COOK COUNTY HEALTH

Op Ex Steering Committee Dashboard for Stroger Hospital

DOMAIN WORKGROUPS	Metrics	Target	Stretch Target	Baseline	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Apr-24
PATIENT EXPERIENCE	Rolling 12-month % Top Box for Comm. w/ Nursing Domain	73.00%	77.00%	69.30%	69.26%	69.01%	68.69%	68.70%	69.17%	69.30%	68.86%	69.45%	68.97%	69.43%	69.27%	69.51%
	Monthly % Top Box for Comm. w/ Nursing Domain	73.00%	77.00%	69.30%	62.66%	67.72%	72.51%	66.51%	76.00%	73.45%	66.51%	69.28%	61.43%	70.34%	75.59%	72.48%

		Target	Stretch Target	Baseline	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24
	Rolling 12-month Survey Response Rate*	15.00%	16.00%	13.60%	13.00%	12.90%	8.30%	13.00%	13.30%	13.50%	13.50%	13.00%	13.70%	13.70%	13.60%	13.50%
	Monthly Survey Response Rate*	15.00%	16.00%	13.60%	14.50%	14.60%	12.90%	13.50%	16.40%	13.90%	14.20%	11.00%	12.60%	12.50%	12.80%	12.80%

CLINICAL OUTCOMES		Target	Stretch Target	2023	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Apr-24
	Monthly Volume of CLABSI			11	1	0	0	2	1	1	1	1	1	1	0	0
	SIR Rate CLABSI	0.8	*n/a*	0.76	0.87	0.00	0.00	2.00	0.76	0.78	0.61	0.60	0.80	0.75	0.00	0.00
		Target	Stretch Target	2023	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Apr-24
	Monthly Volume of CAUTI			11	1	1	2	0	0	0	2	2	1	0	2	0
	SIR Rate CAUTI	0.8	*n/a*	0.47	0.47	0.43	1.00	0.00	0.00	0.00	1.00	1.00	0.51	0.00	0.89	0.00

		Target	Stretch Target	Baseline	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24
	Monthly Volume of VTE PSI-12	<=7	0	14	0	1	0	3	1	0	1	2	2	0	0	1
	Observed over Expected Ratio PSI-12				0.00	0.98	0.00	2.41	0.80	0.00	1.06	2.04	0.90	0.00	0.00	0.82

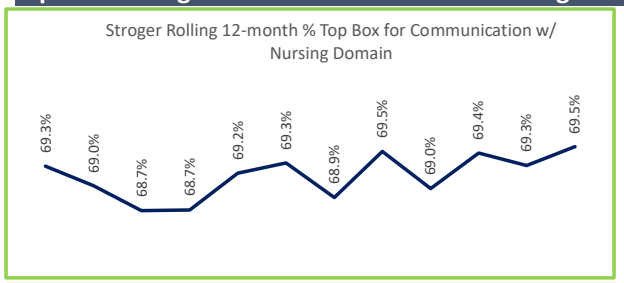
READMISSIONS		Target	Stretch Target	Baseline	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24
	Rolling 12-month All Cause, All Payer, All Age - Readmissions Rate - CMS Definition Same Hospital	8.40%	8.00%	9.40%	8.97%	8.88%	9.15%	9.22%	9.28%	9.19%	9.20%	8.89%	8.91%	8.75%	8.46%	8.52%
	Monthly All Cause, All Payer, All Age - Readmissions Rate - CMS Definition Same Hospital	8.40%	8.00%	9.40%	9.28%	9.04%	10.41%	8.28%	9.45%	8.48%	9.60%	6.65%	8.47%	7.15%	6.67%	8.60%

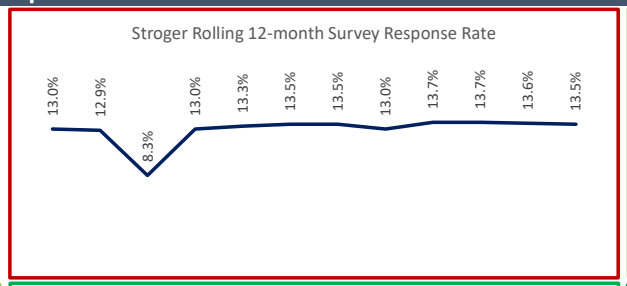
		Target	Stretch Target	Baseline	1/22-12/22	2/22-1/23	3/22-2/23	4/22-3/23	5/22-4/23	6/22-5/23	7/22-6/23	8/22-7/23	9/22-8/23	10/22 - 9/23	11/22-10/23	12/22-11/23
	IHA Rolling 12-Month All Cause All Payer - Readmissions including other hospitals **	13.00%	12.00%	14.00%	14.52%	14.44%	14.10%	14.13%	13.80%	14.08%	13.99%	14.07%	13.84%	13.58%	13.36%	13.42%

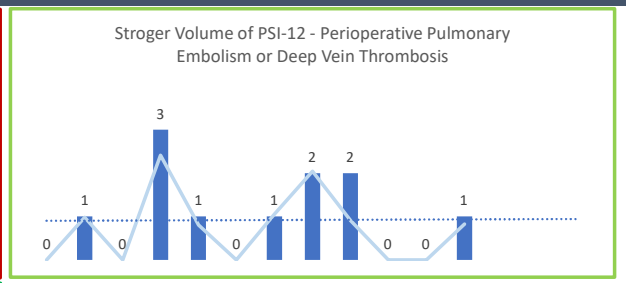
THROUGHPUT	Metrics	Target	Stretch Target	Baseline	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24
	Monthly GMLOS Avg Variance in days, excluding patients >30 days LOS	1.23	0.73	1.73	1.64	1.70	1.58	1.73	1.94	1.56	2.00	1.27	1.71	2.08	2.12	2.57

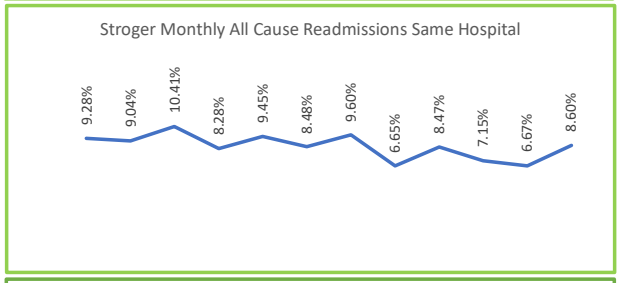
COOK COUNTY HEALTH

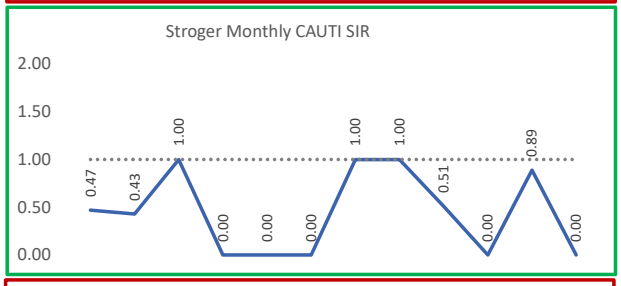
Op Ex Steering Committee Dashboard for Stroger Hospital

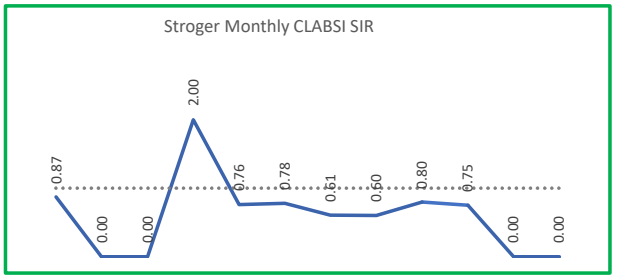


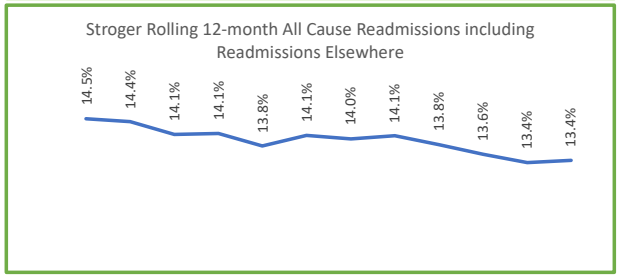


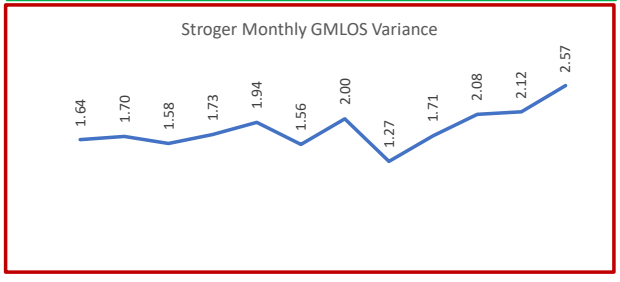












Legend	Not meeting Target and no improvement from baseline performance	Not meeting target but improving from Baseline	Met Goal	Met Stretch Target

Data sources: Patient Experience from Press Ganey; HAIs-Infection Control Dept; VTE PSI - Vizient; Readmissions - Vizient & Illinois Hospital Association; CMI-Vizient

Author: J. Rozenich, BS, MBA

***IHA data is updated quarterly*

COOK COUNTY HEALTH

Op Ex Steering Committee Dashboard for Provident Hospital

DOMAIN WORKGROUPS	Metrics	Target	Stretch Target	Baseline	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Apr-24
PATIENT EXPERIENCE																
	Rolling 12-month % Top Box for Comm. w/ Nursing Domain	79.80%	80.00%	74.63%	72.25%	75.28%	76.07%	77.78%	74.63%	78.55%	76.89%	76.08%	79.13%	78.86%	78.86%	78.60%
	Monthly % Top Box for Communication w/ Nursing Domain	79.80%	80.00%	74.63%	74.07%	100.00%	77.78%	96.30%	66.67%	80.00%	63.64%	55.56%	100.00%	63.89%	85.16%	71.48%

				Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24
	Rolling 12-month Survey Response Rate*	18.00%	20.00%	11.80%	12.00%	11.30%	11.90%	12.00%	11.90%	12.30%	12.70%	12.40%	12.70%	11.80%	12.80%	13.60%
	Monthly Survey Response Rate*	18.00%	20.00%	11.80%	11.40%	6.60%	17.40%	14.30%	10.90%	15.40%	15.40%	12.70%	9.80%	10.90%	16.40%	21.80%

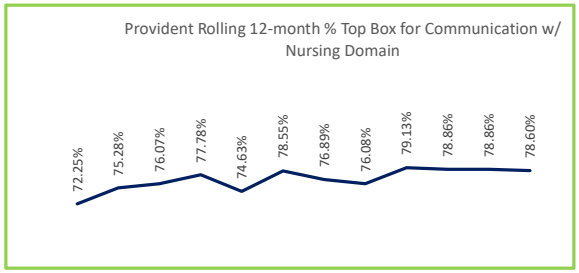
CLINICAL OUTCOMES		Target	Stretch Target	Baseline	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24
	Rolling 12 month SEP-1 Bundle Compliance	60.00%	65.00%	50.00%	44.44%	44.83%	48.48%	48.65%	50.00%	45.00%	46.15%	47.50%	46.15%	42.11%	42.11%	39.53%
	Monthly SEP-1 Bundle Compliance	60.00%	65.00%	50.00%	16.67%	33.33%	75.00%	50.00%	66.67%	25.00%	33.00%	100.00%	0.00%	33.00%	0.00%	33.33%

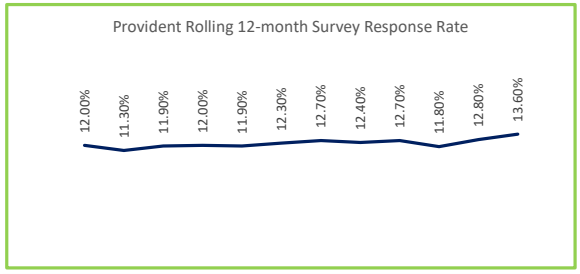
		Target	Stretch Target	Baseline	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Apr-24	May-24
	Monthly Hand Hygiene Compliance	80.00%	90.00%	75.38%	72.78%	67.86%	65.07%	73.51%	75.12%	77.37%	84.73%	88.06%

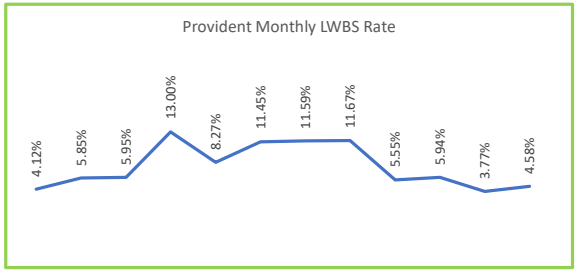
THROUGHPUT		Target	Stretch Target	Baseline	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Apr-24	May-24
	Rolling 12-month LWBS	4.50%	4.00%	5.50%	4.12%	4.30%	4.46%	5.18%	5.51%	5.93%	6.49%	7.17%	7.40%	6.97%	7.63%	7.63%
	Monthly LWBS Rate	4.50%	4.00%	5.50%	4.12%	5.85%	5.95%	13.00%	8.27%	11.45%	11.59%	11.67%	5.55%	5.94%	3.77%	4.58%

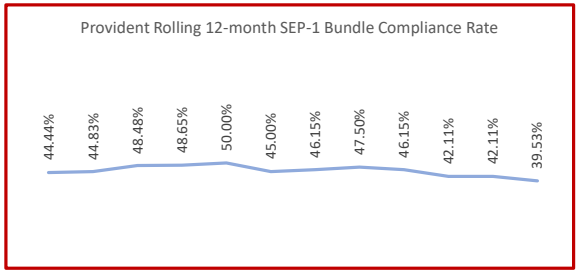
COOK COUNTY HEALTH

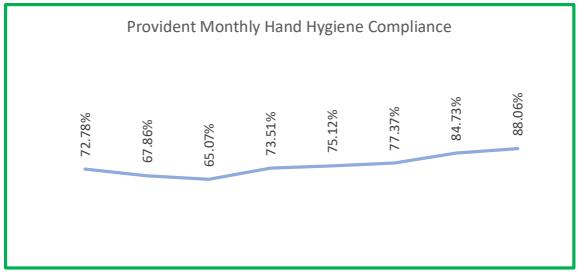
Op Ex Steering Committee Dashboard for Provident Hospital











Legend	Not meeting Target and no improvement from baseline performance	Not meeting target but improving from Baseline	Met Goal	Met Stretch Target

Data sources: Patient Experience from Press Ganey; Sep-1 Bundle chart abstracted CMS measure; Hand Hygiene TST Infection Control observation software; LWBS - BI Tableau

Author: J. Rozenich, BS, MBA

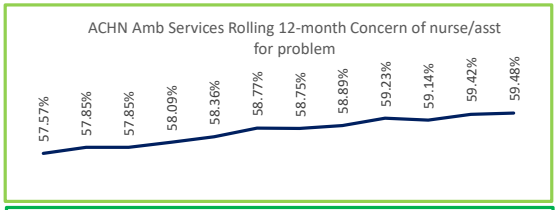
**Survey returns are refreshed historically as data is received*

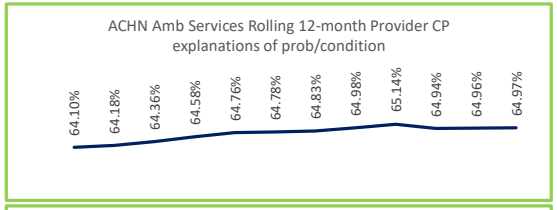
COOK COUNTY HEALTH

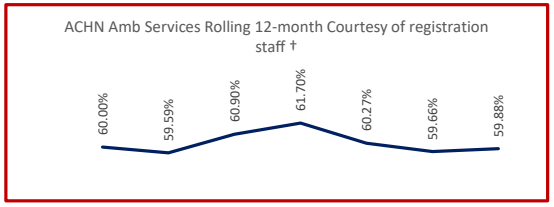
Op EX Steering Committee Dashboard for ACHN

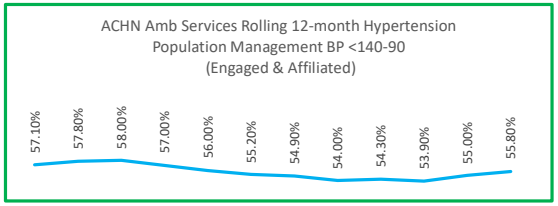
DOMAIN WORKGROUPS	Metrics	Target	Stretch Target	Baseline	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Apr-24
PATIENT EXPERIENCE																
	Rolling 12-month Concern of nurse/asst for problem	61.34%	63.56%	58.77%	57.57%	57.85%	57.85%	58.09%	58.36%	58.77%	58.75%	58.89%	59.23%	59.14%	59.42%	59.48%
	Monthly Concern of nurse/asst for problem	61.34%	63.56%	58.77%	58.32%	58.23%	58.27%	59.52%	59.18%	60.57%	59.56%	61.37%	62.83%	57.25%	61.18%	59.77%
	Rolling 12-month Provider CP explanations of prob/condition	66.80%	69.84%	64.78%	64.10%	64.18%	64.36%	64.58%	64.76%	64.78%	64.83%	64.98%	65.14%	64.94%	64.96%	64.97%
	Monthly Provider CP explanations of prob/condition	66.80%	69.84%	64.78%	65.77%	64.60%	64.56%	65.03%	66.18%	64.88%	64.08%	67.58%	67.38%	62.36%	65.28%	64.04%
	Rolling 12-month Courtesy of registration staff †	60.00%	65.00%	60.00%						60.00%	59.59%	60.90%	61.70%	60.27%	59.66%	59.88%
	Monthly Courtesy of registration staff †	60.00%	65.00%	60.00%						60.00%	59.59%	62.31%	63.55%	58.10%	57.70%	60.96%

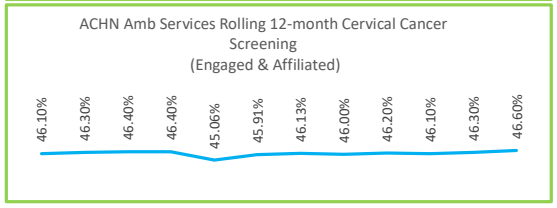
HEDIS	Target	Stretch Target	Baseline	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Apr-24	May-24
Rolling 12-month Hypertension Population Management BP <140-90 (Engaged & Affiliated)	55.00%	60.00%	50.53%	57.10%	57.80%	58.00%	57.00%	56.00%	55.20%	54.90%	54.00%	54.30%	53.90%	55.00%	55.80%
Rolling 12-month Cervical Cancer Screening (Engaged & Affiliated)	47.00%	52.00%	42.83%	46.10%	46.30%	46.40%	46.40%	45.06%	45.91%	46.13%	46.00%	46.20%	46.10%	46.30%	46.60%











Legend	Not meeting Target and no improvement from baseline performance	Not meeting target but improving from Baseline	Met Goal	Met Stretch Target

Data sources: Patient Experience from Press Ganey; Sep-1 Bundle chart abstracted CMS measure; Hand Hygiene TST Infection Control observation software; LWBS - BI Tableau

Author: J. Rozenich, BS, MBA

Op Ex Clinical Outcomes Workgroup Status Report

Dr. Radigan & Heather Lovelace

May 2024

COOK COUNTY HEALTH

WORKGROUP A3

Workgroup Overall A3 Progress

2024 OpEx Stroger Clinical Outcomes Workgroup A3

Workgroup A3 Owner: Dr. Radigan & Heather Lovelace

This Year's Action Plan

Goals	Specific Actions / Tactics	Deployment Leader	January - December 2024
Reduce the number of Hospital Acquired Infections (HAIs) by 50% **CAUTI:** 2023 Performance: .47 2024 Goal: <=.80 **CLABSI:** 2023 Performance: .76 2024 Goal: <=.80	Nursing compliance with CAUTI prevention bundle	Sherrie Spencer	
	Nursing compliance with CLABSI prevention bundle		
	Daily evaluation re: indication for indwelling catheter & removal if not indicated	Dr. Welbel	
	Daily evaluation re: indication for line & removal if not indicated		
Reduce the number of PSI-12, Post-operative PE & DVT occurrences by 50% 2023 Performance: 14 2024 Goal: 7	Provide education and training to surgical residents during monthly orientation	Dr. Campagnoli Geetha Sunny	
	Utilize visual management and communicate re utilization of VTE Advisor & Risk Assessment		
	Review timing and accuracy of abstraction		
	Optimization of heparin and SCD usage		

HAI Subgroup A3

Subgroup Progress

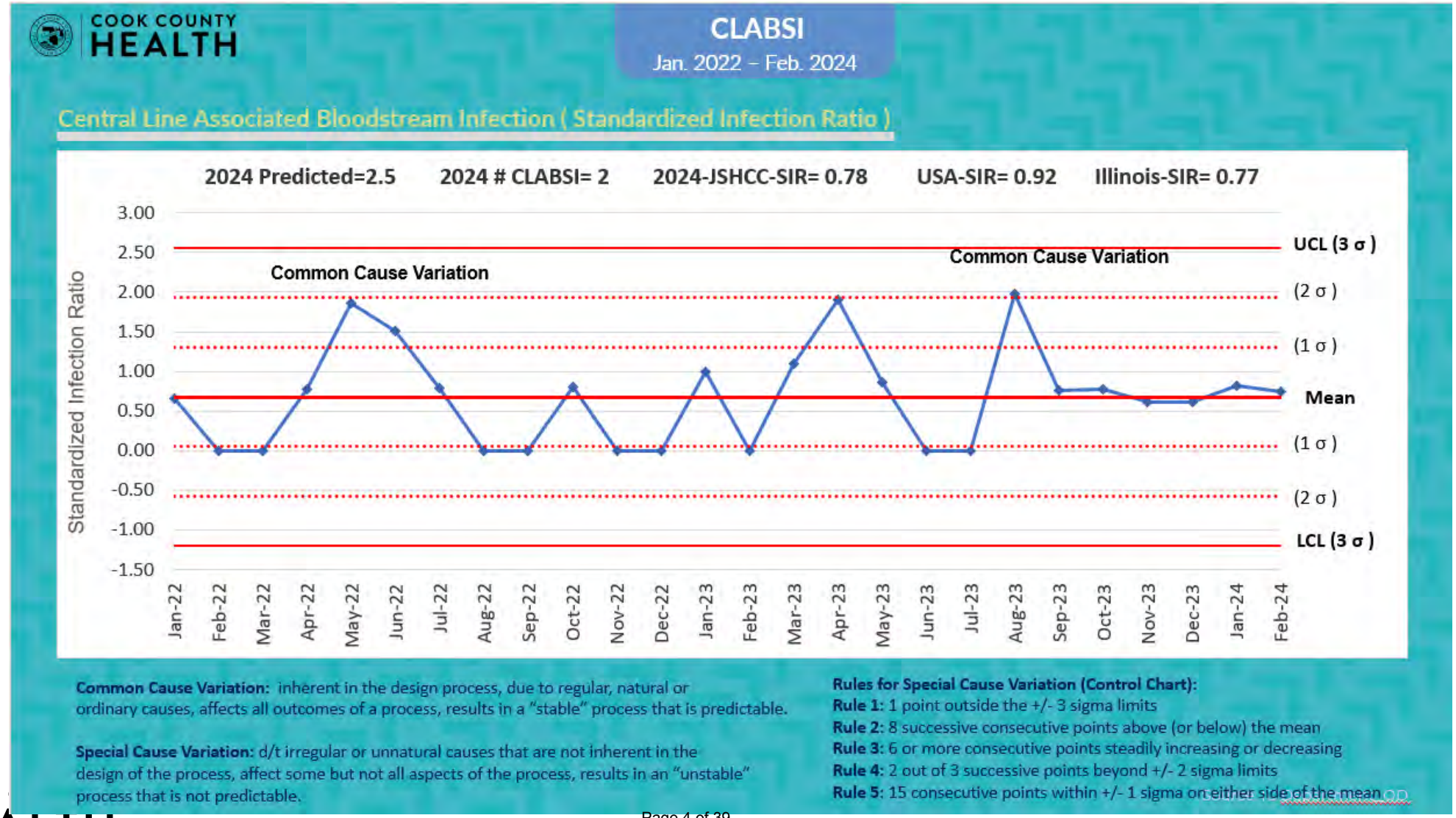
2024 OpEx Stroger Clinical Outcomes HAI Subgroup A3

Subgroup A3 Owner: Dr. Welbel & Sherrie Spencer

This Year's Action Plan														
Goals	**Specific Actions / Tactics**	**Deployment Leaders**	**January - December 2024**											
			J	F	M	A	M	J	J	A	S	O	N	D
CAUTI prevention bundle components **CHG bath compliance goal:** 100% **Catheter education for pts goal:** 100% **Dependent loop identification goal:** 100%	Share bundle compliance data at unit level on a daily basis	Med-Surg Nurse Clinicians												
	Audit charts for catheter appropriateness documentation in the EMR													
	Huddle w/ frontline teams to teach on and reinforce proper documentation													
CLABSI prevention bundle components **CHG bath compliance goal:** 100% **Dressing change compliance goal:** 100% **Cap change compliance goal:** 100%	Share bundle compliance data at unit level on a daily basis	Med-Surg Nurse Clinicians												
	Audit charts for appropriate CHG bath documentation in the EMR													
	Identify a specific day of the week for dressing and cap changes													

Performance Monitoring

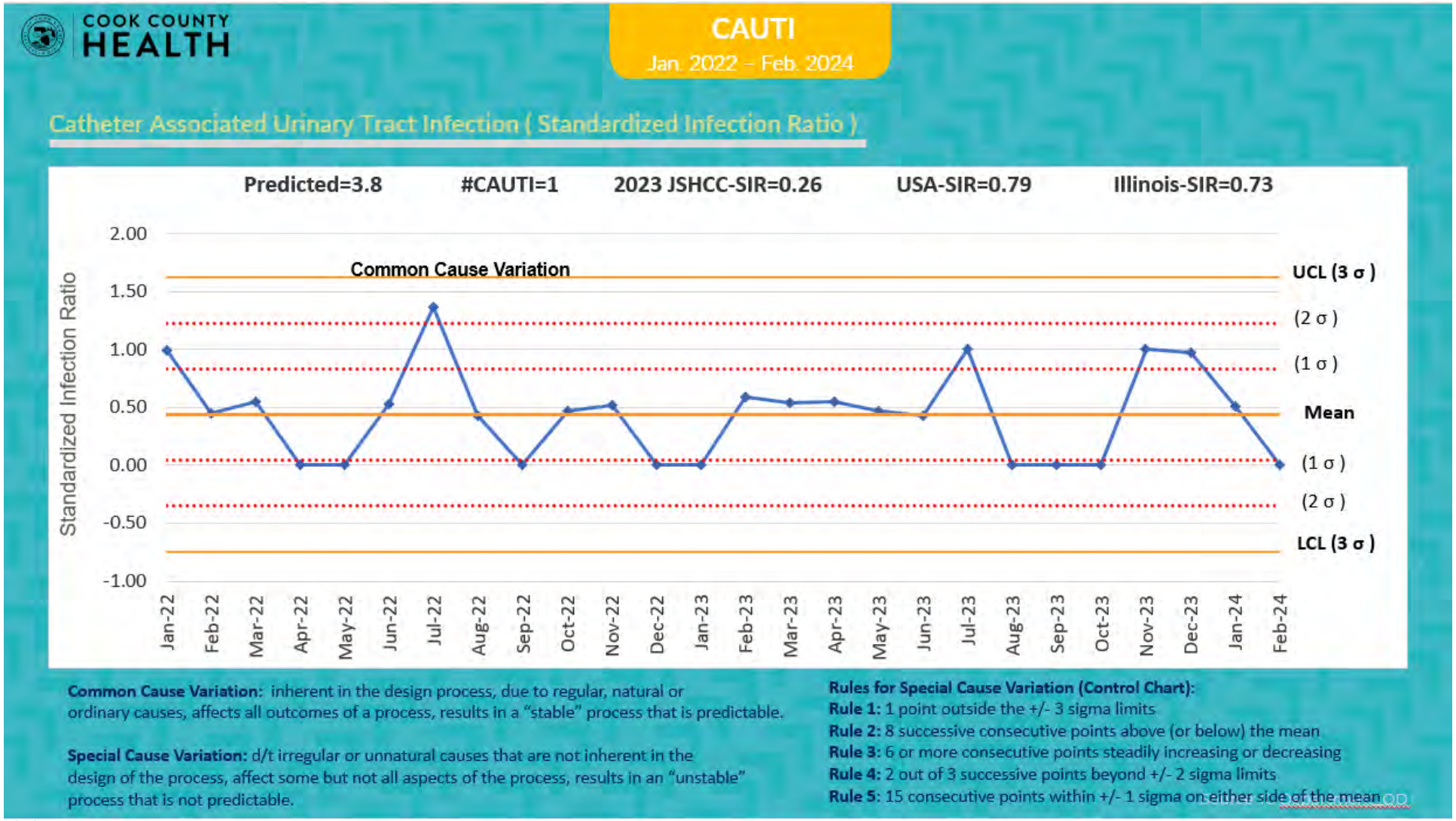
HAI CLABSI | SIR Goal <= 0.8 or 20% reduction



Data sourced from:

Performance Monitoring

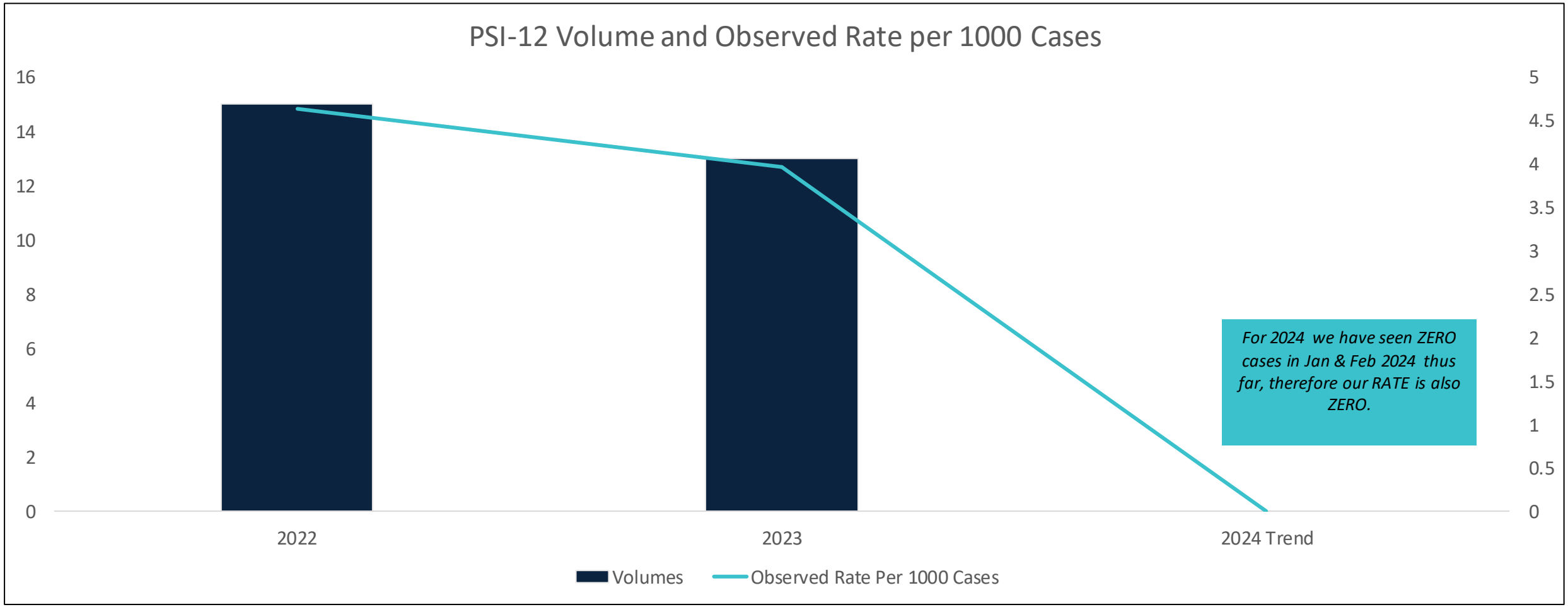
HAI CAUTI | SIR Goal <= 0.8 or 20% reduction



Performance Monitoring

Volume of PSI-12 - Perioperative Pulmonary Embolism or Deep Vein Thrombosis

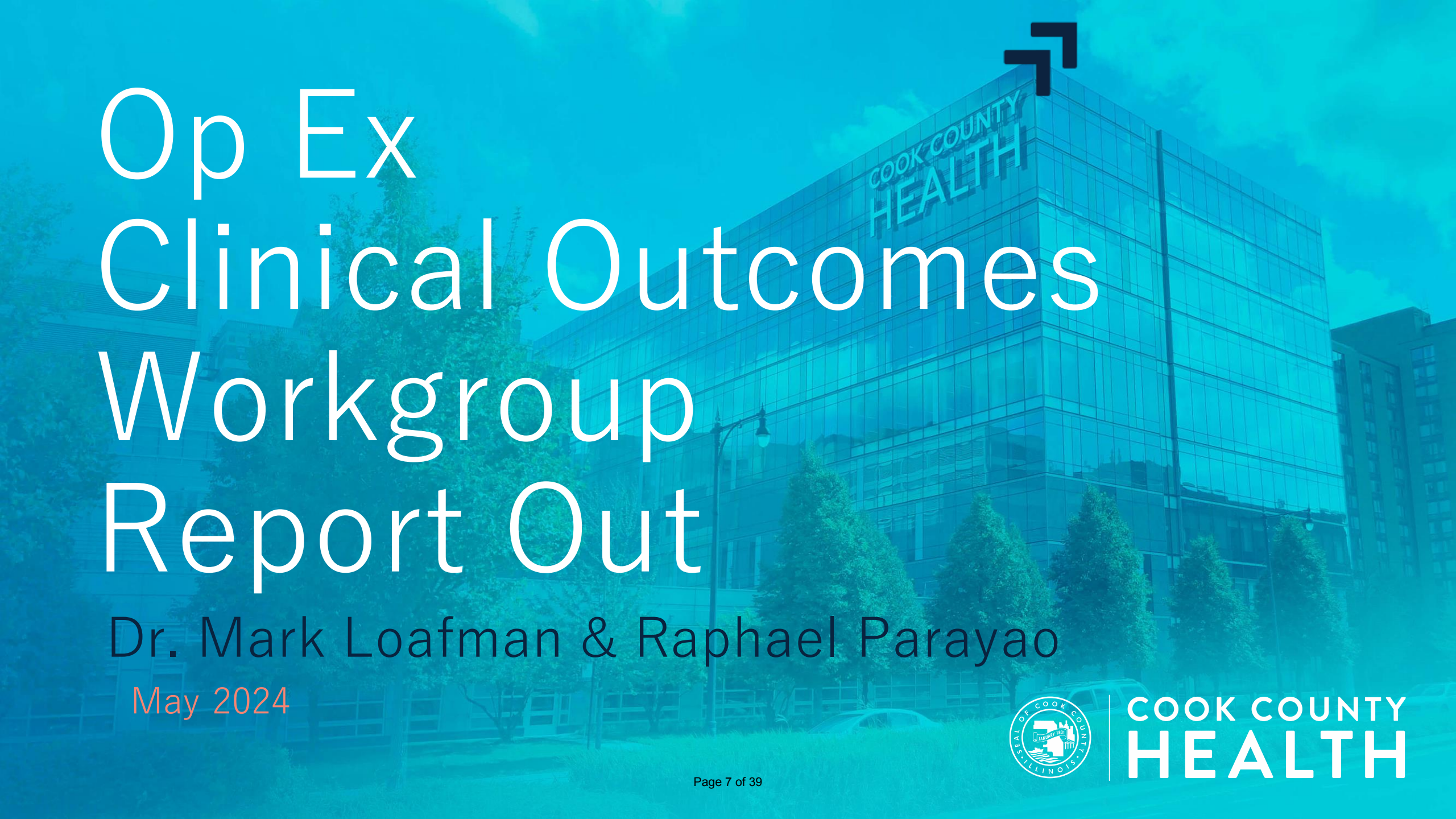
Goal: <=7 Cases for 2024



COOK COUNTY HEALTH

Data Source: Vizient CDB
Lower is better

Op Ex Clinical Outcomes Workgroup Report Out



Dr. Mark Loafman & Raphael Parayao

May 2024

COOK COUNTY HEALTH

Provident Op Ex Clinical Outcomes Workgroup A3

Workgroup Overall A3 Progress

2024 OpEx Provident Clinical Outcomes Workgroup A3

Workgroup A3 Owner: Dr. Loafman & Raphael Parayao

This Year's Action Plan														
Goals	**Specific Actions / Tactics**	**Deployment Leader**	**January - December 2024**											
			J	F	M	A	M	J	J	A	S	O	N	D
CMS SEP-1 Bundle Compliance **2023 Performance:** 50% compliance **2024 Goal:** 60% compliance **Stretch Goal:** 65% compliance	Monthly review of abstraction fallouts to identify improvement opportunities	Dr. Loafman Dr. Hussain												
	Implement reflex lactate order	ED / HIS / Quality												
Hand Hygiene Compliance Program **2023 Performance:** 75% **2024 Goal:** 80% compliance **Stretch Goal:** 90%	Nurse leader observations with real-time coaching and data sharing	Dr. Loafman Raphael Connie												
	Initiate hand hygiene campaign													
	Identify hand hygiene champion program													

Provident Op Ex Clinical Outcomes Subgroup A3

Subgroup: Sepsis

2024 OpEx Provident Clinical Outcomes Sepsis Sub-group A3

Sub-group A3 Owner: Dr. Hussain

This Year's Action Plan													
Goals	**Specific Actions / Tactics**	**Deployment Leader**	**January - December 2024**										
			J	F	M	A	M	J	J	A	S	O	N	D
Monthly review of abstraction fallouts to identify improvement opportunities	Quality Data Analytics to send abstraction results for clinical review	Quality Data Analytics												
	Clinical review of abstraction results	Dr. Hussain												
	Ensure patient locations are tied to TigerConnect roles for sepsis alerts	Raphael Marla Lax												
Implement reflex lactate order	Leverage technology to pull vitals into EMR in real-time	HIS Dr. Hussain Nursing Quality												
	Meet w/ stakeholders to develop reflex order logic													
	Modify current reflex lactate order logic to include Provident													

Provident Op Ex Clinical Outcomes Workgroup A3

Workgroup Overall A3 Progress

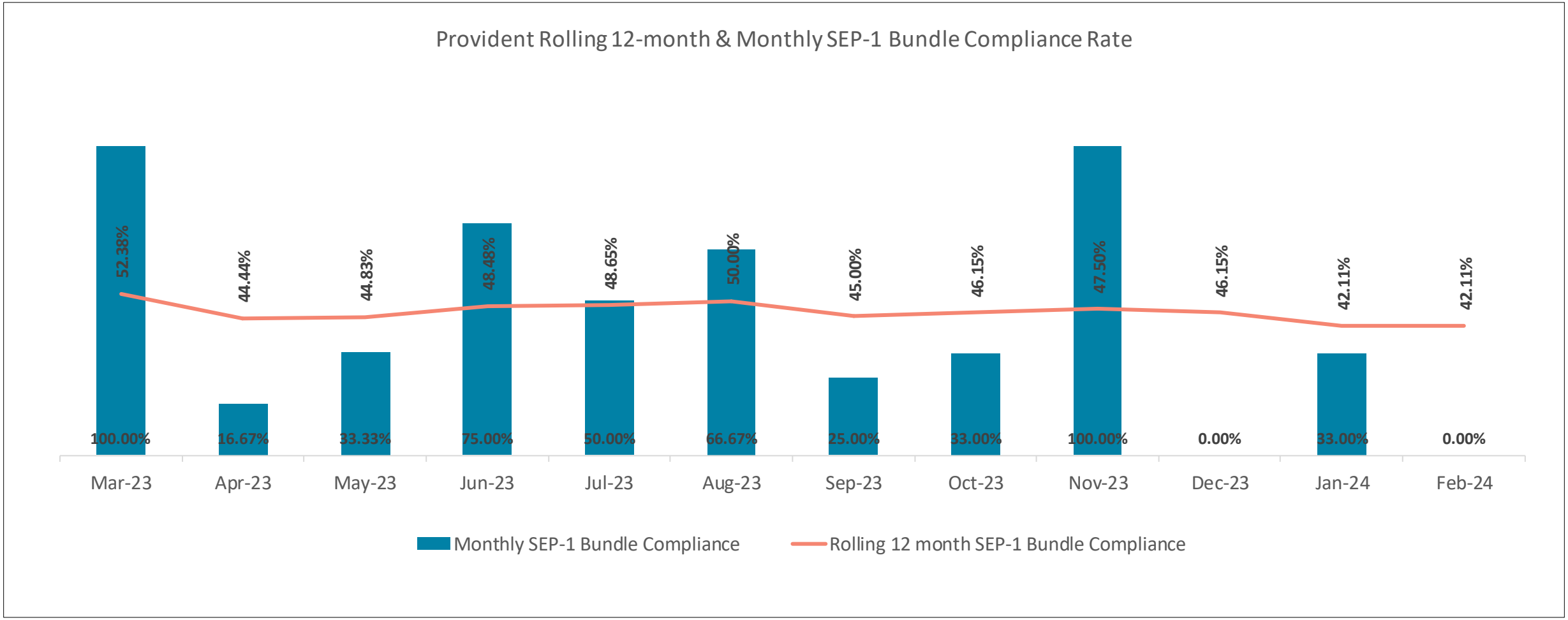
2024 OpEx Provident Clinical Outcomes Hand Hygiene Sub-group A3

This Year's Action Plan			
Goals	**Specific Actions / Tactics**	**Deployment Leader**	**January - December 2024** (J F M A M J J A S O N D)
Minimum 100 observations per month on Medical Surgical unit and 12 observations per month in ICU	Collaborate with leadership in areas of highest opportunity	Raphel Parayao	
Initiate hand hygiene campaign	Bring to QPI meeting for engagement & accountability	Dr. Loafman	
	Review hand hygiene data at QPI		
Identify hand hygiene champions in areas of highest opportunity	Food & Nutrition Services champion	Raphel Parayao	
	Nursing champion		
	Surgical Services champion		

Performance Monitoring

SEP-1 Bundle Compliance

Goal: 60%| Stretch Goal: 65%

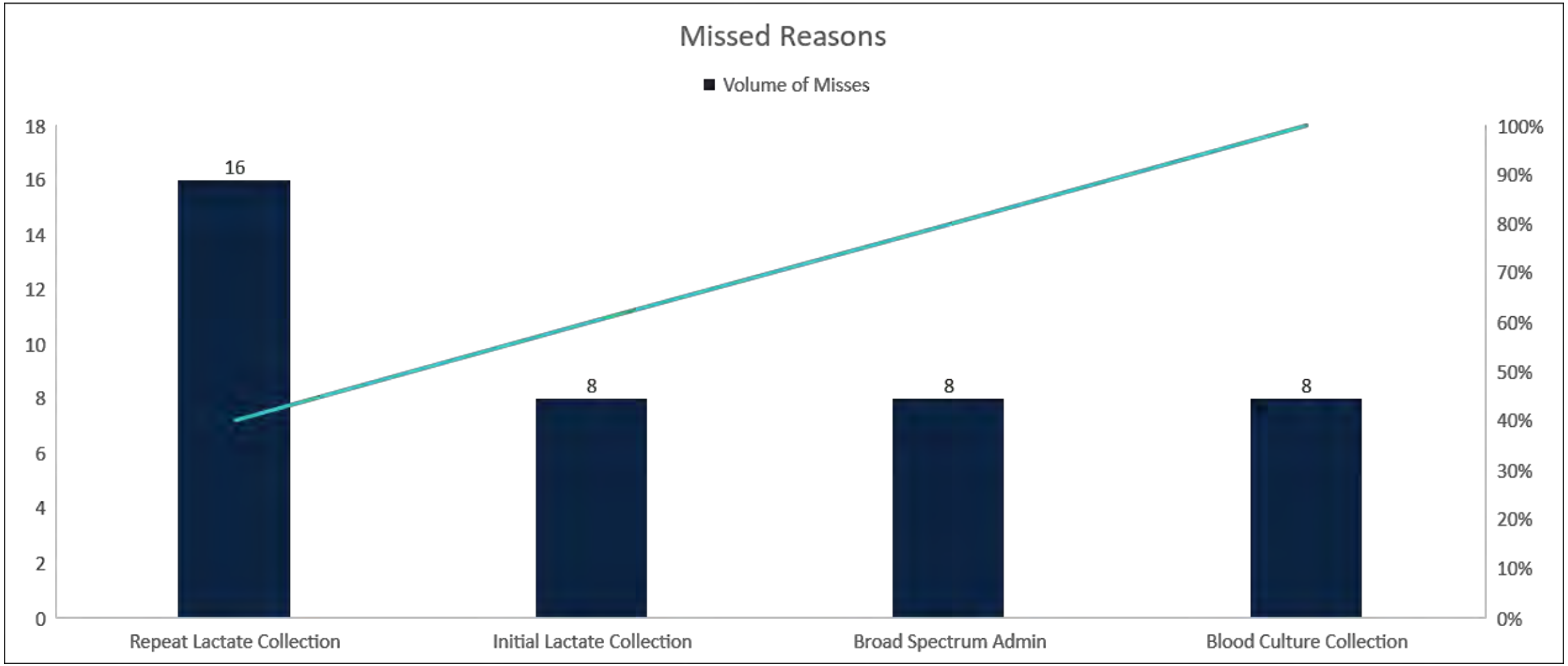


COOK COUNTY HEALTH

Data Source: Chart Abstracted/CERNER-EMR
Higher is better

Performance Monitoring

SEP-1 Bundle Compliance Missed Reasons Pareto Chart

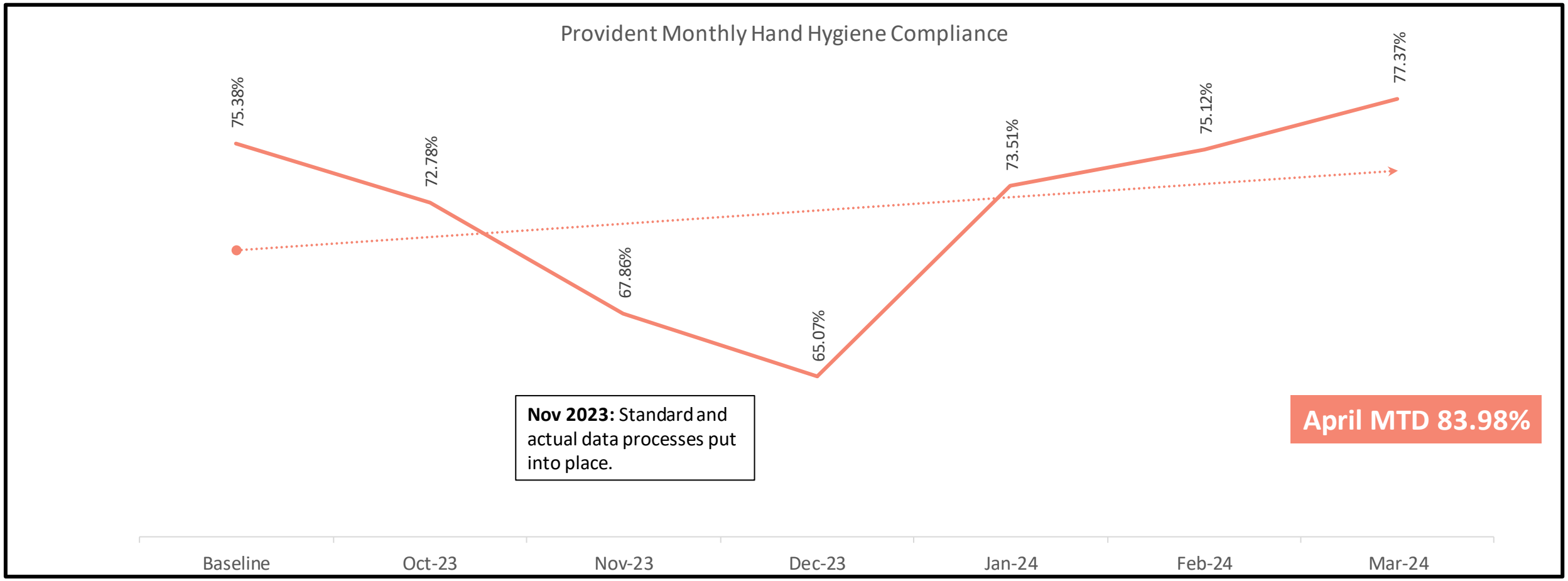


Data Source: Chart Abstracted/CERNER-EMR
Lower is better
Dates: Jan 2022 – March 2024

Performance Monitoring

% of Hand Hygiene Compliance

Goal: 80%| Stretch Goal: 90%



Nov 2023: Standard and actual data processes put into place.

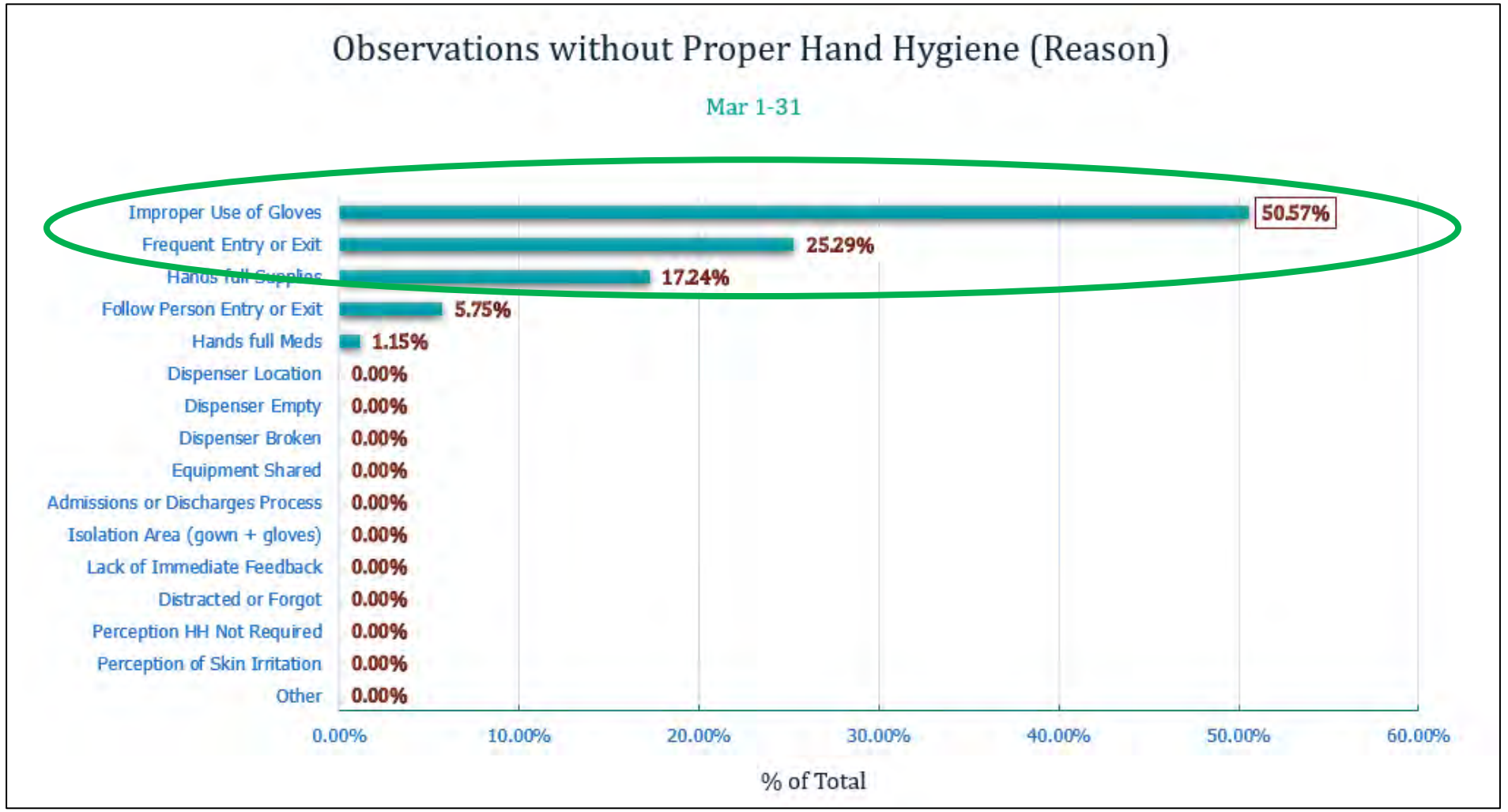
April MTD 83.98%

COOK COUNTY HEALTH

Data Source: **TST System -** Infection Control
Higher is better

Performance Monitoring

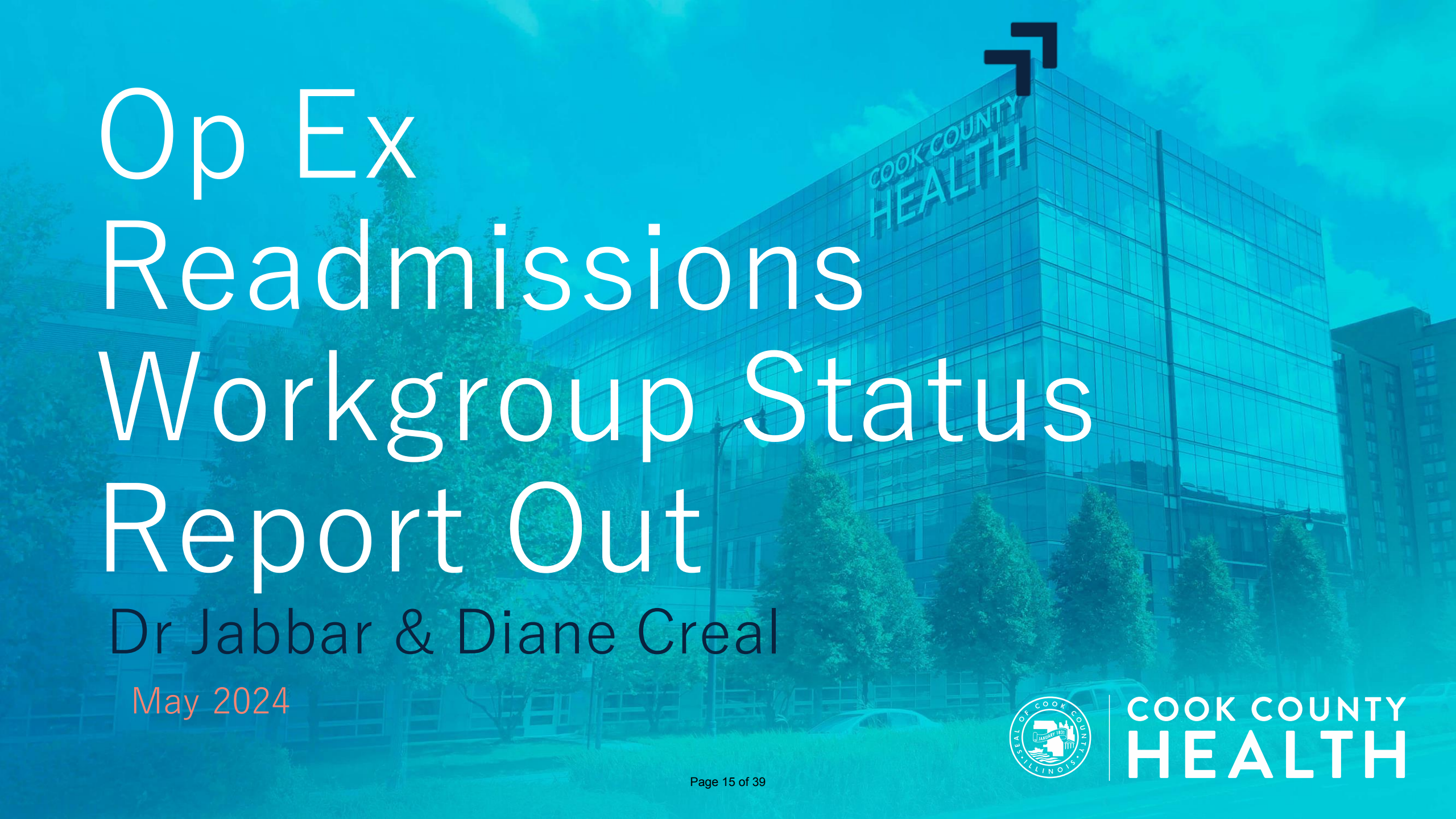
Reasons for Hand Hygiene Non-Compliance



COOK COUNTY HEALTH

Data Source: TST Infection Prevention
Lower is better
Dates: Mar 2024

Op Ex Readmissions Workgroup Status Report Out



Dr Jabbar & Diane Creal

May 2024

COOK COUNTY HEALTH

Stroger Op Ex Readmissions A3

Workgroup Overall A3 Progress

2024 OpEx Stroger Readmissions Workgroup A3

Workgroup A3 Owner: Dr Jabbar & Diane Creal

This Year's Action Plan

Goals	Specific Actions / Tactics	Deployment Leader	January - December 2024											
			J	F	M	A	M	J	J	A	S	O	N	D
Reduce all cause readmissions, inclusive of all payors and admitted elsewhere **2023 Performance:** 14% **2024 Goal:** 13% **Stretch Goal:** 12%	Improve post-hospitalization follow-up for patients with CHF	**CHF:** Dr Maria Demori, Dr Pete Antonopoulos **COPD:** Dr. Sherene Fakhran, Dr. Nancy Quesada												
	Provide post-discharge support for patients with CHF and COPD utilizing our TOC RN program													
	Provide patients with CHF and COPD self-management tools and education													
	Improve Oncology Readmission Rates by increasing use of Palliative Care services	Dr. Orlanda Mackie, Dr. Hernan Grewal												
	Project: High Risk Readmission Model Implementation	HIS/Acute Care Management												

Stroger Op Ex Readmissions A3

CHF Subgroup Overall A3 Progress

CHF Subgroup A3

Tactical A3 Owner: Dr Maria Demori, Dr Pete Antonopoulos

This Year's Action Plan														
Goals	**Specific Actions / Tactics**	**Deployment Leader**	**January - December 2024**											
			J	F	M	A	M	J	J	A	S	O	N	D
Increase % of CHF patients managed by Cardiology who are seen within 7 days post-acute discharge **2023 performance:** 63% **2024 goal:** 69.3% **Stretch:** 76.2%	Increase availability of cardiology post-discharge appointments	Dr. Maria Demori												
	Coordinate and schedule patients according to clinical and patient preferences	Jessica Chavez-Hernandez, MA												
Increase % of CHF patients who receive a phone call for post discharge support **2023 Performance:** 83% **2024 Goal:** 91.3% **Stretch:** 100%	Ensure stable staffing and prioritization of phone calls by Transition of Care Team	Ean Pino, RN												
Ensure CHF Patients receive self-management tools and education upon admission ***Performance Monitoring TBD***	Flag CHF patients in EMR for nursing to initiate education	Bernadine Okeh, RN												
	7 East - RN Navigator to distribute educational folders and oversee daily teaching													
	Create reporting to assess fidelity													

Stroger Op Ex Readmissions A3

COPD Subgroup Overall A3 Progress

COPD Subgroup A3

Tactical A3 Owner: Dr. Sherene Fakhran, Dr. Nancy Quesada

This Year's Action Plan

Goals	Specific Actions / Tactics	Deployment Leader	January - December 2024											
			J	F	M	A	M	J	J	A	S	O	N	D
Increase % of COPD patients who receive a phone call for post discharge support **2023 Performance:** 50.8% **2024 Goal:** 55.88% **Stretch:** 61.47%	Ensure stable staffing and prioritization of phone calls by Transition of Care Team	Ean Pino												
Improve % of COPD patients receiving inhaler teaching concordant to d/c inhalers **2023 Performance:** 33.3% **2024 Goal:** 36.6% **Stretch:** 40.2%	Simplify inpatient formulary to match most common discharge inhalers	Dr. Pete Antonopoulos, PharmD												
	Lung Health Educators focus teaching on most common prescribed inhalers	Maritza Pantoja												
Increase % of patients with smokers with COPD receiving quit aids at discharge **2023 Performance:** 23% **2024 Goal:** 25.3% **Stretch:** 27.6%	Educational sessions and data feedback for Physicians	Dr. Bharath Pendyala												
	Lung Health Educators recommend physicians to prescribe Chantix or Zyban with nicotine replacement	Maritza Pantoja												

Stroger Op Ex Readmissions A3

Oncology Subgroup Overall A3 Progress

Oncology Subgroup A3

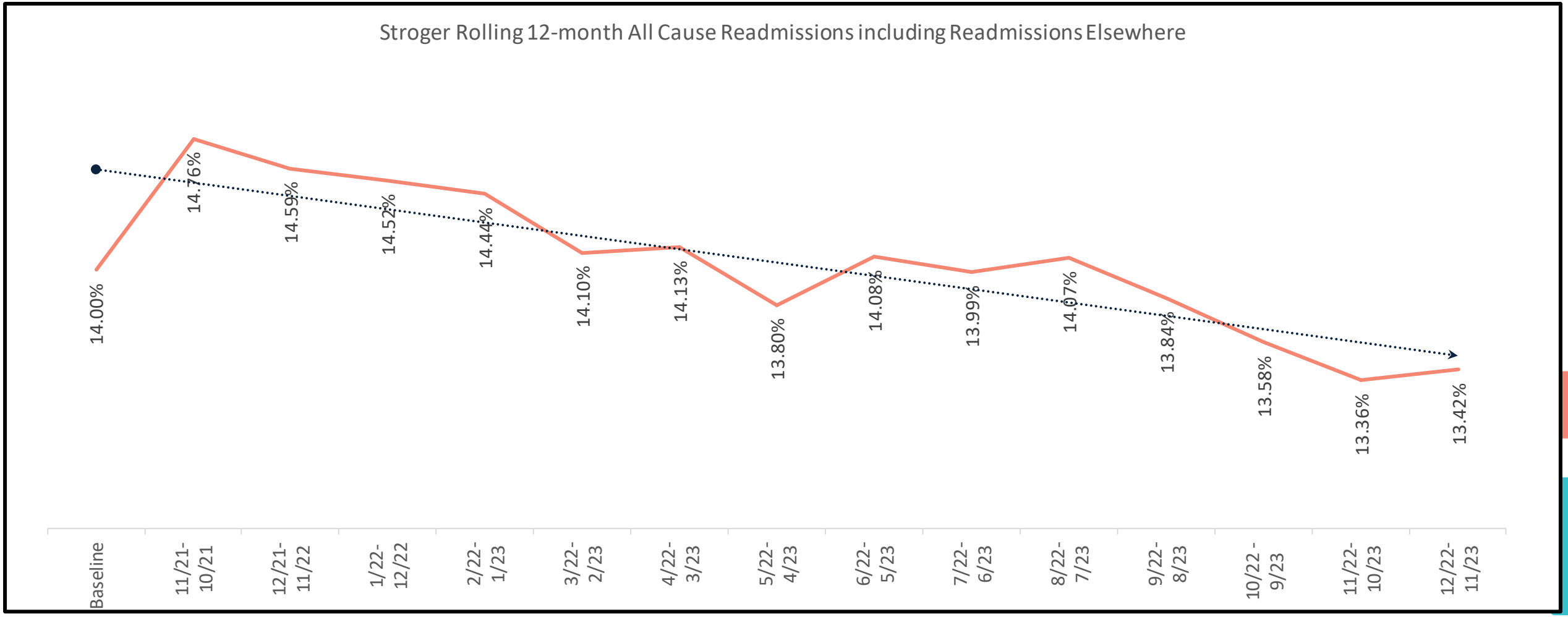
Tactical A3 Owner: Dr. Orlanda Mackie, Dr. Hernan Grewal

This Year's Action Plan													
Goals	**Specific Actions / Tactics**	**Deployment Leader**	**January - December 2024**										
			J	F	M	A	M	J	J	A	S	O	N	D
Increase palliative consults on patients within oncology service line **2023 performance:** 15.5% **2024 goal:** 21% **Stretch:** 29%	Foster cultural change for physicians at education sessions	Dr. Jabbar											
	Develop palliative care decision support in EHR	Dr. Orlanda Mackie, Dr. Hernan Grewal											

Stroger Op Ex Readmissions Performance Monitoring

Rolling 12-month All Cause Readmissions including Readmissions Elsewhere

Baseline: 14.0% | Goal: 13.0% | Stretch: 12.0%



Data Source: IHA Comp Analytics, only available quarterly

Lower is better

Op Ex Throughput Workgroup Status Report Out

Krzysztof Pierko, MD, MBA
Peter Sesi, MBA, BSN, RN

May 2024

COOK COUNTY HEALTH

Stroger Op Ex Throughput A3

Workgroup

Overall A3 Progress

2024 OpEx Stroger Throughput Workgroup A3

Workgroug A3 Owner: Dr. Pierko & Peter Sesi

Performance, Gaps & Targets

The OpEx Stroger Throughput 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.

Reflection on Last Year's Activities & Key Accomplishments

TAT for TTE		~30hrs in 2022 to 12.5 hrs in 2023 (58% improvement)
LWBS		~5.9% in 2022 to ~3.1% in 2023 (47% improvement)
EVS Bed TAT		~125min in 2022 to ~87min in 2023 (30% improvement)
DC order to actual dc time		~124min in 2022 to ~89min in 2023 (28% improvement)
Transportation TAT		~44.5 min in 2022 to 36.5min in 2023 (18% improvement)
Improved ED triage process Improved Nurse-to-Nurse reporting process		
Created Virtual Unit to accomodate 10 patients Ongoing improvements to optimize IDRs		

Rationale for this Year's Activities

OpEx: Throughput Workgroup focus this year is to reduce variance in GLOS and reduce TAT for radiologic testing (especially MRI and CT).
At the same time all subgroups will continue to work on last year initiatives to sustain significant wins.

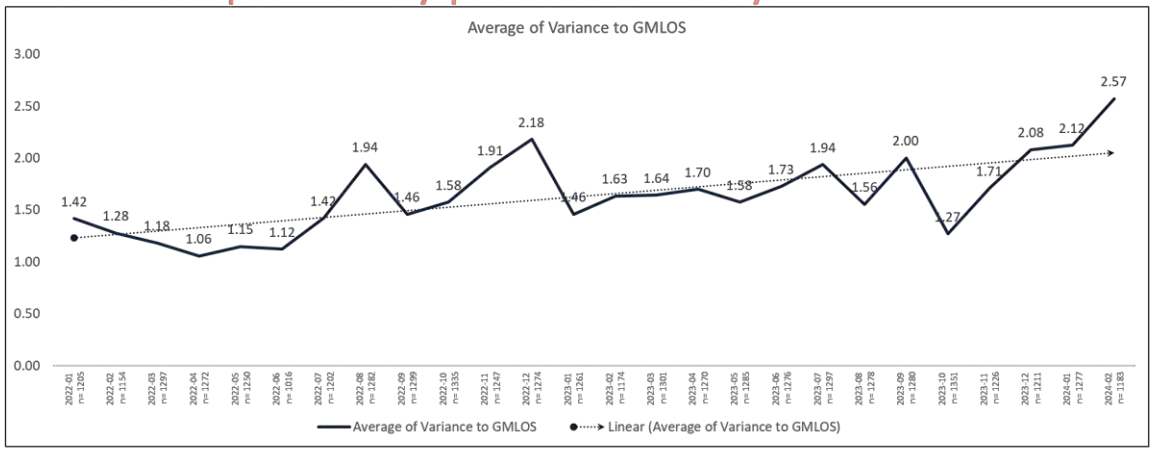
This Year's Action Plan

Goals	Specific Actions / Tactics	Deployment Leader	January - December 2024 (J F M A M J J A S O N D)
Decrease GMLOS (Geometric Mean Length of Stay) **variance** 2023 performance: 2.2 days variance 2023 Goal: **0.5 day reduction** 2023 Stretch Goal: **1.0 day reduction**	Modify Medicine Service admission model (go live 07/01/2024	Dr. Pierko	
	Standardize discharge planning processes on the medical units	Dr. Taddese	
	Decrease operational throughput turnaround times including bed assignment, patient transport, & room		

Stroger Op Ex Throughput Performance Monitoring

Monthly Avg Variance to GMLOS Expected

Baseline: 1.73 | Goal: 1.7 days| Stretch Goal: 1.2 days



Data Source: Vizient/CMS Table by MSDRG weights
Lower is better
Exclusions: GeoMean OBS LOS >30

COOK COUNTY HEALTH

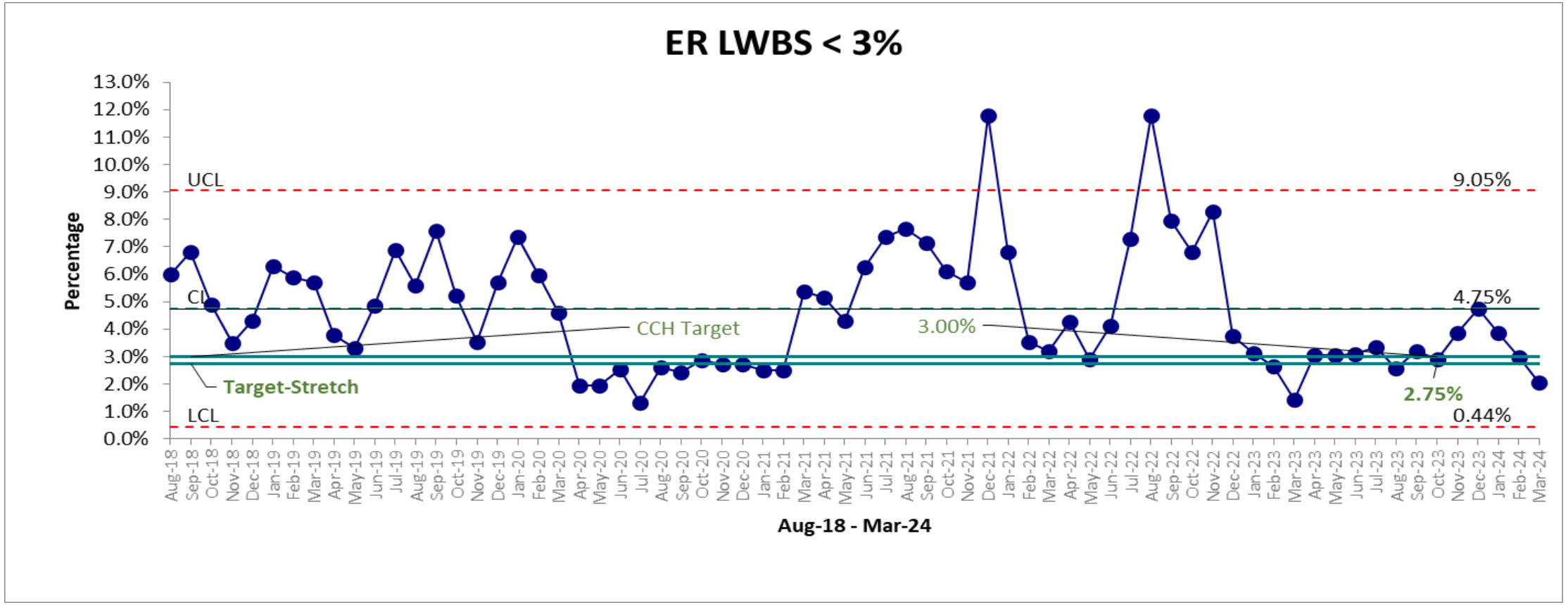
Stroger Op Ex Throughput Subgroup A3

ED Throughput

This Year's Action Plan													
Goals	**Specific Actions / Tactics**	**Deployment Leader**	**January - December 2024**										
			J	F	M	A	M	J	J	A	S	O	N
Reduce LOS by 1 day	Reinstate bolus (q4 days) admission model	Dr. Pierko											
	Modify Cerners orders	Dr. Caudil											
	Optimize Tiger Connect for admission model	Sam Stathos											
	Optimize ED to Medicine admisison process	Dr. Needleman											
LWBS <2%, stretch <1.5% ED Arrival to Departure (DC) <220, Stretch <191	ED Triage space/Relocate financial advisors	Dr. Needleman Mr. McCracken											
	Improve Door to UA/Pregnancy test/XR/Respiratory viral panel TAT	Dr. Needleman Mr. McCracken											
	Increase #of ED transfers to Provident	Dr. Lewis											

Stroger Op Ex Throughput Subgroup A3

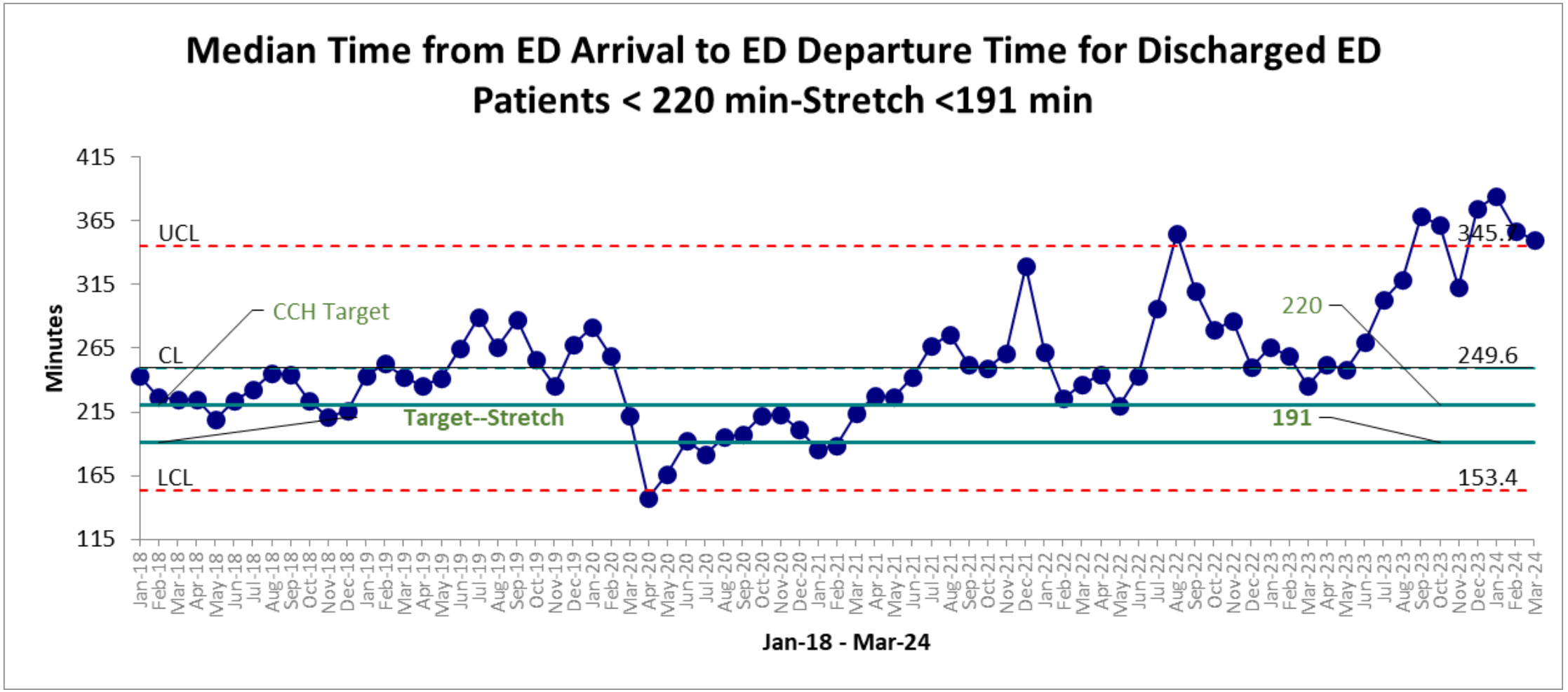
ED Throughput



COOK COUNTY HEALTH

Stroger Op Ex Throughput Subgroup A3

ED Throughput



COOK COUNTY HEALTH

Stroger Op Ex Throughput Subgroup A3

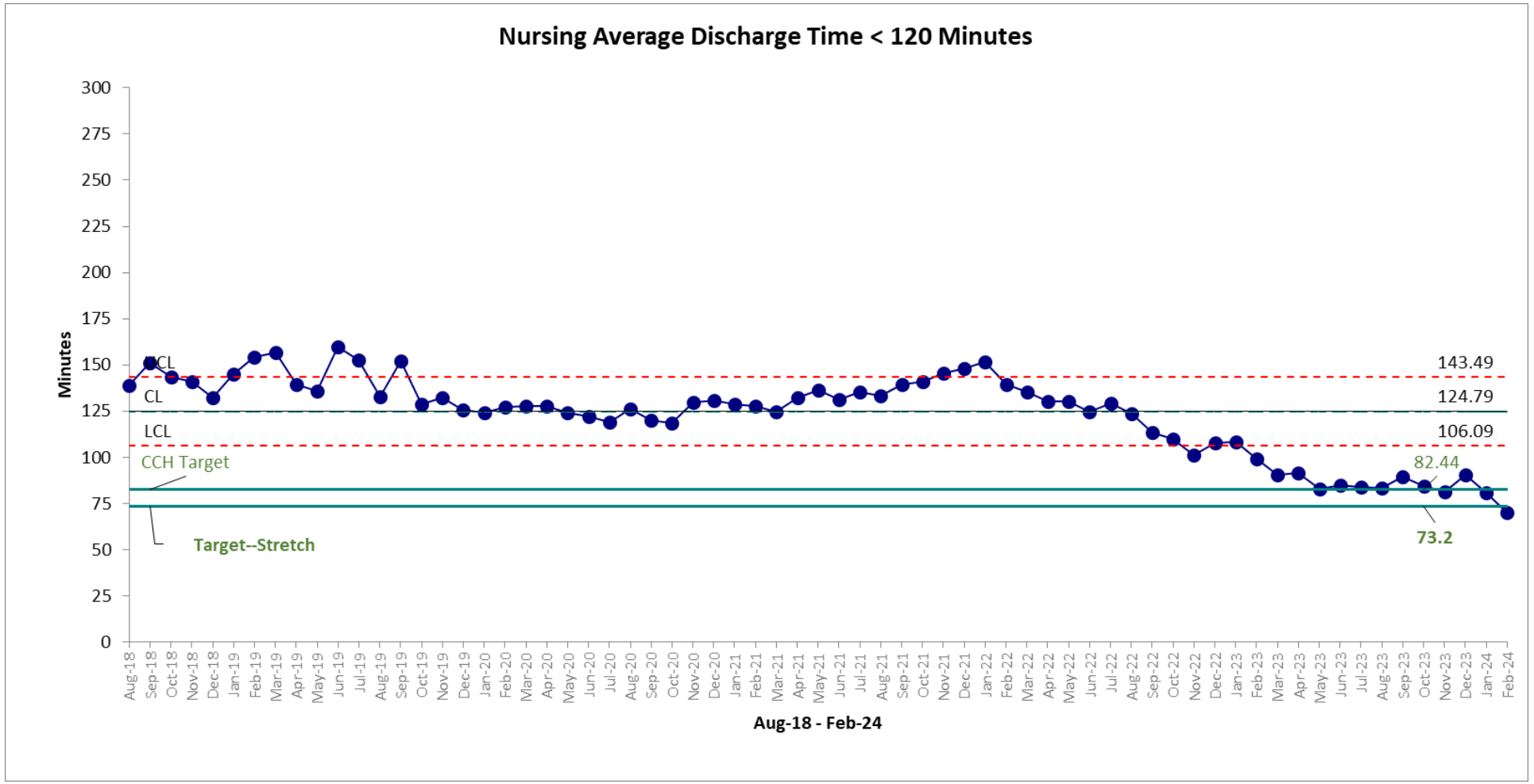
Inpatient Througput

This Year's Action Plan			January - December 2024										
Goals	**Specific Actions / Tactics**	**Deployment Leader**	J	F	M	A	M	J	J	A	S	O	N
Standardize Interdisciplinary Rounds IDRs) on the medical units	Provide training on Discharge Barriers to Nuring Managers	Dr. Pierko											
	Provide training on Discharge Barriers to Case Managers	Dr. Pierko											
	Ensure standardized reporting on all units	Dr. Pierko											
Optimize Discharge Lounge	Expand Discharge Lounge inclusion criteria	Mrs. Zhang											
	Provide a cost-analysis for the RN/PCT/HA staffed Discharge Lounge; identify the light-duty RN resource	Mrs. Zhang											
	Study the needs of inpatient at discharge to identify the service needed in the Discharge Lounge	Mrs. Zhang											
	Pilot a RN and HA/PCT staffed Discharge Lounge staffing model	Mrs. Zhang											
	Create staff version Discharge Lounge Information Flier for quick reference	Mrs. Zhang											
Patient average discharge time - Pilot a new workflow on the unit monitoring the discharge timer and escalation process	Develop a 30/45 Workflow to monitor discharge milestone and remind staff to prioritize discharge and to escalate timely	Mrs. Zhang											
	Collaborate with the Transport Team for an escalation process to complete discharge within the set discharge turnaround time	Mrs. Zhang											
	Educate the designated staff on monitoring the discharge timer and to follow the escalation process	Mrs. Zhang											
Proactive assessment and resolution of discharge barriers	1. Discharge Readiness assessment educaiton. 2. Tiered Tiger alerts of Discharge TAT timer to Charge RN and Manager. 3. Officer srtaffing for Cermak patients	Dr. Taddese											
	Timely consultant recommendations, Imporve DME/Oxygen TAT, Medication delivery	Dr. Taddese											
	Early idenitification for placement with early family engagement	Dr. Taddese											
	System-wide palliative triggers	Dr. Taddese											
	Increase testing capacity by Cardiology (weekend coverage)	Dr. Taddese											
	Increase testing capacity by Radiology 9mobile MRIs)	Dr. Taddese											

COOK COUNTY HEALTH

Stroger Op Ex Throughput Subgroup A3

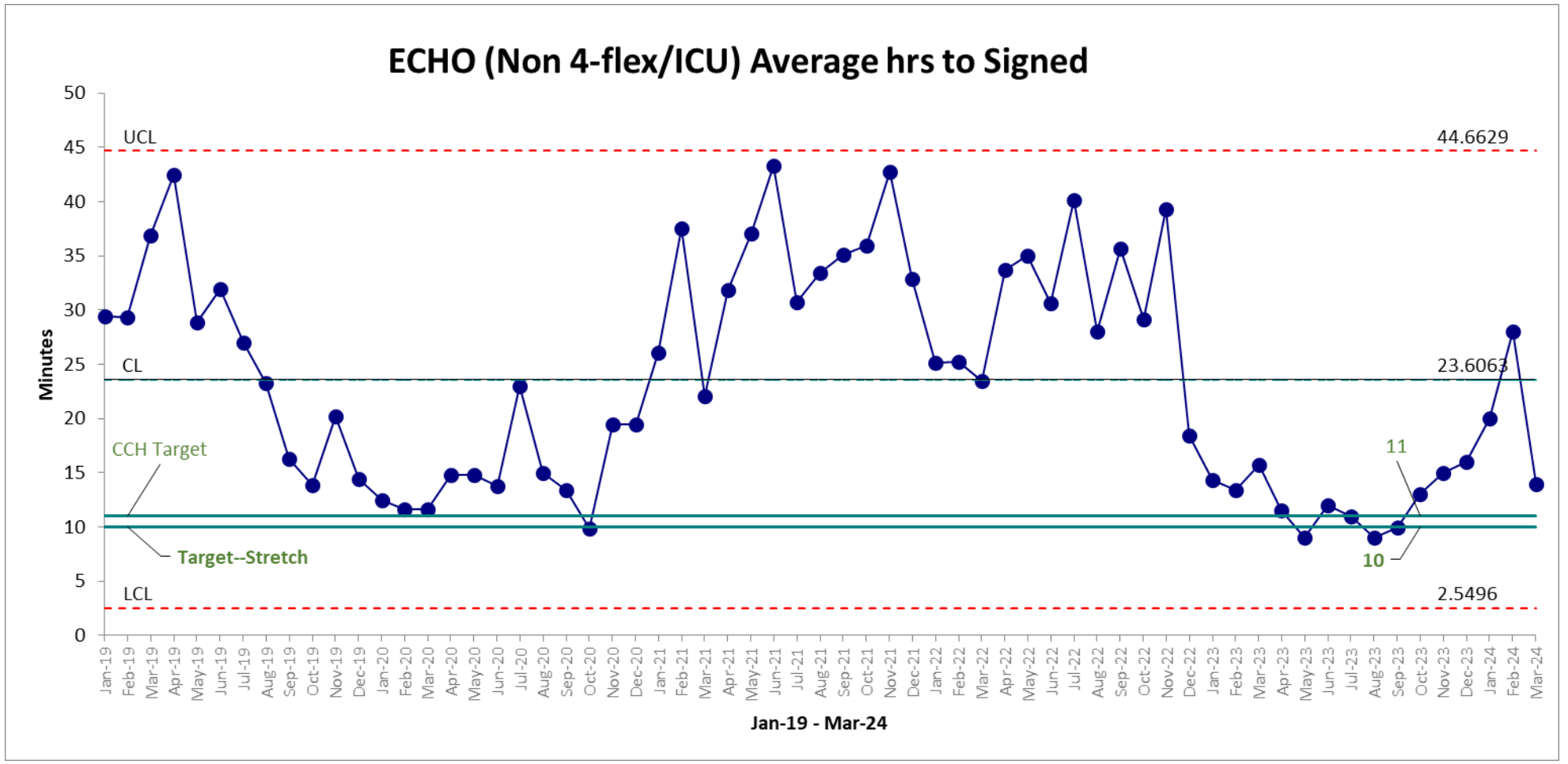
Inpatient Througput



COOK COUNTY HEALTH

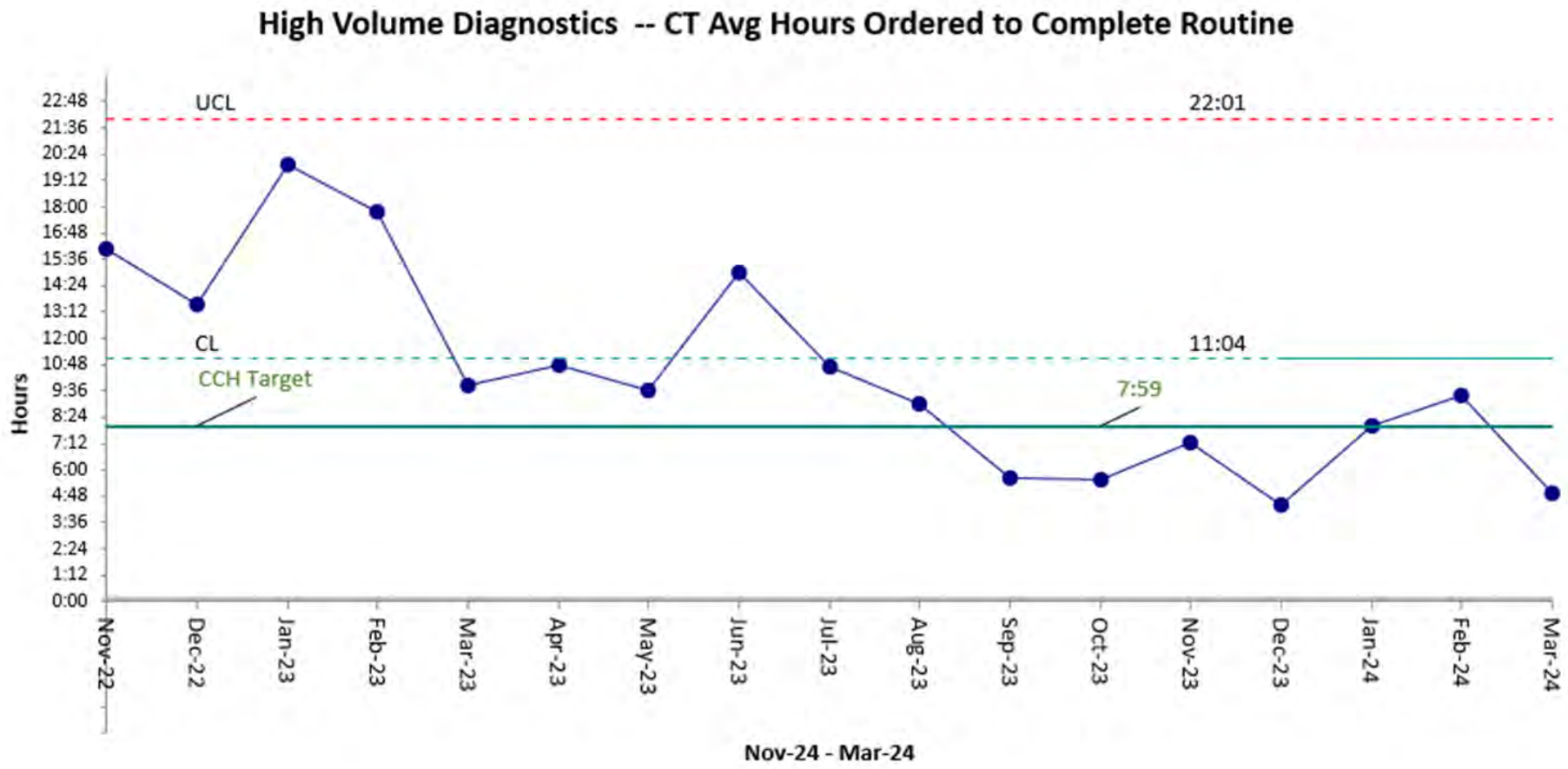
Stroger Op Ex Throughput Subgroup A3

Inpatient Througput



Stroger Op Ex Throughput Subgroup A3

Inpatient Througput



COOK COUNTY HEALTH

Stroger Op Ex Throughput Subgroup A3

Operational Throughput

Workgroug A3 Owner: Dr. Pierko & Peter Sesi

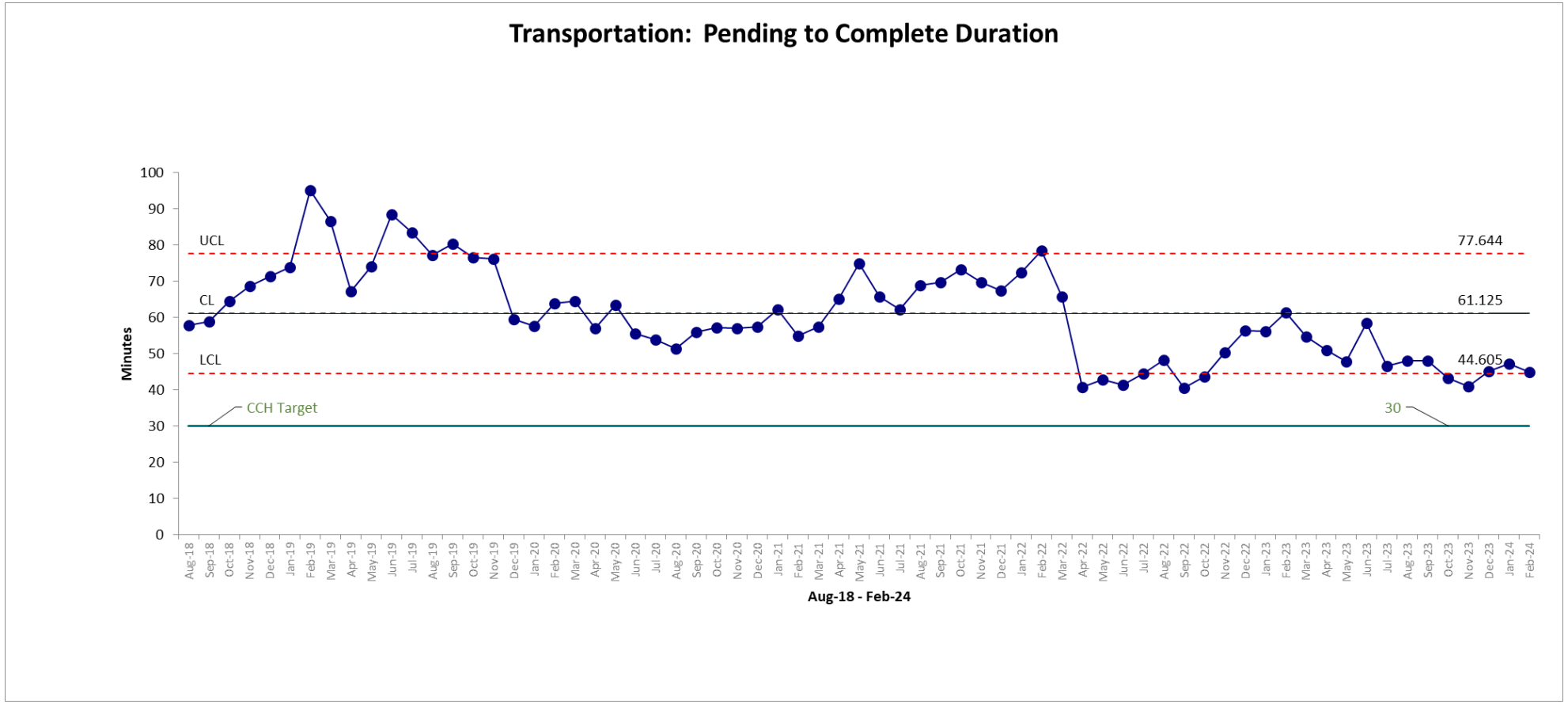
This Year's Action Plan

Goals	Specific Actions / Tactics	Deployment Leader	January - December 2024
Reduce patient transport TAT **2024** **Goal:** < 37 minutes	Initiate zoning for Radiology Department	Towanda Bell	
	Track efficiency and jobs per hour	Towanda Bell	
Reduce room turnover time **2024** **Goal** : < 60 minutes	Discahrge cleaning 1PM-9PM	John Jordan Ruben Gonzalez	
	Additional staff during surge times	John Jordan Ruben Gonzalez	
Reduce bed assignment time **2024** **goal:** < 15 minutes (counted from the time bed becomes available)	Keep track of blocked, furloughrd, and reserved beds	Michelle King-Robledo Yemisi Taylor	
	Cross-trained clerical poll	Michelle King-Robledo Yemisi Taylor	

J	F	M	A	M	J	J	A	S	O	N	D

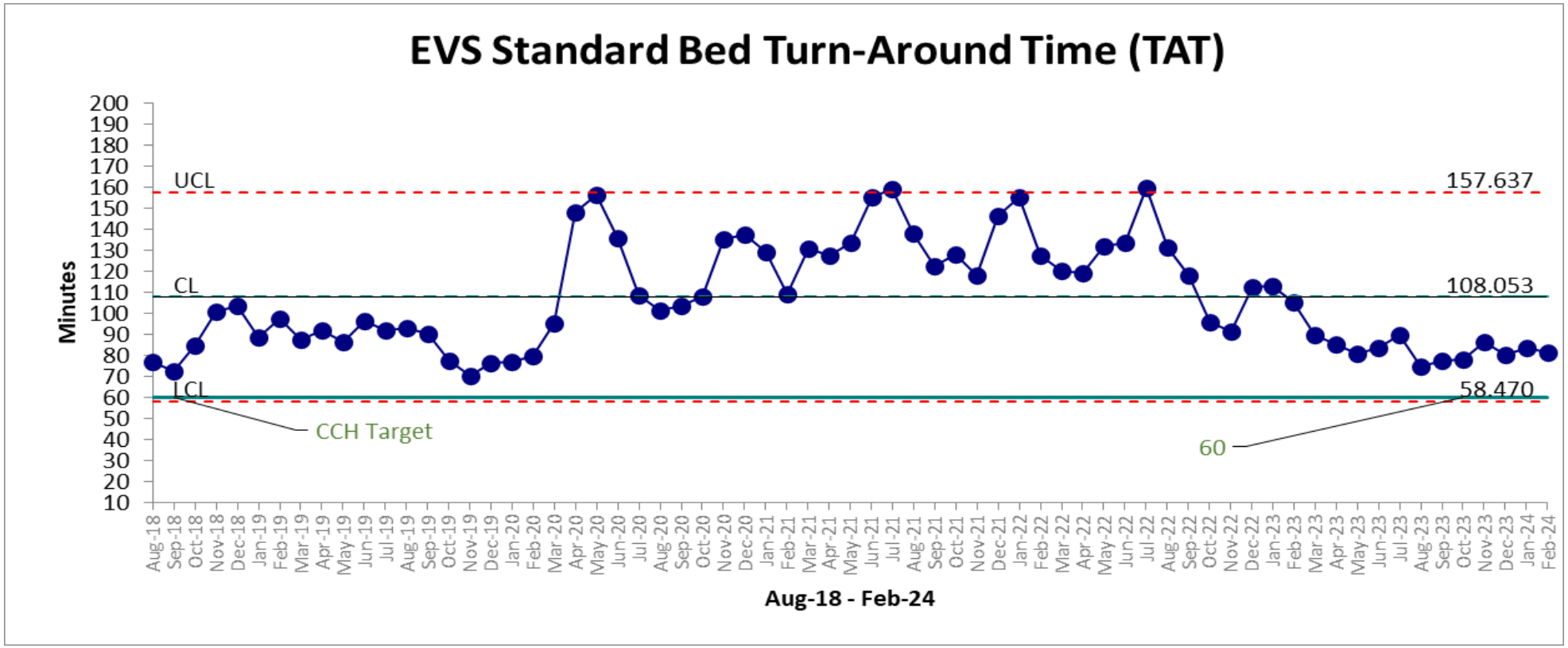
Stroger Op Ex Throughput Subgroup A3

Operational Throughput



Stroger Op Ex Throughput Subgroup A3

Operational Throughput



COOK COUNTY HEALTH

Thank you

Questions?

Op Ex HEDIS/Healthe Registries Workgroup Report Out

Dr. Charles Edoigiawerie & Beth Vaclavik

May 2024

Amb Services Op Ex HEDIS/Healthe Registries A3

Workgroup Overall A3 Progress

2024 OpEx ACHN HEDIS Workgroup A3

Workgroup A3 Owner: Dr. Edoigiawerie & Beth Vaclavik

This Year's Action Plan

Goals	Specific Actions / Tactics	Deployment Leader	January - December 2024											
			J	F	M	A	M	J	J	A	S	O	N	D
Greater than 55% of patients aged 18 - 85 will have a blood pressure < 140/90 **Baseline:** 50.53% **Goal:** 55.00%| **Stretch Goal:** 60.00%	Procure necessary equipment for hypertension assessment in the clinics	Dr. Tinfang Dr. Abonia												
	Create and implement a hypertension protocol to be used by all support staff													
Women aged 21-65 will have their cervical cancer screening completed **Baseline:** 42.83% **Goal:** 47% | **Stretch goal:** 52%	Train all medical assistants on pap smear set-ups and ensure sites have the necessary equipment	Dr. Abrego Christina Urbina												
	Spread best practices from high performing sites across the network													

Amb Services Op Ex HEDIS/Healthe Registries Subgroup A3

Subgroup – Hypertension Management

2024 OpEx ACHN HEDIS Hypertension Subgroup A3

Tactical A3 Owner: Dr. Tinfang, Dr. Abiona

This Year's Action Plan

Goals	Specific Actions / Tactics	Deployment Leader	January - December 2024											
			J	F	M	A	M	J	J	A	S	O	N	D
Procure necessary equipment for hypertension assessment in the clinics	Clinic leaders to create list of needed equipment	ACHN Clinic Managers												
	Request equipment based off of submitted lists	ACHN Clinic Managers												
Create and implement a hypertension protocol to be used by support staff	Partner with key stakeholders to create protocol	Subgroup Leaders												
	Partner with clinic leaders and teams to implement protocol													
Participate in the American College of Preventive Medicine Reducing HTN Amongst Priority Group grant	Provide remote monitoring equipment to patients													
	Integrate remote monitoring data in the 'EMR/Cerner	HIS												

Amb Services Op Ex HEDIS/Healthe Registries Subgroup A3

Subgroup – Cervical Cancer Screenings

2024 OpEx ACHN HEDIS Cervical Cancer Subgroup A3

Subgroup A3 Owner: Dr Abrego, Skyler Bateast & Christina Urbina

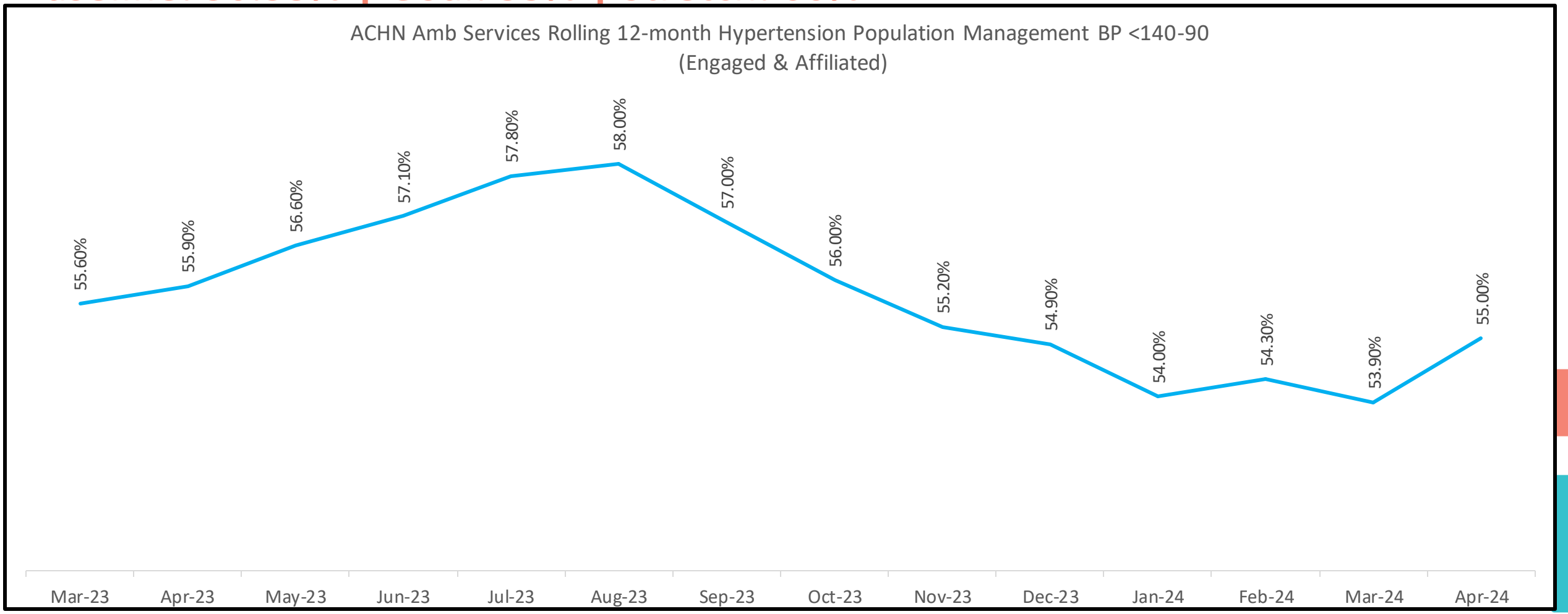
This Year's Action Plan

			January - December 2024										
			J	F	M	A	M	J	J	A	S	O	N	D
Train all medical assistants on pap smear set-ups and ensure sites have the necessary equipment	Skills Fairs -completed recently to re-educate	Christina Urbina												
	Visual Setups for paps and other procedures (PPT) shared													
	Cindy to develop an Audit tool for the setup compliance check and provide to Skyler	Cindy Walsh												
	Accountablity audits, start GMC in May	Skyler Bateast												
Spread best practices from high performing sites across the network	Clinicial Documentation Improvement Education on exclusions, programmic outline for how done at GMC	Skyler Bateast												
	Cascade communication of this education thoroughout the organization once core subgroup has a programmic outline	Christina Urbina												

ACHN Op Ex Hypertension Performance Monitoring

% of Hypertension Patients with Blood Pressure <140/90

Baseline: 50.53% | Goal: 55% | Stretch: 60%



COOK COUNTY HEALTH

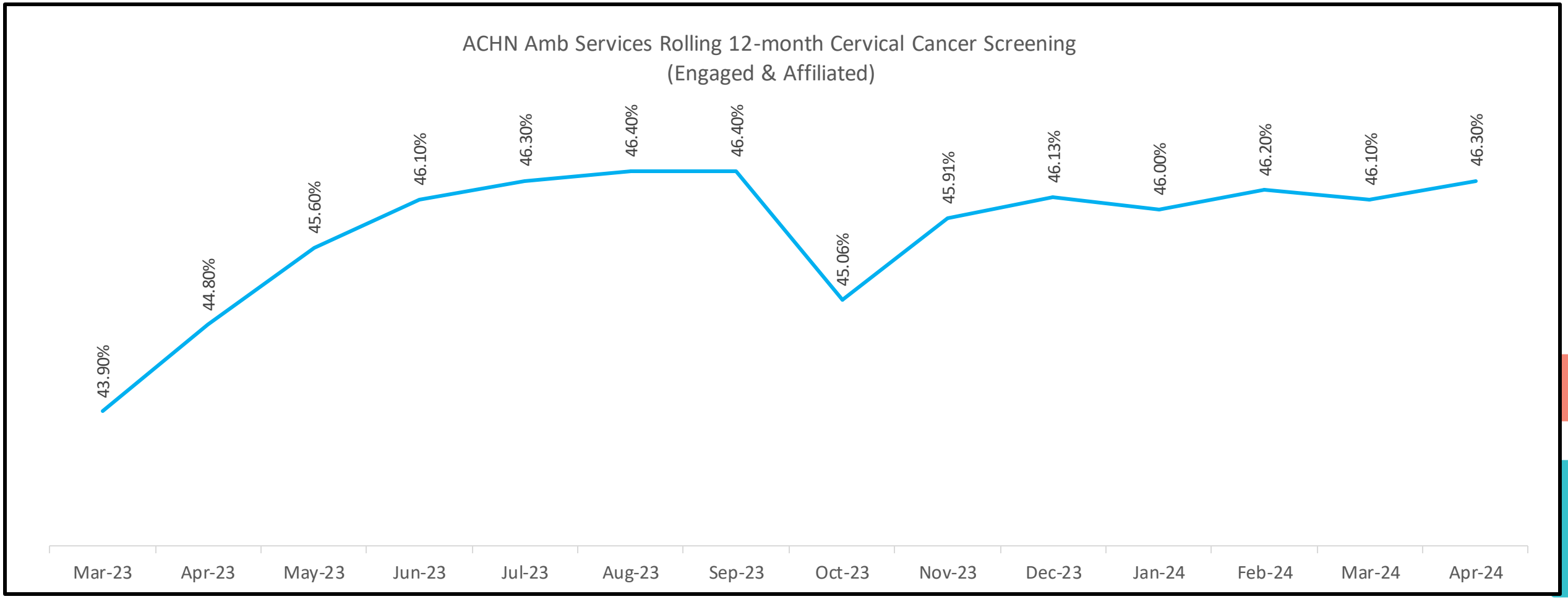
Data Source: Cerner, Healthe Intent Platform

Higher is better

ACHN Op Ex Cervical Cancer Performance Monitoring

% of Patients with Cervical Cancer Screening

Baseline: 42.83% | Goal: 47.00% | Stretch: 52.00%



COOK COUNTY HEALTH

Data Source: Cerner, Healthe Intent Platform

Higher is better

Regulatory Updates

June 2024

- Stroger Hospital and Ambulatory Clinics completed the Joint Commission Triennial Accreditation and Primary Care Medical Home survey June 4 thru June 7.

- There was 97% compliance with all standards and elements of performance. There were 47 findings out of 1484 standards & EPs assessed. Corrective actions are underway.

- Leadership training on the Joint Commission AMP Tracer tool is planned later this month. It will be tailored toward the survey findings and promote continuous regulatory readiness.

- The Joint Commission 13-part Breakfast Briefing Webinar will be offered weekly on Mondays, August 19 thru November 18, 2024, to support ongoing leader and staff accreditation education. Includes an overview of the Joint Commission standards for each chapter.

Stroger Hospital Quality Improvement & Patient Safety (HQuIPS) Committee Summary Report to the Executive Medical Staff (EMS) Committee and Quality and Patient Safety (QPS) Committee
For June 2024
Chairs: Dr. Fakhran and Dr. Gomez-Valencia
Meeting Date: April 23rd, 12-1:30PM In-Person
Regular or Special Meeting: Regular
Minutes/Attendance: Minutes are attached for review at EMS, summary only for QPS

April Highlights:

Environment of Care

- January and February Fire/Life Safety indicators of areas free of Power strips and no microwaves in private offices was 100%.
- Fire extinguishers inspections are 100% compliant for both January and February
- Staff areas free of food items was 100% in January, 67% in February, and 60% in March

Radiology

- CT inpatient TAT goal is <4 hours and have consistently met that goal since August 2023 and until March 2024.
- The ED CT TAT goal is <2 hours and they have met that goal for Q1/2024 with an average time of 1 hr, 49 minutes,

Patient Experience

- All grievances are to be closed within 30 days and they are 93.3% on target for Q1 24
- The total number of grievances has remained low at an average of 26 cases a month.
- The vast majority of grievances/complaints are categorized as a delay in care followed by behavior/respect. Quality of care complaints are less than half of time delay complaints.

There are no action items for the EMS Committee.
There are no actions for the QPS Committee.

Provident Hospital Quality & Performance Improvement Committee
Summary Report to the Medical Executive Committee (MEC)
For June 2024

Chair: Dr Loafman
Meeting Date: April 27th 11:00am-12:30pm via WebEx
Regular or Special Meeting: Regular
Minutes/Attendance: Minutes are attached for review at MEC, summary only for QPS

April Highlights

Regulatory Report outs for TJC compliance

8 West

PC.01.02.01 EP 1 – Number of Telemetry Strips with RN Analysis every 8 hours / 8-hour Increments while Patient on Telemetry

- **70/70 100% Compliance**

PC.04.01.05 EP 7 – Number of Patients Discharged with Follow up Healthcare Appointment / Number of Patients Discharged

- **76/76 100% Compliance**

RC.01.01.01 EP 5 – Number of Discharge Nursing Notes on Correct Patient / Number of Patients Discharged

- **76/76 100% Compliance**

MS.01.01.01 EP5 – Number of Consults Completed with a Consult Note within 48 hours / Number of Consult Orders

- **52/52 (2 Neurology Consults) 100% Compliance**

ICU

PC.02.01.03 EP 1 – Number of Titrated Medications given by nurse with an order / Number of Titrated Medication Orders

- **1/1 100% Compliance (ICU closed intermittently)**

Pharmacy

- Appropriate use of anticoagulants: Q4 2023 was 100%
- The total # of Rxs dispensed in the Outpatient Pharmacy for the 1st Qtr. of 2024 was 25,559 with an overall medication fill accuracy rate of 99.99%
- The total # of doses dispensed in the Inpatient Pharmacy for the 1st Qtr. of 2024 was 60,817 with an overall medication fill accuracy rate of 99.9% (Goal = 100%)

Inpatient Care coordination

- Patients seen within 48 hours of admit was 91% for Q1/2024
- 2024 Denials upheld went up to 42% in March from a low of 19% in February
- Positive outcomes of denials was 80% for Q1 of 2024.

There are no action items for the MEC Committee.
There are no actions for the QPS Committee.