Stony Brook Medicine

Quality Improvement Department Stony Brook University Hospital

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Overview of Strategy for Quality Management

Our Mission: improve the lives of our patients, families, and communities, educate skilled healthcare professionals, and conduct research that expands clinical knowledge.

Our Vision: Stony Brook University Hospital will be:

- A world-class healthcare institution, recognized for excellence in patient care, research and health care education
- The first choice of patients for their care and the care of their families
- An academic medical center that attracts educators and students with the desire and ability to provide and receive the highest quality, innovative education
- One of the top ranked institutions for scientific research and training.

Our Vision for Quality & Safety of Care:

We will be a Top Decile performer within 3 Years

Strategic Vectors

Clinical Outcomes	Patient Safety	Patient Experience
Top Decile Outcomes	Zero Preventable Harm	Best Place to Receive Care

Foundational Enablers

Physician Engagement	Technology	Throughput Optimization	Organization & Staffing	Culture
Physician Driven Quality Program	Technology Accelerated Care	No Wasted Time or Resources	Quality Management At Your Service	Culture of Excellence & Accountability

Our Values → ICARE: Integrity, Compassion, Accountability, Respect, Excellence

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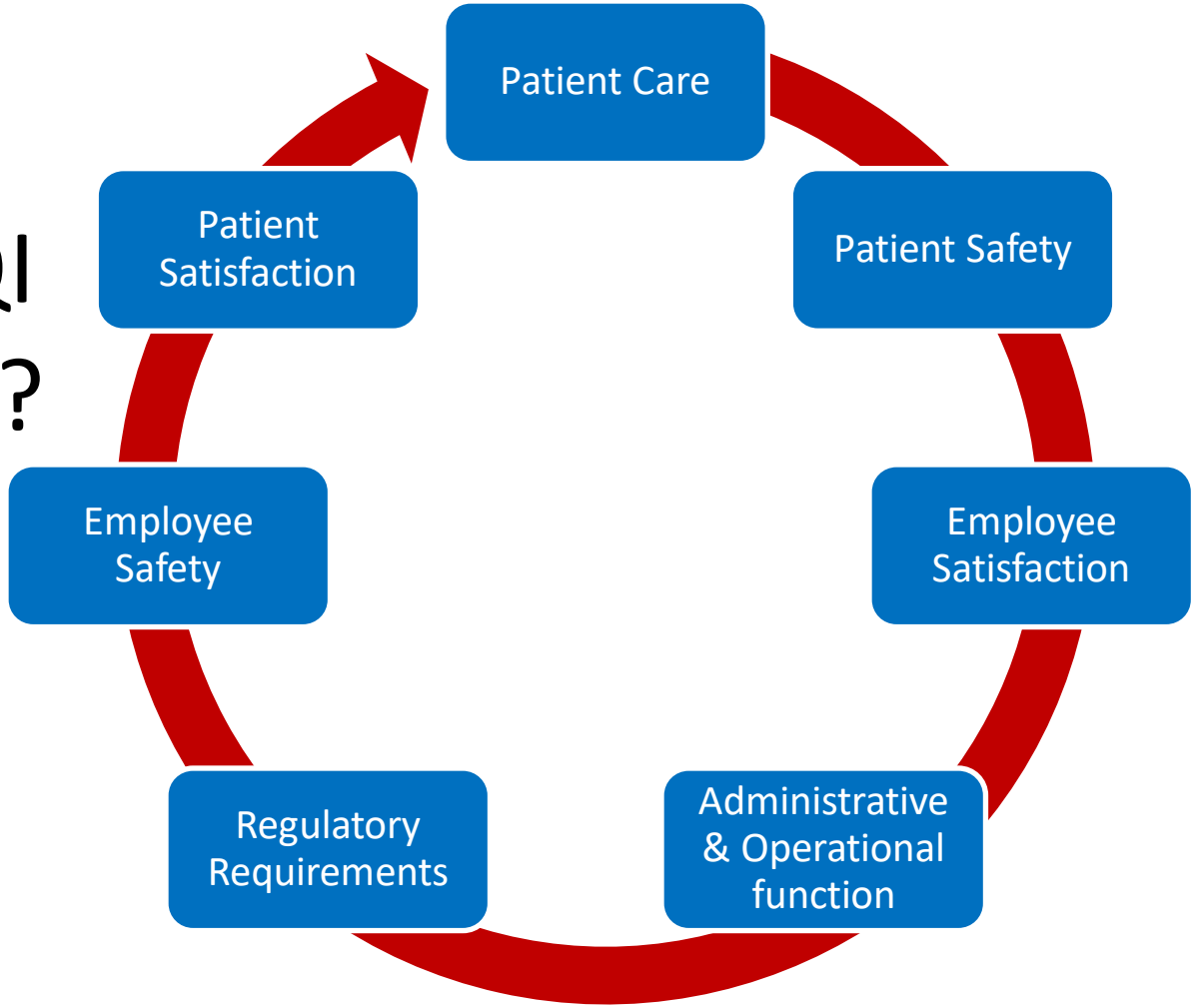
What does QI Encompass?



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QI Principles

- All work is part of a **process**
- Quality is achieved through **people**
- Decision making is done with **facts**
- **Patients and customers** are our first priority
- Quality requires **continuous improvement**
- QI focuses on the **process not the person**

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Methodology for Improving a Process

F **Find a process to improve**

O **Organize a team that knows the process**

C **Clarify current knowledge about the process**

U **Understand causes of process variation**

S **Select the process improvement**

P

D

C

A

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Sentinel Event

- A sentinel event is an **unexpected occurrence** involving death or serious physical or psychological injury, or the risk thereof.
- Examples include: **Suicide - Rape - Loss of limb - Elopement -Death**

Root Cause Analysis

- A process for identifying the contributing factors that underlie variations in performance; includes the occurrences of the sentinel events, adverse event or close calls.
- Process that features interdisciplinary involvement of those closest to and/or most knowledgeable about the situation to find out:
  - **What happened?**
  - **Why did it happen?**
  - **How can we prevent it?**
  - **How do we know we made a difference?**

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Failure Mode and Effects Analysis (FMEA)

- **Proactive** risk assessment
- A team based, systematic approach for identifying the ways a process or design can fail, why it might fail, and how it can be made safer.
- The team uses an evidence based severity scoring tool to determine points of highest risk in the process being evaluated.
- An action plan is then developed to mitigate the high risk points.

Conducting an annual hospital wide FMEA is a Joint Commission Requirement

- What performance improvement initiative has our department implemented recently?

Hint: It **MUST** be supported by data

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Core Measure of Excellence

- **CMS** (the Center for Medicare & Medicaid Services) established the Core Measures in 2000 and began publicly reporting data in 2003
    - Addresses clinical care, person and caregiver-centered experiences and outcomes, safety, efficiency and cost reduction, care coordination and Community / population health.
- The overarching goal of CMS quality reporting programs are to support the National Quality Strategy's goal of:
    - ✓ Better health care for individuals
    - ✓ Better health for populations
    - ✓ Lower costs for health care
- **CMS** ties some parts of reimbursement to reporting the data; in some cases reimbursement is tied to how well we deliver specific elements of care, known as **Value-Based Purchasing**

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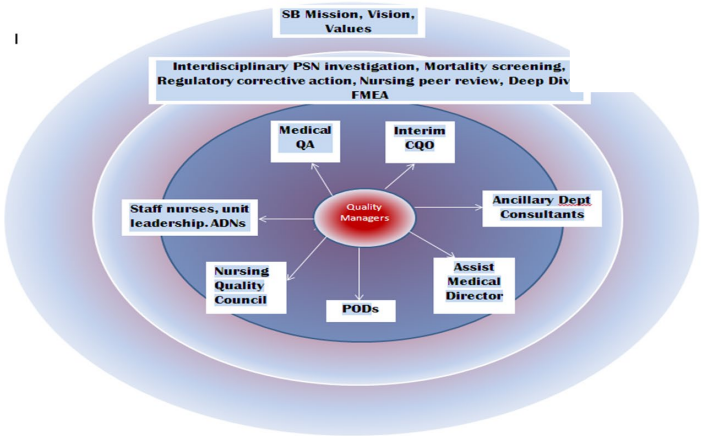
SB SAFE
Patient Safety Event Reporting

- Any untoward event noted throughout the day:
  - Hand off • Code Blue • Medication errors • Equipment
  - Unexpected OR occurrences • Patient Care Transfer • Lab / Specimen
  - Mortalities • Safety / Security • Provision of care • ID/ Documentation
- Use of system taught at the unit level
- "See Something – Say Something"
- Collaborative analysis among Nursing Leadership
  - Cases identified for peer review
  - Issues identified presented monthly with proposed solutions & actions.
  - Reported to Nursing Quality Council



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High Reliability Unit (HRU) – Multidisciplinary Unit Based Quality Teams

- Physicians, Nurses, SW/ CM, Respiratory therapists, Pharmacy, HED, QI
- Quality metric can be unit specific or a hospital wide initiative
- Prevent a breakdown in patient care or operations
- **Hospital Metrics**
  - ✓ Preventing CLBSI / CAUTI
  - ✓ Falls
  - ✓ Pressure Ulcers
  - ✓ DVT's
  - ✓ Sepsis
- **Unit Specific Metrics**
  - ✓ Drug / ETOH screen
  - ✓ ED Door to Doctor times
  - ✓ Restraints
  - ✓ Post op complications for spinal surgery
  - ✓ TAVR – acute kidney injury
- Best practice guides reviewed for each metric
- Do you have the tools you need to be successful in the care you give to patients