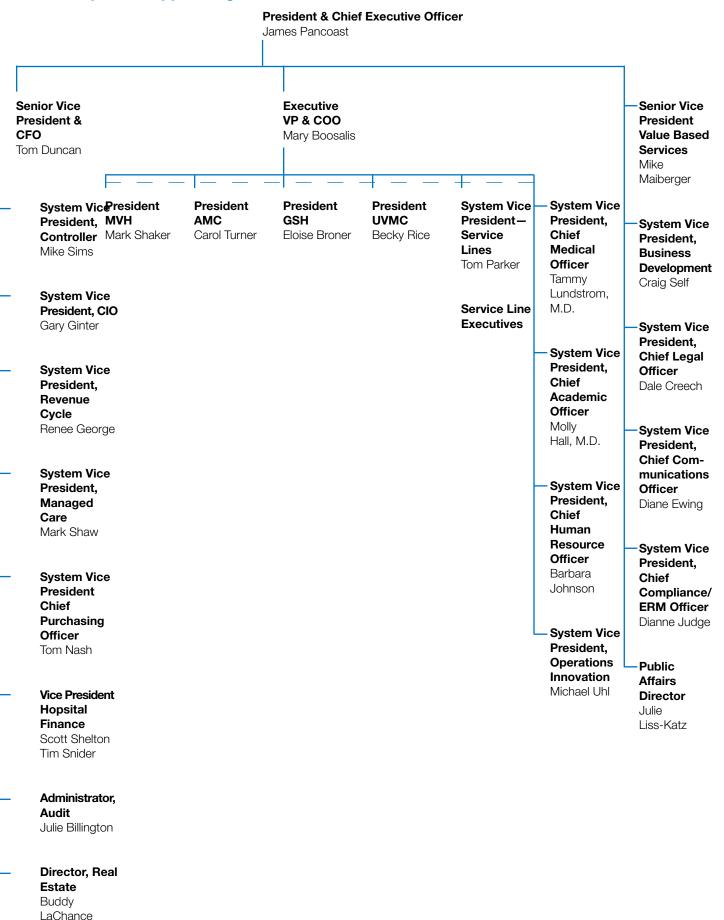


Participating Site, Miami Valley Hospital, part of the Premier Health System

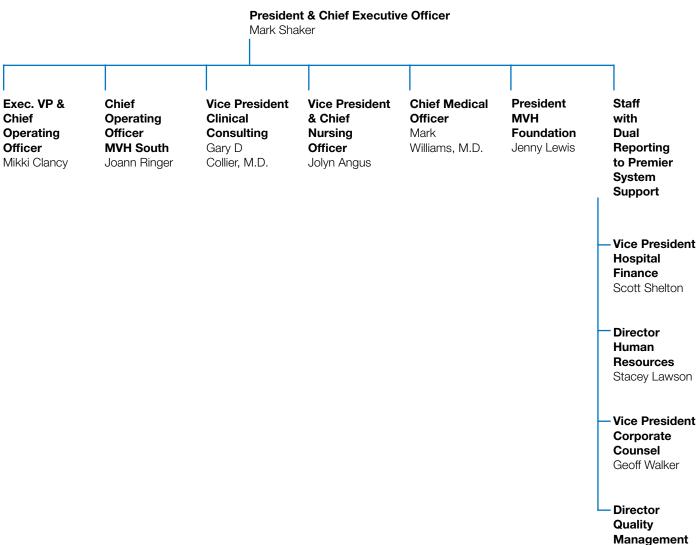
# Organizational Chart and Quality Safety Departments



# **Premier System Support Organizational Chart**



# **Miami Valley Hospital Organizational Chart**



Ed Syron

# **System CMO Organizational Chart**

System Vice President, **Chief Medical Officer** Tammy Lundstrom, M.D., J.D.

**Vice President** Quality Innovation

**Vice President Medical Affairs** & Chief Medical Officer AMC

Jeffrey Hoffman, M.D.

Dan

**UVMC** 

**Vice President** Medical Affairs & **Chief Medical** Officer

Bailey, D.P.M.

**Vice President Medical Affairs** & Chief Medical Officer MVH

Mark Williams, M.D. **Vice President Medical Affairs** & Chief Medical Officer **GSH** 

Daniel Schoulties, M.D. **Director Patient Experience** Melissa Tallmadge

# **Quality and Medical Safety Plan**

### I. INTRODUCTION

### **A.PURPOSE**

Premier Health Quality and Safety plan is designed to support the mission of Premier Health. This plan will be implemented through the integration of the performance improvement philosophy, which is aimed at improving the quality of the system's governance, management, clinical and support processes and medical safety activities. The purpose of this plan is to provide guidelines to ensure high quality care, eliminate preventable harm to patients, minimize risk to the patients, employees, and the organization, and promote cost effectiveness. It also includes professional/peer review; review of professional practices to reduce morbidity, mortality, and improve quality care; and review of professional practices to prevent potential risks.

### **B.GUIDING STATEMENTS**

Premier Health Quality Statement

Premier Health is committed to ensuring the safest, highest quality of care for its patients that embodies the Institute of Medicine principles of best healthcare. Our Patient Experience encompasses Safety, Quality, Service and Inclusion. Premier Health will implement all nationally recognized safety best practices and will strive to eliminate all preventable harm to our patients, through standardization of care, continuous process improvement, advanced information technology and a culture of safety and fairness. Premier Health promises to deliver care that is built on the foundation of our core values. Everyone deserves our respect, integrity, compassion, and excellence. Premier Health is committed to providing correct, evidence based care that is safe by elimination of all preventable harm, adherence to national and evidence based best practices, regulatory s/accreditation readiness and care that are patient/family centered.

### Premier Health Clinical Safety

Premier Health is committed to promoting the safety of all patients, visitors, volunteers, healthcare workers, and trainees. This commitment includes incorporating safety concerns as a component of newly designed and redesigned activities. The organization-wide clinical safety plan is designed to reduce medical/health system errors and hazardous conditions by utilizing continuous improvement methods and strategies for medical safety initiatives that are ongoing, proactive and in response to actual occurrences. Our goal is to have zero preventable harm. In order to achieve our desired outcomes the leaders of Premier Health will ensure that expectations for performance and behaviors are clear, all members of Premier Health have the knowledge and skills necessary to perform the task and an effective accountability system is in place to build and sustain a system-wide culture of safety.

### **II OVERVIEW**

The Quality and Clinical plan is comprised of clinical quality, patient safety, infection control, accreditation and regulatory preparedness, environment of care and emergency management; involves all hospital departments and services (including those services under contract or arrangement), ambulatory and home health services; and focuses on indicators related to improved health outcomes and the prevention of medical errors and adverse events.

Premier Health System Leadership promotes an organizational safety climate which:

- Encourages recognition, reporting, and acknowledgement of risks to patient/visitor and employee safety and medical/health system errors.
- Initiates/monitors actions to reduce these risks/errors.
- Reports findings internally and actions are taken.
- Promotes a non-punitive environment for reporting and follow-up of medical errors and adverse events.
- Supports staff that has experienced a clinical health system error.
- Educates staff to assure that all members of the healthcare team participate in the plan.
- Assures that patients/families are informed about the results of care, including unexpected outcomes and clinical healthcare errors.

### A.DEVELOPMENT OF QUALITY AND SAFETY PLAN

Criteria used to prioritize performance improvement and medical safety activities selected are based on one or more of the following:

- Areas identified as high volume, high risk, or problem prone; considering the incidence, prevalence and severity of problems in those areas.
- Patient safety, health outcomes and quality of care
- Internal and external customer satisfaction
- Patient and family complaints and grievances.
- Leadership patient safety rounds and daily check-ins
- Objectives and targets for quality and environmental management system
- Resources

Criteria from external sources, include, but are not limited to:

- Center for Medicare and Medicaid Services (CMS)
- The Joint Commission (TJC)
- Agency for Healthcare Research and Quality (AHRQ)
- Centers for Disease Control and Prevention (CDC)
- Institute for Healthcare Improvement (IHI)
- Institute for Safe Medication Practices (ISMP)
- Emergency Care Research Institute (ECRI)
- National Forum for Healthcare Quality Measurement and Reporting (NQF)
- National Database Nursing Quality Indicators (NDNQI)
- Occupational Safety and Health Administration (OSHA/MIOSHA)
- Ohio Quality Improvement Organization (KePRO)
- Ohio Department of Health (ODH)
- Ohio Hospital Association (OHA)
- Ohio Patient Safety Institute (OPSI)
- Greater Dayton Area Hospital Association (GDAHA)
- Published literature

### III. STRUCTURE

### A. Quality and Clinical Safety Organizational Structure

Premier Health supports the continuous improvement philosophy, which defines quality as the on-going improvement of all processes. All performance improvement and medical safety efforts are promoted throughout the system and supported by the Board, Medical Staff and leadership team. Performance improvement at Premier Health is system, hospital, department and unit based. Senior leadership ensures that the quality, safety and environmental plans are communicated and understood within the organization. Information flow occurs as outlined in the Roles and Responsibilities section of this plan. Premier Health provides resources for an ongoing comprehensive performance improvement and medical safety plan. Performance improvement activities are tracked and measures of success reported to ensure that performance is sustained and learning occurs throughout the system and hospital.

### **B.ROLES AND RESPONSIBILITIES**

- **1. Governing Body Leadership:** Final authority and responsibility for the quality of patient care and safety of patients and employees at Premier Health rests with its Board of Trustees. Trustees assign specific responsibility for day-to-day management of performance improvement activities to the medical staff and site leadership through the individual Hospital Boards.
- 2. Individual Facility Hospital Medical Executive Committee: The individual site organized medical staff is responsible for overseeing the quality of care provided by individuals with privileges. The facility's Medical Executive Committee (MEC) comprises both appointed and elected medical staff leadership as outlined in each facility's Medical Staff By-laws. Premier Health Medical Executive Committees receive reports from hospital operations committees related to clinical improvement physician performance, including GME. When appropriate the MEC also provides oversight for the quality of care, treatment, and services provided by practitioners with privileges, maintain credentialing through the offices of medical affairs and provides for a uniform quality of care, treatment, and services within each facility. Hospital medical staff is engaged in activities to measure, assess, and improve

performance on a departmental, hospital, and organization-wide basis. Some of these activities include measurement of outcomes and processes with respect to:

- Medical assessment and treatment of patients.
- Use of information about adverse privileging decisions for any practitioner privileged through the medical staff process.
- Use of medications.
- Use of blood/blood components.
- Operative and other procedures.
- Appropriateness of clinical practice patterns.
- Significant departures from established patterns of clinical practice.
- Use of developed criteria for autopsies.
- Sentinel event data.
- Patient safety data.
- Education of patients and families.
- Coordination of care, treatment, and services with other practitioners and hospital personnel, as relevant to the care, treatment
  and services of an individual patient.
- Accurate, timely, and legible completion of patient's medical records.
- Review of findings of the assessment process that are relevant to an individual's performance. The organized medical staff is
  responsible for determining the use of this information in the ongoing evaluations of a practitioner's competence.
- Communication of findings, conclusions, recommendations, and actions to improve performance to appropriate staff members and the governing body.
- 3. System Leadership of Premier Health: Consists of Premier Health Chief Executive Officer, Chief Operations Officer, Chief Medical Officer, Chief Financial Officer as well as facility Chief Executive Officers. The Chief Clinical Officers committee has oversight and responsibility for ensuring that Premier Health maintains its commitment to quality and safety by upholding the commitment to the Premier Health Quality Statement to ensure the safest, highest quality of care for its patients Premier Health System Leadership sets priorities, tracks metrics, and assures accountability for quality and safety throughout Premier Health. System Leadership has responsibility and oversight of prioritizing organization improvement opportunities (Attachment A- Scorecard 2014)
- Chartering system-wide multidisciplinary improvement teams
- Allocating resources, including resources for education and training
- Reviewing system-wide data and information
- Structuring the flow of information to ensure the appropriate reporting and communication of key issues enabling the organization
  to learn from internal and external unexpected clinical events and changes in regulatory requirements.
- Reviewing system-wide data and information
- Structuring the flow of information to ensure the appropriate reporting and communication of key issues enabling the organization
  to learn from internal and external unexpected clinical events and changes in regulatory requirements.
- **4. System Safety Committee:** The System Safety Committee is comprised of Premier Health System VP Pharmacy Operations, Director Risk Management, Compliance, Infection Prevention and Quality/Safety, Fidelity Home Care CEO, Director of Clinical and Quality Premier HealthNet, Director of Quality/ Safety Wright State University, Director of Quality Improvement VHA as well as the facility Quality/Safety Directors. The responsibilities of the System Safety Committee include the following:
- Review of all Root Cause Analysis/ Intense Analysis conducted at each site
- Ensuring all investigations are thorough and credible and supporting the implementation of corrective action plans
- Structuring the flow of information across the system to ensure the appropriate reporting and communication of key issues
  enabling the system and site to learn from internal and external unexpected clinical events
- Report ongoing findings, evaluations, conclusions, recommendations and actions of activities to the Chief Clinical Officers
   Committee with an annual evaluation to Premier Health System Leadership Committee and the individual Hospital Boards of
   Trustees as well as Premier Health Board via the Community Health Improvement Committee
- **5. System Pharmacy & Therapeutic Committee:** Premier Health Pharmacy and Therapeutic Committee (PTC) may be composed of, but not limited to, medical staff representatives of the various specialties and practice sites of PH, pharmacists, nurses, representatives from administration, ad hoc risk management, nutrition, and others as designated.
- The Pharmacy & Therapeutics Committee (PTC) shall govern the Formulary of Accepted Drugs, their formulations for all PH hospitals, including allowable therapeutic substitutions; and drug policy development

- The PTC is the medication use decision-making body and its responsibility is delegated by the hospital site medical executive committees. The PTC report decisions and recommendations to the site medical executive and medication management committees for implementation
- **6. Individual Facility Hospital Medication Management Committees:** Medication Management Committees (MMCs) are designated for each Premier Health site or sites served by an individual pharmacy. MMCs are responsible for:
- Soliciting feedback/input regarding issues to be addressed at the system level
- Addressing site-specific medication and nutrition use issues
- Site medication safety issues
- Implementing procedures related to system drug use polices/formulary decisions
- Oversight of pharmacist clinical consult agreement services
- Review quality and medication safety indicators and plan interventions to improve quality and/or safety at the site level
- **7. Individual Hospital Boards:** The individual Hospital Boards of Trustees have responsibility for monitoring the delivery of quality care provided by the individual Hospitals and fulfilling the statutory responsibility of the individual Hospitals for quality of care rendered. The individual Hospital Board and/or designated Quality Committee oversees quality improvement activities and patient safety by receiving and assessing regular reports on quality and medical staff performance improvement activities through their site individual Hospital Quality Department. (Attachments B- G; Facility Committee Structure). The Quality Committee of the Board reports regularly on these activities to the full Hospital Board. At its discretion, the Hospital Board may elect to receive standing reports directly from quality committees, in lieu of a Quality Committee of the Board.
- 8. Individual Facility Hospital Quality Improvement Committees: The Quality Improvement Committee (QIC) is hospital specific, multidisciplinary and representative of facility departments and functions including medical staff representation. The QIC is a standing committee, which is given delegated responsibility from the hospital Leadership team as a committee for tracking, reporting and making recommendations for ongoing performance improvement within the hospital. The Quality Improvement Committees reports information to the Hospital Management Team, the Medical Staff Executive Committee for issues affecting medical staff, and System Quality—Safety Council and site Quality Committees of the site Board. The objectives of the committees include:
- The provision of sufficient support and resources for improvement efforts
- Communicate internally and externally on Sentinel Events.
- Communicate changes in regulatory requirements.
- Annual review and update of the site-specific, operational improvement plans.
- Prioritize and make recommendations to the executive teams regarding specific opportunities that may need to be pursued by hospital, region or system.
- Implementation of system-wide improvement plans
- Monitor facilities' progress on system-wide balanced scorecards, quality scorecard and service line scorecards
- Determine appropriate measures and review of data collected to monitor organizational performance. Data collection will include but not limited to the following:
  - Operative or other procedures that place patients at risk of disability or deaths.
  - Significant discrepancies between preoperative and postoperative diagnosis, including pathologic diagnosis.
  - The use of blood and blood component utilization
  - Adverse events related to using moderate or deep sedation or anesthesia
  - Reported and confirmed transfusion reactions
  - Results of resuscitation
  - Behavioral management and treatment
  - Significant medication errors
  - Significant adverse drug reactions
  - Drug incompatibilities
  - Patient perception of the safety and quality of care, treatment, or services

- Effectiveness of all fall reduction activities, including assessment, interventions and education.
- Effectiveness to response for change or deterioration in a patient's condition
- Analyzes organ procurement conversion rate date
- **9. Site Management & Leadership:** Leaders will ensure ongoing evaluation of patient care and support processes. In addition, leaders retain accountability for implementation and maintenance of improvement initiatives. Summaries of these activities will be reported to the site Quality Improvement. It is the responsibility of site management and leadership to perform the following activities:
- Define the departmental service and scope of care.
- Develop process, quality control and outcome measures, which relate to the services provided by each department.
- Utilize process improvement methodology, that includes collaborative interdepartmental problem solving or process improvement activities as appropriate.
- Complete employee evaluations and competency assessment as indicated.
- Incorporate internal and external comparative data as appropriate.
- Report ongoing findings, evaluations, conclusions, recommendations and actions of activities periodically with an annual evaluation to the Quality Improvement Committees and the site Management teams.
- Receive updates, presentations and requests for action by performance improvement teams.
- Provide opportunities for communication and collaboration and participates in system-wide improvement efforts
- **10. Quality improvement staff:** Performance Improvement efforts and educational needs are supported by quality improvement staff that assist hospitals and system support departments in development, reporting, and follow-up of quality and medical safety measures.

### IV. APPROACH AND METHODOLOGY

### A.THE ORGANIZATION WIDE APPROACH

Premier Health maintains a singular system wide approach to implementing all interdisciplinary and service activities. The methodology for this approach is based on a process improvement cycle.

### **B.METHODOLOGY**

Plan-identify customers and goals

Do-collect data to measure objectives

Study-analyze data

Act—make improvements

### C. MEASUREMENT PLAN

A performance improvement measurement plan is utilized to define the measures. The measurement plan identifies the dimensions of performance that are important to a process or outcome. Each measure is defined and includes a numerator, denominator, data source, comparative data, and responsible persons.

### D. PERFORMANCE IMPROVEMENT AND CLINICAL SAFETY EDUCATION AND TRAINING

To support Premier Health philosophy of continuous improvement and clinical safety efforts, all employees of Premier Health receive ongoing education. Education includes, but is not limited to, safety, infection prevention and control, patient rights, performance improvement using analytical tools, data interpretation, Premier Health non-punitive approach to medical errors, responsibility to report errors and near misses when they occur, process for reporting of medical safety concerns/ medical errors in addition to department and discipline-specific competency validation. All new hires to Premier Health will receive the same education and training as part of the orientation process. In addition to yearly competency validation, on-going education and just in time training will be provided to committees, groups, and individuals. New management staff receives additional training through the Human Resources Department.

### V. DOCUMENTATION AND COMMUNICATION

### A.DOCUMENTATION

Documentation of measures reflects performance over time and identifies performance targets and variances. Analytical tools are used to interpret and display data. System wide clinical safety measures are compared within the organization and to external benchmarks, where available. Interpretation of data includes identification of areas for improvement.

### **B.REPORTING/COMMUNICATION**

Reporting will occur as outlined in the organizational performance improvement committee structure. Data will be collected as appropriate. Trending and analysis shall occur at least quarterly with recommendations for improvement opportunities as appropriate. The leaders of teams and committees are responsible for ensuring that clinical safety activities are reported as scheduled.

### C. CONFIDENTIALITY

Confidential information is prepared at the direction of and is intended to be made available only to the Medical Staff quality Improvement Subcommittees, Nursing Quality Improvement Committees, Quality Improvement Council, Board Quality Committee, and Credentialing Committee members of Premier Health, and is intended to be used by such committees and their members only in the exercise of the proper functions of such committee. Any other use of this information is against Premier Health's policy and may subject you to civil liability per O.R.C. Section 2305.251 et seq.

Confidential Committee and legal information will be stored in a locked file cabinet in a room that is to remain locked outside of regular business hours.

### D. AUTHORIZATION FOR RELEASE OF CONFIDENTIAL INFORMATION

The senior most Premier Health Executive over Legal Affairs and Compliance or designee should be consulted prior to the release of confidential information.

- 1. RELEASE OF INFORMATION: (including access to and duplication of documents) may be authorized in the following manner:
- By the Chairperson of each Committee to its membership and staff; or
- By the Chairperson of the Committee in consultation with Compliance for the purpose of obligatory reporting in accordance with written policy or by law to another individual or entity assigned a similar review function; or
- By the President and Chief Executive Officer; or
- Medical staff which the President designates; in writing, to act on his/her behalf to an individual committee, or other entity assigned a care review function by the Hospital and/or having a legitimate need to know, e.g. legal counsel for the Hospital. Records shall be maintained and disclosure made pursuant to this provision.

### 2. LEGAL PROCEEDINGS:

In the event of legal proceedings that seek production of Committee or legal information, the President and Chief Executive Officer or his/her designee shall be empowered and shall authorize Legal Affairs/ Corporate Compliance to review the matter and determine whether it is appropriate to release such information. If it is not appropriate to do so, then Legal Affairs/ Corporate Compliance shall authorize legal counsel to take such steps as are reasonably necessary and advisable to lawfully resist document production, including the making of motions or taking of appeals.

# 3. SANCTIONS FOR UNAUTHORIZED DISCLOSURE

Unauthorized disclosure of Committee or legal information designated as confidential may result in:

- Progressive discipline, up to and including termination, or loss of Committee membership for any hospital employees; and
- Corrective action, including loss of Committee membership, reprimand or non-reappointment for any Medical Staff members.

In determining the sanction appropriate, the degree of inadvertence or willfulness of the disclosure, the manner of disclosure, the likelihood of recurrence and the magnitude of harm done by the disclosure to the Premier Health activities, patients, and/or staff members will be considered.

### **VI. METHOD FOR EVALUATION**

The Quality and Clinical Safety Plan, including the written plan and criteria employed in the review process, will be reviewed and evaluated at least annually. Revisions to the Plan will occur as appropriate in line with the findings of committee activities and new regulations/statutes and guidelines from external agencies

Approved by: Date:

Chief Clinical Officers Committee April 15, 2014

System Leadership MVH Quality Council MVH Board April 15, 2014 May 16, 2014

Attachments:

Attachment A Premier Health Balance Scorecard
Attachment B Miami Valley Hospital Committee Structure

# 2014 Premier Health Quality Scorecard

**TARGETS** 

PHP Target Percentile: 2013 = 90th Percentile

> Recommendation: 2014 = 90th Percentile unless otherwise stated

PHP Threshold Percentile: 2013 = 50th Percentile

2014 = 50th Percentile

1. CMS Core Process Measures 2013 Used FY2015 VBP Measures and Threshold (50th Percentile) and Mean of Top Decile

VBP Measures for FY2016 uses Composite Rate for Performance Period Jan-Dec 2014

Recommendation: 2014 Use FY2016 VBP Measures and Threshold (50th Percentile) and Mean of Top Decile

2. Mortality - Acute Inpatient - All APR-DRGs

Age Greater than 64 2013 Used All Acute Inpatients Age GT64 (Including Palliative Care)

2013 Truven Methodology for Top 15 Systems Includes Palliative Care

2014 Use All Acute Inpatients Age GT64 (Including Palliative Care) Recommendation:

3. Surgical Site Infections 2013 Measures 9 high risk procedures

> Recommendation: 2014 NHSN Procedures using Standardized Infection Ratio (SIR) for SCIP Procedures

4. CMS 30 Day Readmits 5 target populations

2013 Measure - Bundle Index for 3 Populations under CMS Readmission Penalty (AMI HF and PN) Since CMS Readmission Penalty is not based on bundle but individual population scorecard

reflects number of populations at target index as follows:

Green = All 3 Populations at Target

Red = Any one of the populations below threshold (Index >1.0) or greater than 50th percentile

Yellow = All 3 Populations better than threshold but not all at target

2014 - Change measure to Bundle index for 5 populations—AMI HF Pneumonia COPD Recommendation:

Hip/Knee replacements"

5. AHRQ Patient Safety Indicators (PSI)2013 CMS FY 2015 VBP includes PSI 90 Composite Measure consisting of 8 PSIs

Truven Top 15 Systems Methodology uses 10 PSIs

Used PSI Bundled Rate of 12 PSIs (VBP&Truven) & Truven Top 15 Sys Benchmark for

observed/expected

2014 Use PSI Bundled Rate of 12 PSIs (VBP&Truven) & Truven Top 15 Sys Benchmark Recommendation:

for observed/expected

6. NHSN CLABSI

**Central Line Assoc Blood** 

Stream Infection 2013 Used NHSN CLABSI Observed/expected and VBP thresholds for 50th Percentile and

NHSN Top Quartile

Recommendation: 2014 Use NHSN CLABSI Observed/expected and VBP thresholds for 50th Percentile and

NHSN Top Quartile

Note: Top decile is zero

7. NHSN CAUTI

**Catheter Associated Urinary** 

**Tract Infection** 2014 Propose new measure

CMS FY 2016 VBP includes CAUTI

Use NHSN CAUTI Observed/expected and VBP thresholds for 50th Percentile and NHSN Recommendation:

Top Quartile

Note: Top decile is zero

8. NHSN C-diff

Clostridium difficile (C-diff) 2014 Propose new measure

> Recommendation: Goal based on a 25% reduction based on 2013 YTD NHSN data submissions

9. NHSN MRSA

Methicillin-resistant

Staphylococcus aureus (MRSA) 2014 Propose new measure

Recommendation: Goal based on a 25% reduction based on 2013 YTD NHSN data submissions

# **Attachment A 2014 Org Scorecard Final Targets**

Measure	Benchmark Source	Population	Population Measured	Severity Adjustment	Measure Type	Number Measures in Bundle	Favorable Direction
CMS Core Process Measures	CMS VBP FY 2016	All	IMM Pneumonia Surgical Care	None	VBP Composite Rate	7	Higher is Better
Mortality — Acute Inpatient — All APR-DRGs	MIDAS DataVision	Medicare	All Acute Care Inpatients Including Palliative Care	APR-DRGs	Bundled Rate (See Footnote)	250	Lower is Better
Surgical Site Infections — 10 High Risk Procedures	CDC NHSN	All	10 High Risk Surgical Procedures (see footnote)	NHSN SIR	Bundled Rate (See Footnote)	10	Lower is Better
CMS <b>30 Day Readmits</b> — 5 CMS Focused Areas	MIDAS DataVision	Medicare	AMI HF Pneumonia COPD Hip&Knee	None	Obs/Exp	1	Lower is Better
AHRQ Patient Safety Indicators (PSI)	MIDAS DataVision	All	12 PSIs (see footnote)	None	Obs/Exp	12	Lower is Better
NHSN Central Line Assoc Blood Stream Infection (CLABSI)	CDC NHSN	All	CLABSI	NHSN SIR	Obs/Exp	1	Lower is Better
NHSN Catheter Assoc Urinary Tract Infection (CAUTI)	CDC NHSN	All	CAUTI	NHSN SIR	Obs/Exp	1	Lower is Better
NHSN Clostridium difficile (C-diff)	CDC NHSN	All	C-diff	NHSN SIR	Obs/Exp	1	Lower is Better
NHSN Methicillin – resistant Staphylococcus aureus	CDC NHSN	All	MRSA	NHSN SIR	Obs/Exp	1	Lower is Better

		Minimum	Target	2013 YTD July Scorecard				
Measure	Statistic	50 p-tile	90 p-tile	PH	MVH	GSH	AMC	UVMC
CMS Core Process Measures	VBP FY 2016 Composite Rate	97.9%	≥99.4%	98.9%				
Mortality - Acute Inpatient - All APR-DRGs	Index Actual/ Predicted	1.00	≤0.830	.75				
NHSN <b>Surgical Site Infections</b> — 10 High Risk Procedures	NHSN SIR	0.715	0.327 (Top Quartile)	0.587				
CMS <b>30 Day Readmits</b> — 5 CMS Focused Areas	Index Actual/ MIDAS Median	1.00	≤0.931.19	1.19				
AHRQ Patient Safety Indicators (PSI)	Index Actual/ MIDAS Expected	1.00	≤ 0.771	1.09				
NHSN Central Line Assoc Blood Stream Infection (CLABSI)	NHSN SIR	0.469	0.171 (Top Quartile)	0.44				
NHSN Catheter Associated Urinary Tract Infection (CAUTI)	NHSN SIR	0.675	0.228 (Top Quartile)	0.64				
NHSN Clostridium difficile (C-diff)	NHSN SIR	0.960	0.80 25% Reduction	1.06				
NHSN Methicillin-resistant Staphylococcus aureus	NHSN SIR	0.768	0.64 25% Reduction	0.85				

### Footnotes

<sup>&</sup>quot;Composite Rate: Combined Rate for VBP Core Measures Target set at Mean of Top Decile"
Bundled Rate: Combined performance for all measures using actual compared to predicted rates.

### **AHRQ Patient Safety Indicators (PSI)**

- 1. \*=PSI 90
- 2. \*PSI3-Pressure Ulcer
- 3. PSI4-Death Surg IP
- 4. \*PSI6-latrogenic Pnuemothorax
- 5. \*PSI7-Central Ven Cather BSI
- 6. \*PSI8-Post-op Hip Fracture
- 7. PSI9-Post-op Hemmorrhage
- 8. PSI10-Post-op Physiologic and Metabolic Derangement
- 9. PSI11-Post-op Respiratory Failure
- 10. \*PSI12-Post-op PE or DVT
- 11. \*PSI13-Post-op Sepsis
- 12. \*PSI14-Post-op Wound Dehiscence
- 13. \*PSI15-Accidental Puncture or Laceration

### **Surgical Site Infection Procedures**

- 1. Abd Hysterectomy
- 2. Vag Hysterectomy
- 3. Hip Prosthesis
- 4. Knee Prosthesis
- 5. Colon
- 6. Coronary Artery Bypass Graft (CABG) Chest & Leg
- 7. Abdominal Aortic Aneurysms (AAA)
- 8. Carotid Endarterectomy (CEA)
- 9. Peripheral Vascular Bypass Surgery (PVBY)
- Cardiac (valves and other surgeries on heart)

### **VBP Core Process Measures**

- 1. Pneumonia Appropriate Initial Antibiotic Selection (PN-6)
- 2. Influenza Immunization (IMM-2)
- Surgical Care Antibiotic Selection (SCIP INF-2)
- Surgical Care Antibiotic Discontinued within 24 Hrs Surgery (SCIP INF-3)
- 5. Surgical Care Postop Urinary Catheter Removal Postop Day 1 or 2 (SCIP 9)
- 6. Surgical Care Appropriate Venous Thromboembolism (SCIP VTE-2)
- Surgical Care Patients on Beta Blocker Prior to Arrival that Received Beta Blocker during Perioperative Period (SCIP CARD-2)

# **Performance Improvement Reporting Structure**

