



The MetroHealth System

Board of Trustees

Wednesday, May 28, 2025

11:00am - 1:00pm

The MetroHealth System Board Room K-107 or via YouTube Stream

Quality, Safety and Experience Committee

Regular Meeting

The MetroHealth System Board of Trustees

QUALITY, SAFETY AND EXPERIENCE COMMITTEE

DATE: Wednesday, May 28, 2025
TIME: 11:00am – 1:00pm
PLACE: MetroHealth Board Room K107 / Via YouTube Stream:
<https://www.youtube.com/@metrohealthCLE/streams>

AGENDA

- I. **Approval of Minutes**
Committee Meeting Minutes of February 26, 2025
- II. **Information Items**
 - A. Patient Experience Story (Video) – *J. Lastic* (5 minutes)
 - B. Improving the Patient Experience – *M. Sullivan* (20 minutes)
 - C. Nursing Annual Quality Review – *Dr. Mori* (20 minutes)
- III. **Executive Session**

Return to Open Meeting

The MetroHealth System Board of Trustees

QUALITY, SAFETY AND EXPERIENCE COMMITTEE MEETING

Wednesday February 26, 2025

11:00 am – 1:00 pm

In-person K107/Via Zoom

Meeting Minutes

Committee Members: Ronald Dziedzicki-I, E. Harry Walker, MD-I

Other Trustees: Sharon Dumas-I, Michael Summers-I,

Staff: Christine Alexander-Rager, MD-I, Agnieszka Ardelt, MD-I, Robin Barre-I, Ivan Berkel-I, Michelle Block-I, Stacey Booker, RN-I, Chris Briddell-I, Robert Bruce, MD-I, Nabil Chehade, MD-I, Joseph Golob, MD-I, Michelle Hecker, MD-I, Derrick Hollings-I, Matthew Kaufmann-I, Nisrine Khazaal-I, William Lewis, MD-I, Srinivas Merugu, MD-I, Charles Modlin, MD-I, Candy Mori, RN-I, Allison Poullos-I, Nicole Rabic, RN-I, Amy Ray, MD-I, Brian Rentschler-I, Tamiyka Rose-I, Jon Schrock, MD-I, Deborah Southerington-I, David Stepnick, MD-I, Maureen Sullivan, RN-I, James Wellons-I, Donald Wiper, MD-I

Guests: Mike Cronin (Deloitte)

Mr. Dziedzicki called the meeting to order at 11:01 am with a quorum present.

The minutes are written in a format conforming to the printed meeting agenda for the convenience of correlation, recognizing that some of the items were discussed out of sequence.

I. Approval of Minutes

Mr. Dziedzicki requested a motion to approve the minutes of the October 23, 2024, Quality, Safety, and Experience Committee meeting as presented, which was given, seconded and unanimously approved.

II. Information Items

Patient Safety Story Video

Mr. Dziedzicki introduced Dr. Golob, EVP, Chief of Quality and Safety and Stacey Booker, Director of Patient Safety and High Reliability, who presented a video to the committee discussing the MetroHealth Great Catch Program. The video highlighted the importance of near miss or great catch reporting. A near miss is a patient safety event that is caught by staff members, by process, or even by

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chance, before it reaches the patient to avoid harm to the patient. These events are crucial to proactively identify issues and finding solutions to prevent patient harm. An example of a near miss is when a nurse was about to administer a medication and used barcode scanning which alerted her that it was the wrong patient. This incident was reported by the nurse, which prompted a closer look at the process and identify areas where intervention could have been made earlier to prevent harm to the patient. This process is not limited to inpatient care but also extends to ambulatory services such as Radiology and Laboratory.

The patient safety team reviews all safety events and takes a report of all near misses from the month. The patient safety committee votes on the great catch of the month in collaboration with the Office of Professional Affairs. Last year, a great catch of the year was incorporated in patient safety week to allow caregivers to vote on the great catch of the year.

Last year, over 2,100 near misses were reported throughout the organization, which is important because the Great Catch program seeks to improve patient safety measures and reach the true north goal of eliminating patient harm.

Review System Quality Assurance Performance Improvement (QAPI) Plan

Dr. Golob directed the Committee's attention to the QAPI plan that was included in the meeting material. Dr. Golob explained that the QAPI plan does not require a resolution but provides a summary of the Quality Safety Experience Group. The QAPI plan is reviewed by the Joint Commission at the start of a survey and recently the Quality team was complimented by the Joint Commission on the QAPI plan.

Antimicrobial Stewardship Program

Mr. Dziedzicki introduced Dr. Michelle Hecker, Medical Director of the MetroHealth Antimicrobial Stewardship Team, who discussed the Antimicrobial Stewardship Program (ASP) and its mission and purpose. The program was established to combat antibiotic resistant bacteria and was mandated by the Joint Commission in 2016 to establish an antimicrobial stewardship program in all hospitals.

MetroHealth formally established an antimicrobial stewardship program in 2012, one of the first programs established in the region. The antimicrobial stewardship program aims to optimize necessary antibiotic use and decrease unnecessary use, contributing to the provision of safe and high-quality patient care and population health. Antibiotics are commonly prescribed and used sub-optimally, affecting not only individual patients but the entire population. Antibiotics also have the potential for causing significant adverse effects, such as C. difficile infection, acute kidney injury, and allergic reactions. To ensure the proper use of antibiotics, the

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program has implemented interventions such as prospective audits, feedback, division/department lectures/meetings, and annual medical staff updates.

The Adult stewardship program includes collaboration with the Emergency Department (ED), comprised of 3 ED pharmacists who closely monitors and reviews pre-procedural antibiotic administration. The team reviews order sets and manage the "Culture Call Back" program, reviewing culture results or microbiologic tests to determine if a patient has not received the appropriate antibiotic treatment. They also collaborate closely to optimize processes and outcomes to manage sepsis cases.

The Pediatric/Neonatal Stewardship program involves working with the Neonatal Intensive Care Unit team and participating in the development of guidelines related to antibiotic use in pediatrics/neonatology with one pharmacist who reviews order sets and manages the pediatric/neonatal stewardship program.

Stroke Certification with Resolution

Mr. Dziedzicki introduced Dr. Agnieszka Ardelt, Chair, Department of Neurology, and Dr. Jon Schrock, Co-Chair, Stroke Program, to discuss the importance of stroke certification. Dr. Ardelt explained that MetroHealth has been certified as a comprehensive stroke center, providing the highest level of stroke care, by The Joint Commission since 2014. In 2019 MetroHealth Parma and MetroHealth Brecksville were certified by the Accreditation Commission for Health Care (ACHC) as stroke ready emergency departments. The Joint Commission requires specific minimums for certain diagnoses and procedures, which MetroHealth is at risk of not meeting the minimums requirement.

Due to The Joint Commission requiring specific minimums for certain diagnoses and procedures, as MetroHealth is the smallest of the major health systems in the Cleveland region, external forces have affected the number of acute stroke patients for whom we care. As a result, some of these diagnosis and procedures require minimums that are very small outside of the entire stroke population. Because the minimums are not negotiable, MetroHealth is at risk of losing comprehensive stroke center certification which could lead to the loss of the sickest stroke patients, loss of talented stroke care providers, and cause a domino effect on other MetroHealth programs, and loss of reputation.

Switching certification requirements from The Joint Commission to the Accreditation Commission for Health Care could result in loss of EMS traffic, but there is still a need to mitigate any decrease or increase in stroke transports to MetroHealth. To address this, the recommendation is to certify our comprehensive

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stroke center with the ACHC which aligns better with MetroHealth's stroke program's vision.

The timeline and cost for the ACHC certification cycle are \$42K for a 3-year certification cycle, no surveyor travel fees for on-site visits and includes an 18-month on-site intracycle review. The timeline and cost for The Joint Commission certification cycle are \$44.5K for a 2-year certification cycle and an additional \$5K for surveyor travel fees. A resolution for the reaffirmation of support for certification of stroke care programs will be presented for committee level approval and then submitted to the Board for full approval.

Executive Session

Mr. Dziedzicki asked for a motion to move into executive session to discuss hospital trade secrets as defined by ORC 1333.61 and to consider the appointment, employment, dismissal, discipline, promotion, demotion, or compensation of a public employee, or the investigation of charges or complaints against a public official, and to conference with the public body's attorney to discuss disputes involving the public body that are the subject of pending or imminent court action as defined by ORC 121.22(G). The motion was made by Dr. Walker and seconded by Mr. Summers. Upon unanimous roll call vote, the Committee went into executive session to discuss such matters at 11:50 am.

Following executive session, the meeting reconvened in open session at approximately 12:59 pm.

Recommendation / Resolution Approvals

A. Reaffirmation of Support for Certification of Stroke Care Programs

Mr. Dziedzicki called for a motion for the approval of the Reaffirmation of Support for Certification of Stroke Care Programs, which was given, seconded and the resolution was passed to be presented to the Board of Trustees for full approval.

There being no further business to bring before the Committee, the meeting was adjourned at approximately 12:59pm.

THE METROHEALTH SYSTEM

Joseph Golob, M.D.
EVP, Chief Quality and Safety Officer

MetroHealth True North





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Patient Experience Story

Jennifer Lastic-Director, Experience Excellence



Patient Experience Story – Jim Hyland



<https://vimeo.com/1078789063/fb2c3e11fd?share=copy>



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Improving the Patient Experience

Maureen Sullivan-VP, Patient Experience & Service Excellence

Topics

- **Reputation: CMS Hospital Compare**
 - **Patient Survey Star Rating**
 - **Progress to Date**
- **Survey Updates**
 - **Response Methods**
 - **Increased response rate**
 - **Provider Communication Scale Changes**
- **Complaints and Grievances**
 - **Performance to Date**
 - **Using Voice of the Patient (VOP) to Improve Our Practice**
 - **Ohio Department of Health - Civil Rights Questionnaire**
- **Improving the Patient Experience**
 - **Empathy Training - Impact on Emergency Department**

REPUTATION

Medicare Care Compare

	Metrohealth System	Uh Cleveland Medical Center	Cleveland Clinic
	2500 Metrohealth Drive Cleveland, OH 44109	11100 Euclid Avenue Cleveland, OH 44106	9500 Euclid Avenue Cleveland, OH 44195
Patient survey rating The HCAHPS star ratings summarize patient experience, which is one aspect of hospital quality. Use the star ratings along with other quality information when making decisions about choosing a hospital.			
Patient survey rating			
Number of completed surveys	894	4035	6928
Survey response rate	14%	18%	24%
Patients who reported that their nurses "Always" communicated well. National average: 80% OH average: 81%	77%	77%	78%
Patients who reported that their doctors "Always" communicated well. National average: 80% OH average: 79%	78%	76%	81%

Source: Medicare.gov (April 2025)
Period: 7/1/23 – 6/30/2024

Medicare Care Compare

	Metrohealth System	Uh Cleveland Medical Center	Cleveland Clinic
	2500 Metrohealth Drive Cleveland, OH 44109	11100 Euclid Avenue Cleveland, OH 44106	9500 Euclid Avenue Cleveland, OH 44195
Patient survey rating The HCAHPS star ratings summarize patient experience, which is one aspect of hospital quality. Use the star ratings along with other quality information when making decisions about choosing a hospital.			
Patient survey rating			
Patients who reported that they "Always" received help as soon as they wanted.	61%	58%	59%
National average: 67% OH average: 66%			
Patients who reported that the staff "Always" explained about medicines before giving it to them.	59%	58%	57%
National average: 62% OH average: 61%			
Patients who reported that their room and bathroom were "Always" clean.	67%	67%	73%
National average: 74% OH average: 74%			

Source: Medicare.gov (April 2025)
Period: 7/1/23 – 6/30/2024

Medicare Care Compare

Metrohealth System

2500 Metrohealth Drive
Cleveland, OH 44109

Uh Cleveland Medical Center

11100 Euclid Avenue
Cleveland, OH 44106

Cleveland Clinic

9500 Euclid Avenue
Cleveland, OH 44195

Patient survey rating

The HCAHPS star ratings summarize patient experience, which is one aspect of hospital quality. Use the star ratings along with other quality information when making decisions about choosing a hospital.

Patient survey rating



Patients who reported that the area around their room was "Always" quiet at night.

60%

51%

50%

National average: 62%
OH average: 58%

Patients who reported that YES, they were given information about what to do during their recovery at home.

84%

87%

88%

National average: 86%
OH average: 88%

Patients who "Strongly Agree" they understood their care when they left the hospital.

47%

51%

57%

National average: 52%
OH average: 52%

Source: Medicare.gov (April 2025)
Period: 7/1/23 – 6/30/2024

Medicare Care Compare

	Metrohealth System	Uh Cleveland Medical Center	Cleveland Clinic
	2500 Metrohealth Drive Cleveland, OH 44109	11100 Euclid Avenue Cleveland, OH 44106	9500 Euclid Avenue Cleveland, OH 44195
Patient survey rating The HCAHPS star ratings summarize patient experience, which is one aspect of hospital quality. Use the star ratings along with other quality information when making decisions about choosing a hospital.			
Patient survey rating			
Patients who gave their hospital a rating of 9 or 10 on a scale from 0 (lowest) to 10 (highest).	70%	69%	76%
National average: 72% OH average: 72%			
Patients who reported YES, they would definitely recommend the hospital.	68%	70%	82%
National average: 70% OH average: 69%			

Source: Medicare.gov (April 2025)
Period: 7/1/23 – 6/30/2024

Monthly Composite Star Rating (Final 2024)

Individual Metric Tracking

1-2 Stars	3 Stars	4 Stars	5 Stars
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MetroHealth 2024 Goal Tracking

2024 DECEMBER

2024 Goal Tracking Metric	2023 Baseline	Jan 2024	Feb 2024	Mar 2024	Apr 2024	May 2024	Jun 2024	Jul 2024	Aug 2024	Sep 2024	Oct 2024	Nov 2024	Dec 2024	2024 YTD
Inpatient Composite Measures (HCAHPS) ¹	n=843	n=81	n=100	n=92	n=84	n=91	n=102	n=79	n=86	n=71	n=104	n=133	n=109	n=1,130
Communication with Nurses	91.5%	90.4%	91.8%	91.7%	91.1%	91.2%	92.5%	93.9%	88.7%	94.0%	91.8%	94.2%	91.8%	92.0%
Communication with Doctors	90.4%	91.7%	92.5%	90.9%	90.7%	92.5%	92.0%	94.3%	90.6%	92.8%	92.8%	92.8%	89.8%	91.9%
Responsiveness of Hospital Staff	83.6%	83.1%	80.6%	85.3%	82.2%	83.9%	82.1%	82.4%	81.9%	84.1%	84.0%	82.9%	80.6%	82.7%
Communication about Medicines	75.8%	76.1%	75.6%	76.6%	81.0%	77.7%	70.2%	73.8%	78.2%	78.6%	73.7%	78.3%	79.8%	76.5%
Discharge Information	84.8%	86.8%	82.6%	88.0%	88.8%	83.9%	85.4%	84.5%	84.9%	82.5%	89.1%	88.2%	86.5%	86.1%
Care Transitions	81.0%	82.1%	77.4%	81.9%	79.9%	76.4%	81.6%	80.1%	82.2%	79.5%	80.7%	84.2%	78.7%	80.5%
Cleanliness of Hospital Environment	86.5%	85.4%	84.8%	89.0%	83.7%	86.3%	84.0%	85.8%	80.0%	90.0%	84.3%	82.4%	84.3%	84.8%
Quietness of Hospital Environment	83.1%	84.0%	79.5%	81.6%	86.6%	81.2%	82.7%	83.8%	78.4%	81.9%	85.7%	83.6%	84.1%	82.8%
Hospital Rating	88.4%	88.5%	88.5%	86.8%	89.8%	86.5%	89.9%	90.1%	87.4%	91.3%	89.4%	90.7%	87.9%	88.9%
Recommend the Hospital	86.9%	89.9%	86.9%	87.5%	88.1%	86.4%	89.5%	88.5%	89.0%	88.6%	87.7%	92.6%	86.8%	88.6%
Inpatient Summary Star Average (Scale: 1-5)	3.25 ★★★★	3.56 ★★★★★	3.25 ★★★★	3.75 ★★★★★	3.69 ★★★★★	3.38 ★★★★	3.38 ★★★★	3.75 ★★★★★	3.19 ★★★★	3.81 ★★★★★	3.69 ★★★★★	3.88 ★★★★★	3.56 ★★★★★	3.50 ★★★★★

HCAHPS Summary Star Rating Average	≥1.00 and <1.50	≥1.50 and <2.50	≥2.50 and <3.50	≥3.50 and <4.50	≥4.50 and <5.00
HCAHPS Summary Star Rating Assignment	1 Star	2 Stars	3 Stars	4 Stars	5 Stars

SURVEY UPDATES

HCAHPS Outreach Schedule

Day	Mail Only	Phone Only	Mail-Phone	Web-Mail	Web-Phone	Web-Mail-Phone
1	Mail 1 st survey	Begin phone calls	Mail survey	Email 1 st invitation	Email 1 st invitation	Email 1 st invitation
3				Email 2 nd invitation		
4					Email 2 nd invitation	Email 2 nd invitation
6				Email 3 rd invitation		Mail survey
7					Email 3 rd invitation	
8				Mail 1 st survey		
10					Begin phone calls	
21	Mail 2 nd survey					
28			Begin phone calls			Begin phone calls
30				Mail 2 nd survey		
49	End data collection	End data collection	End data collection	End data collection	End data collection	End data collection
2024 Response Rate: 13.5%			Q1 2025 Response Rate: 22.5%			

The data collection period is being extended from 42 to 49 days



Provider Communication Scale Change

- **Three questions are asked of patients post-visit:**
 - **Listen: Did this provider listen carefully to you?**
 - **Explain: Did this provider explain things in a way that was easy to understand?**
 - **Respect: Did the provider treat you with courtesy and respect?**
- **New Response Options as of 1/1/2025:**
 - **No**
 - **Yes, somewhat**
 - **Yes, mostly**
 - **Yes, definitely (top box response)**
- **Previous Response Options:**
 - **Yes, definitely (top box response)**
 - **Yes, mostly**
 - **No**

Note: Scores are calculated and reported as a percentage of respondents who answered “Yes, definitely” to each question (“top box”) A composite provider communication score consisting of all three questions is also calculated

Provider Communication Scale Change Rationale

- Typically, with 3-point scales, the most positive response is presented first, which leads to positive **response bias** as respondents' tendency is to select the first presented and most agreeable option.
- With 4-point scales, the most positive response is presented last so patients tend to listen to all options before responding and **more carefully consider** feedback they provide.
- The 4-point scale can yield **lower, less biased**, responses and gives more variability to accurately guide staff to areas that need the most improvement.
- This negatively oriented 4-point scale also adheres to **survey research methodology industry standards** and is in **alignment** with the majority of CMS outreach and most other NRC Health questions as well as is used by a majority of NRC Health's other healthcare clients, allowing for better external **benchmarking** and for more accurate and meaningful comparisons
- The 4-point scale is also **consistently** used for measuring patients' experience in other areas across MetroHealth, including inpatient and emergency patient experience surveys

COMPLAINTS & GRIEVANCES

Q1 2025 30-DAY GRIEVANCE RESOLUTION PERFORMANCE

- 100% of grievances were closed within 30 days in Q1 2025

Grievance Resolution	Baseline 2024	JAN	FEB	MAR	2025
30-Day Grievance Resolution %	100.0%	100.0%	100.0%	100.0%	100.0%
Total Number of Grievances	1,960 (164 per month)	162	124	146	432 (144 per month)

- 100% compliance with grievance process during TJC Triennial Survey (i.e. 0 citations received)

Data source: Origami

Complaints received regarding site accessibility

Ohio Department of Health has transitioned to a new Grants Management portal and requires us to respond to a Civil Rights Questionnaire:

** 25. Please describe any complaints that you have received regarding site accessibility within the past two years as well as the steps that were taken to address the situation.*

Actions to Comply:

- **Reinforce education on Language Access Services- department specific education, education during new employee orientation**
- **Auto door repair and installation**
- **Appointment reminders via phone call vs text for patient preference for patients with vision impairment**
- **Installing and maintaining lower desk for registration in sites for wheelchair accessibility**
- **Implementation of ADA van parking shuttle at Main Campus**

IMPROVING THE PATIENT EXPERIENCE

Empathy In Action

- **Service Excellence Basics and/or Service Recovery previously rolled out to the Emergency Department, Inpatient, Outpatient and Ambulatory Surgery, and the Ambulatory Care Enterprise.**
- **Next phase in service excellence journey – Empathy in Action.**
 - **50 minutes**
 - **In person**
 - **Interactive**
- **Session Objectives:**
 - **Define the concept of empathy and its importance in healthcare.**
 - **Discuss the importance of effectively validating emotions.**
 - **Explore the components of behavioral empathy.**
 - **Demonstrate learning by engaging in scenarios (role play).**
 - **Share key takeaways/reflections.**

National Patient Experience Week 2025

The Power of Empathy

In collaboration with Arts in Health, Volunteer Services & MetroHealthy

- Haiku Poetry Workshop and performance with Avery Lamar Pope
- **NRC Health Talk:** Empathy: The Heart of Patient Experience
- Drum Circle with Olu Manns
- Systemwide MetroHealthy Events
- **Keynote Speaker Dr. Adrienne Boissy:** Designing Systems That Care: Empathy and Beyond
- Guest Guitarist Victor Samalot
- Loving Paws Dog Visits



National Patient Experience Week 2025

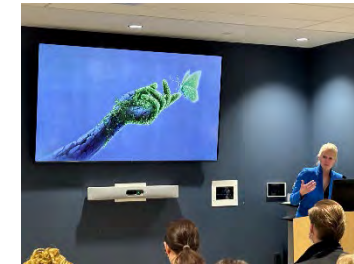
Keynote Speaker

Adrienne Boissy, MD, MA
Chief Medical Officer, Qualtrics
TED Talk Speaker

Designing Systems That Care: Empathy and Beyond

Watch the replay [here](#).

Passcode: L!%HL+0m



THANK YOU



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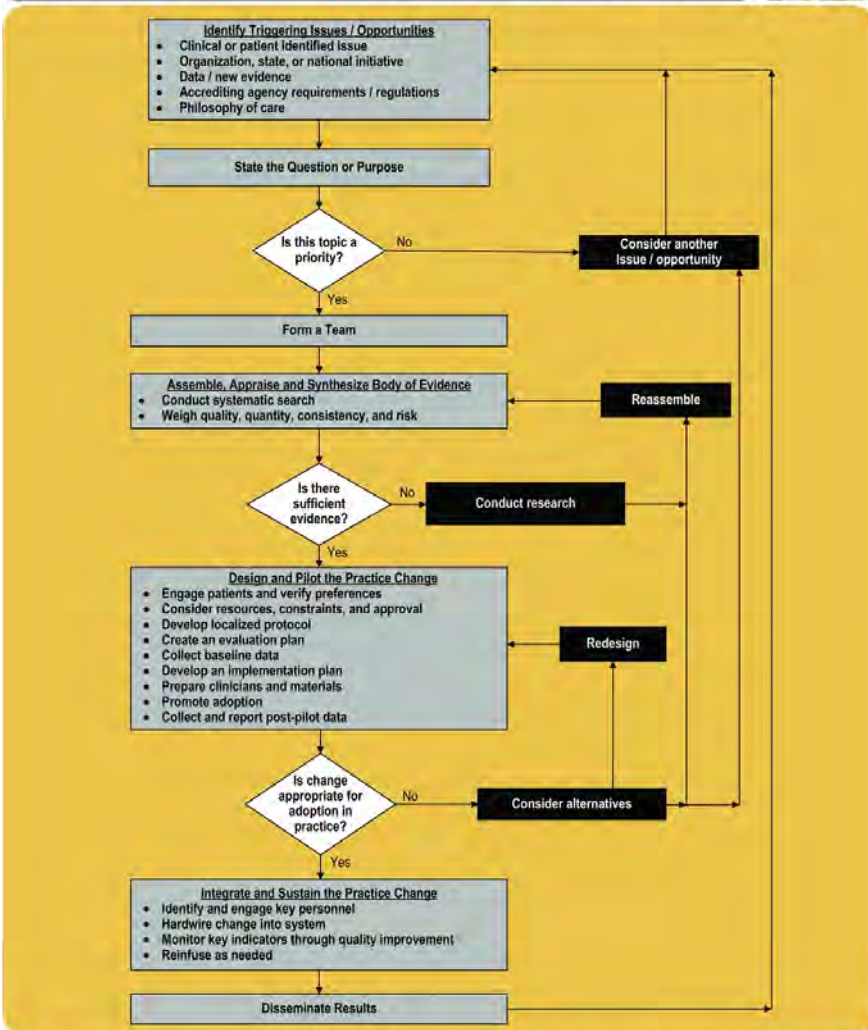
Nursing Annual Quality Review

Dr. Candy Mori-Interim Chief Nursing & Patient Care Services Officer

Dr. Vickie Bowden-Director, Evidence-Based Practice & Quality

Quality Improvement Process

Practice to Promote Excellence in Health Care



- Nursing Department is committed to a continuous state of quality improvement with the goal of becoming a highly reliable organization
- Current Framework for QI/EBP projects is the Iowa Model for Evidenced Based Practice
- Care Program Role- Quality Improvement Facilitator is the formal leader but all Nurse Managers (inpatient & ambulatory) have QI/PI projects as part of their yearly goal structure to ensure continued quality improvement efforts → Ensures that all nursing leaders and areas are involved in continuous QI/PI
- Quality Improvement projects require the following:
 - Patient Centered Goal- often quality or patient satisfaction outcome
 - Table of Evidence- support
- Submitted to Knowledge and Innovation Committee for review, revision and approval

Quality Improvement Submission

-Available on QI TEAMS site

Title:
Date Project Initiated: <i>(once approved)</i>
Contact Person/Team Leader: <i>(primary contact)</i>
Area (Unit(s), Clinic(s), Department(s) working on QI):

Quality Improvement Project Reporting Form

******Please delete all italic instructions prior to submission******

Interdisciplinary Team

**Complete the table of key/active participants involved (all levels and all disciplines-RN, MD, SW, etc.)*

**Add rows as necessary*

Name	Discipline	Title	Department

Define:

Background/Problem Statement

**What is wrong, not working, or not meeting our patients' needs in your area?*

**What is the impact of the problem on our patients?*

(Describe problem(s) that exists and results of literature review – include in-text citations for references in the narrative and include full references in APA format at the end.)

Goal Statement

**State the patient-centered goal(s)/desired improvement/change/result in the form of an Aim Statement. Include baseline data being used to support the goal. An increase by at least 3% from baseline is required.*

[[Increase/decrease] [unit] from a baseline of [baseline] to a target of [goal level] by [date projected to reach target level]].

QI Table of Evidence

Required for all EBP/QI activities as part of review process

- Interventions cited in project must be based upon existing evidence
- If no evidence exists, consider conducting research to add to the body of nursing knowledge

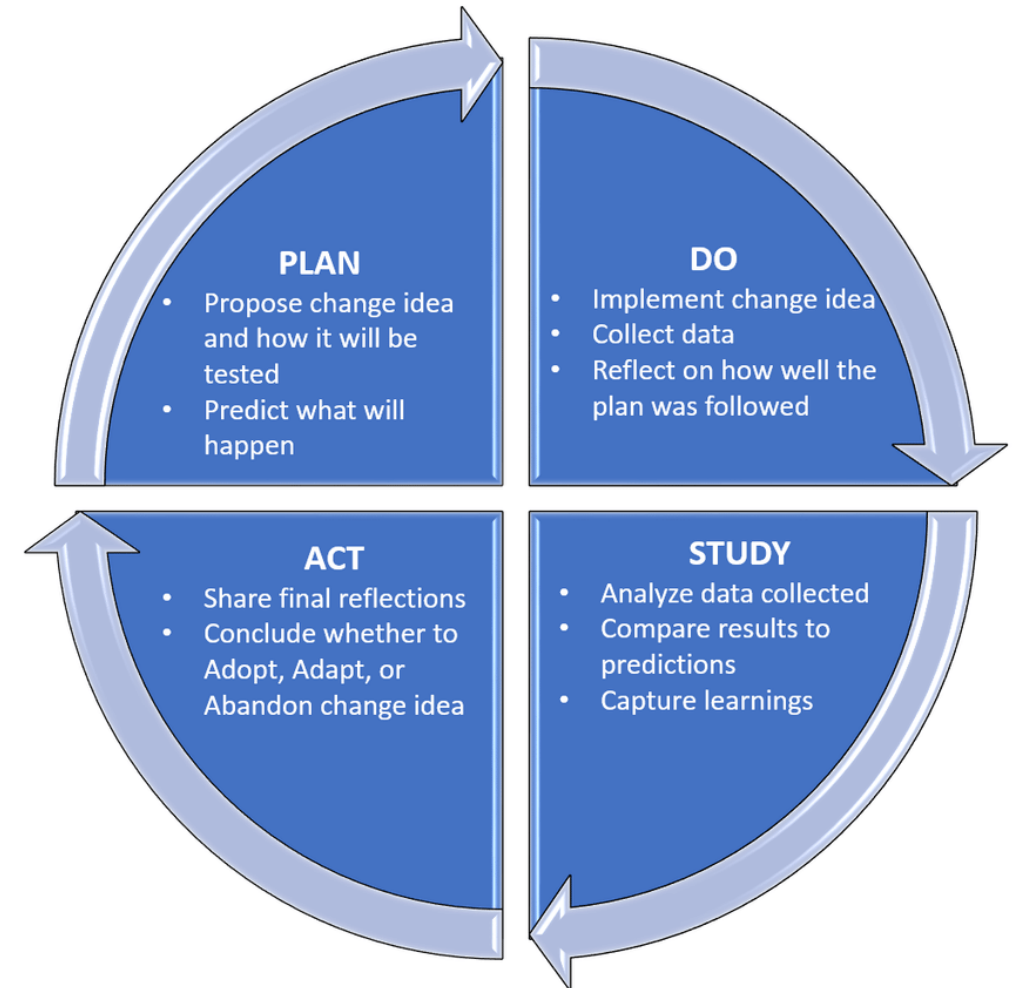
Table of Evidence

**Two citations minimum-please include in text citations in intervention section of QI/PI form

	Who? Citation	What? Purpose/	When? In the recent 5-7 years	Where? Sample & Setting (Hospital, Adult, Peds, Outpatient- where did the project occur?)	Why? Background	How? Interventions Included in Study/Project	Findings/ Results	Does it support your project? Yes or No
1								
2								

Performance Improvement Model

- Plan-Do-Study-Act is the model used for change management throughout the system
- **Plan:** Define the problem, set goals, and plan the action to address it.
- **Do:** Implement the plan and test the changes on a small scale.
- **Study:** Analyze the results of the test and identify what worked and what didn't.
- **Act:** Based on the study, implement the necessary changes, refine the process, and repeat the cycle.



Process Improvement Submission

-Available on QI TEAMS site



Department of Nursing

Process Improvement Project Planning Form

Project Title	
Date of Project Initiation	
Unit/Clinic	
Project Contact(s)/Lead(s)	

Multidisciplinary Team

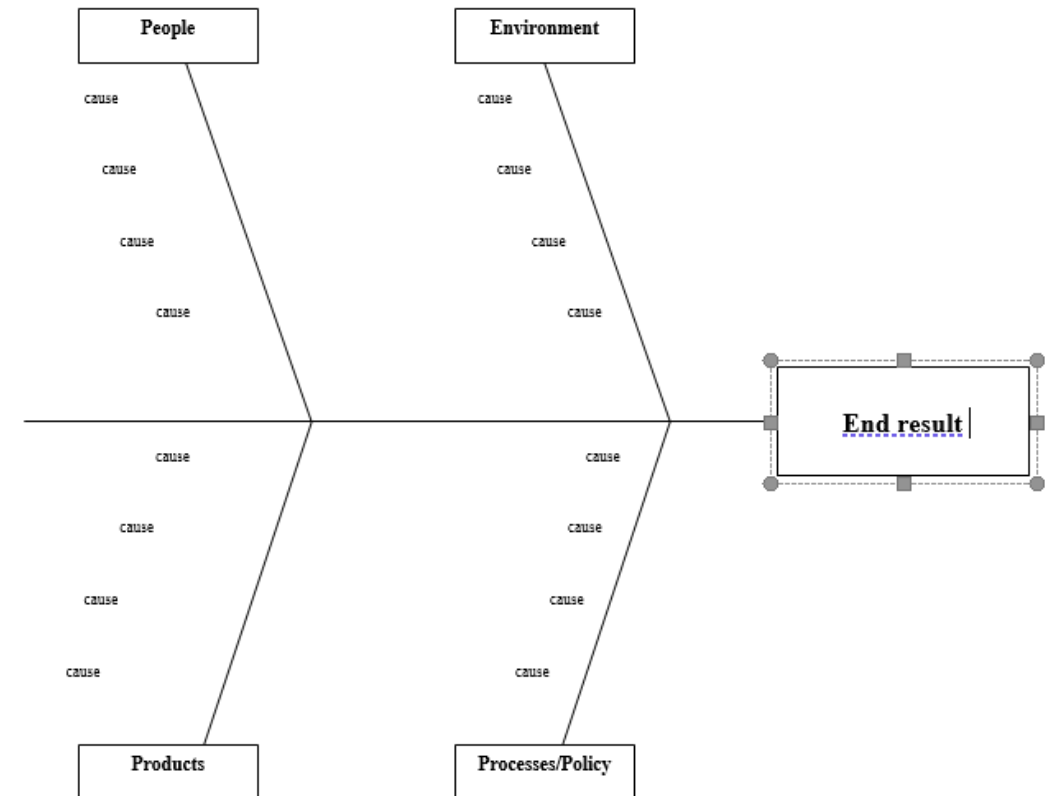
*Complete the table of ALL participants involved (all levels and all disciplines-RN, MD, SW, etc)

*Add more rows if needed to accommodate more participants

Name	Discipline	Department	Title

Use of Fishbone Diagram

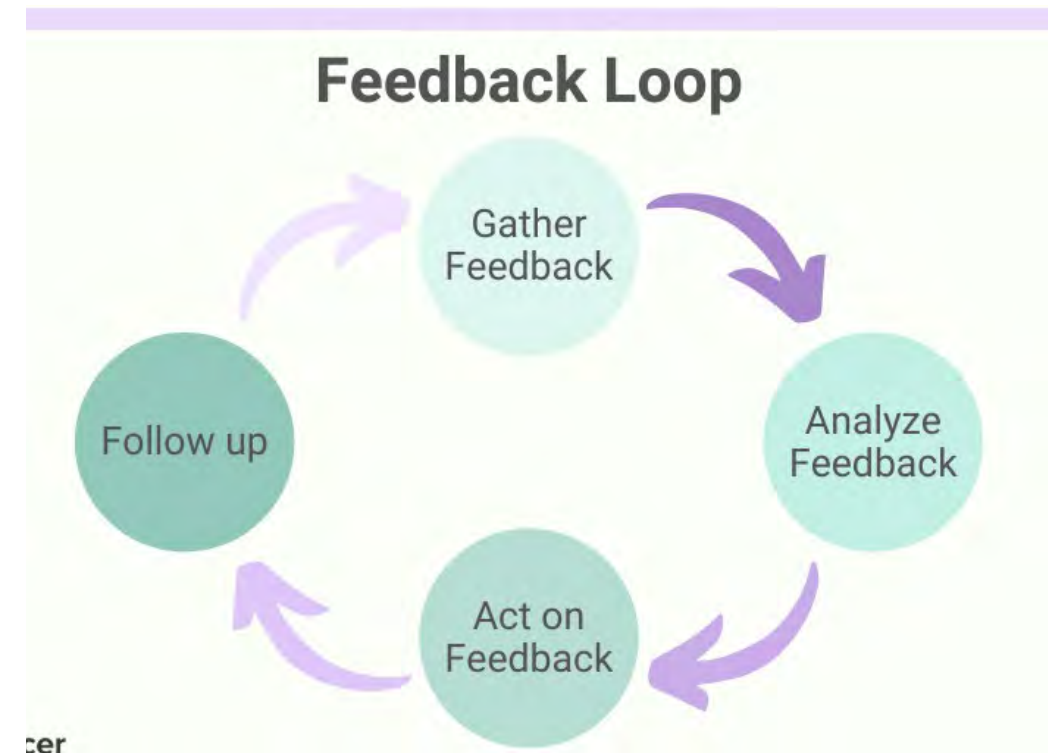
TITLE:



Author, Unit, Date:

Feedback Loop

- Submissions are reviewed by at least the Co-Chairs of the Knowledge & Innovation Committee- Vickie Bowden, DON Quality and EBP & Christina Hronek, ANM 4 East
- Feedback is given throughout the document – specific guidance given with some general suggestions for improvement
- Projects are identified as PI or QI- QI is required to have both a process measure and patient centered outcome measure
- Once approved, an approval letter is sent via email to primary contact



Nursing Quality Improvement Initiatives

Regular Reporting:

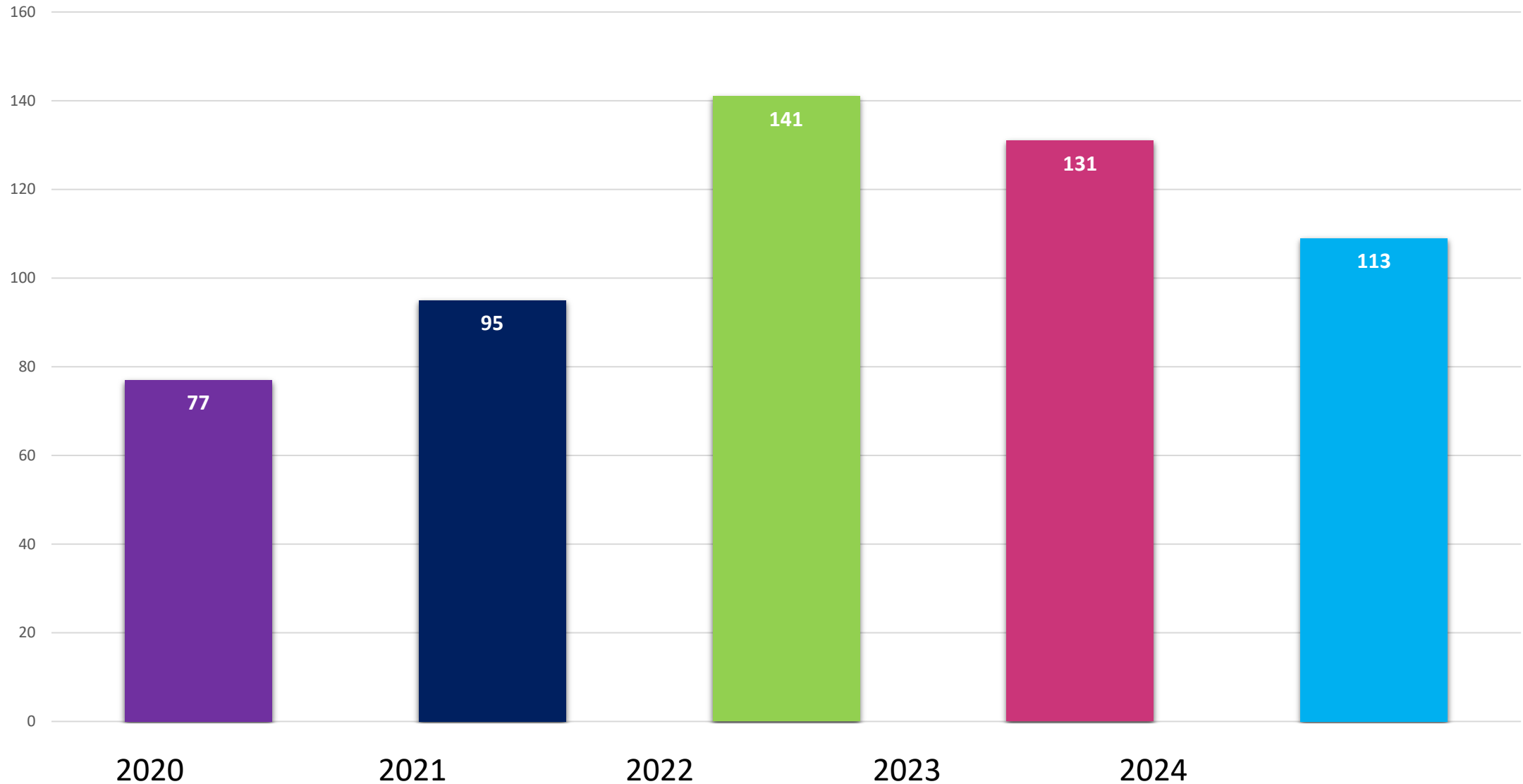
- Monthly review of project status at practice councils and staff meetings
- Quarterly reporting to Nurse Leaders
- Complete project within 12 months of initiation
- Nurse Managers have an expectation of QI built into annual evaluation- NEW in 2025- Evaluation credit given for Process Improvement projects

Tools Used:

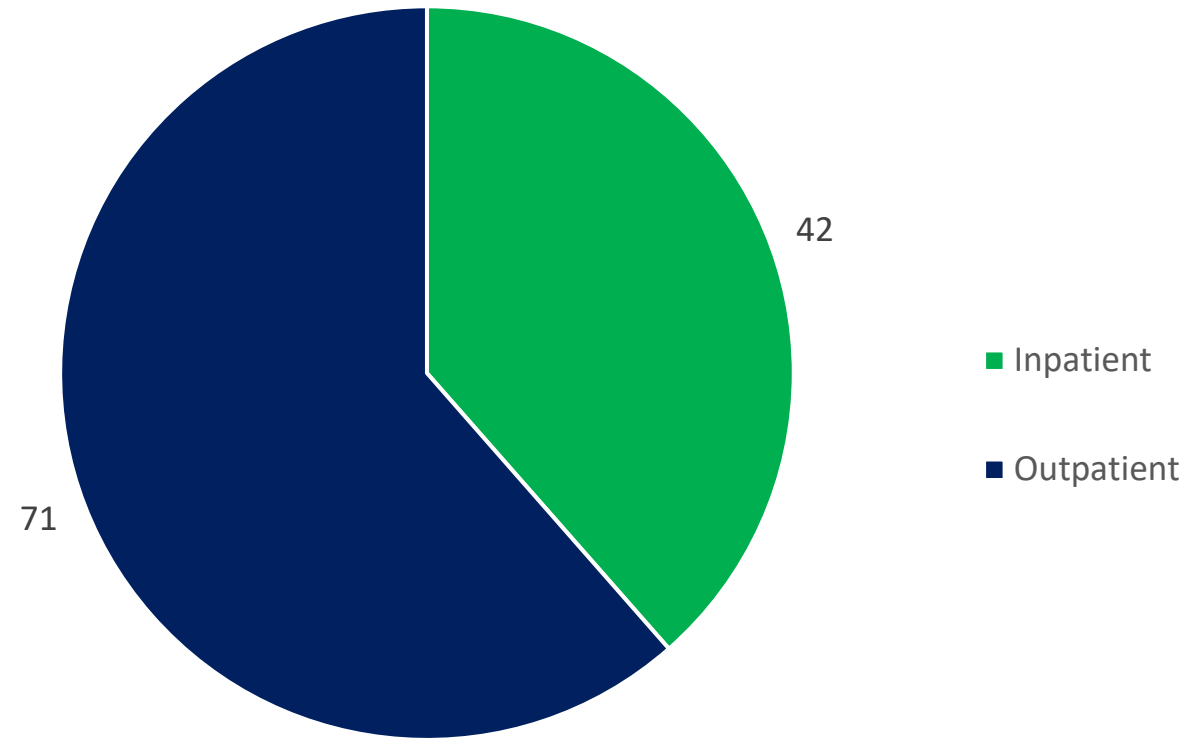
- A template for reporting updates- due quarterly with monthly data (process & outcome measure)
- Re-evaluation of interventions without progress
- QR code developed to increase bedside staff engagement in clinical inquiry- directs to form
- Networking system for project owners to work through barriers
- Knowledge & Innovation Council used to assist team members through barriers
- Projects designed for quick turn around



Active/Closed Nursing QI Projects

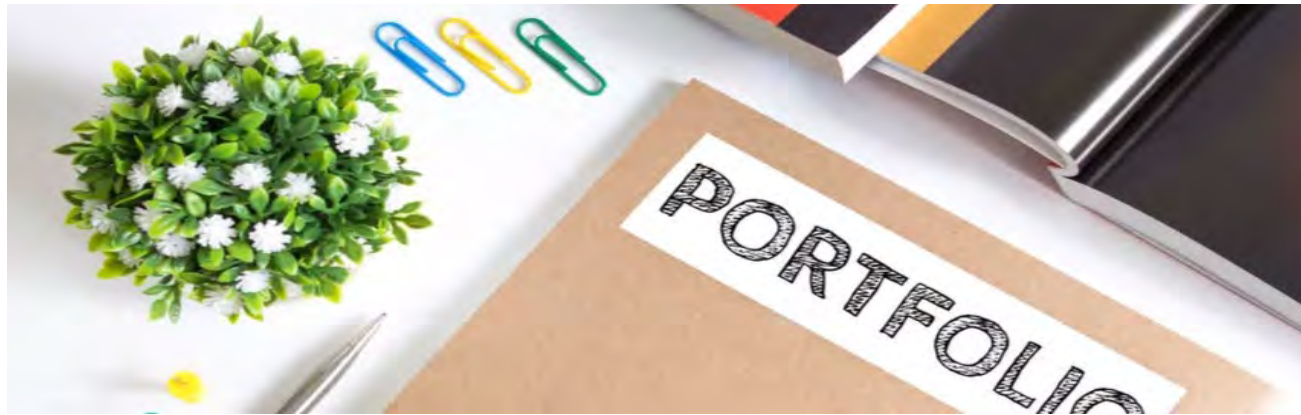


QI by Area 2024



Portfolio/Evaluation Credit

- Both Nurse Managers and CARE Program participants receive credit for both quality and process improvement activities
- Quality Improvement Facilitators are Clinical Ladder participants who receive additional training regarding QI/PI process → often act as mentor for other clinical staff and clinical ladder program participants such as falls, infection control and skin champions



Examples of Current QI/PI Projects Addressing System Level Goals- Ambulatory

- **Provider Wait Time Notification Board-** multiple outpatient clinics are working on a communication project regarding wait times
- Outcome measure- Increase communication patient satisfaction scores – informed of delay/wait times
- **Patient satisfaction Would Recommend Facility-** Endoscopy project working on patient satisfaction and pre-procedural education
- Outcome measure-Increase patient satisfaction scores in the category Would recommend Facility in Endoscopy from a baseline of 82.4% to a target of 87% by December 31, 2024.



Examples of Current QI/PI Projects Addressing System Quality of Care Goals

- **Lifeflight: Improving Intubation First Pass Success and DASH-1A-**
- Process Measure- Increase first-pass success rate of adult intubation without associated hypotension or hypoxia from a baseline mean of 75% in 2023 to a mean of 80% by the end of the fourth quarter of 2024.
- **Internal Medicine- Perform eye exams using the LumineticsCore**
- Process measure- Increase use of Luminetics Core Exams to screen for retinal defects in patients with diabetes



Examples of Current QI/PI Projects Addressing System Quality Goals



- **Pre-Admission Testing: Enhanced Recovery After Surgery (ERAS)**
- Process Measure- Improve compliance through all three (3) phases of Perioperative Care to 50% for each identified service by December 31, 2025 – this includes preop, intraop, and postop/recovery.
- **Inpatient Pediatrics: Use of comfort interventions during pediatric procedures to promote family-centered care.**
- Adding coping/comfort measures to patient “menu of options” available to patients/families. Increase caregivers’ and patients’ knowledge of procedural comfort/coping plan by 30% through using a “comfort plan” on 4W from a baseline of 0% by July 1st, 2025.

Examples of Current QI/PI Projects Addressing System Level Goals

Multiple units: Maintaining patient safety by decreasing patient falls/ Increasing Nurse Adherence to Posey Alarm System to Decrease Patient Falls

Outcome measure- Decrease unit-based fall rate to at or below the NDNQI benchmark of 3.00

Multiple Units: Collaborative effort to reduce pressure injuries with clinical staff and CNS/CQES group

Outcome measure- Decrease HAPI rate to under benchmark of below 1.0 by the end of 2025

Adoption of LEAF turning product for patients at high risk for skin breakdown



Examples of Current QI/PI Projects Addressing System Level Goals



- **8E: Multimodal approach to Improving Nursing team communication and patient satisfaction perception**
- Outcome measure- Increase HCAHPS “Communication with Nurse” averaged scores from baseline 2023 YTD score of 59.2% to a target of 62% or a stretch goal of 64% by end of 2024.
- **Postpartum: Decreasing newborn falls/drops**
- Outcome measure- Decrease newborn falls/drops from a baseline of four from January to September of 2024 to a target of less than 2 by 4/14/2025 (6 months from start of QI).

Examples of Current QI/PI Projects Addressing System Level Goals

- **NICU: Golden Hour**
- Outcome measure- Decrease percent of hypothermic VLBW infants from the baseline of 47% from June 1st, 2021 to June 30th, 2024 to a target of 25%
- **Brooklyn Health Center: Increase the number of clinical depression screening (PHQ 9) for Brooklyn Health Center Patients**
- Process Measure- Increase the percentage of patients that have a PHQ 9 completed when due, during a primary care visit from 85.6%, to a target of 92%, and stretch goal of 94%

