The STEEEP Climb To Quality for AHS: A Primer

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“Quality is Job 1”

Quality is Job 1.

Ford Motor Company

Ford

Quality is Job 1.

Quality is Job 1

"Smoothing these welds makes the trim fit properly."

Ford

Quality is Job 1.

FORD · LINCOLN · MERCURY
FORD TRUCKS · FORD TRACTORS

For 6 years running...
1986,'85,'84,'83,'82,'81,
Ford has designed
and built
the highest quality
American cars and trucks.
No other company can
make this statement.

Ford

Quality is Job 1.

Quality is Job 1.

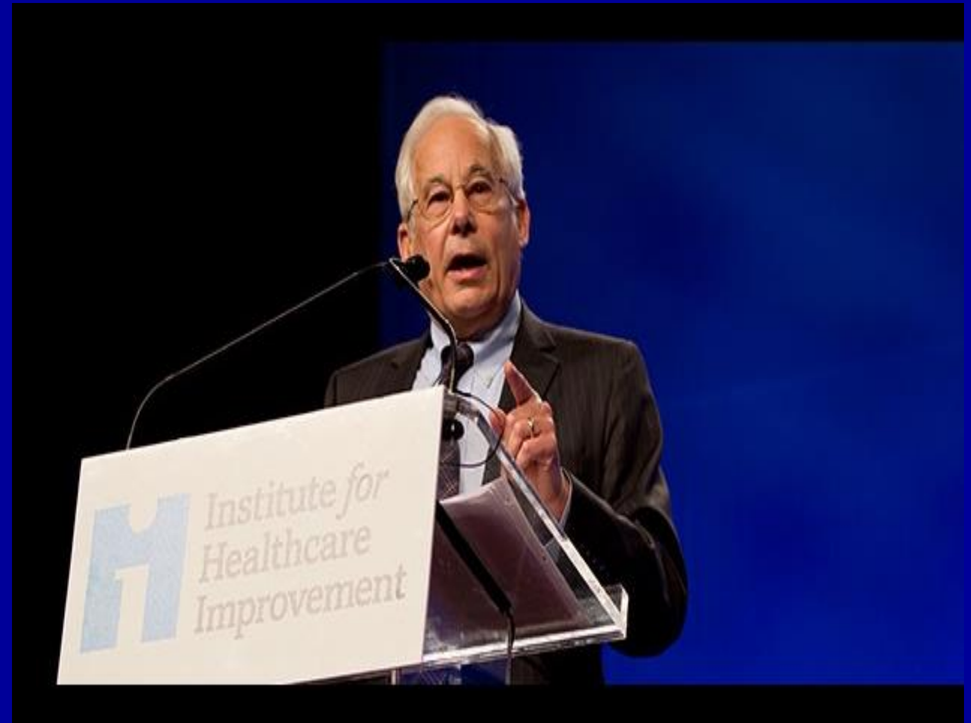
Profile in Quality #19:
Continued Recognition.

Ford, Mercury, Lincoln, Ford Trucks.
Our goal is to build the highest quality cars and trucks in the world.

Main, Jeremy. <u>Quality Wars: The Triumphs and Defeats of American Business</u>. 2007.

Defining the Dimensions of Healthcare Quality: STEEEP

- Safety
- Timeliness
- Effectiveness
- Efficiency
- Equity



Don Berwick, MD, MPP

- Patient(or People???)-Centeredness

Institute of Medicine. Crossing the quality chasm. A new health system for the 21st century. National Academy Press. 2001.
Berwick, Donald. Defining quality: aiming for a better health system. Insitute for Healthcare Improvement. Video.

Do We Do Quality Like This At AHS?

12 TNM Quality Related Metrics: 2019-20

AHS Pillar	Metric	SBU	STEEEP Domains
Access	Clinic cycle time - PC	Ambulatory	Time, Efficient, PC
Access	Clinic cycle time - Specialty	Ambulatory	Time, Efficient, PC
Access	Obs:Expected LOS	Acute	Time, Efficient, Effect
Access	Admit order to bed- HGH	Acute	Time, Efficient, PC
Access	Avoidable Days	Acute	Efficient
Quality	PRIME on target	Ambulatory	Effect, Equitable
Quality	QIP on target	Ambulatory	Effective, Equitable
Quality	All cause 30 day readmit	Acute	Effective
Quality	HospAcquired infxn index	Acute	Safe
Quality	HospAcquired harms index	Acute	Safe
Experience	HCAHPS hospital	Acute	Patient Centered
Experience	CGCAHPS provider	Ambulatory	Patient Centered

The 6 Pillars = Access, Quality, Experience, Network, Sustainability, Workforce

Quality Should Flow Up/Down/ Sideways

AHS Board of Trustees (BOT)

AHS BOT: QPSC

Admin Exec Leadership
(CEO, COO, CMO, CAOs)

Clinical Leadership
(MECs, Nursing)

Admin Quality Infrastructure
(VP Quality, Compliance, Regulatory, Patient Affairs)

Clinical Quality Infrastructure
(QRCs, IPPC, QC, Depts/Div)

Patients & Providers

Why We Have A Chance To Be Successful

What Can WE Do?

- 1) Help grow a “STEEEP” culture at AHS.
  - Unit – Department – Hospital – System - BOT
  - STEEEP language. STEEEP dashboards.
- 2) Embed Quality considerations in ALL decisions.
  - Standardize this as process.
  - Adopt the mindset that you are creating a system where you would want to receive care.
- 3) Effectively engage the existing infrastructure towards positive change.

Wouldn't It Be Nice?

Quality is Job 1.

Harm Classification System

- A: No error, capacity to cause error.
- B: Error that did not reach the patient.
- C: Error that reached the patient but unlikely to cause harm (omissions considered to reach patient). Ex: Multivitamin not ordered on admission.
- D: Error that reached the patient and could have necessitated monitoring and/or intervention to preclude harm. Ex: Regular release metoprolol was ordered instead of extended release.
- E: Error that could have caused temporary harm. Ex: BP meds were inadvertently omitted from orders.
- F: Error that could have caused temporary harm requiring initial or prolonged hospitalization. Ex: Anticoagulant was ordered daily when patient takes it every other day.
- G: Error that could have resulted in permanent harm. Ex: Immunosuppression medication was unintentionally ordered at ¼ dose.
- H: Error that could have necessitated intervention to sustain life. Ex: Anticonvulsant meds were inadvertently omitted.
- I: Error that could have resulted in death. Ex: Beta blocker was not ordered post-operatively.

What Is A “Never Event”

29 “serious reportable events” in 7 categories

Surgical Events:

• Surgery/invasive procedure performed on the wrong body part
• Surgery/invasive procedure performed on the wrong patient
• Wrong surgical/ invasive procedure performed on a patient
• Unintended retention of a foreign object in a patient after surgery or other procedure
• Intraoperative or immediately post-op/post-procedure death in an ASA 1 patient.

Patient Protection Events:

• Discharge/release of a patient/resident of any age who is unable to make decisions to other than an authorized person
• Patient death/serious disability associated with patient elopement
• Patient suicide, attempted suicide, or self-harm resulting in serious disability while being cared for in a health care facility

Environmental Events:

• Patient/ staff death or serious disability assoc w electric shock
• Any incident in which a line designated for O2 or other gas to be delivered to a patient contains no gas or wrong gas or contaminated toxic substances
• Patient/staff death or serious injury assoc with a burn from any source in the course of patient care
•Patient death/ serious injury assoc with the use of restraints or bedrails while being cared for in a health care setting

Radiologic Events:

• Death/serious injury of patient/staff associated with introduction of a metallic object into the MRI area

Care Mgmt Events:

• Patient death/serious injury assoc with medication error
• Patient death/serious injury assoc with unsafe admin blood products
• Maternal death/serious injury of a neonate assoc with labor or delivery in a low risk pregnancy
• Death/serious injury of a neonate associated with a fall
• Artificial insemination with the wrong donor sperm or wrong egg
• Patient death/ serious injury associated with a fall while being cared for
• Any stage 3/4/ unstageable pressure ulcers acquired after admission
• Patient death/serious disability resulting from irretrievable loss of an irreplacable biological specimen
• Patient death/ serious injury resulting from failure to followup or communicate lab, path or radiology result

Product or Device Events:

• Patient death/serious injury assoc with the use of contaminated drugs or devices provided by a health care setting
• Patient death/serious injury associated with the use or function of a device in patient care in which the device is used for functions other than as intended
• Patient death/serious injury associated with intravascular air embolism that occurs while being cared for i

Criminal Events:

• Any instance of care ordered or provided by an impersonator
•Abduction of a patient/resident of any age
•Sexual abuse/ assault on a patient within or on the grounds of a health care setting
• Death/ significant injury of a patient/staff resulting from physical assault that occurs on the grounds of a health care setting

Source: National Quality Forum. List of Serious Reportable Events. https://psnet.ahrq.gov/primers/primer/3