JOHN H. STROGER JR. HOSPITAL OF COOK COUNTY
2021 QUALITY AND PATIENT SAFETY PLAN

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I. Mission and Vision

Mission

To deliver integrated health services with dignity and respect regardless of a patient's ability to pay; foster partnerships with other health providers and communities to enhance the health of the public, advocate for policies which promote and protect the physical, mental, and social well-being of the people of Cook County.

Vision

In support of its public mission, CCH will be recognized locally, regionally, and nationally — and by patients and employees — as progressively evolving model for an accessible, integrated, patient-centered and fiscally-responsible health care system focused on assuring high-quality care and improving the health of the residents of Cook County.

II. Introduction

The Quality and Patient Safety Plan ("the Plan") provides a framework for an integrated and comprehensive program to monitor, assess, and improve the quality and safety of patient care that is delivered. This Plan supports the organizational mission to provide clinical excellence at a reasonable cost and continuously improve patient outcomes.

The Plan infrastructure supports a commitment to quality, safe, evidence-based care, and continuous learning to provide the highest level of care to the communities we serve. The committees and councils within the structure are multidisciplinary and include representatives from impacted entities such as providers, staff, and outpatient care area representatives where appropriate. Ultimate accountability is with the CCH Board of Directors through the Quality and Patient Safety (QPS) Committee of the Board, the Executive Medical Committee (EMS), and Hospital Quality Improvement and Patient Safety Committee (HQuIPS), which has direct oversight of the quality and safety of care delivered along with the High Reliability Organization (HRO) workgroups reporting structure. The Plan is implemented by the HQuIPS Committee pursuant to the Medical Studies Act (735 ILCS 5/8-2101, et seq.), the Illinois Licensing Act and the Patient and Quality Improvement Act of 2005.

III. Purpose

The purpose of the Plan supports the systematic organization-wide approach to plan, design, measure, assess and improve organizational performance, identify, minimize, and prevent organizational risks, and ensure delivery of safe patient care.

Under this Plan, initiatives are designed to:

- Achieve performance improvement goals in an efficient manner.
- Minimize risks and hazards of care.
- Support an engaged workforce and safe workplace.
- Enhance appropriate utilization.

- Develop and share best practices.

The Plan is intended to provide a framework of guiding principles for all participants in the provision of care. This structure will set proper expectation and encourage all to participate proactively in the improvement process and in sustaining of a safety-oriented culture.

IV. Definition of Quality

Quality is defined as a never-ending cycle of continuous improvement. Quality is providing the right care at the right time, for the right patient and right the first time and every time. Care should be based on the strongest clinical evidence and provided in a technically and culturally competent manner with good communication and shared decision making. Therefore, the organization commits to continuous measurement, analysis, and improvement.

V. Scope

This Plan applies to all inpatient services and sites of care including contracted services. The Plan includes an ongoing assessment (using internal and external knowledge and experience), to prevent error occurrence and maintain and improve healthcare safety and quality. It is recognized that patients, staff, visitors, and other customers have the right to expect the best possible clinical outcomes, a safe environment, and an error free care experience. Therefore, the organization commits to continuous measurement, analysis, and improvement.

VI. Goals and Objectives

The approach to performance improvement is continuously assessed and revised to meet the goal of ensuring that patient outcomes are continually improved, and safe patient care is provided. Examples of information utilized to achieve this goal include variance related data such as medication errors and falls; infection prevention surveillance; sentinel event alerts; and TJC clinical measures data, as well as patient experience reports. The criteria used to prioritize opportunities for improvement include, but are not limited to:

- Patient Safety
- Strategic plan goals/objectives
- Mission/vision
- Quality outcomes
- Efficiencies of care

The John H. Stroger Jr. Hospital of Cook County recognizes that to be effective in improving quality and patient safety there must be an integrated and coordinated approach to improving patient outcomes and reducing preventable harm. This plan established the following goals:

1. Promote a culture of safety throughout the organization.
2. Improve the reporting of safety events by maintaining and acting upon the adverse

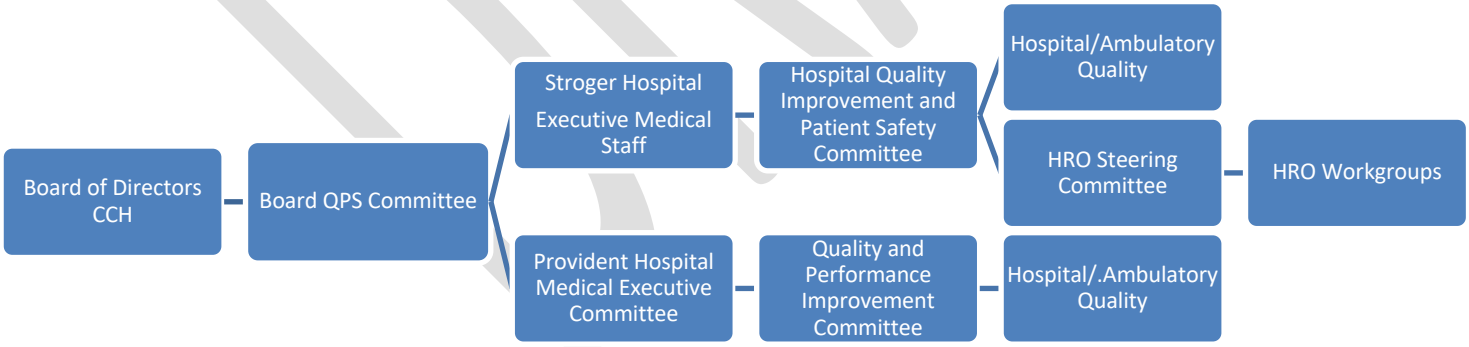
event reporting policy. This policy promotes a safe reporting environment where reporting of events is encouraged in a non-punitive manner.

3. Foster the use of the confidential electronic event reporting system (eMERS) which includes documentation and follow-up.
4. Expand the implementation of evidence-based practices.
5. Monitor system-wide indicators for established areas of focus.
6. Reduce the number of serious safety events.
7. Conduct proactive risk assessment utilizing the Failure, Mode, Effects Analysis (FMEA) Methodology as appropriate.
8. Monitor and improve areas identified through Patient Experience Surveys.

Performance improvement priorities and activities may be reprioritized based on significant organizational performance findings, changes in regulatory requirements, patient population, environment of care, and expectations and needs of patients, staff, or the community. Priorities may be reset by the multidisciplinary HQuIPS Committee in consultation with senior management and the Executive Medical Staff.

VII. Organizational Structure, Committees, Responsibilities

The Plan supports the reporting structure established by the CCH Board of Directors through the Board QPS Committee, EMS, HQuIPS Committee and HRO workgroup structure. Communication between all the elements of the structure is essential for the successful implementation of this plan.



A. CCH Board of Directors-Responsibilities

The CCH Board of Directors **(Appendix A**) is ultimately responsible for the safety and quality of care, treatment, and services. They are accountable and ultimately responsible for holding senior management, medical staff, and leaders accountable for the quality improvement goals and ensuring they are integrated with the organization's strategic initiatives. The CCH Board of Directors is composed of committees and subcommittees. The QPS Committee of the Board **(Appendix B**) shall oversee the quality, safety, and performance improvement programs of CCH with the goal of recognizing the critical importance of maintaining high quality service and patient and staff safety and satisfaction.

B. Board Quality and Patient Safety Committee (QPS)-Responsibilities

Additional responsibilities of the Board QPS Committee include:

- Provides for the resources needed to maintain safe, quality care, treatment, and services.
- Ensures all patients are provided with the highest-quality care possible while incorporating the foundations of the Plan.
- Reviews summaries of improvement activities and performance indicators to track results of overall performance.
- Reviews medical staff credentialing and privileging/appointment process to ensure compliance with established procedures and the Medical Staff Bylaws for John H. Stroger Hospital.
- Serves as a liaison between the CCH hospital Affiliate Medical Staffs and the System Board of Directors.
- Establishes committees and subcommittees as necessary to fulfill their role of the overseer of quality.
- Is accountable for, and delegates to, the HQuIPS Committee who has oversight of organization-wide quality, safety, and performance improvement efforts.

C. The Executive Medical Staff Committee (EMS)-Responsibilities

The full scope of responsibility of the EMS is outlined in the Stroger Hospital Bylaws and policies of the Medical Staff. Activities related to quality and safety include **(see Appendix C for membership):**

- Makes recommendation to the CCH Board of Directors through the CCH QPS Committee on a regular basis regarding the credentialing and privileging of the Medical Staff.
    - Provides leadership for measuring, assessing, and improving processes.
    - Actively participates in the oversight, evaluation, and performance improvement activities of the organization to improve the quality and safety of patient care.
    - Reviews medical staff compliance with standards and regulations set forth by CMS, the Joint Commission (TJC), or other state or federal agencies as required.

- Provides medical staff oversight for the quality improvement activities of the medical staff departments and the committees of the medical staff.

D. Hospital Quality Improvement and Patient Safety Committee (HQuIPS)-Responsibilities

The HQuIPS Committee develops and supports the implementation of the strategic plan for quality and patient safety for the organization. The Committee includes membership representing the medical staff, senior executive leadership, and the quality management leadership of the organization (**Appendix D**). The System CMO appoints a designee to serve as the Chair of the Committee, which is endorsed by the Board QPS Committee. For purposes of direction and oversight of the organization's improvement strategies, the HQuIPS Committee reports to the EMS and the CCH QPS Committee of the Board. The HQuIPS Committee functions as a synergistic group that shares thoughts and ideas on best practices in the organization (**see Appendix E for reporting schedule**). Additional functions include:

- Develop and implement data collection processes that support performance improvement. Data are fundamental components of all performance improvement processes. Data can be obtained from internal sources (for example, documentation, records, staff, patients, observations, risk assessments) or from external sources (for example, regulatory organizations, insurers, the community). The purpose of data collection is to ensure that data necessary to identify, address, and monitor areas for improvement are available.
- Collected data must be analyzed to be useful. The purpose of data analysis is to determine the status of the hospital's quality of care and to inform any plans for improvement.
- Develop and implement performance improvement processes that increase safety and quality. All performance improvement activities must be based on relevant data that have been collected and analyzed according to hospital policies and procedures. Performance improvement is a continual process. The purpose of performance improvement is to ensure the safest, highest-quality care is always provided to all patients
- Review and revise the Plan as needed and submit it to the EMS and the CCH Board of Directors through its QPS Committee for approval on an annual basis.
- Review organizational performance and priorities for improvement across the system and evaluates the effectiveness of quality initiatives, as they relate to individual units and to organizational interests on an annual basis.
- Fosters the use of a planned, systematic approach to quality improvement by using the PDSA cycle (**Appendix F**).

E. HRO Workgroup Structure

The HRO workgroups are multidisciplinary teams focused on the major drivers of external ratings. Each workgroup has an explicit charter including objectives, data, and timelines. There are 6 Workgroups with a focus on the following (**see Appendix G** for specific reporting metrics):

- Mortality
- Readmissions
- Process of Care
- Patient Experience
- Clinical Documentation
- HEDIS

- Reporting structure of the HRO Workgroups:

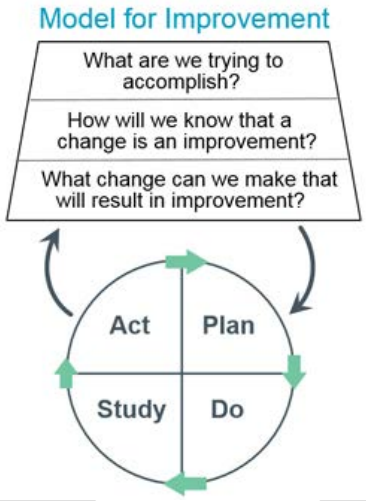
- Functions of the HRO Steering Committee include:
    - Provides oversight for organizational success and drives accountability.
    - Prioritizes specific measures in each domain for focus workgroups.
    - Identifies leaders for the focus workgroups.
    - Approves charters for each focus workgroup.
    - Designates the reporting tool to be used by workgroups.

- Functions of the Vizient Measures Workgroup include:
    - Assess clinical outcome performance.
    - Identification and evaluation of major opportunities for mortality, readmissions, hospital acquired conditions, patient experience, and ambulatory measures.
    - Utilizes external benchmarking tools (Vizient Clinical Data Base and Press Ganey) and data from public reporting programs to provide expected values and comparison group metrics.
    - Provides supportive function to HRO Steering Committee.
    - Team reviews monthly outcomes, monitors trends, and provides feedback and suggestions to the Steering Committee.

VIII. Design/Process-Quality

A. Methodology-Framework

All teams and improvement efforts will utilize the Institute for Healthcare Improvement's (IHI) model for improvement: Plan, Do, Study, Act (PDSA) process for their activities.



PLAN:

- Name the process that needs improvement.
- Baseline measurement data/ current state
- Voice of the customer
- What are we trying to accomplish? What is our objective/goal/vision?
- What would be the benefits to the customers, the organization, the department, you, of reaching our goal?
- How will we know that a change is an improvement?
- What specifically will we do to begin to move toward our goal? What changes can we make that will result in improvement?
    - Plan to carry out the action (who, what, where, when).
    - How will we measure it?

DO:

- Carry out the plan
- Collect the data
- Begin analysis of the data

STUDY:

- Complete analysis of the data
- Compare data to predictions
- Summarize what was learned

ACT:

- What changes are to be made?
- Continue P-D-S-A cycle

B. Data Collection

Data collected needs to be accurate, complete, and reliable. The HQuIPS committee chooses processes and outcomes to monitor based on the mission and scope of care and services provided and populations served: The HQuIPS Committee:

Collects data on the following:

- Improvement priorities, as identified by leadership
    - Procedures, including operative procedures, that put patients at risk of disability or death
    - Significant discrepancies between preoperative and postoperative diagnoses
    - Adverse events related to moderate or deep sedation or anesthesia
    - Use of blood and blood components
    - Reported and confirmed transfusion reactions
    - Results of resuscitative services
    - Significant medication errors
    - Significant adverse drug reactions
    - Sentinel events
    - Near misses
    - Patient perception of safety and performance
    - Thermal injuries that occur during magnetic resonance imaging (MRI) exams
    - Incidents and injuries related to the presence of ferromagnetic objects in the MRI scanner room
    - Pain assessment and pain management

  Collects data on topics in the following areas:
    - Environment of care
    - Infection prevention and control
    - Use of restraint and seclusion
    - Medication management system
    - Patient safety issues (for example, falls, self-harm)

  Uses internal and external sources to collect data, including but not limited to the following:
    - Incident reports
    - Minutes from committee meetings
    - Patient, family, and staff satisfaction surveys
    - Performance measure data
    - Reports on mortality and autopsy data
    - Joint Commission *Sentinel Event Alerts*
    - Ongoing medical record review
    - Risk assessments
    - Reports and/or alerts from governmental agencies (for example, Centers for Disease Control and Prevention, Occupational Safety and Health Administration, Food and Drug Administration)
    - Performance reports from other comparable health care organizations

  Includes the following information when recording data:
    - Data source
    - Collection frequency
    - Reporting frequency
    - Report audience
    - Responsible department(s)
    - Indicators for intervention

C. Data Analysis

The analysis process includes comparing data within our organization, with comparable organizations, with standards, and with best practices. Data is aggregated and analyzed within a time frame appropriate to the process or area of study. Data will also be analyzed to identify system changes that will help to improve patient safety. In addition, analysis includes:

- Uses statistical tools and techniques to analyze and display data.
- Compares internal data over time to identify the following:
- Levels of performance
- Patterns or trends in performance
- Variations in performance
- Identifies the types of data displays preferred by the HQuIPS Committee and the Board QPS Committee.
- Engages the assistance of relevant departmental management and/or staff to collect and analyze data.
- Analyzes data using methods that are appropriate to the type of data and the desired metrics, which include but are not limited to:
- Comparisons
- Benchmarks
- Thresholds
- Reports and presents data using appropriate and preferred display types.
- Reports, in writing, to leadership on issues and interventions related to adequacy of staffing. This occurs at least once a year.

D. Performance Improvement

- Collaborates with department managers, staff, and others to create and implement corrective actions to address identified areas for improvement.
- Monitors effects of all corrective actions through additional data collection and analysis activities.
- Identifies corrective actions that do not result in expected or sustained improvement.
- Continues the cycle of creating, implementing, monitoring, and evaluating corrective actions.
- Reports to leadership on the implementation and results of performance improvement activities. This occurs at least quarterly.

IX. Design/Process-Patient Safety

- The HQuIPS Committee provides some oversight and guidance for the patient safety program. The committee receives reports of patient safety events reported through the event management reporting system (eMERS). This is a standardized automated reporting system which allows all users across each facility the ability to report patient safety events. All adverse events, near misses, or unsafe conditions must be reported into the eMERS system. The Serious Event Review Team (SERT) provides direct oversight for the discussion and classification of safety events. The Hospital-wide Oversight Committee (HOSC) provides direct oversight and discussion related to patient safety events of a more serious nature.
- An effective Patient Safety Program cannot exist without optimal reporting of safety events. Therefore, the plan adopts a just approach in its management of errors and occurrences. All personnel are *required* to report suspected and identified safety events and should do so without the fear of punishment. The organization supports the concept that errors occur due to a breakdown in systems and processes and will focus on improving systems and processes. Emphasis will be placed on corrective actions and individual development to assist staff members rather than punish them.

- All departments within the organization are responsible to report healthcare safety occurrence and potential incidents. Summary data from the event reporting system will be aggregated and presented periodically to the HQuIPS and the CCH QPS Committee of the CCH Board of Directors, who will determine further safety and risk reduction activities as appropriate.
- Upon identification of an actual or potential safety event, the healthcare delivery team will perform in accordance with the adverse event management policy.
- The organization will select at least one high-risk safety process to undergo Failure Mode and Effects Analysis (FMEA) annually based on both internal and external resources.
- The Plan includes an assessment of the culture of safety through an evidence-based survey tool.
- The Plan includes an ongoing assessment of patient experience using a comprehensive survey tool.
- Patients, and when appropriate, their families are informed about the outcomes of care, including unanticipated event, or when the results differ significantly from the anticipated outcomes, following guidelines outlined in this plan.
- Staff will educate patients and their families about their role in helping to facilitate the safe delivery of care. Patient and family safety education interventions are documented in the patient's medical record.
- Staff will receive education and training during their initial orientation and onan ongoing basis regarding job-related aspects of patient safety, including the need to report and reduce potential and actual safety events and the process of reporting into the electronic reporting system.
- Patient safety events and occurrences, including sentinel events, will be reported in accordance with all national and regulatory body rules, laws, requirements, and CCH policies.
- Leaders will provide feedback to staff when they have identified and reported a safety event.

A. Classification of Safety Events

A. Patient safety event*:* An event, incident, or condition that could have resulted or did result in harm to a patient.

B. Adverse event: A patient safety event that resulted in harm to a patient.

C. Sentinel event (SE): A subcategory of adverse events, a sentinel event is a patient safety event (not primarily related to the natural course of the patient's illness or underlying condition) that reaches a patient and results in any of the following:
  - Death
  - Permanent Harm
  - Severe temporary harm

D. Close call or near miss, no harm, or good catch: A patient safety event that did not cause harm as defined by the term *sentinel event*.

E. Hazardous (or unsafe) conditions: A circumstance (other than a patient's own disease process or condition) that increases the probability of an adverse event.

B. RCA

- An RCA is used to identify the basic or causal factors that underlie variation in performance, including the occurrence or possible occurrence of an SE. An RCA focuses on systems and processes, not individual performance.

- RCA data are used internally for improving healthcare systems and processes that impact quality and patient safety. At all levels of the organization, information obtained through an RCA, to the greatest extent possible, will not be used in adverse administrative, privileging, or other personnel actions, including disciplinary action.

- An RCA must be completed by the facility on all SEs, including TJC reviewable SEs, within 45 calendar days of the facility becoming aware of the SE. Extensions for reviewable RCA completion will not ordinarily exceed 90 calendar days. RCAs conducted on other less serious events should be completed as soon as practicable or as dictated by the respective facility CEO.

- CCH uses the Root Cause Analysis squared (RCA2) tool endorsed by the National Patient Safety Foundation (NPSF). This tool is designed to accomplish the objective of what happened, why it happened, and what needs to be done to correct the problem, and then to take positive action to prevent it from happening again (**Appendix H**).

C. Proactive Risk Assessment-Failure Modes and Effects Analysis (FMEA)

- Several tools are available to help conduct a proactive risk assessment. One of the best known of these tools is FMEA and is the tool that CCH uses to conduct proactive risk assessments (**Appendix I**). FMEA is a tool for conducting a systematic, proactive analysis of a process in which harm may occur. In an FMEA, a team representing all areas of the process under review convenes to predict and record where, how, and to what extent they system might fail. Then, the team members work together to devise improvements to prevent those failures. The FMEA tool prompts teams to review, evaluate, and record the following:
    - Steps in process
    - Failure modes (what could go wrong?
    - Failure causes (why would the failure happen?)
    - Failure effects (what would the consequence of each failure be?)
- Teams use FMEA to evaluate processes for possible failures and to prevent them by correcting the processes proactively rather than reacting to adverse events after failures have occurred. The emphasis on prevention may reduce risk of harm to both patients and staff. FMEA is useful in evaluating a new process prior to implementation and in assessing the impact of a proposed change to an existing process.

X. Annual Program Evaluation

It is the intent of the Plan to continue to develop its people and processes in its commitment to performance excellence and continuous improvement. Annually, the HQuIPS Committee reviews organizational performance and priorities for improvement across the system and evaluates the effectiveness of quality and patient safety initiatives, as they relate to individual units and to organizational interests. The evaluation process is conducted using the Annual Evaluation of PI Indicators tool (**Appendix J)**. The results of this evaluation are reported to the EMS, Board QPS Committee, and the CCH Board of Directors.

XI. Communication

Department leaders will communicate their quality and patient safety activities to their staff and to the Senior Leader to whom they report. Measurement and assessment activities are reported to the HQuIPS Committee, EMS, Board QPS Committee, and to the CCH Board of Directors at the frequency specified by the Board QPS Committee.

XII. Confidentiality

All activities set forth in this Plan, including any information collected by any medical staff committee, administrative committee, team, or hospital department to evaluate the quality of patient care, is to be held in the strictest confidence, and is to be carefully safeguarded against unauthorized disclosure. They are strictly confidential under the Illinois Studies and Hospitals 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.

XIII. Appendices

A. CCH Board of Directors Members

Chair Lyndon Taylor

Vice Chair Hon. Dr. Dennis Deer, LCPC, CCFC

Directors:

Robert Currie
Raul Garza
Ada Mary Gugenheim
Joseph M. Harrington
Karen E. Kim, MD, MS
Mike Koetting
David Ernesto Munar
Heather M. Prendergast, MD, MS, MPH
Robert G. Reiter, Jr.
Otis L. Story, Sr

B. QPS Committee Members

Chair: Ada Mary Gugenheim

Members:

Raul Garza
Heather M. Prendergast, MD, MS, MPH
Otis L. Story, Sr.
Patricia Merryweather (Non-Director Member)

C. EMS Members-Voting

	EMS President	Abayomi Akintorin, MD
1.	EMS Vice President	Neha Yadav, MD
2.	EMS Secretary	Neha Bhandari, MD
3.	EMS Treasurer	Lakshmi Warrior, MD
4.	Anesthesiology & Pain Management (Chair)	Gennadiy Voronov, MD
5.	Anesthesiology Division Chair	Maria Torres, MD
6.	Anesthesiology, Alternate 1	Kenneth Toth, MD
7.	Correctional Health Services (Chair)	Connie Mennella, MD
8.	Correctional Health Services Division Chair	Chad Zawitz, MD
9.	Correctional Health Services Alternate	Salim Dawalibi, MD
10.	Emergency Medicine (Chair)	Trevor Lewis, MD

11. Emergency Medicine, Member 1	George Paul, MD
12. Family Medicine and Community Medicine (Chair)	Mark Loafman, MD
13. Family Medicine, Associate Chair	Nimmi Rajagopal, MD
14. Family Medicine, Member 1	Priscilla Auguston, MD
15. Family Medicine, Alternate	N. McCammon–Chase, MD
16. Medicine (Chair)	Suja Mathew, MD
17. Medicine, Division Chair	Reena Ghode, MD
18. Medicine, Member 1	Michael Hoffman, MD
19. Medicine, Member 2	Umair Jabbar, MD
20. Medicine, Member 3	Fran Norlock, DO
21. Medicine, Member 4	Shreeyala Uday, MD
22. Medicine, Alternate 1	Seema R. Gandhi, MD
23. Medicine, Alternate 2	Kalyani Perumal, MD
24. Medicine, Alternate 3	Shalini T Reddy, MD
25. Medicine, Alternate 4	Elizabeth Gobbi, MD
26. Medicine, Alternate 5	Jessica Huang, MD
27. OB/GYN (Chair)	Fidel Abrego, MD
28. OB/GYN, Member 1	Helen Cejtin, MD
29. OB/GYN, Member 2	Amanda Dhuyvetter, MD
30. Oral Health (Chair)	Jorelle R. Alexander, DMD
31. Oral Health, Member	Clarissa Couch, DDS
32. Oral Health, Alternate	Lori Lightfoot, DDS
33. Pathology (Chair)	Marin Sekosan, MD
34. Pathology, Member 1	Frances Manosca, MD
35. Pathology, Alternate	Rohini Chennuri, MD
36. Pediatrics (Chair)	Mopelola Akintorin, MD
37. Pediatrics Member 1	Kenneth Soyemi, MD
38. Pediatrics, Member 2	Rajeev Kumar, MD
39. Pediatrics, Alternate 1	Karen Simpson, MD
40. Pediatrics, Alternate 2	Sadhana Dharmapuri, MD
41. Psychiatry (Chair)	Joyce Miller, MD
42. Psychiatry, Member 1	

43. Psychiatry Voting Non-member	Giries Sweis, Psy.D.
44. Radiology (Chair)	Mark Pisaneschi, MD
45. Radiology, Member 1	Daniel Kay, MD
46. Radiology, Alternate	Paul Mullarkey, MD
47. Surgery (Chair)	Richard Keen, MD
48. Surgery, Division Chair	Steven Bonomo, MD
49. Surgery, Member 1	Sarah McDonald, MD
50. Surgery, Member 2	Jaqueline Harrison, MD
51. Surgery, Member 3	Kristine Makiewicz, MD
52. Surgery, Member 4	Neha Sheng, MD
53. Surgery, Alternate 1	James Murphy, MD
54. Surgery, Alternate 2	Daniel Kacey, MD
55. Surgery, Alternate 3	Thomas Komar, MD
56. Surgery, Alternate 4	Benjamin Bruce, MD
57. Trauma & Burns (Chair)	Faran Bokhari, MD
58. Trauma, Member	Frederic Starr, MD
59. Trauma, Alternate	Matt Kaminsky, MD

D. HQuIPS Committee members

NAME	DEPARTMENT/SPECIALITY
1. Abrego, Fidel	Interim Chair, Obstetrics & Gynecology
2. Ada Mary Gugenheim	Chair, Board Quality & Patient Safety Committee
3. Agomo, Helen	Case Management
4. Akintorin, Mopelola	Chair, Pediatrics
5. Alexander, Jorelle	Chair, Oral Health
6. Bajjappa, Mamatha	Manager Clinical Excellence Quality
7. Bokhari, Faran	Chair, Trauma
8. Brown-Ellington, Lezah	Life Safety Officer

9. Fegan, Claudia	Chief Medical Officer
10. Ferrer, Marilisa	Director, QI Ambulatory
11. Frain, Leslie	Associate Chief Quality Officer

12. Giuntoli, Anita	Director of Patient Safety
13. Gugenheim, Ada Mary	Chair, Board Quality/Safety Committee
14. Irons, Sharon	Medical Director, Ambulatory Services
15. Keen, Richard	Chair, Surgery
16. Kumapley, Rudolf	Medical Director
17. Lewis, Trevor	Interim Medical Director, ED
18. Loafman, Mark	Chair, Family Medicine
19. Mathew, Suja	Chair, Medicine
20. McCutchan, Jeffrey	General Counsel
21. Mennella, Connie	Correctional Health
22. Miller, Joyce	Interim Chair, Psychiatry
23. Mora, Iliana	Chief Operating Officer, ACHN
24. Mosby, Angela	Admin. Asst. Quality
25. Norwood, CaTanya	Director of Pharmacy (System)
26. O'Brien, John	Medical Education
27. Peters, Beena	Chief Nursing Officer
28. Pierko, Krzysztof	Chair, HQuIPS Committee & Dept. of Medicine
29. Pisaneschi, Mark	Chair, Radiology
30. Rocha, Israel	Chief Executive Officer

31. Sekosan, Marin	Chair, Pathology/Laboratory

32. Toliver, Constance	Director, Patient Relations
33. Vittum, Daniel	Ambulatory Services
34. Voronov, Gennadiy	Chair, Anesthesia/Pain Service
35. Washington, Diane	Executive Director, Behavioral Health
36. Welbel, Sharon	Director of Infectious Disease (System)
37. Wise, Le-Nel	Quality Data Analyst
38. Yankey-Frempong, Sarah	Quality Data Analyst

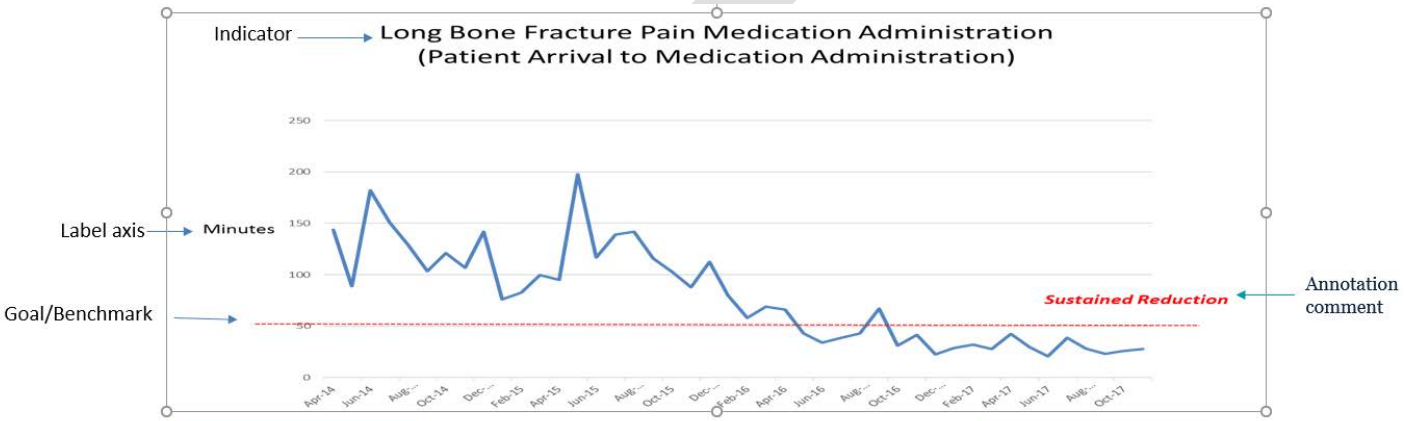
E. HQuIPS Reporting Schedule

Stroger HQuIPS 2021 Reporting Schedule:

- **Occurs on the 4th Tuesday of every month**
- **No meeting in December**

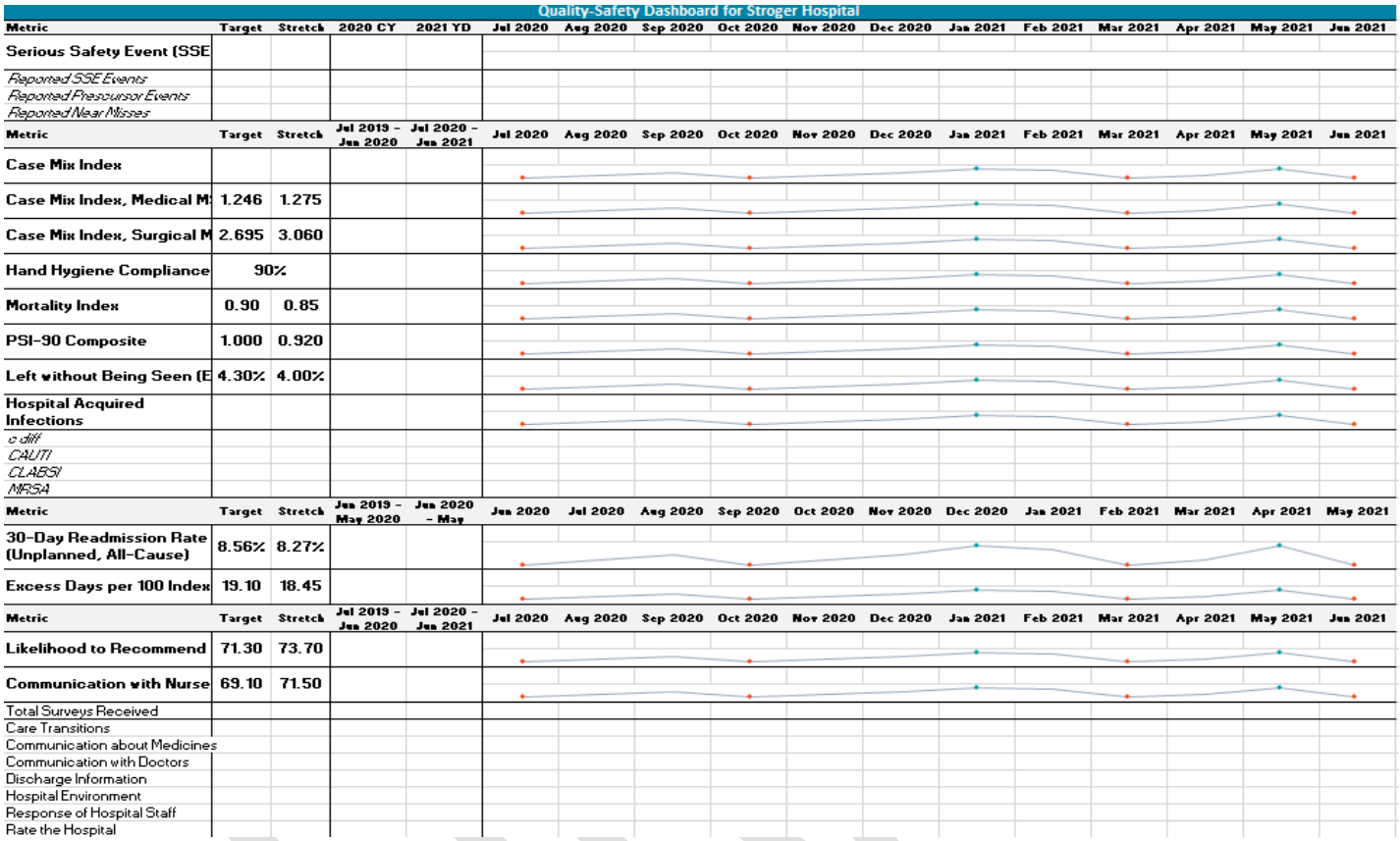
Jan. 26th	Feb. 23rd	March 23rd	April 27th	May 25th	June 22nd	July 27th	Aug. 24th	Sept. 28th	Oct. 27th	Nov. 23rd
Departmental Reports (3-4 times per year)										
Reporting Period Q4 2020			**Reporting Period Q1 2021**			**Reporting Period Q2 2021**			**Reporting Period Q3 2021**	
Quality Dashboard	Quality Dashboard	Quality Dashboard	Quality Dashboard	Quality Dashboard	Quality Dashboard	Quality Dashboard	Quality Dashboard	Quality Dashboard	Quality Dashboard	Quality Dashboard
Patient Safety	Patient Safety	Patient Safety	Patient Safety	Patient Safety	Patient Safety	Patient Safety	Patient Safety	Patient Safety	Patient Safety	Patient Safety
EOC Dashboard	Infection Control	ACHN	EOC Dashboard	Infection Control	ACHN	EOC Dashboard	Infection Control	ACHN	EOC Dashboard	Infection Control
Laboratory	Nursing	Contracts	Laboratory	Nursing	Patient Experience	Laboratory	Nursing	Contracts	Laboratory	Nursing
Radiology	Pharmacy	Stroke	Radiology	Pharmacy	Case Management	Radiology	Pharmacy	Stroke	Radiology	Pharmacy
Patient Relations	Case Management	Patient Experience	Patient Relations		Patient Experience	Patient Relations		Patient Experience	Patient Relations	Case Management
HRO Workgroups										
HRO Patient Experience	HRO Employee Engagement	HRO Process of Care (Pt1)	HRO HEDIS	HRO Process of Care (Pt2)	HRO Readmissions	HRO Health Equity	HRO Clinical Doc.	HRO Mortality	HRO-Patient Experience	HRO-
Informational Reports										
	HIM PT/OT Food and Nutrition	Respiratory Therapy		HIM PT/OT Food and Nutrition	Respiratory Therapy		HIM PT/OT- Food and Nutrition	Respiratory Therapy	HIM PT/OT Food and Nutrition	Respiratory Therapy

F. HQuIPS Reporting Template-PDSA



Plan	Do	Study	Action
• Identify your indicator/ operational definitions and benchmark/goal (Be Specific) • Example- Turn around time is the minutes from pt. arrival to discharge, pt. arrival to registration, etc.	• Initiate your plan • Begin data collection • Establish a baseline	• Conduct analysis. Overall compliance compared to the benchmark, previous qtr. or year. • Do you have a trend? (i.e. positive, negative or no change)	• Develop an action plan/recommendations for improvement

G. HRO Workgroup-Quality and Patient Safety Dashboard



Quality-Safety Dashboard for Stroger Hospital

Metric	Target	Stretch	2020 CY	2021 YD	Jul 2020	Aug 2020	Sep 2020	Oct 2020	Nov 2020	Dec 2020	Jan 2021	Feb 2021	Mar 2021	Apr 2021	May 2021	Jun 2021
Serious Safety Event (SSE																
Reported SSE Events																
Reported Precursor Events																
Reported Near Misses																

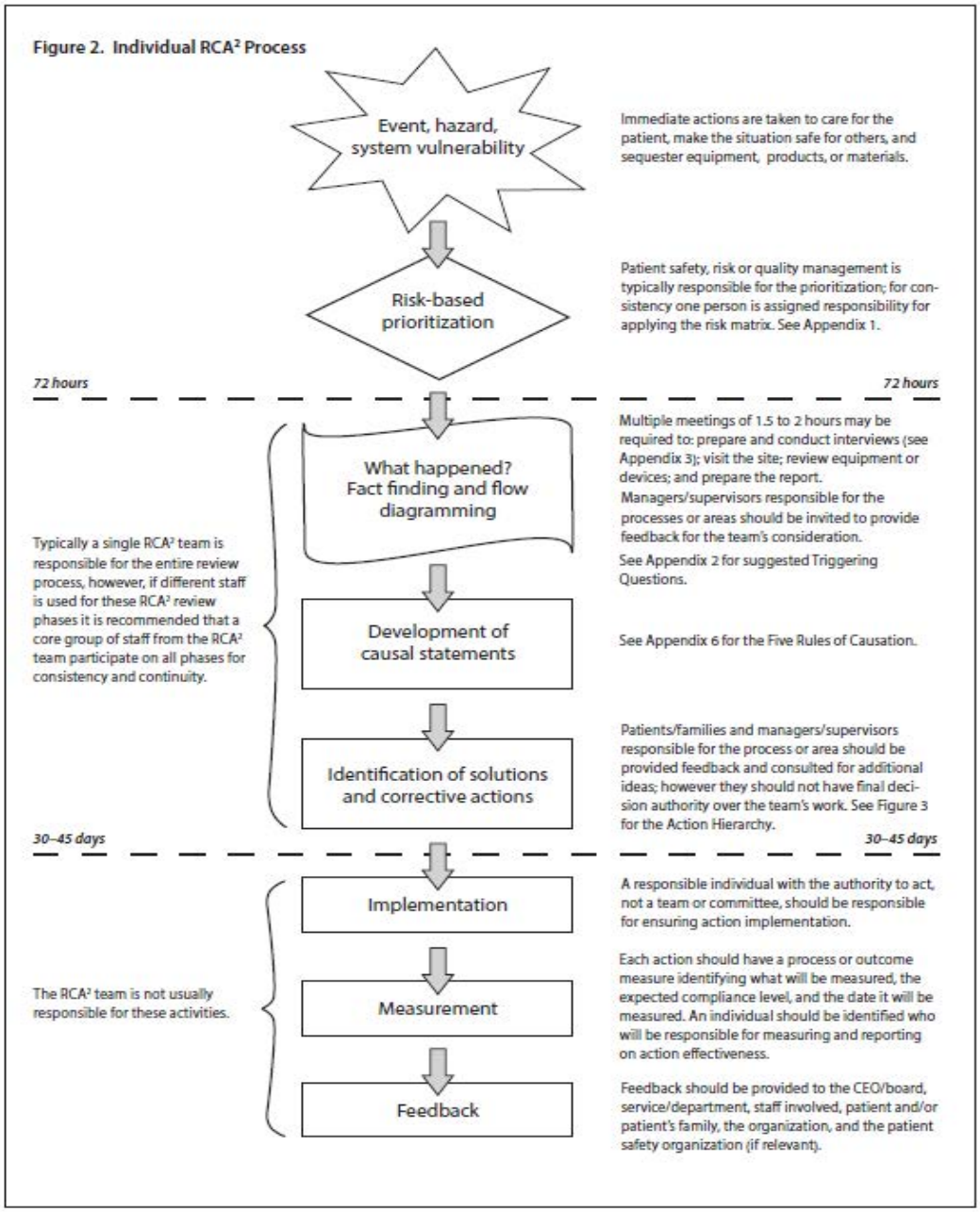
Metric	Target	Stretch	Jul 2019 – Jun 2020	Jul 2020 – Jun 2021	Jul 2020	Aug 2020	Sep 2020	Oct 2020	Nov 2020	Dec 2020	Jan 2021	Feb 2021	Mar 2021	Apr 2021	May 2021	Jun 2021
Case Mix Index																
Case Mix Index, Medical M	1.246	1.275														
Case Mix Index, Surgical M	2.695	3.060														
Hand Hygiene Compliance	90%															
Mortality Index	0.90	0.85														
PSI-90 Composite	1.000	0.920														
Left without Being Seen (E	4.30%	4.00%														
Hospital Acquired Infections																
c diff																
CAUTI																
CLABSI																
MRSA																

Metric	Target	Stretch	Jun 2019 – May 2020	Jun 2020 – May	Jun 2020	Jul 2020	Aug 2020	Sep 2020	Oct 2020	Nov 2020	Dec 2020	Jan 2021	Feb 2021	Mar 2021	Apr 2021	May 2021
30-Day Readmission Rate (Unplanned, All-Cause)	8.56%	8.27%														
Excess Days per 100 Index	19.10	18.45														

Metric	Target	Stretch	Jul 2019 – Jun 2020	Jul 2020 – Jun 2021	Jul 2020	Aug 2020	Sep 2020	Oct 2020	Nov 2020	Dec 2020	Jan 2021	Feb 2021	Mar 2021	Apr 2021	May 2021	Jun 2021
Likelihood to Recommend	71.30	73.70														
Communication with Nurse	69.10	71.50														
Total Surveys Received																
Care Transitions																
Communication about Medicines																
Communication with Doctors																
Discharge Information																
Hospital Environment																
Response of Hospital Staff																
Rate the Hospital																

H. RCA2 Process

Figure 2. Individual RCA² Process



I. FMEA Tool

Template: Failure Modes and Effects Analysis (FMEA)

Steps in the Process	Failure Mode	Failure Causes	Failure Effects	Likelihood of Occurrence (1-10)	Likelihood of Detection (1-10)	Severity (1-10)	Risk Profile Number (RPN)	Actions to Reduce Occurrence of Failure
1								
2								
3								
4								
5								
6								
7								
8								
9								
10								
11								
12								
13								
14								
15								
							Total RPN (sum of all RPNs):	

Failure Mode: What could go wrong?
Failure Causes: Why would the failure happen?
Failure Effects: What would be the consequences of failure?
Likelihood of Occurrence: 1–10 [10 = very likely to occur]
Likelihood of Detection: 1–10 [10 = very unlikely to detect]
Severity: 1–10 [10 = most severe effect]
Risk Priority Number (RPN): Likelihood of Occurrence × Likelihood of Detection × Severity

J. Annual Evaluation of PI Indicator Tool

2020 ANNUAL EVALUATION OF PERFORMANCE IMPROVEMENT INDICATORS

Department/Service Unit: Nursing

Key Quality Indicators	Effective in improving quality outcomes	Effective in maintaining an acceptable level of quality	Not an effective measure of quality	Benchmark	Annual Compliance Average	Outcomes Achieved Legend*/	Proposal for the indicator*	Comments re: Accomplishments & Brief analysis of the data

*** Outcomes Achieved Legend:**
1 = Improved Clinical Outcomes/Efficiency
2 = Improved Patient/Employee Safety
3 = Improved Customer Satisfaction
4 = Improved Financial Status (increased rev/decreased exp)
5 = No improvements noted

**** Proposal Indicator**
1 = Continue Indicator
2 = Discontinue Indicator
3 = Modify Indicator
4 = New Indicator

XIV. References:

NPSF National Patient Safety Foundation, RCA2; Improving Root Cause Analysis and Actions to Prevent Harm

Institute for Healthcare Improvement (IHI) QI Essential Toolkit: Failure Modes and Effects Analysis (FMEA)

The Joint Commission (TJC) Comprehensive Accreditation Manual for Hospitals 2021 edition