Rome Health

An affiliate of St. Joseph's Health

Rome Memorial Hospital & Residential Healthcare Facility (RHCF)

2021-2022 Performance Improvement (PI) Plan

Rome Memorial Hospital & Residential Healthcare Facility's 2021-2022 Performance Improvement Plan

Revised plan adopted by the Board of Trustees Quality Council on Nov 13th, 2015.
2021-2022 Plan approved by the Board of Trustees on Dec 10th, 2020.

Rome Memorial Hospital & Residential Healthcare Facility's Performance Improvement (PI) Plan

Note: The new **2021-2022 Performance Improvement (PI) Plan Quality Goals** start on Page 11 of this document, all other information preceding has remained unchanged since the 2017 updates.

Introduction

Rome Memorial Hospital believes that **performance improvement (PI)** is a continuous process. Its focus is on the measurement and analysis of the hospital's critical processes in an effort to identify opportunities to enhance performance. These improvements should support the hospital's vision, mission and goals.

Further, the PI program is dedicated to assisting internal efforts in obtaining clinical and service excellence throughout Rome Memorial Hospital. The program should provide expertise and support to the hospital centered on continuous quality improvement (QI), innovation and project management techniques. Under the direction of senior leadership, the program staffs and supports various project teams.

Hospital Mission Statement

We provide quality healthcare with compassion.

Purpose

The purpose of this PI Plan is to: **(1)** clearly identify the functions of all quality stakeholders in the organization's pursuit of providing the highest quality of care, **(2)** describe the methods of achieving this level of quality.

Establishing Priorities for PI

Priorities for PI are established collaboratively by the organizational leadership comprising the Senior Administration Team, Department Directors and the Medical Executive Committee. The Quality Council evaluates input from these groups in determining resource allocation (financial, time, and human) for designation of interdisciplinary teams.

The following criteria are considered in establishing priorities:

- Rome Memorial Hospital's Mission, Vision, and Strategic goals
- Needs and expectations of patients and families
- Patient and family feedback via satisfaction surveys
- Community needs
- High volume events (diagnosis, procedure, process)
- High risk, problem-prone or sentinel events
- High-cost diagnoses, procedures, or processes
- Input from medical staff and employees
- Input from external sources (licensing, regulatory agencies, and other groups)

- Identified competency and training needs
- Financial and human resources

Authority and Responsibility

The **Board of Trustees (BOT)** is responsible for overall quality of care and maintains oversight through its **Quality Council (QC).** The BOT works cooperatively with the hospital's Administration and Medical Staff leadership to achieve the goals of the PI Plan. In doing so, the **BOT:**

- Provides direction in setting PI priorities based on the Mission, Vision, and Strategic goals
- Oversees the design, implementation, and ongoing monitoring of the organization-wide PI function
- Establishes an organizational culture which supports commitment to quality, PI, and patient safety
- Provides adequate resources, both materials and manpower, to accomplish the PI function
- Receives, reviews and accepts reports regarding the effectiveness of organization-wide PI activities
- Assures that Medical Staff credentialing and the granting of clinical privileges allows only qualified physicians and allied health professionals to be granted privileges
- Assures that, on advice and guidance of the Medical Staff, all credentialed practitioners perform within the scope of their licenses, capabilities, and expertise
- Requires mechanisms to assure that patients receive comparable levels of care throughout the organization

The responsibility of the **QC** is to direct and assist the **BOT** in overseeing, reviewing, monitoring, evaluating, and establishing priorities for all hospital-wide, residential health care facility (RHCF), and medical staff PI and patient safety activities. The QC consists of members of the BOT, Medical Staff, Senior Administration, Nursing, Nursing Home Administration, and several department Directors. The QC meets at least monthly, and may convene whenever deemed necessary. The QC:

- Supports compliance with the requirements of the Healthcare Facilities Accreditation Program (HFAP), Centers for Medicare and Medicaid Services (CMS), New York State Department of Health (NYSDOH), and other regulatory/accrediting agencies.
- Reviews monthly, quarterly, and annual PI reports which may include:
    - Hospital and Residential Health Care Facility (RHCF) PI activities; all departments and services, including any newly formed services
    - Medical staff quality/utilization activities
    - HFAP, IPRO and DOH plans of correction
    - Risk Management reports

    - Patient/family complaints and grievances
    - Comparative data reports; Press Ganey (Inpatient/Outpatient measures), HANYS, and CMS Quality Initiatives
    - Infection Prevention reports
    - Root cause analysis reports
    - Medical record reviews
    - Patient/employee/visitor safety issues
    - Failure Mode and Effect Analysis (FMEA) reviews
    - Medication occurrence reports
    - Patient satisfaction (HCAHPS)
- Reviews **Performance Improvement Committee (PIC)** activities; approving recommendations for actions on discussion items and case reviews
- Reviews, makes recommendations for revisions, and approves hospital-wide and medical staff PI reports
- Maintains confidentiality, security, and integrity of patient information and PI information.
- Directs and oversees the evaluation of the PI program and plan, making recommendations for improvements in the plan and all related activities
- Performs any specific tasks and duties that are requested by the BOT

The responsibility of the **PIC** is to ensure medical staff participation in the measurement, assessment, and improvement of patient care processes, as well as ongoing evaluation of the effectiveness of peer review activities. Additionally the PIC is responsible for oversight of the hospital-wide Utilization Review (UR) function. The PIC is comprised of a member from each medical staff department, QC Chairperson, the Chief Medical Officer, the Performance Improvement Director, the Compliance Manager, and representatives of Nursing and Senior Administration and applicable Hospital Support Services. The PIC meets at least quarterly and may convene whenever deemed necessary.

The PIC

- Ensures that objective and clinically-valid criteria are used in evaluating the appropriateness and quality of patient care
- Ensures that recommendations for actions on discussion items and selected case reviews are referred to QC and Medical Executive Committee (MEC) for review and approval
- Reviews and monitors peer review activities to include proctoring, external reviews, educational assignments, actions taken, and resolution/closure
- Reviews medical staff PI activities
- Reviews and evaluates the following as appropriate:
    - Admissions/Readmissions (admitting/discharging provider) to the institution

- Length of stay (LOS)
- Medication usage
- Use of blood and blood components
- Medical record documentation
- Infection prevention issues
- Core Measure indicators (Press Ganey – Inpatient/Outpatient measures)
- Patient/family complaints and grievances
- Risk management issues
- Sentinel events
- Root cause analysis reports
- Physician related trending reports
- Patient/employee/visitor safety issues
- Failure Mode and Effect Analysis reviews
- Patient satisfaction reports (HCAHPS)

The **PIC's** UR responsibilities are outlined in the Rome Memorial Hospital Utilization Management Plan. **(Approved by BOT 2/23/16)**

The **Medical Executive Committee (MEC)** has the responsibility for reviewing the significant activities, findings, and recommendations submitted by the PIC. Particular emphasis is based upon review of all data generated for medical staff monitoring functions, as well as the specification of any additional information required to ensure provision of consistent improvement in quality of care and patient safety. In so doing, the MEC will monitor conclusions, recommendations and actions taken by Medical Staff departments, PIC, and other medical staff committees with PI responsibilities, assuring that appropriate actions have been taken to resolve identified problems. Corrective actions will be conducted in accordance with the Bylaws, Rules and Regulations of the Medical Staff.

The **Safety and Patient Safety Committees** have the responsibility of ensuring ongoing, interdisciplinary, reactive and proactive patient safety programs. These committees function to identify risks to patient safety and to reduce exposures to patients and/or the general public. The committees consist of representatives from Senior Administration, (RMH and RHCF), Nursing, Pharmacy, Emergency Department, Surgery, Education, Infection Prevention, Laboratory, Medical Imaging, Plant Operations, Biomed, Material Management, SBHU, and Quality and PI. These committees meet at least quarterly and report to the QC and BOT.

The **Chief Medical Officer (CMO)** has oversight responsibility for the Medical Staff's ongoing participation in the continuous assessment and improvement of the quality and safety of medical care rendered. The CMO guides department chairpersons in formulating and achieving objectives for the improvement of the quality of medical care, ensures that predetermined criteria and professional standards are used, and that effective systems for ongoing review and evaluation are maintained.

The **Quality and PI Department** is committed to providing prioritization and guidance for all organizational PI activities that are aligned with RMH's strategic goals. This guidance extends to departmental directors, PI teams, medical staff, patient safety committee, and the BOT with respect to the design, measurement, assessment and improvement of processes under study. Further, the Quality and PI staff reviews and analyzes all PI-related information for reporting to PIC, QC, and BOT. The CMO has a close working relationship with the Quality and PI Department.

Each hospital **department/unit** is ultimately responsible (with guidance from PI) for the development and implementation of appropriate monitoring criteria and standards to be routinely utilized in their assessment of the quality and appropriateness of the services rendered by that area. The **department director/manager** provides the overall direction and supervision of the department's PI activities and is accountable for insuring that the activities are meaningful, effective, and integrated with the hospital-wide PI program. Each department director/manager is responsible for the ongoing collection, screening and evaluation of information with respect to their identified indicators. Appropriate action will be taken by the department directors or their designee in acting on opportunities for improvement. These actions may include, but need not be limited to:

- Educational and training programs
- Development and implementation of new or revised policies and procedures
- Root cause analysis review (with assistance from Quality and PI/Risk Management)
- Staffing changes
- Equipment or facility changes
- Counseling or coaching

The findings, recommendations, conclusions, and results of actions taken are documented and reported to the appropriate Vice-President, Medical Staff department or committee, if applicable, and to the Quality and PI department as least quarterly.

PI Multidisciplinary Teams may be formed, with the approval of the directors of the departments involved, when an opportunity for a process improvement is identified. The team's mission must be consistent with the hospital mission and follow the process as outlined in this plan. The team should be cross-functional and multi-disciplinary with an aim to measure and assess important functions and processes within the organization. A summary of activities and results will be included in PI reports and presented to the Quality and PI department.

Rome Memorial Hospital's PI Process

The objective of Rome Memorial Hospital's organization-wide PI process is to ensure that the quality and appropriateness of patient/resident care and services delivered are of high quality, that there is an established framework for PI activities, and that the process supports the organization's mission, vision and values.

The process begins with the BOT's strong commitment, modeling, and leadership. Improving organizational performance and patient safety is fostered through multidisciplinary patient care processes and employee involvement in improving work flow. Improving organizational performance requires a combination of the following:

- Systems thinking and prioritizing
- Focusing on important processes through outcomes measurements
- Traditional quality assurance and quality control methods
- Interdisciplinary processes
- Use of total quality management (TQM, Lean Six Sigma) techniques
- Utilization of comparative databases
- Internal and external benchmarking

Department directors and/or PI teams develop indicators to monitor the quality of important dimensions of performance in patient care and/or their areas of assigned responsibility. The indicators include clinical criteria which are objective, measurable, and are based upon current, professionally accepted knowledge and clinical experience. Data are collected for each indicator based on the frequency, significance, and extent of problem potential associated with the activity being monitored.

The **Dimensions of Performance** that may be monitored include:

- **Efficacy:** accomplishes the desired or expected outcomes.
- **Appropriateness:** is relevant to patient's needs, using current evidence-based medicine.
- **Availability:** addresses accessibility of service to patients' needs.
- **Timeliness:** assures service is provided in the most beneficial or necessary time.
- **Effectiveness:** assures service is provided in correct and complete manner.
- **Continuity:** assures that care is coordinated and consistent among practitioners over time.
- **Safety:** clinical and environment risks are minimized for patients, visitors and employees.
- **Efficiency:** correlation between outcomes and resources used to deliver services. Waste of equipment, supplies, ideas, and energy is avoided.
- **Respect and Caring:** services are provided with sensitivity and respect for each patient's individual needs, allowing for the patient and their family's involvement in the decisions making process.
- **Patient-centered:** ensures that the provision of care is respectful of and responsive to individual patient preferences, needs and values that guide all clinical decisions.
- **Equitable:** provides care that does not vary in quality based on personal characteristics such as gender, ethnicity, geographic location or socio-economic status.

Continuous PI Model

Rome Memorial Hospital has adopted Deming's **FOCUS PDCA** model to improve interdisciplinary systems and processes:

- **F**ind a process to improve; anyone in the organization can identify a process or system that requires improvement
- **O**rganize a team that knows the process
- **C**larify current knowledge of the process (Failure Mode and Effects Analysis)
- **U**nderstand the cause of process variation (Root Cause Analysis)
- **S**elect the process to improve; the data is then analyzed to provide focus
- **P**lan the improvement and continue data collection
- **D**o the pilot test
- **C**heck the results and the lessons learned from the team effort
- **A**ct to standardize the improvement and continue to continue to improve the process

Process Design

We would use the Continuous Performance Model in the following situations:

- Improving an existing process
- Redesigning an existing process
- Designing an essentially new process
- Reducing variation or eliminating undesirable variation in established processes or outcomes

The following considerations regarding process design assist with performance expectations of processes, functions, and services:

- Evidence that the proposed design supports RMH's Mission, Vision, Guiding Principles and strategic goals, or evidence that the proposed design meets or exceeds stipulated quality control or other regulatory requirements and/or standards
- The assessed or expressed needs of individuals, staff, and others
- Current practice information i.e., the use of practice guidelines, evidence-based clinical standards, and information from relevant literature
- Sound business practice
- The use of available information from other organizations about the occurrence of sentinel events to reduce the risk of similar sentinel events
- The results of PI activities

Performance Measurement (Data Collection)

Monitoring performance through data collection (performance measurements) and analysis is the foundation of all PI activities.

In an effort to continually improve our organization's performance and maintain quality of patient care, Rome Memorial Hospital collects and utilizes data to perform an examination of its systems and processes.

Data collection is used to:

- Establish a performance baseline
- Assess the dimensions of performance relevant to functions, processes, and outcomes

- Measure the level of performance and stability of important existing processes (identify variations)
- Identify areas for possible improvement of existing processes
- Determine whether process redesign resulted in improvement
- Verify that improvements have been sustained over time

Aggregation and Analysis

Data is periodically aggregated, analyzed and compared. This facilitates the transformation of data into conclusions about performance. Analysis includes but is not limited to:

- Assessment of process stability over time.
- Predictability in relation to performance expectations.
- Comparison of RMH's performance with other organizations, professional groups and recognized standards of practice.

Intensive analysis is initiated when comparisons indicate negative trends or performance that is below expectations. This includes a detailed study of processes and systems to detect factors influencing stability and performance, as well as the basic or causal factors that underlie variation in performance, especially in sentinel events.

Events requiring intensive analysis may include:

- Incidents reportable to New York State (NYPORTS)
- Important single events, patterns, or trends that vary significantly and undesirably from those expected
- When performance varies significantly & undesirably from benchmarks or recognized standards
- All sentinel events
- All confirmed transfusion reactions
- All serious adverse drug reactions
- All significant medication errors
- Major discrepancies or patterns of discrepancies between pre- and post-operative diagnosis, including those identified during the pathologic review of specimens removed during surgical or invasive procedures
- Adverse events or patterns of adverse events during moderate or deep sedation or anesthesia use
- Hazardous conditions
- Staffing Effectiveness issues
- Never Events

Improving Performance: Action Planning

Whenever an action is established to improve a process, the following elements should occur:

- Planning of the specific process changes
- Implementing process changes on a trial basis
- Measuring and assessing the effectiveness of actions taken
- Planning and testing a new action if initial actions are not effective

- Implementing successful actions on an organization-wide basis, as applicable

When actions have demonstrated success, and have been evaluated and approved by QC, the results are shared with others in the organization through any of the following:

- Leadership forums
- Board summaries
- Bulletin Board postings
- Storyboards
- Medical staff mailings
- Relevant department meetings and relevant committees.

Education

PI and the Patient Safety Committee members receive training in the concepts of Continuous Quality Improvement. This training extends from top leadership throughout the organization. As such, all individuals are expected to perform in accordance with the principles of continuous quality improvement.

PI Team members are trained in the principles and tools of the Focus-PDCA model including practical application. Employees are introduced to principles of PI concepts and objectives during new hire orientation, staff meetings, RMH publications, and applicable seminars.

Every employee is expected to participate in PI activities as requested. Employees unable to perform this responsibility because of a lack of knowledge regarding methods and approaches will be trained as indicated.

Training will be conducted at regular intervals as well as on an "as needed" basis. Team facilitators will act as primary resources for training. Staff will be oriented to the ongoing benefits and theories of PI. Ongoing educational and departmental feedback will serve to reinforce progress.

Methods of education may include but are not limited to:

- New employee orientation
- Web-broadcasts and teleconferences
- Literature
- On-site conferences/classes/in-services
- Seminars, conferences, workshops or other meetings devoted to PI education
- Shared success stories from PI teams
- Individual training sessions with department directors and staff from individual units

Records and Reports

Summary reports of PI activities will be submitted to the PI department by department directors on a quarterly, monthly, or yearly basis. These reports shall include graphical representations of data collected and trended over time if possible. The data should then be

compared to historical data or benchmarks from recognized sources; and the Director's analysis of that data, with an action plan and follow-up, as indicated. Other PI activities undertaken by the department or service shall also be included in the report and presented in a format acceptable to the Director of Quality and PI.

Clinical committees, task forces and PI teams will submit copies of their records and reports to the Quality and PI Department after each meeting. Summaries will be provided to the QC on a periodic basis.

Confidentiality

All PI material shall be labeled and treated as strictly confidential and protected from disclosure as stated by Section 2805 j, k, l, & m of the Public Health Law and subsection 3 of 6527 NYS Education Law. All PI activities are conducted in a manner that assures the confidentiality of the patient and complies with HIPAA requirements.

Rome Memorial Hospital's primary goals listed below demonstrate an effective and ongoing hospital-wide quality assessment and performance improvement (PI) program:

- To achieve a Leapfrog Safety Grade of "A"
- To achieve a CMS Star Rating of 4 or greater

It is important to note that the following PI goals cannot be achieved without multidisciplinary collaboration. This includes but is not limited to the hospital's board of trustees, administration, medical staff, service-line leadership, and front-line staff.

For the 2021-2022 PI period, the initiatives that fall under the primary goals listed above are as follows:

OPIOID STEWARDSHIP

Objective: Establish an Opioid Stewardship Collaborative consistent with standards outlined in the Leapfrog Hospital Survey, BlueCross BlueShield Blue Distinction program, and HANYS Eastern US Quality Improvement Collaborative (EQIC). In developing an opioid stewardship collaborative within our hospital, we will be a step closer to improving overall patient safety, understanding our own prescribing patterns, establishing best practices for opioid use within our organization, and be able to optimize pain management better for our patients.

Strategies:

- Align organizational efforts with best practice standards that are outlined within the Leapfrog, HANYS EQIC, and Excellus Blue Distinction programs
- Establish a multidisciplinary Opioid Stewardship Committee, through which the collaborative will be managed.
    - Develop a workflow of best practices for opioid utilization in inpatient and outpatient settings
    - Through collaboration of IT and Quality, monitor all available resources for data related to opioid use and overdose prevention, an example would be starting with overall acute opiate prescribing
    - Enhancing the oversight of current opioid reporting that includes opioids prescribed upon discharge from the Emergency Department (ED) and make the data more accessible organization-wide
- Disseminate updates through existing medical staff and organizational communication outlets.

Outcome: Achievement of opioid prescribing practices, policies and procedures consistent with established best practice. Specific measurable goals will be developed through the Opioid Stewardship Committee.

FALL REDUCTION

Objective: Enhancement of current falls reduction programming to reduce instances of patient falls and improve the post-fall follow-up process

Strategies:

- Completion of accurate and timely incident reports to address issues in falls in real-time
- Include a detailed progress note in the patient's record for appropriate follow-up and communication of critical information to other care providers for enhanced care planning
- Integrate regular fall reviews/audits to identify areas for improvement in interventions and modify the patient's plan of care as needed or indicated
- Improve communication to all shifts and across departments when a patient falls or is labeled a fall risk
- Incorporate responsive and real-time reporting across all units through the Quality department, this includes comprehensive analysis that identifies easily distinguishable trending through visual data

Outcome: To achieve the EQIC and National Database for Nursing Quality Indicators (NDNQI) benchmarks related to patient falls, specifically patient falls per 1,000 patient days. EQIC will provide fall benchmarks in relation to the hospitals acute care units (2E, 2N, ICU) for several eastern states whereas the NDNQI will provide benchmarks for all units including SBHU and RHCF that is national and correlates the information with staffing levels and experience. Both benchmarks will be established in 2021; EQIC begins in January and NDNQI will go through a rapid improvement program to establish regular reporting of unit level data.

GLYCEMIC CONTROL

Objective: Rome's Pharmacy department continues to focus on all results from the Inpatient Glycemic Control program that was fully established in 2018. After continuous monitoring, it was recognized that our facility has an opportunity for improvement in reducing hyperglycemic results, specifically those that are greater than or equal to 300 mg/dL.

Strategies:

- Review of patients with insulin orders upon admission
- Provider and Pharmacy discuss Insulin Management and orders during a patient's stay
- Pharmacy will discuss the reasoning with patient for Basal Bolus and discontinuation of oral agents during their acute stay
- Establish key performance indicators (KPI) to track information daily for an increased focus on real-time results.

- Development of a repeat offender list to flag patients on admission as well as separate diabetic ketoacidosis (DKA) patients to review them separately
- Regularly share results with all clinical units and medical staff,
- Re-educate the importance of finger sticks prior to meals and make a note in medication administration if there are obvious reasons for elevated results

Outcome: Achieve a 10% reduction of the hyperglycemic results greater than 300 mg/dL starting with December 2020 as a baseline. Establish a renewed push to follow the "no oral hypoglycemic" best practice on the acute medical units.

MEDICATION SAFETY

Objective:

- Medication Occurrence/Near Miss Reporting:
  - Improve the current monitoring program for medication occurrences through enhanced data collection and a facility-wide program geared toward near miss reporting.
  - The hospital aims to have zero Category E occurrences or greater (those in which harm reaches the patient) to reduce any risk of harm to patients.
  - Increase the reporting of Category A and B occurrences (near-miss opportunities) that are useful in learning from and correcting system issues or staff errors in the safe administration of medications.
- Barcode Medication Administration (BCMA):
  - Maintain BCMA compliance at $\geq$ 95%.

Strategies:

- Medication Occurrence/Near Miss Reporting:
  - Enhance reporting of medication occurrences to identify trending in the categories of errors and the shifts where more or less reporting occurs.
  - Identification of which hospital shifts report more frequently will assist in re-education and interventions in regards to occurrence reporting.
  - Communication of a hospital-wide policy that near miss reporting is encouraged and that the organization adheres to Just Culture principles.
  - Demonstrate to front line staff how near misses can impact the safety of the patient overall through real cases.
- BCMA:
  - Identify noncompliant medication administrations and the causes behind them.
  - Ensure that each unit is responsible for maintaining surveillance of unit-level results.
  - Continue a weekly review of scanning rates by unit and individual RN scan rates.

Outcome(s):

- Medication Occurrence/Near Miss Reporting:
  - Achieve zero category E or greater medication occurrences.
  - Increase near miss reporting related to medication administration by 20%.
- BCMA:
  - Maintain at least 95% compliance with scanning patient and medications during administration in applicable units where BCMA is implemented.

CONTINUOUS IMPROVEMENT IN HOSPITAL-ACQUIRED INFECTION (HAI) OUTCOMES

Objective: Continue to meet nationally recognized benchmarks for CAUTI, CLABSI, and wounds in the facility. Monitor and further enhance focused efforts to reduce instances of in C. difficile and Surgical Site Infection (SSI).

Strategies:

- C. diff
  - Monitor utilization of the order set created in 2020 and application of appropriate criteria for c-diff testing
  - Track the results of the audit on order set utilization; a key performance indicator (KPI) has been created in 2020 and present outcomes through medical staff meetings and clinical leadership updates.
- SSI
  - Collaborative engagement with our surgeons to optimize patient education related to post-operative wound management.
- Completion of a root cause analysis for all suspected/confirmed SSI to determine underlying reasons and to recommend interventions and follow-up.

Outcome: Achievement and maintenance of HAI rates at or below national benchmarks for CAUTI, CLABSI, SSI, C-Diff and pressure injuries.

PATIENT SATISFACTION

Objective: Improve overall patient satisfaction through targeted interventions. Complaints are frequently focused on communication and behavior/attitude from the care provider.

Strategies:

- Initiate bedside nurse hand-off on all patient care units
- Real time distribution of patient comments so that they can be discussed at staff huddles
- Continuation of provider/COC family meetings with virtual options available when family cannot be physically present

- Establish a multidisciplinary patient experience committee chaired jointly by the Director of Patient Experience and a designated Nursing leader that includes community members as well as physician partners.

Outcome: Achieve 75th percentile for the overall Hospital CAHPS (HCAHPS), Emergency Department, and Outpatient Ambulatory Surgery with a primary focus on nursing communication, provider communication, and staff responsiveness.

READMISSIONS REDUCTION

Objective: Reduction of 30-day readmissions as a reflection of effective medical management, discharge planning, and post-acute patient services.

Strategies:

- Establish a concurrent review process with Continuum of Care, Medical Records, Quality, and the Hospitalist team to determine common reasons for readmissions and opportunities for improvement in the hospitals processes.
- Audit that medication reconciliation is 100% complete upon admission and discharge.
- Develop a process with the Article 28 clinics to determine the level of compliance with post-hospitalization follow-up appointment for patients within our practices. Through the Hospitalist Director, work with clinical leaders and physicians to ensure post-discharge phone calls are made 48-72 hours after discharge.
- Evaluate the current use of teach-back methods and educate further with front-line staff when necessary.
- Adjust discharge instructions accordingly for high acuity patients for specialized or prolonged care services.
- Bridge interventions from hospital to primary care and specialty services through transition coaches that assist with the continuity from inpatient to outpatient care.
- Develop a standardized report that is readily accessible to all stakeholders of readmissions that will also allow for regular review of cases to determine a need for follow-up or intervention.

Outcome:

- Achieve the benchmark established through CMS Hospital Compare of 15.6 for the rate of readmission after discharge from the hospital (hospital-wide).
    - An outcome measure will be a decreased rate of all-cause 30 day readmissions for same or similar diagnoses, targeting those diagnoses that are the most commonly occurring among readmitted patients.
- Identify all barriers to delivering the highest quality of evidence-based care for patients that are readmitted to the facility. In pinpointing areas where the team can develop improved processes, our staff will be more educated and alert in addressing factors that lead to patients coming back for same of similar conditions.
- Establish a process to concurrently review cases through a multidisciplinary team to determine learning opportunities for the prevention of future readmissions.

FACILITY AND SPECIAL CARE ACCREDITATION ACTIVITIES

HEALTHCARE FACILITIES ACCREDITATION PROGRAM (HFAP) REACCREDITATION

Objective: Achieve HFAP reaccreditation during the 2021 resurvey period. Minimize deficiencies cited during the process and ensure that the facility is not cited on the same deficiencies as the last survey period.

STROKE ACCREDITATION

Objective: Achieve Primary Stroke Center designation through CMS and New York State. This specialty designation allows first responders to bring patients suspected of having a stroke to our emergency department. Without this designation, ambulance services must bypass our ED and take patients to the nearest designated stroke center for treatment. HFAP is the certifying body and surveys on behalf of CMS. The standards through which designation is achieved are consistent with best practice and promote stroke team engagement and a focus on quality.

BARIATRIC PROGRAM ACCREDITATION

Objective: Achieve the Metabolic and Bariatric Surgery Accreditation and Quality Improvement Program (MBSAQIP) designation through the American College of Surgeons. The purpose is to maintain safe, high-quality care for bariatric patients. Bariatric surgery accreditation promotes uniform standard benchmarks and supports continuous quality improvement the MBSAQIP recognizes facilities that implement defined standards of care, document their outcomes, and participate in regular reviews to evaluate their bariatric surgical programs.

BLUE DISTINCTION IN SPINE SURGERY

Objective: Achieve designation as a Blue Distinction Specialty Care for Spine Surgery. This includes distinction for comprehensive inpatient spine surgery services; including discectomy, fusion and decompression procedures. Facilities that achieve this designation are found to have lower readmission rates and fewer returns to the OR.

BLUE DISTINCTION IN MATERNITY CARE

Objective: Achieve designation as a Blue Distinction Specialty Care for Maternity Care. This includes distinction for quality care for vaginal and cesarean section deliveries. Facilities that achieve this designation are found to demonstrate better overall patient satisfaction and a lower percentage of early elective deliveries.

In achieving the Blue Distinction designation for specialty care through BlueCross BlueShield, facilities are conferred based on evidence-based quality measures, and processes and aggregate outcomes for clinical care. Blue Distinction Centers demonstrate quality care, treatment expertise and better overall patient results.