John H. Stroger Jr. Hospital of Cook County 2021 Quality and Patient Safety Plan

QPS Committee

October 2021

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Why Have a Quality and Patient Safety (QPS) Plan?

Purpose

- The purpose of the Plan supports the systematic organization-wide approach to plan, design, measure, assess and improve organizational performance, identify, minimize and prevent organizational risks, and ensure delivery of safe patient care.
- A QPS Plan is designed to continually strive toward our purpose of:
    - Doing the right thing
    - Doing the right thing well
    - Continually improving
- It is one of the required Plans by TJC and requires review and approval by the Board annually.
- Currently, CCH has three QPS Plans: Stroger, Provident, ACHN.
- Plan is to develop one system QPS Plan for 2022.

Revisions

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Revisions made from 2018 QPS Plan to 2021 QPS Plan

- 2018 QPS Plan
  - 27 pages of content
  - No Table of Contents
  - No Appendices
  - No References
- 2021 QPS Plan
  - 14 pages of content
  - Table of Contents added
  - 10 Appendices added-to support processes
  - HRO Workgroup Structure added to Quality infrastructure
  - Annual Program Evaluation added
  - References added

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2021 QPS Plan Table of Contents

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Mission, Vision, Purpose, Definition

- **Mission**

  To deliver integrated health services with dignity and respect regardless of a patient's ability to pay; foster partnerships with other health providers and communities to enhance the health of the public, advocate for policies which promote and protect the physical, mental, and social well-being of the people of Cook County.

- **Vision**

  In support of its public mission, CCH will be recognized locally, regionally, and nationally — and by patients and employees — as progressively evolving model for an accessible, integrated, patient-centered and fiscally-responsible health care system focused on assuring high-quality care and improving the health of the residents of Cook County.

Definition of Quality

- Quality is defined as a never-ending cycle of continuous improvement.
- Quality is providing the right care at the right time, for the right patient and right the first time and every time.
- Care should be based on the strongest clinical evidence and provided in a technically and culturally competent manner with good communication and shared decision making.

Therefore, the organization commits to continuous measurement, analysis, and improvement.

Goals

This plan establishes the following goals:

- Expand the implementation of evidence-based practices.
- Monitor system-wide indicators for established areas of focus.
- Improve patient outcomes.
- Promote a culture of safety throughout the organization.
- Reduce the number of serious safety events.
- Improve the reporting of safety events by maintaining and acting upon the adverse event reporting policy which promotes a safe reporting environment where reporting of events is encouraged in a **non-punitive manner.**
- Foster the use of the confidential electronic event reporting system (eMERS) which includes documentation and follow-up.
- Conduct Root Cause Analysis (RCA) on all sentinel events.
- Conduct proactive risk assessment utilizing the Failure, Mode, Effects Analysis (FMEA) methodology as appropriate.

Organizational Structure- Responsibilities

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CCH-Board of Directors-Responsibilities

- The CCH Board of Directors is ultimately responsible for the safety and quality of care, treatment, and services.
- They are accountable and ultimately responsible for holding senior management, medical staff, and leaders accountable for the quality improvement goals and ensuring they are integrated with the organization's strategic initiatives.
- Members:

Chair Lyndon Taylor
Vice Chair Hon. Dr. Dennis Deer, LCPC, CCFC

Directors:

- Robert Currie
- Raul Garza
- Ada Mary Gugenheim
- Joseph M. Harrington
- Karen E. Kim, MD, MS
- Mike Koetting
- David Ernesto Munar
- Heather M. Prendergast, MD, MS, MPH
- Robert G. Reiter, Jr.
- Otis L. Story, Sr

Board QPS Committee-Responsibilities

- The QPS Committee of the Board oversees the quality, safety and performance improvement programs of CCH with the goal of recognizing the critical importance of maintaining high quality service and patient and staff safety and satisfaction.
- Provides for the resources needed to maintain safe, quality care, treatment, and services.
- Ensures all patients are provided with the highest-quality care possible while incorporating the foundations of the Plan.
- Reviews summaries of improvement activities and performance indicators to track results of overall performance.
- Reviews medical staff credentialing and privileging/appointment process to ensure compliance with established procedures and the Medical Staff Bylaws for John H. Stroger Hospital.
- Serves as a liaison between the CCH hospital Affiliate Medical Staffs and the System Board of Directors.
- Is accountable for, and delegates to, the HQuIPS Committee
- Members:
  - Chair: Ada Mary Gugenheim
  - Members:
    - Raul Garza
    - Heather M. Prendergast, MD, MS, MPH
    - Otis L. Story, Sr.
    - Patricia Merryweather (Non-Director Member)

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The Executive Medical Staff (EMS)-Responsibilities

The full scope of responsibility of the EMS is outlined in the Stroger Hospital Bylaws and policies of the Medical Staff. Activities related to quality and safety include:

- Makes recommendation to the CCH Board of Directors through the CCH QPS Committee on a regular basis regarding the credentialing and privileging of the Medical Staff.
- Provides leadership for measuring, assessing and improving processes.
- Responsible for the performance improvement activities of the organization to improve the quality and safety of patient care.
- Reviews medical staff compliance with standards and regulations set forth by CMS, the Joint Commission (TJC), or other state or federal agencies as required.
- Provides medical staff oversight for the quality improvement activities of the medical staff departments and the committees of the medical staff.

HQuIPS Committee-Responsibilities

Stroger HQuIPS 2021 Reporting Schedule:

- Occurs on the 4th Tuesday of every month
- No meeting in December

Jan. 26th	Feb. 23rd	March 23rd	April 27th	May 25th	June 22nd	July 27th	Aug. 24th	Sept. 28th	Oct. 27th	Nov. 23rd
Departmental Reports (3-4 times per year)										
Reporting Period Q4 2020			**Reporting Period Q1 2021**			**Reporting Period Q2 2021**			**Reporting Period Q3 2021**	
Quality Dashboard	Quality Dashboard	Quality Dashboard	Quality Dashboard	Quality Dashboard	Quality Dashboard	Quality Dashboard	Quality Dashboard	Quality Dashboard	Quality Dashboard	Quality Dashboard
Patient Safety	Patient Safety	Patient Safety	Patient Safety	Patient Safety	Patient Safety	Patient Safety	Patient Safety	Patient Safety	Patient Safety	Patient Safety
EOC Dashboard	Infection Control	ACHN	EOC Dashboard	Infection Control	ACHN	EOC Dashboard	Infection Control	ACHN	EOC Dashboard	Infection Control
Laboratory	Nursing	Contracts	Laboratory	Nursing	Patient Experience	Laboratory	Nursing	Contracts	Laboratory	Nursing
Radiology	Pharmacy	Stroke	Radiology	Pharmacy	Case Management	Radiology	Pharmacy	Stroke	Radiology	Pharmacy
Patient Relations	Case Management	Patient Experience	Patient Relations		Patient Experience	Patient Relations		Patient Experience	Patient Relations	Case Management
HRO Workgroups										
HRO Patient Experience	HRO Employee Engagement	HRO Process of Care (Pt1)	HRO HEDIS	HRO Process of Care (Pt2)	HRO Readmissions	HRO Health Equity	HRO Clinical Doc.	HRO Mortality	HRO-Patient Experience	HRO-
Informational Reports										
	HIM PT/OT Food and Nutrition	Respiratory Therapy		HIM PT/OT Food and Nutrition	Respiratory Therapy		HIM PT/OT-Food and Nutrition	Respiratory Therapy	HIM PT/OT Food and Nutrition	Respiratory Therapy

- The HQuIPS Committee develops and supports the implementation of the strategic plan for quality and patient safety for the organization.
- Has oversight of organization-wide quality, safety, and performance improvement efforts
- The Committee includes membership representing the medical staff, senior executive leadership, and the quality management leadership of the organization.
- For purposes of direction and oversight of the organization's improvement strategies, the HQuIPS Committee reports to the EMS and the CCH QPS Committee of the Board.
- The HQuIPS Committee functions as a synergistic group that shares thoughts and ideas on best practices in the organization

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HRO Workgroup Structure

- The HRO workgroups are multidisciplinary teams focused on the major drivers of external ratings.
- Each workgroup has an explicit charter including objectives, data, and timelines. There are 6 Workgroups with a focus on the following: Mortality, Readmissions, Process of care, Patient Experience, Clinical Documentation, HEDIS

- Functions of HRO:
  - Provides oversight for organizational success and drives accountability.
  - Prioritizes specific measures in each domain for focus workgroups.
  - Identifies leaders for the focus workgroups.
  - Approves charters for each focus workgroup.
  - Designates the reporting tool to be used by workgroups
- Functions of the Vizient Measures Workgroup
  - Assess clinical outcome performance.
  - Identification and evaluation of major opportunities for mortality, readmissions, hospital acquired conditions, patient experience, and ambulatory measures.
  - Utilizes external benchmarking tools (Vizient Clinical Data Base and Press Ganey) and data from public reporting programs to provide expected values and comparison group metrics.
  - Provides supportive function to HRO Steering Committee.
  - Team reviews monthly outcomes, monitors trends, and provides feedback and suggestions to the Steering Committee.

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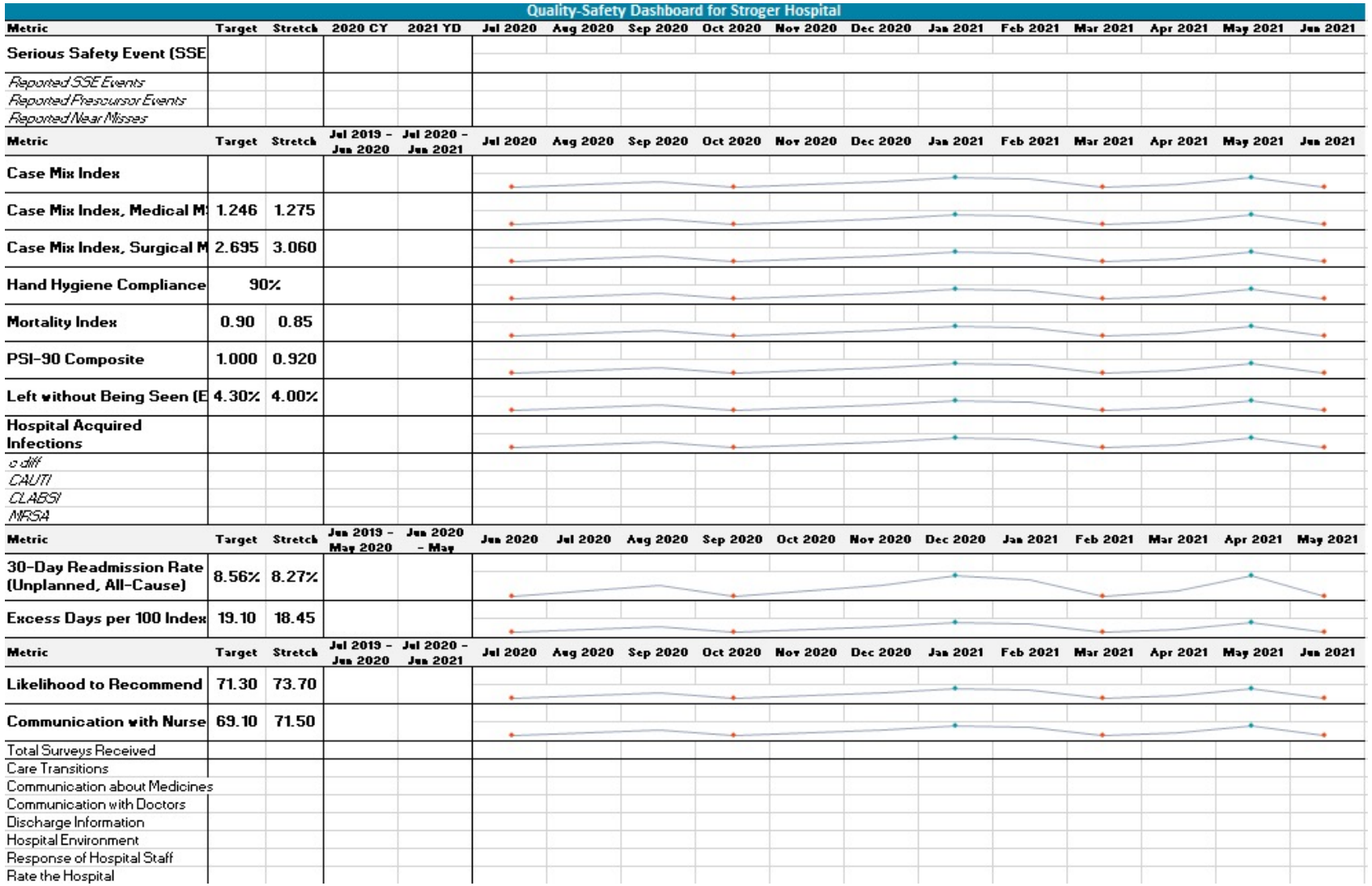
HRO Workgroups-Quality and Patient Safety Dashboard



Quality-Safety Dashboard for Stroger Hospital

Metric	Target	Stretch	2020 CY	2021 YD	Jul 2020	Aug 2020	Sep 2020	Oct 2020	Nov 2020	Dec 2020	Jan 2021	Feb 2021	Mar 2021	Apr 2021	May 2021	Jun 2021
Serious Safety Event (SSE																
Reported SSE Events																
Reported Precursor Events																
Reported Near Misses																

Metric	Target	Stretch	Jul 2019 – Jun 2020	Jul 2020 – Jun 2021	Jul 2020	Aug 2020	Sep 2020	Oct 2020	Nov 2020	Dec 2020	Jan 2021	Feb 2021	Mar 2021	Apr 2021	May 2021	Jun 2021
Case Mix Index																
Case Mix Index, Medical M	1.246	1.275														
Case Mix Index, Surgical M	2.695	3.060														
Hand Hygiene Compliance	90%															
Mortality Index	0.90	0.85														
PSI-90 Composite	1.000	0.920														
Left without Being Seen (E	4.30%	4.00%														
Hospital Acquired Infections																
c diff																
CAUTI																
CLABSI																
MRSA																

Metric	Target	Stretch	Jun 2019 – May 2020	Jun 2020 – May	Jun 2020	Jul 2020	Aug 2020	Sep 2020	Oct 2020	Nov 2020	Dec 2020	Jan 2021	Feb 2021	Mar 2021	Apr 2021	May 2021
30-Day Readmission Rate (Unplanned, All-Cause)	8.56%	8.27%														
Excess Days per 100 Index	19.10	18.45														

Metric	Target	Stretch	Jul 2019 – Jun 2020	Jul 2020 – Jun 2021	Jul 2020	Aug 2020	Sep 2020	Oct 2020	Nov 2020	Dec 2020	Jan 2021	Feb 2021	Mar 2021	Apr 2021	May 2021	Jun 2021
Likelihood to Recommend	71.30	73.70														
Communication with Nurse	69.10	71.50														
Total Surveys Received																
Care Transitions																
Communication about Medicines																
Communication with Doctors																
Discharge Information																
Hospital Environment																
Response of Hospital Staff																
Rate the Hospital																

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Design/Process-Quality

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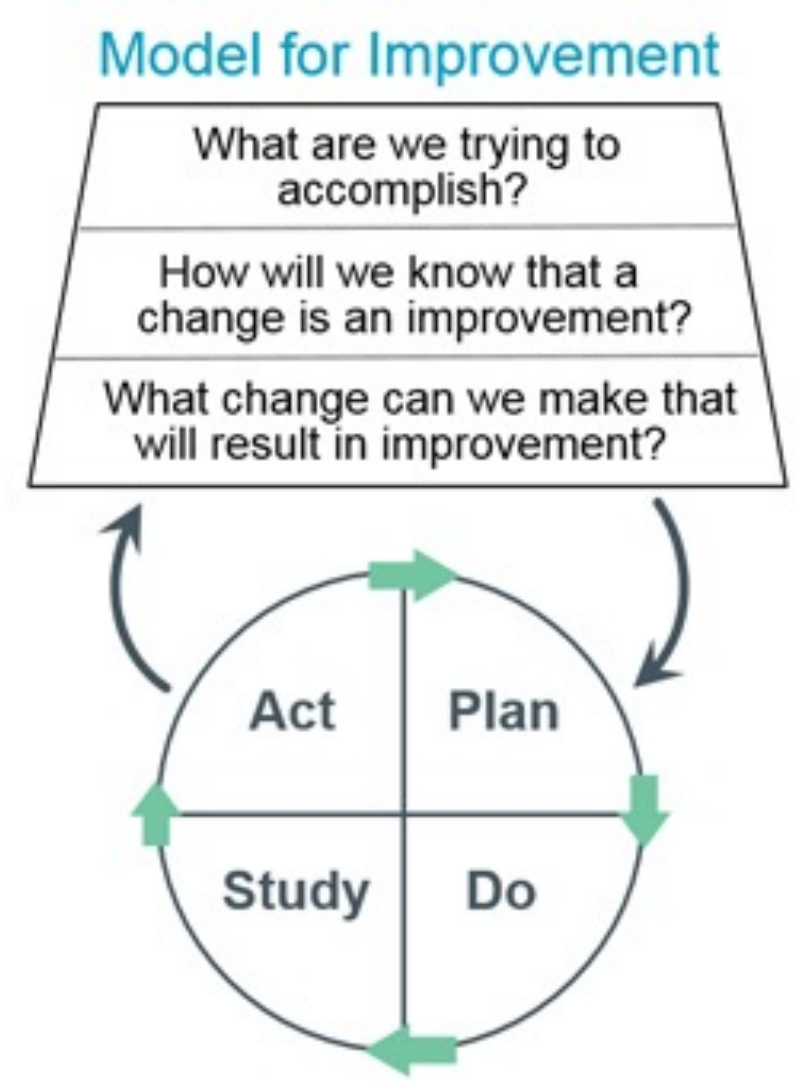
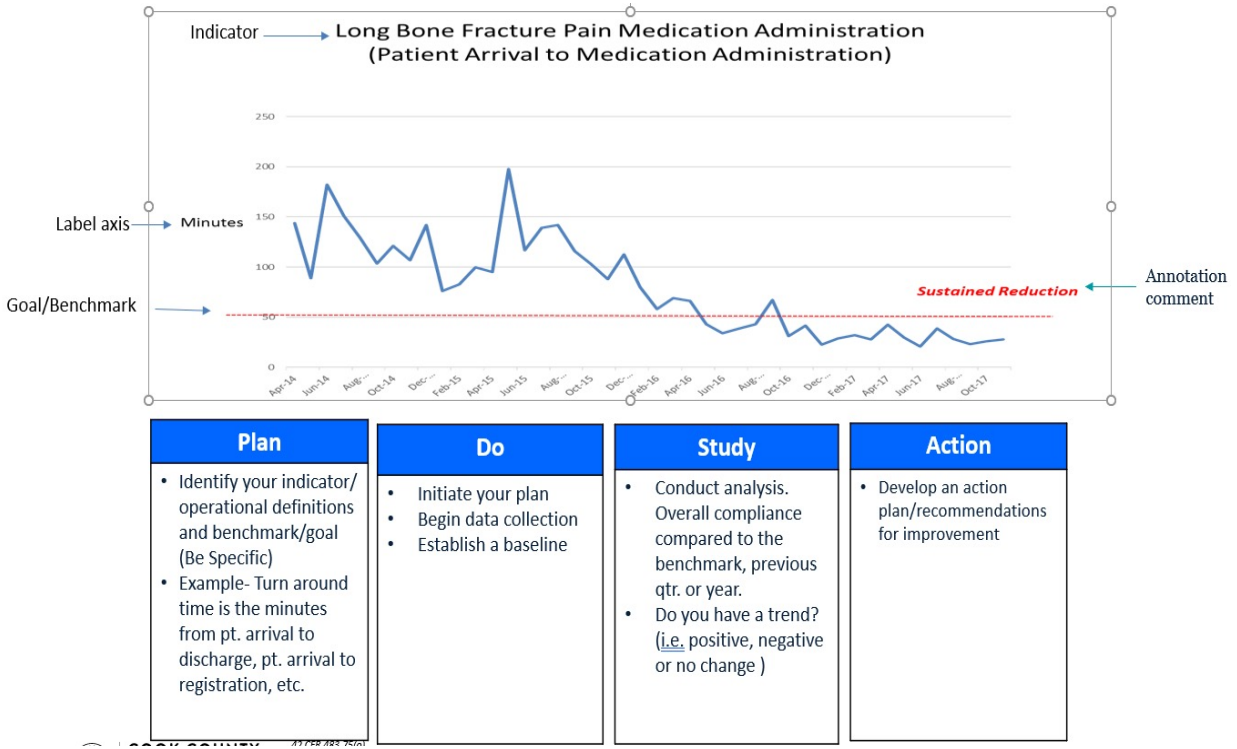
Methodology-Framework





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Alignment with TJC PI Chapter

- I. Data Collection PI 01.01.01
- II. Data Analysis PI 02.01.01
- III. Performance Improvement PI 03.01.01

Overview: All hospitals want better patient outcomes and, therefore, are concerned about improving the safety and quality of the care, treatment, and services they provide. The best way to achieve better outcomes is by first measuring the performance of the processes that support the care and then using that data to make improvements. The standards of this chapter stress the importance of using data to inform positive change.

Can’t Fix What You Don’t Measure!

Design/Process-Safety

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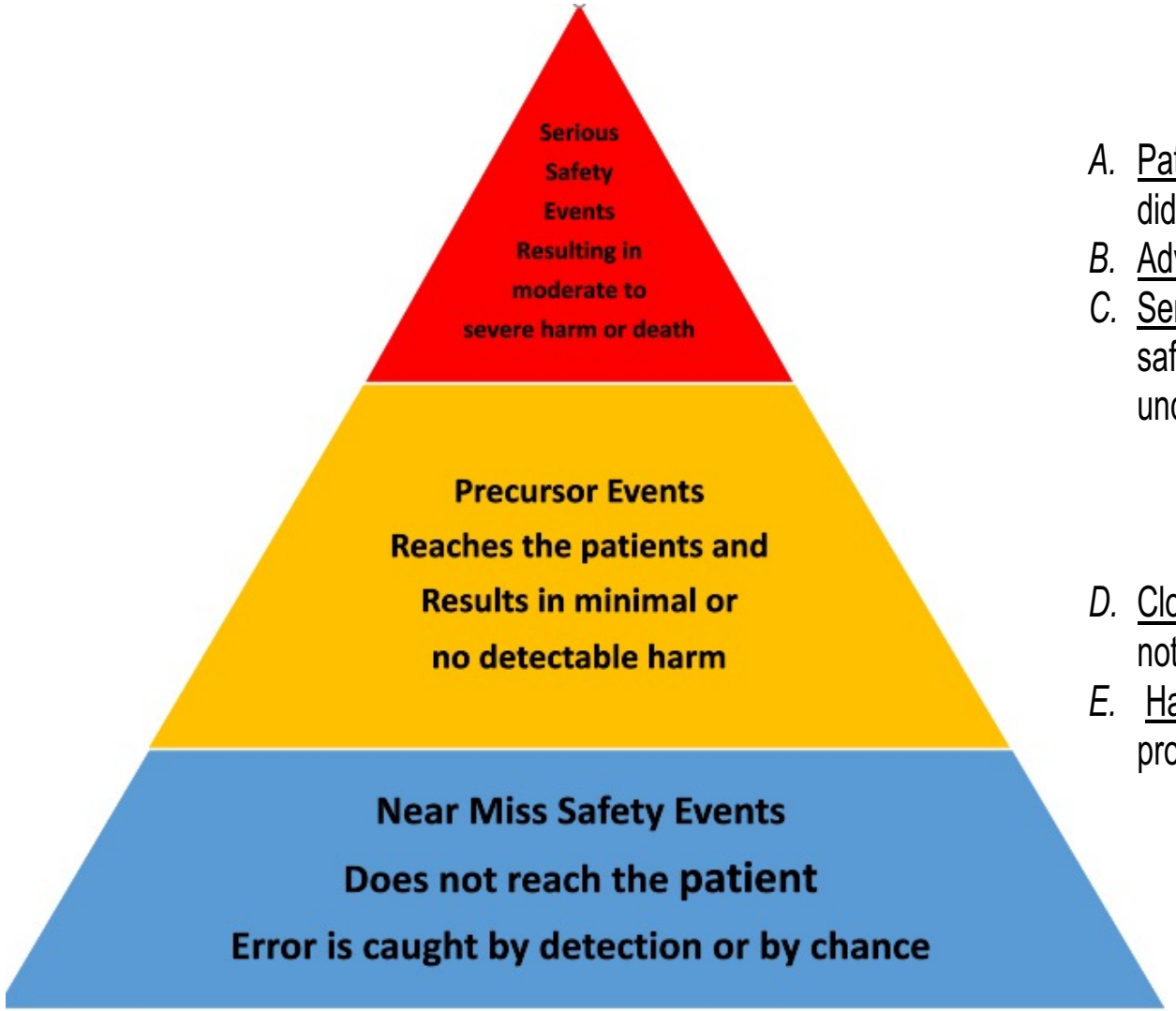
Patient Safety Program

- All adverse events, near misses, or unsafe conditions must be reported into the eMERS system.
- The Serious Event Review Team (SERT) provides direct oversight for the discussion and classification of safety events.
- The Hospital-wide Oversight Committee (HOSC) provides direct oversight and discussion related to patient safety events of a more serious nature.
- An effective Patient Safety Program cannot exist without optimal reporting of safety events. Therefore, the plan adopts a just approach in its management of errors and occurrences. All personnel are *required* to report suspected and identified safety events and should do so without the fear of punishment.
- The organization supports the concept that errors occur due to a breakdown in systems and processes and will focus on improving systems and processes.
- Emphasis will be placed on corrective actions and individual development to assist staff members rather than punish them.
- Summary data from the event reporting system will be aggregated and presented periodically to the HQuIPS and the CCH QPS Committee of the CCH Board of Directors, who will determine further safety and risk reduction activities as appropriate.
- Upon identification of an actual or potential safety event, the healthcare delivery team will perform in accordance with the adverse event management policy.

Patient Safety Program (con't)

- The organization will select at least one high-risk safety process to undergo Failure Mode and Effects Analysis (FMEA) annually based on both internal and external resources.
- The Plan includes an assessment of the "Culture of Safety" through an evidence-based survey tool.
- The Plan includes an ongoing assessment of patient experience through the use of a comprehensive survey tool.
- Patients, and when appropriate, their families are informed about the outcomes of care, including unanticipated event, or when the results differ significantly from the anticipated outcomes, following guidelines outlined in this plan.
- Staff will educate patients and their families about their role in helping to facilitate the safe delivery of care.
- Staff will receive education and training during their initial orientation and on an ongoing basis regarding job-related aspects of patient safety, including the need to report and reduce potential and actual safety events and the process of reporting into the electronic reporting system.
- Patient safety events and occurrences, including sentinel events, will be reported in accordance with all national and regulatory body rules, laws, requirements, and CCH policies.
- Leaders will provide feedback to staff when they have identified and reported a safety event.

Classification of Safety Events



A. Patient safety event: An event, incident, or condition that could have resulted or did result in harm to a patient.
B. Adverse event: A patient safety event that resulted in harm to a patient.
C. Sentinel event (SE): A subcategory of adverse events, a sentinel event is a patient safety event (not primarily related to the natural course of the patient's illness or underlying condition) that reaches a patient and results in any of the following:
    - Death
    - Permanent Harm
    - Severe temporary harm
D. Close call or near miss, no harm, or good catch: A patient safety event that did not cause harm as defined by the term *sentinel event*.
E. Hazardous (or unsafe) conditions: A circumstance (other than a patient's own disease process or condition) that increases the probability of an adverse event.

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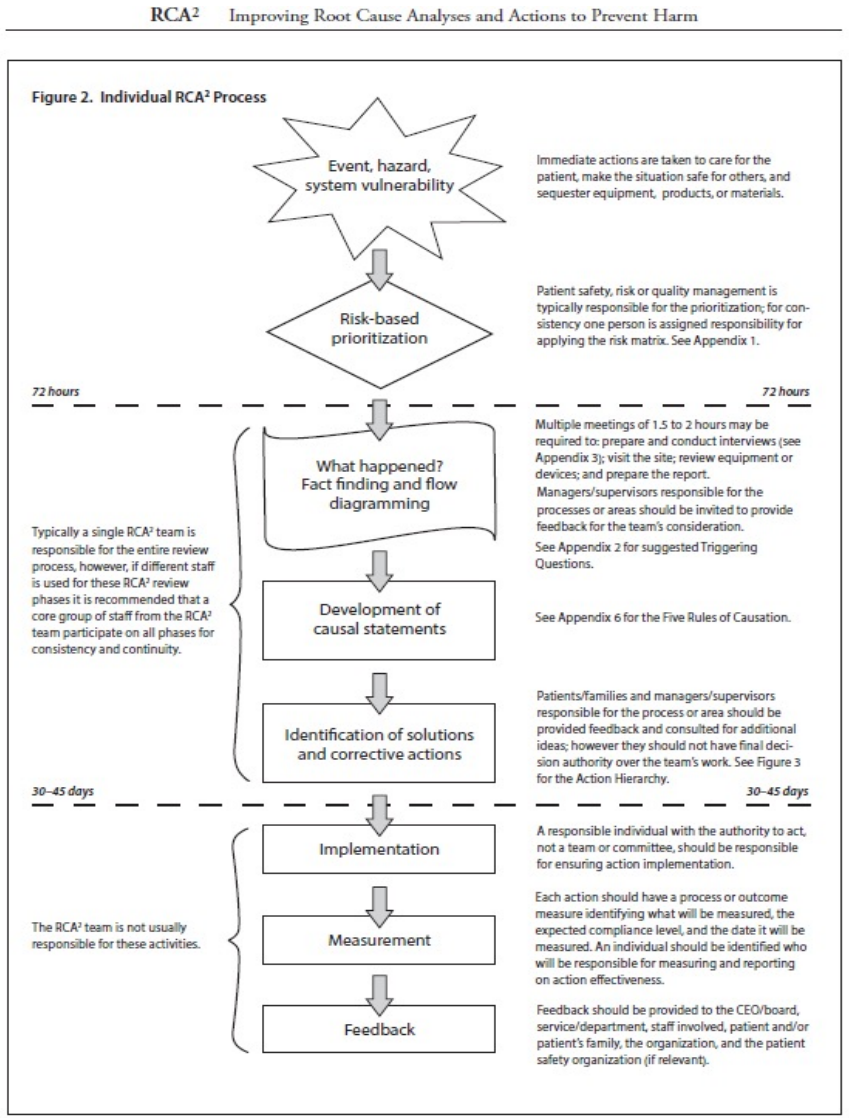
Root Cause Analysis (RCA) Process



- An RCA is used to identify the basic or causal factors that underlie variation in performance, including the occurrence or possible occurrence of an SE. An RCA focuses on systems and processes, not individual performance.
- CCH uses the Root Cause Analysis squared (RCA2) tool endorsed by the National Patient Safety Foundation (NPSF). This tool is designed to accomplish the objective of:
  - What happened
  - Why it happened
  - What needs to be done to correct the problem
  - Take positive action to prevent it from happening again

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Failure Modes Effect Analysis (FMEA)

- An FMEA is a tool for conducting a systematic, proactive analysis of a process in which harm may occur.
- In an FMEA, a team representing all areas of the process under review convenes to predict and record where, how, and to what extent they system might fail.
- The team members work together to devise improvements to prevent those failures. The FMEA tool prompts teams to review, evaluate, and record the following:
    - Steps in the process
    - Failure modes (what could go wrong?
    - Failure causes (why would the failure happen?)
    - Failure effects (what would the consequence of each failure be?)

Template: Failure Modes and Effects Analysis (FMEA)

Steps in the Process	Failure Mode	Failure Causes	Failure Effects	Likelihood of Occurrence (1-10)	Likelihood of Detection (1-10)	Severity (1-10)	Risk Profile Number (RPN)	Actions to Reduce Occurrence of Failure
1								
2								
3								
4								
5								
6								
7								
8								
9								
10								
11								
12								
13								
14								
15								
							Total RPN (sum of all RPNs):	

Failure Mode: What could go wrong?
Failure Causes: Why would the failure happen?
Failure Effects: What would be the consequences of failure?
Likelihood of Occurrence: 1–10 [10 = very likely to occur]
Likelihood of Detection: 1–10 [10 = very unlikely to detect]
Severity: 1–10 [10 = most severe effect]
Risk Priority Number (RPN): Likelihood of Occurrence × Likelihood of Detection × Severity

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Annual Program Evaluation

2020 ANNUAL EVALUATION OF PERFORMANCE IMPROVEMENT INDICATORS

Department/Service Unit: Nursing

Key Quality Indicators	Effective in improving quality outcomes	Effective in maintaining an acceptable level of quality	Not an effective measure of quality	Benchmark	Annual Compliance Average	Outcomes Achieved Legend*/	Proposal for the indicator*	Comments re: Accomplishments & Brief analysis of the data

* Outcomes Achieved Legend:
1 = Improved Clinical Outcomes/Efficiency
2 = Improved Patient/Employee Safety
3 = Improved Customer Satisfaction
4 = Improved Financial Status (increased rev/decreased exp)
5 = No improvements noted

** Proposal Indicator
1 = Continue Indicator
2 = Discontinue Indicator
3 = Modify Indicator
4 = New Indicator

- It is the intent of the Plan to continue to develop its people and processes in its commitment to performance excellence and continuous improvement.
- Annually, the HQuIPS Committee reviews organizational performance and priorities for improvement across the system and evaluates the effectiveness of quality and patient safety initiatives, as they relate to individual units and to organizational interests.
- The evaluation process is conducted using the Annual Evaluation of PI Indicators tool
- The results of this evaluation are reported to the EMS, Board QPS Committee, and the CCH Board of Directors

Thank You!

Any Questions??

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