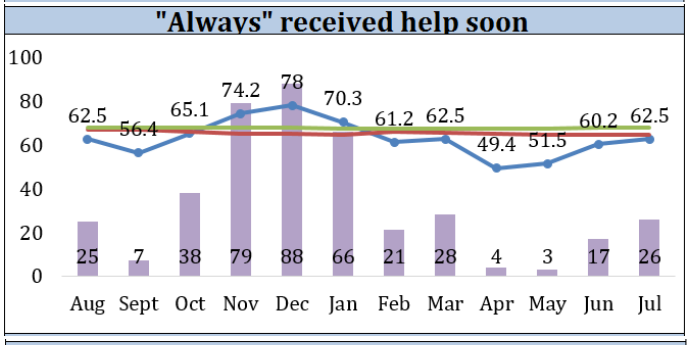


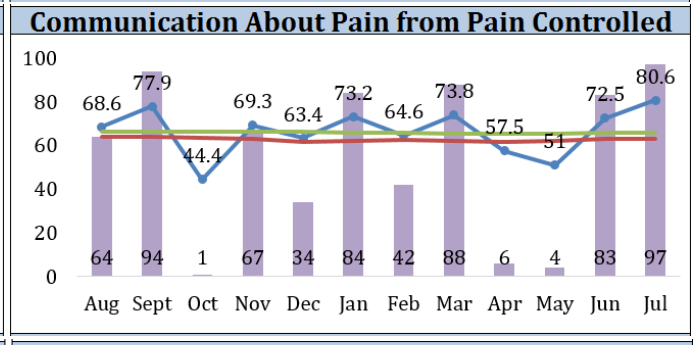


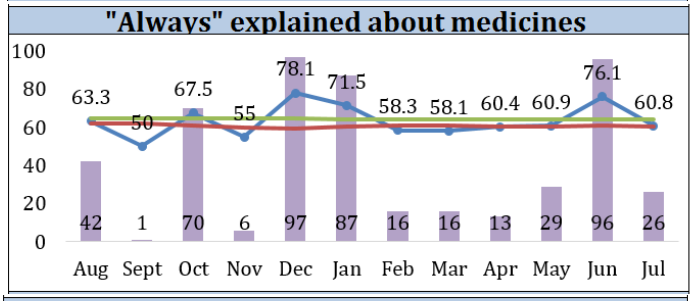


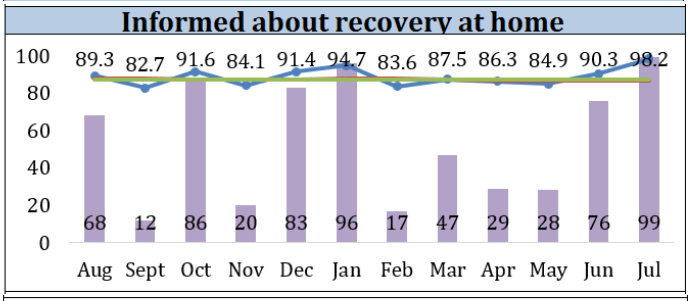


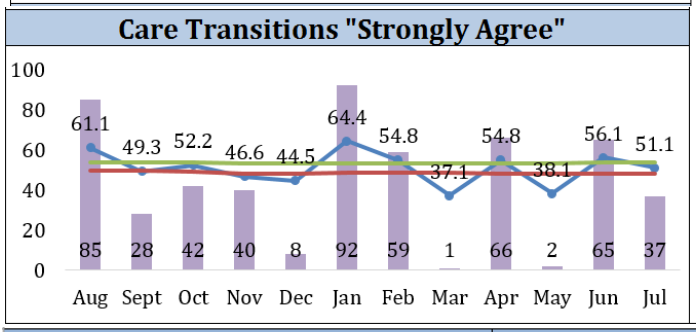


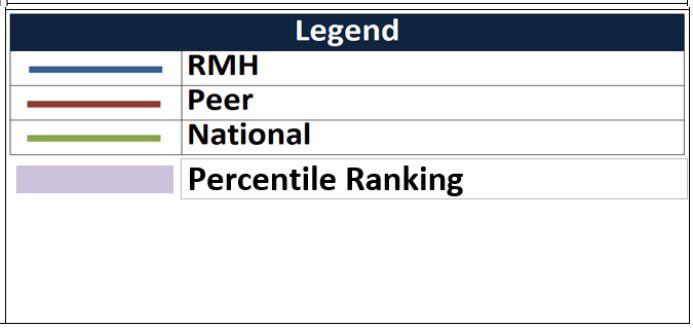












"n" = number of respondents	2018					2019						
	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul
	30	28	31	26	42	46	37	36	38	31	38	29

OVERALL RMH PATIENT SATISFACTION UPDATES PER DOMAIN

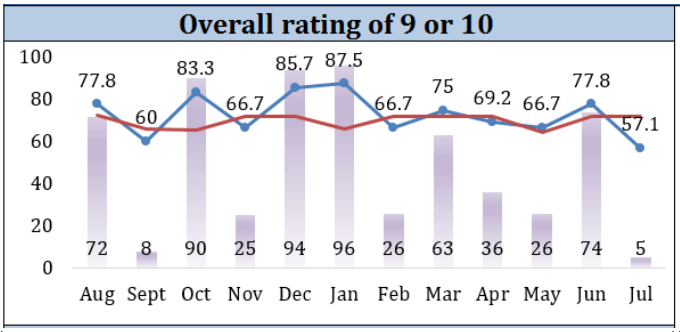
Domain	Update on activities that influence each Patient Satisfaction domain
Nurses "Always" communicated well	The formal SBAR handoff tool, generated from clinical care station was implemented with the expectation that it would be printed out each shift to provide on coming primary nurses with pertinent information regarding their patients. The tool is being used with more consistency. Charge nurse huddles with safety, experience and quality topics chosen by nursing leadership with input from charge nurses were implemented in all nursing units. The intent is to deliver a consistent message to the staff to address opportunities for improved care. Topics change weekly has messages and specific behaviors are hardwired or kept on to ensure messages are delivered and expected behaviors are demonstrated consistently. Ensuring that patients and

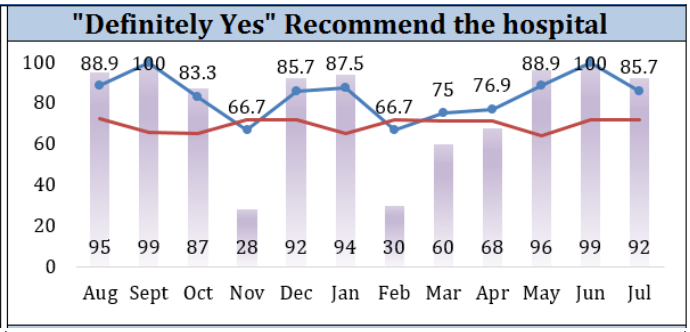
	their families' feel that they are listened to, well informed about care, and integrated into the patient care process is a major driver of patient satisfaction.
Doctors "Always" communicated well	The majority of our patients are answering "always" to the physician communication domain, however, RMH remains below the national average, impacting our overall score. Ensuring doctors round on their patients timely and explain plans of care in a way that patients understand are areas of focus. It has been discussed at the medical executive committee the need and obligation for our providers to commit to focusing on quality of their interactions with their patients. As part of the Relationship Based Care model, team rounding with the hospitalist, case manager and primary nurse, and other ancillary clinical services will begin in June, 2019 and is expected to create an efficient and supportive environment through which team communication is enhanced, allowing physician and other team members to spend the necessary time at the patient bedside.
Informed about recovery at home	Historically, RMH has performed well in this measure, although we have seen a decline in the first several months of 2019. Discharge phone calls are being made with an option for patients to hear a recording of their discharge instructions at home and they may listen to their instructions as many times as they need. Additionally, Pharmacists are stationed on the floors to meet with patients throughout their stay and at discharge to discuss their medication lists and address questions prior to discharge. An ongoing source of frustration for patients is the length of our written discharge instructions. An improved discharge instructions format is under development through an interdisciplinary workgroup and input from the Patient Family Advisory Council. The revised format is expected to be introduced by the end of July 2019.
Care Transitions "Strongly Agree"	This particular domain is heavily influenced by the extent to which patients and their families feel that they are part of the care team. Consistent and frequent communication with the patient and their families is key. When messages between team members are inconsistent misunderstandings about discharge expectations are more likely to occur. A team of case managers, nurses, and nurse leaders has been pulled together with the patient experience team to identify opportunities to eliminate miscommunication. It is anticipated that interdisciplinary rounding and a more defined role for continuum of care related to communication surrounding transitions in care will positively influence this domain. Of particular importance is the incorporation of caregivers and family into the discharge planning process.
Rate this hospital "9 or 10"	Overall, patients state they would rate the hospital at an 8, 9, or 10 on their surveys, and the goal is to move patient's ratings up the scale from an 8 to a 9 or from a lower number up the scale. There has historically been notable inconsistency in these domains. The smallest acts of compassion will often have a much greater impact on the overall experience than the routine medical care itself. Too many of our patient complaints and grievances center around breakdowns in communication and insensitivity to the needs of the patient and family. To help us add an additional element of communication and connection with our patients, the Ambassadors Program began November 1st, 2018 with team members from Medical Records, Patient Access, Building Services, Plant Operations and Performance Improvement rounding on patients so that whenever possible we can address concerns in real time and give patients a chance to share their experience before leaving the hospital. Initial reports indicate patient and staff satisfaction with the program although there is more work to be done to increase the visibility of the ambassadors as well as in sharing the feedback they are receiving from our patients. As Ambassadors settle in to rounding, more rooms will be assigned and additional Ambassadors will be assigned to rooms. All patient rooms are expected to have an assigned ambassador by the end of the second quarter 2019. Clinical Services and the Patient Experience department are collaborating on a new model for the review and application of performance improvement centered on the patient experience. It is expected that with interdisciplinary rounds and a new patient satisfaction performance improvement model, these domains will improve as a reflection of improved relationship based care.
Likelihood of Recommending	
Communication About Pain from Pain Controlled	The high variability of this domain appears to reflect inconsistency in staff practice in how pain is discussed with patients. This has not been a domain with specific targeted efforts for the past 6 months. There is a clear need to identify current staff practice, particularly as it relates to how we discuss pain and pain management with our patients.
"Always"	Pharmacists are on the floors to assist with medication questions. More than half of our patients

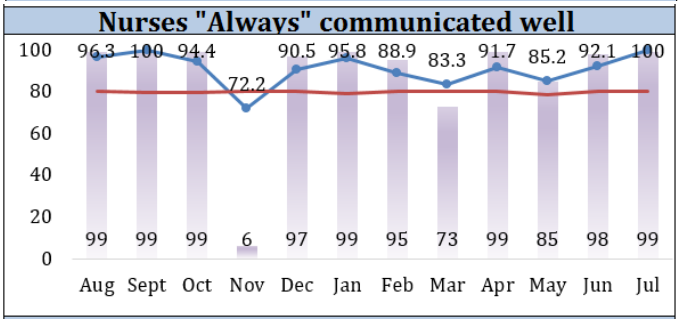
explained about medicines	stated they were "never" given information about medication side effects or told what their new medications were for. This is an area of opportunity to educate our primary nurses on the importance of discussing medications and side effects each and every med pass. Patient safety post-discharge is compromised when patients and their families do not understand indications for and potential side effects of the medications that are prescribed. This domain continues to be difficult to manage, even though there was marked improvement in December 2018 and January 2019. Utilization of the pharmacists on the units to assist in answering patient questions about medications and the incorporation of pharmacy into the multidisciplinary rounds starting in June should both help with this domain.
Hospital Environment "Quietness"	To address lagging quiet scores, "Quiet at Night" signs have been placed in all patient rooms near the whiteboards offering comfort items and promoting creating a calm, healing environment. Noise monitors have been purchased with support from the Bright Ideas Fund, to monitor and record decibel levels in strategic patient care areas. Data will be provided to each unit to determine what time of day tends to have increased noise levels and the monitors will provide a visual for all staff, patients and visitor to help maintain a calm, quiet environment. This PI project will be fully implemented by July 1, 2019.
Hospital Environment: Cleanliness "Room and Bathroom Always Kept Clean"	Efforts going in to the 1st quarter of 2019 to improve patients perceptions of cleanliness include: a clean rounds with a member of the Patient Family Advisory Council (PFAC) to see the hospital from a patient's perspective (completed March 15th, 2019);Weekly clean rounds with Building Services Director and VP of Support Services; increased collaboration between Building Services and Nursing to engage in more frequent changes in bed linen or making patients beds when they are out of the room for tests as well as scheduling room cleaning while patients are at a test with some form of signage stating their room has been cleaned while they are out.

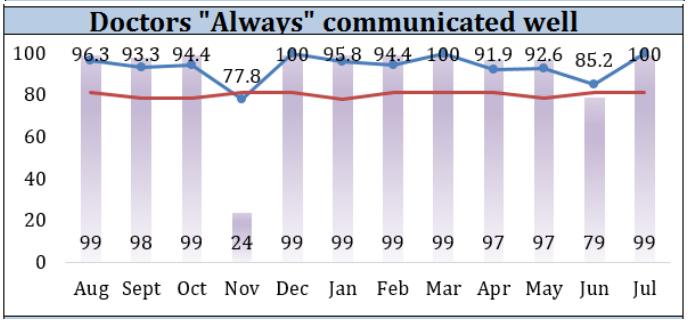
UNIT SPECIFIC HCAHPS DATA

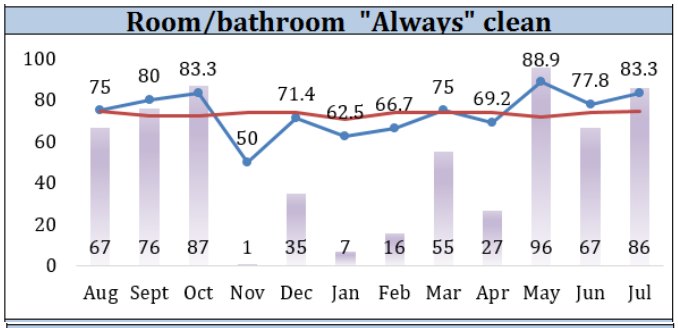
MATERNITY UNIT

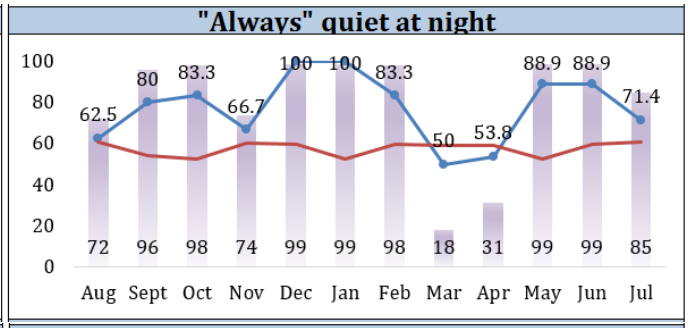


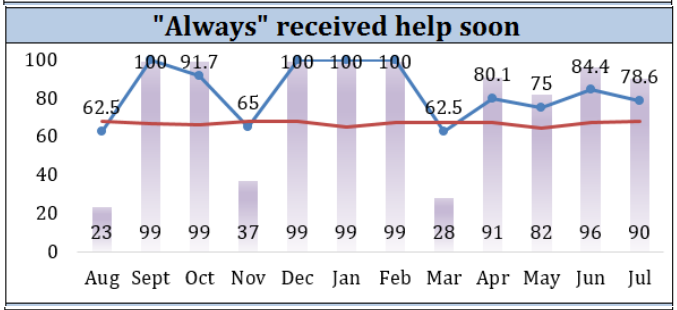


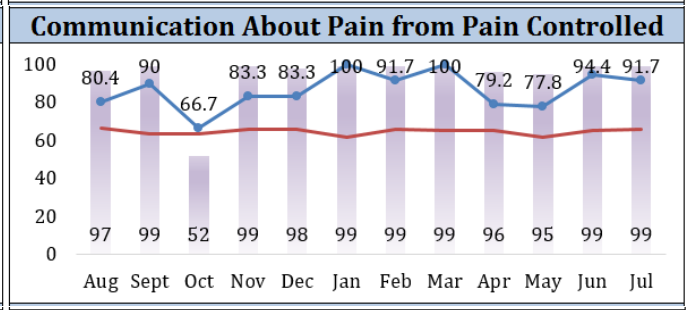


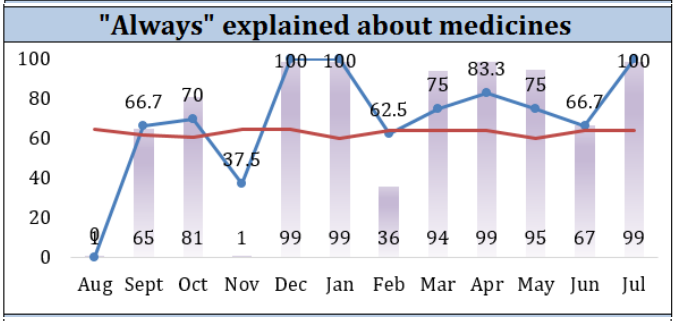


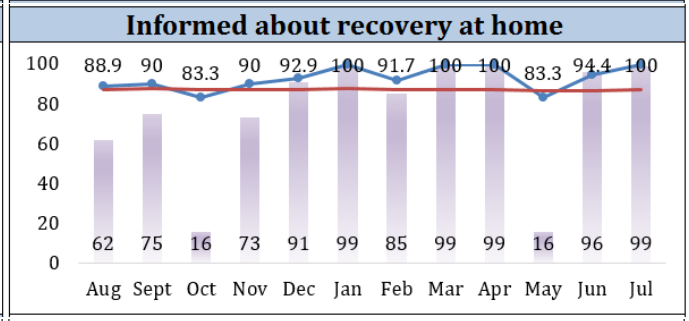


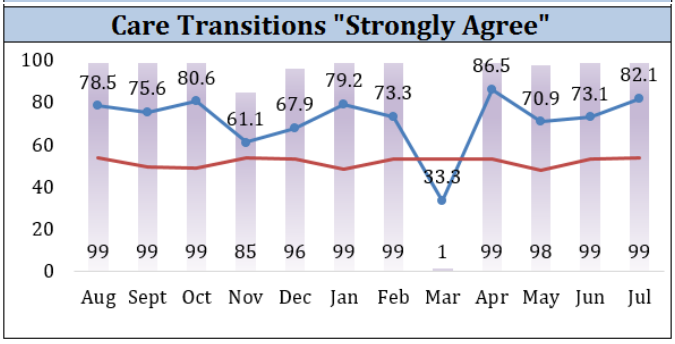






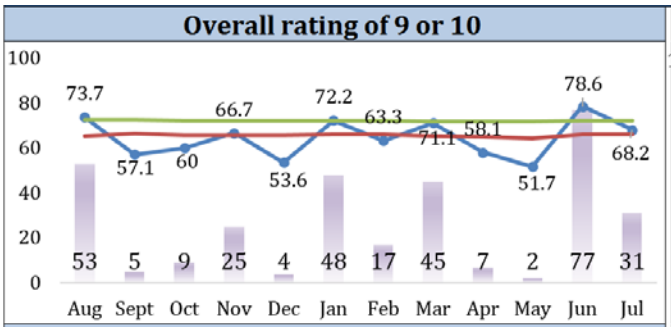


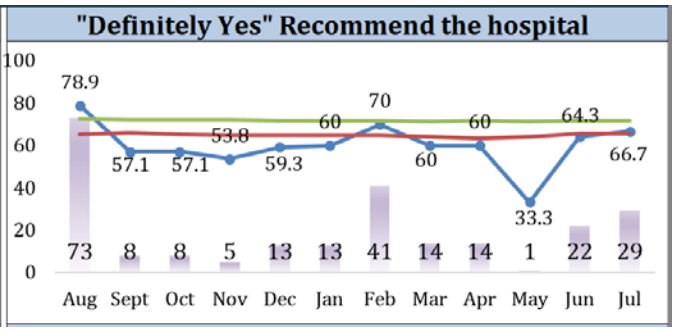


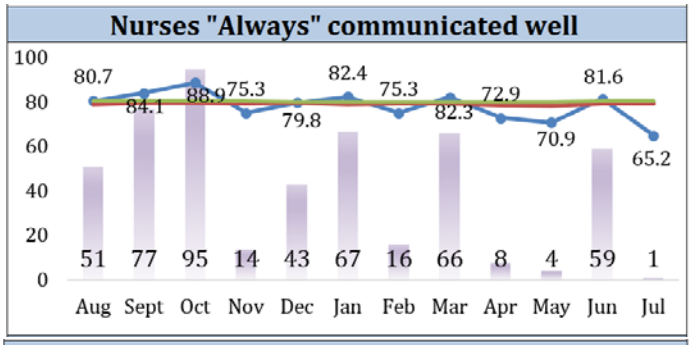


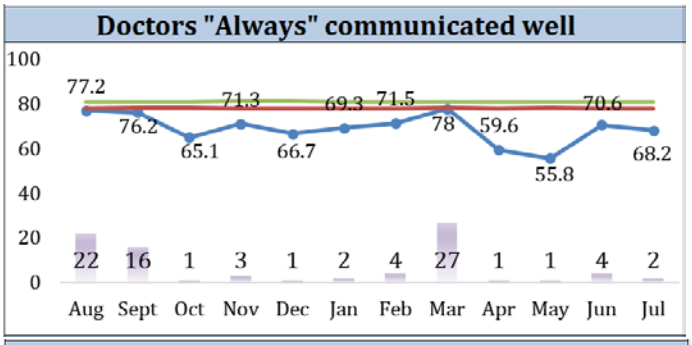
"n" = number of respondents	2018					2019						
	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul
	9	5	6	6	7	8	6	4	13	7	9	7

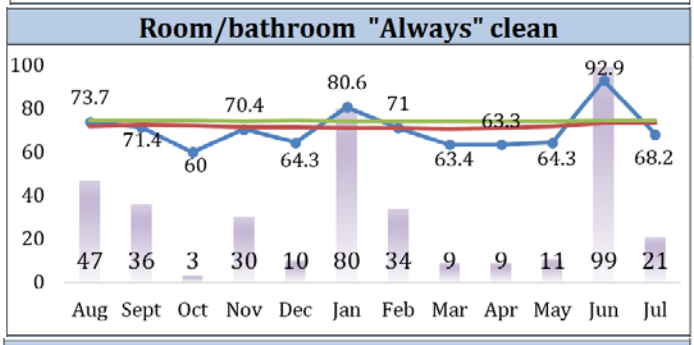
MED/SURG & PROGRESSIVE CARE UNIT (PCU) HCAHPS COMBINED RESULTS

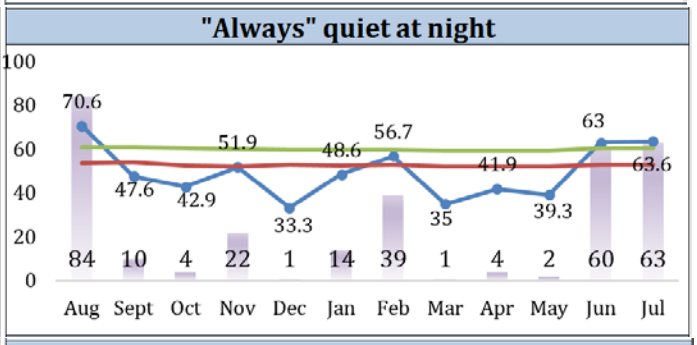


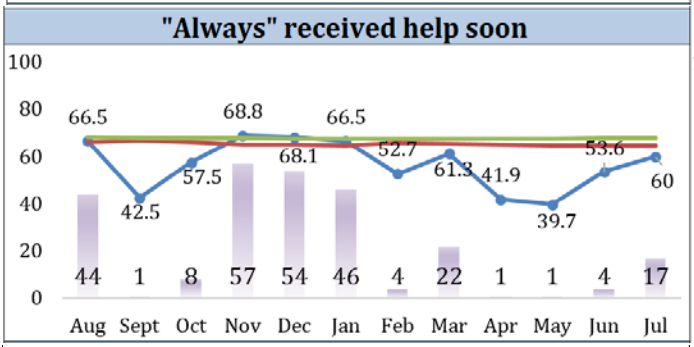


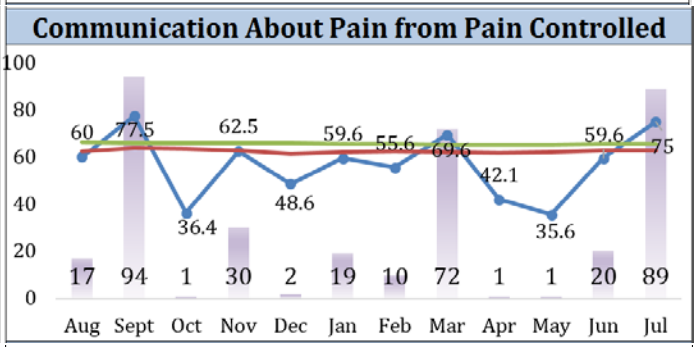


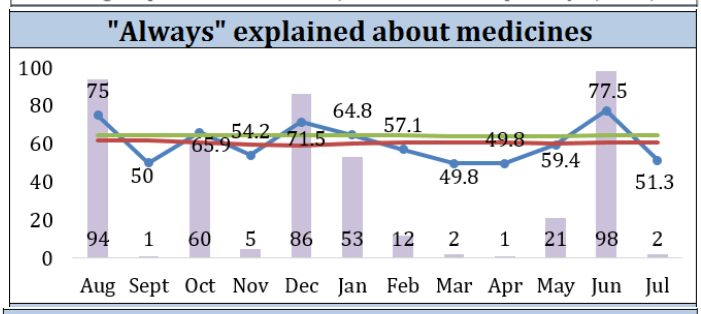


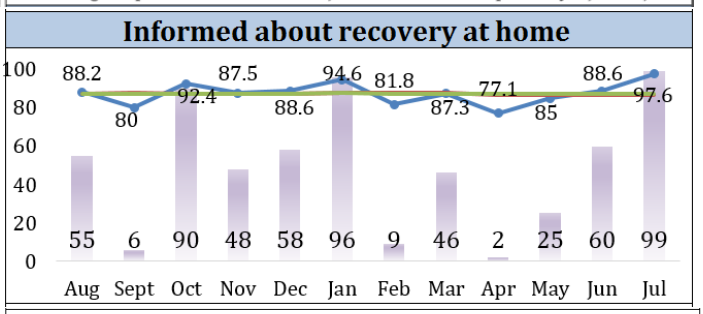


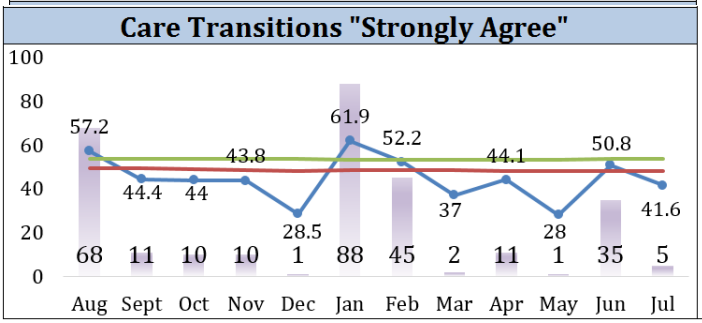


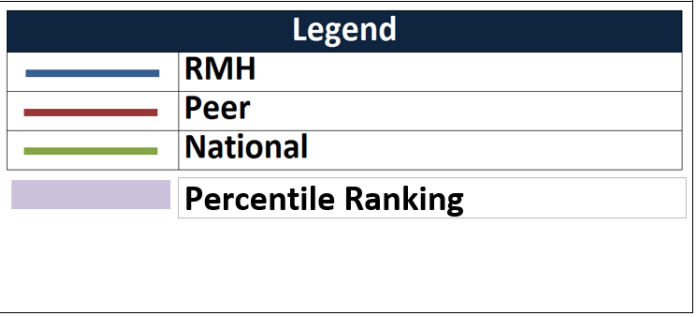








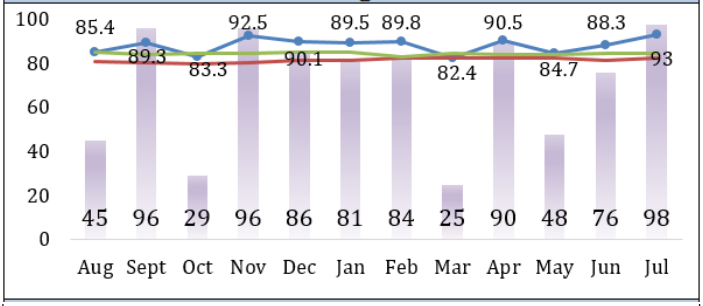




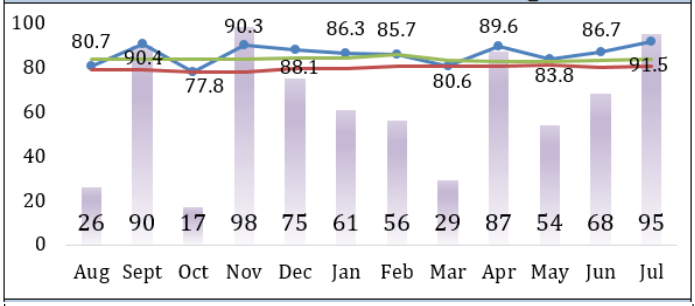
	2018					2019						
"n" = number of respondents	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul
	19	21	21	27	28	36	31	41	31	29	28	22

EMERGENCY DEPARTMENT PATIENT SATISFACTION

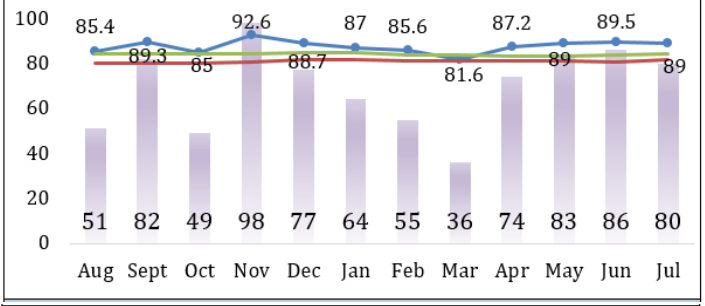
Overall rating of ER Care



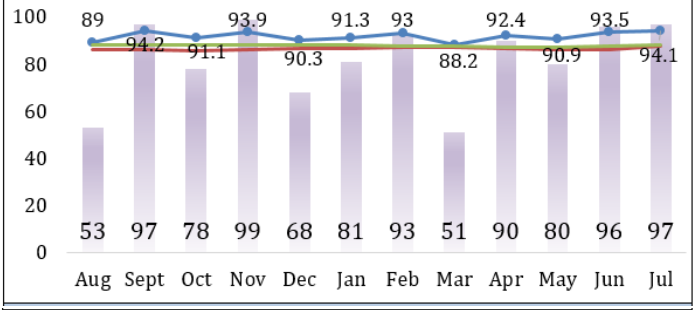
Likelihood of recommending



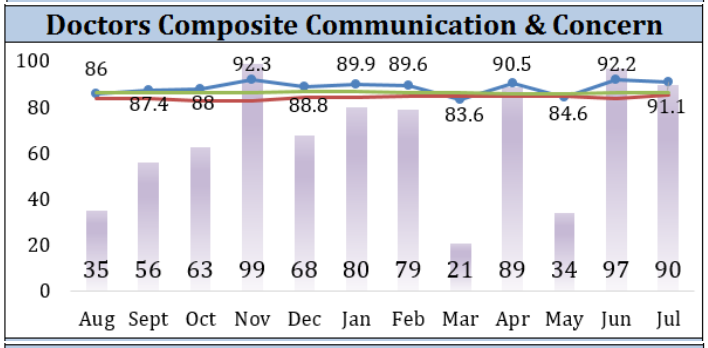
Arrival Composite Helpfulness & Wait Time



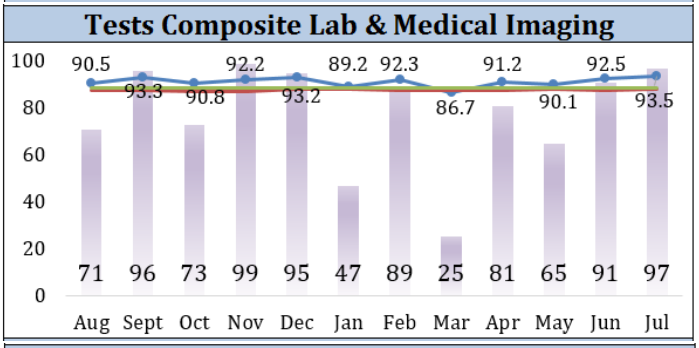
Nurses Composite Communication & Concern



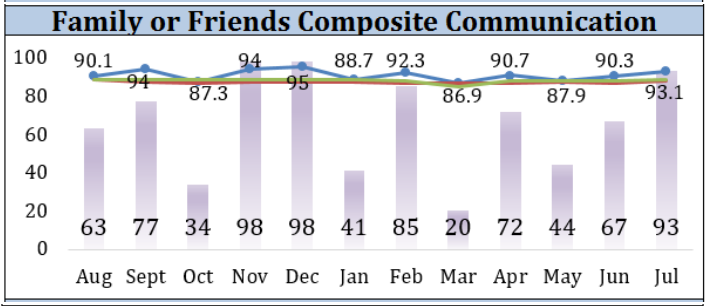
Doctors Composite Communication & Concern



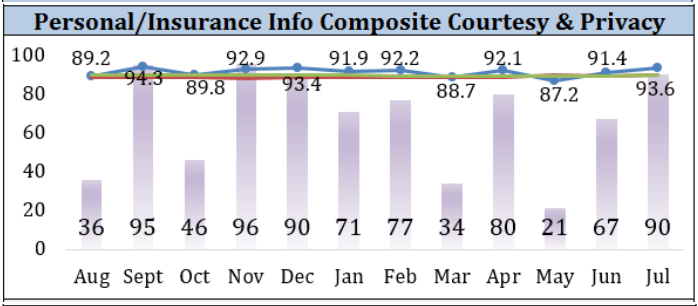
Tests Composite Lab & Medical Imaging



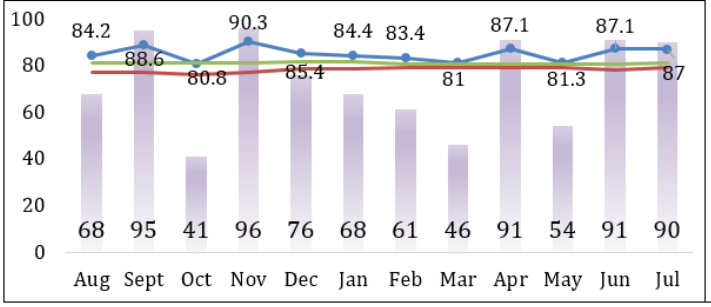
Family or Friends Composite Communication



Personal/Insurance Info Composite Courtesy & Privacy



Personal Issues Composite Pain, Empathy, Delays Explained



Legend

	RMH
	Peer
	National
	Percentile Ranking

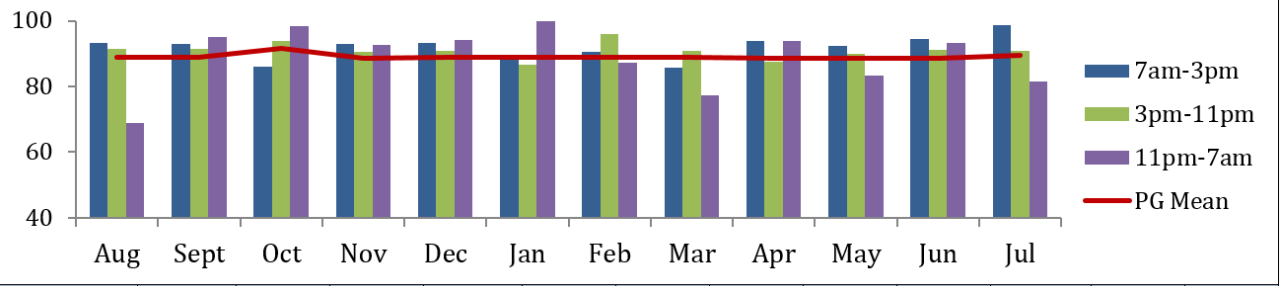
"n" = number of respondents	2018					2019						
	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul
	70	66	55	60	64	76	54	58	56	58	75	54

Category/Dept.	Update
EMERGENCY DEPARTMENT (ED)	ED Committee and ED PI meet monthly to discuss staffing, ED metrics, patient satisfaction, and performance improvement initiatives. Teamwork and collaboration have afforded the ED improved results in many areas. The department is very aware that there is still work to be done, the monthly meetings allow for discussion of barriers and other areas of improvement in an open forum. **Provider in Triage (PIT):** The process for ED patients arriving between the hours of 11am-10pm has been altered based on evidence based practice and comments received on Press Ganey surveys. The ED Nurse Practitioners and Physician Assistants are working congruently with the triage RN and triage NA/PCT immediately upon their arrival to decrease LWBS, Door to Doctor, Door to Triage, overall length of stay. This process has increased patient satisfaction and patient safety by ensuring immediate evaluation by a medical provider. This process was initiated by the ED staff, researched by the ED staff and implemented with the buy-in of all parties, and continually reviewed by ED leadership and Team Health Staff for its efficacy. However, we have noticed that our level 4 and 5's length of stay have begun to increase. For this reason, we are putting together a GEMBA walk with the ED staff and providers to review the process and determine areas of opportunity for increased efficiency. **Staff Champion Focused on Urine Collection:** Nurse Staff Champion to focus on barriers to urine sample collection. Collections of urine samples is negatively impacting patient length of stays and increasing the amount of time to a disposition decision. In some instances, urines are required for a pregnancy test prior to a diagnostic study, leading to a delay in care. Decrease time of collection for necessary labs and appropriate treatment. Decrease overall length of stay and increase patient satisfaction. **Lab Collection:** Laboratory kiosk and phlebotomy staff stationed in ED weekdays 11a-11p. This allows for phlebotomists to review ordered labs immediately and decreases time to draw, affording the patient timely results. This has increased communication between ED staff and laboratory staff for the safety and satisfaction of our patients. Decrease time of collection for necessary labs and appropriate treatment. Decrease overall length of stay and increase patient satisfaction.
ED OVERALL MEAN	The employee recognition board has been established to promote employee engagement and teambuilding and continues to be successful. ED team members are able to write comments recognizing and valuing each other. This practice also aligns with the Relationship Based Care tenant of care of others. Staff who are engaged and appreciative of one another demonstrate collegiality and are better equipped to provide compassionate, connected patient care. A shared governance model continues to help the ED team work on what matters most to patients while allowing front line staff to drive change in the ED environment. Comfort of the waiting room is a consistently low scoring question and will be a focus in the 4th quarter and into the 1st quarter of 2019. Comfort of the waiting room is a consistently low scoring question and will be a focus in the 4th quarter and into the 1st quarter of 2019. A pamphlet is being designed to explain the provider in triage process and wait times. Staff champions have been identified for specific areas of improvement such as pain management, safety and falls. This model of shared governance provides for staff ownership and accountability. Weekly charge nurse huddles continue with charge nurses choosing topics of safety, quality and experience to huddle out to each shift. High patient volume and long hold times in the ED due to acute care units being combined has been a source of staff and patient frustration, leading to lower overall scores for the end of the 1st quarter.
MEDICAL IMAGING EFFORTS TO IMPROVE ED PATIENT SATISFACTION	The medical imaging department has partnered with the patient experience and emergency departments to track and monitor patient satisfaction related to medical imaging committed to improving the ED patient satisfaction.

MEDICAL IMAGING EMERGENCY DEPARTMENT PATIENT SATISFACTION

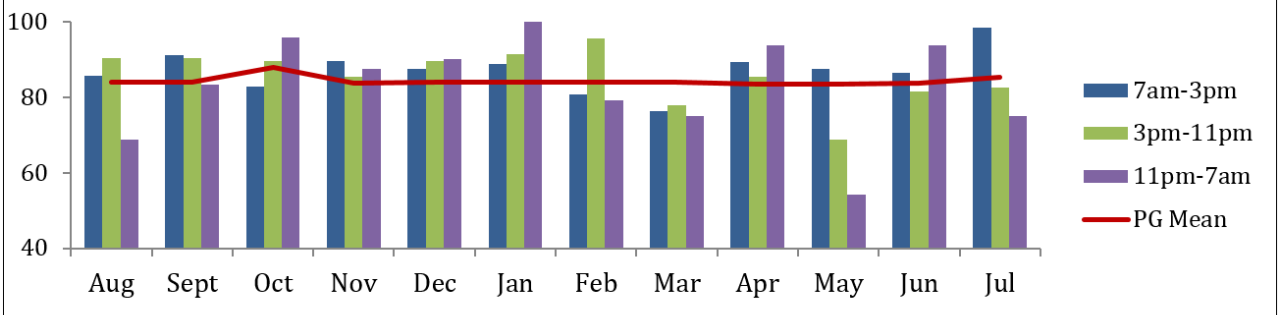
	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19
n	50	45	50	51	55	74	44	48	49	47	29	40

Overall Test Composite



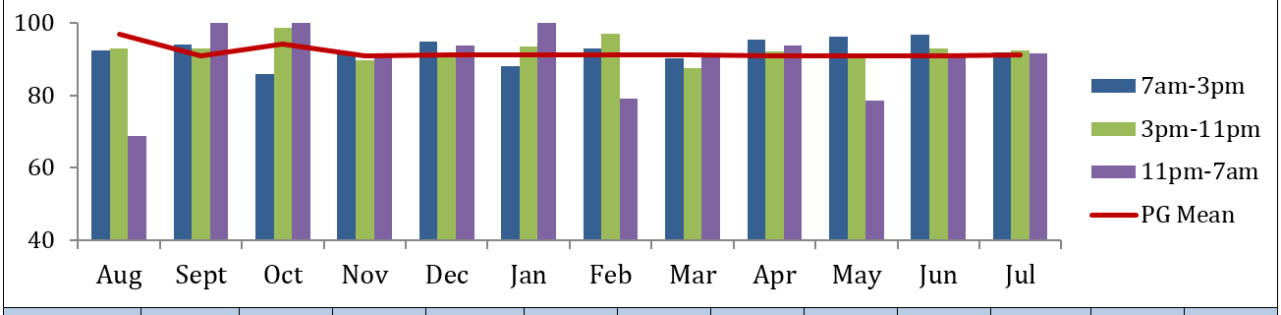
	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul
PG Mean	88.8	88.8	91.5	88.7	88.8	88.9	88.9	88.8	88.5	88.5	88.6	89.6
7am-3pm	93.3	93	85.9	92.8	93.2	88.1	90.6	85.6	93.7	92.4	94.3	98.8
3pm-11pm	91.3	91.3	93.9	90.4	90.7	86.7	95.8	90.7	87.5	89.8	91.1	90.9
11pm-7am	68.8	95	98.3	92.6	94	100	87.2	77.4	93.8	83.3	93.3	81.5

Waiting time for radiology test



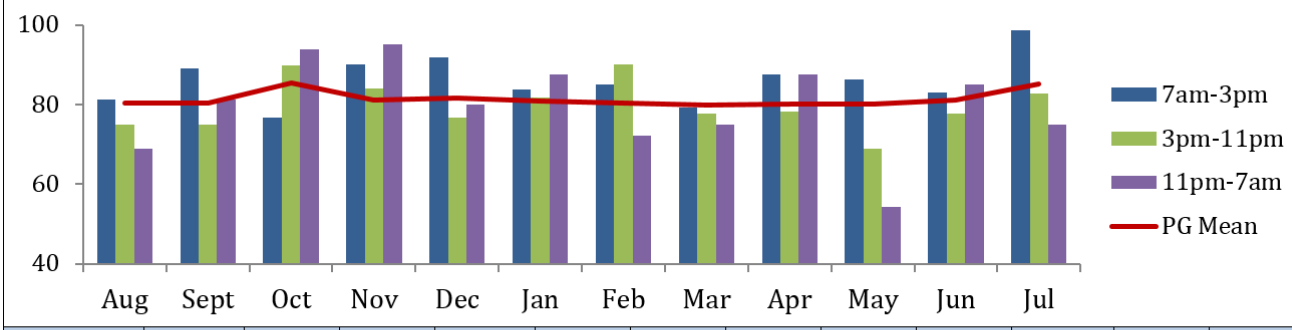
	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul
PG Mean	83.9	83.9	87.8	83.8	84	84.1	84	83.9	83.6	83.6	83.7	85.2
7am-3pm	85.7	91.2	82.8	89.7	87.5	88.9	80.8	76.4	89.3	87.5	86.4	98.5
3pm-11pm	90.3	90.3	89.5	85.4	89.6	91.4	95.6	77.8	85.5	68.8	81.6	82.7
11pm-7am	68.8	83.3	95.8	87.5	90	100	79.2	75	93.8	54.2	93.8	75

Courtesy of radiology staff



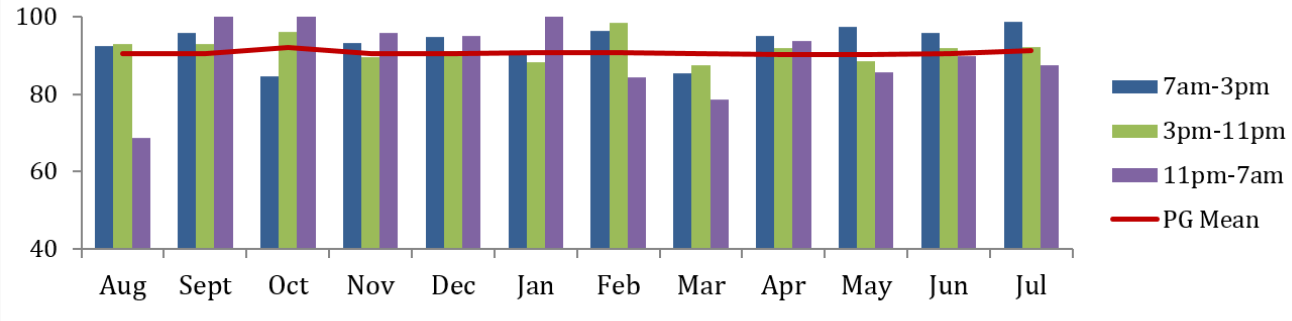
	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul
PG Mean	97	91	94.1	91	91.1	91.2	91.2	91.1	90.9	90.9	91	91.3
7am-3pm	92.5	94.1	85.9	91.7	94.8	88	92.9	90.3	95.5	96.3	96.7	92
3pm-11pm	93.1	93.1	98.6	89.6	91.1	93.5	97.1	87.5	92.1	90.4	93.1	92.3
11pm-7am	68.8	100	100	91.7	93.8	100	79.2	91.7	93.8	78.6	91.7	91.6

Waiting time for test results



	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul
PG Mean	80.4	80.4	85.4	81.2	81.6	80.9	80.3	79.9	80.1	80.1	81	85.2
7am-3pm	81.3	89.1	76.6	90	91.7	83.7	85	79.2	87.5	86.3	83	98.5
3pm-11pm	75	75	89.7	84.1	76.7	81.7	90	77.8	78.3	68.8	77.8	82.7
11pm-7am	68.8	81.3	93.8	95	80	87.5	72.2	75	87.5	54.2	85	75

Concern for care and comfort during radiology testing



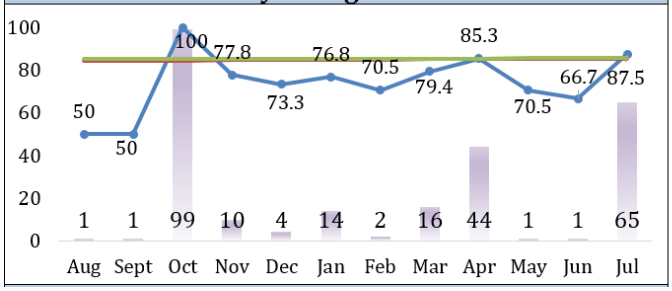
	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul
PG Mean	90.6	90.6	92.2	90.5	90.6	90.8	90.7	90.6	90.4	90.4	90.5	91.2
7am-3pm	92.4	95.8	84.7	93.3	94.8	90.8	96.4	85.5	95	97.4	96	98.7
3pm-11pm	93.1	93.1	96.1	89.6	91.1	88.4	98.5	87.5	92.1	88.5	92.1	92.3
11pm-7am	68.8	100	100	95.8	95	100	84.4	78.6	93.8	85.7	90	87.5

Note: Scale of charts is set at 40-100% to magnify any significant changes in results

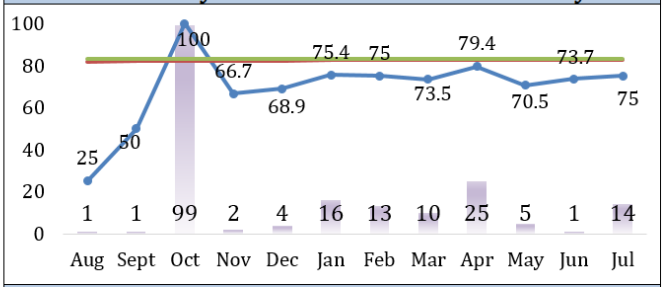
MEDICAL IMAGING	The emergency department patient satisfaction surveys have several questions related to the patient experience for medical imaging studies. The incorporation of this information into the monthly Radiology Department meeting through the medical staff office has allowed the radiology department to identify specific areas of improvement for their departmental patient experience conversations.

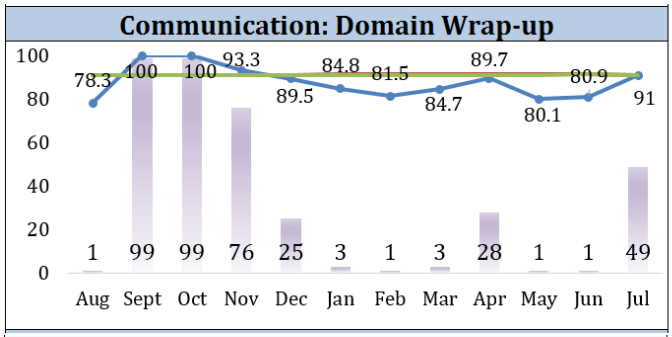
OUTPATIENT AMBULATORY SURGERY (OAS) HCAHPS RESULTS

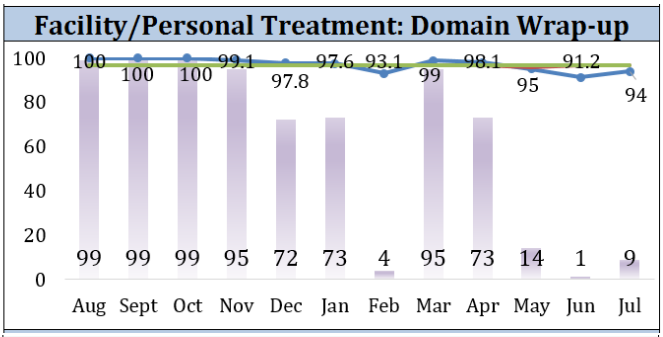
Facility rating of 9 or 10

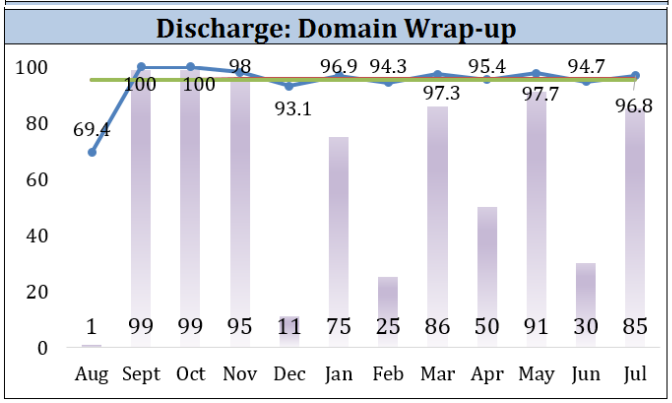


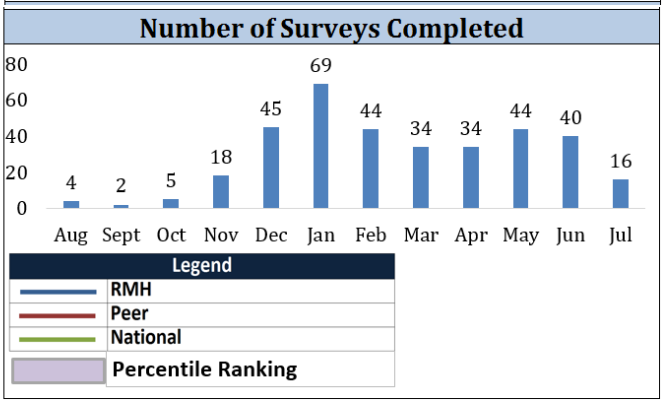
"Definitely Yes" Recommend the Facility











OR/PACU	OR and PACU staff are working collaboratively to improve ambulatory surgery HCAHPS scores. The domains (facility rating, recommend the facility, communication, facility/personal treatment, discharge) that tie to the departments rating are effected by first case on time, turnover times, and the amount of time patient is in PACU. Scores are regularly monitored and brought to each respective committee for review. Staff will need to receive more detailed education on how their delivery of care effects the patient's overall satisfaction. A more comprehensive look at how the department can improve numbers across the board will be performed prior the end of the year. The Risk Management Director is now meeting with the Director of Surgical Services and OR/PACU Manager monthly to discuss strategies and scores.

2. **STUDY AND IMPROVE SAFE MEDICATION ADMINISTRATION AND APPLICATION OF BEST PRACTICE FOR MEDICATION UTILIZATION WITHIN THE FACILITY. THESE PROJECTS INCLUDE:**

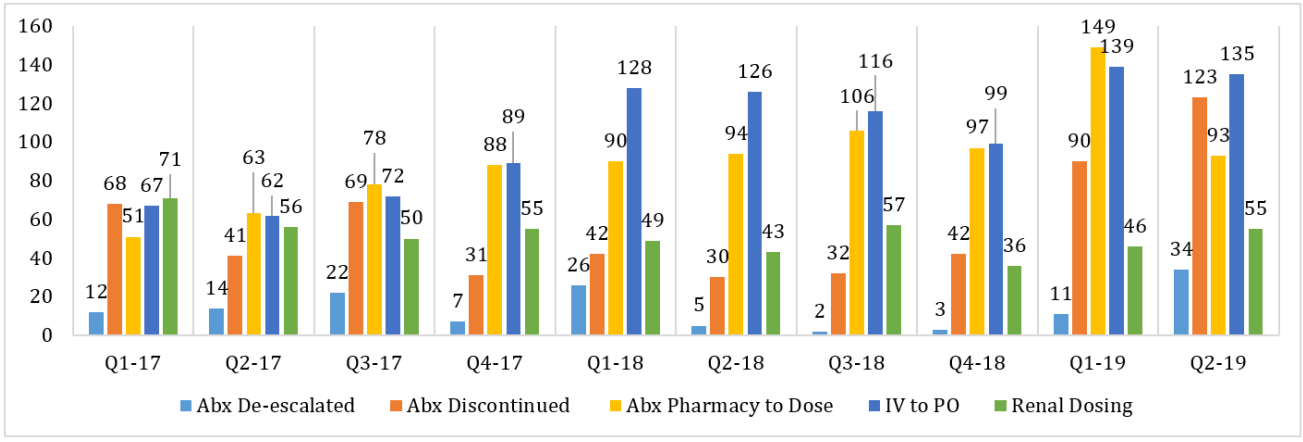
Rationale: The collection and analysis of data related to medication-related hazardous conditions, near-misses, errors, and other adverse drug events has been proven to have a profound effect in the prevention of these events. Additionally, this practice strengthens the improvement process related to safe medication use. The purpose behind collecting antibiotic management data is to ensure that every patient receives optimal antibiotic therapy through de-escalation of broad spectrum antibiotics and reducing duration accordingly.

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

a. **Antibiotic Management**
   - The Antibiotic Management Program continues to expand. Data has been collected to track and trend appropriate antibiotic selection. Information will continue to be presented through the Infection Prevention and P&T Committees. Pharmacy and Nursing assist in changing to appropriate antibiotic therapy and recommendations are logged in an effort to assess the level to which physicians are responding to recommendations that are provided. Antibiotic Utilization (AU) and Antibiotic Resistance (AR) data is submitted to NHSN for benchmarking purposes. This assists us in determining areas for further improvement.
   - Pharmacy driven initiative to modify antibiotic administration practice specific to infusion times and the incorporation of a change from IV antibiotic infusion to IV push. This has a financial benefit as well as a patient benefit. Staff education on antibiotic administration will continue through 2018.
   - Antibiotic Stewardship efforts continue to evolve. One such program change is access to additional infectious disease (ID) support through the review of all IV antibiotics at day 3 by an ID physician.

Intervention Data

	Q1-17	Q2-17	Q3-17	Q4-17	Q1-18	Q2-18	Q3-18	Q4-18	Q1-19	Q2-19
Abx De-escalated	12	14	22	7	26	5	2	3	11	34
Abx Discontinued	68	41	69	31	42	30	32	42	90	123
Abx Pharmacy to Dose	51	63	78	88	90	94	106	97	149	93
IV to PO	67	62	72	89	128	126	116	99	139	135
Renal Dosing	71	56	50	55	49	43	57	36	46	55



b. **Medication Barcode Overrides:** For a period of 6 months, unit specific bar-code override data, specific to IV solutions, was provided to nursing unit leaders. The unit leaders were able to identify those staff

members who routinely engaged in inappropriate bar-code overrides and provide targeted education. The number of override occurrences dramatically dropped and comprehensive monitoring was discontinued.

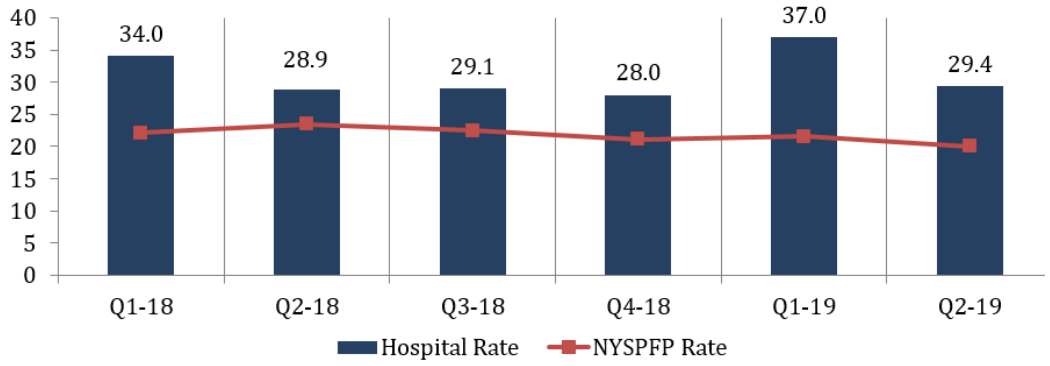
- Each medication occurrence is investigated, and if any trending in barcode overrides is observed, the pharmacy and performance improvement departments will resume barcode override monitoring and reporting.

c. **Inpatient Glycemic Control:** The inpatient glycemic control workgroup was initiated in December 2017, and championed by our, then Hospitalist Medical Director, Mark Emerick, MD. The intent of this initiative has been to incorporate evidence-based glycemic control practices, i.e. the basal-bolus protocol, within our inpatient units.

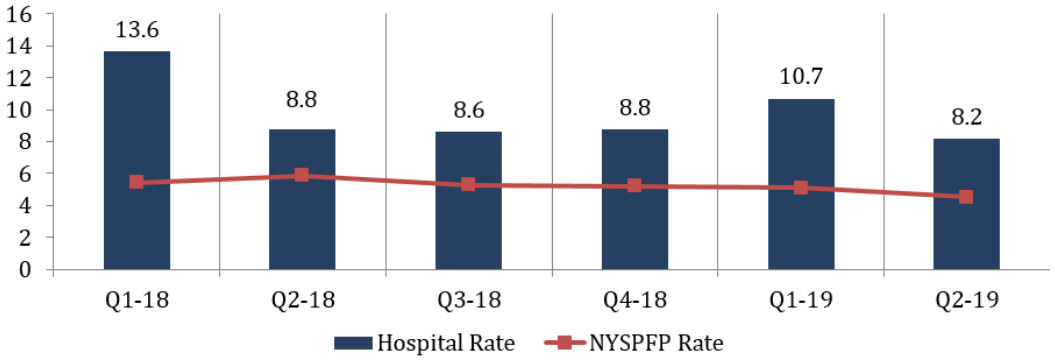
- Extensive nursing and provider education was undertaken in 2018, and the proposed basal-bolus protocol was adopted by the hospital medical staff. While it is not universally applied.
- Adverse Drug Event (ADE): An occurrence/incident that results in an injury from the use of a drug. For purposes of NYSPFP, this includes adverse drug reactions, errors in medication preparation, administration, prescribing, dosing, or the discontinuation of drug therapy that results in harm. ADE data is monitored through monthly submissions to the New York State Partnership for Patients (NYSPFP). This information provides the hospital comparative data to similar hospitals in the area. Our 2018 andQ1 2019 data reflects that our hypoglycemic data is below the NYSPFP Hospital average and that we have ongoing opportunities to address the frequency of hyperglycemic events. The nursing, pharmacy and hospitalist functions will continue to work together to enforce best-practice utilization of the Basal-Bolus protocol.

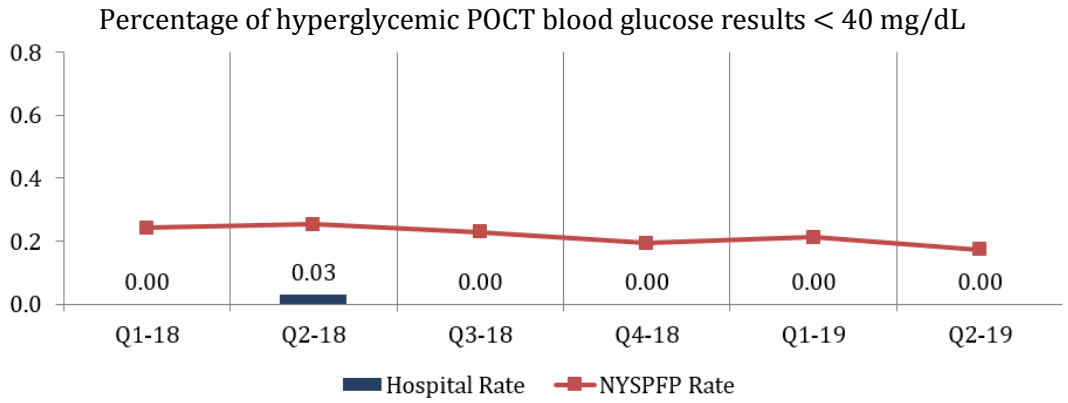
Results

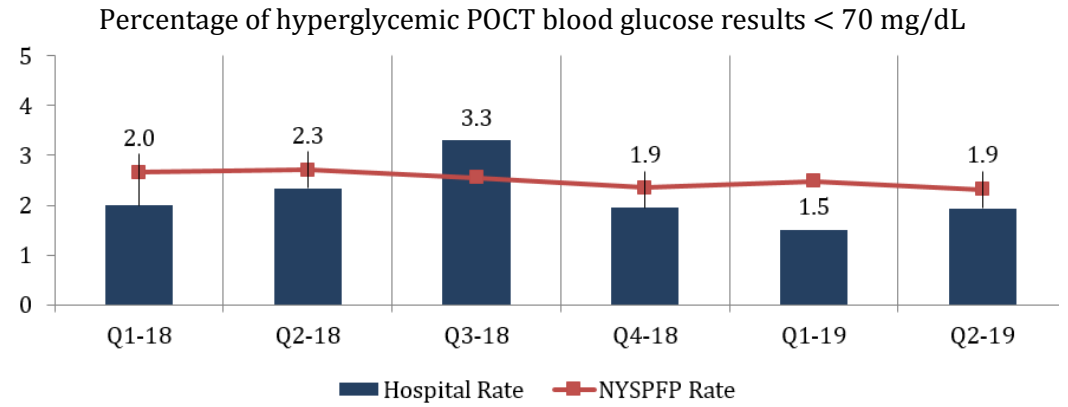
Percentage of hyperglycemic POCT blood glucose results > 200 mg/dL



Percentage of hyperglycemic POCT blood glucose results > 300 mg/dL





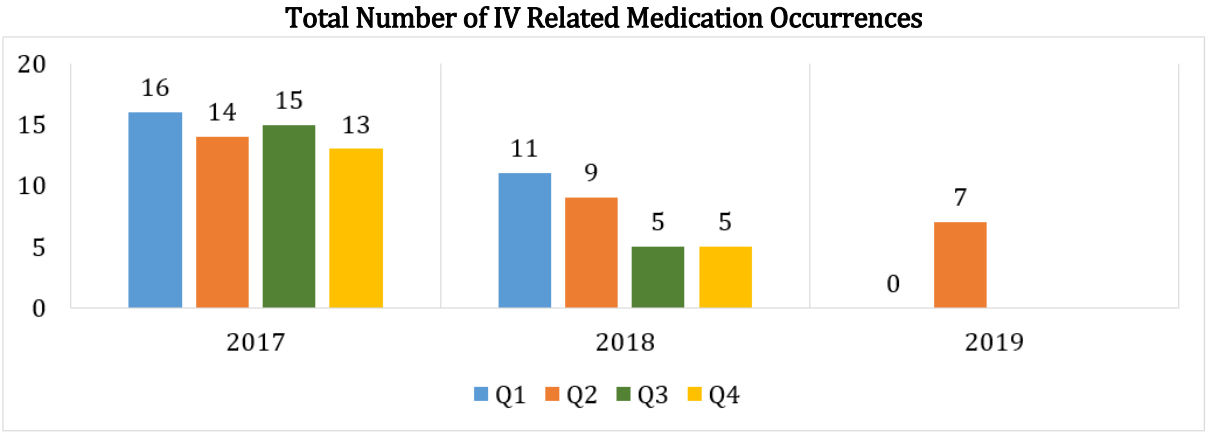


d. **Medication Occurrence Follow-Up and Review:** The frequency of medications occurrences has decreased significantly when compared to previous years' data. The process of reviewing every medication occurrence and systematically eliminating known barriers has created a safer medication administration environment within the organization. It is important that we are also readily encouraging the reporting of near misses (category A and B events) and unsafe conditions so that we are able to address issues before they result in harm to a patient. If there is concern for under-reporting, we must address that through targeted conversations with our front-line staff.

Acute Quarterly											
Category	**Description**	**Q1-17**	**Q2-17**	**Q3-17**	**Q4-17**	**Q1-18**	**Q2-18**	**Q3-18**	**Q4-18**	**Q1-19**	**Q2-19**
Total Med Occurrences		**33**	**26**	**34**	**31**	**22**	**21**	**14**	**21**	**10**	**19**
A	Circumstances or events that have the capacity to cause error.	**2**	**0**	**2**	**9**	**12**	**3**	**2**	**5**	**5**	**7**
B	An error occurred but did not reach the patient.	**1**	**6**	**5**	**4**	**1**	**0**	**3**	**6**	**0**	**1**
C	An error occurred that reached the patient but did not cause patient harm	**29**	**20**	**27**	**17**	**7**	**13**	**7**	**9**	**3**	**7**
D	An error occurred that reached the patient and required monitoring to confirm that it resulted in no harm to the patient and/or required intervention to preclude harm	**1**	**0**	**0**	**1**	**2**	**4**	**2**	**1**	**2**	**4**
E	An error occurred that might have contributed to or resulted in temporary harm to the patient and required intervention	**0**	**0**	**0**	**0**	**0**	**1**	**0**	**0**	**0**	**0**
F	An error occurred that might have contributed to or resulted in temporary harm to the patient and required initial or prolonged hospitalization	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
G	An error occurred that may have contributed to or resulted in patient harm	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
H	An error occurred that required intervention necessary to sustain life	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
I	An error occurred that may have contributed to or resulted in the patient's death	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
Note: Category A and B occurrences - The higher the number the better as it indicates that the hospital is reporting potential process issues prior to reaching the patient											

RHCF Quarterly											
Category	Description	Q1-17	Q2-17	Q3-17	Q4-17	Q1-18	Q2-18	Q3-18	Q4-18	Q1-19	Q2-19
Total Med Occurrences		9	11	9	4	5	4	4	8	3	4
A	Circumstances or events that have the capacity to cause error.	0	1	0	1	0	0	0	0	1	1
B	An error occurred but did not reach the patient.	0	1	1	0	0	1	2	0	1	0
C	An error occurred that reached the patient but did not cause patient harm	9	8	8	3	3	3	2	6	1	2
D	An error occurred that reached the patient and required monitoring to confirm that it resulted in no harm to the patient and/or required intervention to preclude harm	0	1	0	0	2	0	0	2	0	1
E	An error occurred that might have contributed to or resulted in temporary harm to the patient and required intervention	0	0	0	0	0	0	0	0	0	0
F	An error occurred that might have contributed to or resulted in temporary harm to the patient and required initial or prolonged hospitalization	0	0	0	0	0	0	0	0	0	0
G	An error occurred that may have contributed to or resulted in patient harm	0	0	0	0	0	0	0	0	0	0
H	An error occurred that required intervention necessary to sustain life	0	0	0	0	0	0	0	0	0	0
I	An error occurred that may have contributed to or resulted in the patient's death	0	0	0	0	0	0	0	0	0	0
Note: Category A and B occurrences - The higher the number the better as it indicates that the hospital is reporting potential process issues prior to reaching the patient											

e. Safe Administration of IV Fluids



3. 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.

Rationale: Encourage transparency through regular reporting of adverse and sentinel events. Support a non-punitive culture of error reporting that allows staff the confidence to go to management in the event an error (without the intent to do harm) occurred. Increase communication and strengthen relationships between departments by learning from our errors and identifying whether there may have been an error in the process rather than the individual.

Strategies:

- Provide training for staff, administration (managers, directors, supervisors) and providers
- Develop checks and balances (i.e. monitoring and follow-up) to ensure application of Just Culture values in response to errors
- Conduct the Agency for Healthcare Research & Quality (AHRQ) Safety Culture Survey in 2018

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.

Update:

- Provide training for staff, administration (managers, directors, supervisors) and providers
  - Executive team Just Culture education and strategy development as well as Nov. 2018 leadership training related to the interdependency of relationship-based care and Just Culture.
  - Staff education on relationship based care and just culture through mandatory organization-wide Relationship Based Care introduction was accomplished in the 3rd quarter of 2018. Ongoing staff education on operating within a just culture will be incorporated into our annual staff education and should be included in our CEO town hall conversations.
  - All new hires receive an introduction to just culture as part of our orientation program.
- Develop checks and balances (i.e. monitoring and follow-up) to ensure application of Just Culture values in response to errors
  - To date, we have not satisfied this portion of our just culture PI objectives. On an individual basis, the outcome of investigations and their associated corrective actions are reviewed for appropriateness, and many have resulted in more comprehensive reviews of the systems and processes through which they occurred. We have not had the resources to identify any trending (positive or negative) in the application of just culture concepts following documented occurrences. We have, however, identified several opportunities to improve how we document follow-up activity within our events reporting software.
  - Additional emphasis, from and HR and risk management standpoint should be put into whether appropriate employee corrective actions were applied and that they are consistent with a just culture environment. Most importantly is whether department leaders follow through on education opportunities and other supportive measures related to staff development. Given our very limited resources within the risk management department, we have to identify an appropriate and realistic expectation for the review of follow-up item completion. This element of the PI plan should be carried through into our next PI plan.
- Conduct the Agency for Healthcare Research & Quality (AHRQ) Safety Culture Survey in 2018
  - The Safety Culture Survey will be conducted in 3Q 2019 with results reported through the quality council by the end of Q3 2019.

4. **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.

Goals/Strategies:

1. Recruit motivated and high quality providers
   Update: None provided

2. Identify affiliated resources that provide best practice support
   Update: None provided

3. Promote physician engagement and participation in QAPI efforts.
   Update:
   - Physician engagement is a core element of quality and performance improvement initiatives at RMH. There has been a facility-wide push to include physicians in initiatives where their expertise can provide valuable insight. A main factor in including physicians is to consider them as partners of the project and to have them be a part of the decision-making process. Including a physician in the planning phases and allowing them control of prioritizing improvement efforts provides a team oriented approach. It has been proven in other healthcare organizations that the success of healthcare related projects often depend heavily on the level of engagement demonstrated by members of the physician team.
   - When core team members are being selected for an initiative, a physician champion is listed as one of the key members. Throughout 2018-2019, physician champions have been selected for the following priority initiatives:
     - **RHCF Falls and Injuries**
       - Physician Champion: Dr. Joel Amidon
     - **ALTO (Alternatives to Opioids) in the ED**
       - Physician Champion: Dr. Andrew Bushnell
     - **Antibiotic Management**
       - Physician Champion: Dr. Waleed Albert
     - **Inpatient Glycemic Control Workgroup**
       - Interim Physician Champion: Dr. Mark Emerick (Hospitalist Director)
       - Dr. Emerick has since left RMH, however with his assistance the Inpatient Glycemic Control Workgroup was able to continuously review information regarding results of our diabetic patients. Best practice education has been distributed to front line staff and nursing supervisors and data is regularly incorporated into the P&T Committee and Medication Safety meetings. The Director of Pharmacy has continued the momentum behind the project by staying current with data submitted to the New York State Partnership for Patients (NYSPFP) and educational webinars aimed at providing free education to facilities to distribute to clinical leaders and front-line staff.
     - **3 Day Length of Stay (LOS)**
       - Interim Physician Champion: Dr. Mark Emerick (Hospitalist Director)
       - Length of stay monitoring under the hospitalist function increased dramatically with the involvement of Dr. Emerick. A simple to use dashboard was created through the Quality department to ensure transparency of data that can be regularly viewed monthly. Dr. Emerick reported this information out to administration and individual committees to keep them informed of fluctuations and concerns in our overall length of stay.
       - As of September 2019, the 3 day LOS initiative has evolved into the **Efficiency of Care-Patient-Centered Length of Stay Reduction Initiative.** This meeting includes Dr. Bushnell and Dr. Khokhar as the primary physician representation.

- **Readmissions Workgroup**
  - Physician Champion: Dr. Andrew Bushnell
  - Historically, the Readmissions Workgroup had not had any physician champions. However, in 2019 the workgroup will reconvene monthly to discuss real-time analytics, Continuum of Care engagement, nursing education, and case discussions under the director of our CMO, Dr. Bushnell.
- **New York State Breastfeeding Quality Improvement in Hospitals (BQIH) Collaborative**
  - Physician Champion(s): Dr. Lauren Giustra, Dr. Ankur Desai
  - Annie Wafer, FNP-C

- With physician involvement, each project has had its own level of success. Actionable items retain their accountability and individual responsibilities are assigned to members of each project. Also, clinical expertise and first-hand experience is provided in meetings where it may have been lacking to support priority initiatives focused on clinical processes.

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

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.

Strategies:

- MAX NY Data Series focuses on patients that have been identified as high-utilizers of inpatient services (4 or greater)
- Continued partnership with the DSRIP CNY Care Collaborative
- Internal readmission workgroup focusing on length of stay (LOS), level of care determination, readmissions, and inappropriate/appropriate transfers out of the facility. Also, focusing on appropriate utilization of resources for patients in observation status.
- 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)

Frequency of Data Collection: Individual case reviews for unnecessary transfers, 30-day readmissions, monthly readmission report by attending/discharging physician, daily 30-day readmissions, and high utilization of high-value testing reported monthly to our ongoing service utilization workgroup inclusive of action plans for areas for improvement.

Update:

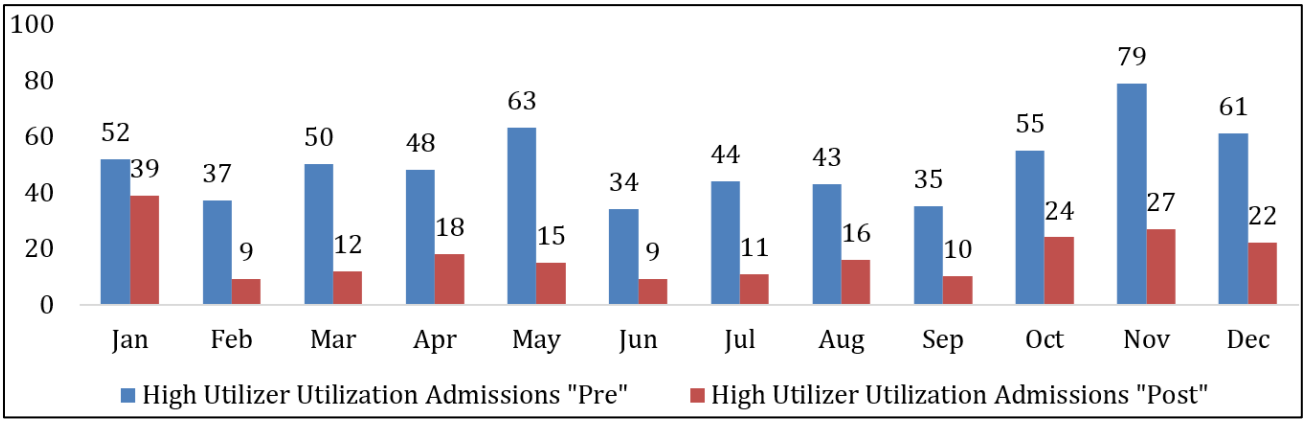
- **Audits**
  - Audits are performed on incomplete documentation, incorrect disposition, delays in discharges, and increased ALOS to support the following: (1) Workgroups dedicated to readmission reduction; (2) Alignment with the hospital's pillars found in the strategic plan that outlines a sustained patient-centered comprehensive care transitions model for improved patient outcomes across the continuum of care.
  - **Goal:** (1) Consistency in the discharge planning process that will be evident when variations with provider are minimized/eliminated. (2) Improved documentation for transfers (in and out of the facility). (3) Improved medication reconciliation during the admit/discharge process.
  - **Measure:** The measures are ALOC days-Reduce by 0.30% of total patient days. **June 2018:** New documentation review tool for staff consistency with a goal of 100%.
- **MAXNY**
  - Part of **MAXNY** are population health strategies that have goals to identify and reach out to disparate and at-risk populations who receive limited or no care in the community or may lack essential resources as well as high utilizers of health care/hospital services.
  - **Goal:** Continue to work to improve outcomes of the program through earlier involvement of community PCPs in the discharge planning process of our high utilizers. In addition, partnering with our preferred providers, including Nunn's with a respiratory pathway, Hospice, and their Palliative care expertise.
  - **Measure:** The IT team has extended efforts over the last 12+ months to assist the MAXNY team in identifying individuals that are considered "high utilizers" or 4 or more admissions. IT setup the automated template that allows the team to identify patients that fall into the high utilizer category on a daily basis, this allows the MAXNY team to bring those specific cases to their 10:00am daily huddle to discuss the patient's care plan and any gaps that exist.

TARGET	High Utilizers, inpatients with four or more inpatient or observation visits in the last 12 months.
GOAL	In an effort to reduce readmissions, the Continuum of Care team will proactively identify high utilizers, understand patient perspective and psycho-social needs, and connect them with appropriate resources offered through the enhanced collaboration of our community partners.

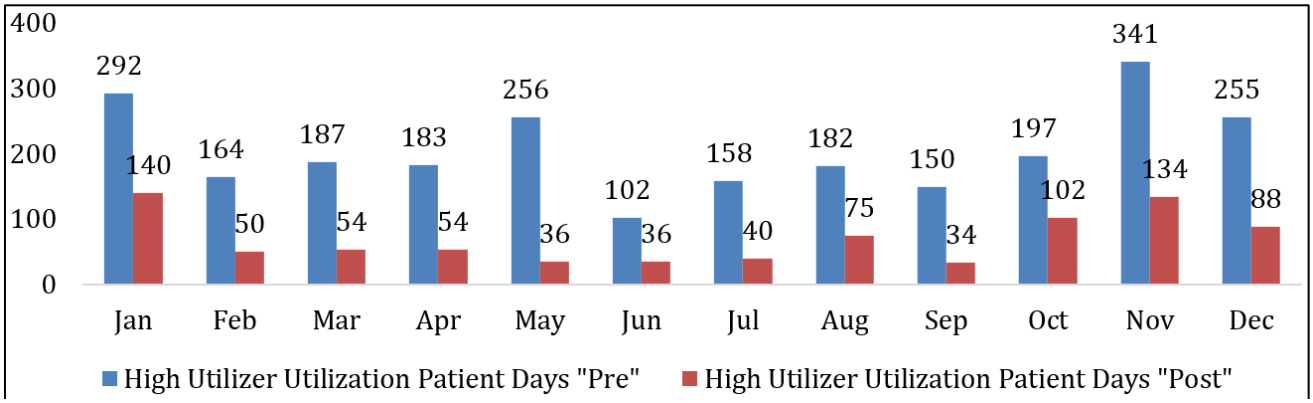
2018 RESULTS

Measure/Indicator	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	2018 Total
Admissions Prevented	13	28	38	30	48	25	33	27	25	31	52	39	389
Admissions Days Saved	152	114	133	129	220	66	118	107	116	95	207	167	1,624
Number of High Utilizers Number of patients with 4 or more hospitalizations in 12 months inclusive of the index date	16	16	24	19	21	16	18	22	16	22	29	20	239
High Utilizer Utilization Previous 12 months Number of admissions in the 12 months prior to and inclusive of the index date	84	77	124	96	118	88	92	110	88	123	150	124	1,274
High Utilizer Utilization Admissions "Pre"	52	37	50	48	63	34	44	43	35	55	79	61	601
High Utilizer Utilization Admissions "Post"	39	9	12	18	15	9	11	16	10	24	27	22	212
High Utilizer Utilization Patient Days "Pre"	292	164	187	183	256	102	158	182	150	197	341	255	2,467
High Utilizer Utilization Patient Days "Post"	140	50	54	54	36	36	40	75	34	102	134	88	843

HIGH UTILIZER UTILIZATION ADMISSIONS



HIGH UTILIZER UTILIZATION PATIENT DAYS



- **High Utilizer Transition RN Case Manager:**
  - Successfully implemented this position in the emergency room in November. This transition RN Case Manager is working in collaboration with our par provider Nascentia Health with the goal of assisting our patients in transitioning from hospital to home, thus ensuring a successful outcome and patient satisfaction and reducing the likelihood of a readmission. A dedicated Care Transition Coach is being provided by Nascentia to collaborate with the RN Case Manager and engage the patient in their care plan that has been established during the hospital stay.

- **Reduction in unnecessary hospitalizations amongst the SNF population:**
  - A partnership with IPC, a physician led organization under Team Health, who represents the medical services of Rome area SNF's, was developed. This has been successful in reducing SNF admissions. The goal being to reduce rates of readmissions and ensure residents are receiving the appropriate care in the correct setting. The IPC medical director continues to report a decrease in the number of residents requiring hospitalization. In addition, the length of stay for those individuals who are hospitalized has decreased.

Measure	1Q-17	2Q-17	3Q-17	4Q-17	1Q-18	2Q-18	3Q-18	4Q-18	1Q-19	National Benchmark	Criteria
Avoidable Hospitalizations	5.9%	1.9%	9.8%	14%	5.1%	14%	8.9%	10.4%	12.9%	11.4%	Percentage of Residents readmitted to an ACF within 30 days of admission to the facility.*

- **Active participation in the CNYCC DSRIP Rome Coalition group:**
  - The Rome Coalition has brought together representatives from area SNFs, Assisted living, health home agencies, Developmental Services Office, Hospice, Office of the Aging, Resource Center for Independent Living, Central New York Food Bank, and Nascentia Visiting Nurse services who serve the needs of our mutual patients. This group decided to work beyond the one year requirement mark and $135,000 payment as it has been a positive and successful collaboration focused on facilitating improved health care and social needs. It has allowed us to wrap our arms around the patients and provide them with numerous touch points in the community post discharge. The Coalition has collaborated with DSRIP champions in the hospital, its practices, and outpatient facilities with the goal of transforming care to achieve the NYS Triple Aim to qualify for nearly 1 million in payments in 2018 for project deliverables. This brings our total DSRIP funding to 2.4 million since 2016 resulting from CNYCC-DSRIP Performance Activities. RMH Continuum of Care services participated in and generated many DSRIP projects which resulted in excess of $73,000 in the most recent DSRIP Phase 2 contracting period ending June of 2018.

6. INVENTORY QUALITY METRICS AND BENCHMARKS WITH THE GOAL OF CENTRALIZATION OF DATA AND ANALYTICS IN THE HOSPITAL

Rationale: Increases transparency of information. Supports current and proposed new initiatives with data. Minimizes confusion on the source of data. Supports 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).

Strategies: Develop leadership skills specific to QAPI and 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

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.

Update:

- The Quality Department worked with individual departments to reformat and revise their individual dashboards. Not only were metrics added and removed but data from the Healthcare Safety Zone Portal (Clarity) for each respective unit was included to formulate an overall picture of operations in the department. This includes transfers, medication occurrences, patient and employee injuries, complaints and grievances, and falls. Also included is information on midnight census, average length of stay, and overall volume on the units. The new information is summarized in each dashboard and the information is backed up with source data on individual sheets in the same Excel workbook (ex. individual tabs for medication occurrences with individual occurrence detail). By including this information in each department's workbook, they can refer to the information, act upon it, and treat it as a working document and means of communication for others to view.
- Previously, the shared K: drive with all department dashboards was utilized as mostly a repository. Now the folder is strongly encouraged to be used as a means for departments to improve on metrics and processes through frequent meaningful updates.
- Other new features of the dashboards include any and all information collected for that department through Quality. Also, where possible, dashboards and metrics have been set for auto-formatting (calculations, trend colors, and uniform appearance to other dashboards). This has been done to ensure that information being entered is not done manually. The Quality department has done further investigation into department's metrics to display the information behind the data rather than showing a generic number. Each department has been asked, where possible, to include a numerator and denominator of any given percentage or rate in their dashboards and to elaborate on the criteria of the metric. Criteria may include inclusion and exclusion criteria, why the measure is important for quality, and established goals and benchmarks through nationally or state recognized organizations.
- The Quality department has successfully implemented new and revised dashboards for the following departments: Cardiopulmonary Services (CPS); Clinical Informatics; Continuum of Care (COC); Emergency Department/Critical Care Services; Hospitalist Report; ICU; Infection Prevention; Medical-Surgical Unit (Med/Surg); NICHE; Obstetrics/Maternity; Operating Room (OR)/PACU; Perioperative Services; Pharmacy-Retail; Prenatal Care; Progressive Care Unit (PCU); Senior Behavioral Health Unit (SBHU); Wound Prevalence
- Separate folders will be created to focus on priority projects at RMH such as: Falls, Readmissions, Sepsis, and Inpatient Glycemic Control. The purpose of this is to increase transparency of those committees/workgroups/meetings and to develop a centralized location of information.
- Lastly, the Quality Department has been working with the Compliance Director to ensure that information pertaining to HFAP Plans of Correction can be easily found in its own separate folder. This will be the location to go to when HFAP requires an update on major audits occurring in clinical services areas and when they ultimately return for their 3 year reaccreditation survey.

- The changes listed above have been well received as of the May 2019 Clinical Services Departments QA/QI meeting. Individual department heads understand the amount of work that goes into this initiative and why it is important for the organization overall to have a location with all their departments information available.