



COOK COUNTY
HEALTH

HRO Dashboard 2.0

April 2023

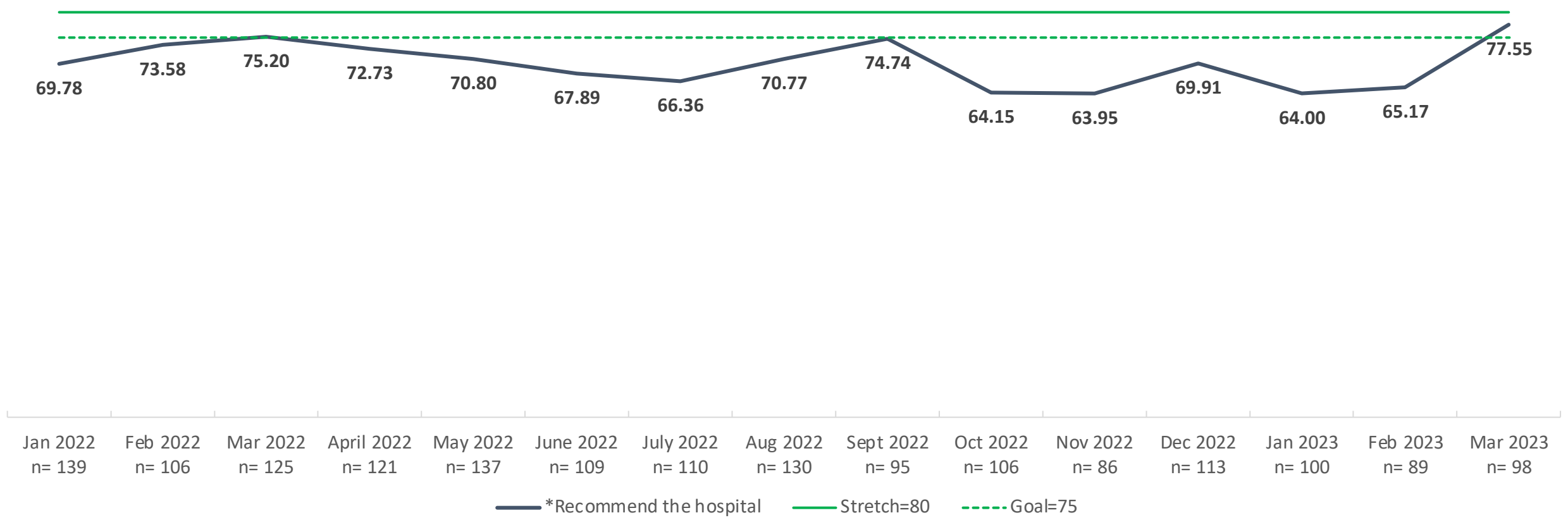


COOK COUNTY
HEALTH

HRO Patient Experience Workgroup

Likelihood to Recommend Stroger Hospital – Top Box Score by Received Date

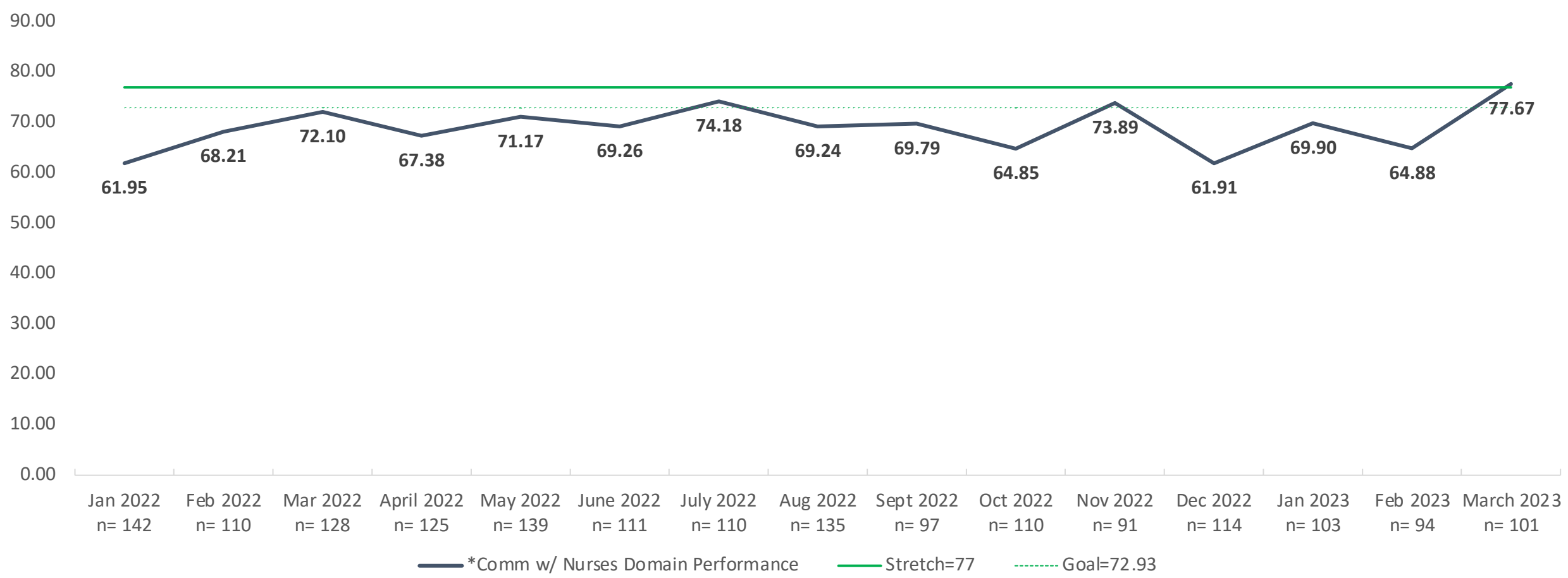
Rolling 12 months 4/1/22-3/31/23 70.02



HRO Patient Experience Workgroup

Communication with Nursing Domain Stroger Hospital – Top Box Score by Received Date

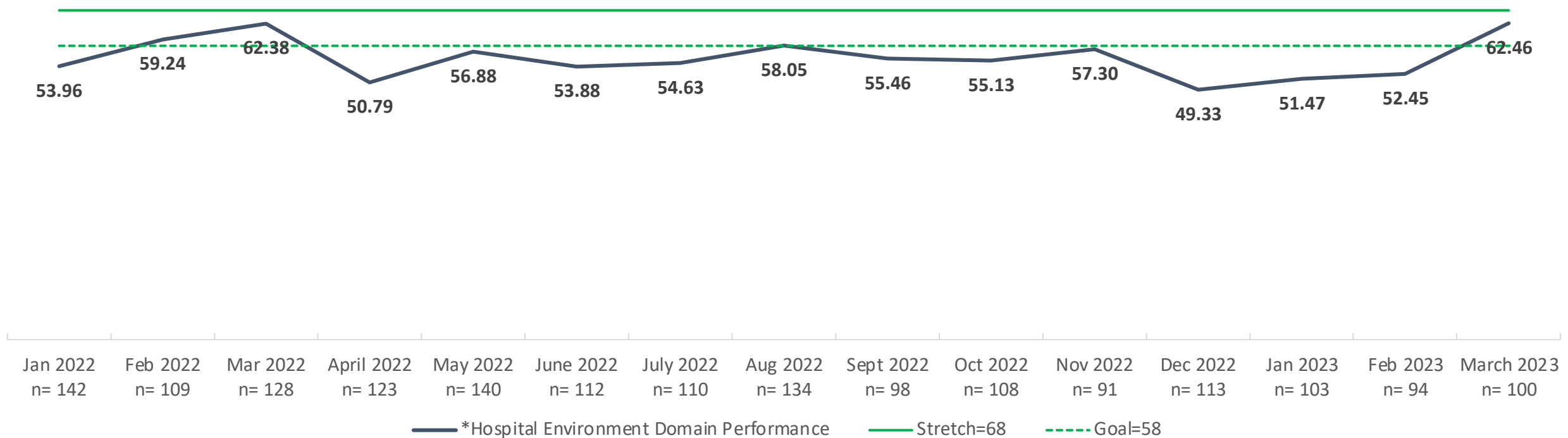
Rolling 12 months 4/1/22-3/31/23 69.39



HRO Patient Experience Workgroup

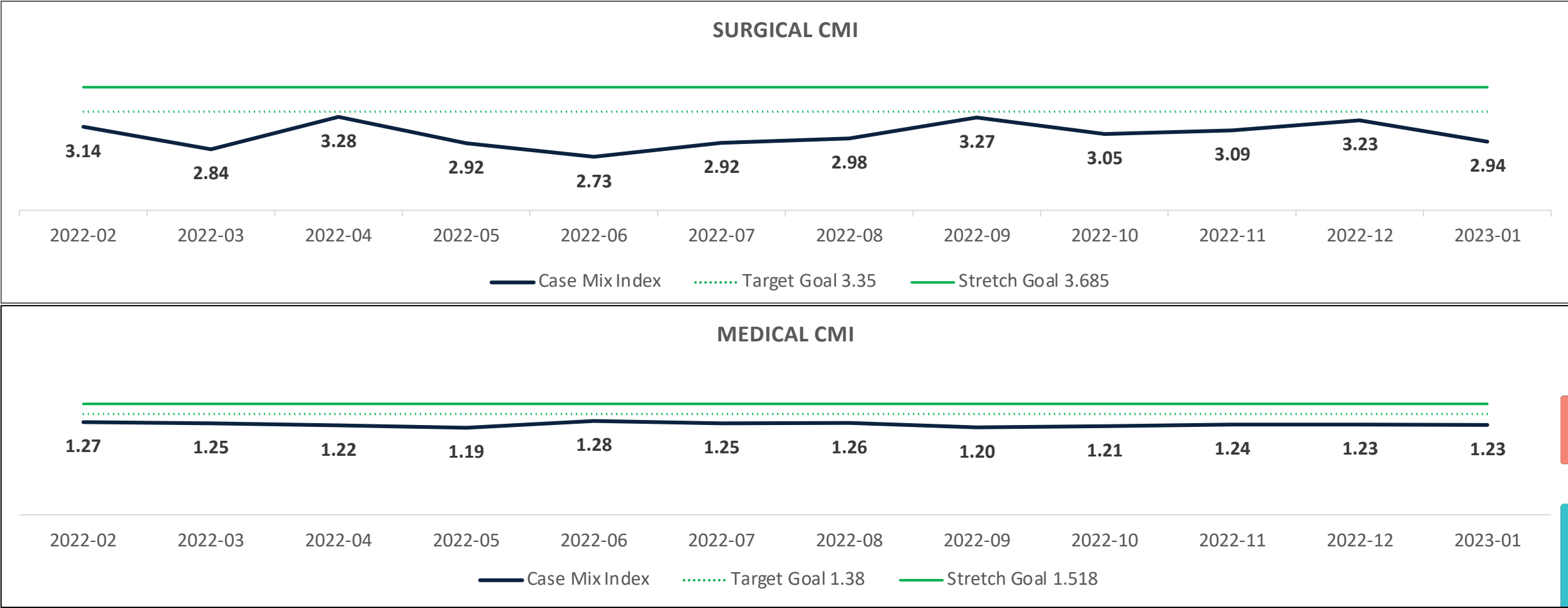
Environment Domain Stroger Hospital – Top Box Score by Received Date

Rolling 12 months 4/1/22-3/31/23 54.47



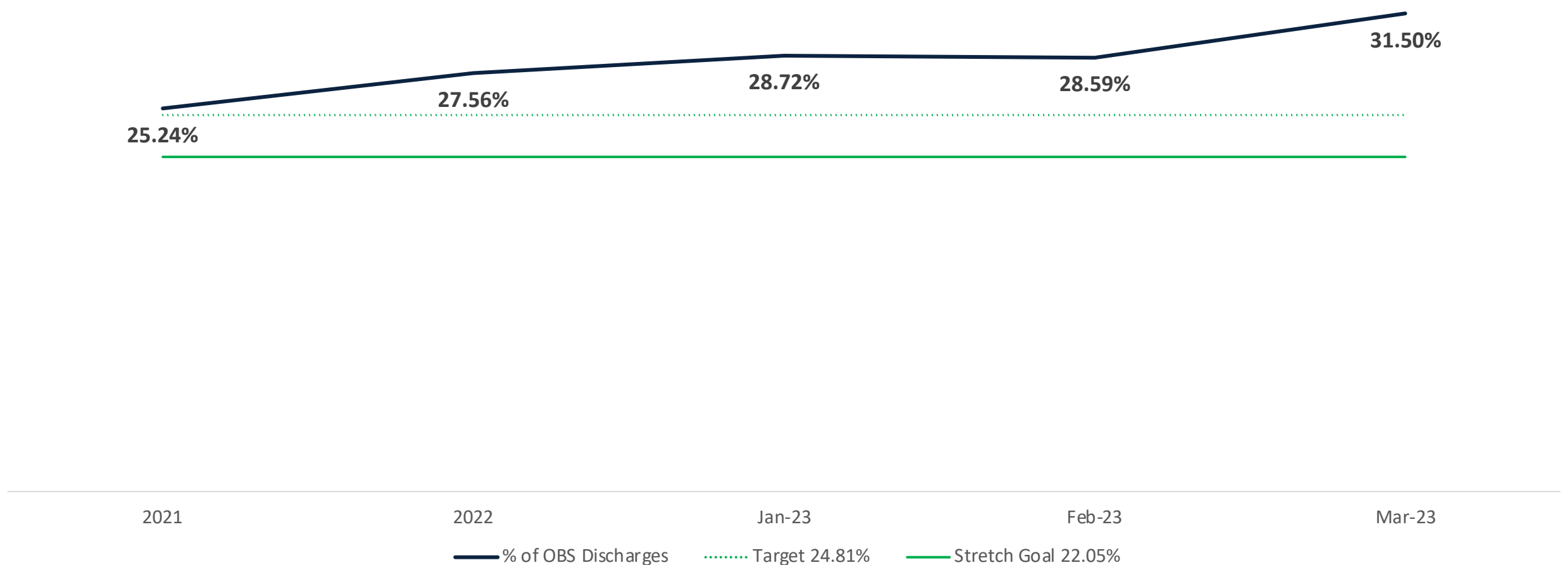
HRO Clinical Documentation Workgroup

Medical CMI & Surgical CMI - Stroger Hospital



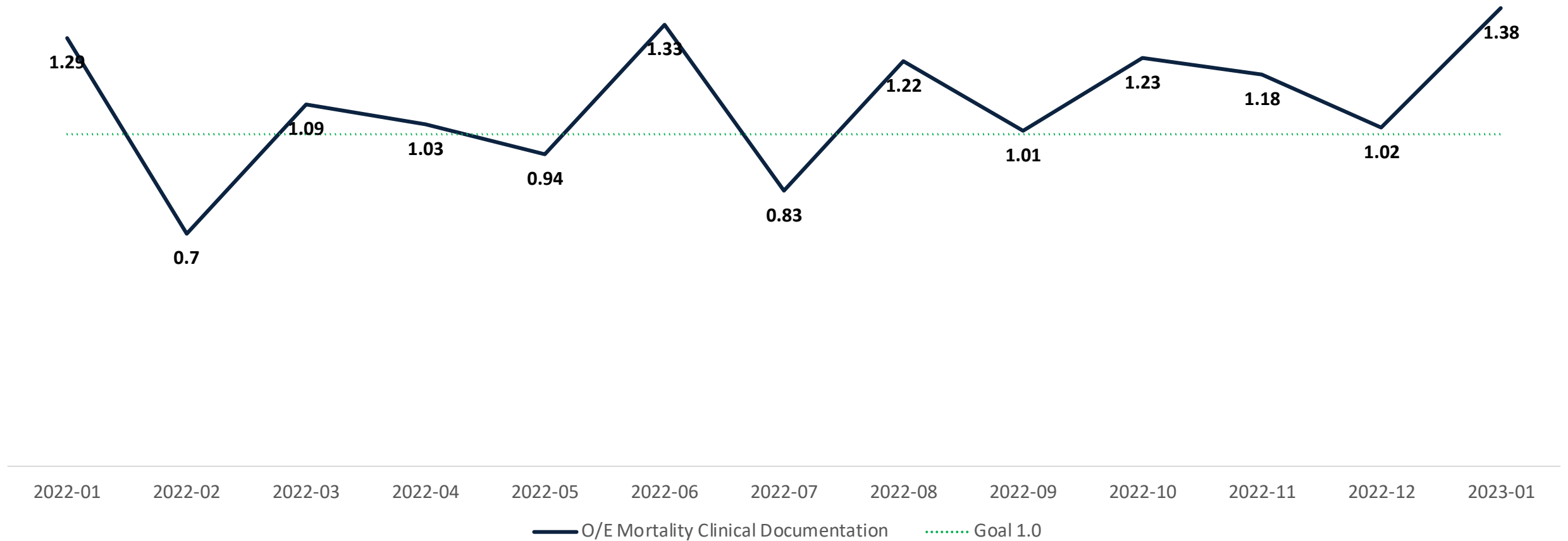
HRO Clinical Documentation Workgroup

Observation % of All Discharges - Stroger Hospital



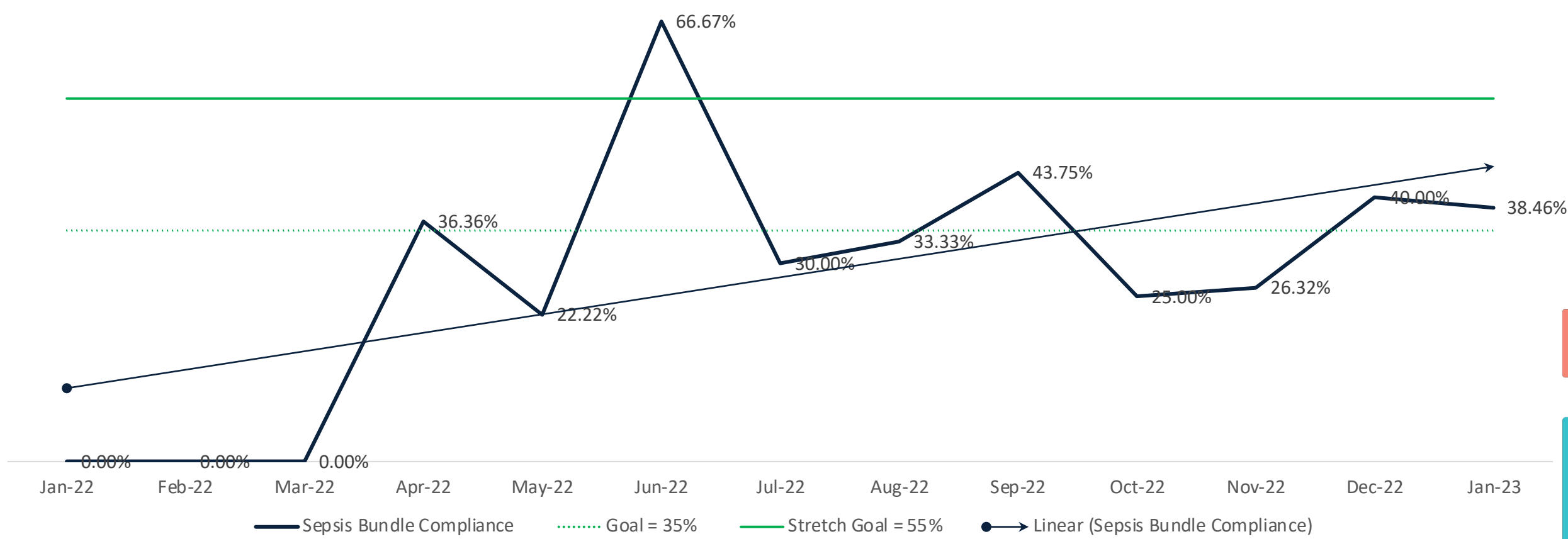
HRO Clinical Documentation Workgroup

Observed over Expected Mortality Improvement – Stroger Hospital



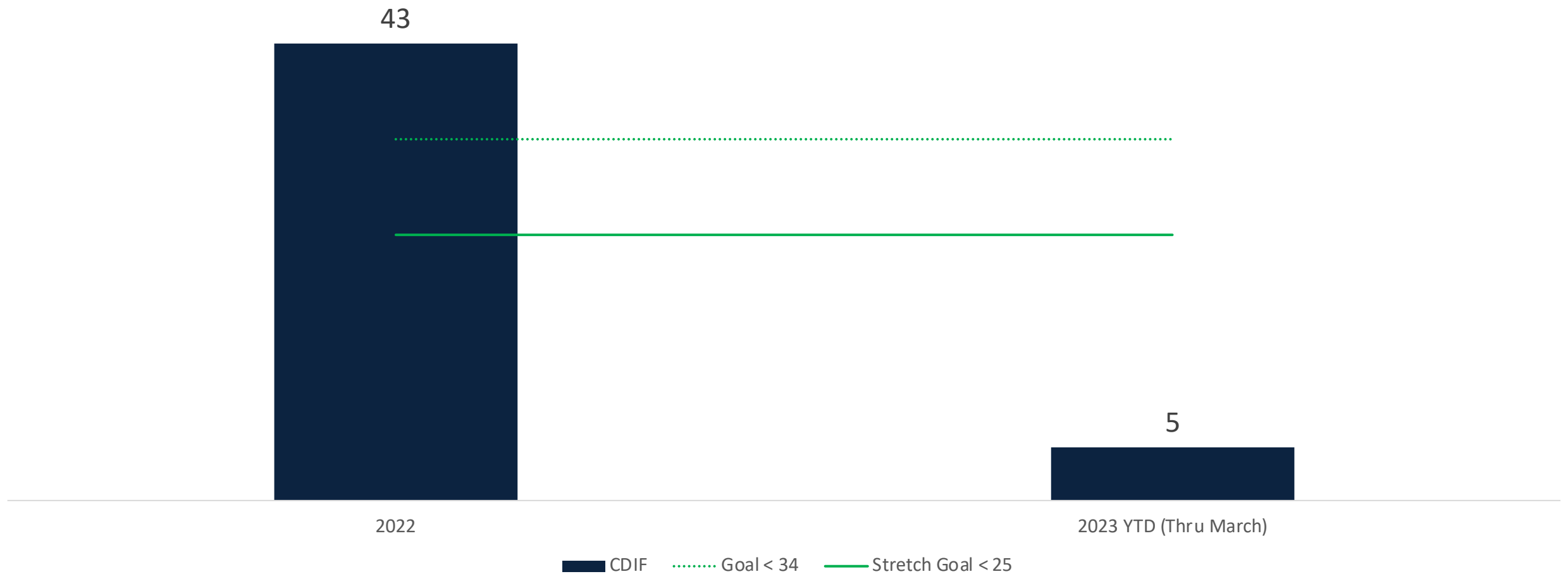
HRO Clinical Outcomes Workgroup

CMS SEP-1 % of Patients with met Compliance



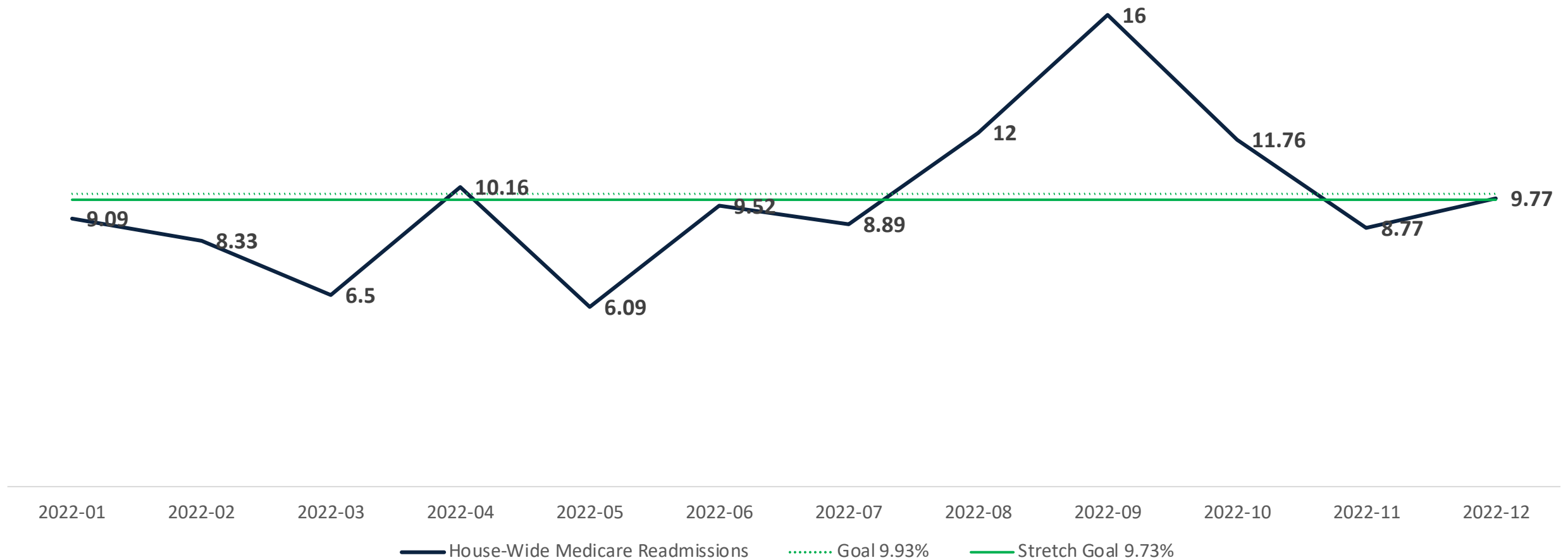
HRO Clinical Outcomes Workgroup

CDIFF Volume



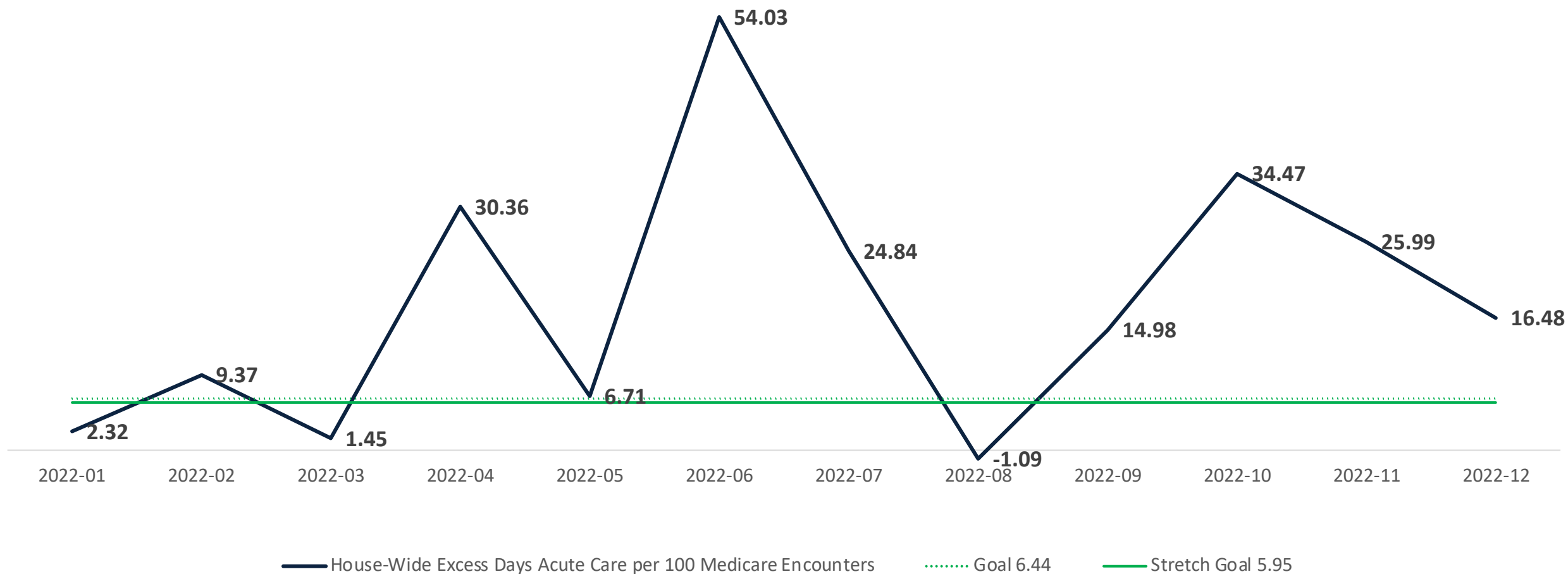
HRO Readmissions Workgroup

CMS Medicare House-Wide Readmissions Rate – Stroger Hospital



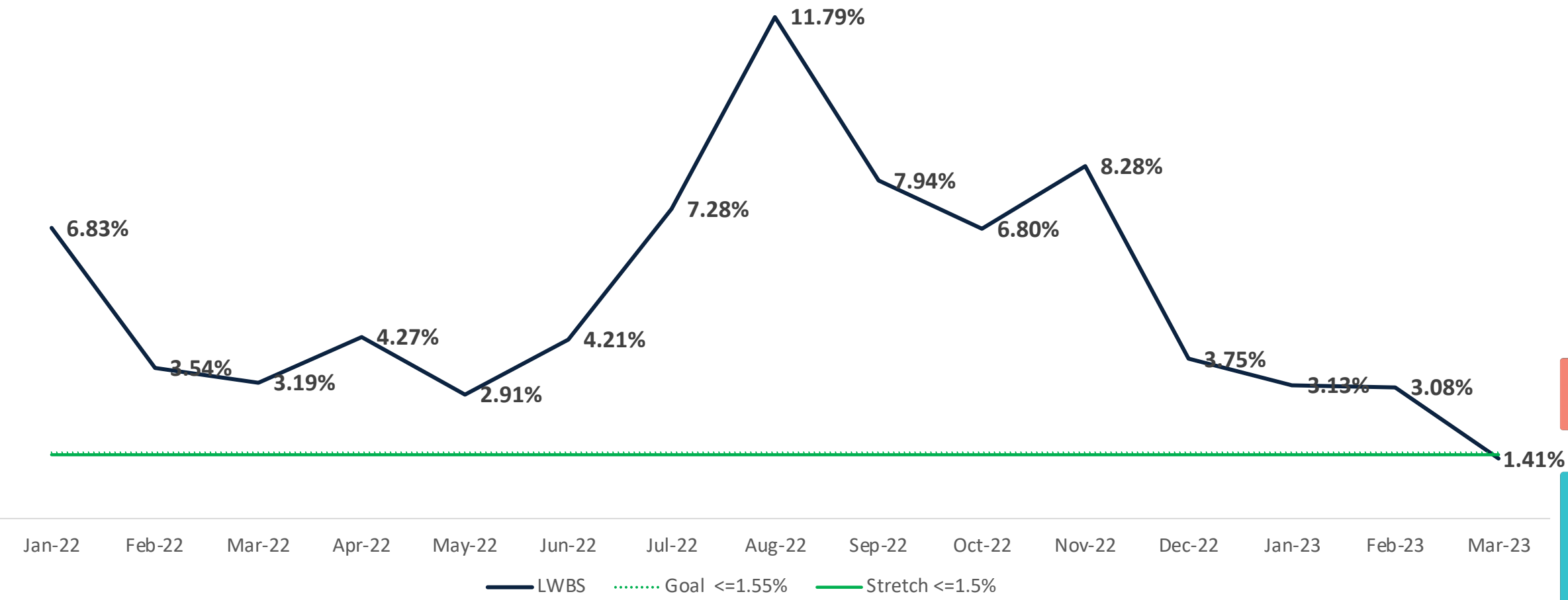
HRO Readmissions Workgroup

CMS House-wide Excess Days Acute Care per 100 Medicare Encounters – Stroger Hospital



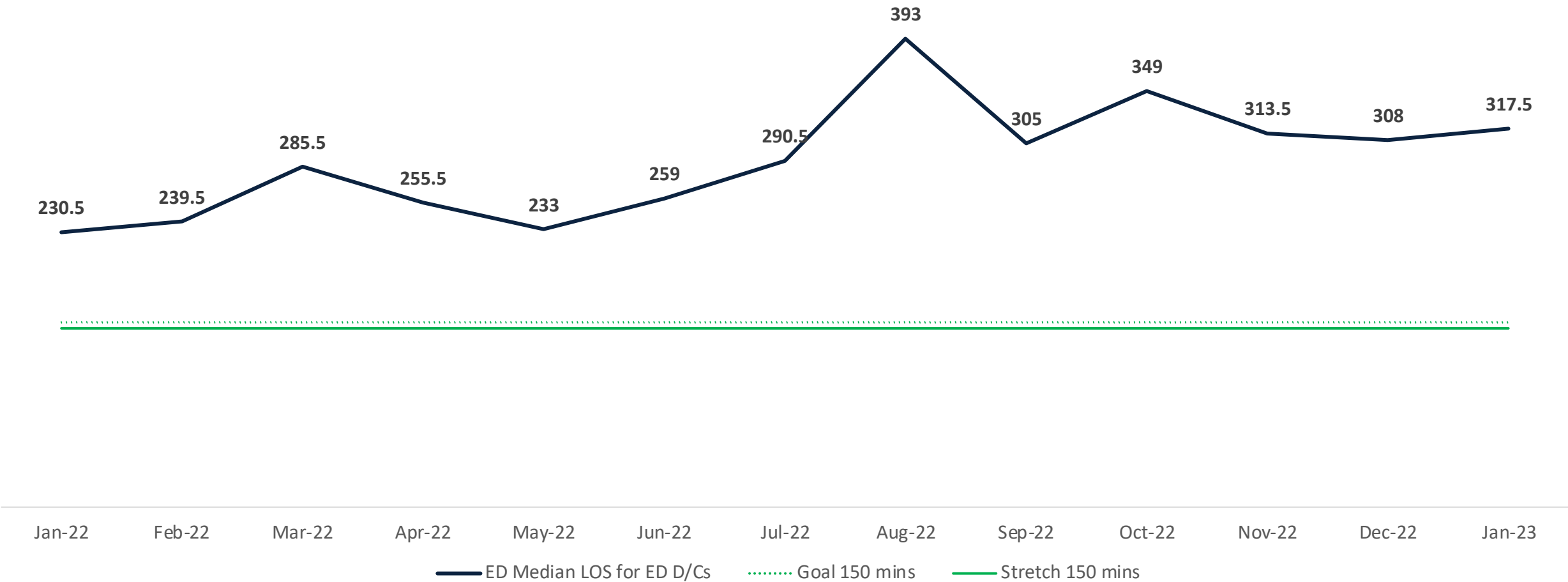
HRO Throughput Workgroup

ED Left Without Being Seen



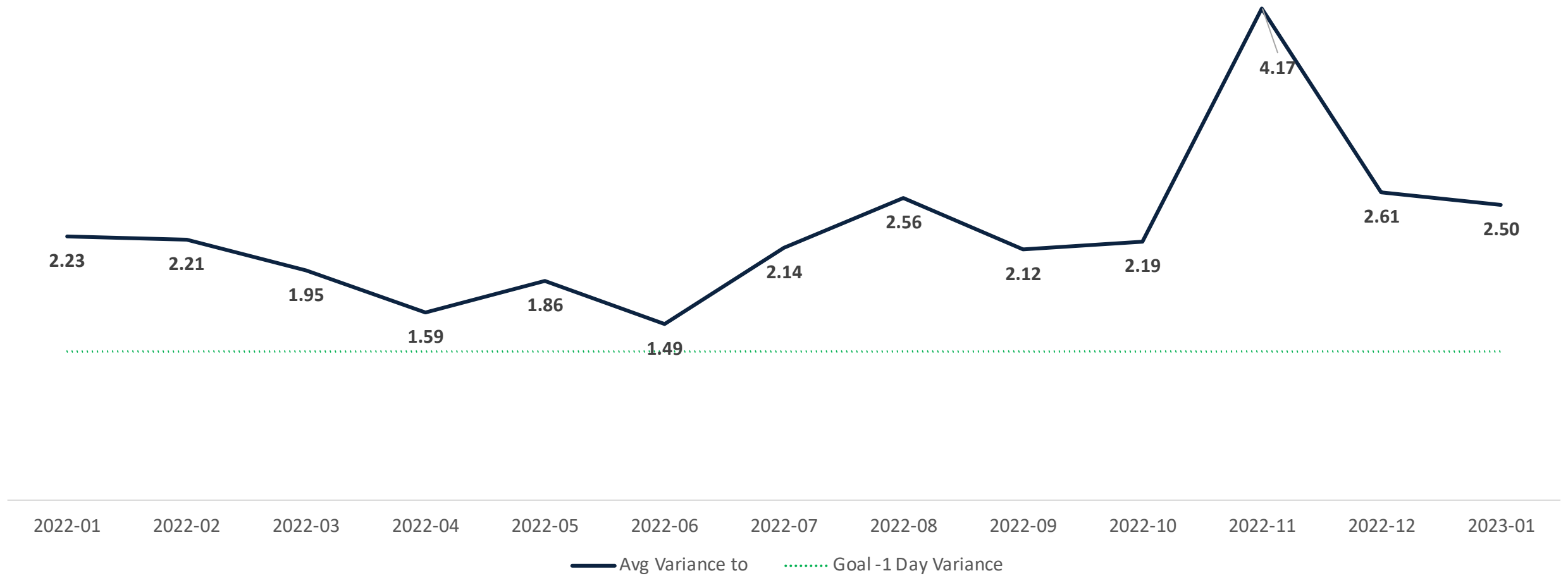
HRO Throughput Workgroup

ED Median Length of Stay for ED Discharges



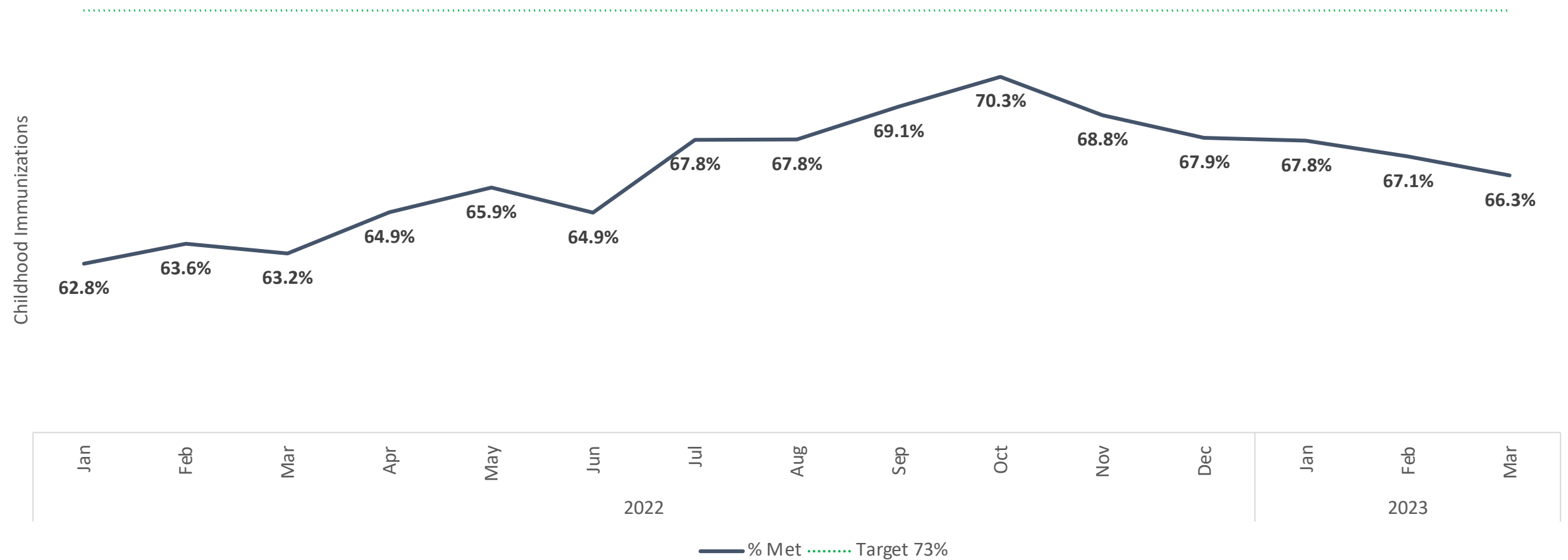
HRO Throughput Workgroup

Average Variance MSDRG-GMLOS



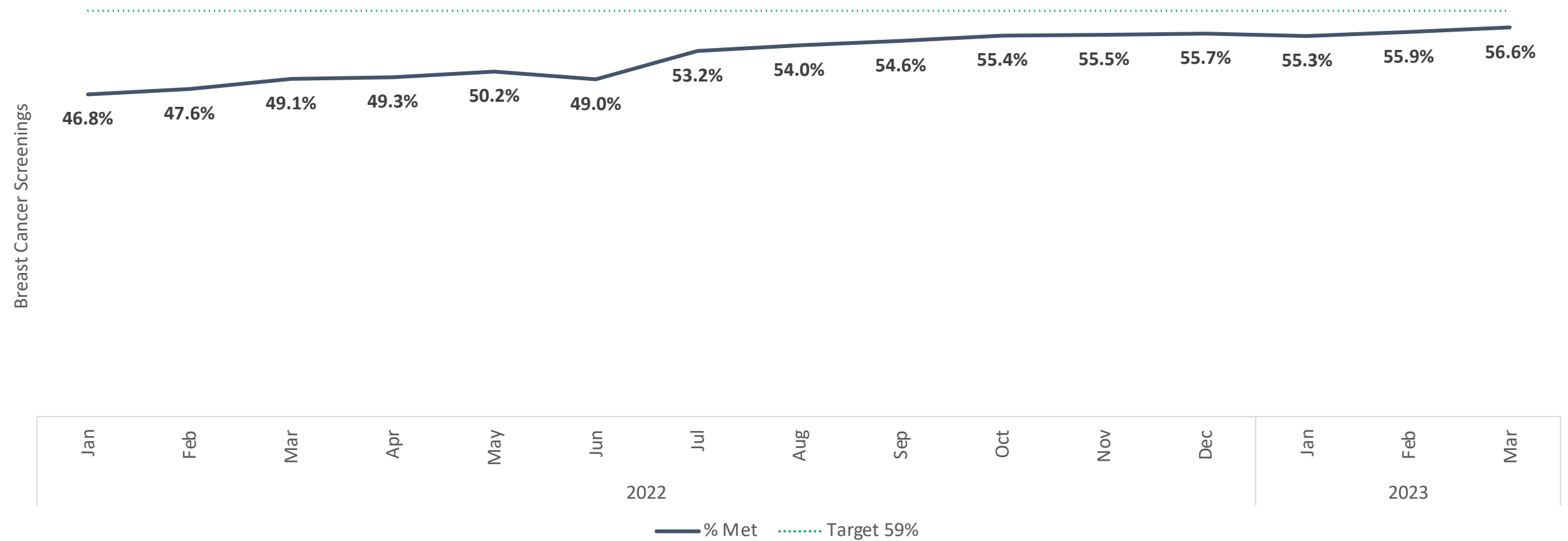
HRO HEDIS Workgroup

Childhood Immunizations for <2 yrs. of age > 73%



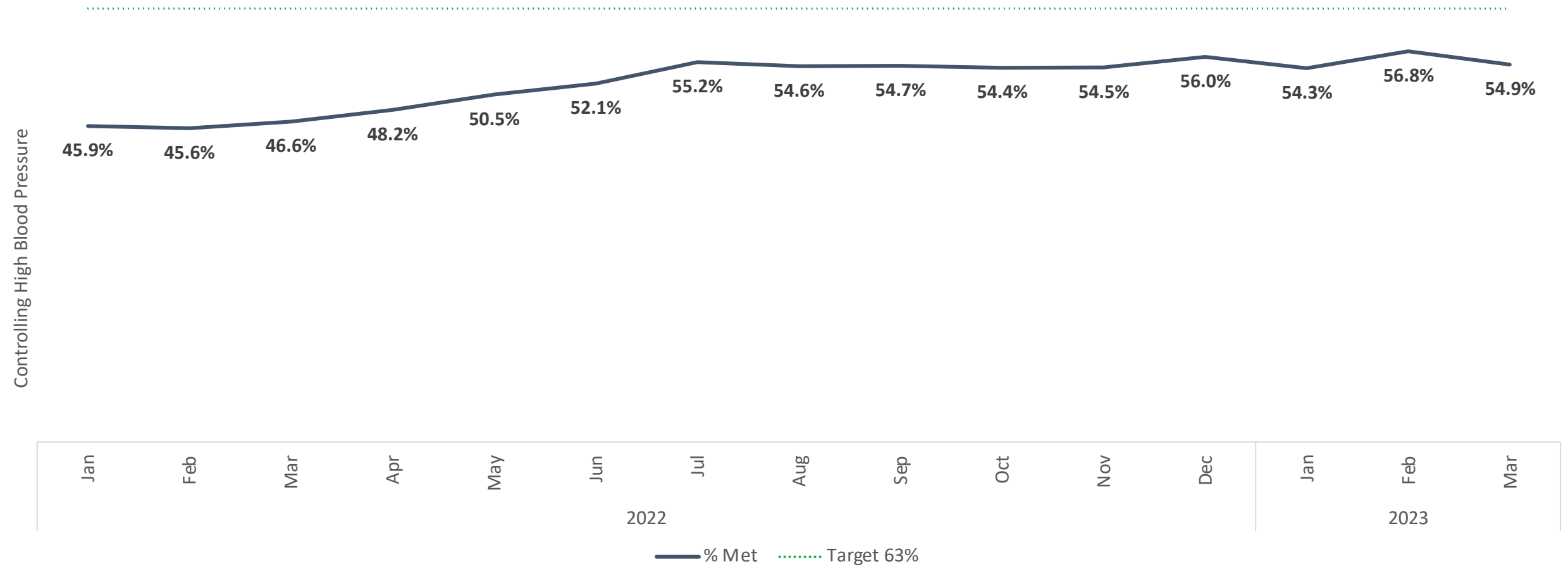
HRO HEDIS Workgroup

Breast Cancer Screening for women 52-74 > 59%



HRO HEDIS Workgroup

Hypertension Blood Pressure <140/90 Compliance



HRO Patient Experience Workgroup A3

Overall Progress

HRO Patient Experience Workgroup A3													Tactical A3 Owner:											
Performance, Gaps & Targets			This Year's Action Plan																					
			Goals	Specific Actions / Tactics	Deployment Leader	January - December 2023																		
						J	F	M	A	M	J	J	A	S	O	N	D							
			Likelihood to Recommend Hospital 2022 Performance: S 70.15 P 52.50 2023 Goal: 75																					
			Communication with Nurses Domain 2022 Performance: S 68.5 P 71.12 2023 Goal: 72.93	CI-CARE training Commit to Sit Nurse leader rounding	Sherrie Spencer																			
			Communication with Doctors Domain 2022 Performance: S 81.85 P 74.97 2023 Goal: 85	CI-CARE training Physician shadowing (iRounds)	Dr. Ezeokoli																			
Reflection on Last Year's Activities & Key Accomplishments			Discharge Information Domain 2022 Performance: S 80.75 P 73.08 2023 Goal: 84%	Customized discharge folders	Cassandra Waldington																			
			Care Transitions Domain 2022 Performance: S 48.6 P 45.67 2023 Goal: 51%	Identify patient education plan for medications	Denise Goodie																			
			Cleanliness of Hospital Environment 2022 Performance: S 56.19 P 59.09 2023 Goal: 58	Updates to nursing units Visual management after cleaning has been Use iRound for cleanliness follow-up	Adam Weber & John Jordan																			
			Quietness of Hospital Environment 2022 Performance: S 55.05 P 70.45 2023 Goal: 58	Quiet packs Considering white noise machines	Adam Weber & John Jordan																			

HRO Clinical Documentation Workgroup A3

Overall Progress

HRO Clinical Documentation A3

Tactical A3 Owner:

This Year's Action Plan														
Goals	Specific Actions / Tactics	Deployment Leader	January - December 2023											
			J	F	M	A	M	J	J	A	S	O	N	D
Increase Surgical CMI by 10% 2022 baseline: 3.0492 Goal: 3.35412	Trauma subcommittee	William Brigode												
	SICU subcommittee	Dan Kasey												
	Cardio-thoracic subcommittee	Ray Sawaqed												
	Orthepedic subcommittee	Joel Williams												
	General surgery subcommittee	Tom Komar												
	Vascular subcommittee	Maggie Rigamer												
Increase Medical CMI by 10% 2022 baseline: 1.2537 Goal: 1.37907	Target MICU	Ashvini Damodaran												
	Target CCU and cardiology floor	Tareq Alyousef												
	Target general-medical floors	Michael Alebich												
	Medical consultation co-management	Michael Hoffman												
Decrease mortality index 2022 baseline: 1.07 Goal: less than or equal to 1.0	Mandatory mortality review	Leslie Frain												
Institute an auditing and quality control process to include CDI specialists & coders	TBD	Leathecia Arnold												
Documentation Integrity for admissions status	TBD	TBD												

HRO Clinical Outcomes Workgroup A3

Overall Progress

Tactical A3 - Clinical Outcomes Workgroup Committee Chairs- Jafar Hasan, MD & Margaret Carroll, RN																	
Performance, Gaps & Targets	This Year's Action Plan																
In 2022, we had a total of 12 HAPI, 8 CLABSI, 12 CAUTI and 43 C-Diff cases across CCH. We had 14 VTEs from Jan-Nov 2022. We did not meet compliance with sepsis alert response and 3-hour bundle compliance. The long-term plan is 1-hour sepsis bundle compliance. Total hip and knee complications, iatrogenic pneumothorax, perioperative hemorrhage and post-operative respiratory failure were not significant areas of quality and performance improvement focus. The data suggests that hip and knee complications are largely related to VTE, so if that data is verified, hip and knee complications will be included in the VTE prevention committee.	2022 Performance	2023 Goals	Tactics	Deployment Leader	January - December 2023												
	HAPI PREVENTION				J	F	M	A	M	J	J	A	S	O	N	D	
	2022 baseline: 12 total - Stroger and Provident - 9 at Stroger/3 at Provident comp. hospital:	Stroger: goal maintain no more than 9/Stretch goal - 10% reduction	Institute Prevalence and Incidence surveillance at Provident	Jessica Salgado, MSN,RN &													
		Provident: goal __, stretch	Develop Wound Champions at Provident	Ahmed Ali, MD													
	SEPSIS																
	SEP-1 Bundle Compliance 2022 baseline: 27% Goal 35% Stretch : 55%	3h lactate 2022 - 47%, increase by 10%	Move to Bundle Compliance	Kathryn Radigan, MD & Heather Prescero, MSN,RN													
		3h blood cx 2022 - 56%, increase by 10%	Documentation of Care														
		3h antibiotics 2022 - 74%, increase by 10%	Coding Compliance														
		3h fluids 2022 - 31%, increase by 10%	Abstraction accuracy														
	6h lactate 2022 - 31%, increase by 20%	Raise Awareness															
PSI-13 (incidence per 1,000): 12 mo. baseline 6.48, 7 cases	Goal <6 Stretch <5																
INFECTION PREVENTION																	
CAUTI: 2022 baseline: 12 cases in 2022	Goal 15% reduction / Stretch Goal - 25% reduction	Bundle Compliance	Sherrie Spencer, MSN,RN & Sharon														
CLABSI: 2022 baseline: 8 cases in 2022	Goal 10% Stretch 25%	Bundle Compliance															
C-DIFF: 2022 baseline: 43 cases in 2022	Goal 20% reduction (<34) Stretch 25% reduction (<25%)	Identification of all POA C-Diff	Welbel, MD														
POST-PROCEDURAL COMPLICATIONS																	
PSI-06 Pneumothorax (#/1,000 cases) 2022 baseline .392, 3 cases	Goal <3 Stretch <2		Julie Comer, MD & Margot Abacarian, MSN,RN														
PSI-09 Hemorrhage & Hematoma (#/1,000 cases) 2022 baseline 2.68, 5 cases	Goal <5 Stretch <4																
PSI-11 Respiratory Failure (#/1,000 cases) 2022 baseline 8.33, 14 cases	Goal <11 Stretch <10																
VTE PREVENTION																	
PSI-12 Postoperative VTE		Maximize use of the VTE Risk	Thomas Komar, MD														
Reflection on Last Year's Activities & Key Accomplishments																	
Not applicable with regard to the Clinical Outcomes Committee Level (newly formed Committee in 2023). Last year's activities for the subgroups are as follows: HAPI Prevention -Total of 9 HAPI at Stroger and 3 at Provident in 2022.While Provident had an increase from 0 in 2021 to 3 in 2022, overall, HAPIs in the health system reduced by 25% from 16 in 2021 to 12 in 2022. Stroger continues to benchmark at or below the 10th percentile nationally. Sepsis - Physician and Nursing education completed. 73% compliance with sepsis alert to provider notification w/i 15 minutes and 80% compliance with sepsis alert to completion of																	

Overall Progress

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HRO Throughput Workgroup A3

Overall Progress

Performance, Gaps and Targets	Action Plan			
The HRO Throughput Tactical Working Group (TTWG) tracks and trends data that is nursing, EVS, and transport centric and utilizes that data to develop actionable items and tactics to improve efficiencies within each department. Overarching goal is to create visibility, transparency, and synergies to improve patient flow. TeleTracking platform will be the source of truth for data analysis and be the measurement of successes and opportunities. The HRO TTWG will meet twice a month to review findings and measure progress on outstanding actions.	Workgroup	Focus	Actions/Tactics	January - December 2023
Last Year's Activities and Key Accomplishments	ED Throughput	Identify ED process bottlenecks	Review Process Map to identify actionable bottlenecks	
		Update ED Throughput metrics	Identify metrics to reflect improvement processes in ED	
	Dr. Robert Needleman	LWBS <4.3%, stretch <2%	Dr. Quick area to remain open daily	
	William McCracken	ED Arrival to Departure (DC) <420		
		ED Arrival to Departure (Adm) <240		
		Boarders (patients waiting for bed >6 hours)	Create the Virtual Unit to accommodate up to 20 patients to initiate inpatient care pending bed assignment	
		RTM to assign (15min), occupied, compliance		
	Operational Throughput	Identify Bed Control, EVS, Transportation bottlenecks	Create Process Map for Bed Control, EVS and Transportation to identify actionable bottlenecks	
		EVS response time (<30)		
	Adam Weber	EVS Bed TAT (<60min)		
	Lynell Wright	EVS Clean Time (30min)		
	George Esher	Trans Time Pending to Complete		
		Transport Delay Times		
		Bed Control Metrics		
		Geographic localization compliance		
	Inpatient Throughput	Discharge Orders by noon - MD		
		% Pending Discharge Compliance		
	Dr. Nigist Taddese	% Nursing Discharge by 2pm		
	Shery Spencer	Confirmed dc to actual dc time <120		
	Dr. Anshu Singh	Cardiology TAT		
	Dr. Tejinder Randhawa	Radiology TAT		
	Dr. Yasmine Golzar			
	Cassandra Waddlington			
	Helen Agomo			
	OR Throughput	First Case Start Time <5min		
	Dr. Richard Keen	Turnover Times		
	Daphne Mitchell	Cancellation Rates		
	Data Throughput	ALOS VS GMLOS		
	Andrea Gibson	IT Support		
	Chris Caudill	QI Data Support		
	Angela O'Banion			
	Andrea Ramel			
Rationale for this Year's Activities				
HRO: Throughput Workgroup focus this year is to identify system bottlenecks that limit productivity and efficiency of patient movement from the admission in ED, through inpatient unit management to discharge. We will identify major bottlenecks in the respective areas of care: ED, bed control, transportation, EVS, diagnostic testing, discharge process; identify additional metrics to monitor improvements; implement processes to reduce idle time of the bottleneck resources, examine and change operations on processes that fed into the bottleneck and that are directly fed by the bottleneck resources, and focus on adding capacity vs. reducing demand of the bottleneck resources on the clinical side.				

Overall Progress

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