



Maimonides
Health

MAIMONIDES MEDICAL CENTER

**ORGANIZATIONAL QUALITY IMPROVEMENT AND
PATIENT SAFETY PLAN**

2026 – 2027

MAIMONIDES MEDICAL CENTER

ORGANIZATIONAL QUALITY IMPROVEMENT AND PATIENT SAFETY PLAN (2026-2027)

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MAIMONIDES MEDICAL CENTER

ORGANIZATIONAL QUALITY IMPROVEMENT AND PATIENT SAFETY PLAN

2026-2027

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 while continuously evaluating and improving our patient care processes, systems and support services.

Maimonides Medical Center is the premier provider of health services and the hospital of choice in the communities we serve, particularly Southern Brooklyn. 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, advance performance, and achieve organizational goals. We remain both mission-focused and market-wise.

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)

- **Honesty:** Establishing trustworthy and dependable relationships through continuous provision of open, transparent and sincere communication
- **Empathy:** Being sensitive and taking the time to understand what someone is experiencing and showing them compassion
- **Accountability:** Taking responsibility for one's actions, performance and outcomes of care which ultimately benefits our well-being
- **Respect:** Demonstrating commitment to fostering an environment where everyone is valued through non-judgmental acceptance whereby we treat each other with dignity, kindness and compassion.
- **Teamwork:** Collaborating effectively with each other by empowering and supporting the utilization of individual strengths to achieve common goals and to deliver safe, high-quality care.

AUTHORITY

The Board of Trustees holds the overall authority and responsibility for implementing and ongoing support 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—together with the Steering Committee/Governing Body for Quality and Safety, including Senior Leadership and Medical Staff Leadership—oversee the coordination and performance of organizational and departmental quality improvement initiatives.

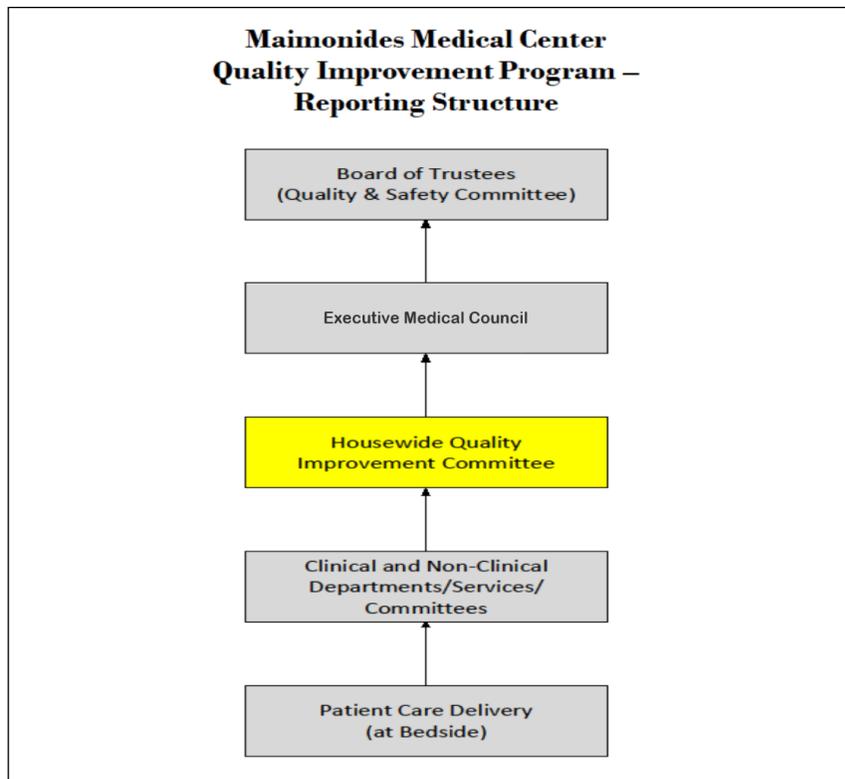
ORGANIZATION AND REPORTING STRUCTURE

The Department of Quality Management is responsible for maintaining and updating the hospital Quality Improvement Plan and for ensuring appropriate communication with hospital Departments regarding all performance improvement activities. The Quality Management team, led by the Vice President of Quality Management and composed of the Director of Quality Outcomes, Performance

Improvement Specialists, Clinical Data Abstractors, and Analysts, provides support to clinical and ancillary Departments in evaluating, organizing, designing, planning, analyzing, and reporting Quality Improvement and Patient Safety initiatives. The Department also ensures that these activities align with the Hospital's strategic priorities and goals.

Each hospital Department is responsible for coordinating Quality Improvement efforts within its 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 that supplements the institutional QI plan. All members of the hospital and Medical Staff participate in Quality Improvement and Patient Safety activities, reflecting the core values of the institution. Each Department maintains a Quality Improvement Council/Committee to address and report quality issues and monitor progress on 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 representation from the Board of Trustees, the Chief Executive Officer, the Chief Operations Officer, the Chief Nursing Officer, the Patient Safety Officer, Clinical Chairs, Medical Staff, and Senior Leaders from all clinical and ancillary Departments. The Committee meets monthly to review and discuss 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 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 Provides a monthly summary of the quality improvement activities to the Executive Medical Council (EMC), and the Board of Trustees Committee for Quality & Safety (CQS).



HOSPITAL PRIORITIES FOR STRATEGIC DIRECTION

The hospital's strategic priorities are designed to advance patient- and family-centered care; enhance quality and patient safety; support physicians and staff; ensure fiscal sustainability; strengthen internal and external partnerships; and promote effective organizational communication. The Quality Improvement Plan aligns directly with these strategic directions.

To support these aims, the hospital has established the following **Enterprise priorities and domains**:

- **People-Centered Culture** – Advance our culture to improve experiences for patients, personnel, partners, payors, and policymakers.
- **Three-year Organizational Initiatives** – Align multi-year initiatives that reinforce our position as Brooklyn's essential hub for outstanding specialty and community care.
- **Medical Group Development** – Build the identity and capabilities of a multispecialty medical group grounded in unity, shared vision, and mission, establishing the foundation for sustained performance.
- **Total Cost of Care Management** – Coordinate population health efforts to: (1) Secure Waiver safety net funding; (2) Improve Total Cost of Care; and (3) Advance Health Equity.
- **EPIC Implementation** – Begin implementation of new EHR and revenue cycle solutions

The domains include key drivers as well as specific organizational initiatives and activities. Each Initiative has measurable goals and is monitored regularly to assess progress and identify needed adjustments.

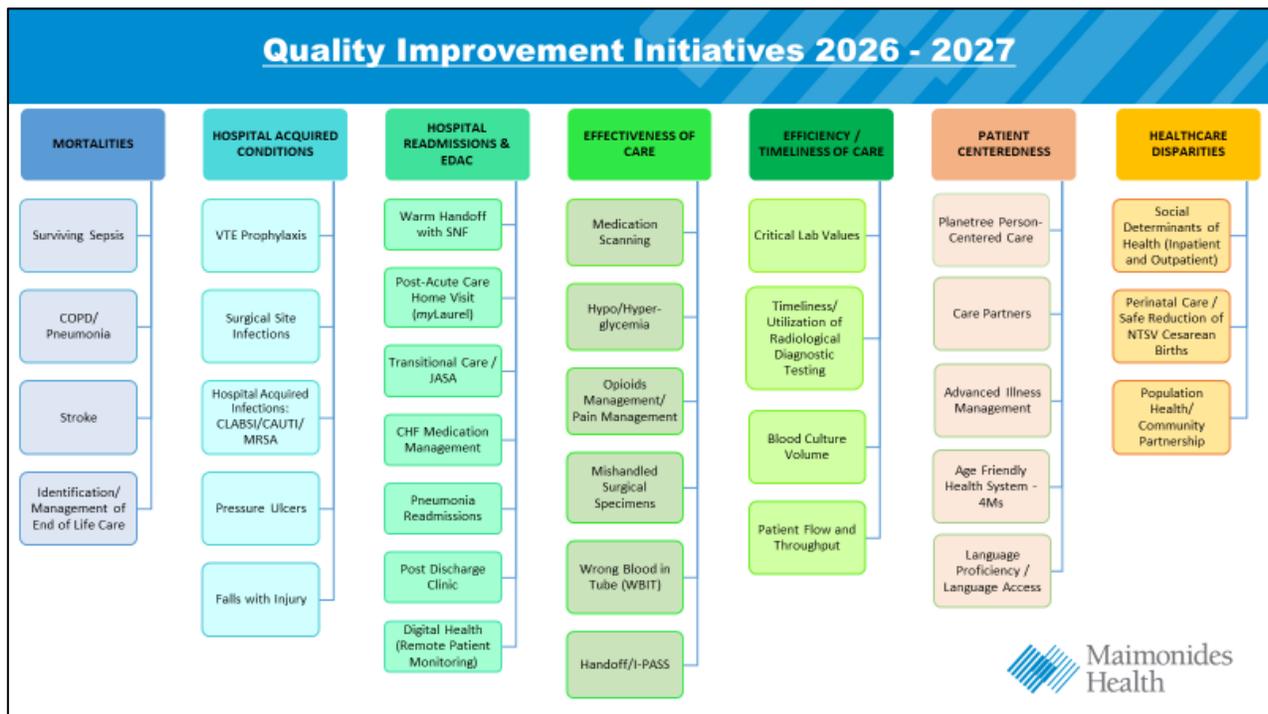
Main Organizational Goals:

1. **Access:** Make it easier, faster, and more convenient for current and new patients-including employees-to obtain care at Maimonides
2. **Service:** Improve the experience for patients, families, referring physicians, and employees across all points of interaction
3. **Finances:** Ensure appropriate reimbursement for services provided and act as responsible stewards of hospital resources.

STRATEGIC PRIORITIES FOR QUALITY AND SAFETY (2026-2027)

The Quality Improvement (QI) Plan is grounded in the Institute of Medicine's Six Aims of Quality—Safe, Effective, Efficient, Equitable, Patient-Centered, and Timely care. It establishes the framework for achieving the organization's performance goals and priorities. The primary objectives of the QI Plan are to advance the organization toward high-reliability performance, identify and pursue opportunities to improve patient care, enhance population health, and provide a systematic structure for continuous quality improvement. The Department of Quality Management collaborates closely with Clinical and Administrative Leadership to support, facilitate, and oversee all Quality Improvement activities aligned with the following priorities:

- I. Improving Clinical Quality, Safety & Health Outcomes
- II. Enhancing Patient-Centered Care and Improving Patient and Family Experience
- III. Enhancing Operational Efficiency, Financial Performance, and Clinical Integration
- IV. Improving Population Health
- V. Enhancing Hospital Growth and its Role as a Tertiary Care Destination
- VI. Enhancing Workforce Capacity to Effectively Reduce Health Care Disparities
- VII. Strengthening Academics, Research, and Innovation to Drive Organizational Excellence



I. Improving Clinical Quality, Safety & Health Outcomes

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

- Continue improving the CMS Star Rating to achieve at least “Three Stars” by the end of 2027
- Maintain MMC’s high national ranking for low mortality rates and continue to further reduce mortality across all CMS mortality measures, including AMI, Stroke, COPD, Pneumonia, CHF, CABG as well as Hybrid Hospital-Wide All-Cause Risk Standardized Mortality Rate
- Improve compliance and performance with all CMS quality-based payment initiatives including the VBP Core Measures (Chart-abstracted and e-CQMs measures)
- Strengthen compliance with the CMS Sepsis bundles and reduce our Severe Sepsis & Septic Shock mortality rates as monitored by the DOH.
- Continue improving the Leapfrog Safety Grade to achieve at least a “B” grade within 24 months (2027 Fall report)
- Enhance performance on the Anthem Q-HIP (Quality-in-Sights Hospital Incentive Program) scorecard and improve outcomes on the associated reimbursement scale
- Continue to improve our ranking in key public and benchmarking reports, including U.S. News & World Report, Healthgrades, the Lown Institute, and other national rating organizations.
- Improve compliance with Health First/HEDIS outpatient measures
- Advance the Health Equity Program to reduce healthcare disparities among both inpatient and outpatient population
- Maintain 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 (VBP), Hospital Acquired Conditions (HAC), and Readmissions**. In 2016, CMS developed the **Star Rating** program to help consumers make more informed decisions by providing them a way to compare hospitals based on a single aggregated quality score. Hospitals submit data through the Hospital Inpatient Quality Reporting (IQR), Outpatient Quality Reporting (OQR), and Inpatient Psychiatric Facility Quality Reporting (IPFQR) Programs. CMS then applies a clustering algorithm to assign hospitals a Star Rating on a one-to-five scale. The overall Star Rating is based on quality measures across five domains: mortality, safety of care, readmissions, patient experience, and

effectiveness/timeliness of care. Strengthening clinical practices and documentation in these areas is essential to improving the hospital's overall Star Rating.

Core Measures

MMC participates in the collection and reporting of Core Measures required by CMS and The Joint Commission (ORYX). Core Measures that should be captured through chart abstraction or administrative claims include:

Inpatient Measures

- Perinatal Care (PC 06 only for JC)
- Sepsis Bundle Compliance

Outpatient Measures

- Stroke imaging efficiency
- Emergency Department arrival to discharge time
- Colonoscopy follow up interval
- Hospital visits following outpatient procedures
- Left Without Being Seen

Inpatient Psychiatry Measures

- HBIPS (Hospital Based Inpatient Psychiatric Services)
- Restraints use
- Seclusion use,
- Alcohol use
- Substance use
- Tobacco use
- Transition of care
- Screening for metabolic disorders
- Influenza immunization for Psych patients
- Follow-up after Psych Hospitalization
- IPF unplanned readmission
- Medication continuation following Psych discharge,

Core measure data is transmitted to the Joint Commission and CMS through an authorized vendor (Medisolv). A Hospital Core Measure Quality Summary Report is presented to the House-wide Quality Improvement & Patient Safety Committee, the Executive Medical Council (EMC) and the Board of Trustees Committee for Quality & Safety (CQS). Action plans and follow-up activities are developed for all measures with low compliance.

CMS Hybrid Mortality and Readmission measures

Hybrid Hospital-Wide All-Cause Readmission (HWR) and *Hybrid Hospital-Wide All-Cause Mortality (HWM)* measures combine administrative claims with electronic health record (EHR) clinical data to improve accuracy in evaluating hospital performance. These measures were developed to provide a more comprehensive view of patient outcomes by incorporating vital signs, lab results, and other clinical elements alongside traditional administrative data. By blending these data sources, CMS aims to reduce bias, enhance risk adjustment, and create better comparisons across hospitals.

CMS Electronic Clinical Quality Measures (e-CQMs)

Electronic clinical quality measures (e-CQMs) use data electronically extracted from electronic health records (EHRs) and health information technology systems to assess the quality of care delivered. The Centers for Medicare & Medicaid Services (CMS) uses e-CQMs across multiple quality reporting and value-based programs. Key benefits include:

- Reducing the burden of manual chart abstraction
- Supporting real time data access for point of care quality improvement and clinical decision support

Measured entities use e-CQMs to provide feedback on their care delivery systems and to identify opportunities for clinical quality improvement. Hospitals report eCQMs to CMS, The Joint Commission, federal agencies, and commercial payers for quality monitoring and reimbursement purposes.

The list of submitted eCQMs for 2026 (reflecting CY2025) includes: Safe Use of Opioids, Cesarean Birth, Severe Obstetric Complications, Hospital Harm – Severe Hypoglycemia, STK-02 Discharged on Antithrombotic Therapy, STK-03 Anticoagulation Therapy for Atrial Fibrillation/Flutter, STK-05 Antithrombotic Therapy by End of Hospital Day two. Starting in 2026, the metric submission will increase to a minimum of eight eCQMs for all four quarters and increasing to nine measures in 2027. Beginning in 2028, CMS will require all hospitals to submit five new eCQMs in addition to existing requirements. Hospitals participating in the TEAM model must also report two additional measures: Hospital Harm- Postoperative Respiratory Failure (HH-RF) and Hospital Harm Falls with Injury (HH-FI). One outpatient e-CQM-Appropriate Treatment for STEMI (OP-40)-is currently required.

CMS Structure Measures

- The **Patient Safety Structural Measure (PSSM)** is a newly required measure under the Inpatient Quality Reporting (IQR) program. The purpose of this structural measure is to ensure organizations are approaching patient safety in a comprehensive, systematic and integrated approach, ensuring that safety is a core value and integrated into all aspects of their operations at all levels of the hospital. The PSSM is structured into five key domains, each worth one point. Hospitals must attest to all statements within a domain to earn that point. The measure is worth five points, and score will be displayed on Care Compare in a range from 0 to 5.
- The **Maternal Morbidity Measure** assesses hospital participation in a Statewide or National Perinatal Quality Improvement (QI) Collaboratives, and implementation of patient safety practices and/or bundles related to maternal morbidity.
- The **Age Friendly Hospital measure** is a structural measure designed to assess and enhance the quality of care for patients aged 65 and older in hospitals. It aims to ensure that hospitals provide high-quality, patient-centered care that improves outcomes and reduces risks associated with hospitalization. This measure is required under the Inpatient Quality Reporting (IQR) program and serves as an important indicator of a hospital's commitment to age-friendly care.

To meet the Age Friendly Health Systems measure, the hospital is expanding its Age-Friendly Initiative (AIM) and fully integrating the 4Ms framework—What Matters, Medication, Mentation, and Mobility—into everyday practice. As part of this effort, the hospital launched a dedicated AIM program in the Emergency Department, to ensure that older adults receive age-appropriate care from the moment they arrive. This includes standardized 4Ms assessments, early identification of geriatric needs, and alignment of care with each patient's priorities. To further support what matters most, the hospital implemented a process in which every patient aged 65 and older receives an Advance Care Planning (ACP) note, ensuring that goals, preferences, and decision-making supports are documented and accessible across the continuum of care. Organization wide, interdisciplinary teams are embedding 4Ms workflows into electronic health records, expanding staff training, and scaling AIM practices to additional units. These coordinated efforts create a reliable, proactive system that reduces harm, improves communication, and elevates the overall experience of care for older adults. The hospital has also extended these practices beyond its walls, partnering with skilled nursing facilities and JASA to advance age-friendly care throughout the community.

CMS TEAM Measure

The new CMS TEAM measure, officially called the *Transforming Episode Accountability Model (TEAM)*, is a mandatory bundled payment program starting January 1, 2026. It requires selected hospitals to coordinate care for Medicare beneficiaries undergoing five major surgical procedures, with accountability for costs and quality across a 30-day episode of care.

CMS Total Hip Arthroplasty/Total Knee Arthroplasty Patient-Reported Outcome-Based Performance Measure (THA/TKA PRO-PM)

For the first time, MMC will be required to participate in the THA/TKA PRO-PM measure under the CMS's Inpatient Quality Reporting (IQR) program. This measure will rely directly on patient input to calculate performance and will evaluate improvement in patients' self-reported pain and functional status following elective primary total hip or knee arthroplasty. Reporting is voluntary in 2025–2026 and becomes mandatory in 2027.

❖ CMS National Health Care Safety Network (NHSN) and NYS Hospital Acquired Infection Reporting (HAIR)

MMC submits Hospital acquired infection data through both the New York State HAIR system and CMS NHSN. Reportable measures include:

- Central Line-Associated Bloodstream Infections (CLABSI)
- Catheter-Associated Urinary Tract Infections (CAUTI)
- Postoperative Surgical Site Infections (SSI) for Colon surgery, Abdominal Hysterectomy, CABG with chest and donor site, Hip prosthesis, and Spinal Fusion
- MRSA Bacteremia
- Clostridium Difficile (*C. difficile*) infections
- CRE infections
- Influenza Vaccination Coverage Among Healthcare Personnel

Hospital-acquired infection data are reviewed regularly by the Quality Improvement Committee and evaluated against New York State and CMS benchmarks to monitor performance and identify opportunities for improvement.

❖ NYSDOH Sepsis

The New York State Department of Health (NYSDOH) has revised its sepsis reporting methodology, transitioning from manual abstraction to an electronic data abstraction process (e-Sepsis). The primary goals of this initiative are the automation of data collection, a stronger focus on outcome measures, and the inclusion of COVID-19 cases. This transition requires full implementation of, and compliance with, the DOH-specific data dictionaries for both adult and pediatric sepsis. The MIS Department has established processes to ensure accurate data flow, including defining and coding all qualifying cases. The Quality Management Department will continue to monitor and validate sepsis outcomes and ensure adherence to standardized adult and pediatric protocols and bundles that support early recognition and management of septic patients.

❖ Leapfrog Hospital Survey and Safety Grade

Since the fall of 2018, the Medical Center has participated in the Leapfrog Hospital Survey. The Leapfrog Safety Grades reflect 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 combined to produce a single composite score, which is published as a letter grade (A, B, C, D or F).

The Leapfrog Hospital Safety Grade is designed to educate and encourage consumers to consider patient safety when choosing a hospital for themselves or their families. The grading system also creates strong market incentives for hospitals to prioritize safety. Leapfrog Hospital Safety Grades are publicly reported and released twice each calendar year, once in the fall and once in the spring. The overall Leapfrog Survey is updated annually in July.

❖ **Q-HIP Hospital Incentive Program**

The Quality-In-Sights: Hospital Incentive Program (Q-HIP) is 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. The clinical measures used in the program are developed by national quality organizations such as The Joint Commission (JC) and the National Quality Forum (NQF).

The Medical Center is committed to participating in Q-HIP. Required data submissions include measures related to Patient Safety, Health Outcomes, Patient Satisfaction, and designated Bonus Measures. High compliance with CMS Core Measures, NHSN, ACC, and STS data will support strong performance within the program. All documentation submitted by the Facility must have been in active use during the Measurement Period to be considered in the evaluation process. The Facility is notified once the scorecard is finalized and published, which occurs within 30 days after the final data submission deadline. The annual Q-HIP report highlights strengths and opportunities for improvement, presenting each Facility's performance alongside comparative data for all Q-HIP participants.

Measures added for 2026 include:

- CMS SEP-1 – Severe Sepsis and Septic Shock Bundle Management
- CMS Hybrid Hospital-Wide Readmission Rate
- JC Healthcare Sustainability

2. Prevention of Avoidable Patient Harm and Improvement of Patient Safety & Outcomes

❖ **Reduction of Hospital Acquired Events**

Monitor and reduce CMS hospital acquired events on the “No Harm” Dashboard targeting 5-10% annual reduction in avoidable events

Based on the No-Harm Dashboard data, Task forces will focus on key areas, including:

- Hospital Acquired Infections
- Peri-Op Patient Safety indicators
- Pressure Injuries
- Falls with Trauma/Injury
- Never events

❖ **Hand Hygiene Compliance**

Maintain 95% or higher hand hygiene compliance to reduce Healthcare-Associated Infections (HAIs) through:

- Ongoing education to reinforce competence
- Monitoring and feedback to sustain performance
- Empowering staff to speak up when breaches occur
- Active senior leadership engagement to ensure accountability

❖ **TJC Failure Mode and Effect Analysis (FMEA) Initiatives**

Continue conducting FMEA projects with emphasis on:

- Reducing the incidence of mislabeled and or mishandled surgical specimens
- Minimizing the Wrong Blood in Tube (WBIT) events
- Reducing hypoglycemia incidence and recurrence
- Decreasing opioids overutilization across the institution

❖ **Medication Safety Improvement**

- Enhance medication scanning/barcoding compliance across the Medical Center
- Continue to optimize the CPOE (Computerized Physician Order Entry) to reduce and alert clinicians to serious prescribing errors
- Strengthen the Medication Reconciliation process to ensure accurate and complete medication lists at both admission and discharge

❖ **Surgical Safety Enhancement**

- Continue to enhance full compliance with the Time Out and Universal Protocol prior to all surgeries and bedside procedures
- Expand standardized post-operative debrief and sign-out processes to improve communication, reduce errors, and support continuous learning

3. Improving Care Transitions and Reducing Preventable Hospital Readmissions

Goal: Reduce hospital-wide all-cause readmissions to the national mean by implementing standardized, patient-centered transitional care processes.

Key Strategies

❖ **Risk Identification and Discharge Planning**

- Identify high-risk patients using a validated readmission risk score.
- Use a standardized discharge-rounds checklist for all high-risk patients.
- Engage designated Care Partners/givers in care planning, discharge preparation, and post-discharge follow-up.
- Assess home care needs and insurance barriers early in the hospitalization.

❖ **Medication Safety and Access**

- Improve medication reconciliation by integrating Pharmacy into the discharge workflow.
- Provide a 30-day supply of discharge medications for high-risk patients through the MMC Pharmacy.
- Establish CHF Medication Management program

❖ **Patient & Family Education**

- Strengthen discharge education for patients and families.
- Enforce the teach-back method for both discharge instructions and medication education.

❖ **Post-Discharge Support & Care Coordination**

- Partner with comprehensive home healthcare vendors (e.g. myLaurel) to support continuity of care.
- Use a standardized warm handoff process with skilled nursing facilities (SNFs).
- Schedule follow-up appointments within 7 days of discharge.
- Conduct follow-up calls within 48 hours for high-risk patients via the Transitional Care team.
- Expand home-visit programs (e.g., JASA).
- Maximize utilization of home healthcare services such as CHHA, LCHSA, and Medicaid Health Home.
- Establish a Post-Discharge Clinic to ensure seamless follow-up and care continuity

❖ **Virtual Care & Remote Monitoring**

- Enhance ED tele-urgent care to support early intervention.
- Expand virtual care and Remote Patient Monitoring (RPM) for post-discharge and transitional care.

❖ **Palliative Care & Advanced Care Planning**

- Develop a reporting process using the surprise question and key clinical indicators (DNR/DNI status, comfort-measures orders, ACP notes) to identify patients who may benefit from Palliative Care consults or inpatient Hospice referrals.

❖ **Utilization of Observation Unit**

- Strengthen the process to identify and flag all 30-day readmission patients upon arrival to the Emergency Department.
- Assess returning patients for Observation Unit (CDU) eligibility when clinically appropriate.

❖ **Readmission Review**

- Review all readmission cases for documentation accuracy, coding appropriateness, and missed clinical opportunities during the index admission

4. Promotion of Culture of Safety and Enhancement of Effective Communication and Teamwork

The Hospital continues its journey toward becoming a High Reliability Organization (HRO). The key elements of an HRO include:

- Preoccupation with failure: Maintaining constant vigilance for potential problems—whether small errors or near misses—to prevent larger failures.
- Reluctance to simplify: Avoiding oversimplified explanations of issues and instead recognizing complexity and exploring deeper root causes.
- Sensitivity to operations: Sustaining strong situational awareness of frontline activities so leaders understand real-time conditions.
- Commitment to resilience: Building the capacity to adapt, recover, and learn quickly when unexpected events occur.
- Deference to expertise: Ensuring that in critical moments, decision-making authority shifts to those with the most relevant knowledge, regardless of rank.

In order to advance this goal, the Organization established a Patient Safety Office and appointed a Patient Safety Officer. A series of strategies and initiatives have been implemented to strengthen communication among care providers and support teams in adapting quickly to changing clinical situations. These initiatives include:

- Monitor and improve **the CMS/AHRQ Culture of Safety and Workplace Safety Survey** results through targeted action plans
- Monthly safety rounding with front-line staff, focusing on Culture of Safety domains in order to gather feedback and address issues in a timely manner
- Maximize the utilization of the RL Datix Program as a centralized and unified system for reporting all adverse events, and identifying safety trends, patterns and opportunities for improvement
- Support the non-punitive error-reporting policy (AD-102 Patient Occurrence Reporting and Disclosure) and the Code of Mutual Respect Policy
- Support Dyads on each unit to improve interdisciplinary teamwork and patient safety
- Transition current safety huddles towards a Tiered Huddling structure
- Promote the use of a structured Hand off tool (I-PASS) across the Medical Center
- Promote digital communication methods to enhance clarity and efficiency
- Enhance teamwork amongst providers and groups throughout the hospital using best practice models such as TeamSTEPPS
- Scale in-situ simulation and clinical event debriefing to monitor and propose solutions for latent safety errors across the organization, and support the development of high-performing teams
- Expand leadership rounds on clinical units
- Enhance employee safety through Psychological First Aid training
- Promote Patient Safety Awareness week through staff development activities (e.g. workshops and educational sessions)

II. Enhancing Patient-Centered Care and 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 Patient-Centered 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, Press Ganey 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.
 - Maimonides Health practices continuous improvement through a culture of co-design efforts by actively involving and collaborating with all relevant stakeholders such as staff, leadership, patients, caregivers, and/or community members to ensure the plan is well-rounded and addresses key priorities effectively. By fostering a culture of co-design, the institution empowers patients, families, and staff to contribute their voices to shaping care delivery, and creating shared accountability for continuous improvement.
 - 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
 - Strive to be recognized for person-centered excellence by Planetree International, which is a leading global nonprofit organization who partners with healthcare institutions
 - Conduct Planetree’s Reconnecting to Purpose Communication Workshops for all employee participation
 - Enhance the Patient and Family Advisory Council (PFAC) through recruitment and retention efforts
 - Manage the Person-Centered Care Steering Committee to engage key stakeholders in transforming care through implementation and sustainment of person-centered care practices and principles
 - 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
 - Maintain the peer-to-peer recognition program which supports teamwork and boosts staff morale.
 - Manage the PX data comment dashboard for seamless access for administrative and clinical leaders.
 - Continue real-time pro-active patient rounding to ensure service excellence.
- ❖ **Care Partner/Giver 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 five hospitals in New York State and the first in Brooklyn 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 2027)

Caring for Caregivers: Supporting the Invisible Backbone of Patient Care is an Age-Friendly Hospital initiative designed to recognize and uplift the essential role of family and informal caregivers. By prioritizing caregiver support, the program aims to strengthen both caregiver well-being and the quality of care their loved ones receive. The initiative focuses on reducing caregiver stress and burnout; improving caregivers’ physical, emotional, and mental health; enhancing patient outcomes by supporting those who provide day-to-day care; and building a hospital culture that is welcoming and responsive to caregiver needs. This work is funded by the John A. Hartford Foundation, Rush University Medical Center, and the Samuel Foundation.



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

Strengthen the efficiency and value of care delivery through initiatives focused on value-based care and reducing clinical resource variation, including efforts to:

- Continue reducing unnecessary diagnostic and laboratory testing
- Improve blood culture volume and turnaround time (Goal: average volume at least 8.0 ml)
- Increase compliance with timely communication of radiological critical results (Goal: 90% within 1 hour)
- Enhance response times for laboratory critical values
- Reduce overutilization of high-cost medications and optimize medication selection
- Promote standardization of trays and reduce waste of single-use disposable supplies in the OR
- Increase appropriate Palliative and Supportive Care consultations
- Improve team processes for shared decision-making in end-of-life care
- Expand staff training and education on bioethical and palliative care issues
- Improve documentation accuracy of the H&P “surprise question”
- Strengthen the Advanced Illness Management (AIM) program
- Enhance Advance Care Planning documentation
- Advance the Age-Friendly Health System initiative for patients aged 65+ in both inpatient and outpatient settings
- Expand the Inpatient Hospice Program
- Support documentation and coding improvement efforts to ensure accurate reflection of patient acuity
- Continue improving assessment and documentation of protein-calorie malnutrition
- Improve patient throughput and reduce inter-unit transfer times to optimize length of stay and decrease excess patient days
- Strengthen the “Discharge Before Noon” (DBN) process
- Enhance screening and documentation for breast cancer, diabetes control, and blood pressure control across Ambulatory Network Clinics

IV. Improving Population Health

The Maimonides Department of Population Health develops and supports programs, as well as a network of healthcare and social services organizations working to improve health and well-being in Brooklyn. The department works to address health related social needs, with a focus beginning within a healthcare setting and extending beyond the traditional walls of a providers’ office to improve 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. Spanning the health system, payers, and the community, these programs towards the goals of improved care and overall wellbeing. The Department of Population Health’s efforts fall into four main focus areas:

- Improving coordinated access to essential services, including quality primary, specialty care and essential hospital care, all while improving primary care capacity
- Integrating care coordination and transitions into all initiatives
- Engaging the community through the identification of community-defined needs and the development of programs to meet them
- Improving quality through data analytics and technical support

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 of care management services through **Brooklyn Health Home, CCB Navigator**, and Maimonides Care Management, Case Management, and

Transitional Care – extending care coordination beyond the Medicaid health home and connecting all Brooklynites to community-based resources and programs;

- Implement and evaluate the **TEAM (Transforming Episode Accountability) Model**, a mandatory alternative payment model that includes episode-based payments with two-sided financial risk and quality incentives;
- Strengthen connections between health systems, community-based organizations, and community members through **Brooklyn Communities Collaborative’s** strategies, which strengthen access to health and social services and 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;
- Expand access to and quality of Ambulatory Care by providing a variety of adult and pediatric services. Support of patients’ use of ambulatory care can lead to reduced healthcare costs, increased patient satisfaction, and better management of chronic conditions.

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 screenings
- Managing chronic conditions
- Managing 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

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

The organization will continue to expand its regional impact by advancing high-quality tertiary care services and strengthening partnerships with other health systems.

Strategic priorities include:

- Enhancing growth through excellence in the provision of tertiary care and maintaining strong commitment to primary care network development and collaboration with key partner organizations across Brooklyn.
- Supporting and enhancing quality initiatives across the Ambulatory Network and Outpatient Procedural Services, ensuring seamless integration between inpatient and outpatient care.
- Advancing quality activities for the Brooklyn Parenting Center, reinforcing excellence in family-centered programs.
- Progressing and refining business terms for the H+H integration to ensure strategic and operational alignment.
- Expanding clinical collaborations with SUNY Downstate, and One Brooklyn Health, facilitating increased referrals and growth across MMC’s tertiary programs while broader integration with H+H continue.

The Quality Management Department supports MMC’s role as a Tertiary Care Destination and Safety Hub by ensuring high-quality programs across all expanding service lines, including Heart

& Vascular, Cancer, Bone & Joint, Spine, Children’s Hospital, Maternity & Women’s Services, Neurosciences, Pediatric ED, Behavioral Health ED, and other surgical and medical specialties.

❖ **Alignment and Integration With MMCH (Maimonides Midwood Community Hospital)**

Maimonides Midwood Community Hospital (MMCH) is a 134-bed hospital located in Midwood, Brooklyn, dedicated to caring for the whole person across the southern tier communities of the borough. As a stabilizing presence in these neighborhoods, MMCH is committed to meeting patients’ evolving physical, emotional, spiritual, intellectual, and social needs. Its Mission emphasizes commitment to patients, leadership, and excellence, while its Vision focuses on delivering high-quality medical care and a diverse array of services to the surrounding communities.

MMCH is deeply committed to advancing a culture of quality, safety, and continuous improvement through full alignment and integration with the strategic goals, quality infrastructure, and regulatory initiatives of the Maimonides Medical Center (MMC) main campus. This unified approach strengthens organizational performance, ensures compliance with CMS, The Joint Commission, and NYSDOH requirements, and promotes consistent excellence in patient outcomes across the expanding Maimonides Health System.

MMCH’s Performance Improvement and Patient Safety Plan reflects a comprehensive commitment to enhancing the quality of care. It outlines the hospital’s goals and strategies for ensuring patient safety, delivering optimal care, and achieving high levels of patient satisfaction by anticipating and responding to the needs of patients and the communities served.

As both campuses move toward full integration, MMCH will collaborate closely with MMC to standardize evidence-based practices, enhance data integrity, and streamline performance across all electronic Clinical Quality Measures (eCQMs), ORYX reporting requirements, and external quality programs. This includes active participation in MMC-led initiatives such as the Leapfrog Hospital Survey, the QHIP Hospital Incentive Program, and CMS Value-Based Purchasing, with a strong focus on patient safety, infection prevention, and medication safety. Integration of data systems and quality dashboards will support real-time monitoring, analytics, and informed decision-making.

This systemwide collaboration fosters a unified culture of safety, accountability, and continuous learning through shared leadership, staff engagement, and coordinated care pathways. By standardizing performance measures, enhancing care coordination, and leveraging best practices from both campuses, the integrated Maimonides Health System strengthens operational excellence, regulatory compliance, and the delivery of equitable, high-quality, patient-centered care. Through this aligned approach, we aim to:

- Standardize evidence-based care pathways and performance measures to ensure equitable, high-quality outcomes across all care settings.
- Integrate data systems and quality dashboards to enable real-time performance monitoring, analytics, and informed decision-making.
- Advance a unified culture of safety and accountability through shared leadership, staff engagement, and continuous learning.
- Streamline care coordination and transitions to improve efficiency, reduce variability, and enhance the patient experience throughout the Maimonides network.
- Leverage best practices from both campuses to strengthen operational excellence, regulatory compliance, and patient-centered care.

This coordinated approach reinforces our commitment to clinical excellence and positions the integrated Maimonides Health System as a model for quality, safety, and innovation in both community and tertiary care delivery.

MMCH Quality Improvement Goals for 2026-2027

- **Enhance Hospital Performance Rankings** – Strengthen Maimonides Midwood Community Hospital’s performance in internal and external evaluations, including CMS Star Ratings and public reporting programs, to elevate the hospital’s overall quality profile
 - **Optimize Regulatory Compliance and Reporting** – Improve the accuracy, timeliness, and completeness of submissions to key regulatory and benchmarking programs such as CMS, Leapfrog, The Joint Commission, Get With The Guidelines (GWTG), QHIP, and electronic Clinical Quality Measures (eCQMs).
 - **Strengthen Sepsis Management** – Improve early identification, treatment, and outcomes for patients with sepsis by ensuring full adherence to evidence-based sepsis bundles and maintaining alignment with QHIP, IPRO, and CMS performance expectations.
 - **Optimize Stroke Care** – Enhance the management of acute and subacute stroke patients through consistent compliance with the 2026 Stroke Core Measures, ensuring timely interventions and improved clinical outcomes.
 - **Advance Patient Safety** – Implement targeted patient safety initiatives to improve the hospital’s Leapfrog Hospital Safety Grade, with emphasis on infection prevention, medication safety (including barcode scanning compliance), rapid response to critical events, and transparency measures.
 - **Reduce Hospital Readmissions** – Lower readmission rates through focused clinical interventions and strategic partnerships, including collaboration with MyLaurel, to strengthen care continuity and post-discharge follow-up.
 - **Promote Workforce Engagement and Just Culture** – Foster a supportive, accountable, and transparent environment that encourages reporting of safety events, near misses, and process gaps without fear of punitive action. Through education, collaboration, and empowerment, strengthen a culture of safety, continuous learning, and shared responsibility.
 - **Improve Operational Efficiency and Data-Driven Performance** – Enhance organizational performance by leveraging analytics platforms such as Vizient and Medisolv, standardizing clinical and operational processes, and fully integrating MMCH operations with the Maimonides Health System to support unified quality, safety, and operational excellence.
- improve operational efficiency and data-driven performance**

VI. Enhancing Workforce Capacity to Effectively Reduce Health Care Disparities

❖ 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 health 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

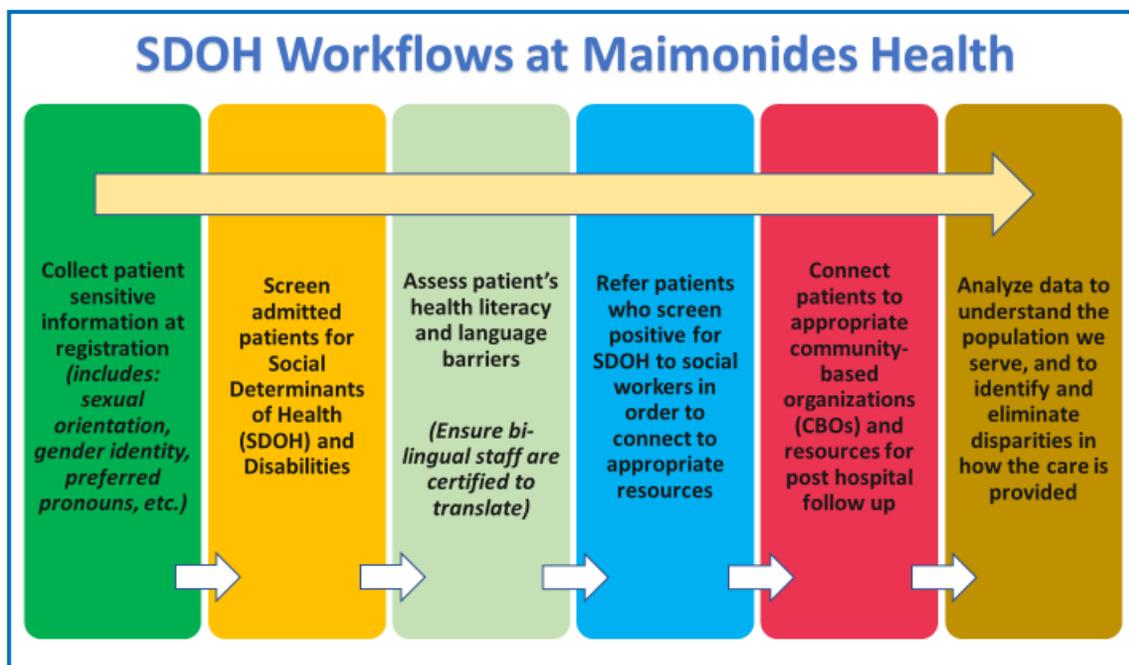
4. **Priority 4:** Assess Causes of Disparities and Address Inequities in Policies and Operations to Close Gaps. Prioritize health equity improvement projects as needed

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 assesses 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 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.



Measurement

An Organizational Health Equity Dashboard has been developed to monitor progress and performance for this initiative. The dashboard includes the following measures:

- Percent of patient records with REaL(Race, Ethnicity and Language) data complete.
- Percent of patient records with sexual orientation data complete.
- Percent of patients Screened for SDOH (age 18 and above)
- Percent of patients Screened positive for SDOH (age 18 and above)
- Number of CCB (Community Care of Brooklyn) Navigator Referrals
- Percent of Z-Coding Utilization
- Percent of patient and family complaints related to Health Equity and Cultural sensitivity
- Percent of Overall patient satisfaction scores by Race, Ethnicity and Gender
- Readmission Rate by Race, Ethnicity, Gender and Language

❖ **Employee Engagement & Belonging Committee (formerly Diversity, Equity and Inclusion-DE&I)**

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

Activities include but not limited to:

- Medical supplies drive
- Disaster Relief for hurricane victims (ex. food, toiletries, socks, formula, diapers, etc.)
- Staff Appreciation week activities
- Talent Show
- Employee Block Party
- Night Shift Recognition

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 BERG 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

VII. Strengthening Academics, Research, and Innovation to Drive Organizational Excellence

Academics and research play a critical role in elevating hospital performance because they drive continuous learning, innovation, and evidence-based practice. When a hospital actively engages in research and scholarly activity, it strengthens clinical decision-making, accelerates quality improvement, and positions the organization as a leader in advancing patient care. A strong academic and research culture also attracts high-caliber clinicians, supports staff development, and fosters an environment where new ideas translate into measurable improvements in safety, outcomes, and operational excellence.

The Quality Management Department supports this strategic priority by equipping teams with the QI tools and data necessary to conduct meaningful research and high-impact clinical improvement projects. Through data-driven analysis, research development, training, and organization-wide dissemination of best practices, the department ensures that academic inquiry directly enhances clinical quality and patient outcomes. Key initiatives include:

- Supporting data collection and analysis for research purposes across the organization.
- Establishing an infrastructure for Health Services Research to support the publication of high-value QI projects in national quality journals and conferences.
- Leveraging experiential learning—including simulation—to strengthen patient safety concepts and skills.
- Participating in national quality and safety conferences and professional training programs.
- Encouraging staff to pursue advanced education and training in quality improvement and patient safety, including recognized certifications such as CPHQ, Lean, and Six Sigma Green or Black Belt.
- Maximizing the use of the Vizient Clinical Data Base (CDB) to drive data-informed QI projects and research.
- Hosting a Safety and Quality Day Symposium with subject-matter expert speakers and staff poster presentations that showcase quality and safety improvement initiatives.
- Maintaining a comprehensive QI Library that provides frameworks, tools, and training materials—including presentations and videos—covering data analysis, process analysis, team management, and project management methods. These resources are available to all Maimonides staff through the Quality Management SharePoint site.

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 Performance 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:

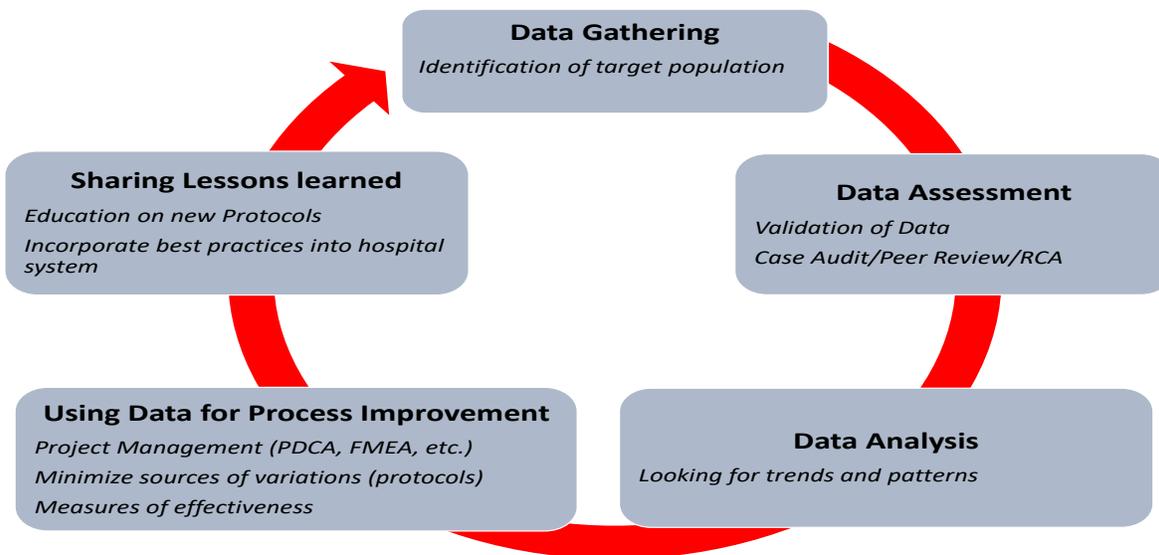
- Medication Management and significant Medication Errors
- Adverse Drug Reactions
- Blood, Blood Product Use, Transfusion Reactions
- Restraint use
- Fall rates
- Rapid Response and Resuscitation outcomes
- Infection Control and Hospital Acquired Infections
- Antimicrobial Stewardship
- Mortality and 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 Post-op 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, NSQIP, STS, ACS, TQIP, VQI, LVAD and others). These data-driven and outcomes-based programs afford the opportunity for benchmarking with other facilities.

Quality/Process Improvement Data Cycle



No Harm Dashboard

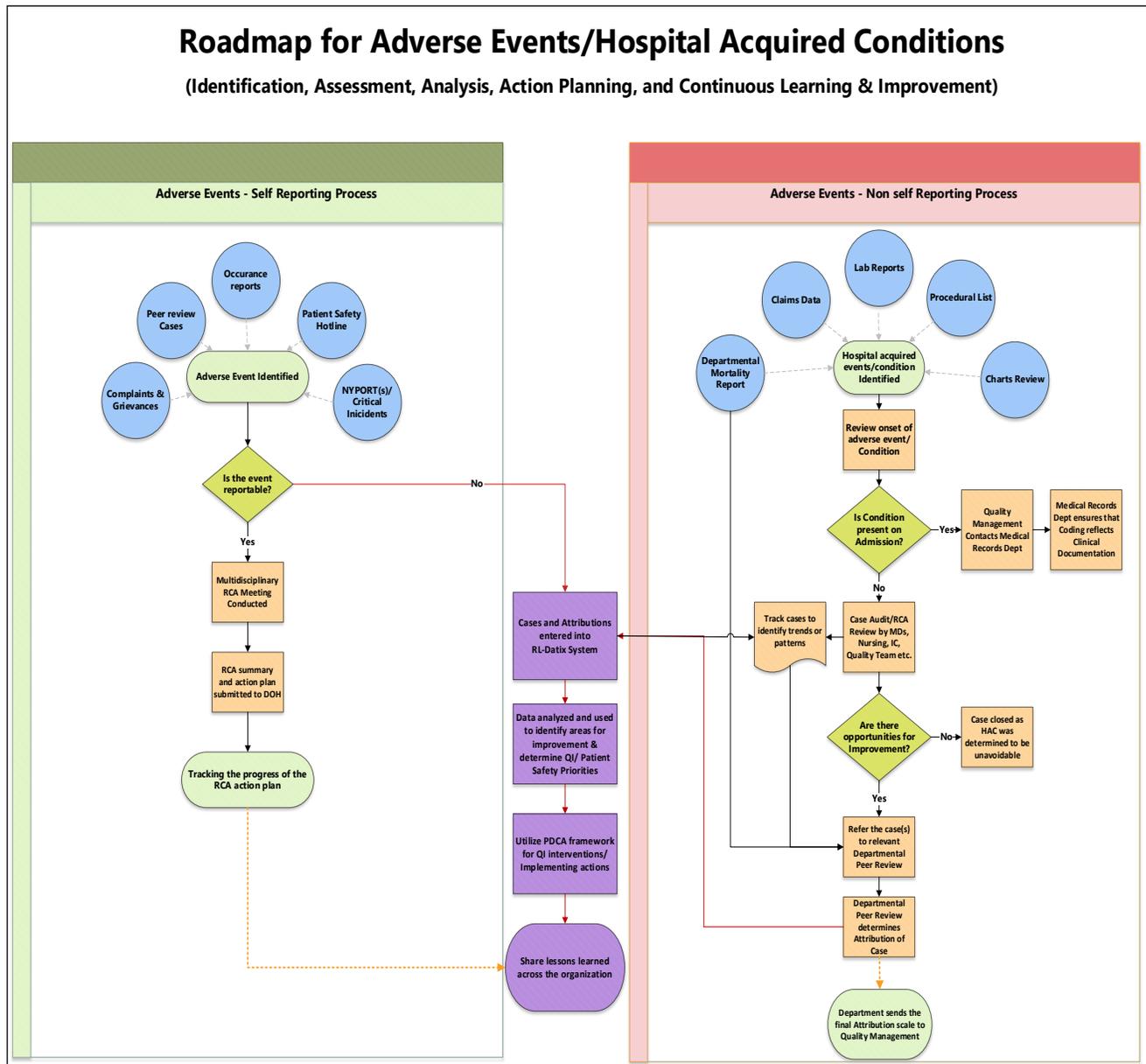
MMC has a data driven process for identifying and acting upon areas of concern with regard to CMS Hospital Acquired Conditions (HACs). The No Harm Dashboard was created to be able to capture the HACs in a timely fashion before the data become public. The main data sources are chart reviews and claims 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

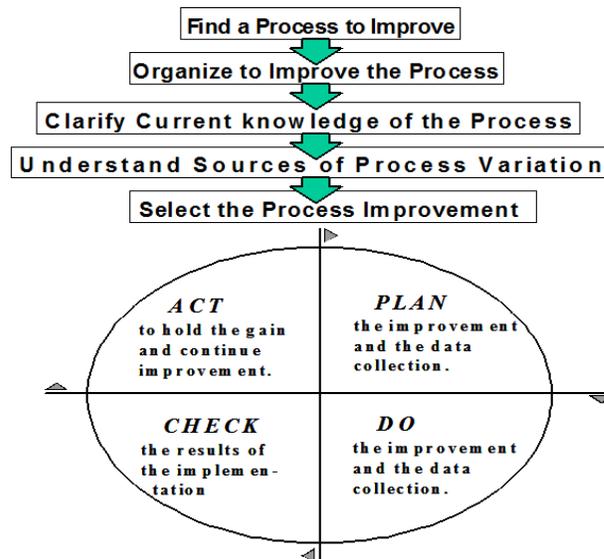
or existing high-risk processes. At least one new FMEA analysis is completed every 18 months as per Joint Commission requirements.

▪ **PROCESS IMPROVEMENT METHODOLOGY AND FRAMEWORK**

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) or **LEAN model**. 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 Director 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 Performance Goals (NPGs)**

All requirements related to the Joint Commission National Performance Goals are put in place. When a new NPG (formerly known as a National Patient Safety Goal) 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 Director monitors NPG compliance on a monthly basis and reports the data semiannually to the House-wide Quality Improvement/Patient Safety Committee. The purpose of the NPGs is to improve patient safety. The goals focus on:

1. The hospital ensures that the correct patient receives the correct care at the correct time.
2. The governing body and leadership team foster a culture of safety.
3. The hospital has an emergency management program.
4. The hospital prioritizes health care equity and excellent health outcomes for all
5. The hospital prioritizes infection prevention and control.
6. The hospital prioritizes pain management and safe prescribing practices.
7. The hospital respects the patient's right to safe, informed care.
8. The hospital reduces the risk for suicide.
9. The hospital develops and implements safe transplant practices.
10. The hospital performs waived testing in a safe and consistent manner.
11. The hospital maintains workplace and patient safety.
12. The hospital is staffed to meet the needs of the patients it serves, and staff are competent to provide safe, quality care.
13. The hospital safely performs imaging services.
14. The hospital has a medication management program that focuses on safety.

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. Departments are expected to use the hospital- based Peer/Event Review Attribution Template which is digitally translated in RLDatix

❖ **Incident, Clinical Event, and Critical Incident/RCA Reviews**

Departments monitor and track trends from Peer/Event Reviews based on the institution "Peer/Event Review Attribution Template" c/w their semiannual QI reporting schedule. Any cases with identified systems hazards categorized with High-Risk Safety Assessment Codes will be summarized as part of the semiannual report with an action plan and measure of success.

The above-described process for tracking and trending departmental incident reports in RLDatix will mirror the described Peer/Event Reviews process (i.e. identify systems issues, assess SAC, and identify Action Plans as appropriate. Similarly, hospital wide/multidisciplinary critical incident and RCA

reviews with identified systems issues should have an action plan that is summarized in their semiannual QI reports.

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

The Risk Management Department tracks the following indicators on a monthly basis:

- **Number of Alerts:** An alert is defined as a potentially compensable event identified to the medical malpractice and liability insurance carrier.
- **Fact Finding Meetings:** A fact finding meeting, also known as a critical incident review, is a forum with pertinent staff to discuss the course of a patient's care which led to a near-miss or adverse outcome. The meeting is co-chaired by the Vice President of Risk Management and the Chief Medical Officer or his designee, and includes staff from the Department of Risk Management and Quality Management.
- **DOH On-Site Visits:** NYS Department of Health visits to the facility in response to an investigation or other cause for an investigation.
- **NYPORTS – 900 series:** Events which require a Root Cause Analysis
- **Summonses:** A summons is an official notice of the initiation of litigation.
- **Medical Malpractice:** Actions regarding the care and treatment of a patient

- General Liability: Actions concerning property, accidents and other losses attributable to the facility
- **OPMC Subpoenas:** Office of Professional Medical Conduct (physicians and physician assistants only) request for information
- **OPD Subpoenas:** Office of Professional Discipline (nursing and other licensed professionals) requests for information
- **RL Datix Risk Reports:** All unusual patient events are documented in RL Datix.
- Patient Falls w/injury # of Reports identifying patient falls with any type of injury
- **Complaints/Grievances:** # of each category received

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.

INFECTION CONTROL

The Infection Control department interfaces with all clinical and nonclinical departments throughout the institution including the Division of Infectious Diseases and the Department of Quality Management. Customers of the Infection Control department include all patients, visitors, and the hospital staff. Infection Control Practitioners perform consultative and surveillance activities for areas throughout the organization including ambulatory sites. The clinical staff provides patients with infection control education specific to their needs. Infection Control staff provide education for patients when requested by the clinical staff. Outcome surveillance data are compared to internal outcomes as well as, NYSDOH and CMS national data for performance benchmarking and are presented to our staff at various forums, including the Infection Control Committee, House-wide Quality Improvement Committee, Quality and Safety Steering Committee, Executive Medical Council and Board of Trustees.

The Infection Control department’s primary purpose is to improve healthcare services by minimizing (with the aim of eliminating) the spread of infection to patients, employees and visitors. This effort is an integral part of the organizational strategies intended to facilitate patient-focused and centered-care, fiscal viability, a supportive environment for physicians and staff, and an improved patient experience through patient safety. In addition to surveillance data collection the department collaborates with other departments to improve the environment of care such as Environmental Services in conducting EOC rounds and Design and Construction by performing Infection Control Risk Assessments prior to beginning new construction projects.

MEDICATION MANGEMNET AND SAFETY

Medication Management standards at Maimonides provide responsible medication-related care that ensures that medications are used safely, effectively and efficiently for the purpose of achieving definite outcomes that improve a patient’s quality of life. The medication use process addresses patient-specific drug dosing regimens based on the pharmacokinetic and pharmacological characteristics of the drugs used, the objectives of drug therapy, and the most effective method of utilizing professional resources. Physicians, pharmacists, nurses, and other health care providers engaged in the medication use process work in

collaboration to provide safe and effective medication therapy and education across the continuum of care.

- Medication use processes are organized and systematized throughout the hospital
- Policy and procedures support safe medication prescription and ordering including adhering to applicable laws, regulations, licensure and standards of practice
- Preparation and dispensing of medications are properly controlled
- Monitoring for effects of medications is conducted as per policy
- Medication reconciliation is conducted as per policy

In keeping with the Medical Center's strategic priorities, the Pharmacy's new quality improvement initiatives for 2026 – 2027 include:

- Antithrombotic Stewardship Program
- Glycemic Management Support
- Improving Compliance with Smart Pump Technology Across the Medical Center
- Expansion of Pharmacy Services Related to Compounded Products for Pediatric Patients
- Antimicrobial Stewardship

INFORMATION MANAGEMENT AND TECHNOLOGY

The mission of Management Information Services (MIS) Department is to support the delivery of healthcare and organizational operations by providing information to improve patient outcomes and hospital quality. To achieve this the following processes must be performed effectively and efficiently:

- Design, implement and provide the necessary technical infrastructure and communication systems that support all users.
- Design and implement technology and applications to meet clinical, financial, administrative and regulatory imperatives across the continuum of Maimonides Medical Center (MMC), Maimonides Midwood Community Hospital (MMCH) and the multiple communities we serve.
- Define, capture and transform data into actionable information and knowledge using clinical analytics and business intelligence tools.
- Provide capability for the clinical leadership to promote best clinical practice using electronic health records (EHR) and clinical decision support tools.
- Provide MMC leadership and management with business intelligence and reporting tools to assist in decision-making.
- Continue to advance the interoperability of systems including those within MMC, MMCH, affiliated physicians and organizations, health information exchanges (HIE) and governmental agencies.
- Ensure the privacy, integrity and security of all data and information.

The above processes are achieved through the collaboration with leadership, providers and employees in various forums and committees.

Maimonides Health has launched an Epic implementation project in partnership with NYC Health and Hospitals that is planned to take 15-17 months to complete. This initiative will replace the multitude of Maimonides Health EHR's and Revenue Cycle systems with a single unified EHR and patient record supported by an integrated revenue cycle solution. Epic will dynamically improve the access to comprehensive information on our patients and streamline the care delivery process for our physicians and nurses.

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 Associate DIO for Quality Improvement and Patient Safety. 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 2025-2026 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

To ensure oversight of the transitions in care process and enhance the standardized use of I-PASS across all disciplines, both inter and intra-departmentally, the "I-PASS Point Prevalence Study" has been implemented. In this MMC-CIR joint quality project, with continued collaboration with the I-PASS Patient Safety Institute, patient hand-offs given by residents will be observed on a quarterly basis. Focused PDCA cycles based on our findings will be conducted and reported back to each department so that necessary interventions may be made prior to subsequent observation sessions.



Illness Severity

Stable, "Watcher," Unstable



Patient Summary

Summary statement; events leading up to admission; hospital course; ongoing assessment; plan



Action List

To do list; timeline and ownership



Situation Awareness & Contingency Planning

Know what's going on; plan for what might happen



Synthesis by Receiver

Receiver summarizes what was heard; asks questions; restates key action/to do items

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.

AMBULATORY HEALTH SERVICES NETWORK (AHSN)

The Department of Ambulatory Health Services Network develops the Ambulatory Health Services Network QI Program and Plan in close collaboration with, but not exclusively with, the Departments of Pediatrics, OB/GYN, Medicine, and Psychiatry, and reports QI activities to the MMC House-wide Quality Improvement and Patient Safety Committee on a biannual (twice a year) basis. The Senior Vice President for Ambulatory Care and Ambulatory Care service line and the Medical Directors are responsible for the Ambulatory Health Services Network Quality Improvement Program. All interdisciplinary members of the Ambulatory Health Services Network participate in quality improvement activities. Communication related to these activities is accomplished during the monthly Ambulatory Health Services Network QI Committee meetings, which supplement the MMC QI Plan.

The scope of the Ambulatory Health Services Network QI Program activities will encompass comprehensive monitoring and evaluation of both primary medical and subspecialty ambulatory care services provided by the Ambulatory Health Services Network through its clinics and off-site centers including: Adult Primary Care at 57th St.; Pediatric Primary Care at 57th St; Adult and Pediatric Care at Newkirk Avenue; Adult and Pediatric Care at 7th Avenue; and OPD. Telehealth services in the AHSN is offered on an emergency only basis. An interdisciplinary staff provides services to an ethnically and culturally diverse community of Brooklyn residents, from newborns to the elderly.

The Ambulatory Health Services Network 2026-2027 strategic QI priorities to support MMC priority objectives are as follows:

- Improve screening and documentation for breast cancer.
- Improve rate and documentation for Child and adolescent well visits.
- Improve screening and documentation of diabetes control.
- Improve screening of and documentation of blood pressure control.
- Improve screening and documentation for colon cancer.
- Improve cycle time in pediatric clinic.

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: 1/22/2020

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



Date: 1/22/2020