Minutes of the meeting of the Quality and Patient Safety Committee of the Board of Directors of the Cook County Health and Hospitals System held Wednesday, December 11, 2013 at the hour of 8:30 A.M. at 1900 W. Polk Street, in the Second Floor Conference Room, Chicago, Illinois.

I. Attendance/Call to Order

Chairman Collens called the meeting to order.

Present: Chairman Lewis M. Collens and Director Luis Muñoz, MD, MPH (2)

                         Director M. Hill Hammock
Present
Telephonically: Director Wayne M. Lerner, DPH, FACHE (1)

Absent: None (0)

Chairman Collens stated that Director Lerner was unable to be physically present, but was able to participate in the meeting telephonically.

> Chairman Collens, seconded by Director Muñoz, moved to allow Director Lerner to participate as a voting member for this meeting telephonically. THE MOTION CARRIED UNANIMOUSLY.

Director Lerner indicated his presence telephonically.

Additional attendees and/or presenters were:

Peter Daniels – Chief Operating Officer, Hospital-Based Services
Krishna Das, MD – System Director of Quality, Patient Safety, Regulatory and Accreditation
Jesus (Manny) Estrada – Cermak Health Services of Cook County
Randolph Johnston –System Associate General Counsel
Cindy Kienlen – Cermak Health Services of Cook County
Concetta Mennella, MD – Cermak Health Services of Cook County

Ram Raju, MD, MBA, FACS, FACHE – Chief Executive Officer
Elizabeth Reidy – System General Counsel
Deborah Santana – Secretary to the Board
John Jay Shannon, MD – Chief of Clinical Integration
Ozuru Ukoha, MD – John H. Stroger, Jr. Hospital of Cook County
Pierre Wakim, MD – Provident Hospital of Cook County

II. Public Speakers

Chairman Collens asked the Secretary to call upon the registered speakers.

The Secretary responded that there were none present.

III. Report from System Director of Quality, Patient Safety, Regulatory and Accreditation

A. Regulatory and Accreditation Updates
B. Publicly Reported Ratings

There were no updates to report regarding these matters at this time.

C. Update on patient and staff vaccinations for influenza

Dr. John Jay Shannon, Chief of Clinical Integration provided an update on the status of the influenza vaccinations for the 2013/2014 influenza season. This year's influenza vaccine became widely available for both CCHHS staff and patients in the first week of October 2013. With regard to vaccination of patients, he stated that there is not a single standard for reporting that is utilized industry-wide. At the System, what has been devised is a mechanism for following opportunities for vaccination of patients that takes into account the different areas where the patients enter the System, including the Emergency Department (ED), inpatient environment, and primary and specialty care areas. At the end of November, approximately 21% of potential patients had been vaccinated across all of those different encounters – there were a lower proportion of patients being vaccinated in the ED milieu, and a far higher proportion of patients being vaccinated in the primary care milieu. Overall performance, as of the end of November, is that approximately 23-24% of potential patient encounters resulted in an influenza vaccination.

Chairman Collens inquired regarding the total number of patients that were offered the vaccination. Dr. Shannon responded that that question is one of the issues on which staff is working. One of the activities for this year is to create standardized standing orders - this is an order that can be signed off by the medical director for an area that does not require a conscious act at every encounter in those different areas. There are standing orders in certain parts of the organization, but not across the board. Creating standardized standing orders is a joint effort of staff from the Quality, Nursing, and Information Technology departments.

With regard to the subject of influenza vaccinations of staff, Dr. Shannon stated that there has been a growing movement for the expectation of health care workers to be vaccinated in the influenza season; however, it has not yet reached the level of being a regulation of the federal or state government. He noted that trends are being seen in that direction, both at the national and local levels, but currently, the recommendations for seasonal influenza vaccination are mostly just strong recommendations, not a legal requirement. He stated that, currently, influenza vaccination is not a condition of employment that has been put into the System's collective bargaining agreements; however, he noted that the administration signed a policy in 2012 that clarifies that it is the expectation that personnel employed by CCHHS receive influenza vaccination.

Dr. Shannon stated that, historically, the high point of staff vaccination performance for this organization was in 2009; this was when the H1N1 outbreak occurred. CCHHS had documentation of vaccination for over 5,000 employees that year; that was against a background of some 7,200 total budgeted full-time equivalent employees (FTEs) that year. The staff vaccination performance has declined in the years since then – from the first week of October to the last week of November (the reporting period beginning with when the vaccine first became available), the administration has documented vaccination for over 3,000 (roughly 50%) of the employees across the organization. The majority of those vaccinations were provided by CCHHS; there is also a procedure that allows staff to come in with documentation reflecting that they received the vaccination elsewhere. Dr. Shannon stated that, because CCHHS does not have a sophisticated employee management system or employee health application, the administration relies largely on a

III. **Report from System Director of Quality, Patient Safety, Regulatory and Accreditation**

    C. **Update on patient and staff vaccinations for influenza (continued)**

paper-based system and manual entry into a database maintained by Employee Health Services; data is fed back to the departmental level – the information contains performance at a proportion level, not at the individual staff level. The employee is to bring documentation of vaccination to their manager, and the accountability resides at the local manager level. Dr. Shannon pointed out two areas that have achieved over 90% performance – the Pharmacy Department and the Ruth M. Rothstein CORE Center of Cook County.

Dr. Shannon stated that, moving forward, the administration would like to put more accountability in place, with improvements in both the tracking of employees and around the opportunities for vaccinating patients. Additionally, in the upcoming year, he indicated that the administration will be bringing the seasonal influenza vaccination requirement to the bargaining table to make it a condition of employment. He stated that he cannot predict how that negotiation will go, but that will be the stance the administration is taking.

Chairman Collens expressed his concerns regarding the low rates of seasonal influenza vaccinations of staff; he believed that the hospital's position is that this is a medically necessary and required vaccination in order to protect the safety of the patients. Elizabeth Reidy, System General Counsel, stated that staff are currently reviewing the question of whether there is actually a duty to bargain. This is an evolving area of case law; there are states that are currently litigating it. She stated that the administration would like to further review the issue and return with a response[1].

Following discussion, Dr. Shannon stated that evidence has shown that the seasonal influenza vaccine improves safety for patients, improves safety for the person who gets vaccinated, reduces absenteeism and improves community health; it is also a safety measure for the family members of the person who gets vaccinated.

    D. **Report on Cermak Health Services** (Attachment #1)

Peter Daniels, Chief Operating Officer for Hospital-Based Services, provided a brief introduction to the item. The following individuals from Cermak Health Services of Cook County reviewed the presentation and overview of Cermak Health Services: Dr. Concetta Mennella – Interim Chief Medical Officer; Jesus (Manny) Estrada – Interim Chief Operating Officer; and Cindy Kienlen – Chief Nursing Officer.

The presentation included information on the following subjects: Mission Statement; Overview of Services; Cermak at the Juvenile Temporary Detention Center (JTDC); Trends; Activity; Residential Treatment Unit; Nursing Care; Pharmacy Services; Mental Health Services; Infection Control; Department of Justice – Agreed Order; Accomplishments and Areas of Improvement 2013; and Moving Forward – 2014 Goals. The Committee reviewed and discussed the information.

During the discussion of the information on the newly built Residential Treatment Unit, Director Hammock inquired regarding how the building was financed. Mr. Estrada indicated that the cost of the building was $90 million but was unsure as to the question regarding financing. Director Hammock noted that he will follow-up on the question with John Cookinham, System Chief Financial Officer.

IV. **Action Items**

A. **FY2014 Quality and Performance Improvement Plan** (Attachment #2)

This item was taken out of order.

Dr. Krishna Das, System Director of Quality, Patient Safety, Regulatory and Accreditation, reviewed the presentation regarding the proposed FY2014 Quality and Performance Improvement Plan.

The presentation contained information on the following subjects: Regulatory Framework; Hospital-Wide Quality Improvement and Patient Safety (HQuIPS) Committee; Governance-Reporting; Patient Safety; Sentinel and Adverse Events; Performance Improvement Requirements; Addressing High-Risk, High Volume Areas; EMS Committee Reports; Key Indicators-Inpatient, Outpatient, Nursing; Department Indicators; and Use of Data in Performance Improvement. The Committee reviewed and discussed the information.

Chairman Collens inquired whether the Committee will be seeing the chart in this form going forward, with an indication in each of the boxes. Dr. Das responded affirmatively. She stated that, although staff have been following the indicators, they have not been charting them in a graphical way that makes the direction of the activities very explicit.

Dr. Das noted that, on page sixteen of the presentation, she will need to submit a correction to the plan – the Trauma Department has an additional indicator of negative laparotomy rate, as well as an indicator for time to operating room for trauma cases.

Following the presentation, Chairman Collens stated that this is a very impressive start for a program of reporting to the Board. This plan underscores the commitment that everyone has to quality; he would expect that by communicating this commitment, not only within the hospital generally but also to patients, it might very well impact the score in patient satisfaction, as well.

> Director Lerner, seconded by Director Muñoz, moved to approve the proposed FY2014 Quality and Performance Improvement Plan. THE MOTION CARRIED UNANIMOUSLY.

B. **Minutes of the Quality and Patient Safety Committee Meeting, November 20, 2013**

This item was taken out of order.

> Director Muñoz, seconded by Director Lerner, moved to accept the Minutes of the Quality and Patient Safety Committee Meeting of November 20, 2013. THE MOTION CARRIED UNANIMOUSLY.

C. ****Medical Staff Appointments/Re-appointments/Changes** (Attachment #3)

This item was taken out of order.

IV. <u>**Action Items**</u>

C. **Medical Staff Appointments/Re-appointments/Changes (continued)

The Committee was informed of a revision to an initial appointment included on page one of the materials – the proposed period for the appointment of Dr. Salman Khan was changed from a two year appointment to a one year appointment.

> Director Muñoz, seconded by Director Lerner, moved to approve the Medical Staff Appointments/Reappointments/Changes, as amended. THE MOTION CARRIED UNANIMOUSLY.

D. Any items listed under Sections IV, V and VI

V. <u>**Recommendations, Discussion/Information Items**</u>
   A. Reports from the Medical Staff Executive Committees
      i. Provident Hospital of Cook County
      ii. John H. Stroger, Jr. Hospital of Cook County

Dr. Aaron Hamb, Medical Director of Provident Hospital of Cook County, indicated that there was no report to be provided at this time; he spoke on behalf of Dr. Pierre Wakim, President of the Executive Medical Staff (EMS) of Provident Hospital of Cook County.

Dr. Ozuru Ukoha, President of the EMS of John H. Stroger, Jr. Hospital of Cook County, presented his report. He stated that the EMS met the previous evening. At that meeting, Dr. Das presented the FY2014 Quality and Performance Improvement Plan; it was approved unanimously.

At last month's Quality and Patient Safety Committee meeting, Dr. Ukoha had said that in order for the medical staff to play its part in the system-wide attention to quality and patient safety, it would need to begin with a framework. This framework is being created through the remodeling of the hospital's quality committee. Changes to the Bylaws of the Medical Staff are being proposed to change the name, function, composition and duties of the hospital's committee, to ultimately be able to provide the information that the System Board will need going forward. The proposed revisions to the Bylaws will go to the medical staff at large for their approval; following that, they will be presented to the System Board for approval.

VI. <u>**Closed Session Items**</u>
   A. **Medical Staff Appointments/Re-appointments/Changes
   B. Litigation Matter(s)

The Committee did not recess the regular session and convene in closed session.

VII. <u>**Adjourn**</u>

As the agenda was exhausted, Chairman Collens declared that the meeting was ADJOURNED.

Respectfully submitted,
Quality and Patient Safety Committee of the
Board of Directors of the
Cook County Health and Hospitals System

<u>XXXXXXXXXXXXXXXXXXXXXX</u>
Lewis M. Collens, Chairman

Attest:

<u>XXXXXXXXXXXXXXXXXXXXXXX</u>
Deborah Santana, Secretary

---

[1] Follow-up: response regarding question of whether there is a duty to bargain relating to staff influenza vaccinations. Page 3.

ATTACHMENT #1

CERMAK HEALTH SERVICES
CORRECTIONAL HEALTH SERVICES AT
COOK COUNTY JAIL
AND THE
JUVENILE TEMPORARY DETENTION CENTER

CCHHS Board of Directors
Quality and Patient Safety Committee
December 11th, 2013

1

Mission Statement

- Provide constitutionally required quality, timely and cost efficient medical services in accordance with acceptable community standards, accreditation and regulatory requirements

- Early detection and prevention of communicable diseases

2

Overview of Services: Cermak

- Collective Responsibility: Cook County Sheriff, Department of Facilities Management, and Cermak Health Services
- Provided on 96 acre campus of Cook County Jail
- Current average daily population > 10,000
- 100,000+ intake screenings annually
  - 5% County Care participants enrolled during intake process
- Providing on-site care (173,000 combined visits annually)
  - Urgent care
  - Infirmary (not a hospital)
  - Primary care and specialty care clinics
  - Diagnostics
  - Pharmacy Services

3

Cermak at JTDC

- Average daily population = 295
- Medical, Nursing, Dental, Medical Observation Unit, Medication administration and Health Service Requests
- National Commission on Correctional Healthcare accreditation since December 2012
- Work plan for 2014:
  - Governor Quinn signed House Bill HB2404 to include 17 year olds, projected increase in population by 30%.
  - Begin Electronic Medical Records Project
  - Consultation Room
  - Pharmacy services: blister packs

4

Cermak Health Services: trends

Intake Assessments
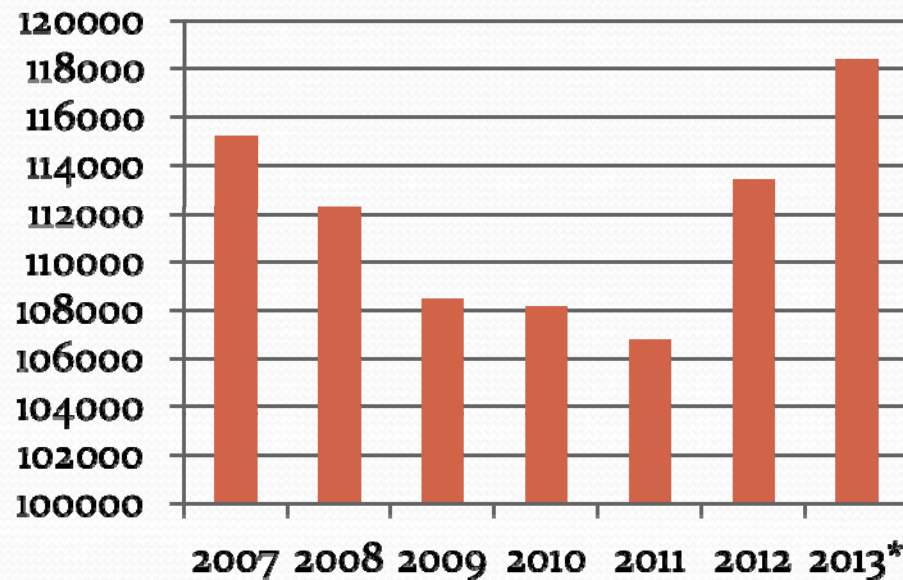
* 2013 clinic visits annualized

Figure 1: Average Daily Population (ADP) of the Cook County Jail

5
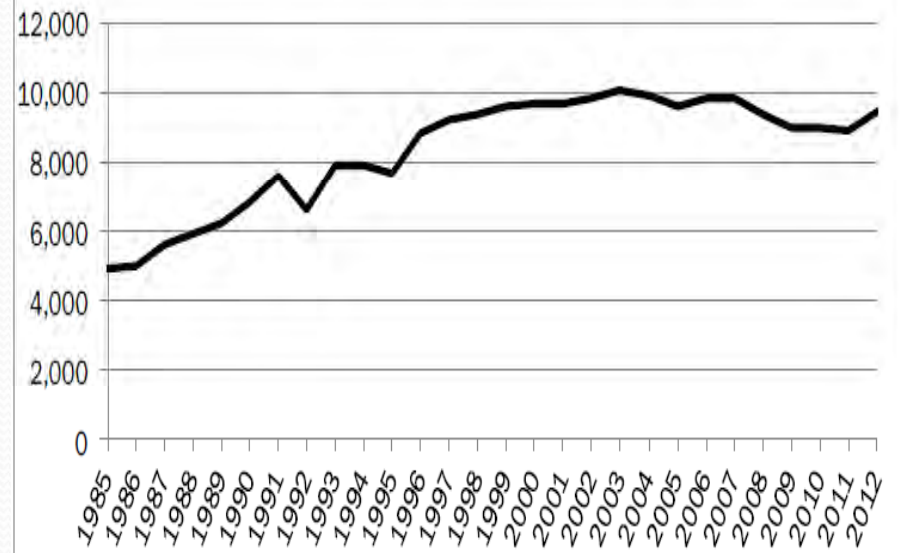
Activity

Year	Budgeted Expenses
2010	$41,278,000
2011	$41,238,000
2012	$40,080,000
2013	$40,700,000
2014	$46,600,000

Legend:
- Intake Screenings
- Clinic/Urgent Care Visits
- Infirmary Patient Days
- Average Inmate Census

6
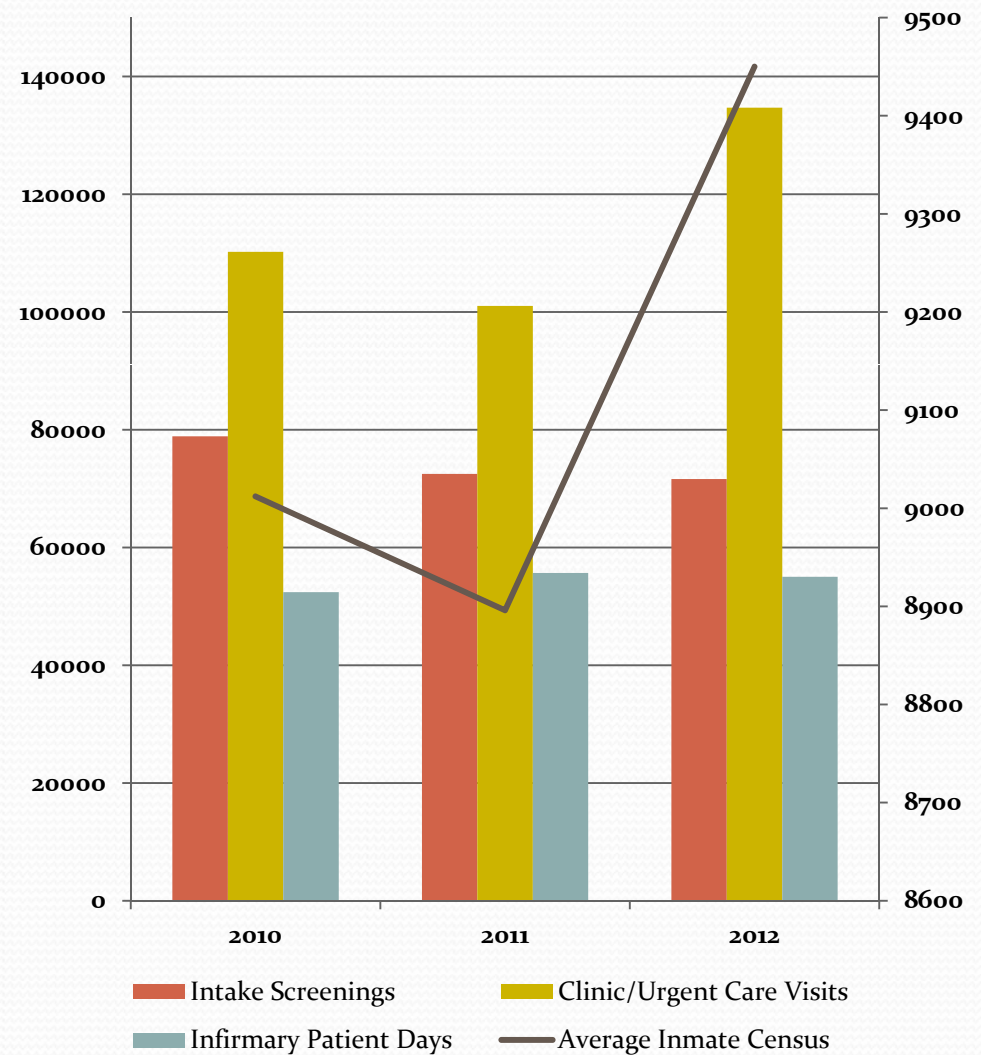
Activity (continued)

- Chronic Disease Management
- Opiate Withdrawal: approximately 550 inmates are treated monthly for withdrawal symptoms
- Methadone Program: An average of 98 inmates are registered in the Methadone Program monthly
- Varying levels of care
- Transfers
  - Average daily census of inmates at Stroger or outlying hospitals = 20
  - Average daily transport of inmates to Stroger Emergency Department = 5
  - Average daily transport of inmates to Specialty Care Clinic (Stroger, Core, Fantus) = 18

7

Residential Treatment Unit

- Access to 24/7 Nursing (Intermediate Care)
- Dose by Dose Medication
- Adds 979 additional beds for Intermediate Levels of care
  - Male: 274 medical, 274 mental health, 157 detox
  - Female: 274 medical and mental health
- Intake Screening and Medical/Mental Health Assessments

8

Nursing Care

- Access to Health Care
  - Process 6500+ Health Service Requests Monthly
  - Inmates must be seen by a nurse for all symptom based complaints within 48 hours of receipt of health service request form
  - >60% will require additional medical, dental, or mental health intervention
- Daily Bed Control (130 weekly interventions)
  - Increases patient safety
  - Housing movement based on medical and mental health orders for transfer in and out of infirmary or other housing need
  - Additionally, incorrectly housed inmates identified by nursing using a query based on medical and mental health classification
  - Nursing coordinates with CCDOC transfer of these inmates to appropriate housing
- Medication Administration
  - On average, 50% or 5000 patients require medication
    - 1750 patients receive dose-by-dose medication administered by a nurse on the tier
    - 3000 patients self-administer a weekly supply of medications transported to the patient by the Medication Delivery Team

9

Pharmacy Services

- Prescription Volume
  - 630,000 New prescriptions annually
  - 5,781,000 Doses filled annually
- Distribution Methods
  - Nurse administered: daily = 7,750 doses
  - Detainee self-administered medication: number of prescriptions daily = 800
  - 31 Automated Dispensing Cabinets: number of doses dispensed monthly = 5800
- Other Services:
  - Opioid Treatment Program (Methadone)
  - Anticoagulation Clinics and monitoring

10

Mental Health Services

- 40% of females and 20% of males at intake have positive mental health findings

- Growing Mental Health Caseload: 2010 = 1100 patients, currently nearly 2000 out of 10,000

- Varying levels of care

Mental Health Services

Programming Hours Per Patient Per Week: Intermediate Care

Chart: # of Programming Hours

Department of Justice Target

	2011	2012	Jan-13	Feb-13	Mar-13	Apr-13	May-13	Jun-13	Jul-13	Aug-13	Sep-13
■ Series1	5	10.15	10.1	10.4	10.2	8.6	10.7	11.5	11.2	15.2	14.9

12
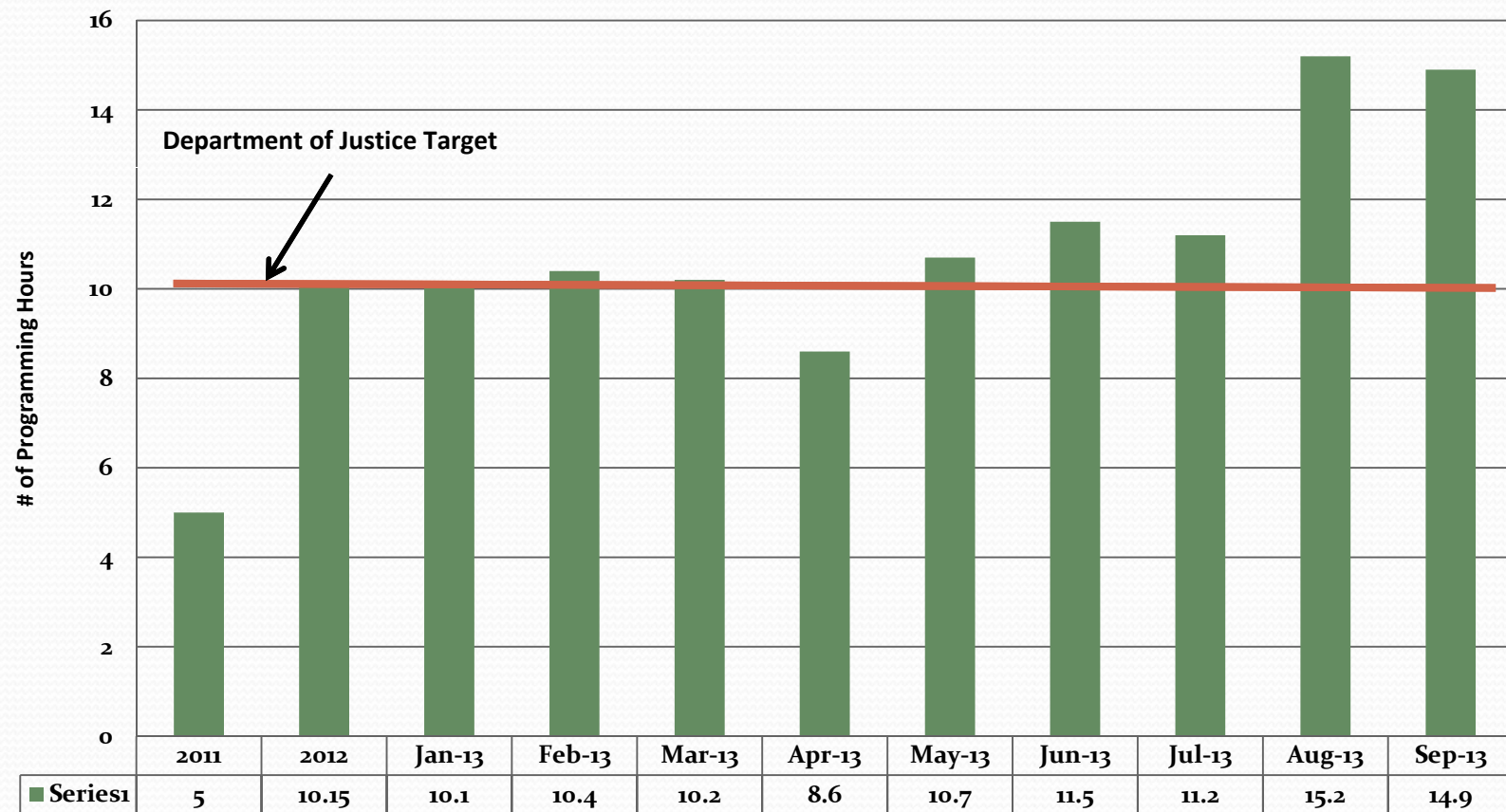
Infection Control

- Monitor jail compound for outbreaks of communicable diseases
- Conducts annual health maintenance for Tb screenings on an average of 250 detainees per month with 100% capture rate
- Provides 67 Infection Control training sessions annually, reaching >3,000 Cook County Department of Corrections Officers
- Activity:
  - Flu Shots Administered: 4,551 (January 2012 – March 2013)
  - Employee Annual Tb Screening 100% compliance reaching 650 employees
  - Ectoparasite assessments: 380 (January – August 2013)
  - Acute gastroenteritis and influenza-like illness assessments: 125 (January – August 2013)
  - Hepatitis B Vaccine Grant with CDPH: vaccinated 755 detainees since 07/15/2013

13

Department of Justice: Agreed Order

- Collective Responsibility: Cook County Sheriff, Department of Facilities Management, and Cermak Health Services
- Agreement signed 2010
- 48 separate provisions
- Medical Monitoring
  - 9 provisions are in Substantial Compliance
  - 12 provisions are in Partial Compliance
- Mental Health Monitoring
  - 1 provisions are in Compliance
  - 12 provisions are in Substantial Compliance
  - 24 provisions are in Partial Compliance

14

Accomplishments and Areas of Improvement 2013

- Medical:
  - Intake Screening
  - Medical Facilities
  - Staff, Training, Supervision and Leadership
  - Urgent Care
  - Record Keeping
  - Mortality Reviews
  - Access To Care
  - Acute Care Infirmary
  - Medication Administration Process

- Mental Health:
  - Intake Screenings
  - Programing hours increase
  - Timely and clinically appropriate treatment
  - 24/7 Psychiatric Coverage
  - Crisis Services
  - Suicide Prevention Policy and Committee
  - Suicide Risk Assessments and Precautions

15

Moving Forward: 2014 Goals

- Structures:
  - Operational implementation and staffing of the Residential Treatment Unit (Intermediate Medical/Mental Health Services)
- Processes:
  - Full implementation of Electronic Medication Administration Record
  - Decrease off site movement by securing specialized clinical services, i.e., Orthopedic Services
  - Population Health Management
- Outcomes:
  - Continued progress in achieving substantial compliance of the Department of Justice Agreed Order

16

ATTACHMENT #2

Quality Assessment and Improvement Plan FY 2014:
OVERVIEW

CCHHS Board of Directors

Quality and Patient Safety Committee

December 11th, 2013

1

Presentation Goals

- Provide the regulatory framework guiding the development of a quality plan
- Describe the structure and reporting responsibilities of quality committees
- Describe the requirements and details of the patient safety program, including specific indicators and targets
- Describe required quality reporting and priorities for performance improvement
- Discuss the preferred approach to data handling and clinical performance improvement

2

Regulatory Framework

CMS CoP: The hospital must develop, implement, and maintain an effective, ongoing, hospital-wide, data driven quality assessment and performance improvement program.

LD.01.03.01
The governing body is ultimately accountable for the safety and quality of care, treatment, and services.

MS.05.01.01
The organized medical staff has a leadership role in organization performance improvement activities to improve quality of care, treatment, and services and patient safety.

LD.04.04.01
Leaders establish priorities for performance improvement.

LD.04.04.05
The hospital has an organization-wide, integrated patient safety program within its performance improvement activities.

LD.03.01.01
Leaders create and maintain a culture of safety and quality throughout the hospital. 3

Hospital Wide Quality Improvement and Patient Safety (HQuIPS) Committee*
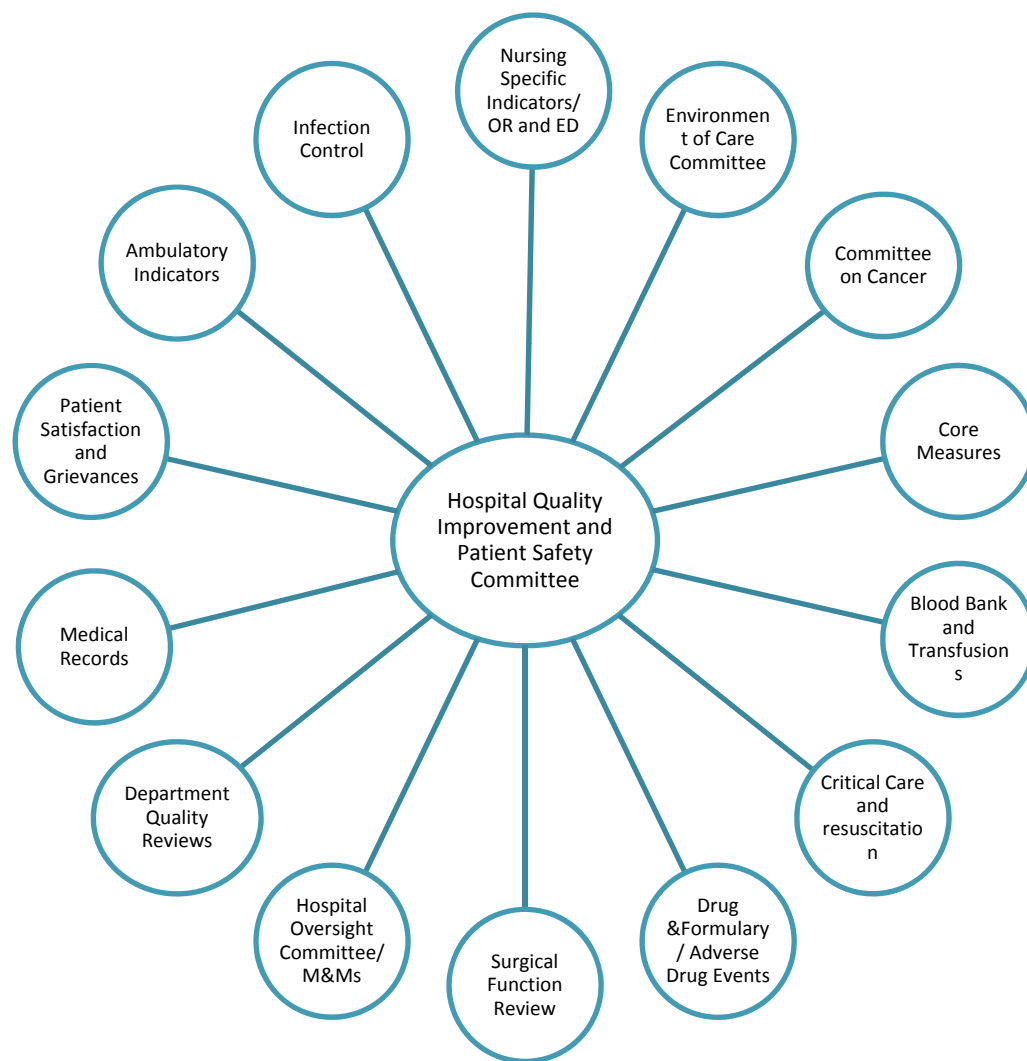
Representation:

Chair- appointed by EMS president + COO

Department Chairs

Key Administration
- Chief Nursing Officer
- Executive Medical Director
- COO
- Finance
- IT
- Quality

Ex Officio Members

Circle diagram with center "Hospital Quality Improvement and Patient Safety Committee" connected to: Nursing Specific Indicators/ OR and ED, Environment of Care Committee, Committee on Cancer, Core Measures, Blood Bank and Transfusions, Critical Care and resuscitation, Drug &Formulary / Adverse Drug Events, Surgical Function Review, Hospital Oversight Committee/ M&Ms, Department Quality Reviews, Medical Records, Patient Satisfaction and Grievances, Ambulatory Indicators, Infection Control

* For Stroger Hospital. Provident and ACHN committees have similar structure

4

Governance: Reporting
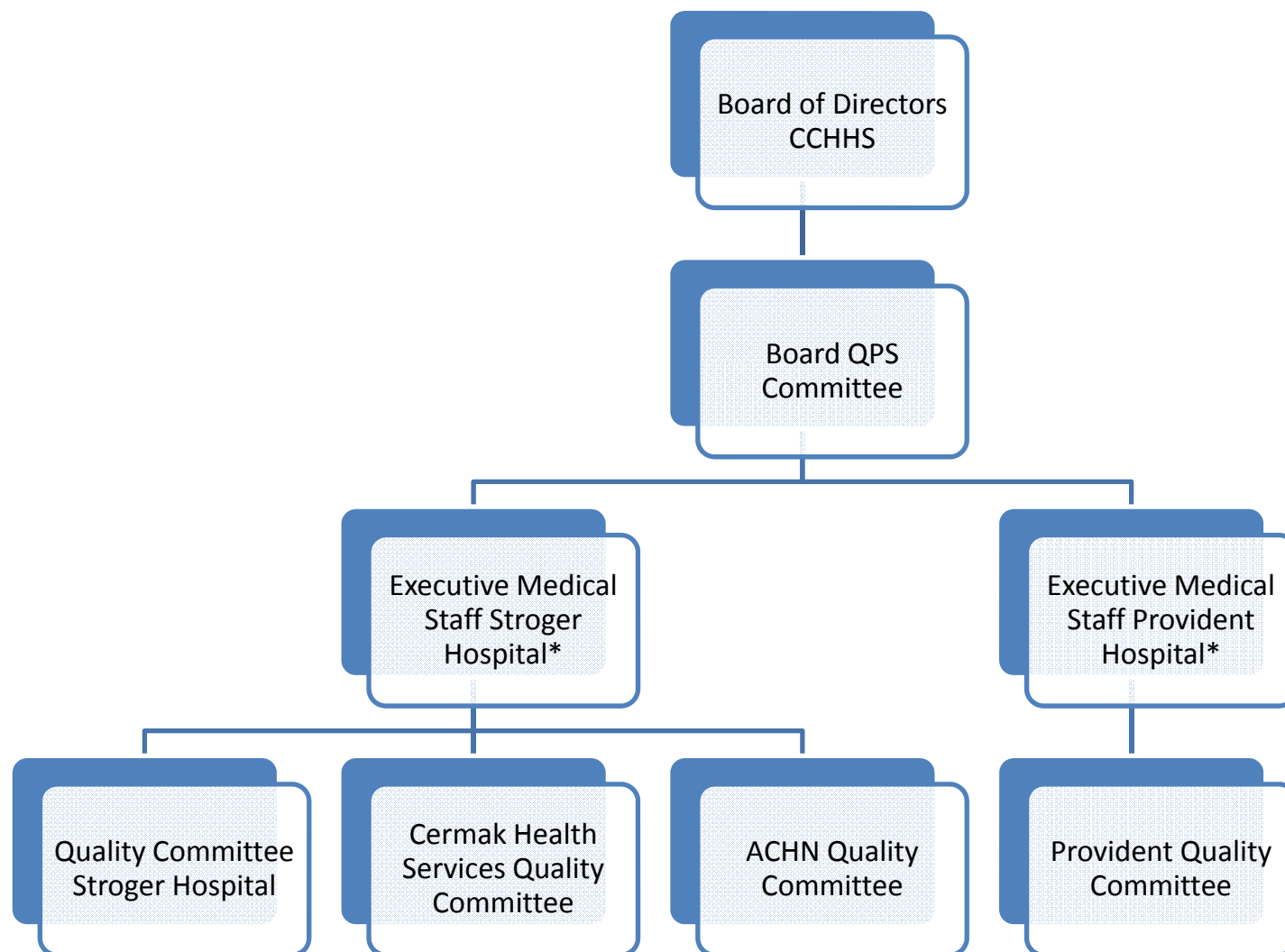
* Reporting may occur through the Chief Quality Officer, the Executive Medical Director, the Affiliate Chief Operating Officer, or directly by the President of the respective Medical Staff or their designees.

5

Patient Safety

- Address all adverse events and sentinel events in a thorough and systematic fashion
- Address high risk, high volume areas
- Safety priorities for 2014:
  - Discharge transitions
  - Procedural safety, particularly outside the OR
  - Medication safety; adverse drug reactions
  - Critical laboratory and pathology results, focusing on timely reporting of malignant pathology
- Responsibility is allocated to committees, departments and task forces
- Hospital must measure and improve culture of safety

6

Sentinel and Adverse Events

- All serious events will be referred immediately to the respective facility leadership and departmental oversight committees

- All sentinel events will have urgent (within 7 days) root cause analysis (RCA) using the approach outlined by the Joint Commission

- A 'just culture' algorithm will be utilized to determine accountability in cases of adverse outcomes

- Results are reported to the Hospital Quality Committee and the medical staff

- The oversight committee or RCA committee will direct performance improvement activities as required

- The oversight committees will make referrals to peer review committees as required

7

Performance Improvement Requirements
JOINT COMMISSION

- Operative procedures
- Discrepancies between preop and postop diagnoses
- Adverse events related to moderate or deep sedation
- Use of blood transfusions & transfusion reactions
- Results of resuscitation & response to changes in a patient's condition
- Behavior management/ restraint use
- Significant medication errors and adverse drug reactions
- Fall reduction activities
- Organ procurement conversion rate
- Patient perceptions of treatment
- Staff opinions, needs & perception of risk to individuals

8

Address High Risk, High Volume Areas

- Discharge Transitions
  - Medication reconciliation
  - Patient education
  - Post discharge appointments
- Procedural safety
  - Presedation assessment
  - Time outs
- Medication safety
  - Increase reporting of ADRs
  - Use of trigger tools for proactive identification of potential events
  - FMEA for medication administration process
- Reporting of malignant pathology
  - Monthly reporting of all malignant pathology and cytology
  - Feedback to clinicians

9

EMS Committee Reports
STROGER HOSPITAL

Committee	Indicators			Data Source	Reporting Frequency
Blood Bank & Transfusion	Transfusion Reactions	Red Cells -- Appropriate	Platelets -- Appropriate	Chart review	Biannually
Critical Care & Resuscitation	Ventilator complication rate	Restraint prevalence & complications	Resuscitation Results	Inf Control data Nursing review Chart review	Biannually
Drug Usage Evaluation	# ADRs reported monthly	Allergy alerts overridden by user	Drug-lab alerts overridden	Incident Reporting system; Cerner	Quarterly
Environment of Care	Fire Safety	Integrity Fire Doors	Hospital Environment	EOC rounds	Quarterly
Infection Control	CAUTI rate	CLABSI rate	Handwashing compliance	Infection control dept	Biannually
Medical Education	Medication reconciliation performed	Enunciate knowledge re DC safety	Satisfaction with doctors	Cerner HCAHPS Survey	Biannually
Medical Information	DC summary completed 30 days	Operative notes completed	Admission H&P signed 48 hours	Cerner reports	Quarterly
Operating Room	Intra-operative Deaths	Reoperation in 7 days	On time starts	Chart reviews Incident reports	Quarterly
Surgical Function Review	Discrepancies pre and post op diagnoses	% Malignant Path reported in 7 days	% PAP smears F/U in one month	Lab system reports	Quarterly

10

Key Indicators

- Hospitalwide indicators describe areas of focus for 2014
- Includes type and source of data, and baseline and target performance
- Reflects priorities:
  - Access to care
  - Quality of care
  - Patient satisfaction
- Will be reported quarterly to quality committees and the Board
- Full set of indicators is as reflected in CMS reporting requirements and described in the Quality Plan

11

Key Indicators: Inpatient Services

Indicator	Target Performance	Baseline Performance	Data Source	Reporting Interval
ED Registration to Discharge (outpatient)	240 minutes	347 minutes	Cerner Lighthouse	Quarterly
ED Registration to Inpatient (inpatients)	480 minutes	620 minutes	Cerner Lighthouse	Quarterly
Core Measures HF, MI, PN and SCIP*	100%	97%, 99%, 90%, 98%	Cerner Lighthouse	Quarterly
Patient Satisfaction: Recommend Hospital	71%	61%	HCAHPS	Quarterly

HF=heart failure, MI=myocardial infarction or heart attack, PN=pneumonia, SCIP=surgical care improvement program

12

Key Indicators: Outpatient

Indicator	Target Performance	Baseline Performance	Data Source	Reporting Interval
Ease of moving through the clinic 'good'	75%	63%	HCAHPS	Quarterly
Ease of reaching clinic on the phone 'good'	75%	59%	HCAHPS	Quarterly
Children with UTD immunization at 24 months	> 71%	68%	CMApp	Quarterly
Diabetics with A1C > 9%	< 29%	24%	CMApp	Quarterly

13

Key Indicators: Nursing

Indicator	Target Performance	Baseline Performance	Data Source	Reporting Interval
Communication with nurses 'good'	73%	63%	HCAHPS survey	Quarterly
Fall rate/ falls with injury	Decrease by 25%		Cerner/IView Chart review	Quarterly
Hospital acquired pressure ulcers	Decrease by 25%		Cerner/IView Chart review	Quarterly

14

Departmental Indicators

Department	Indicators	Data Source(s)	Frequency
Anesthesia	•SCIP measure: VTE prophylaxis •Handoff to PACU staff •Moderate sedation assessment and complications	Cerner Lighthouse Cerner IView Cerner Report	Quarterly
Emergency Med	•Left without being seen •Registration to provider (outpt) •Registration to decision to admit	Cerner Lighthouse	Quarterly
Family Med	•Heart Failure measure •Pneumonia measure •Med records- admission and DC completion	Cerner Lighthouse	Quarterly
Internal Med	•Heart Failure measure •Pneumonia measure •Med records- admission and DC completion	Cerner Lighthouse	Quarterly
Obstetrics/ Gynecology	•Caesarean section rate •Elective delivery 37-39 weeks •Breast feeding initiation	OB database	Quarterly

15

Departmental Indicators, contd.

Department	Indicators	Data Source	Frequency
Pathology	•Turnaround time – inpatient •Critical results reported – outpatient •Critical results reported -- inpatient	Lab system	Quarterly
Pediatrics	•Mortality in v. low birthweight infants •Pediatric immunization rates •Appropriate asthma care	VON network CMApp Cerner	Quarterly
Psychiatry	•Outpatient clinic show rates •Completion of postnatal depression screen	TBD	Quarterly
Radiology	•Critical result reporting •Contrast: abdominal CT •Contrast: thoracic CT	TBD	Quarterly
Surgery	•SCIP: antibiotic choice •SCIP: glucose control •H&P completion 48 hours •Operative note completion 30 days	Cerner Lighthouse Cerner reports	Quarterly
Trauma	•Organ procurement •TBD	Gift of Hope	Quarterly

Departmental Indicators, contd.

- Each department reviews its performance on a range of indicators under the leadership of the Chair of the Department

- Departments may have additional indicators which are reported biannually to the Quality Committee

- All departments will report compliance with clinical contracts affecting their department

- All departments will report OPPE and FPPE for inclusion in personnel files

- All departments will report results of oversight activities as noted below

17

Use of Data in Performance Improvement

- Current evaluation methods:
- Plan-Do-Check-Act PI method
- Data display – dashboard format

- Proposed evaluation methods:
- Data display – run charts to show improvement over time
- Performance improvement activity is reported to the Quality Committee
- Proposed improvement methodology: transition to lean/six sigma
- Intermediate steps: introduce concept of variation and statistical process control to display of QI data
- Increase staff training in lean/six sigma concepts
- Use selected projects to apply concepts

18

Questions

19

John H. Stroger, Jr. Hospital Quality Plan
Outline

I.   Introduction

II.   Background, Scope and Purpose

III.   Governance and Leadership
   a.   Role of the Governing Board
   b.   Role of the Executive Medical Staff
   c.   Role of the Hospitals Quality Committees
   d.   Role of the Quality Department and the Chief Quality Officer

IV.   Transparency

V.   Patient Safety
   a.   Adverse and Sentinel Events
   b.   Event Awareness and Notification
   c.   Evaluation of Adverse and Sentinel Events
        i.   Referral for Evaluation
        ii.   Root Cause Analysis
        iii. Just Culture
   d.   Event Resolution and Action Plans
   e.   Proactive Risk Assessments
        i.   Medical Staff Committees Which Measure and Improve Patient Safety
              (a) Blood Bank Committee
              (b) Critical Care and Resuscitation Committees
              (c) Drug and Formulary and Drug Use Evaluation Committees
              (d) Environment of Care Committee
              (e) Infection Control Committee
              (f) Operating Room Committee
              (g) Surgical Function Review Committee
        ii.   Failure Modes and Effects Analysis
        iii. Priorities Patient Safety Projects
   f.   Culture of Safety
        i.   Assessment
        ii.   Intervention

VI.   Patient Complaints and Patient Satisfaction

VII.   Quality Metrics
   a.   Description
   b.   Data Abstraction
   c.   Performance Targets
   d.   PQRS- Physician Quality Reporting System

VIII.   System Quality Priorities
   a.   Inpatient Metrics
   b.   Outpatient and Population Based Metrics
   c.   Nursing Specific Indicators
   d.   Medical Staff and Quality Priorities

IX.   Data Acquisition and Analysis

X.   Performance Improvement

XI.   Confidentiality

XII.   APPENDICES
   a.   Appendix A: CMS Regulation for Quality Plan
   b.   Appendix B: Joint Commission Leadership Standards
   c.   Appendix C: Joint Commission Performance Improvement Standards
   d.   Appendix D: Quality Reporting Structure
   e.   Appendix E: Hospital Wide Quality Improvement and Patient Safety Committee
   f.   Appendix F: Recognition and Reporting of Adverse Events
   g.   Appendix G: Sentinel Events (Joint Commission)
   h.   Appendix H: Never Events (NQF)
   i.   Appendix I: Med Staff Committees
   j.   Appendix J: IQR metrics
   k.   Appendix K: OQR Metrics
   l.   Appendix L: System Quality Priorities
   m.   Appendix M: Departmental Quality Indicators
   n.   ATTACHMENT: Hospital Inpatient Quality Reporting Program Measures

John H. Stroger, Jr. Hospital of CCHHS
Quality Assessment and Performance Improvement Plan 2014

I. **Purpose:** The Mission of the Cook County Health and Hospitals System (CCHHS) is to provide a comprehensive program of quality healthcare, with respect and dignity, to all residents of Cook County, regardless of their ability to pay. To support this mission, the System develops a Quality Assessment and Performance Improvement Plan for each affiliate, to specify the approach to quality improvement and to enunciate achievement targets for performance improvement, and to assure approval of the plan by the leaders of the organization including the Board of Directors and the Executive Medical Staff. The purpose of this document is to set forth the Quality Assessment and Performance Improvement Plan for John H. Stroger, Jr. ('Stroger') Hospital for FY 2014.

II. **Background and Scope:** A comprehensive quality improvement plan supports the Cook County Health and Hospitals System's and John H. Stroger, Jr. Hospital's goals to provide excellent, high quality patient care and outlines the specific mechanisms to achieve this goal. The plan is a requirement under the Conditions of Participation of the Centers for Medicare & Medicaid Services (CMS) (**APPENDIX A)** and fulfills specific requirements of The Joint Commission (**APPENDIX B and APPENDIX C)**, the accrediting organization for the Hospital and the System. The plan is designed to be approved by the governing body of CCHHS which is the Board of Directors, upon the recommendation of its committee on Quality and Patient Safety, and upon approval by the Executive Medical Staff of Stroger Hospital and System Leadership. By approving the plan, the Board of Directors, the System Leadership and the Executive Medical Staff are:

   a. Overseeing the quality and patient safety activities within the organization
   b. Ensuring that the organization takes a proactive approach to planning for patient safety and quality patient care
   c. Ensuring that an integrated safety program exists within the organization
   d. Setting priorities for performance improvement, evaluating the performance improvement practices in the organization and ensuring that performance improvement strategies and methodologies are implemented throughout the organization
   e. Ensuring data collection and monitoring in diverse areas as specified below
   f. Ensuring that the hospital analyzes and compares the data it collects using statistical techniques and that data and other information are used systematically for decision making.

This plan reflects institutional patient safety and quality priorities for FY 2014 for Stroger Hospital and provides substantial guidance for quality priorities for all entities within the health System. The written plan allows the hospital's Executive Medical Staff and the Board of Directors to ensure that the program reflects the complexity of the hospital's organization and services and involves all departments and services. The plan enumerates the indicators related to improved health outcomes and describes the hospital's process to prevent and reduce medical errors. This plan provides direction for the ongoing hospital-wide, data driven quality assessment and performance improvement program.

3

The structure of the Quality Assessment and Performance Improvement Plan is derived from the Triple Aim enunciated by the national quality strategy within the Affordable Care Act. This directs health care providers to improve the care for individuals, assess and improve the care of populations and to lower per capita costs in health care. In addition, as outlined by the Institute of Medicine Report, '*To Err is Human*', quality improvement efforts in health care should ensure that patient care is safe, timely, effective, efficient, equitable and patient centered. CCHHS and Stroger Hospital are committed to addressing all of these dimensions of quality within the Quality Improvement Plan.

At CCHHS and Stroger Hospital, quality assessment and performance improvement functions are divided into three major domains. Thus the Quality Improvement plan is divided into sections to address each of the following:

  a. *Patient safety* involves the recognition, assessment and mitigation of adverse patient events, including sentinel events, and involves retroactive as well as proactive risk assessment (described further below).
  b. *Quality assessment* and reporting of quality metrics include the 'core measures' or process measures required for reporting to CMS and the Joint Commission; outcome measures such as mortality, readmission rates, and rates of hospital acquired conditions; and measures of patient satisfaction with care.
  c. *Performance improvement* efforts focus on high risk, high volume activities and problem prone areas and set specific performance targets for these areas. Performance improvement projects may arise from tracking medical errors and adverse patient events which require corrective actions for risk mitigation. Interdisciplinary processes are used for performance improvement as described below. After implementing improvement projects, the performance is tracked over time to assess the sustainability of improvement efforts.

III. **Governance and Leadership:** Oversight of the quality plan for CCHHS and Stroger Hospital is provided by its governing body, the Board of Directors; by the medical staff through its elected representatives, the Executive Medical Staff Committee; and by the leadership of CCHHS. The plan is to be approved by the Quality Committee of the hospital known as the Hospital Wide Quality Improvement Committee; by the Executive Medical Staff Committee of the Hospital; by the Quality and Patient Safety Committee and the Board of Directors of the CCHHS. Results of patient safety assessments, quality metrics and results of performance improvement projects are also reported to the Executive Medical Staff and the Board of Directors in the same manner as described in **APPENDIX D.**

Implementation of the Quality Plan is the responsibility of the Department of Quality and Patient Safety led by the Chief Quality Officer and executed in collaboration with the Hospital Quality Committee, departmental quality committees, hospital and system leadership and the System Departments of Risk Management, Legal, and Compliance.

The Hospital Wide Quality Improvement Committee is to be renamed the Hospital Quality and Patient Safety Committee through an amendment in the Medical Staff bylaws and will serve the dual function of oversight of the Quality Program as well as the Patient Safety

• • •
4

Program. The composition and leadership of this committee is presented in **APPENDIX E**. This committee meets monthly and reviews all quality metrics, departmental and committee quality data, and prioritizes performance improvement projects. The committee chair or designee reports the activities of the committee to the Executive Medical Staff on a monthly basis and the Medical Staff approves the minutes and activities of the committee prior to presentation to the Board of Directors.

IV.   **Transparency:** CCHHS is committed to transparency in the abstraction and reporting of quality metrics. These metrics, together with the performance targets set by the leadership, are to be disseminated widely among leadership and staff and will be available for viewing internally on the CCHHS website. In FY 2014 there will be efforts to develop the CCHHS public website to allow the reporting of quality data for public review.

V.   **Patient Safety Program:** The Stroger Hospital Quality Improvement and Patient Safety Committee ('Quality Committee') is the multidisciplinary committee (**APPENDIX E**) which provides guidance and leadership for the Hospital's patient safety program under the direction of the Patient Safety Officer. The Quality Committee receives reports from medical staff committees as well as of reports of adverse and sentinel events. The Quality Committee determines the priorities for corrective action plans or performance improvement projects arising from the evaluation of such events as well patient safety hazards identified by the medical staff committees which assess such risks.

   a. *Adverse and Sentinel Events:* The definition, reporting and evaluation of adverse events are dictated by regulation and hospital policy. The initial reporting process is outlined in **APPENDIX F**. All significant events are evaluated by departmental and hospital wide oversight committees. Root cause analyses are performed for all sentinel events as defined by hospital policy and the Joint Commission (**APPENDIX G**). Other serious adverse events are defined by the National Quality Foundation (**APPENDIX H**). These are known as 'Never Events' and may have serious consequences to the health and outcomes of patients under the care of the hospital. All reported incidents and adverse events are tracked, analyzed and preventive actions are identified and instituted committees. The results of investigations and recommendations for performance improvement are presented to the Quality Committee which prioritizes performance improvement activities and monitors progress toward the achievement of the plans. All significant events and the results of the evaluation of such events are reported to the Executive Medical Staff.

   b. *Event Awareness and Notification:* Adverse events may be reported using a variety of systems.
       i.   Electronic event reporting system: Electronic reporting systems such as MERS, function within a PSO (patient safety organization), and the events reported into this system have protection from disclosure in litigation; this feature allows honest and timely reporting which supports efforts to evaluate and mitigate potential risks.
       ii. Phone calls: confidential phone reports may be made by care providers to the Quality Improvement/Patient Safety department, to Risk Management, or to

• • •
5

the Executive Medical Director. These reports are also entered into the event reporting system by quality and risk and this allows tracking of all reported events.

iii. Departmental reports: Medical and Nursing departments have internal review processes to assess the quality of care provided by members of the respective department. This includes oversight activities, case conferences, mortality and morbidity reviews, reviews performed for OPPE or FPPE (ongoing or focused professional practice evaluation), or evaluations conducted by the Medical Staff Peer Review Committee.

iv. Referrals from outside agencies: Although rare, events may be identified during review by the QIO (Quality Improvement Organization) affiliated with the hospital, or by state or national regulators (IDPH; Illinois Department of Public Health, CMS; Centers for Medicare & Medicaid Services, The Joint Commission).

All of the above events, regardless of the method of identification, are reported internally as described in **APPENDIX F** and evaluated as described below.

c. *Evaluation of Adverse and Sentinel Events:* The management of adverse and sentinel events is described in hospital policy. Serious events are evaluated expeditiously and thoroughly with a goal to understand the contributory factors and to mitigate the risk to of future events.

i. Referral for Evaluation: All reported adverse events are reviewed by Patient Safety staff to determine the severity of the event and the urgency of evaluation. Stroger Hospital is committed to performing a timely, thorough and credible root cause analysis (RCA) on all sentinel events and 'Never Events', as well as all adverse events which do not fit either criteria but are deemed to require further investigation. This determination is made by the Executive Medical Director with the input of the Hospital's oversight committee or the Quality Committee. Events which do not require an RCA are referred to departmental oversight committees for further investigation. Results of departmental oversight reviews are presented to the Hospital Wide Oversight committee which then reports its findings to the Quality Committee.

ii. Root Cause Analysis: The root cause analysis includes participation by hospital leadership, and the individuals most closely involved with the event or with the systems which contributed to the event. The framework for the RCA is the one developed by the Joint Commission; focuses on systems, and not individuals; evaluates both system and human factors which contributed to the event; progresses from special causes to more common causes in the organization; and, is exhaustive in asking 'Why?' serially and exhaustively to identify a complete set of risk points and potential contributors to the event.

iii. Just Culture and Accountability: Stroger Hospital uses a 'Just Culture' approach to determine the level of individual accountability for adverse events. The focus is on system factors but if there is an issue of individual accountability it will be referred to the management of that individual's department as appropriate.

d. *Event Resolution and Action Plans:* The RCA should identify a series of changes in systems and processes to reduce the risk of recurrence of similar and should result in an

action plan. The action plan will identify the person(s) responsible for the implementation of the plan, and define measures of success for the plan. Responsibility for monitoring the effectiveness of the action plan is delegated to the Quality Committee.

e. *Proactive Risk Assessments*: Stroger Hospital conducts proactive risk assessments in several high risk areas. Some of these assessments are conducted by the Medical Staff committees which evaluate specific clinical processes, as listed below (also, **APPENDIX I**). One high risk process is selected annually for an in-depth analysis of risk points utilizing the methods of failure modes and effects analysis (FMEA). Several additional high-risk, high-volume areas are targeted by the hospital for special projects in FY 2014 and these are described below.

    i. Medical Staff Committee Which Measure and Improve Patient Safety: Medical Staff committees are required to collect and report data related to high-risk processes in patient care. These committees define priorities for process improvement and engage in improvement activities which are reported to the Quality Committee.

        1. Blood Bank Committee: collects data on the appropriateness of the use of blood and blood products and on all reported and confirmed transfusion reactions. The Blood Bank committee is prioritizing the safety of ordering and administration of blood products through a process redesign in collaboration with Nursing, Blood Bank staff and the Information Technology (IT) departments.

        2. Critical Care and Resuscitation Committees: the Critical Care committee collects data on diverse indicators related to intensive care. FY 2014 priorities for this committee include standardizing the approach to prevention of ventilator associated complications (VACs), monitoring restraint prevalence and improving the reporting of resuscitation results. This committee also plans and monitors the responses to changes in patients' conditions ('rapid response') and is engaged in process redesign efforts to optimize the rapid response process.

        3. Drug and Formulary and Drug Use Evaluation Committees: recognition and mitigation of ADRs (adverse drug reactions) and medication errors is a major safety priority for the hospital. The Drug Use Evaluation Committee monitors the reported ADRs and conducts proactive risk assessment using indicators within the electronic medical record. In FY 2014 the scope of this committee will be expanded to include additional risk assessments using trigger tools known to predict patient safety events.

        4. Environment of Care committee: Evaluates environmental and life safety hazards, monitors the response to product safety and device alerts and recalls, and provides oversight of the Emergency Response Plan.

        5. Infection Control Committee: Priorities for this committee for FY 2014 include reducing the risks of catheter associated urinary tract infections and monitoring and improving compliance with hand hygiene.

7

6. Operating Room Committee: works collaboratively with the Departments of Surgery, Anesthesia and Nursing to improve procedural safety and to decrease reoperations and surgical complications.

7. Surgical Function Review Committee: a high priority for FY 2014 (see below) is to improve the timeliness of reporting of serious pathology results and to assure appropriate care for such patients. This committee also monitors for significant discrepancies between preoperative and postoperative diagnoses.

ii. FMEA, or Failure Modes and Effects Analysis: This is a multidisciplinary process which utilizes process mapping, identifies potential failure modes and examines the impact of these failure modes on patient care. A risk scoring system is used for identifying and evaluating improvement opportunities. Stroger Hospital has selected the medication administration process for further evaluation with an FMEA and intends to structure process improvement initiatives to improve the timeliness and accuracy of medication administration, to include, but not limited to, the implementation of a bar-code medication administration program.

iii. Priority Patient Safety Projects: Stroger Hospital has prioritized four high-risk, high-volume clinical processes for robust multidisciplinary process improvement initiatives. These are described below:

1. Medication Safety: as described above, an FMEA will be continued through FY 2014 for the medication administration process. Education will be provided to all hospital staffs to increase understanding and appreciation for the importance of reporting latent errors, or near misses; ADR reports will be tracked and evaluated.

2. Procedural Safety: in addition to the monitoring by the Operating room committee, bedside procedures will be monitored for the performance of pre-sedation assessments, time outs and the full application of the universal protocol. In FY 2014 there are planned policy changes and educational activities pertinent to these goals.

3. Discharge Transitions: discharge from the inpatient setting is a particularly vulnerable time for patients and even more so when there are limited financial, family and social resources available to the patient. To optimize the safety of the discharge transition in FY 2014, Stroger Hospital will reinforce and measure compliance with medication reconciliation, and optimize processes for patient education and post discharge appointing for patients.

4. Reporting of Malignant Pathology: Stroger Hospital provides care for a large and vulnerable group of cancer patients. Early diagnosis and enrollment in care is a priority for the hospital. A systematic process using computerized reporting is to be implemented to expedite the early recognition of new malignant diagnoses and to reinforce and expand outreach efforts to enroll patients in care.

f. **Culture of Safety**: Stroger Hospital is taking steps to improve the culture of safety in the organization by implementing structures and processes known to improve the

8

culture of safety. Culture reflects the beliefs and attitudes of the hospital's staffs, and is measured using a validated survey. A positive culture of safety is associated with increased reporting of adverse events and reporting behaviors strengthen patient safety efforts.

    i. *Assessment:* An assessment tool (developed and validated by AHRQ) which allows comparison to benchmark data is used at CCHHS for the assessment of safety culture. It is administered at all CCHHS affiliates and is analyzed using national benchmark data. It is expected that a repeat survey will be performed in the Fall of 2014.

    ii. *Interventions*: Several interventions based on the culture of safety survey results are implemented to enhance the culture of safety at CCHHS. These include:

        1. Leadership walk rounds: allows leaders to directly communicate safety priorities, support reporting behaviors and to hear staff concerns.

        2. Interdisciplinary rounds: allow robust interdisciplinary planning of patient care, including pain management, infection prevention and discharge planning; these utilize a structured format and are led by unit based staff.

        3. Unit based safety programs provide opportunities for all staff to participate in quality improvement programs.

VI.   **Patient Complaints and Patient Satisfaction:** Patient feedback and perceptions of the safety and quality of care are vitally important to the development of a responsive, patient centered organization. Stroger Hospital welcomes feedback, comments and complaints from patients and recognizes that patients and their families have the right to have complaints reviewed by the hospital. An established complaint resolution process implemented by the Office of Patient Satisfaction receives, prioritizes and responds to all complaints from patients. Serious consideration is given to every complaint, and hospital policy is established regarding timeliness of resolution. These processes are designed not only to enhance patient satisfaction but to also identify conditions which may impact on patient safety.

    Structured surveys of selected samples of discharged patients are administered by an independent organization and the results are reported to hospital leadership. This type of feedback from patients is used to restructure processes to support patient safety, communication and patient education.

VII.   **Quality Metrics:** Quality measures are collected and reported to monitor and enhance quality of care; to report to the federal state and county governments; for legal and regulatory purposes and to support reimbursement and pay for performance initiatives. Currently reported metrics and performance reports for FY 2012 (the last fiscal year of data available) are displayed in **APPENDIX J** for inpatients and **APPENDIX K** for outpatients and are also described below. This section describes the metrics, the methods of abstraction and performance targets for FY 2014.

a. *Description of Metrics:* Under the inpatient and outpatient quality reporting (IQR and OQR) programs of CMS the metrics reported in **APPENDIX J** and **APPENDIX K** are abstracted and reported on a quarterly basis to CMS. A subset of these measures are reported to the Joint Commission. These measures are reported publicly on the site Hospital Compare and constitute a key portion of the CCHHS quality dashboard.

   i. Process Measures: Evidence based process measures reflect good clinical practice and high levels of achievement in these areas correlate with good patient outcomes. These processes include the care of patients with myocardial infarction, heart failure, pneumonia and those who undergo surgery. Recently, measures of thromboembolism prophylaxis and stroke care were added to the required measures. The hospital's performance in these areas is used to determine the priorities for performance improvement projects.

   ii. Outcome Measures - Mortality and Readmissions: CMS uses administrative data to calculate overall mortality, readmission rates to the hospital and rates of hospital acquired conditions.

   iii. Outcome Measures- Hospital Acquired Conditions: Hospital acquired infections represent a major, and preventable, source of morbidity in the hospital. Several types of hospital acquired infection rates must be reported by law and are listed in **APPENDIX J** and the Attachment.

   iv. Outcome Measures – Emergency Department(ED) Throughput: Wait times in the ED for both inpatients and outpatients are monitored. ED wait times reflect hospital throughput and a hospital wide capacity management.

b. *Data Abstraction:* CCHHS uses computer supported data abstraction through the electronic medical record (EMR) system for all process measures. Abstractors are given a menu of cases which are sampled using the logic in the abstraction program (denominator) as well as data and links to support manual abstraction. Numerator data are assessed case by case after chart review by the abstractor and compliance is measured as a percentage. Data is abstracted monthly for all process measures but is reported quarterly; reporting to the Joint Commission occurs concurrently with CMS reporting. Data submission is through a third party. Data for outcome measures may be abstracted by hospital abstractors (ED data), reported to CMS via alternative channels (infection control data which is first reported to the Centers for Disease Control) or abstracted by CMS directly from its administrative database (mortality, readmissions and hospital acquired conditions).

c. *Performance Targets:* These are determined by the type of data (process or outcome) and by indicator. A subset of process measures have been selected for the Hospital's and System's quality priorities for FY 2014 (see below). Performance targets are set at a higher threshold for these metrics, to the top decile (or > 90th %ile) of achievement. One set of outcome measures, ED throughput, has also been selected as a quality priority (see below). For all other process measures, the achievement target for FY 2014 is above median performance (> 50th %ile). For outcome measures, the achievement threshold is to have all measures above the national average.

    d.   *Physician Quality Reporting System (PQRS)*: CCHHS and Stroger Hospital Clinics will be reporting through the PQRS program for physician specific outpatient quality measures. The metrics will reflect the burden of disease and major risk factors in our ambulatory population but the exact indicators are yet to be determined.

VIII.   **System Quality Priorities/ Stroger Hospital Quality Priorities:** The System and Hospital quality priorities are to improve access to care, demonstrate excellence in the delivery of care and to improve patient satisfaction. These priorities are divided into Inpatient, Outpatient and Nursing priorities, listed in **APPENDIX L** and discussed below**. APPENDIX L** also displays the baseline and target performance for each indicator. The baseline measurement is Q3 of 2013 and the achievement of targets will be assessed in Q3 of 2014. Data on progress toward the targets will be reported quarterly to the Board of Directors.

    a.   *Inpatient:* Delays in ED throughput may result in ED overcrowding and admission delays. A comprehensive program to reduce ED wait times and improve hospital throughput is planned for FY 2014 and a Capacity Management workgroup has been convened. Moderate targets reflect the complexity of the task of reducing wait times. The selected quality indicators reflect the major disease processes seen in the inpatient population; this includes myocardial infarction, heart failure, pneumonia and surgical care. Top decile performance, which is synonymous with the achievement of 100% compliance with these measures is the Stroger Hospital target for FY 2014. This is an aggressive goal which will require a comprehensive multidisciplinary effort including nursing, pharmacy and IT. Patient satisfaction with hospital care is reflected in the summary measure of 'willingness to recommend the hospital'.

    b.   *Outpatient:* Outpatient metrics focus on clinic throughput and patient satisfaction with care and measures of accessibility of the clinic. Diabetes management, and the measure of the effectiveness of treatment of diabetes is one of two priority quality indicators for the outpatient setting, and reflects the degree to which diabetes is driver for cardiovascular disease in our population. The second is the accomplishment of childhood immunization. Both of these goals represent a focus on population health and prevention.

    c.   *Nursing Sensitive Indicators:* Nursing sensitive indicators include fall rates and hospital acquired pressure ulcer rates. Accurate data collection systems are being set in place for these indicators harnessing the reporting capabilities in the electronic medical record (EMR) system; target performance is reduction of these outcomes by 25%. The nursing indicator of communication with patients reflects the hospital's goal to provide excellent customer service and to enhance patient satisfaction.

    d.   *Role of Medical Staff in Achieving Quality Priorities*: The department chairs and medical staff are responsible to the Executive Medical Staff Committee and the Quality Committee for maintaining a consistently high level of patient care. Each department has identified quality priorities which support the institutional goals as outlined above and has selected high priority indicators for regular reporting to the Quality Committee. These indicators are listed by department in **APPENDIX M**.

IX. **Data Acquisition and Analysis:** The hospital collects data in a variety of settings to support the quality enterprise. The Board of Directors along with System Leadership and the Executive Medical Staff set the priorities for data collection as well as the frequency of data collection. The Board of Directors assures adequate resources to accomplish data acquisition and analyses required for the quality program. The priorities and requirements for data collection for FY 2014 are summarized in the tables in **APPENDICES I, L and M**. Data is compared to external benchmarks whenever these are available and the significance of the comparison is evaluated using statistical techniques. Data is displayed using run charts which show the evolution of performance over time and is correlated with performance improvement initiatives. The data will be assessed using statistical process control techniques which can differentiate between special and common causes of variation; this information will be used to describe the nature of performance improvement initiatives which can best address variation. The goal is to achieve high reliability in quality measures.

X. **Performance Improvement:** Priorities for performance improvement are established by the organizations leadership, which includes the Quality Committee, Executive Medical Staff, System Leadership and the Board of Directors. High-risk, high-volume or problem prone areas are prioritized for performance improvement projects after consideration of the incidence, prevalence and severity of problems in these areas and whether these problems are known to affect health outcomes, patient safety and quality of care. Performance improvement projects are proportional to the scope and complexity of the hospital's services, as outlined in **APPENDICES I, L and M**.

The hospital's approach to performance improvement projects is in a transitional phase from P-D-C-A to a Lean/Six Sigma Approach. This choice reflects the emphasis on value in health care operations and the alignment of Lean concepts with value and the reduction of waste. This approach accurately reflects the multidisciplinary nature of health care and the processes under study. The Lean approach also supports the possibility of rapid cycle performance improvement which may be used in selected cases, particularly in unit based improvement programs. Six Sigma addresses the variation in quality measurement which reflects the stability of the process under study. Performance improvement projects will address variation by designing high-reliability interventions which are known to create sustained changes. This includes system redesign, forcing functions, checks and redundancies and consideration of human factors. Monitoring of performance improvement activities will be provided by the hospital Quality Committee. Staff in the Department of Quality and Patient Safety will process data required for performance improvement projects and provide facilitation for these projects as required.

XI. **Confidentiality**: All information, data, reports, minutes or memoranda relating to the implementation of this Quality Assessment and Performance Improvement Plan are solely for use in the course of internal quality control for the purpose of reducing morbidity and mortality and improving patient care. As such, they are strictly confidential under the Illinois Medical Studies and Hospital Licensing Act. The confidentiality of patient specific data will be protected in observance of HIPAA regulations and aggregated, de-identified data will be used whenever possible for quality data reporting.

12

XII.   APPENDIX A
CMS (Centers for Medicare and Medicaid Services) Regulations Guiding Quality Plans

Regulation (CFR 482.21 sections A-0263 - A-0267):

The hospital must develop, implement and maintain an effective, ongoing, hospital-wide, data-driven quality assessment and performance improvement program. The hospital's governing body must ensure that the program reflects the complexity of the hospital's organization and services, involves all hospital departments and services (including those services furnished under contract or arrangement), and focuses on indicators related to improved health outcomes and the prevention and reduction of medical errors. The hospital must maintain and demonstrate evidence of its QAPI program for review by CMS.

(a)Standard: Program Scope

    i.   The program must include, but not be limited to, an ongoing program that shows measurable improvement in indicators for which there is evidence that it will improve health outcomes and identify and reduce medical errors.

    ii.   The hospital must measure, analyze, and track quality indicators, including adverse patient events and other aspects of performance that assess processes of care, hospital service and operations.

(b)Standard: Program Data

    (1) The program must incorporate quality indicator data including patient care data and other relevant data, eg information submitted to or received from the hospital's Quality Improvement Organization.

    (2) The hospital must use the data collected to (i) monitor the effectiveness and safety of services and quality of care and (ii) identify opportunities for improvement and changes that will lead to improvement.

    (3) The frequency and detail of data collection must be specified by the hospital's governing body.

(c)Standard: Program Activities

    (1) The hospital must set priorities for its performance improvement activities that: (i) focus on high-risk, high-volume, or problem-prone areas; (ii) consider the incidence, prevalence, and severity of problems in those

• • •
13

areas and (iii) affect health outcomes, patient safety and quality of care.

(2) Performance improvement activities must track medical errors and adverse patient events, analyze their causes, and implement preventive actions and mechanisms that include feedback and learning throughout the hospital.

(3) The hospital must take actions aimed at performance improvement and after implementing those actions the hospital must measure its success and track performance to ensure that improvements are sustained.

(d)Standard: Performance Improvement Projects

As part of its quality assessment and performance improvement program the hospital must cnduct performance improvement projects.

(1) The number and scope of distinct improvement projects conducted annually must be proportional to the scope and complexity of the hospital's services and operations.

(2) A hospital may.. develop and implement an information technology system explicitly designed to improve patient safety and quality of care.

(3) The hospital must document what quality improvement projects are being conducted, the reasons for conducting these projects and the measurable progress achieved on these projects.

(e)Standard: Executive Responsibilities

The hospital's governing body, medical staff, and administrative officials are responsible and accountable for ensuring the following:

(1) That an ongoing program for quality improvement, and patient safety, including the reduction of medical errors, is defined, implemented, and maintained.

(2) That the hospital-wide quality assessment and quality improvement efforts address priorities for improved quality of care and patient safety and that all improvement actions are evaluated.

(3) That clear expectations for safety are established.

(4) That adequate resources are allocated for measuring, assessing, improving and sustaining the hospital performance and reducing risk to patients.

(5) The determination of projects is conducted annually

• • •

14

<div align="center">

APPENDIX B:
Joint Commission Leadership Standards

</div>

LD.01.03.01

The governing body is ultimately accountable for the safety and quality of care, treatment and services. The governing body defines in writing its responsibilities

LD.02.03.01

The governing body, senior manager and leaders of the organized medical staff regularly communicate with each other on issues of safety and quality. Leaders discuss issues that affect the hospital and the population it serves, including performance improvement activities, reported safety and quality issues, proposed solutions and their impact on resources, reports on key quality measures and safety indicators, safety and quality issues specific to the population served.

LD.03.01.01

Leaders create and maintain a culture of safety throughout the hospital. Leaders regularly evaluate the culture of safety and quality using valid and reliable tools and prioritize and implement changes identified by the evaluation.

LD.03.02.01

The hospital uses data and information to guide decisions and to understand variation in the performance of processes supporting safety and quality.

LD.03.05.01

Leaders implement changes in existing processes to improve the performance of the hospital. Structures for managing change and performance improvement exist. The hospital has a systematic approach to change and performance improvement. Leaders provide resources required for performance improvement and change management.

LD.04.04.01

Leaders establish priorities for performance improvement; set priorities for performance improvement activities and patient health outcomes, and give priority to high-volume, high-risk or problem prone processes for performance improvement activities.

LD.04.04.03

New or modified services and processes are designed incorporating multiple factors (i.e. patient/staff needs, results of quality activities, information about patient risks, and sentinel event information)

LD.04.04.05

The hospital has an organization-wide, integrated patient safety program within its performance improvement activities. The leaders implement a hospital-wide patient safety program. One or more qualified individuals or an interdisciplinary group manages the safety program. The scope of the safety program includes the full range of safety issues, from potential or no-harm errors to hazardous conditions and sentinel events. All departments, programs and services within the hospital participate in the safety program.

<div align="center">• • •

15</div>

APPENDIX C:
Joint Commission Performance Improvement Standards

PI.01.01.01, EP 1-8, 11, 12, 14-16, 30, 38
The hospital collects data to monitor its performance. Leaders set priorities for data collection. The leaders identify the frequency for data collection. The hospital collects data on
- the performance improvement priorities identified by leaders
- operative and other procedures that place the patient at risk of disability or death
- all significant discrepancies between preoperative and postoperative diagnoses, including pathologic diagnoses
- adverse events related to using moderate or deep sedation
- use of blood and blood components
- all reported and confirmed transfusion reactions
- results of resuscitation
- behavior management and treatment
- significant medication errors
- significant adverse drug reactions
- patient perception of the safety and quality of care, treatment, and services
- effectiveness of fall reduction activities
- effectiveness of response to change or deterioration in a patient's condition

PI.02.01.01, EP 1-8
The hospital compiles and analyzes data. The hospital compiles data in usable formats, identifies the frequency for data analysis, uses statistical tools and techniques to analyze and display the data, analyzes and compares internal data over time to identify levels of performance, patterns, trends and variations, and compares data with external sources, when available.

PI.03.01.01, EP 1-4
The hospital improves performance on an ongoing basis. Leaders prioritize the identified improvement opportunities. The hospital takes action on improvement priorities. The hospital evaluates actions to confirm that they resulted in improvements.

APPENDIX D:
CCHHS Quality Reporting Overview

```
                    Board of Directors
                         CCHHS
                           |
                      Board QPS
                      Committee
                           |
           ┌───────────────┴───────────────┐
    Executive Medical              Executive Medical
    Staff Stroger                  Staff Provident
    Hospital*                      Hospital*
           |                               |
  ┌────────┼────────┐                      |
Quality        Cermak Health    ACHN        Provident Quality
Committee      Services Quality Quality     Committee
Stroger        Committee        Committee
Hospital
```
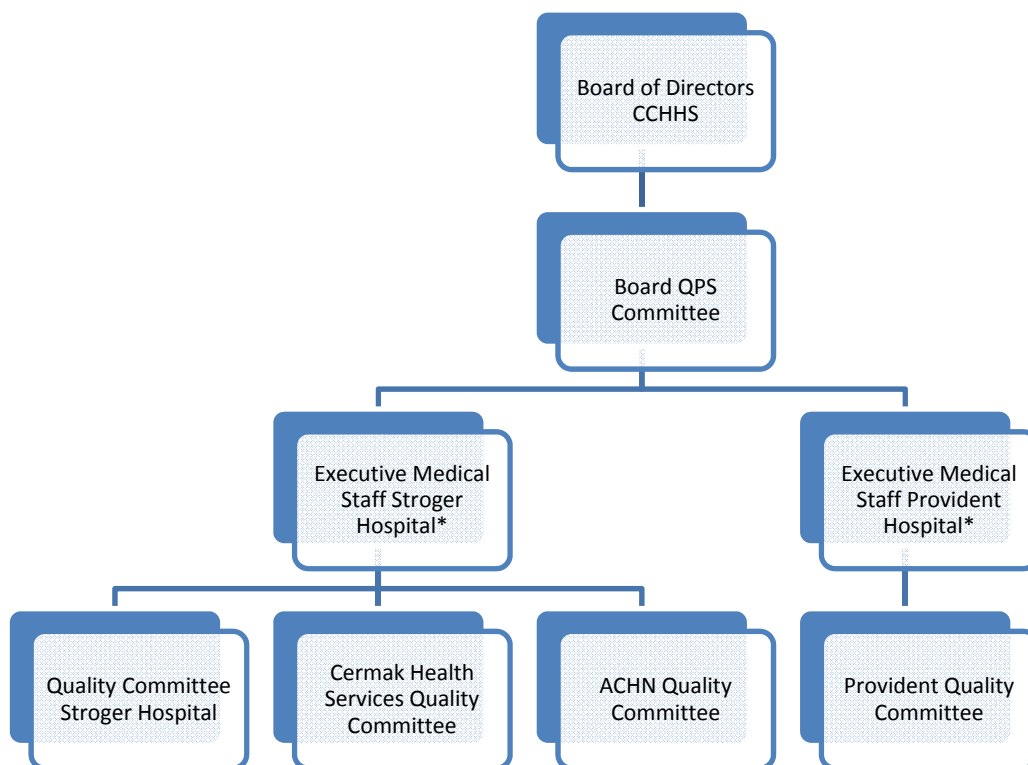
*Reports to the Board may be provided by the Chief Quality Officer, the Executive Medical Director, the Chief of Clinical Integration, the affiliate Chief Operating Officer or directly by the President of the respective medical staffs or their designees.

• • •
17

APPENDIX E:
Hospital Wide Quality Improvement and Patient Safety Committee Description

Committee Reports Received:

```
                    Nursing
                    Specific
         Infection  Indicators/OR    Environment
         Control    and ED           of Care
                                     Committee

  Patient                                          Committee on
  Satisfaction                                     Cancer
  and
  Grievances

                        Hospital Quality
  Medical               Improvement and            Core
  Records               Patient Safety             Measures
                        Committee

                                                   Critical Care
  Department                                       and
  Quality Reviews                                  Resuscitation

         Hospital                     Drug
         Oversight      Surgical      &Formulary/
         Committee/     Function      Adverse Drug
         M&Ms           Review        Events
```

Committee Membership:

Committee Chair co-appointed by EMS President and COO
Medical Department Chairs
Executive Medical Director (System)
Chief Quality Officer (System)
Chief Operating Officer (Stroger Hospital)
Chief Operating Officer (ACHN)
Chief Nursing Officer (Stroger Hospital)
Chief Financial Officer (Stroger Hospital)
Director of Supply Chain Management (System)
Chief Clinical Informatics Officer
Director of Health Information (System)
Director of Patient Experience (System)
Director of Pharmacy (System)
Director of Infection Control (System)

Ex Officio

Chief of Clinical Integration
Chief Business Officer
Executive Director of Nursing
Director of Multicultural Affairs
Chief Financial Officer (System)
Chair, Quality and Patient
      Safety Subcommittee,
      CCHHS Board of Directors

● ● ●
18

APPENDIX F:
Recognition and Reporting of Adverse Events

```
                    ┌─────────────────────────┐
                    │  Clinical Adverse Event  │
                    │    or Near Miss Event    │
                    └─────────────────────────┘
                     │                       │
        ┌────────────────────────┐   ┌────────────────────────┐
        │  Clinical Adverse Event │   │   Near Miss Event: No   │
        │                         │   │      Patient Harm       │
        │   Attending Physician   │   └────────────────────────┘
        │        Notified         │               │
        └────────────────────────┘   ┌────────────────────────┐
         │                      │     │ Enter into On-Line Event│
┌──────────────────┐  ┌──────────────────┐ │  Reporting System   │
│  Sentinel Event  │  │ Not Sentinel Event│ │                     │
│                  │  │                  │  │   Notify Supervisor │
│ Significant Risk │  │  No Critical Factors per │└────────────────┘
│                  │  │  Attending Physician │
│ Patient or Family│  └──────────────────┘
│     Concern      │          │
└──────────────────┘  ┌──────────────────┐
   │          │       │ Notify Department Chair │
┌──────────────┐ ┌──────────────┐ │ or Oversight Committee │
│ Notify Risk  │ │ Notify Chief │ │                        │
│ Management   │ │   Medical    │ │     Notify Quality     │
│ Immediately  │ │Officer/Exec..│ └──────────────────────┘
└──────────────┘ └──────────────┘           │
   │                          ┌────────────────────────┐
┌──────────────────┐          │  Disclosure to Patient  │
│ Leadership Notif.│          │   and/or Representative  │
│ COO, Exec Medical│          └────────────────────────┘
│ Director, Quality│
└──────────────────┘
   │
┌──────────────────┐
│ Disclosure to    │
│ Patient and/or   │
│ Representative   │
└──────────────────┘
```

19

APPENDIX G:
Sentinel Events (Joint Commission)

The event has resulted in an unanticipated death or major permanent loss of function not related to the natural course of the patient's illness or underlying condition§ ||

or

1. The event is one of the following (even if the outcome was not death or major permanent loss of function not related to the natural course of the patient's illness or underlying condition):
2. Suicide of any patient receiving care, treatment and services in a staffed around the-clock care setting or within 72 hours of discharge
3. Unanticipated death of a full-term infant Abduction of any patient receiving care, treatment, and services
4. Discharge of an infant to the wrong family
5. Rape, assault (leading to death or permanent loss of function), or homicide of any patient receiving care, treatment, and services#
6. *Rape, assault (leading to death or permanent loss of function), or homicide of a staff member, licensed independent practitioner, visitor, or vendor while on site at the health care organization*
7. Hemolytic transfusion reaction involving administration of blood or blood products having major blood group incompatibilities (ABO, Rh, other blood groups)
8. Invasive procedure, including surgery, on the wrong patient, wrong site, or wrong procedure**
9. Unintended retention of a foreign object in a patient after surgery or other invasive procedures
10. Severe neonatal hyperbilirubinemia (bilirubin >30 milligrams/deciliter)
11. Prolonged fluoroscopy with cumulative dose >1,500 rads to a single field or any delivery of radiotherapy to the wrong body region or >25% above the planned radiotherapy dose

**

_____

§A distinction is made between an adverse outcome that is primarily related to the natural course of the patient's illness or underlying condition (not reviewed under the Sentinel Event Policy) and a death or major permanent loss of function that is associated with the treatment (including "recognized complications") or lack of treatment of that condition, or otherwise not clearly and primarily related to the natural course of the patient's illness or underlying condition (reviewable under the Sentinel Event Policy). In indeterminate cases, the event will be presumed reviewable and the hospital's response will be reviewed under the Sentinel Event Policy according to the prescribed procedures and time frames without delay for additional information such as autopsy results.

||*Major permanent loss of function* means sensory, motor, physiologic, or intellectual impairment not present on admission requiring continued treatment or lifestyle change. When major permanent loss of function cannot be immediately determined, applicability of the policy is not established until either the patient is discharged with continued major loss of function or two weeks have elapsed with persistent major loss of function, whichever is the longer period.

#*Sexual abuse/assault (including rape),* as a reviewable sentinel event, is defined as unconsented sexual contact involving a patient and another patient, staff member, or other perpetrator while being treated or on the premises of the hospital, including oral, vaginal or anal penetration or fondling of the patient's sex organ(s) by another individual's hand, sex organ, or object. One or more of the following must be present to determine reviewability:

n Any staff-witnessed sexual contact as described above
n Admission by the perpetrator that sexual contact, as described above, occurred on the premises
n Sufficient clinical evidence obtained by the hospital to support allegations of unconsented sexual contact

• • •
20

APPENDIX H:
Never Events (National Quality Foundation)

Surgical or Invasive Procedures

1A. Surgery or other invasive procedure performed on the wrong site

1B. Surgery or other invasive procedure performed on the wrong patient

1C. Wrong surgical or other invasive procedure performed on a patient

1D. Unintended retention of a foreign object in a patient after surgery or other invasive procedure

1E. Intraoperative or immediately postoperative/postprocedure death in an ASA Class 1 patient

Product or Device Events

2A. Patient death or serious injury associated with the use of contaminated drugs, devices, or biologics provided by the healthcare setting

2B. Patient death or serious injury associated with the use or function of a device in patient care, in which the device is used or functions other than as intended

2C. Patient death or serious injury associated with intravascular air embolism that occurs while being cared for in a healthcare setting

Patient Protection Events

3A. Discharge or release of a patient/resident of any age, who is unable to make decisions, to other than an authorized person

3B. Patient death or serious injury associated with patient elopement (disappearance)

3C. Patient suicide, attempted suicide, or self-harm that results in serious injury, while being cared for in a healthcare setting

Care Management Events

4A. Patient death or serious injury associated with a medication error (e.g., errors involving the wrong drug, wrong dose, wrong patient, wrong time, wrong rate, wrong preparation, or wrong route of administration)

4B. Patient death or serious injury associated with unsafe administration of blood products

4C. Maternal death or serious injury associated with labor or delivery in a low-risk pregnancy while being cared for in a healthcare setting

4D. Death or serious injury of a neonate associated with labor or delivery in a low-risk pregnancy

4E. Patient death or serious injury associated with a fall while being cared for in a healthcare setting

4F. Any Stage 3, Stage 4, and unstageable pressure ulcers acquired after admission/presentation to a healthcare setting

4G. Artificial insemination with the wrong donor sperm or wrong egg

4H. Patient death or serious injury resulting from the irretrievable loss of an irreplaceable biological specimen

4I. Patient death or serious injury resulting from failure to follow up or communicate laboratory, pathology, or radiology test results

APPENDIX H, cont'd:
Never Events (National Quality Foundation)

Environmental Events

5A. Patient or staff death or serious injury associated with an electric shock in the course of a patient care process in a healthcare setting

5B. Any incident in which systems designated for oxygen or other gas to be delivered to a patient contains no gas, the wrong gas, or are contaminated by toxic substances

5C. Patient or staff death or serious injury associated with a burn incurred from any source in the course of a patient care process in a healthcare setting

5D. Patient death or serious injury associated with the use of physical restraints or bedrails while being cared for in a healthcare setting

Radiologic Events

6A. Death or serious injury of a patient or staff associated with the introduction of a metallic object into the MRI area

Potential Criminal Events

7A. Any instance of care ordered by or provided by someone impersonating a physician, nurse, pharmacist, or other licensed healthcare provider

7B. Abduction of a patient/resident of any age

7C. Sexual abuse/assault on a patient or staff member within or on the grounds of a healthcare setting

7D. Death or serious injury of a patient or staff member resulting from a physical assault (i.e., battery) that occurs within or on the grounds of a healthcare setting

APPENDIX I:
Medical Staff Committees and Patient Safety Indicators

Committee	Indicators			Data Source	Reporting Frequency
Blood Bank & Transfusion	Transfusion Reactions	Red Cells -- Appropriate	Platelets -- Appropriate	Chart review	Biannually
Critical Care & Resuscitation	Ventilator complication rate	Restraint prevalence & complications	Resuscitation Results	Inf Control data Nursing review Chart review	Biannually
Drug Usage Evaluation	# ADRs reported monthly	Allergy alerts overridden by user	Drug-lab alerts overridden	Incident Reporting system; Cerner	Quarterly
Environment of Care	Fire Safety	Integrity Fire Doors	Hospital Environment	EOC rounds	Quarterly
Infection Control	CAUTI rate	CLABSI rate	Handwashing compliance	Infection control dept	Biannually
Medical Education	Medication reconciliation performed	Enunciate knowledge re DC safety	Satisfaction with doctors	Cerner HCAHPS Survey	Biannually
Medical Information	DC summary completed 30 days	Operative notes completed	Admission H&P signed 48 hours	Cerner reports	Quarterly
Operating Room	Intra-operative Deaths	Reoperation in 7 days	On time starts	Chart reviews Incident reports	Quarterly
Surgical Function Review	Discrepancies pre and post op diagnoses	% Malignant Path reported in 7 days	% PAP smears F/U in one month	Lab system reports	Quarterly

23

APPENDIX J:
Inpatient Quality Reporting Metrics: Process Measures
Baseline: 2012

140124-JOHN H STROGER JR HOSPITAL

Address: 1901 W HARRISON ST
City, State, ZIP: CHICAGO, IL 60612
Phone Number: (312) 864-6000
County Name: COOK

Type of Facility: Short-term
Type of Ownership: Government - Local
Emergency Service Provided: Yes

Structural Measures	
Participation in a Systematic Database for Cardiac Surgery	Does Not Have a Program
Participation in a Systematic Clinical Database Registry for Stroke Care	No
Participation in a Systematic Clinical Database Registry for Nursing Sensitive Care	No

	Hospital Quality Measures	Your Hospital Performance Aggregate Rate for All Four Quarters	10% of All Hospitals Submitting Data Scored Equal to or Better Than	State Performance	National Performance
Acute Myocardial Infarction (AMI)					
AMI-2	Aspirin Prescribed at Discharge	100% of 249 patients(2)	100%	99%	99%
AMI-7a	Fibrinolytic Therapy Received Within 30 Minutes of Hospital Arrival	N/A(2,7)	100%	33%	61%
AMI-8a	Primary PCI Received Within 90 Minutes of Hospital Arrival	80% of 10 patients(1,2)	100%	96%	95%
AMI-10	Statin Prescribed at Discharge	97% of 253 patients(2)	100%	98%	98%
Heart Failure (HF)					
HF-1	Discharge Instructions	94% of 280 patients(2)	100%	96%	94%
HF-2	Evaluation of LVS Function	100% of 284 patients(2)	100%	99%	99%
HF-3	ACEI or ARB for LVSD	99% of 148 patients(2)	100%	97%	97%
Pneumonia (PN)					
PN-3b	Blood Cultures Performed in the Emergency Department Prior to Initial Antibiotic Received in Hospital	97% of 117 patients(2)	100%	98%	97%
PN-6	Initial Antibiotic Selection for CAP in Immunocompetent Patient	73% of 101 patients(2)	100%	94%	95%
Surgical Care Improvement Project (SCIP)					
SCIP-Inf-1	Prophylactic Antibiotic Received Within 1 Hour Prior to Surgical Incision	97% of 274 patients(2)	100%	99%	99%
SCIP-Inf-2	Prophylactic Antibiotic Selection for Surgical Patients	96% of 269 patients(2)	100%	99%	99%
SCIP-Inf-3	Prophylactic Antibiotics Discontinued Within 24 Hours After Surgery End Time	98% of 261 patients(2)	100%	98%	98%
SCIP-Inf-4	Cardiac Surgery Patients with Controlled 6 A.M. Postoperative Blood Glucose	89% of 106 patients(2)	100%	96%	96%
SCIP-Inf-9	Urinary Catheter Removed on Postoperative Day 1 (POD 1) or Postoperative Day 2 (POD 2) with Day of Surgery being Day Zero	97% of 157 patients(2)	100%	97%	96%
SCIP-Inf-10	Surgery Patients with Perioperative Temperature Management	100% of 287 patients(2)	100%	100%	100%
SCIP-Card-2	Surgery Patients on Beta-Blocker Therapy Prior to Arrival Who Received a Beta-Blocker During the Perioperative Period	98% of 103 patients(2)	100%	98%	97%
SCIP-VTE-1	Surgery Patients with Recommended Venous Thromboembolism Prophylaxis Ordered	96% of 217 patients(2)	100%	98%	98%
SCIP-VTE-2	Surgery Patients Who Received Appropriate Venous Thromboembolism Prophylaxis Within 24 Hours Prior to Surgery to 24 Hours After Surgery	96% of 217 patients(2)	100%	98%	98%
Emergency Department					
ED-1b	Median Time from ED Arrival to ED Departure for Admitted ED Patients	614 Minutes based on 1191 patients(2)	175 Minutes	261 Minutes	273 Minutes
ED-2b	Admit Decision Time to ED Departure Time for Admitted Patients	234 Minutes based on 1190 patients(2)	42 Minutes	90 Minutes	96 Minutes
Immunization					
IMM-1a	Pneumococcal Immunization	43% of 721 patients(2)	98%	90%	89%
IMM-2	Influenza Immunization	69% of 305 patients(2)	99%	90%	88%

24

APPENDIX J, cont'd:
Inpatient Quality Reporting Metrics: Outcome Measures
Baseline: 2012

140124-JOHN H STROGER JR HOSPITAL

Address: 1901 W HARRISON ST
City, State, ZIP: CHICAGO, IL 60612
Phone Number: (312) 864-6000
County Name: COOK

Type of Facility: Short-term
Type of Ownership: Government - Local
Emergency Service Provided: Yes

30-Day Risk-Standardized Mortality Measures

	Hospital Quality Measures	Your Hospital's Performance	Your Hospital's Number of Eligible Medicare Admissions	Your Hospital's Risk-Standardized Mortality Rate (Lower Limit, Upper Limit of 95% Interval Estimate)	U.S. National Rate		Number of Hospitals...	Better than U.S. National Rate	No Different than U.S. National Rate	Worse than U.S. National Rate	Number of Cases Too Small
Acute Myocardial Infarction (AMI)											
MORT-30-AMI	Acute Myocardial Infarction (AMI) 30-Day Mortality Rate	No Different than U.S. National Rate	57	14.8% (11.0%, 19.3%)	15.2%		in the **Nation** that Performed ...	77	2579	19	1889
							in the **State** that Performed ...	8	112	0	61
Heart Failure (HF)											
MORT-30-HF	Heart Failure (HF) 30-Day Mortality Rate	No Different than U.S. National Rate	141	10.4% (7.4%, 14.6%)	11.7%		in the **Nation** that Performed ...	181	3732	139	725
							in the **State** that Performed ...	16	156	5	7
Pneumonia (PN)											
MORT-30-PN	Pneumonia (PN) 30-Day Mortality Rate	No Different than U.S. National Rate	63	10.8% (7.3%, 15.8%)	11.9%		in the **Nation** that Performed ...	203	4014	223	377
							in the **State** that Performed ...	16	157	7	4

30-Day Risk-Standardized Readmission Measures

	Hospital Quality Measures	Your Hospital's Performance	Your Hospital's Number of Eligible Medicare Discharges	Your Hospital's Risk-Standardized Readmission Rate (Lower Limit, Upper Limit of 95% Interval Estimate)	U.S. National Rate		Number of Hospitals...	Better than U.S. National Rate	No Different than U.S. National Rate	Worse than U.S. National Rate	Number of Cases Too Small
Acute Myocardial Infarction (AMI)											
READM-30-AMI	Acute Myocardial Infarction (AMI) 30-Day Readmission Rate	No Different than U.S. National Rate	62	19.8% (15.9%, 24.4%)	18.3%		in the **Nation** that Performed ...	22	2333	24	2085
							in the **State** that Performed ...	0	103	5	71
Heart Failure (HF)											
READM-30-HF	Heart Failure (HF) 30-Day Readmission Rate	No Different than U.S. National Rate	185	25.5% (21.2%, 30.2%)	23.0%		in the **Nation** that Performed ...	105	3904	146	631
							in the **State** that Performed ...	0	169	10	5
Pneumonia (PN)											
READM-30-PN	Pneumonia (PN) 30-Day Readmission Rate	No Different than U.S. National Rate	76	18.7% (14.8%, 23.2%)	17.6%		in the **Nation** that Performed ...	25	4331	101	376
							in the **State** that Performed ...	0	172	8	5

25

APPENDIX J, cont'd:
Inpatient Quality Reporting Metrics: Hospital Acquired Infections
Baseline: 2012

Healthcare Associated Infection							
Hospital Quality Measures	Your Hospital's Reported Number of Infections	Device Days / Procedures	Your Hospital's Predicted Number of Infections	Ratio of Reported to Predicted Infections (SIR) (Lower Limit, Upper Limit of 95% Interval Estimate)	Your Hospital's Performance	State Standardized Infection Ratio, State Lower Limit, State Upper Limit of 95% Interval Estimate	U.S. National Standardized Infection Ratio
Central Line Associated Bloodstream Infection	14	11251	29.901	0.468(0.256,0.786)	Better than the U.S. National Benchmark	0.567 (0.515, 0.624)	0.551
Catheter Associated Urinary Tract Infections	40	10217	29.378	1.362(0.973,1.854)	No Different than U.S. National Benchmark	2.159 (2.017, 2.307)	1.097
SSI-Colon Surgery	2	200	7.080	0.282(0.034,1.020)	No Different than U.S. National Benchmark	0.683 (0.599, 0.775)	0.808
SSI-Abdominal Hysterectomy	0	212	2.292	0.000(--,1.609)(8)	No Different than U.S. National Benchmark	0.934 (0.755, 1.142)	0.934

26

APPENDIX J, cont'd:
Inpatient Quality Reporting Metrics: Patient Satisfaction Measures
Baseline: 2012

140124-JOHN H STROGER JR HOSPITAL

Address: 1901 W HARRISON ST
City, State, ZIP: CHICAGO, IL 60612
Phone Number: (312) 864-6000
County Name: COOK

Type of Facility: Short-term
Type of Ownership: Government - Local
Emergency Service Provided: Yes

HCAHPS Survey Completion and Response Rate	
Number of Completed Surveys	1287
Survey Response Rate	16

HCAHPS Composites and Individual Items

		Your Hospital's Adjusted Score			State Average			U.S. Average		
HCAHPS Composites		% Sometimes to Never	% Usually	% Always	% Sometimes to Never	% Usually	% Always	% Sometimes to Never	% Usually	% Always
Composite 1 (Q1 to Q3)	Communication with Nurses	12	21	67	5	17	78	5	17	78
Composite 2 (Q5 to Q7)	Communication with Doctors	5	14	81	4	15	81	4	15	81
Composite 3 (Q4 & Q11)	Responsiveness of Hospital Staff	21	25	54	10	24	66	9	24	67
Composite 4 (Q13 & Q14)	Pain Management	11	24	65	7	23	70	7	22	71
Composite 5 (Q16 & Q17)	Communication about Medicines	28	19	53	20	17	63	19	17	64
Hospital Environment Items		% Sometimes to Never	% Usually	% Always	% Sometimes to Never	% Usually	% Always	% Sometimes to Never	% Usually	% Always
Q8	Cleanliness of Hospital Environment	23	24	53	9	18	73	9	18	73
Q9	Quietness of Hospital Environment	18	28	54	11	30	59	10	30	60
Discharge Information Composite		% Yes		% No	% Yes		% No	% Yes		% No
Composite 6 (Q19 & Q20)	Discharge Information	78		22	85		15	85		15

HCAHPS Global Items

		Your Hospital's Adjusted Score			State Average			U.S. Average		
Q21	Overall Rating of Hospital	% 0 to 6 rating	% 7 and 8 rating	% 9 and 10 rating	% 0 to 6 rating	% 7 and 8 rating	% 9 and 10 rating	% 0 to 6 rating	% 7 and 8 rating	% 9 and 10 rating
Overall Rating of Hospital (0 = Worst Hospital 10 = Best Hospital)		16	30	54	9	22	69	8	22	70
		Your Hospital's Adjusted Score			State Average			U.S. Average		
Q22	Willingness to Recommend this Hospital	% No: Definitely or Probably Not Recommend	% Yes: Probably Recommend	% Yes: Definitely Recommend	% No: Definitely or Probably Not Recommend	% Yes: Probably Recommend	% Yes: Definitely Recommend	% No: Definitely or Probably Not Recommend	% Yes: Probably Recommend	% Yes: Definitely Recommend
Willingness to Recommend this Hospital		8	30	62	5	26	69	5	24	71

27

APPENDIX K:
Outpatient Quality Reporting Metrics
Baseline: 2012

140124-JOHN H STROGER JR HOSPITAL

Address: 1901 W HARRISON ST
City, State, ZIP: CHICAGO, IL 60612
Phone Number: (312) 864-6000
County Name: COOK

Type of Facility: Short-term
Type of Ownership: Government - Local
Emergency Service Provided: Yes

	Structural Measures		
OP-12	Does/did your facility have the ability to receive laboratory data electronically directly into your ONC certified EHR system as discrete searchable data?	Yes
OP-17	Does your facility have the ability to track clinical results between visits?	Yes
OP-22	Patient left before being seen	7735/30911 (25%)

	Hospital Quality Measures	Your Hospital Performance for All Quarters	10% of All Hospitals Submitting Data Performed Equal to or Better Than	State Performance	National Performance
	AMI Cardiac Care				
OP-1	Median Time to Fibrinolysis	N/A(5)	20 Minutes	22 Minutes	29 Minutes
OP-2	Fibrinolytic Therapy Received Within 30 Minutes of ED Arrival	N/A(5)	100%	67%	56%
OP-3b	Median Time to Transfer to Another Facility for Acute Coronary Intervention- Reporting Rate	N/A(5)	38 Minutes	60 Minutes	58 Minutes
OP-4	Aspirin at Arrival	N/A(5)	100%	96%	97%
OP-5	Median Time to ECG	N/A(5)	3 Minutes	6 Minutes	7 Minutes
	Surgical Care				
OP-6	Timing of Antibiotic Prophylaxis	96% of 196 patients	100%	97%	97%
OP-7	Prophylactic Antibiotic Selection for Surgical Patients	91% of 194 patients	100%	97%	97%

	Hospital Quality Measures	Your Hospital Performance for All Quarters	10% of All Hospitals Submitting Data Performed Equal to or Better Than	State Performance	National Performance
	Outpatient Imaging Efficiency (OIE)				
OP-8	MRI Lumbar Spine for Low Back Pain	N/A(1)	N/A	36.0%	36.5%
OP-9	Mammography Follow-up Rates	N/A(1)	N/A	8.5%	8.8%
OP-10	Abdomen CT - Use of Contrast Material	14.3% of 546 scans	N/A	13.2%	12.7%
OP-11	Thorax CT - Use of Contrast Material	2.1% of 469 scans	N/A	3.9%	3.7%
OP-13	Cardiac imaging for preoperative risk assessment for non-cardiac low-risk surgery	2.0% of 98 patients	N/A	5.6%	5.5%
OP-14	Simultaneous use of brain Computed Tomography (CT) and sinus Computed Tomography (CT)	N/A(1)	N/A	2.7%	2.8%
	Emergency Department				
OP-18b	Median Time from ED Arrival to ED Departure for Discharged ED Patients	346 Minutes based on 605 patients	92 Minutes	139 Minutes	138 Minutes
OP-20	Median Time from ED Arrival to Provider Contact for ED patients	170 Minutes based on 551 patients	14 Minutes	31 Minutes	28 Minutes
	Pain Management				
OP-21	Median Time to Pain Management for Long Bone Fracture	172 Minutes based on 326 patients	38 Minutes	54 Minutes	60 Minutes
	Stroke				
OP-23	Head CT Scan Results for Acute Ischemic Stroke or Hemorrhagic Stroke Patients who Received Head CT or MRI Scan Interpretation Within 45 Minutes of ED Arrival	N/A(5)	88%	57%	47%

28

APPENDIX L:
System Quality Priorities: 2014

Key Indicators: Inpatient Services

Indicator	Target Performance *	Baseline Performance *	Data Source	Reporting Interval
ED Registration to Discharge (outpatient)	240 minutes	347 minutes	Cerner Lighthouse	Quarterly
ED Registration to Inpatient (inpatients)	480 minutes	620 minutes	Cerner Lighthouse	Quarterly
Core Measures HF, MI, PN and SCIP*	100%	97%, 99%, 90%, 98%	Cerner Lighthouse	Quarterly
Patient Satisfaction Recommend Hospital	71%	61%	HCAHPS	Quarterly

Key Indicators: Outpatient Services

Indicator	Target Performance	Baseline Performance	Data Source	Reporting Interval
Ease of moving through the clinic 'good'	75%	63%	HCAHPS	Quarterly
Ease of reaching clinic on the phone 'good'	75%	59%	HCAHPS	Quarterly
Children with UTD immunization at 24 mo	> 71%	68%	CMApp	Quarterly
Diabetics with A1C > 9%	< 29%	24%	CMApp	Quarterly

Key Indicators: Nursing Services

Indicator	Target Performance	Baseline Performance	Data Source	Reporting Interval
Communication with nurses 'good'	73%	63%	HCAHPS survey	Quarterly
Fall rate/ falls with injury	Decrease by 25%		Cerner/IView Chart review	Quarterly
Hospital acquired pressure ulcers	Decrease by 25%		Cerner/IView Chart review	Quarterly

* Baseline reflects Q3, 2013; target performance to be evaluated Q3, 2014

APPENDIX M:
Departmental Quality Indicators

Department	Indicators	Data Source(s)	Frequency
Anesthesia	• SCIP measure: VTE prophylaxis • Handoff to PACU staff • Moderate sedation assessment	Cerner Lighthouse Cerner IView	Quarterly
Emergency Med	• Registration to provider (outpt) • Registration to decision to admit • AMI door to needle time	Cerner Lighthouse	Quarterly
Family Med	• Heart Failure and Pneumonia measures • Med records- admission and discharge	Cerner Lighthouse	Quarterly
Internal Med	• Heart Failure and Pneumonia measures • Med records- admission and DC completion	Cerner Lighthouse	Quarterly
Obstetrics/ Gynecology	• Caesarean section rate • Elective delivery 37-39 weeks • Breast feeding initiation	OB database	Quarterly
Pathology	• Turnaround time – inpatient • Critical results reported – outpatient • Critical results reported -- inpatient	Lab system	Quarterly
Pediatrics	• Mortality in v. low birthweight infants • Pediatric immunization rates • Appropriate asthma care	VON network CMApp Cerner	Quarterly
Psychiatry	• Outpatient clinic show rates • Completion of postnatal depression screen • Depression treatment - appropriateness	Chart review	Quarterly
Radiology	• Critical result reporting • Contrast: abdominal CT • Contrast: thoracic CT	Cerner PACS data	Quarterly
Surgery	• SCIP: antibiotic choice & glucose control • H&P completion 48 hours • Operative note completion 30 days	Cerner Lighthouse Cerner reports	Quarterly
Trauma	• Time to Operating room • Negative laparoscopy rate • Completion of operative report in 24 hrs	Chart review Cerner	Quarterly

ATTACHMENT #3

John H. Stroger, Jr. Hospital of Cook County

Medical Staff Appointments/Reappointments and Non-Medical Staff Action Items Subject to Approval by the CCHHS Quality and Patient Safety Committee

INITIAL APPOINTMENT APPLICATIONS

Awad, Sawsan, MD Appointment Effective:	Pediatrics/Cardiology December 11, 2013 thru December 10, 2015	Voluntary Physician
Khan, Salman, MD Appointment Effective:	Pediatrics/ACHN December 11, 2013 thru December 10, ~~2015~~ **2014**	Active Physician
Mehta, Annu P., MD Appointment Effective:	Family Medicine/ACHN December 11, 2013 thru December 10, 2015	Active Physician
Roach, Paul, MD Appointment Effective:	Trauma December 11, 2013 thru December 10, 2015	Voluntary Physician

Initial Non-Physician Appointment Applications

Benoit, Jenna M., PA-C With Patel, Urjeet A., MD Alternate McDonald, Sarah F., MD Effective:	Surgery / Otolaryngology December 11, 2013 thru December 10, 2015	Physician Assistant
Obilor, Isabel O., CNP With Chin, Sophia Y., MD Effective:	Family Practice December 11, 2013 thru December 10, 2015	Nurse Practitioner

REAPPOINTMENT APPLICATIONS

Department of Correctional Health

Ezike, Ngozi MD Reappointment Effective:	Juvenile Detention Center December 21, 2013 thru December 20, 2015	Active Physician
Ting, Andrew, MD Reappointment Effective:	Medicine December 18, 2013 thru December 17, 2015	Active Physician
Watson-Montgomery, Melanie DDS Reappointment Effective:	Oral Health December 16, 2013 thru December 15, 2015	Active Physician

Department of Family Medicine

Siddiqi, Alvia H., MD Reappointment Effective:	Family Medicine/ACHN January 17, 2014 thru January 16, 2016	Voluntary Physician

Department of Medicine

Krishnan, Kousik, MD Reappointment Effective:	Adult Cardiology January 22, 2014 thru January 21, 2016	Voluntary Physician
Lad, Thomas E., MD Reappointment Effective:	Hematology/Oncology January 18, 2014 thru January 17, 2016	Active Physician
Perrin, J. Mary H., MD Reappointment Effective:	General Medicine January 19, 2014 thru January 18, 2016	Voluntary Physician

CCHHS
APPROVED
BY THE QUALITY AND PATIENT SAFETY COMMITTEE
ON DECEMBER 11, 2013

John H. Stroger, Jr. Hospital of Cook County
Reappointment Applications

Department of Medicine (continued)

Shafiei, Shams, MD Reappointment Effective:	Pulmonary & Critical Care January 19, 2014 thru January 18, 2016	Active Physician
Singh, Anshu, MD Reappointment Effective:	Hospital Medicine December 11, 2013 thru December 10, 2015	Active Physician

Department of Pediatrics

Bhobe, Swati S., MD Reappointment Effective:	Pediatrics December 30, 2013 thru December 29, 2015	Consulting Physician

Department of Psychiatry

Watts, Jeffery MD Reappointment Effective:	Psychiatry December 28, 2013 thru December 27, 2014	Active Physician

Department of Surgery

Gandhi, Yogesh, MD Reappointment Effective:	Neurosurgery December 21, 2013 thru December 20, 2015	Active Physician
Wysocki, Robert, MD Reappointment Effective:	Orthopedic Surgery December 11, 2013 thru December 10, 2015	Active Physician

Department of Trauma

Clar, Steven A., MD Reappointment Effective:	Physical Medicine December 11, 2013 thru December 10, 2015	Active Physician

Renewal of Privileges for Non-Medical Staff

Nwigwe, Joy C., CNP With Franco-Sadud, Ricardo A., MD Effective:	Medicine / Hospital Medicine January 19, 2014 thru January 18, 2016	Nurse Practitioner
Ragauskis, Pauline M., PA-C With Kysia, Rashid Fuad, MD Alternate Schaider, Jeffrey, MD With Leekha, Deepak, MD Alternate Shah, Sejal, MD Effective:	Emergency Medicine Medicine / General Medicine December 18, 2013 thru December 17, 2015	Physician Assistant

Medical Staff Status Change with no Change in Privileges

Goldberg, David MD	Active/General Medicine	To Voluntary Physician
Paul, Reena MD	Active/Family Med	Department change from Family Medicine to Correctional Health
Watts, Tabitha MD	Voluntary/Pediatrics	To Active Physician

Medical Staff Additional Clinical Privileges

Lahijani, Sheila C. MD	From Service to Active Physician	Psychiatry/ Core Psychiatry
Napoles, Phyllis MD	Active Physician	Advanced Laparoscopic Privileges

Provident Hospital of Cook County

Medical Staff Appointments/Reappointments and Non-Medical Staff Action Items Subject to Approval by the CCHHS Quality and Patient Safety Committee

INITIAL APPOINTMENT APPLICATIONS

Department of Emergency Medicine

Tai, Jahangir, DO	Emergency Medicine	Voluntary Physician
Appointment Effective:	December 11, 2013 thru December 10, 2015	

Department of Surgery

Napoles, Phyllis MD	General Surgery	Affiliate Physician
Appointment Effective:	December 11, 2013 thru December 10, 2015	

Initial Non-Physician Appointment Applications

Eneogwe, Joy C.P., CNP	Internal Medicine	Nurse Practitioner
With Chukwudozie O. Ezeokoli, MD		
Effective:	December 11, 2013 thru December 10, 2015	

REAPPOINTMENT APPLICATIONS

Department of Internal Medicine

Brannegan, Richard MD	Neurology	Affiliate Physician
Reappointment Effective:	December 18, 2013 thru November 17, 2015	

Department of Obstetrics/Gynecology

Milad, Magdy, MD	Gynecology	Affiliate Physician
Effective:	December 11, 2013 thru July 28, 2015	

Renewal of Privileges for Non-Medical Staff

Baht-Yehudah, Adaminah K., PA-C	Surgery / General Surgery	Physician Assistant
With Crawford, Clifford S. , MD		
Alternate Ansari, Shahid A., MD		
Effective:	December 11, 2013 thru June 10, 2014	

CCHHS
APPROVED
BY THE QUALITY AND PATIENT SAFETY COMMITTEE
ON DECEMBER 11, 2013