TGH Quality Improvement and Safety Goals

Resident Orientation, June 2018
• Quality Domains-Institute of Medicine
• TGH performance among Academic Medical Centers (AMCs)
• 2018 Quality Priorities
• Journey to High Reliability
  • Zero Harm and Safety Events
• Resident involvement quality activities
Six Domains of Healthcare Quality

- Safe
- Effective
- Efficient
- Timely
- Equitable
- Patient-Centered
The frontline has the best understanding of the system
  They need systems thinkers’ skill sets
The frontline has the best ideas to improve it
  They need to do so in data-driven, efficient means → requires specific skill set
The frontline has to own it and be empowered
  Leadership must support
Quality Improvement Department has to identify, support, and coach efforts to become highly reliable
Only High Reliability Organizations (HROs) will succeed
  Provide safe care (zero unintended harm)
  Efficient care (no rework, waste, or non-value-added steps)
High Reliability = Consistent Excellence

Establish and Sustain Near-Zero Rates of Failure for Critical Quality Processes

Safe Culture

- Robust Process Improvement
- Leadership Commitment
### High Reliability Leadership

<table>
<thead>
<tr>
<th>From...</th>
<th>To...</th>
</tr>
</thead>
<tbody>
<tr>
<td>Externally driven safety focus (CMS, TJC, Leapfrog)</td>
<td>Internally driven safety focus (initiatives driven by SSE review)</td>
</tr>
<tr>
<td>Safety is a priority</td>
<td>Safety is a core value that cannot be compromised</td>
</tr>
<tr>
<td>We are creating a safety culture</td>
<td>We are shaping a reliability culture that creates safety</td>
</tr>
<tr>
<td>The board and senior leaders support culture change</td>
<td>The board and senior leaders own and manage the culture</td>
</tr>
<tr>
<td>Medical staff support culture change</td>
<td>Medical staff own and promote safety culture</td>
</tr>
</tbody>
</table>
Focus has been on public reporting
Publically reported metrics are those identified as most impactful on healthcare

Close gaps about what is measured and how patients are impacted
Zero Harm mindset
Vizient Quality Rating Domains

Safety
Efficiency
Mortality
Equity
Readmissions
Patient Centeredness
<table>
<thead>
<tr>
<th>Domain</th>
<th>Rank</th>
<th>Weight</th>
<th>Score</th>
<th>Weighted Score</th>
<th>Vizient Median</th>
<th>Vizient Top Performer</th>
</tr>
</thead>
<tbody>
<tr>
<td>Overall</td>
<td>81</td>
<td>100.00%</td>
<td>45.54%</td>
<td>45.54%</td>
<td>55.30%</td>
<td>80.88%</td>
</tr>
<tr>
<td>Mortality</td>
<td>79</td>
<td>26.25%</td>
<td>38.05%</td>
<td>9.99%</td>
<td>51.09%</td>
<td>93.41%</td>
</tr>
<tr>
<td>Efficiency</td>
<td>86</td>
<td>5.50%</td>
<td>30.81%</td>
<td>1.69%</td>
<td>51.72%</td>
<td>93.62%</td>
</tr>
<tr>
<td>Safety</td>
<td>41</td>
<td>26.25%</td>
<td>55.77%</td>
<td>14.64%</td>
<td>54.24%</td>
<td>76.68%</td>
</tr>
<tr>
<td>Effectiveness</td>
<td>91</td>
<td>21.00%</td>
<td>35.64%</td>
<td>7.48%</td>
<td>49.84%</td>
<td>75.01%</td>
</tr>
<tr>
<td>Patient centeredness</td>
<td>63</td>
<td>15.75%</td>
<td>46.72%</td>
<td>7.36%</td>
<td>51.37%</td>
<td>89.57%</td>
</tr>
<tr>
<td>Equity</td>
<td>94</td>
<td>5.25%</td>
<td>83.33%</td>
<td>4.38%</td>
<td>94.44%</td>
<td>100.00%</td>
</tr>
</tbody>
</table>
Vizient Star Rating

2015

2016

2017
Quality and Safety Improvement timeline

3-star AMC (50\textsuperscript{th} percentile) • FY2019

4-star AMC (top quartile) • FY2020

5-start AMC (top decile) • FY2022
Risk-adjusted mortality is portrayed as the mortality index

Mortality-Index = \text{actual number of patients that died} \over \text{expected number of patient deaths}

Expected number of deaths is determined by degree of illness of the patients
Clinical Focus:
  Sepsis treatment compliance
Documentation focus (risk-adjustment appropriateness):
  Clinical Documentation Improvement (CDI) team at the elbow of the physicians
End-of-life Care
Create a standard for improvement methodology that includes resources to allow efforts to be most safe, efficient and effective.

Resources to guide project that assures:

- Focus is aligned with hospital priorities
- Improvement needs are identified and prioritized
- Maintained in central location, avoiding redundancy
- Involves all stakeholders consistently
USF GME-TGH Sepsis QI Initiative

179 TGH patients with sepsis in March

*84% of most recent cases were POA

31 sepsis patient deaths in March

6 More Patients Died Than Expected

TGH Ranks 88th in SEP-1 bundle compliance

1 Among 90 academic medical centers in Vizient database

2 Based on top quartile performance in Vizient database March 2018

SEP-1 Bundle Compliance

Individual team Goal "TGH Bundle Compliance"

TGH Sepsis Mortality Index

Discharge Quarter

Q1 2016 Q2 2016 Q3 2016 Q4 2016 Q1 2017 Q2 2017 Q3 2017 Q4 2017

% Compliance

0% 5% 10% 15% 20% 25% 30% 35% 40%

Discharge Month


Observed/Expected Rate

0.00 0.20 0.40 0.60 0.80 1.00 1.20 1.40 1.60 1.80

Goal "TGH Bundle Compliance"
Safety

- Hospital-acquired infections
  - CAUTI, CLABSI, MRSA Bacteremia, C. Difficile, Surgical Site Infection

- Patient-Safety Indicators, Complication Rates
Quality Composite- Patient Safety Indicator Composite-90 (PSI-90)

FY15: Education re: PSI, specific interventions in PSI-15, PSI-12
FY16: 3M implemented, followed by training for coding, establishment of hard-stops
FY17: Documentation improvement training for providers
Hospital-Acquired Infections

- Improved testing utilization-driven by ordering processes (CAUTI, CDI)
- Improved device utilization (CLABSI, CAUTI)
- Universal decolonization of high-risk patients (MRSA)
- Infection prevention bundle compliance (SSI, CAUTI, CLABSI)
- Order set compliance (SSI)
• **Doctor-Communication**
  • Doctor listened carefully to you
  • Explained things in a way you could understand
  • Treated you with courtesy and respect

• **What you can do**
  • Knock and ask permission to enter the room
  • Introduce yourself and team
  • Sit down
  • Incorporate the patient in the plan-*What matters to you?*
Readmission (Effectiveness)

- 30-day readmissions by service-line, disease category
- Excess days in acute care, by service-line
Efficiency

- Length of Stay; LOS Index
  - Observed:expected
- Direct costs
- Efficient use of imaging
Safe Culture

- Identify Unsafe Conditions
- Strengthen Systems
- Establish trust
  - Everyone can speak up for patient or staff safety!
Never Events

- At minimum, include the National Quality Foundations (NQF) Serious Reportable Events
- NQF identifies 29 Serious Events (updated 2011) that cause harm to patients or staff
- Never Events Policy recognized as a Best Practice by Leapfrog
### SERIOUS SAFETY EVENT WORKSHEET

<table>
<thead>
<tr>
<th>Event Date:</th>
<th>MRN:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Event Report Date:</td>
<td>Event Number:</td>
</tr>
</tbody>
</table>

#### SERIOUS SAFETY EVENT CATEGORY

<table>
<thead>
<tr>
<th>SURGICAL/INVASIVE PROCEDURE EVENTS</th>
<th>PRODUCT OR DEVICE EVENTS</th>
<th>PATIENT PROTECTION EVENTS</th>
<th>POTENTIAL CRIMINAL EVENTS</th>
<th>ENVIRONMENTAL EVENTS</th>
</tr>
</thead>
<tbody>
<tr>
<td>☐ Surgery or other invasive procedure performed on the wrong site *†</td>
<td>☐ Patient death or serious injury associated with the use of contaminated drugs, devices, or biologics provided by the healthcare setting</td>
<td>☐ Discharge or release of a patient/resident of any age, who is unable to make decisions, to other than an authorized person *†</td>
<td>☐ Any instance of care ordered by or provided by someone impersonating a physician, nurse, pharmacist, or other licensed healthcare provider</td>
<td>☐ Patient or staff death or serious injury associated with an electric shock in the course of a patient care process in a healthcare setting</td>
</tr>
<tr>
<td>☐ Surgery or other invasive procedure performed on wrong patient *†</td>
<td>☐ Patient death or serious injury associated with the use or function of a device in patient care, in which the device is used or functions other than as intended</td>
<td>☐ Patient death or serious injury associated with patient elopement (disappearance)</td>
<td>☐ Abduction of a patient/resident of any age</td>
<td>☐ Any incident in which systems designated for oxygen or other gas to be delivered to a patient contains no gas, the wrong gas, or are contaminated by toxic substances</td>
</tr>
<tr>
<td>☐ Wrong surgical or other invasive procedure performed on a patient</td>
<td>☐ Patient death or serious injury associated with intravascular air embolism that occurs while being cared for in a healthcare setting</td>
<td>☐ Patient suicide, attempted suicide, or self-harm that results in serious injury, while being cared for in a healthcare setting, or within 72 hours of discharge *†</td>
<td>☐ Sexual abuse/assault on a patient or staff member within or on the grounds of a healthcare setting</td>
<td>☐ Patient or staff death or serious injury associated with a burn incurred from any source in the course of a patient care process in a healthcare setting</td>
</tr>
<tr>
<td>☐ Untended retention of a foreign object in a patient after surgery or other invasive procedure *†</td>
<td>☐</td>
<td>☐ Patient death or serious injury associated with patient elopement (disappearance)</td>
<td>☐ Death or serious injury of a patient or staff member resulting from a physical assault (i.e., battery) that occurs within or on the grounds of a healthcare setting</td>
<td>☐ Patient death or serious injury associated with the use of physical restraints or bedrails while being cared for in a healthcare setting</td>
</tr>
<tr>
<td>☐ The performance of a surgical procedure that is medically unnecessary or otherwise unrelated to the patient’s diagnosis or medical condition</td>
<td>☐</td>
<td>☐ Patient death or serious injury associated with an inpatient’s escape</td>
<td>☐ Death of a patient or staff member resulting from a fall while being cared for in a healthcare setting</td>
<td>☐ Any Stage 3, Stage 4, and unstageable pressure ulcers acquired after admission/presentation to a healthcare setting</td>
</tr>
<tr>
<td>☐ The surgical repair of damage resulting to a patient from a planned surgical procedure, where the damage is not a recognized specific risk, as disclosed to the patient and documented through the informed-consent process</td>
<td>☐</td>
<td>☐ Artificial insemination with the wrong donor sperm or wrong egg</td>
<td>☐ Death or serious injury of an irreplaceable biological specimen</td>
<td>☐ Any Stage 3, Stage 4, and unstageable pressure ulcers acquired after admission/presentation to a healthcare setting</td>
</tr>
<tr>
<td>☐ Intraoperative or immediately postoperative/post-procedure death in an ASA Class 1 patient</td>
<td>☐</td>
<td>☐ Patient death or serious injury resulting from the irretrievable loss of an irreplaceable biological specimen</td>
<td>☐ Patient death or serious injury resulting from failure to follow up or communicate laboratory, pathology, or radiology test results</td>
<td>☐ Patient death or serious injury resulting from the irretrievable loss of an irreplaceable biological specimen</td>
</tr>
</tbody>
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#### ROOT CAUSE DETERMINATION:

After analysis, was this event considered preventable?  ☐ Yes  ☐ No  
Disclosure and follow-up to the family?  ☐ Yes  ☐ No

*Joint Commission Sentinel Event; *†Sentinel Event and NQF Never Event; AHCA Code 15 in red
Never Events Policy

- Perform RCA on all never events, include patient in review
- Transparency: policy is available to patients and payers on request
- Disclosure: share occurrence of never event and opportunities for improvement with patient/family
- Psychological safety: Support caregivers involved in never event
- Costs of care related to event not borne by patient
Turn data into information
Simplify patient care paths- make it easy to do the right thing/hard to do the wrong thing
Hardwire best-practice processes
Pre-occupation with failures-opportunities for improvement
We put patients first in everything we do
Opportunities to contribute

QI Bootcamp
QI Elective
Department Clinical Process Improvement Teams
Improvement Task Force
Speak Up!-Support others to do so