Maimonides Health

MAIMONIDES MEDICAL CENTER

ORGANIZATIONAL QUALITY IMPROVEMENT PLAN

2024 – 2025

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INTRODUCTION

In accordance with **Maimonides Medical Center's Mission** to provide high quality, compassionate patient care and comprehensive community services; to educate healthcare professionals, patients, families, and the communities we serve; and to conduct research that improves the lives of our patients, the Organizational Quality Improvement (QI) program is committed to ensuring the delivery of the safest, highest quality patient care, and to continuously evaluating and improving our patient care processes, systems and support services.

In support of the Medical Center's **Vision** to be accessible and compassionate and strive to perform at the highest possible level as recognized by a wide range of customers, the Organizational Quality Improvement program aims to pursue opportunities to strengthen our capabilities and achieve our goals.

The structure of the QI program is designed to support the **Core Values** embraced by the Medical Center which are integral to our identity as an organization and are fundamental principles that guide us every day and will always remain at the forefront of what we do. The main core values adopted by the Maimonides family are: Honesty, Empathy, Accountability, Respect and Teamwork (H.E.A.R.T)

AUTHORITY

The Board of Trustees has the overall authority and responsibility for implementation of the Organizational Quality Improvement Plan.

The Executive Vice President of Medical Affairs/Chief Medical Officer, and the Vice President of Quality Management/Chief Quality Officer, along with the Steering Committee /Governing Body for Quality and Safety including Senior Leadership and Medical Staff Leadership, oversee the coordination of organizational and departmental quality improvement initiatives.

ORGANIZATION AND REPORTING STRUCTURE

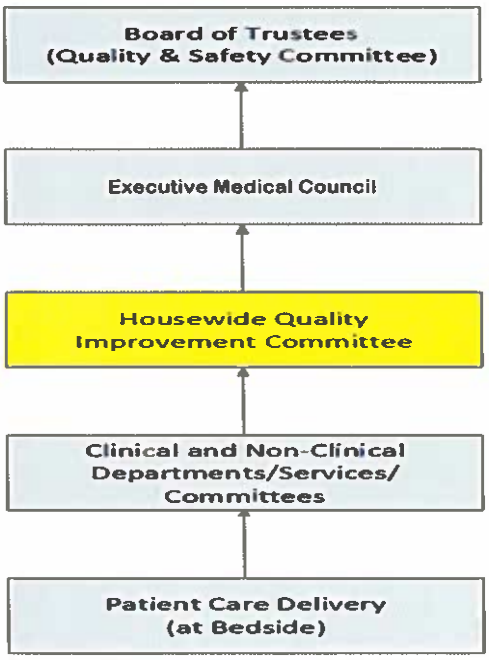
The Department of Quality Management is responsible for maintaining and updating the hospital Quality Improvement Plan and for ensuring appropriate communication with hospital Departments related to all performance improvement activities. The Quality Management team, including a Director of Quality Outcomes, Performance Improvement Specialists, Clinical Data Abstractors and Analysts, provide support to clinical and ancillary Departments in evaluating, organizing, designing, planning, analyzing, and reporting Quality Improvement and Patient Safety initiatives. The Department is also charged with aligning those activities with the Hospital's strategic priorities and goals.

Each hospital Department is responsible for coordinating Quality Improvement efforts within their respective team or service, collecting and reporting relevant quality data, and participating in hospital-wide initiatives. Each Department maintains a Departmental Quality/Performance Improvement Plan, which supplements the institutional plan. All members of the hospital and Medical Staff participate in Quality Improvement and Patient Safety activities; this participation supports the **core values** of the institution.

Each Department maintains a Quality Improvement Council/Committee for addressing and reporting quality issues and monitoring the progress of specific quality indicators. Minutes are maintained by the Department, and are available upon request for review by Senior Leadership, the Department of Quality Management, or regulatory surveyors.

The Hospital-Wide Quality Improvement/Patient Safety Committee is co-chaired by the Executive Vice President of Medical Affairs/Chief Medical Officer, and the Vice President of Quality Management/Chief Quality Officer. The membership includes Board of Trustee representation, the Chief Executive Officer, the Chief Operations Officer, the Chief Nursing Officer, the Patient Safety Officer, Clinical Chairs, Medical Staff, and Senior Leaders representing all clinical and ancillary Departments. The Committee meets monthly, and reviews and discusses the Hospital Quality Improvement Dashboard/Matrix. Departmental reports are presented to the Committee on a semiannual basis. Committee members review the hospital quality matrix and the departmental reports and discuss strategic priorities related to performance improvement and patient safety. Minutes are maintained by the Department of Quality Management and distributed to members and senior leadership. The Hospital-Wide Quality Improvement/Patient Safety Committee reports a summary of the quality improvement activities on a monthly basis to the Executive Medical Council and the Quality & Safety Committee of the Board of Trustees.

Maimonides Medical Center
Quality Improvement Program –
Reporting Structure



HOSPITAL PRIORITIES FOR STRATEGIC DIRECTION

Strategic priorities are intended to facilitate patient and family centered care; enhance quality and improve patient safety; provide a supportive environment for physicians and staff; ensure fiscal viability; create strong internal and external alliances; and assure effective organizational communication. The Quality Improvement Plan is aligned with the aforementioned Strategic Directions as well as the current Enterprise Organizational Performance Domains and Priorities.

The Six Organization Performance Domains/Pillars are:

I. Improving Clinical Quality, Safety & Health Outcomes
II. Enhancing Academics, Research and Innovation
III. Improving Patient and Family Experience
IV. Enhancing Operational Efficiency, Financial Performance, and Clinical Integration
V. Enhancing the Hospital Growth and its Role as a Tertiary Care Destination
VI. Cultivating Highly Performing Teams – "Team Maimonides"

The Top Organizational Priorities are:

1. Service: Improve the experience for patients, families, referring doctors and employees everywhere we interact with them
2. Access: Make it easier, faster, and more convenient for current and new patients, including employees, to get care from Maimonides
3. Finances: Ensure the hospital is appropriately paid for the provided services and act as good stewards of our resources

The performance domains and priorities include key drivers as well as specific organizational initiatives and activities. The Initiatives within each Domain have specific measurable goals and are tracked on an ongoing and regular basis for progress made and changes needed.

STRATEGIC PRIORITIES FOR QUALITY AND SAFETY (2024-2025)

The Quality Improvement (QI) Plan is based upon the guiding principles of the *Institute of Medicine's Six Aims of Quality: Safe, Effective, Efficient, Equitable, Patient Centered, and Timely care.* The QI Plan sets forth the guidelines to accomplish the Organizational performance goals and priorities. The primary objectives are to transform into a high reliability organization, pursue opportunities to improve patient care, improve population health, and provide a systemic framework for continuous quality improvement. The Department of Quality Management works closely with Clinical and Administrative Leadership to Support, facilitate, and manage all Quality Improvement activities related to the following priorities and goals:

I. Improving Clinical Quality, Safety & Health Outcomes

1. Improving Compliance with the Regulatory Quality Requirements and Public Reporting

- Continue improvement in CMS Star Rating to at least "Three Stars" by the end of 2025
- Maintain MMC high National Ranking for low Mortality Rate and/or reduce further for all CMS mortality measures: AMI, Stroke, COPD, Pneumonia, CHF, and CABG mortalities
- Improve compliance and performance with all CMS quality-based payment initiatives including the VBP Core Measures (Chart-abstracted and e-CQM measures)
- Improve compliance with the CMS Sepsis bundles and reduce our Sever Sepsis & Septic Shock mortality rate which is tracked by the DOH.
- Continue to improve our Leapfrog Safety Grade to at least a "B" grade within 24 months (2025 Fall report)
- Continue improvement of Q-HIP (Hospital Incentive Program) scorecard and reimbursement scale
- Improve compliance with Health First/HEDIS outpatient measures
- Advance the Health Equity Program to reduce healthcare disparities
- Organizational Continuous Readiness for The Joint Commission (TJC)

❖ **CMS Quality Based payment Initiatives**

The Medical Center is committed to submitting quality data related to the CMS quality-based payment initiatives: **Value-based Purchasing, Hospital Acquired Conditions, and Readmissions**. In 2016, CMS developed the **Star Rating** program to help consumers make more informed decisions by giving them a way to compare hospitals based on a single aggregated quality score. Hospitals report their data to CMS through the Hospital Inpatient Quality Reporting Program and the Hospital Outpatient Quality Reporting Program. CMS takes this data and uses a clustering algorithm to assign hospitals a Star rating on a one-to-five scale. The overall Star Rating is based on several quality measures related to five main categories: mortality, safety of care, readmissions, patient experience, and effectiveness and timeliness of care. Improving the clinical practices and documentation related to these measures should improve the overall Hospital Star Rating.

Core Measures

MMC participates in data collection related to Core Measures identified by CMS and The Joint Commission (ORYX). The Current Core Measures pertaining to the Medical Center and requiring charts abstraction are as follows:

- Inpatient Measures: Perinatal, and Sepsis
- Outpatient Measures: Stroke Imaging efficiency, ED time from arrival to discharge, Endoscopy/polyp surveillance, Influenza vaccination for healthcare personnel and hospital visits for patients after outpatient procedures
- Inpatient Psychiatry Measures: HBIPS (Hospital-based Inpatient Psychiatry Services), Substance use, Tobacco use, Restraints use, Transition of care, and screening for metabolic disorders

Core measure data is transmitted to the Joint Commission and CMS for publication through an authorized vendor (Medisolv). On a monthly basis, a Hospital Core Measure Quality Summary Report is presented to the House-wide Quality Improvement/Patient Safety Committee. An action plan and follow-up activity are developed for all measures with low compliance.

MMC also participates in the NYS Hospital Acquired Infection Reporting (***HAIR)*** initiative. Data is collected and submitted for Central Line Associated Bloodstream Infections (CLABSI) and Catheter-Associated Urinary Tract Infections (CAUTI). Postoperative surgical site infection data is also being collected and submitted for all CABGs, Colon, Hip Prothesis, Spinal Fusion and Abdominal Hysterectomy procedures. Hospital-specific data is presented to the Quality Improvement Committee on a regular basis and annually with NYS benchmarking.

Electronic Clinical Quality Measures (e-CQMs)

Electronic clinical quality measures (e-CQMs) use data electronically extracted from electronic health records (EHRs) and/or health information technology systems to measure the quality of healthcare provided. The Centers for Medicare & Medicaid Services (CMS) uses e-CQMs in a variety of quality reporting and value-based purchasing programs. There are several benefits of using e-CQMs:

- Use clinical data to assess the outcomes of treatment by measured entities
- Reduce the burden of manual abstraction and reporting for measured entities
- Foster the goal of access to real-time data for point of care quality improvement and clinical decision support

Measured entities use e-CQMs to provide feedback on their care systems and to help them identify opportunities for clinical quality improvement. Measured entities report e-CQMs to CMS, The Joint Commission, other federal health agencies, and commercial insurance payers in programs that track and/or reimburse measured entities based on quality reporting or quality performance.

Acute care hospitals that have 26 or more licensed beds or 50,000 or more outpatient visits should select and submit a minimum of six e-CQMs for four quarters. The 2024 list of e-CQM measures include: Perinatal, Safe use of Opioids, severe hypoglycemia and Stroke measures.

- **NYSDOH Sepsis**

  The NYSDOH introduced a revision in reporting methodology of sepsis data from manual abstraction to an electronic data abstraction process (e-Sepsis). The primary goals of the program are: transition to automated data collection, concentration on outcome measures and inclusion of COVID-19 cases. The transformation to the new electronic process includes implementation and compliance with the DOH specific data dictionary for Adult and Pediatric Sepsis. MIS set up a process to ensure data flow and accuracy, including defining and coding for inclusion cases. Quality Management will continue to monitor and validate sepsis outcomes as well as compliance with the standardized adult and pediatric protocols/bundles for early recognition and management of septic patients.

- **Leapfrog Hospital Survey**

  Since the fall of 2018, the Medical Center participates in the Leapfrog Hospital Survey. The Leapfrog Safety Grades indicate how safe general acute care hospitals are for patients. Publicly available data from the Centers for Medicare & Medicaid Services (CMS), the Leapfrog Hospital Survey, and secondary data sources such as Nation Healthcare Safety Network are weighted and then combined to produce a single composite score that is published as an A, B, C, D or F letter grade. With the Leapfrog Hospital Safety Grade, The Leapfrog Group aims to educate and encourage consumers to consider safety when selecting a hospital for themselves or their families. In addition, the grade fosters strong market incentives for hospitals to make safety a priority. Leapfrog Hospital Safety Grades are publicly reported and are released twice a calendar year, once in the fall and once in the spring

- **Q-HIP Hospital Incentive Program**

  The Quality-In-Sights: The Hospital Incentive Program (Q-HIP) is offered to facilities as a performance-based reimbursement program that financially rewards facilities for practicing evidence-based medicine and implementing industry-recognized best practices in patient safety, health outcomes, and member satisfaction. Clinical measures were developed by national quality organizations such as The Joint Commission (JC) and National Quality Forum (NQF).

  The Medical Center is committed to participating in the program. Data submission includes measures related to: Patient Safety, Health Outcomes, Patient Satisfaction and Bonus measures. High compliance with CMS Core Measures, HAIR, and STS data will help in achieving a high score in Q-HIP. All relevant documentation submitted by the Facility in connection with its performance under Q-HIP must have been in use by the Facility during the Measurement Period to be a part of the measure evaluation. The Facility is notified when the scorecard is final and has been published. It will be published within 30 days after the final data submission deadline. The Q-HIP annual report highlights the strengths and areas for improvement as it includes individual Facility performance along with comparative data for all Q-HIP members. Sepsis was added to the Q-HIP matrix in July 2021.In order to meet the measure requirements, the following actions were put in place:

  - A sepsis improvement team with a designated leader and representation from both nursing and medical staff
  - Action plan to implement and/or improve routine screening for sepsis done by nurses on hospital floors/wards
  - Action plan for hospital floors/wards to implement and/or improve the Surviving Sepsis Campaign Hour 1 Bundle, including lactate measurement, blood cultures, broad-spectrum antibiotics, fluids and vasopressors

- Educational program for nursing and medical staff
- Ongoing monitoring, data collection, reporting and feedback to clinical staff

2. **Prevention of Avoidable Patient Harm and Improvement of Patient safety & Outcomes**
   - Monitor and reduce CMS hospital acquired events on the "No Harm" Dashboard *(Goal: 10% overall reduction of avoidable events)*
     Based on the No-Harm Dashboard data, Task forces will focus on the following opportunities:
     1. Hospital Acquired Infections (CLABSI, CAUTI, MRSA, C. Diff)
     2. Surgical Site Infections
     3. Patient Safety indicators (peri-op Hemorrhage, post-op Respiratory Failure)
     4. Failure to Rescue
     5. Pressure Injuries
     6. Falls with Trauma/Injury
   - Enforce and maintain high hand hygiene compliance (Goal: 95% or above compliance). Proper hand hygiene practices throughout the hospital should decrease the risk of Healthcare Associated Infections (HAI):
     - Ongoing education (Competence)
     - Monitoring compliance and providing feedback
     - Encouraging staff to speak up when proper hand hygiene practice is breached
     - Senior leadership engagement (Accountability)
   - Conduct TJC Failure Mode and Effect Analysis (FMEA) projects focusing on:
     1. Minimize the incidence of mislabeled and mishandled surgical specimens
     2. Continue to minimize hypoglycemia incidence and recurrence
     3. Continue to reduce the overutilization of opioids across the institution
   - Continue to improve the Medication Scanning/Bar Coding across the Medical Center
   - Continue to improve the CPOE (Computerized Physician Order Entry) to reduce and alert clinicians to serious prescribing errors
   - Continue to Improve the Medication Reconciliation process
   - Continue the implementation of standardized Post-op Debrief / Sign-out processes
   - Continue data gathering and analysis of COVID-19 patient outcomes to determine patterns of care and opportunities for improvement

3. **Improving Care Transitions and Reducing Preventable Hospital Readmissions**
   Establish standardized protocols to reduce readmissions for patients with high readmit risk *(Goal: Reduce Hospital-wide all-cause readmissions to the national mean)*
   - Identify patients at high risk for readmissions by using readmit risk score
   - Utilize a standardized checklist during the discharge rounds for patients at high risk for readmissions
   - Identify and engage the "Care Partners" in the plan of care, discharge planning, and post discharge follow up
   - Improve medication management and reconciliation by involving Pharmacy in the process
   - Fill discharge meds for high risk patients at MMC Pharmacy for 30 days
   - Early assessment and recognition of home care needs and insurance issues prior to discharge
   - Improve patient and family education regarding discharge instructions
   - Collaborate and utilize a standardized hand off process with SNFs (Warm Hand Off)
   - Schedule follow-up appointments within 7 days post discharge
   - Follow-up phone call within 48 hours of discharge
   - Enhance home visits programs (e.g. Safe at home, JASA)
   - Enhance the role of virtual care as well as Remote Patient Monitoring (RPM) in post discharge and transitional care
   - Assess returned patients for eligibility of Observation Unit care
   - Review pneumonia readmission charts for documentation accuracy of the index hospitalization

4. **Promotion of Culture of Safety and Enhancement of Effective Communication and Team Work**

The Hospital continues the journey of transformation into a High Reliability Organization. The key elements of High Reliability Organization include:

- Operate in complex, high hazard domains for extended periods without serious accidents or catastrophic failures
- Persistent mindfulness within an organization
- Cultivate resilience by prioritizing safety over other performance pressures
- Use systems thinking to evaluate and design for safety
- Create an environment in which potential problems are identified and addressed

In order to achieve this goal, the Organization built a Patient Safety Office and appointed a Patient Safety Officer and an Associate Patient Safety Officer. Strategies are designed and intended to establish strong and effective communication among care providers that enable care teams to quickly adapt to changing situations. These strategies include:

- Monitor and improve our CMS/AHRQ Culture of Safety Survey results
- Maximize the utilization of the RL Datix Program as a centralized and unified system for reporting all adverse events, which should help identifying safety trends, patterns and opportunities for improvement
- Enforce non-punitive policy regarding reporting errors (AD-102 Patient Occurrence Reporting and Disclosure)
- Enforce the Code of Mutual Respect Policy
- Expand the Dyad model on each unit to improve interdisciplinary team function
- Enforce daily patient safety huddles on all clinical units
- Roll out a structured Hand off tool (I-PASS) across the Medical Center
- Provide TeamSTEPPS tools and continue roll-out of Organizational training
- Roll out in-situ simulation and clinical event debriefing to monitor and propose solutions for latent safety errors
- Expand leadership rounds on clinical units
- Enhance the Psychological First Aid as well as Team Lavender programs
- Improve practitioner documentation

5. **Improving Population Health**

The Maimonides Department of Population Health develops and supports a network of healthcare and social services organizations working to improve health and well-being in Brooklyn. The department works to address the social factors impacting health, with a focus that extends beyond the traditional walls of the hospital to better the quality of lives in communities across Brooklyn.

The Department of Population Health manages a number of population health programs and entities and has collaborative working relationships with a large network of health and social service providers. Working towards the goal of health equity and quality of care, the Department of Population Health's efforts to manage the total cost of care fall into four main focus areas:

- Improving primary care quality and access by enhance primary care capacity and reach
- Ensuring access to specialty care and essential hospital care, including coordinated access to essential services
- Integrating care coordination into all initiatives
- Engaging the community through the identification of community-defined needs and the development of programs to meet them

In order to achieve this goal, the Maimonides Department of Population Health will execute and evaluate progress for the following strategies:

- Support and expand a spectrum care management services through Brooklyn Health Home and the CCB Navigator – extending care management beyond the Medicaid health home, connecting all Brooklynites to community-based resources and programs;
- Develop and implement the Global Health Initiative, a curriculum for all house staff in all training programs at MMC to teach population health principles and the incorporation of population health practices into clinical setting;
- Strengthen connections between patients and community programming through Brooklyn Communities Collaborative's strategies, which include workforce development initiatives, support and capacity building for CBOs;
- Provide quality improvement support and the opportunity to earn shared savings to providers participating in CCB IPA, an ACO created to serve as a vehicle to allow Brooklyn-based health and social service providers to participate and succeed in Value Based Payment (VBP) arrangements

Most of the quality goals and other targets set forth in value-based payment agreements, whether CCB IPA agreements or the Healthfirst contract, align with and complement Maimonides' quality improvement agenda and priorities. Our VBP contracts focus on quality by addressing:

- Improving access to primary care
- Improving preventive care, including immunizations and cancer screening
- Management of chronic conditions
- Management of behavioral health conditions
- Reducing preventable admissions and ED visits and reducing readmissions
- Identifying and addressing health related social needs
- Improving patient satisfaction

The Department of Population Health will continue to work towards addressing health related social needs through care coordination, quality improvement, and performance improvement as part of the integrated Quality Improvement Plan.

II. Enhancing Academics, Research and Innovation

- Establish an infrastructure for Heath Services Research, aiming to publish valuable QI projects in national quality journals and conferences
- Leverage experiential learning (e.g. simulation) to promote patient safety concepts and skills
- Submit completed QI projects for HANYS Commitment to Excellence (C2X) initiative
- Continue to support data gathering and analysis for research purposes across the organization
- Participate in national quality and safety conferences and training courses
- Encourage staff to pursue high levels of education and training in the science of quality improvement/patient safety, and attain well recognized certifications e.g. Certified Professionals in Healthcare Quality (CPHQ), Lean, Six Sigma Green Belt and/or Black Belt
- Maximize the Utilization of Vizient CDB (Clinical Data Base) to support data driven QI projects and research
- Conduct an Annual Safety and Quality Day Symposium with guest speakers and staff presentation of posters demonstrating quality & safety improvement projects
- The Quality Management department created a QI Library which includes the framework, tools, and skills needed for QI project management. The library includes presentations and videos for training on data analysis, process analysis, team management and project management methods. The library materials and tools are placed on the Quality Management SharePoint site and is available as a valuable resource for all Maimonides staff.

III. Improving Patient and Family Experience

- The Mission and Vision of the Patient Experience (PX) program are aligned with the Hospital strategic priorities and goals. The Mission is to ensure our care delivery consistently meets the spiritual and emotional needs of patients in a comfortable, compassionate, and safe environment. The Program's Vision is becoming Brooklyn's premiere hospital of choice by striving to provide an exemplary experience for all patients, families and staff through our commitment to quality of care and unparalleled innovation. The Patient Experience Office Priorities include:
  - Workforce development
  - Service Re-design
  - Quality Improvement
  - Performance Monitoring and Reporting

- The Medical Center administers the CMS *Consumer Assessment of Healthcare Providers and Services (CAHPS)* survey through an authorized vendor (NRC) and transmits the data to CMS for public reporting. Monthly PX Reports are presented to the Quality Improvement Committee. Unit specific reports are used by the Departments to drive performance improvement. The Organization has expanded the use of the Patient Satisfaction surveys to include the Emergency Department, the Department of Psychiatry, various Ambulatory Network Sites, and the Cancer and Breast Center. Survey comments that are designated by the vendor as service alerts are addressed expeditiously on a case by case basis.

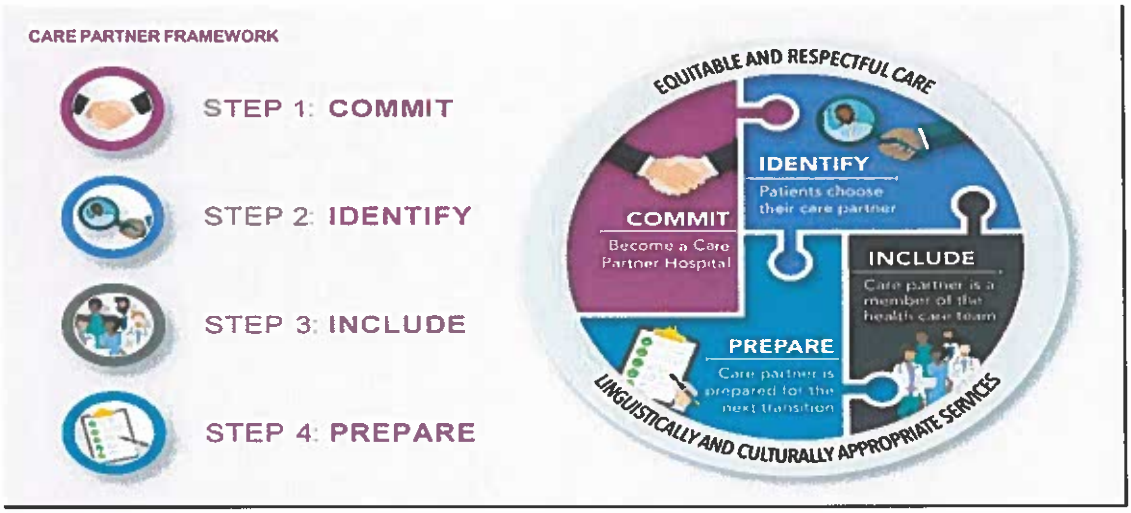
- The key strategies and goals to improve the patient and family experience include:
  - Adopt behavioral expectations through promoting the organizations core values in partnership with Human Resources
  - Implement and manage Planetree's Reconnecting to Purpose Communication Workshops for all employee participation.
  - Identify low performing areas for targeted improvement efforts
  - Utilize qualitative data to identify recurring issues impacting the patient experience and collaborate with department leaders to create action plans
  - Implement Patient Experience Committees by Division to support and co-lead the specific PX initiatives
  - Manage the patient experience recognition program for units/departments based on greatest improvement by quarter and highest achievers
  - Manage the peer to peer recognition program which supports teamwork and boosts staff morale.
  - Create a robust PX data comment dashboard for seamless access for administrative and clinical leaders.
  - Continue real-time pro-active patient rounding to ensure service excellence.
  - Enhance the Patient and Family Advisory Council through recruitment and retention efforts.

❖ ***Care Partner Program***

Maimonides Hospital has been engaged in the Care Partner Initiative and actively participated in the NYSPFP program "Effectively engaging patients and Care Partners", which started in March of 2019. This, along with fulfilling the mandate of the NYS Care Act that required hospitals to provide each patient with the opportunity to identify a caregiver prior to discharge, have spurred the organization's desire to become a Care Partner Hospital.

The Quality Management Department works closely with leadership from Nursing, Case Management, Patient Relations, Physicians and others to implement a comprehensive program to identify and engage the "Care Partners" in The Patient's plan of care and discharge planning.

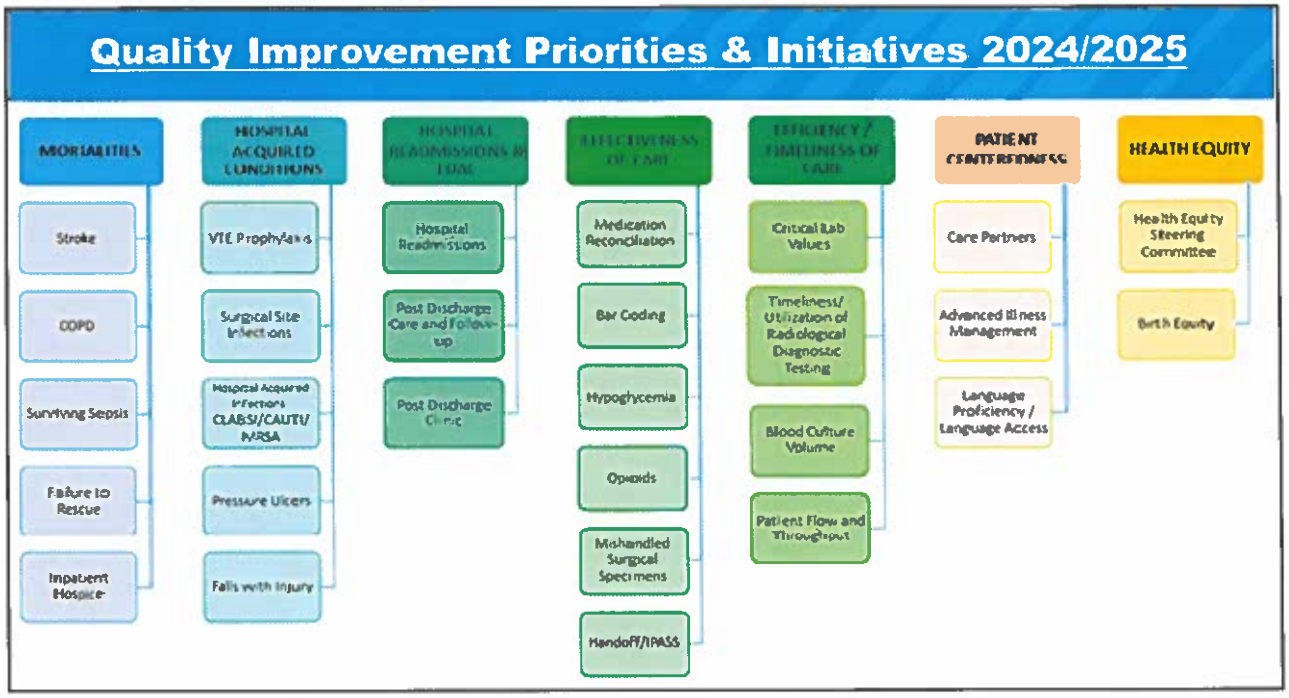
In August 2023, Maimonides received HANYs EQIC Care Partner Hospital Designation; one of three hospitals in New York State to receive this designation at the time. Becoming a Care Partner Designated Hospital represents our commitment to this initiative. The Care Partner program is essential to our diverse and aging population at Maimonides It is anticipated that this program will help improve communication with patients and enhance patient satisfaction efforts as well as reduce unplanned readmissions (Goal: Increase percentage of eligible Care Partners Identified to 75% by end of 2025)



IV. Enhancing Operational Efficiency, Financial Performance, and Clinical Integration

Improve efficiency of care through initiatives focusing on value-based Management and reduction of clinical resource variations:

- Reduce overutilization of high-cost medications and optimization of medication selection
- Reduce unnecessary diagnostic and lab tests
- Continue to improve blood culture volume & turn-around time *(Goal: Average volume=8.0 ml)*
- Improve compliance with the timeliness of radiological critical results (*Goal: 90% compliance within 1 hr.)*
- Improve the response time of Lab critical values
- Promote standardization of trays and reduce waste of single use disposable supplies in OR
- Enhance the Advanced Illness Management (AIM) program
- Enhance appropriate Palliative/Supportive Care consults
- Enhance staff training and education on bio-ethical and palliative care issues
- Improve documentation accuracy of the H&P surprise question
- Improve the Advance Care Planning note documentation
- Expand the Inpatient Hospice Program
- Support documentation and coding improvement efforts to ensure the accuracy of patients' acuity
- Continue to improve assessment and documentation of protein calorie malnutrition
- Improve the "Discharge before Noon" (DBN) process
- Improve Patient throughput and reduction in inter-unit transfer time to optimize average length of stay and reduce excess patient days
- Improve the "Discharge before Noon" (DBN) process
- Improve screening and documentation for Breast Cancer , Diabetes control and Blood Pressure control in the Ambulatory Network Clinics.



V. Enhancing the Hospital Growth and its Role as a Tertiary Care Destination

- Enhancing growth through excellence in the provision of tertiary care and commitment to ongoing primary care network development and collaboration with key partner organizations across Brooklyn.
- The Quality Management Department supports MMC's role as a Tertiary Care Destination and Safety Hub, and to ensure high quality programs across all growing services (Heart & Vascular, Cancer, Bone & Joint, Spine, Children's Hospital, Maternity & Women's services Neurosciences, and other Surgical and Medical services)
- Support and enhance all quality activities across the Ambulatory Network and Outpatient Procedural Services
- Support quality activities for the Brooklyn Parenting Center

Alignment with MMCH (Maimonides Midwood Community Hospital) QI Program:

- Maimonides Midwood Community Hospital is a 134-bed hospital, located in Midwood, Brooklyn. MMCH is dedicated to caring for whole persons throughout the southern tier communities of the Borough. As a stabilizing foundation for these communities, it is committed to meeting the patients' changing physical, emotional, spiritual, intellectual and social needs
- At MMCH, quality health care is based not only on the outcome of the patients' health status, but also on the patients' perception of how their care was delivered
- MMCH's Mission Statement speaks of commitment to excellence, to leadership as well as to patients. MMCH's Vision is to offer the hospital's surrounding communities' quality medical care and a diverse array of medical services
- MMCH's Performance Improvement and Patient Safety Plan is comprehensive and demonstrates the hospital's commitment to improve the quality of care. It outlines the goals and strategies for ensuring patient safety, delivering optimal care, and achieving patient satisfaction by anticipating and responding to the health care needs of the patients and the communities
- MMCH' s top five Quality Improvement goals for 2024 & 2025 are:

1. Improve management of patients with sepsis
2. Improve management of patients with acute stroke
3. Reduce incidence of hospital-acquired Clostridium Difficile
4. Drive performance improvement initiatives to advance health equity
5. Improve patient experience

VI. Cultivating Highly Performing Teams

- Continue to support the organization's TEAM STEPPS training and practice
- Continue to improve the standardized Post-op Debrief / Sign-out process
- Improve the Staff Engagement Survey results
- Improve the team process for end-of–life shared decision making
- Advance the Health Equity Program and Strategic Plan to reduce healthcare disparities
- Support the Diversity, Equity and Inclusion (DE&I) Program
- Standardize the multidisciplinary rounding across the hospital
- Support building high performing teams and managing the team dynamics
- The QI Library provides tools for team Management that facilitate generating ideas, decision making and action planning

❖ **Health Equity Program and Strategic Plan**

Maimonides Medical Center is dedicated to fostering healthy communities. We provide high quality, compassionate patient care, and comprehensive community services. As a premier academic medical center, we are devoted to educating healthcare professionals, patients, families, employees, and the communities we serve. We conduct research that improves the lives of our patients. Health Equity is an organization-wide priority with the goal to support and operationalize various initiatives and intervention strategies addressing disparities and social drivers of health. The ultimate goal is to eliminate healthcare disparities and attain the optimal health for everyone we serve regardless of race, ethnicity, gender, language, sexual orientation, disability, socioeconomic status, or other factors that may affect health outcomes or access to care. An integral part of the Program includes working closely with our community partners to create and foster equity in healthcare, health education and health-related research.

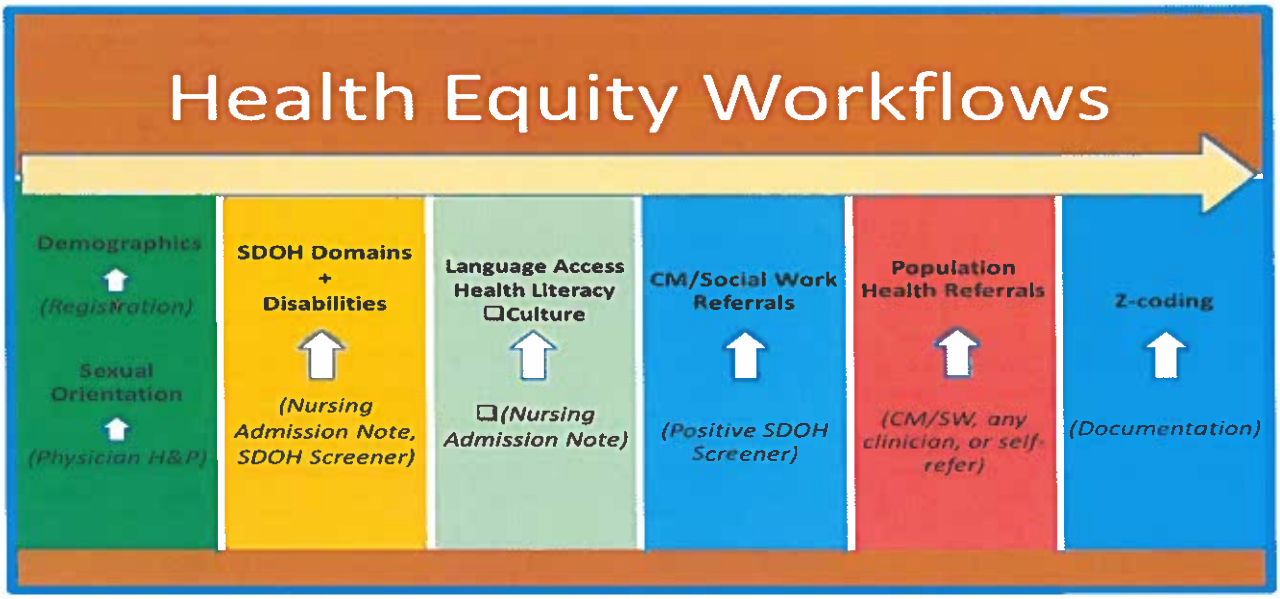
A Health Equity Steering Committee is formed with the responsibility to champion and advance heath equity across the organization. This Committee will report to the Board of Trustees Quality & Safety Committee regarding progress towards the goals and objectives of this strategic plan. The five priorities described below align with the Centers for Medicare and Medicaid Services (CMS) Framework for Health Equity:

1. **Priority 1**: Expand and Improve the Collection, Reporting, and Analysis of Standardized Data.
   Goal: Improve demographic data collection to understand population served and to identify health disparities.
2. **Priority 2**: Advance Language Access, Health Literacy, and the Provision of Culturally Tailored Services
   Goal: Increase promotion and access to interpreter services for limited English proficient, ASL (American Sign Language), and visually impaired patients.
3. **Priority 3**: Build the Capacity of Health Care Organizations and the Workforce to Reduce Health and Health Care Disparities
   Goal: Recruit and retain a diverse workforce
4. **Priority 4**: Assess Causes of Disparities and Address Inequities in Policies and Operations to Close Gaps. Prioritize health equity improvement projects as needed
   Goal: To develop sustainable solutions that close gaps in health and healthcare access, quality, and outcomes, and to dedicate resources that address health disparities. Currently,

there is an ongoing focus on stratified health equity data related to hospital readmissions and maternal care and outcomes (NYS Birth/Perinatal Equity).

5. **Priority 5**: Increase All Forms of Accessibility to Health Care Services and Coverage. Goal: Ensure that individuals and families are able to access healthcare services when and where they need them, and in a way that meets individuals' needs and preferences.

Maimonides Medical Center is committed to health equity. Through the priority areas described, the Health Equity Steering Committee will assess health inequities to identify and overcome healthcare disparities, including refining initiatives, eliminating underlying structural barriers, and planning prospectively across programs to advance health equity. Our patient care programs will deliver equitable and safe care that is embracing and nurturing in an environment of diversity, inclusiveness, equal opportunity, and respect for the similarities and differences in our community. Maimonides Medical Center plays a pivotal role in our community. To achieve the greatest impact, we are fully invested in this strategic plan, with the goal that all individuals we serve (including members of racial and ethnic communities, people with disabilities, members of the LGBTQIA+ community, individuals with limited English proficiency, and persons otherwise adversely affected by persistent poverty or inequality) could achieve their highest level of health and well-being, and the reduction and ultimately elimination of disparities in healthcare quality, access, and outcomes.



❖ **Diversity, Equity and Inclusion (DE&I) Initiative and Committee**

- The Mission for Diversity, Equity & Inclusion Initiative is to provide a safe, equitable, and inclusive environment where diverse employees of all levels and all identities are valued, respected, supported and empowered to thrive
- With the guidance of the Board and Executive Team, Maimonides Medical Center has integrated diverse, equitable, and inclusive practices into the organizational culture and processes to ensure that its team, stakeholders, and communities feel welcomed and have a sense of belonging
- The three Domains of the DE&I Initiative are:
    1. Teams: Support the safety and overall wellbeing of our workforce and promote culture of "belonging"
    2. Patients & Families: Provide deliberate patient focused, culturally sensitive care and address the social heath determinants of our patients
    3. Communities: Utilize research methods & tools to identify areas of health inequities impacting our communities to improve care and ensure optimal health outcomes

- The DEI Committee is organized as an advisory group to assist with building an organizational culture that professes and practices the DEI core values with employees, patients and their families, and the community we serve. The DEI Committee plans and implements various initiatives in promoting DEI core values through providing appropriate DEI education and unconscious bias trainings, sponsoring celebratory events and relevant conferences, supporting various BRG activities, serving as resources and ambassadors for DEI spirit. The DEI Committee establishes annual strategic goals and action plans, monitors and manages its
    - progress, makes recommendations to ensure the goals are accomplished.

BERG (Business Employee Resource Group)

- BERG is composed of a group of voluntary employees with similar interests in working towards the same goals. These employees have a clear mission tied to the business of promoting diversity, equity and inclusion. These are the employees with passion, skills and talent to contribute in meaningful ways to the organization and are results oriented.
- The members of BERG are responsible for supporting, impacting and serving as resources for the organization. They may achieve the goal through networking, mentorship, coaching, professional development, sharing lived experience, and professional engagement.
- The lead and co-lead of each BERG share regularly with each other its goals, relevant action plans and lessons learned. They also report the BRG members' feedback, suggestions and obstacles to the DEI Committee to seek further support and recommendations.
- Current BERGs at Maimonides Health System:

    1. LGBTQIA+ BERG
    2. Hispanic BERG
    3. African, Black & Caribbean American (ABC) BERG
    4. Asian American Pacific Islander (AAPI) BERG
    5. Military Veteran BERG
    6. Maimonides Women's BERG

ALLIANCE WITH EXTERNAL QUALITY PROGRAMS:

❖ **EASTERN US QUALITY IMPROVEMNET COLLABORATIVE (EQIC)**

The Medical Center is committed to participating in this CMS program through HANYS. The Program involves more than 100 hospitals in New York, New Jersey and Connecticut. EQIC offers a large portfolio of resources, including education, analysis tools and materials. It provides a wide range of comparative data and supports the needs and cadence of each individual hospital and its teams. EQIC Initiative Areas include:

1. Medication Management
    - Opioids
    - Insulin
    - Anticoagulants
    - "Never and high-risk medications" in the elderly
    - Co-occurring opioids and benzodiazepines
2. Patient Safety
    - HACs (Falls, PU, VTE, ADE)
    - HAIs (CAUTI, CLABSI, SSI, Sepsis, C.diff. and MRSA)
    - No harm (safety) across the board
3. Readmission Reduction
    - All-cause and FFS with multiple deep dives
    - Care Partner
    - High Utilizers
    - SNF

- Home care
- Community Collaboratives

❖ **HANYS COMMITMENT TO EXCELLENCE (C2X) INITIATIVE**

The Healthcare Association of New York State Commitment to Excellence initiative is designed to showcase New York healthcare organizations' significant and ongoing commitment to quality and patient safety. C2X provides a forum for healthcare providers to profess their dedication to learn and stay on the cutting edge of healthcare practices, and use their combined knowledge, expertise and best practices to achieve healthcare excellence. C2X has a dynamic portfolio of programs, such as preventing antibiotic resistance, opioid addiction prevention and management, creating a high-reliability culture, and sepsis prevention and treatment. In March 2019, Maimonides Hospital actively participated in the program and signed the C2X pledge. Organizations that signed the C2X pledge, agreed to the following:

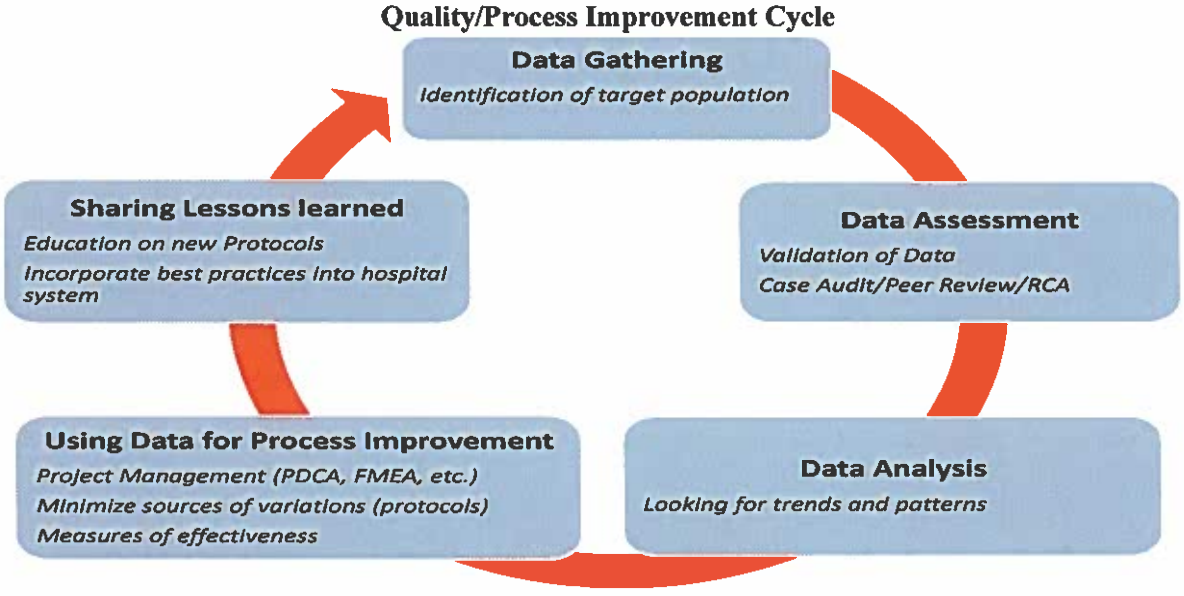
- Have an annual quality improvement plan with board and/or senior leadership oversight
- Actively use evidence-based best practices for quality and patient safety
- Routinely analyze data and outcomes to improve performance
- Submit at least one success story to HANYS for public distribution
- Participate in at least two HANYS education programs per year
- Have your organization's name published on HANYS' website as a C2X participant

❖ **HEALTH RISK ADVISORY (HRA) -THE DOCTORS COMPANY**

HRA is a not-for-profit insurance and risk management organization has a dedicated interest in health care quality initiatives that will effectively reduce injury to patients and improve clinical outcomes.

- Monitor compliance with the Pre-Operative Medical Assessment (POMA)
- Continue to evaluate the effectiveness of medical co-management of surgical patients
- Continue implementation and evaluation of protocols to decrease morbidity and mortality of surgical patients with BMI > 40
- Continue evaluation of the MEWS system (Medical Early Warning System) and expansion to ED

ORGANIZATIONAL APPROACH TO QUALITY MANAGEMENT



❖ MEASUREMENT OF PERFORMANCE

For hospitals that use Joint Commission accreditation for deemed status purposes, the quality assessment and performance improvement program incorporate quality indicator data, including patient care data and other relevant data such as that submitted to or received from Medicare quality reporting and quality performance programs (e.g. data related to hospital readmissions and hospital-acquired conditions.).

Data is collected for high priority and required areas. The data is used to monitor the stability of existing processes, identify opportunities for improvement, and identify changes that lead to or sustain improvement. Collected data is related to patient-focused and organization-focused functions, as defined by The Joint Commission (TJC):

- Environment of Care
- Emergency Management
- Infection Prevention and Control
- Information Management
- Leadership
- Life Safety
- Medication Management
- Medical Staff
- National Patient Safety Goals
- Nursing
- Provision of Care, Treatment, and Services
- Performance Improvement
- Record of Care, Treatment, and Services
- Rights and Responsibilities of the Individual
- Transplant Safety
- Waived Testing

At a minimum, the hospital collects data to measure performance related to the following potentially high-risk processes, as appropriate to the care and services provided and defined by The Joint Commission. Data is presented at the Hospital Quality Improvement/Patient Safety Committee Meeting:

- Medication Management and significant Medication Errors
- Adverse Drug Reactions
- Blood, Blood Product Use, Transfusion Reactions
- Restraint use
- Fall rates
- Rapid Response and Resuscitation outcomes
- Infection Control and Hospital Acquired Infections
- Antimicrobial Stewardship
- Mortality and Readmission Rates
- Ventilator and Weaning Rates
- Adverse Events related to Moderate and Deep Sedation
- Organ Procurement Conversion Rate
- Pain Management and use of opioids
- Patient flow
- Core Measures
- Discrepancies between Pre and Postop Diagnoses
- Behavior Management and Treatment

Departments select indicators reflecting processes that are high risk, problem prone, or which affect large numbers of patients or staff. Departments may initiate or discontinue an indicator at any time, based on findings or identified needs. At least annually, all indicators are reviewed for effectiveness within the Departments to determine whether continued monitoring is warranted and/or revisions are indicated.

MMC submits the required Core Measure data as identified by CMS and The Joint Commission. All CMS Hospital Compare data is presented on a regular basis. Opportunities for improvement are discussed and progress related toward improvement initiatives currently underway is highlighted. The Medical Center participates in the NYS Hospital Acquired Infection Reporting (HAIR) initiative. Hospital-specific data is presented to the PI Committee on a quarterly basis and annually with NYS benchmarking. In addition, the Medical Center submits data to several national Quality Improvement registries and databases (e.g. Stroke Get with Guidelines, STS, ACS, TQIP, VQI, and LVAD). These data-driven and outcomes-based programs afford the opportunity for benchmarking with other facilities.

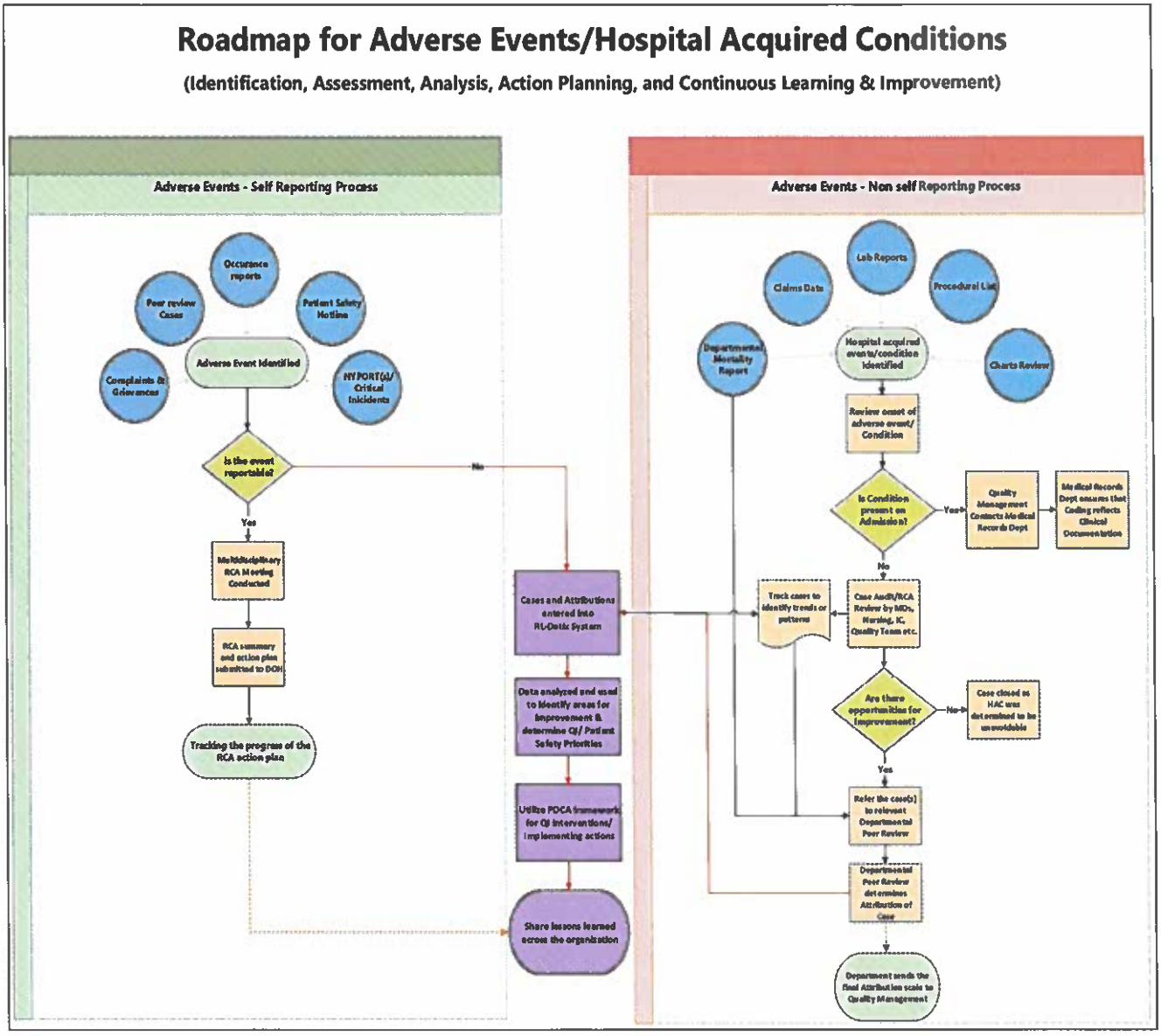
No Harm Dashboard
MMC has a data driven process for identifying and acting upon areas of concern with regard to CMS Hospital Acquired Conditions (HACs). The No Harm Dashboard was created to be able to capture the HACs in a timely fashion before the data become public. The main data sources are chart reviews and claims data. The claims data are captured by using AHRQ methodology and applying the inclusion/exclusion criteria. The data is reviewed and validated by a group of clinicians, Infection Control and the Quality Management team.

The No Harm Dashboard indicators include the following indicators:

- ***Hospital Acquired Infections:***
  - Central Line-Associated Blood Stream Infections (CLABSI)
  - Catheter-Associated Urinary Tract Infections (CAUTI)
  - Clostridium Difficile
  - MRSA Bacteremia
  - CRE
  - Surgical Site Infections (SSI)

- ***Patient Safety Indicators:***
  - PSI-03 Pressure Ulcer
  - PSI-06 Iatrogenic Pneumothorax
  - PSI-08 In-Hospital Fall with Hip Fracture
  - PSI-09 Periop Hemorrhage or Hematoma
  - PSI-10 Postop Acute Kidney Injury Requiring Dialysis
  - PSI-11 Postop Respiratory Failure
  - PSI-12 Periop Venous Thromboembolism (PE/DVT)
  - PSI-13 Postop Sepsis
  - PSI-14 Postop Wound Dehiscence
  - PSI-15 Unrecognized Accidental Puncture or Laceration

- ***Never Events:***
  - Foreign Bodies after Procedures
  - Air Embolisms
  - Blood Incompatibilities
  - Falls and Trauma



❖ ANALYSIS OF PERFORMANCE

Sources of data include, but are not limited to, the Departments of Ambulatory Health, Anesthesiology, Blood Bank, Cancer Center, Cardiology, Case Management, Emergency Department, Environment of Care, Finance, Food and Nutrition, Health Information Services, Infection Control, MIS, Medicine, Nursing, Obstetrics/ Gynecology, Orthopedics/ Rehab, Perioperative Services, Pathology/ Laboratory, Patient Relations, Pediatrics, Pharmacy, Psychiatry, Radiology, Rapid Response Team, Resident Quality Council, Respiratory Care, Risk Management, Safety/ Security, Stroke, Surgery/ Dentistry and

Trauma. Whenever possible, electronic sources of data are utilized to reduce transcription and other human errors.

Data are aggregated within each Department or by Quality Management and analyzed monthly or quarterly. Appropriate statistical tools and techniques are utilized to display and analyze data. Internal and external benchmarks are used for comparative purposes and to determine variability and levels of performance.

When comparisons show that levels of performance, patterns, or trends vary substantially from those expected, from those of other organizations, or from recognized standards, further analysis is conducted to determine where best to focus actions for improvement.
For data collection that is not continuous (that is, when data sampling is needed), the following sample sizes are used, as recommended by The Joint Commission:

POPULATION SIZE	SAMPLE SIZE
Less than 30 cases	100% of available cases
30 – 100 cases	30 cases
101 – 500 cases	50 cases
More than 500 cases	70 cases

Vizient Data Base

The hospital implemented the Vizient Database system in 2021, including the following two main components:

1. Operational Data Base (ODB)
   – Provides financial and operational analytics that identify opportunities to improve performance, reduce costs, improve budgeting and pinpoint best performers
   – Benchmark operations against the staffing and overall performance of 120 Vizient and 650 non-Vizient facilities
   – Reliable workload indicators for identifying potential improvements by department
   – Targeted performance improvement-related reports focusing on staff productivity, overtime utilization, supply expense, managing patient flow, capacity utilization and inpatient utilization
2. Clinical Data Base (CDB)
   – Provides high-quality, accurate and transparent data on patient outcomes – such as mortality, length of stay, complication and readmission rates, and hospital-acquired conditions – that enable hospitals to benchmark against peers
   – Clinical benchmarking tools such as dashboards, simulation calculators, and templated and customizable reports to quickly identify improvement opportunities and their potential impact
   – Resource Manager enhances patient- and physician-level data in the CDB by providing comparative utilization information for select clinical categories such as pharmacy, imaging, laboratory, blood and cardiovascular-vascular services. This information highlights clinical practice variation patterns and helps determine which resources are being used effectively.

❖ IMPROVING PERFORMANCE

Findings from data analysis, whether at the Unit, Department, or Hospital-Wide level, are used to identify opportunities for improvement. When changes are implemented, data collection and analysis are conducted to measure and evaluate the effectiveness of the improvement strategies. When improvement or safety goals are not met, further actions are taken.

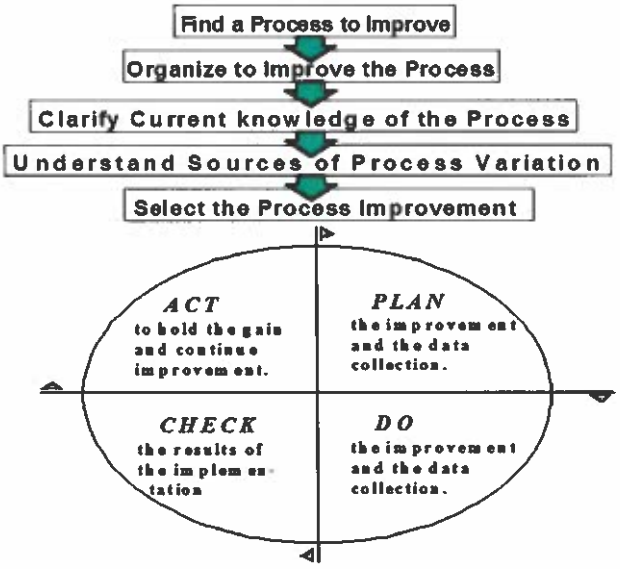
Maimonides Medical Center is committed to ongoing efforts to identify and reduce safety risks for patients and staff. **Failure Mode and Effects Analyses (FMEA)** are conducted as appropriate for new or existing high-risk processes. At least one new FMEA analysis is completed every 18 months as per Joint Commission requirements.

PROCESS IMPROVEMENT METHODOLOGY AND FRAMWORK

Maimonides Medical Center mainly utilizes the **FOCUS-PDCA** model for process improvement:

F – Find a process to improve
O – Organize to improve the process
C – Clarify current knowledge of the process
U – Understand sources of process variation
S – Select the process improvement
P – Plan the improvement and data collection
D – Do the improvement and data collection
C – Check the results of the implementation
A – Act to hold the gain and continue improvement

Some Initiatives may require a more rigorous PI methodology e.g. **the Six Sigma model DMAIC** (Define-Measure-Analyze-Improve-Control). The PI models provide a framework for teams and workgroups to conduct PI projects which are fueled by relevant data.



ORGANIZATIONAL READINESS

The Department of Quality Management supports the philosophy of continuous and ongoing organizational survey readiness. The Organizational Readiness Team meets on a monthly basis, unrelated to any survey schedule. The Readiness meetings are facilitated by the Accreditation Manager and Vice President of the Professional Affairs Department. The team is comprised of representatives from both clinical and ancillary Departments. The team assigns responsibility for particular functions and assessment activities, reports on new or ongoing readiness measurement, and follows up on identified problems. The members of the Readiness Team are responsible for disseminating appropriate information to their respective Departments.

The members of the Organizational Readiness Team represent, but do not replace, the efforts of the hospital staff at large.

The Joint Commission National Patient Safety Goals (NPSG)
All requirements related to the Joint Commission National Patient Safety Goals are put in place. When a new NPSG is added, the Readiness team reviews current processes in place to meet the stated requirements and implements an action plan outlining the strategies to meet the goal. Ongoing compliance with implementation strategies is monitored. The Accreditation Manager monitors NPSG compliance on a monthly basis and reports the data semiannually to the House-wide Quality Improvement/Patient Safety Committee. The purpose of the NPSGs is to improve patient safety. The goals focus on:

- Identifying patients correctly
- Improving staff communication
- Using medicines safely
- Using alarms safely
- Preventing infection
- Identifying patient safety risks
- Preventing mistakes in surgery

PEER REVIEW

One of the primary responsibilities of the Medical Staff is to monitor and improve care that is dependent upon the performance of individuals granted clinical privileges. The peer review process is designed to collect information necessary to conduct ongoing evaluation of clinical performance (OPPE). This in turn serves to maintain and/or enhance the quality and safety of patient care and the systems and processes that support the provision of care.

Each clinical Department regularly conducts peer review and assesses performance based on generally recognized standards of care. Each Department determines criteria for selection of cases, as well as criteria for focused review. The Departmental Peer Review Committee reaches consensus regarding case outcome, practitioner's management of the case, and recommended action, if indicated. Sentinel Events, NYPORTS, and selected critical incident cases are also presented at a standing multi-disciplinary root-cause meeting. Cases are prioritized based upon regulatory requirements and criticality. The meetings are intended to promote a "Just Culture" and focuses on systemic opportunities for improvement. Provider-specific peer review results are used in the credentialing and privileging process. The Peer Review Module of the RL Datix program allows reporting cases in a centralized and unified system which helps identifying trends, patterns and opportunities for improvement.

RISK MANAGEMENT

The Departments of Risk Management and Quality Management communicate both formally and informally. On an ongoing basis, quality issues are discussed collaboratively between the two Departments. Risk Management leadership is represented on the Hospital-Wide Quality Improvement and Patient Safety Committee and attend the monthly meetings. The Vice President of Risk Management presents monthly reports. Risk Management reviews, tracks and trends occurrence report information, NYPORTS, and sentinel events for the hospital. Occurrences are reported to Risk Management through the RL Datix system or by calling the Patient Safety Hotline, which is operational 24 hours/day. The Patient Safety Hotline is confidential and, if the caller wishes, anonymous. Occurrences to be analyzed include, but are not limited to:

- Confirmed transfusion reactions
- Serious adverse drug events
- Significant medication errors
- Major discrepancies between preoperative and postoperative diagnoses

- Adverse events or patterns involving moderate sedation or anesthesia
- Hazardous conditions

Risk Management provides data and other information to the Departments for inclusion in the respective Quality Improvement and Peer Review meetings. The Department of Risk Management is involved in the following areas:

1. Patient Safety
2. Incident Reporting through:
   RL Datix and Investigation
   NYPORTS (New York Patient Occurrence Reporting and Tracking System)
   NIMRS (New York Incident Management Reporting System)
   OMH/Justice Center (Office of Mental Health)
3. Patient Rights/Patient Complaints/Patient Experience
4. Licensure Investigation
   Office of Professional Medical Conduct (OPMC) Office of Professional Discipline (OPD)
5. NYS Department Health Activity
   Surveys (e.g. Title 18, HCFA) Allegation Survey
6. Regulatory Reviews (CMS, OMH, Justice Center)
7. Malpractice and General Liability
8. Apology/Disclosure/Family Meetings

SENTINEL EVENTS/ NYPORTS

Events with actual or potential negative outcome for a patient or the facility may be determined to be a sentinel event, or a reportable NYPORTS occurrence. This determination is made by the Vice President of Risk Management, in collaboration with the Executive Vice President of Medical Affairs. A sentinel event is defined as an unexpected occurrence involving death or serious physical or psychological injury, or the risk thereof. Serious injury specifically includes loss of limb or function. The phrase "or the risk thereof" includes any process variation for which a recurrence would carry a significant chance of a serious adverse outcome. "Serious Events" are occurrences meeting criteria for NYPORTS, Joint Commission, and CMS. For all sentinel events and/or serious events (as specified above), a Root Cause Analysis is completed and coordinated by Risk Management with input from Patient Safety and Quality Management. Risk reduction strategies are implemented and follow-up monitoring to assess effectiveness is completed by the involved Department(s), and reported to the Departments of Risk Management and Quality Management.

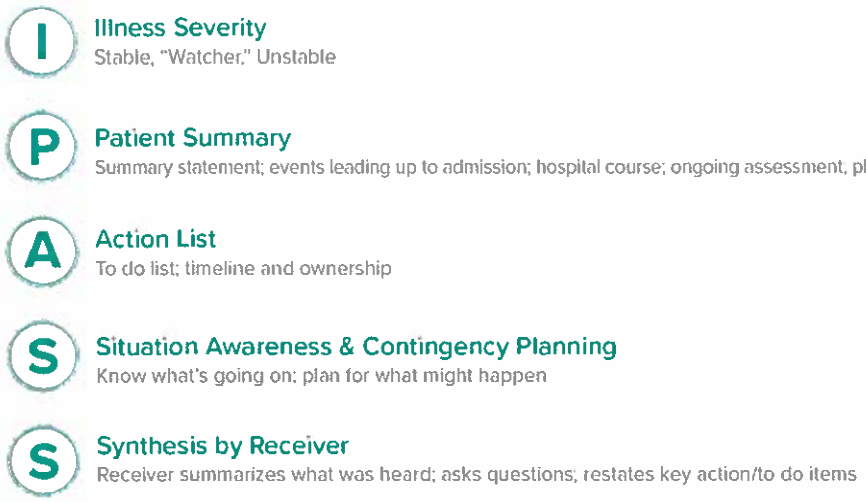
RESIDENT QUALITY AND SAFETY PROGRAM

In accordance with Maimonides Medical Center's mission, vision and values, the Resident Quality and Safety Council (RQSC) maintains a performance improvement program, grounded in safety science and designed to support the provision and advocacy for high-quality education and patient care. The Council supported by the Department of Academic Affairs and its PI plan complements and supplements the hospital organizational Quality Improvement plan. The RQSC is supervised by the Quality Improvement and Patient Safety (QIPS) fellow and two elected resident co-chairs. Advisory support is provided by the DIO, Chief Quality Officer, and Chief Patient Safety Officer. Additional management support is provided by the Departments of Quality Management. Through the RQSC, all residents and fellows have the opportunity to participate in a range of resident-led quality and safety initiatives, as well as resident related peer review activities. These activities provide a better understanding of the complexities of systems, teamwork and leadership.

The RQSC's major initiatives for 2024-2025 are designed to empower resident and fellows to recognize, report, and analyze incidents, near misses and unsafe conditions through a just culture framework. The

initiatives include both educational and project-based interventions which coincide with three of the institutional priorities; strengthening clinical and academic programs, improving patient and family experience, and streamlining clinical and administrative processes.
These components are meant to work in conjunction with one another to provide an integrated approach.

- Patient Safety Incident Reporting System (RL Datix)
- Quality and Safety Project Leadership
- Quality and Safety Programming Participation
- Analysis of Clinical Safety Events
- Improved Clinical Communication Using the I-PASS Handoff Tool



Data from I-PASS handoff observations by residents and faculty will be incorporated into measures of performance for that project

Resident and fellows continue to identify and submit safety reports into RL Datix. When possible, their clinical departments are encouraged to work with them to leverage their reports into PI projects to promote highly reliable, safe, and equitable patient care. Reports are reviewed by the multidisciplinary safety leadership committee and actions on specific reports are evaluated through the Just Culture lens. The RQSC will continue to collect and analyze incident reports via RL Datix. Monthly, quarterly, and semi-annual summary data is incorporated in the Graduate Medical Education Committee as well as the Quality Improvement Committee.

Peer review cases that involve house staff are reviewed by the RQSC and a peer attribution is completed and presented as a part of the house-wide root cause analysis and critical incident review process. Cases reviewed through the resident process particularly focus on the influence of systems issues on error.

CONFIDENTIALITY

All quality and performance improvement information, reports, minutes, records, and other pertinent materials are considered confidential, in accordance with the New York State Education Law Subsection 3 of 6527, and the New York State Public Health Law 2805 (m). Such documents may be labeled "QI" or "PI" or similarly designated to connote this status. This includes information collected, compiled, or prepared with the intention of evaluating and improving patient care and support services; reducing complications and adverse outcomes; or reducing errors that may or may not result in negative outcomes.

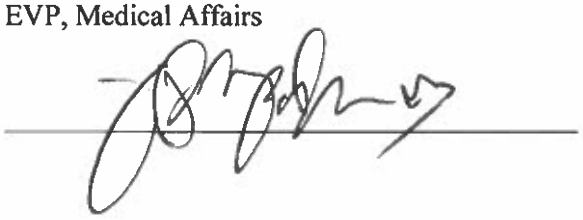
Access to QI records or documentation is controlled and authorized on a "need to know" basis. Such records are maintained in a secured area in each department or service, or in a secured area in the Department of Quality management or Risk Management.

Further information concerning Maimonides Medical Center's policies related to confidentiality and access of information may be obtained from the Department of Legal Affairs.

EVALUATION

In order to continuously improve its effectiveness and meet the needs of the hospital, the Organizational Quality Improvement Plan is evaluated and formally revised every two years.

John Marshall MD, MBA, FACEP
Chief Medical Officer
EVP, Medical Affairs



Date: 1/25/2024

Sameh Samy MBBCh, MSA, CPHQ, CSSBB
Chief Quality Officer
VP, Quality Management

Date: 1/25/2024