The MetroHealth System

Board of Trustees

Wednesday, August 27, 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, August 27, 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 May 28, 2025

II. Information Items
A. Great Catch Story – *S. Booker*
B. Continuous Performance Improvement at MetroHealth – *M. Wainwright*

III. Executive Session

IV. Return to Open Meeting

QUALITY, SAFETY AND EXPERIENCE COMMITTEE MEETING
Wednesday May 28, 2025
11:00 am – 1:00 pm
MetroHealth Board Room K107 / Virtual

Meeting Minutes

Committee Members:	Ronald Dziedzicki-I, E. Harry Walker, MD-I
Other Trustees:	John Corlett-I, Michael Summers-I
Staff:	Christine Alexander-Rager, MD-I, Robin Barre-I, Michelle Block-I, Stacey Booker, RN-I, Victoria Bowden-I, Nabil Chehade, MD-I, William Dube-R, Joseph Golob, MD-I, Derrick Hollings-I, Matthew Kaufmann-I, Jennifer Lastic-I, William Lewis, MD-I, Candy Mori, RN-I, Nicole Rabic, RN-I, Brian Rentschler-I, Tamiyka Rose-I, Deborah Southerington-I, David Stepnick, MD-I, Maureen Sullivan, RN-I, James Wellons-I
Invited Guests:	N/A
Other Guests:	Guests not invited by the Board of Trustees are not listed as they are considered members of the audience and some were not appropriately identified.

Mr. Dziedzicki called the meeting to order at 11:00 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 February 26, 2025, Quality, Safety, and Experience Committee meeting as presented, which was given, seconded and unanimously approved.

II. Information Items

A. Patient Experience Story (Video) – *J. Lastic*

Mr. Dziedzicki introduced Jennifer Lastic, Director of Experience Excellence, who presented a patient experience story to the committee. The video highlighted the experience of Jim Highland, a burn victim who received care at MetroHealth's Burn Unit after a house fire. Mr. Highland's niece, Kelly, who is also a MetroHealth employee, praised the comprehensive and compassionate care provided by all staff, including environmental services, dining, social work,

and clinical care teams. The video illustrates MetroHealth's commitment to holistic, empathetic care and the importance of every employee's role in patient experience. Mr. Highland's recovery journey, supported by his family and the burn center team, was a testament to MetroHealth's excellence in trauma and burn care, reinforcing the burn center's legacy as a critical regional resource.

B. Improving the Patient Experience – *M. Sullivan*

Mr. Dziedzicki introduced Maureen Sullivan, VP, Patient Experience & Service Excellence, who presented an update on patient experience, focusing on four key areas: reputation, survey methodology changes, complaints and grievances, and the year's theme of empathy. The reputation analysis compared MetroHealth's performance against local competitors, using a five-star rating system based on ten dimensions of care. MetroHealth held a middle position in several domains, ranked first in a few, and identified areas for improvement in discharge processes and communication. These insights were derived from patient surveys, which had a 14% response rate, which is considered low. Survey methodology was updated to improve survey participation and data quality. The data collection period was extended from 42 to 49 days, resulting in a significant increase in response rates-from 13.5% in 2024 to 22.5% in Q1 2025. Ms. Sullivan explained that the hospital had standardized survey questions and adopted a four-point scale to improve data consistency and comparability. Although this change initially led to a drop in scores, it was seen as a necessary recalibration to better reflect patient experiences and drive meaningful improvements. MetroHealth also demonstrated excellence in handling complaints and grievances, resolving 100% of 432 grievances within 30 days in Q1 2025, with no citations during The Joint Commission Triennial Survey in December 2024. Additionally, accessibility complaints were addressed by implementing several initiatives, including infrastructure upgrades such as automatic door repair and installation, improved language access services, and enhanced communication methods for patients with visual impairments. A major focus of the improvement strategy, the "Empathy in Action," training program builds on previous service excellence initiatives. This 50-minute, in-person and interactive training session helps staff understand and practice empathy through interactive role-playing and reflection. The goal is to foster a culture of emotional intelligence and compassionate care. National Patient Experience Week 2025 further emphasized the commitment to empathy through creative and engaging events such as poetry workshops, a drum circle, and a keynote by Dr. Adrienne Boissy, a nationally recognized speaker on empathy in healthcare.

C. **Nursing Annual Quality Review –** *Dr. Mori*

Mr. Dziedzicki introduced Dr. Candy Mori, Chief Nursing Officer, and Dr. Vickie Bowden, Director, Evidence-Based Practice and Quality. Dr. Bowden provided an overview of MetroHealth's Nursing Department quality improvement (QI) process, emphasizing its long-standing focus on patient outcomes. The current framework for evidence-based practice (EBP) projects utilizes the Iowa Model, with increasing adoption of the FOLD model from Ohio State University.

The program differentiates between quality improvement, which focuses on evidence-based practice and patient-centered outcomes, and performance improvement (PI) focuses on continuous improvement. The process begins with nurses completing a standardized form, ensuring frontline staff and interdisciplinary involvement to define problems and desired outcomes.

A new initiative implemented in 2024 is the Table of Evidence, requiring staff to cite two literature sources for interventions, which fosters evidence-based practice within nursing and supports MetroHealth's Magnet journey by providing documented quality improvement projects. Similarly, a process improvement project planning form was implemented to capture continuous PI efforts, incorporating Lean Six Sigma principles and utilizing a fishbone diagram to capture feedback from the interdisciplinary team. The Knowledge and Innovation Council, comprised of frontline staff and co-led by Dr. Bowden, reviews submitted projects, provides guidance, and approves initiatives. This council helps differentiate between QI and PI projects, ensuring a focus on patient satisfaction and safety outcomes for QI. Nurse managers and clinical ladder participants are expected to lead or contribute to QI projects, which are tracked through quarterly and monthly reporting, with the goal of completing projects within 6 to 12 months. To encourage frontline engagement, a QR code system was developed that allows staff to submit project ideas directly from their units. This initiative aims to capture grassroots innovations and ensure they are funneled through the appropriate channels for support and implementation. Dr. Bowden acknowledged the challenges of providing protected time for project work but noted that staff are supported through flexible scheduling and assistance from the clinical quality team.

Examples of successful projects include reducing wait times in Express Care, improving patient education in endoscopy, and enhancing communication on inpatient units. The Life Flight team also participates in the QI process and focused on improving first-pass intubation success, while the Internal Medicine clinic implemented early retinal screening for diabetic patients using Luminetics Core technology. Other notable projects include the Enhanced Recovery After Surgery (ERAS) protocol to reduce length of stay, inpatient pediatric initiatives to improve pain management, and ongoing efforts to prevent patient falls and pressure injuries. The "Picture This" project, which involves photographing skin

conditions on admission, has helped accurately document pre-existing conditions and prevent misclassification of hospital-acquired injuries. The Leaf Project, using wearable sensors to monitor patient repositioning, has expanded from ICUs to med-surg units, demonstrating the value of centralized QI oversight in spreading best practices. Projects that reduce harm, improve outcomes, and enhance patient satisfaction are not only ethically imperative but also reduce legal risks and operational costs. Dr. Bowden expressed pride in the nursing team's dedication to continuous improvement and the collaborative spirit that drives innovation across the organization.

III. 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 Mr. Summers and seconded by Mr. Corlett. Upon unanimous roll call vote, the Committee went into executive session to discuss such matters at 11:49 am.

Return to Open Meeting

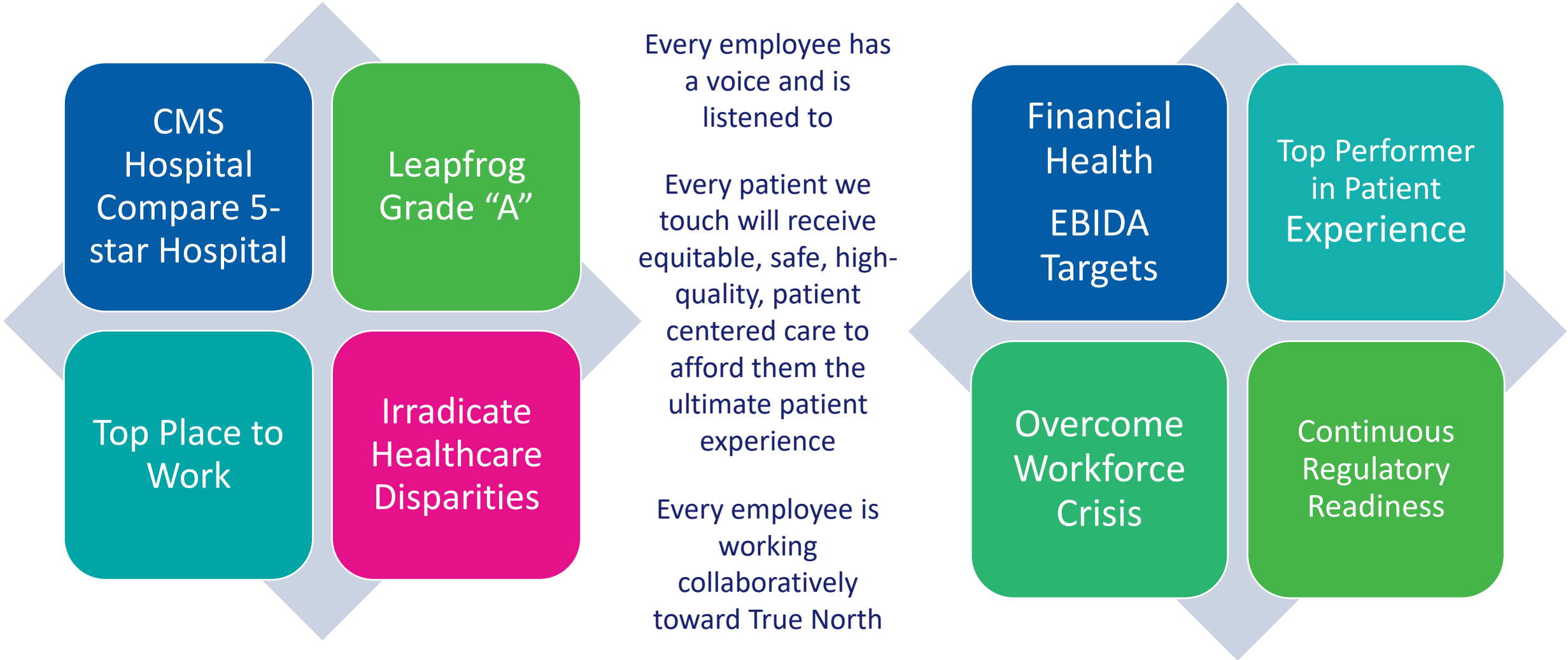
Following executive session, the meeting reconvened in open session at approximately 12:59 pm.

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



MetroHealth
Devoted to Hope, Health, and Humanity

Great Catch Story

Stacey Booker-Director, Patient Safety & HRO

MetroHealth
Devoted to Hope, Health, and Humanity

Continuous Performance Improvement at MetroHealth

Mary Kate Wainwright-Principal, Clinical Performance Improvement

Mission Statement - CPI

The Continuous Performance Improvement (CPI) team is comprised of clinical and non-clinical healthcare professionals. Our work spans across the entire MetroHealth clinical and non-clinical enterprise utilizing Lean Six Sigma methodology to drive continuous improvement. We support the System by working with senior leadership, front-line staff, and cross-functional teams to provide objective, data-driven analyses and workflow development to support system goals. Our focus is to continuously improve the quality, safety, and experience of care for our patients and caregivers.

We accomplish this by:

- Perform Current State Workflow Analysis
- Develop Future State Workflows
- Identify Gaps and inefficiencies in Current State Workflows
- Execute Accelerators and Rapid Process Improvement Events
- Identify and monitor Key Performance Indicators (KPIs)
- Identify and develop technological solutions to problems
- Perform Stakeholder Analysis
- Develop change communication plans
- Accelerate change

… and so much more

CPI Standard Work

Operation: CPI Process Improvement Document Owners: Golob Date: AUG 2025			Continuous Performance Improvement (CPI) Standard Work		
Step #	**Who**	**Duration**	**Major Step** (WHAT)	**Key Point** (HOW)	**Reason** (WHY)
1	CPI Lead	N/A	BACKGROUND **Interview leaders, stakeholders, front- line staff**	Schedule and conduct stakeholder interviews Define the problem, opportunity, and project Complete Charter or Intake form Complete **Stakeholder Analysis**/Change Management tool **Start A3**	PI Project clarity is important. All projects must have clear goals and measurable objectives
2	CPI Lead	N/A	CURRENT CONDITIONS **Understand current state operations and workflows**	Go to Gemba (perform observations) Pull/request and analyze available data Research Evidence Based Practice (EBP) if clinical Determine appropriate KPIs to quantify the problem Complete **Current State workflow, Value Stream Map** Create "Excel Model" Create a simulation model of the current state map ***Ensure frontline staff is actively engaged***	An accurate current state workflow makes the problem easier to understand for all stakeholder groups.
3	Project Team CPI Lead	N/A	ANALYSIS & ROOT CAUSE **Perform gap analysis and validate models**	*Optional: Conduct Rapid Process Improvement Event (RPIE)* Conduct root-cause-analysis Use 5 Whys, 6M, Fishbone Diagram, other tools Verify and validate simulation model(s) ***Ensure frontline staff is actively engaged***	Determining the root cause(s) of the problem ensures countermeasures will appropriately address the issues
4	CPI Lead Operational Owner(s)/ Project Team	N/A	GOALS **Develop S.M.A.R.T. goals for KPIs**	Develop **S.M.A.R.T. goals** for all KPIs – outcome, process and balancing measures Document goals in the Project Charter ***Communicate goals to project team***	With the problem defined, KPIs identified, and root cause(s) determined, now is the time to verify and validate all goals. If we can't measure it, we can't improve it.
5	Project Team CPI Lead	N/A	COUNTERMEASURES & IMPROVEMENTS **Develop future state workflow, standard work, and test-of-change**	*Optional: Conduct Rapid Process Improvement Event (RPIE)* Develop **Future or Ideal State workflow** Determine countermeasures for the problem Test countermeasures in *What If* simulation models Draft and develop **Standard Work** Plan a "small test of change" or "experiment." Update and review Stakeholder Analysis w/Owner-Sponsor ***Ensure frontline staff is actively engaged***	Stakeholder analysis: To proactively identify and address potential risks pre-implementation.
6	Operational Owner(s) CPI Lead	2-4 weeks	IMPLEMENTATION **Implement test-of-change, evaluate standard work, and process measures**	Deliver staff training incl. standard work Develop communication plan Implement "small test of change" ***Ensure frontline staff is actively engaged***	Standard Work ensures all team members are on the same page and agree on who does what and when. **PDSA or Small Tests of Change = continuous performance improvement.**
7	CPI Lead Operational Owner(s)	30 days 60 days 90 days	RESULTS & CONFIRMATION **Evaluate, Confirm, and Monitor Improvement**	Create dashboards (incl. Daily Huddles/Visual Mgmt.) Perform 30-60-90-day review w/project team. Perform 6-month post implementation/project review Confirm operational and financial impact **Complete A3**	If we don't continue to measure it, we won't be able to continue to make incremental improvements

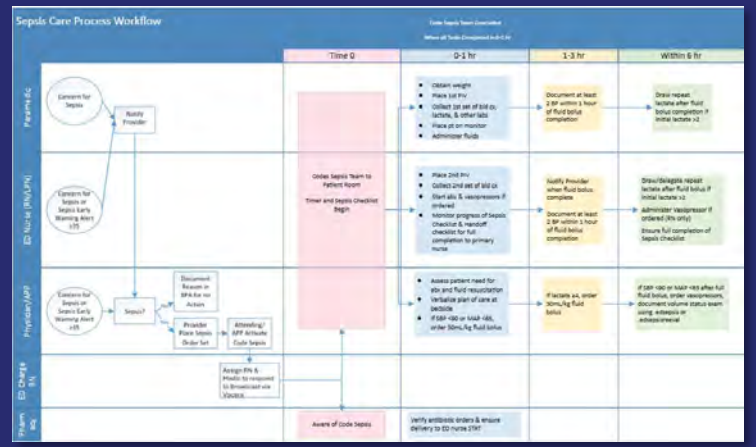
Our Perioperative Improvement Journey

Glossary:
CSPD= Central Sterile Processing Department
IR= Interventional Radiology
PAT= Pre-Admission Testing

CPI Project Highlights

Patient Quality

ED Sepsis/ Sever Shock Bundle Early Identification & Treatment



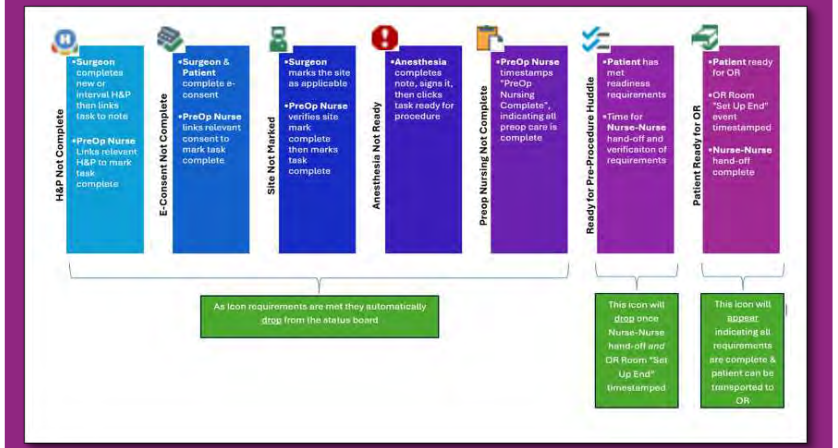
Sepsis Bundle Compliance Results

System Pre-Intervention: 32%
System Post-Intervention: 80%

48% Improvement

Patient Safety

Pre-Procedure Icon Readiness



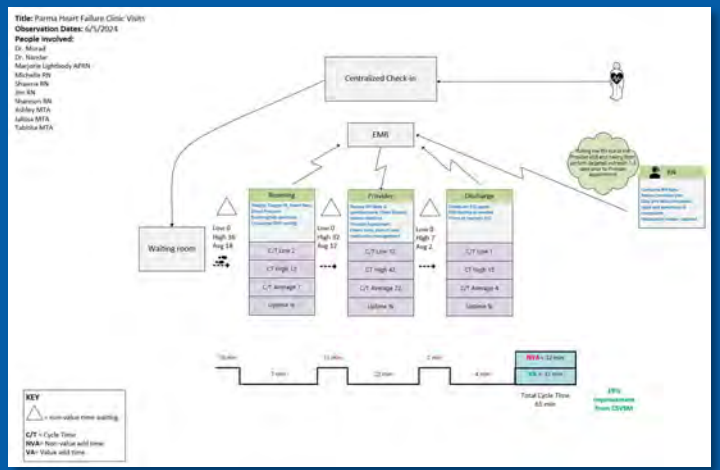
Safety Events Results

Pre-Intervention: 23 events
Post-Intervention: 1 event

96% Improvement

Patient Experience

Parma Heart Failure Clinic Visit Efficiency



Average Visit Length Results

Pre-Intervention: 80 minutes
Post-Intervention: 62 minutes

23% Improvement

Title: Parma Heart Failure Clinic Visit Efficiency
Date: May 2024

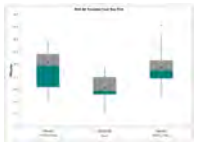
Sponsor: Dr. Murad
Team: Dr. Kondapaneni, Michelle Caruso, Julie Hackney, Brandon Salemi, HF Providers, Nurses, MAs, PSS, CPI, Informatics

Improvement Leaders:
Jessica Higginbotham, Liz Thompson

Background — PLAN

Parma's Heart Failure clinic sessions are running behind, causing patients to wait 1 to 2 hours before seeing the provider. Current visit lengths are 20 minutes for existing patients and 40 minutes for new patients.

Current Conditions — PLAN

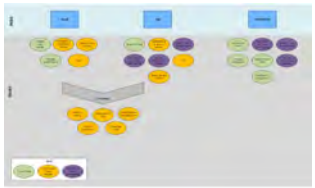
- No distinct difference between new and follow up visit activities & time spent. MA rooming, RN workflow and provider assessment were consistent for new and follow up patients.
- Patient throughput time from check-in to discharge was 80 minutes. Average time with provider is 22 minutes.

Goal/Target Condition (MetroWay *Forward* Objectives) — PLAN

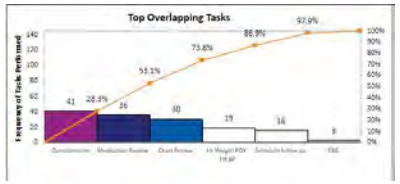
1. Reduce patient throughput time from check-in to discharge by 25% (20 minutes). Patient throughput time was 80 minutes based on current state value stream map.
2. Validate visit lengths for new and existing patients to determine if the visits are distinct.
3. Improve provider/nurse/MA efficiencies to reduce redundancies in roles and responsibilities.

Analysis/Root Causes (The Why) — PLAN

Overlapping tasks by role leads to wasted time



Questionnaire is top overlapping task



Multiple causes lead to 80-minute visit length

Countermeasures/Improvements (The What or Tactics) — PLAN

- Create standard work to ensure each role (MA/RN) is operating at the top of their licensure and certification to reduce redundancies in work. *RN Manager responsible for adherence.*
- Redesign questionnaire content and how it's administered to reduce redundancies and visit length by approx. 5 minutes. *Medical Director responsible for design.*
- Redesign RN workflow to reduce overlapping tasks and reduce in clinic visit length. This should reduce visit length by approx. 19 minutes. *RN Manager responsible for adherence.*
- Recommend changing 20 min follow up and 40 min new patient visit lengths to 30 min for both visit types. Follow KPMG's structure to change visit lengths. *Service line responsible for template changes.*

Implementation Plan (The How) — DO

Initiatives	Status	W1	W2	W3	W4	W5	W6	W7
Redesign Questionnaire	***In progress***							
Review current state with Sponsor	Complete							
Obtain Sponsor buyin to redesign	Complete							
Develop future questionnaire	in progress							
Obtain provider buyin	not started							
Update view in provider note	not started							
Create patient facing view for MyChart	not started							
Develop communication plan	not started							
Train Staff on new workflow	not started							
Go live	not started							

Initiatives	Status	W1	W2	W3	W4	W5	W6
Reducation of Roles & Responsibilities	***not started***						
Develop MA Standard Work	not started						
Develop RN in clinic Standard Work	not started						
Develop RN outreach Standard Work	not started						
Final Review with Nurse Manager	not started						
Approval from Nurse Manager & DON	not started						
Develop communication plan	not started						
Train Staff on new workflow	not started						
Go live	not started						

Initiatives	Status	W1	W2	W3	W4	W5	W6
Redesign RN Workflow	***not started***						
Brainstorm future state	In progress						
Develop future state map	In progress						
Final Review with Nurse Manager	not started						
Approval from Nurse Manager & DON	not started						
Develop communication plan	not started						
Train Staff on new workflow	not started						
Go live	not started						

Confirmation/Results of Improvement (What does success look like?) — CHECK

Avg. Cycle Time Results
Pre-Intervention: 80 minutes
Post-Intervention: 62 minutes
23 % improvement

The results exceeded the anticipated 19% improvement from current state.

Conclusion (Control and Sustainability) — ACT

- Developed standard work for RN & MA
- Redesigned electronic questionnaire



CPI Past and Present Work

Outpatient Division

- Ambulatory Workforce Optimization *Dr. Bruce, K. Rizer*
- TCM Virtual Follow-up Appts post Hospital Discharge *Dr. Bruce*
- MetroWay Forward: Patient Access *Dr. Bruce*
- Asthma/COPD Existing Patient Management *Dr. Ayache*
- Kidney Function Testing & Early Intervention *Dr. Saab, Dr. Sarabu*
- PEG Tube Placement Process Efficiency *Dr. Kurin*

Inpatient/ED Division

- Parma ED Split Flow *L. Schmidt, M. Dudas*
- ED Sepsis Clinical Improvement *Dr. Golob*
- 7th Floor Restructure *Dr. Mori*
- Inpatient Rehab Patient Capture *B. Rentschler, Dr. Whitehair*
- Inpatient Rehab Accelerated Admission *Dr. Whitehair, J. Blevins*

Perioperative Platform

- Periop Platform Main OR Throughput *Dr. Stepnick, K. Conine*
- NEST Add-on Cases Analytics *Dr. Kelly*
- PAT Risk Score Analytics *Dr. Lebak, K. Conine*
- PAT Workflow Optimization *Dr. Tollinche, K. Conine*
- Interventional Radiology Throughput *Dr. Binutu*

System

- Age Friendly Hospital Measure *Dr. Golob, Dr. Chehade*
- CQIC/ESQIC Redesign *Dr. Golob*
- Universal Protocol Policy Updates *K. Conine, Dr. Stepnick*
- Simulation Modeling Software *Dr. Golob*

Appendix

Example of work

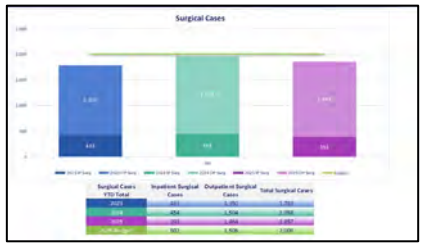
CPI Led Process Improvement

A3 Examples

Title: Periop Platform OR Throughput- Turnover Date: 3/17/2025	Sponsor: Brian Rentschler, Dr. David Stepnick Process Owner: Katrina Conine, RN Team: Jessica Higginbotham, Mary Kate Wainwright, Danielle Garcia

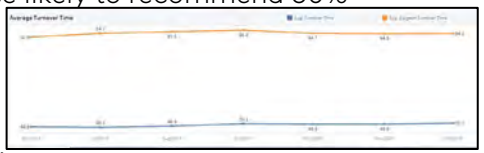
Background (The Past) — PLAN

Patient throughput at main campus OR contains inefficiencies that result in case delays, long room turn times, and poor patient and staff experience. Additionally, surgical case volume is more than >100 cases behind 2025 budget. The OR has contracted with a temporary consultant manager who has implemented improvements, but more change is required to increase cases and improve patient and staff satisfaction.



Current Conditions (The Present) — PLAN

- Main campus OR room turnovers average 51 minutes (as of Dec. 2024).
- Behind projected case volume >100 cases
- Block utilization accuracy 71%Block Utilization from last year- Dr. Golob to look into and get to us
- 2024 patient experience likely to recommend 80%
- Lack of standard work
- Lack of clarity on roles and responsibilities
- Poor communication with CSPD/Supply Chain



Analysis / Root Cause (The Why) — PLAN

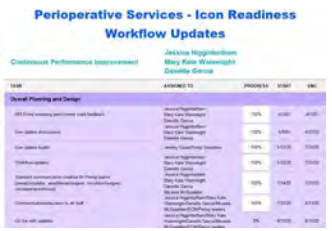
Goals (System Goals, Outcomes, and Process Metrics) — PLAN

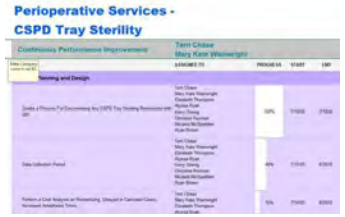
- Decrease monthly average room turnover at main campus from 51 minutes to 42 minutes on or before September 30, 2025.
- Increase first case on time starts from 59% to 75% on or before September 30, 2025.

Countermeasures/Improvements (The What or Tactics incl. Owners) — PLAN

- Develop Standard Work for Roles & Responsibilities across Periop Platform by staff role Project
- Case OrderSet Evaluation Project
- Preop Icon Readiness Reevaluation Project
- CSPD Holes in Trays Project
- Subsequent Case Missing Items Project
- PAT in OrderSets Project
- Education for Standard Work for Roles & Responsibilities across Periop Platform by staff role Project
- Case OrderSet Education Project
- Patient Education Standardization Project
- Execution for Standard Work for Roles & Responsibilities across Periop Platform by staff role Project
- Case OrderSet Execution Project

Implementation Plan (The Who, Detailed Tasks, and When) — DO





Confirmation/Results of Improvement (What does success look like?) — CHECK

Conclusions (Control and Sustainability Plan) — ACT

Asthma/COPD Existing Patient Management
March 2025 - Sponsor: Lisa Ramage and Dr. Mirna Ayache

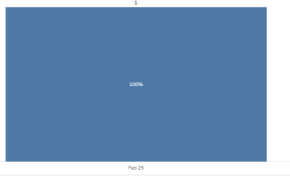
Process Owner: Michelle Mays, RN Team: Julie Hackney, Rich Mozden, Jill McCourt, APRN, Andrew Lewis, MD, Maureen Hall, RN, Mark Kohler, RN, Dominique Trocchio

Improvement leaders: Mary Kate Wainwright, Liz Thompson

Background (The Past) — PLAN

Patients with Asthma and/or COPD and established pulmonary providers that are having exacerbated airway concerns are often referred directly to the Emergency Department (ED) for care. Many of these patients could be treated for their airway issues in the clinic. The ability to treat patients in the clinic instead of ED, provides specialized care to quickly assess and treat exacerbated airway symptoms. This provides the most efficient care for our patients in the clinic setting with the established provider. This will also help decrease overcrowded EDs within the system.

Current Conditions (The Present) — PLAN

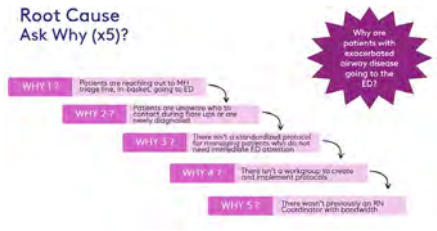


Patients on the COPD or Asthma Registry	
# of patients with an ED visit @MHS	2,882
# of patients with a pulmonary visit within the last 3 years	4,940
% of patients with ED visit who have had a pulmonary visit	58%
Total # of ED visits at any system	12,595

Analysis / Root Cause (The Why) — PLAN

Need to determine a process for RN Coordinator to Triage patients who do not need ED but need to see a Provider into Urgent Visit slots and conduct urgent visits.

Need to create process for new patient diagnosis referrals To be scheduled into a provider visit within one week of Diagnosis.

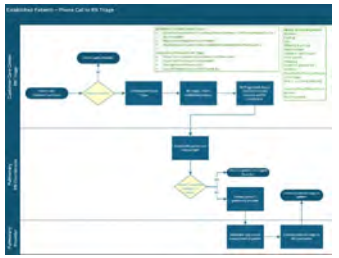


Goals (System Goals, Outcomes, and Process Metrics) — PLAN

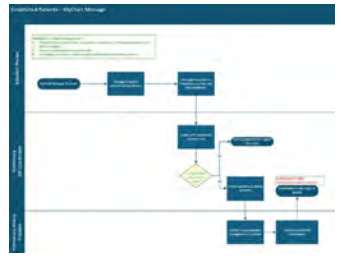
Goals completed by 12/31/25:

1. Complete 40 urgent pulmonary visits
2. Increase referral completion rate from ED & IP to Pulmonary from 13% to 25%
3. Decrease Days to completion average for ED & IP referrals to Pulmonary from 35 days to 7 days
4. Reduce COPD/Asthma registry patients with a COPD/Asthma primary diagnosis ED encounter from an avg of 172 per month to 165 per month

Countermeasures/Improvements (The What or Tactics incl. Owners) — PLAN



Go-Live: April 28



Go-Live: June 2

Implementation Plan (The Who, Detailed Tasks, and When) — DO

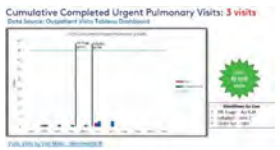
<u>Objective 1: Create Urgent Visit Slots for exacerbated airway patients</u>

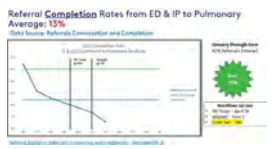
- Visit Type exists; Clinics have proper supplies
- 6 slots/ week added (Rich Mozden)

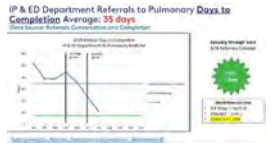
<u>Objective 2 : Create referral workflow for patients newly diagnosed with</u> COPD/Asthma

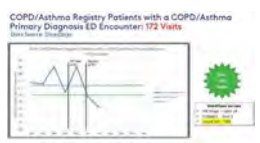
- Rich working with Epic on updating referral (Rich Mozden) Go – Live TBD
- <u>Objective 3 : RN Coordinator Workflow</u>
- Workflows created for RN triage line (Maureen Hall) & inBasket team (Mark Kohler)

Confirmation/Results of Improvement (What does success look like?) — CHECK









Conclusions (Control and Sustainability Plan) — ACT

Title: ED Sepsis/Severe Shock Bundle Date: 2/5/2024	Sponsor: Dr. Golob Team: Emergency Department Service Line	Process Owner: Kacie Parimi

Background (The Past) — PLAN

- Sepsis is a medical emergency
- Around 87% of cases are presented on admission
- Early identification and treatment is critical to patient outcomes
- In 2023, in the Early Management Bundle, Severe Sepsis/Septic Shock we ranged from 0%-75% and are currently performing at a 32%
- The state average is 56% and the national average is 60%

Current Conditions (The Present) — PLAN

- ED Sepsis performance/workflow is inconsistent.
- Poor SEP-1 Core Measure bundle compliance, well below state and national averages.
- Sepsis mortality index performance in bottom half of Vizient cohort (Large Specialized Complex Care Medical Centers).
- Current ED sepsis workflow was developed in 2019.

Analysis / Root Cause (The Why) — PLAN

Results of Sepsis RPI Event:

- No dedicated sepsis team causing delays in treatment and inconsistency in quality performance
- Lacking efficient, well-structured process within Epic to provide documentation tools and guidance of Sepsis workflow
- Lack of knowledge/understanding of time zero and next steps
- Lab results for sepsis are slow due to batching labs
- Lack of blood culture supplies

Goals (True North Objectives, System Goals, Outcomes, and Process Metrics) — PLAN

- Outcome Measures: Increase SEP-1 Core Measure Compliance (ED-Specific) to ≥ 38.75% (5% increase from baseline) and Improve Sepsis Mortality O/E Ratio (Mortality Index) to ≤ 1.09 by June 30th, 2025 (Rolling 12-month performance May 2024- April 2025).
- Process measures: Goal ≥90% of Sepsis Alert patients receive all appropriate 3-hour bundle care (lactate collected, blood cx collected & before abx and abx started) from time of activation.
- Staff satisfaction with Code Sepsis process

Countermeasures/Improvements (The What or Tactics incl. Owners) — PLAN

- Educate provider and nursing staff on Time Zero and Next Steps
- Create a Code Sepsis Workflow that mirrors Trauma, STEMI, Stroke
- Implement Epic Sidebar Checklist and Timer for Nursing
- Optimize silent BPA from Sepsis Cognitive Computing Model and make if visible to nursing and providers
- Get colored paper to place in lab bags to prioritize ED labs for Sepsis
- Par Up on Blue Bins for Blood Culture Bottles

Implementation Plan (The Who, Detailed Tasks, and When) — DO

Task	Who	Deadline
Implement adding slip of paper to prioritized STAT labs including Sepsis	KP & CC & LS	8/6
Par up on Blue Bins for blood culutre bottles	Travis	7/8
Educate: Time zero & next steps (reference tool creation)	KP & CC & AG	7/15
Create technology within Epic with Sidebar Checklist and Timer	NW & BM	10/22
Educate and communicate the use of the Dot Phrase	KP & KC	7/24
Create a Code Sepsis Workflow mirroring Trauma, STEMI & Stroke	KP & CC & AG	7/17
Implement Code Sepsis Workflow with Epic Sidebar Checklist and Timer	KP & CC & AG	10/29
Create a workflow for the Sepsis Early Warning Alert for RN and Providers	KP & CC	7/15
Informatics optimizes the BPA to make it visible and actionable	MD	10/22
Go Live Electronic tools (OPA, timer, sidebar checklist) & Code Sepsis Alert r	MD, BM, NW	10/22

Confirmation/Results of Improvement (What does success look like?) — CHECK

3 hour Bundle Compliance			Lactate Collected			Bld Cx Before or within 3 hrs			ABX started before or w/3 hrs		
2024			2024			2024			2024		
	Oct	78.26%		Oct	98.55%		Oct	79.71%		Oct	100.00%
	Nov	84.52%		Nov	98.71%		Nov	87.10%		Nov	97.42%
	Dec	78.15%		Dec	98.01%		Dec	80.13%		Dec	97.35%
2025			2025			2025			2025		
	Jan	79.58%		Jan	95.92%		Jan	83.67%		Jan	95.92%

Conclusions (Control and Sustainability Plan) — ACT

- Continue to monitor Blood Culture supplies/workflows to determine need for adjustments
- Technology in Epic is the trigger to sustainability
- Continue to monitor technology for alert fatigue
- Continue to monitor data and make workflow/technology adjustments as necessary
- Continue to get feedback from frontline staff

Title: New PEG Tube Placement Workflow Date: January 2025	Sponsor: Dr. Fass, Nataliya Vasylkevych, CNP Team: Endoscopy, IS, Nutrition, Social Work, Home Health Care	CPI Team Lead: Jessica Higginbotham

Background — PLAN

Current ambulatory PEG Tube placement ordering process lacks coordinated consults with other services for full wrap around services. Patients oftentimes go home with the new PEG tube without having needed consults to Nutrition, Social Work (SW), or Home Health Care (HHC) Services.

Current Conditions — PLAN

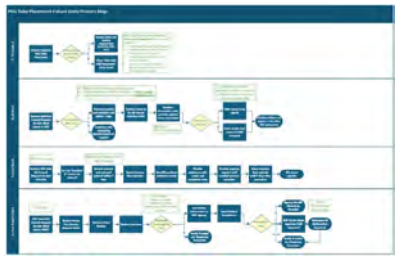
- Variation in how PEG Tube placement orders are completed between services (Cancer Care, ENT, GI, Trauma)
- No coordination with other needed consult services (SW, HHC, Nutrition)
- No current standard workflow exists

Analysis/Root Causes (The Why) — PLAN

- Different services place PEG Tube placement orders
- Low volume of procedures

Goal/Target Condition (MetroWay *Forward* Objectives) — PLAN

- Create a timely, well coordinated patient experience for new PEG Tube placements
- Work with frontline teams to create consistent, timely patient care
- Update pre/post PEG Tube placement instructions



Countermeasures/Improvements (The What or Tactics) — PLAN

1. Create a standard Order Panel for PEG Tube placements; including SW, HHC, Nutrition
2. Create standard workflow for timely & coordinated patient care
3. Update Pre/Post Procedure education for patient use
4. Create work queue standards for timely handling of consults to SW, HHC, and Nutrition

Implementation Plan (The How) — DO

- Work with department Chairs to create standard order panel and patient instructions
- Work with leaders from SW, HHC, Nutrition to develop standard timeline to complete consult requests
- Develop Future State workflow and Tip sheet for proper Order Panel usage
- Communicate work queue standards for timely completion of consults

Confirmation/Results of Improvement (What does success look like?) — CHECK

- Improved coordination of patient care; patient having consults completed prior to procedure
- Patient aware of pre/post procedure instructions

Conclusion (Control and Sustainability) — ACT

- Continue to monitor procedure workflows to determine need for adjustments
- Monitor work queue timeliness of PEG Tube placement consults
- Epic technology and staff documentation review
- Continue receiving feedback from frontline staff on effectiveness and improvements

A3 Title: **(TCM) Discharge Mgmt Follow-Up Visits** Owner: **Dr. Bruce** Date: **April 2024** **Team: IP Unit Secretaries, Care Coordination, Express Care Providers**

Version:

Background — PLAN

Patients are not showing up to their hospital discharge follow up appointments. This leads to gaps in patient care, hospital readmissions, inequitable health outcomes, and health disparities.
Express Care Providers previously covering Virtual on Demand line were underutilized resource and this work fits into the care they can provide

Current conditions — PLAN

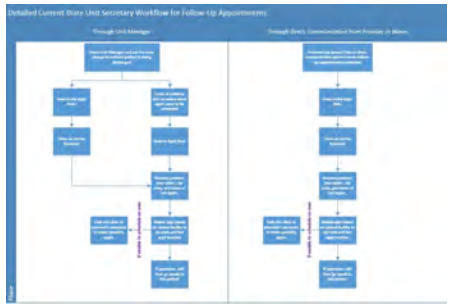
When a patient is discharged from their inpatient hospitalization, follow up appointments are not consistently made. If the appointments are made, they are not made with the patient's appointment preferences in mind. In addition, the AVS at time of discharge is not thoroughly reviewed with the patient to include future appointment review.
PCP Third Next Available- 28 days

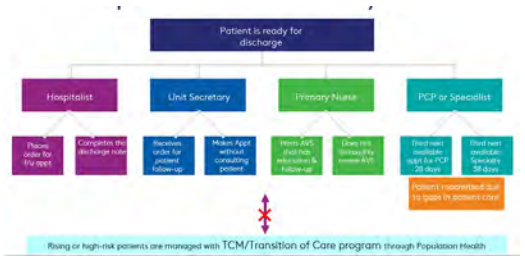
Site	Total Completed	InPerson Completed	In Person No Show %	Telehealth Completed	Telehealth No Show%	Telephone Completed	Telephone No Show%	Video Completed	Video No Show%
Grand Total	7,773	7,090	39.3%	683	24.4%	591	25.0%	92	20.7%

Goals / Target Condition (MetroWAY Forward Objectives) — PLAN

- Schedule Discharge Mgmt. Follow-up Visits with the patient preference 100% of the time
- Schedule based on Hospital Readmission Risk Score, Moderate(11-21) and High(22-100)
- Care Coordinator will outreach patient within 2 business days after discharge
- Patients will have a Telehealth touch base 14 days of hospital discharge by Express Care Provider
- Decrease no-show rates for hospital follow up by 10% (by when?)
- Reduce 30-day Readmissions for the at-risk population by 3% (by when?)
- Will be measured by Epic Workbench Reporting by Population Health

Analysis/Root Causes (The Why – Headlines) — PLAN

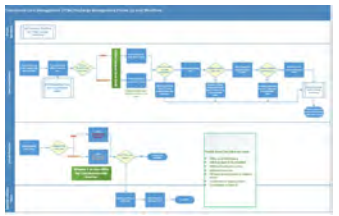




Countermeasures/Improvements (The What – Tactics) — PLAN

- Schedule using a **Patient Preference Appointment card** with the Unit Secretaries going to the patient based on Hospital Readmission Risk Score
- Care Coordination will provide Transitions of Care outreach to all patient identified at time of discharge to qualify for appointment **within 2 business days**
- Express Care provider will have Telehealth Transitional Care Mgmt. appointment slots for Unit Sec to schedule into- complete high risk **within 7 days**, moderate risk **within 14 days** of discharge

Implementation Plan (The How – How we do what we do) — Do



Confirmation /Results of improvements (What does success look like) — CHECK

Workbench reporting currently being developed

TCM Discharge Management Follow-up Visits

Site	Total Completed	InPerson Completed	In Person No Show %	Telehealth Completed	Telehealth No Show%	Telephone Completed	Telephone No Show%	Video Completed	Video No Show%
Grand Total	50	0		50	13.8%	45	13.5%	5	16.7%

Conclusion (Follow up actions for control and sustainability) — ACT

- Unit Secretaries like the ease of scheduling these appts and the use of the Patient Preference cards
- Patients prefer telephone visits over video
- Many of the Telehealth visits uncovered medication errors on patient end- get pharmacy involved
- Care Coordination typically outreaches top five payers- this new workflow is straining their capacity
    - Look at new defining metrics for you gets the full TCM/TOC workflow and who only gets the TCM workflow (develop tier 1 and tier 2 workflows)
- Next step is to educate PCP on TCM visits and have an in-person option for patients
- Need reporting completed to align on next steps

Title: Increase surgical cases with PAT appointments Date: Jan 2024	Sponsor: Katrina Conine Process Owner: Chris Lovejoy Team: Kathy Glazer, Melissa Snahnican

Background (The Past) — PLAN

- Department's goal is for every patient to have a PAT appointment before a surgery or procedure.
- Each patient is a assigned a risk score based on patients' medical history (e.g. ED visits, hospitalizations, comorbidities) which determines the PAT visit type and provider type.
- RNs have a telephone visit with low-risk patients (0-5), APPs have an in person visit with medium risk patients (6-11) and Physicians have an in person visit with high-risk patients (12+).

Current Conditions (The Present) — PLAN

- PAT clinic staffing needs are determined based on volume.
- There is not an easy way to pull data patient risk score & visit type.
- Current Epic Dashboard looks 1-8 days out and reports volume by risk score. It doesn't look at the visit type and who the appointments are scheduled with.

Analysis / Root Cause (The Why) — PLAN

Reporting is not readily available to answer:

- Can we expand PAT to other services? (i.e., Endoscopy)
- Are PAT services available where our patients live?
- Are we scheduling with the appropriate provider based on risk score?

Goals (System Goals, Outcomes, and Process Metrics) — PLAN

- Department goal is for every patient to have a PAT appointment before a surgery or procedure.
- Shed insight into :
  1. Analyzes % of cases that had a PAT appointment by location, service and month to identify which services to target.
  2. Patient Risk score by visit type & provider type to identify where the staffing needs are.

Countermeasures/Improvements (The What or Tactics incl. Owners) — PLAN

- Develop tableau dashboards to provide insight into management of PAT patient risk and appointment scheduling. Supports PAT operations and staffing decisions.

Proof of concept→

Implementation Plan (The Who, Detailed Tasks, and When) — DO

Task	Responsible	Date
Develop Workbench Report	J. Quast	January 2024
Create Proof of Concept Dashboard	L. Thompson	February 2024
Make Risk Score Reportable Field	J. Quast/J. Lewis	July 2025
Build Managed Data Set	DORA	August 2025
Build Tableau Dashboard	L. Thompson	September 2025

Confirmation/Results of Improvement (What does success look like?) — CHECK

Conclusions (Control and Sustainability Plan) — ACT

System Led Process Improvement

CQIC/ESQIC A3 examples

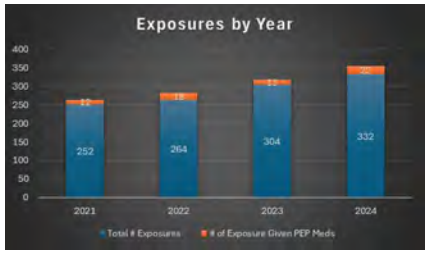
System leaders coached by CPI team

Optimizing BBPE Treatment Ordering Process from Manual to Electronic
Date: 1/1/2025

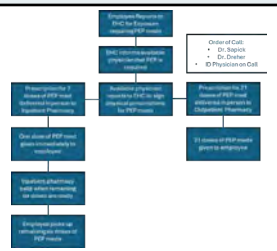
Sponsor: Kelly Seabold
Process Owner: Thomas Nemunaitis
Team: Dr. Dreher, Dr. Sapick, Nina Murphy, Adam Ritzler

Background (The Past) — PLAN

- Bloodborne Pathogen: microorganisms present in human blood that can cause disease (HIV).
- Transmission: Sharps & Splashes
- Post-Exposure Prophylaxis (PEP): antiretroviral medication used to help prevent these diseases.
- CDC recommends PEP medications be started within 72 hours of a possible HIV exposure. The sooner PEP meds are started, the better the outcome.
- Across the MetroHealth System from 2021 to 2024, the total number of bloodborne pathogen exposures (BBPEs) has increased by 32% and the number of exposures requiring post-exposure prophylaxis (PEP) medications increased by 83%.



Current Conditions (The Present) — PLAN



- Current ordering process for PEP medications is manual and time consuming

Analysis / Root Cause (The Why) — PLAN

The ordering process of PEP medications is convoluted.

1 Why?	Why is the ordering process convoluted?	The excessive steps to order the medications makes it time consuming.
2 Why?	Why is the ordering process time consuming?	The ordering physician must come on site to write physical prescriptions for PEP medications.
3 Why?	Why is the ordering process time consuming?	The prescriptions are hand delivered to inpatient pharmacy.
4 Why?	Why is the ordering process time consuming?	PEP medications are hand delivered from pharmacy to exposed employee.
5 Why?	Why are physical prescriptions delivered to and PEP medications from pharmacy?	There is no electronic ordering system built for PEP medications.

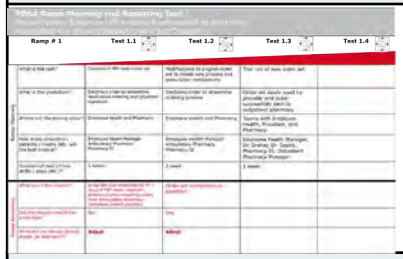
Goals (True North Objectives, System Goals, Outcomes, and Process Metrics) — PLAN

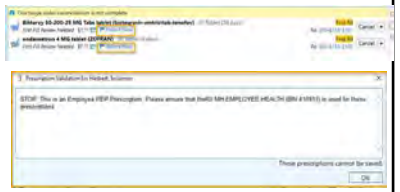
Goal: optimize the BBPE medication ordering process from manual to electronic
How: create order set in Epic for physician to electronically order PEP meds to a single location (outpatient pharmacy)
Metrics: Reduce time from when an employee reports an exposure to when they receive PEP medication

Countermeasures/Improvements (The What or Tactics incl. Owners) — PLAN

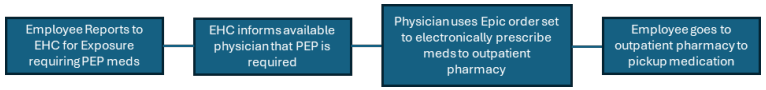
Tasks to be Completed	Person Responsible	Due Date
Epic chart audit time to medication (manual)	EHC	1/31/25
Gather stakeholders to discuss new order set	EHC, Pharmacy, IS, ID	2/3/25
Pharmacy IS to create order set	Pharmacy IS	3/24/25
Revisions to order set	Pharmacy IS	5/9/25
Test new order set	EHC, Pharmacy, IS, ID	5/16/25
Implement new order set	EHC, Pharmacy, IS, ID	5/19/25
Epic chart audit time to medications	EHC	June, July, August 2025

Implementation Plan (The Who, Detailed Tasks, and When) — DO





Confirmation/Results of Improvement (What does success look like?) — CHECK



Conclusions (Control and Sustainability Plan) — ACT

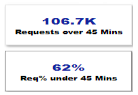
Title Dining Services Room Service Process Date April 1, 2025	Sponsor: Patty McClain Process Owner: Denise Lemin Team: Naskia Adams, Lauren Avery, Antonio Barnett, Mike Blackman, Darrell Ragland

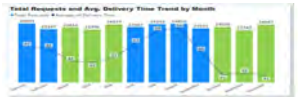
Background (The Past) — PLAN

Room Service (RS) is the main campus meal service model. In most instances, a patient with an eligible diet order uses a bedside menu to choose meal components, call in their order and receive the meal at bedside within 45 minutes of order placement. A successful meal is on time, at good temperature and tastes good for our patients. The RS process has not been evaluated since we moved into the Glick Center in late 2022. We have a lot of data available from operations but only some is readily helpful. KPMG set up a RS Dashboard utilizing Power BI in 2024 which revealed 62% of meals delivered in <45Mins.

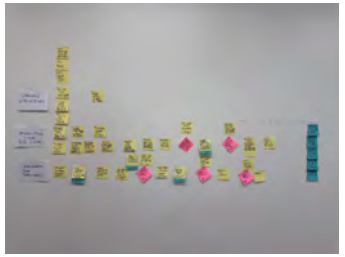
Current Conditions (The Present) — PLAN

Q1 results reflect 67% of trays were delivered within 45min and 24.1K of 72.4K requests delivered >45min. During the Gemba walks, there appears to be a high level of variation in the process, especially once a tray goes into a cart.





Reference slide 2



Analysis / Root Cause (The Why) — PLAN

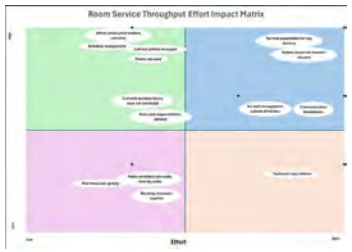
Group identified many reasons for trays delivered late. Leadership then aligned these findings with the known points of delay per historically tracked checkpoints-On Line, In Cart, En Route.

Goals (True North Objectives, System Goals, Outcomes, and Process Metrics) — PLAN

Improve tray delivery promise to achieve 71% of Glick Room Service trays delivered within 45 minutes by end of year.

Countermeasures/Improvements (The What or Tactics incl. Owners) — PLAN

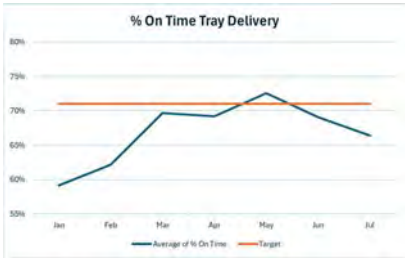
- ✓ Effort impact analysis prioritized our countermeasures
- ✓ Active Cart Management is our first small test of change



Implementation Plan (The Who, Detailed Tasks, and When) — DO

Countermeasures	Status	Date
Cart Management	In progress	Jul-25
Software Education and Training for Supervisors	Complete	July 15-16, 2025
Expectations of Active Cart Management report out	In progress	Jul-25
Collate feedback from post education survey	In progress	Jul-25
Open lines a communication	Not started	Aug-25

Confirmation/Results of Improvement (What does success look like?) — CHECK



Conclusions (Control and Sustainability Plan) — ACT

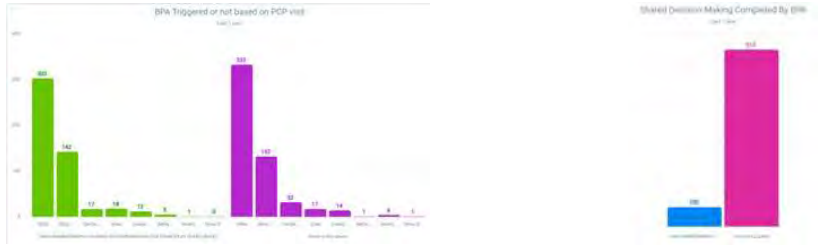
Title Improve Breast Cancer Early Risk Identification Date July 2025	Sponsor: Dr. Perzy	Process Owner: Drs. Daprano/MansourTeam: Craig, Daprano, Mansour

Background (The Past) — PLAN

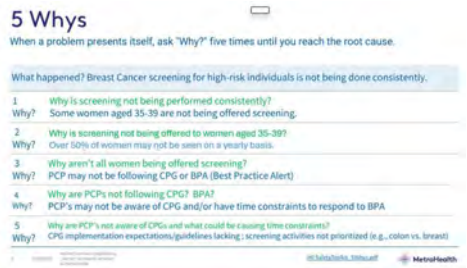
At least 9% of all cancers are found in the US are under 45 years of age (from SEER data).
At MetroHealth:

- 25% of breast cancers diagnosed occur in women under the age of 50
- 5% of that 25% occur in women under the age of 40
- "Tendency towards late-stage diagnosis"
- An important strategy to reduce overall breast cancer mortality is the use of the Gail Model for high-risk stratification of women ages 35-39 but this is not currently occurring consistently.
- Currently the Breast Cancer CPG (activated in 2022) at MH recommends utilizing shared decision making to offer breast cancer risk evaluation to women ages 35-39

Current Conditions (The Present) — PLAN



Analysis / Root Cause (The Why) — PLAN



Goals (True North Objectives, Outcomes, and Process Metrics) — PLAN

- Increase number of women 35-39 screened for breast cancer using Gail model risk assessment from 10% to 30% by Dec 31, 2025
- Achieve 80% PCP utilization of BPA and life-time risk identification for high-risk pts by Dec 31st.
- Refer 70% of high-risk women 35-39 to MH Breast Clinic for counseling and risk reduction strategies by Dec 31, 2025.

Countermeasures/Improvements (The What or Tactics incl. Owners) — PLAN

1. Actively communicate and provide guide for BPA utilization for women 35-39 (June 2025)
2. Develop a convenient process for PCP to engage patient by explicitly by identifying the historical risk factors using the Gail Model via an online risk calculator to determine the lifetime risk of breast cancer in real time.

Implementation Plan (The Who, Detailed Tasks, and When) — DO

- MedPeds PCP providers were taught the use of the BPA for early risk identification and informed consent for women 35-39. This included a specific how to power-point and hands on training using the EMR and test patient during the 6-6-25 MedPeds Faculty retreat.
- Data will be gathered to determine the effectiveness, efficiency, and equity of this project over the next six months using a IS GIVA data gathering tool.
- Pre-intervention Provider survey was completed 6-6-25 and a follow up survey and discussion will be completed at MedPeds Faculty meeting in late 2025.

Confirmation/Results of Improvement (What does success look like?) — CHECK

- Providers completing early risk identification and informed consent in 80% or more of primary care patients SEEN within the study period.
- Providers satisfied and engaged via survey results with an 80% satisfaction rate in late 2025.
- 70% of high-risk women identified provided with a mammogram and a Breast Cancer clinic referral.
- 70% of women at high-risk and referred with a completed appointment in the Breast Cancer clinic. *
- Meaningful information about barriers and successes learned through the project by the QI team and PCP providers for use in subsequent cycles and iterations. MedPeds providers are embedded throughout the primary care facilities at MHMC. This will should provide important information for the generalization of this screening process at MetroHealth.

Conclusions (Control and Sustainability Plan) — ACT

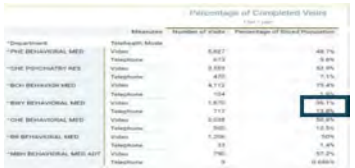
What have we learned that does or does not improve the situation? What do we need to learn next?
TBD

Title: Improving Show Rate at BWY BH Clinic Date: July 2025	Sponsor: Laurel Ralston, DO Process Owner: Cristi Zavarella, LPCC-S Team: Dr. Kathleen Alto; Deborah Casciato; Ami Nelson; Benjamin Rubin; Lori-Anne Schulte-Laird; Delmecia Wilkins

Background — PLAN

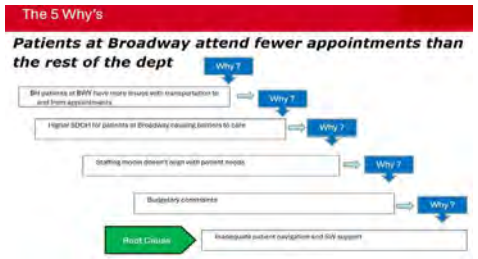
-Nationally, no show rates in community mental health can reach up to 50%
-At Metro, no show rates in behavioral health (BH) are higher than other departments.
-Out of all Metro BH locations, Broadway has the highest no-show rate, particularly for in person visits.
-Missed appointments create gaps in patient care and can lead to poorer outcomes.
-No show appointments are slots that could have been used by other patients.
-High no show rates affect revenue and morale.

Current Conditions — PLAN



Analysis/Root Causes (The Why) — PLAN

BWY has higher NS rate than the rest of the system
Patients have more transportation issues
Patients have higher SDOH needs
Staffing model does not meet SDOH needs
Budgetary constraints
Lack of pt navigation & SW support



Goal/Target Condition (S.M.A.R.T goal) — PLAN

By 12/31/25, Broadway BH clinic will:

- Decrease overall no-show rate: 25.9% ➡ 18%
- Increase in person appointments: 49.6% ➡ 55%
- Decrease audio only telehealth visits: 13.8% ➡ 7.5%

Countermeasures/Improvements (The What or Tactics) — PLAN

TBD

Implementation Plan (The How) — DO

TBD

Confirmation/Results of Improvement (What does success look like?) — CHECK

TBD

Conclusion (Control and Sustainability) — ACT

TBD

MetroHealth
Devoted to Hope, Health, and Humanity

ABOUT METROHEALTH

Founded in 1837, MetroHealth is leading the way to a healthier you and a healthier community through service, teaching, discovery, and teamwork. Cuyahoga County's public, safety-net hospital csystem, MetroHealth meets people where they are, providing care through five hospitals, four emergency departments, and more than 20 health enters and 40 additional sites. Each day, our almost 9,000 employees focus on providing our community with equitable healthcare—through patient-focused research, access to care, and support services—that seeks to eradicate health disparities rooted in systematic barriers. **For more information, visit metrohealth.org**

connect **@metrohealthcle**

MyChart
metrohealth.org/mychart