

Cape Cod Healthcare
Quality and Safety Dashboard as of February 22, 2011
Core Measure Data through Quarter 3 2010

Opportunity Statement	Reporting Party	Goal/ Benchmark	CCH 2010	CCH Analysis/Action Plan	FH 2010	FH Analysis/Action Plan		
Falls								
All inpatient falls in facility Number/rate per 1,000 patient days	CCH: Lisa Tager,JD,LICSW,MSW FH: Melinda Dunne, RN Phyllis Peacock, RN	Goal: 2.5 / 1000 inpatient days	Jan	11/2.16	Analysis: Falls rate has been maintained below 2.5 for seven consecutive months. Action: Continue fall prevention activities that are in place	Jan	7 / 3.5	Analysis: Inpatient fall rate continues to vary in a pattern similar to the previous year. There is no specific Identifiable cause. Action: Staff is updated regularly on the fall rate to encourage active participation in determining additional fall prevention strategies.
			Feb	12/3.05		Feb	8 / 4.2	
			Mar	12/2.34		Mar	11 / 4.9	
			Apr	11/2.43		Apr	7 / 3.8	
			May	9/2.03		May	3 / 1.8	
			Jun	6/1.17		Jun	6 / 2.9	
		Benchmark: Midas '07 2.50 Midas '08 2.52 Midas '09 2.48 Midas '10 2.52	Jul	12/2.24		Jul	2 / 0.93	
			Aug	12/2.44		Aug	3 / 0.98	
			Sep	10/1.91		Sep	7 / 3.7	
			Oct	11/2.30		Oct	3 / 1.51	
			Nov	5/1.18		Nov	7 / 4.1	
			Dec	7/1.48		Dec	4 / 1.9	
Inpatient Falls with injury Number/rate per 1,000 patient days	CCH: Lisa Tager,JD,LICSW,MSW FH: Melinda Dunne, RN Phyllis Peacock, RN	Goal: 0	Jan	3/0.58	Analysis: Rate remains below 1.0 Action: Continue fall prevention activities that are in place	Jan	0.00	Analysis: The fall with injury rate remains low. Action: Staff continues to use the reassessment of a patients' fall risk with any change in the patient's condition in order to prevent injury.
			Feb	1/0.25		Feb	1 / 0.55	
			Mar	1/0.19		Mar	2 / 0.88	
			Apr	4/0.81		Apr	1 / 0.48	
			May	2/0.45		May	2 / 1.19	
			Jun	2/0.33		Jun	2 / 0.95	
		Benchmark:	Jul	4/0.74		Jul	1 / 0.47	
			Aug	2/0.40		Aug	0.00	
			Sep	3/0.57		Sep	1 / 0.53	
			Oct	4/0.85		Oct	0.00	
			Nov	2/0.47		Nov	0.00	
			Dec	3/0.63		Dec	1/0.48	
Inpatient Falls that were controlled descents Number/1,000 patient days	CCH: Lisa Tager,JD,LICSW,MSW FH: Melinda Dunne, RN Phyllis Peacock, RN	Goal:0	Jan	0/0	Analysis: Controlled descents account for a very small number of inpatient falls. Action: Continue to monitor.	Jan	2 / 0.93	Analysis: Controlled descents remain a small contribution to the fall numbers. No injuries related to these falls has occurred. Action: Staff recognizes and reports this to recognize better assessment of patients' ability to mobilize and assess follow-up for any potential injury.
			Feb	2/0.5		Feb	2 / 1.16	
			Mar	1/0.19		Mar	0.0	
			Apr	2/0.4		Apr	1 / 0.5	
			May	0/0		May	0.0	
			Jun	0/0		Jun	0.0	
		Benchmark:	Jul	0/0		Jul	1 / 0.47	
			Aug	0/0		Aug	0.0	
			Sep	0/0		Sep	0.0	
			Oct	3/0.64		Oct	0.0	
			Nov	0.0		Nov	0.0	
			Dec	0.0		Dec	0.0	
EC								
Patients presenting with Chest Pain get EKG within 10 minutes of arrival	CCH: Craig Cornwall, MD Deb Robinson, RN FH: Rob Davis, MD Carole Kibner, RN	Goal: Mean arrival to ECG time = 10 minutes 90% of the time	Jan	99%	Analysis: Goal met. *NQF measure is median time Action: Will continue to monitor; this indicator was added to the 2010 Service Line dashboard.	Jan	66.7%	Analysis: Variances in small N population resolved by actions taken by Nursing Director during 2Q10. ECGs were performed in less than 10 minutes since June 2010.. Action: None Required since 2Q10.ED Nursing Director posted a reminder to staff regarding peculiar presentations of patients with chest related pain and to increase "suspicion" for cardiac related symptoms.
			Feb	96%		Feb	NP	
			Mar	98%		Mar	100.0%	
			Apr	95%		Apr	50.0%	
			May	96%		May	80.0%	
			Jun	97%		Jun	100.0%	
		Benchmark:	Jul	94%		Jul	100.0%	
			Aug	94%		Aug	100.0%	
			Sep	95%		Sep	100.0%	
			Oct	96%		Oct	100.0%	
			Nov	96%		Nov	100.0%	
			Dec	97%		Dec	100.0%	

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To ED bed within 25 minutes of arrival	CCH: Craig Cornwall, MD Deb Robinson, RN FH: Rob Davis, MD Carole Kibner, RN	Goal: 90% of time	Jan	99%	90% goal met Quarter 4, 2010 Action: Process Improvement Team action plan completed. Measurement will continue to be monitored with the ongoing goal to sustain 90% even during peak volume months.	Jan	88%	Analysis: For 4Q10, the average was 88.0%, improved from 3Q10 at 79%. Goal almost met. Action: 1) Integrate Blue area into main ED; 2) Dedicated Registration area in main ED; 3) Doctor at Triage; 4) Paramedics as techs in ED.
		Benchmark:	Feb	97%		Feb	87%	
			Mar	98%		Mar	81%	
			Apr	98%		Apr	91%	
			May	96%		May	88%	
			Jun	90%		Jun	78%	
			Jul	80%		Jul	73%	
			Aug	78%		Aug	77%	
			Sep	91%		Sep	88%	
			Oct	96%		Oct	87%	
			Nov	97%		Nov	92%	
			Dec	95%		Dec	85%	
			Seen by physician within 40 minutes (ED)	CCH: Craig Cornwall, MD Deb Robinson, RN FH: Rob Davis, MD Carole Kibner, RN		Goal: 90% of time	Jan	
Benchmark:	Feb	94%			Feb	80%		
	Mar	95%			Mar	73%		
	Apr	94%			Apr	85%		
	May	91%			May	75%		
	Jun	86%			Jun	63%		
	Jul	75%			Jul	61%		
	Aug	74%			Aug	65%		
	Sep	87%			Sep	76%		
	Oct	92%			Oct	80%		
	Nov	96%			Nov	88%		
	Dec	94%			Dec	80%		
	Patients admitted thru ED that return to waiting room after triage	CCH: Craig Cornwall, MD Deb Robinson FH: Rob Davis, MD Carole Kibner, RN			Goal: < 2% of admitted patients	Jan	3%	Analysis: 2% or less goal unmet, Decreased monthly trend Quarter 4. Action: Indicator added to 2010 dashboard, and monitored for improvement. New indicator will be added to the EC dashborad 2011 to monitor admitted patient's that wait in the waiting area greater than 15 minutes.
Benchmark:			Feb	4%	Feb	11%		
			Mar	4%	Mar	14%		
			Apr	5%	Apr	9%		
			May	8%	May	7%		
			Jun	9%	Jun	15%		
			Jul	19%	Jul	15%		
			Aug	21%	Aug	11%		
			Sep	15%	Sep	18%		
			Oct	14%	Oct	7%		
			Nov	9%	Nov	10%		
			Dec	8%	Dec	8%		
			ER cases with length of stay (LOS) greater than 6 hours (%)	CCH: Craig Cornwall, MD Deb Robinson, RN FH: Rob Davis, MD Carole Kibner, RN	Goal: 0%	Jan	12%	
Benchmark: Midas '07 10.86 Midas '08 12.14 Midas '09 10.82 Midas '10 11.34	Feb	11%			Feb	12.4%		
	Mar	12%			Mar	13.3%		
	Apr	11%			Apr	10.5%		
	May	10%			May	11.8%		
	Jun	11%			Jun	11.0%		
	Jul	11%			Jul	10.2%		
	Aug	13%			Aug	10.8%		
	Sep	11%			Sep	10.2%		
	Oct	11%			Oct	11.0%		
	Nov	11%			Nov	10.4%		
	Dec	10%			Dec	11.2%		

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Median time from ED arrival to ED departure for discharged patients. (hours)	CCH: Craig Cornwall, MD Deb Robinson, RN FH: Rob Davis, MD Carole Kibner, RN	Goal: 2 hours	Jan	1.8	Analysis: EC Arrival to departure goal is 2 hours and that has been Met	Jan		Analysis: Data reported to DPH by ED Staff. Trending downward over six months. Goal met for each of last six months
		Benchmark:	Feb	1.8		Feb		
			Mar	1.8	Action: Continue to trend and monitor.	Mar		Action: Maintain processes to maintain below goal median time.
			Apr	1.8		Apr		
			May	1.8		May		
			Jun	1.9		Jun		
			Jul	2.1		Jul	2.0	
			Aug	2.2		Aug	1.8	
			Sep	1.9		Sep	1.7	
			Oct	1.8		Oct	1.6	
			Nov	1.8		Nov	1.6	
			Dec	1.8		Dec	1.7	
Median time from ED arrival to ED departure for admitted patients. (hours)	CCH: Craig Cornwall, MD Deb Robinson, RN FH: Rob Davis, MD Carole Kibner, RN	Goal: =<5 hours	Jan	5.6	Analysis: EC arrival to transfer to inpatient floor for the admitted patients within 5 hours or less remains unmet.	Jan		Analysis: Data reported to DPH by ED Staff. Trending downward over six months. Goal not met for each of last six months.
		Benchmark:	Feb	5.6		Feb		
			Mar	5.6	Action: Data Collection has Identified specific target throughput barriers, PI Team meetings are on going	Mar		Action: 1) Integrate Blue area into main ED; 2) Dedicated Registration area in main ED; 3) Doctor at Triage; 4) Paramedics as techs in ED.
			Apr	5.5		Apr		
			May	5.4		May		
			Jun	5.7		Jun		
			Jul	5.9		Jul	6.4	
			Aug	6.1		Aug	5.6	
			Sep	5.5		Sep	5.5	
			Oct	5.6		Oct	5.8	
			Nov	5.2		Nov	5.8	
			Dec	5.4		Dec	6.0	
Throughput								
ED patients to critical care bed within 3 hours of admit order **ED patients to critical care bed within 3 hours of arrival	CCH: Lori Jewett, RN FH: Carole Kibner, RN	Goal: 90%	Jan	18%	Analysis: Goal unmet, process time stamps show small improvement in time of admit order scanned to bed assignment, and once bed assigned to transport to critical care.	Jan		Analysis: Measures written in Midas to attempt data capture for this numerator. Problems with structure of the location history where data resides.
		Benchmark:	Feb	25%		Feb		
			Mar	22%	Action: Reported on EC & Critical Care Service line Dashboards 2010, EC consult for critical care admission PI ongoing.	Mar	P	Action: Midas Service Manager has been requested to review indicators and address aberrancies in registrations.
			Apr	26%		Apr	E	
			May	32%		May	N	
			Jun	27%		Jun	D	
			Jul	25%		Jul	I	
			Aug	26%		Aug	N	
			Sep	20%		Sep	G	
			Oct	21%		Oct		
			Nov	32%		Nov		
			Dec	28%		Dec		
ED patient to inpatient bed within 5 hours of arrival	CCH: Lori Jewett, RN FH: Carole Kibner, RN	Goal: 90%	Jan	35%	Analysis: Goal unmet, Improvement noted noted Q4 = 41%, mean 2010 = 37%	Jan	29.0%	Analysis: Rate improving overall through third quarter. 1Q33%, 2Q 36%. 3Q 35%, 4Q 34%, the mean for the year is 35% and the control chart is flat.
		Benchmark:	Feb	37%		Feb	35.0%	
			Mar	36%	Action: Reported on EC & Critical Care Service line Dashboards 2010, monitored daily and reported to leadership. Active PI	Mar	34.0%	Action: To improve ED LOS from arrival to inpatient bed, something in the process needs to be changed.
			Apr	39%		Apr	39.0%	
			May	41%		May	40.0%	
			Jun	36%		Jun	30.0%	
			Jul	32%		Jul	28.0%	
			Aug	30%		Aug	38.0%	
			Sep	38%		Sep	40.0%	
			Oct	36%		Oct	34.0%	
			Nov	46%		Nov	34.0%	
			Dec	41%		Dec	34.0%	

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Two eligible patients per nursing unit discharged by 10 am. (Presented as Avg of # elig pts d/c'd per day by 10 am)	CCH: Molly Nadeau, RN FH: Pamela Kendrick, RN	Goal: CCH-10 patients/day FH-6 patients/day Benchmark:	Jan Feb Mar Apr May Jun Jul Aug Sep Oct Nov Dec	2.9 4.2 4.1 3.7 3.1 3.2 2.7 2.2 3.1 3.9 4.6 3.1	Analysis: 2 patients per inpatient floor, has not been met at CCH. Action: The "Early Bird" PI Team is ongoing, all disposition types are potential discharges by 10AM if the parameters are met. Nurse mgrs, primary RNs, supervisors, case managers and physicians are all team members.	Jan Feb Mar Apr May Jun Jul Aug Sep Oct Nov Dec	1.10 0.67 0.39 0.67 0.84 0.97 0.58 0.55 0.67 0.60 0.48 0.32	Analysis: The line graph with a linear trend line trends down from a high of 1.1 eligible patients discharged by 10 am to a low of 0.32 patients. During 4Q10, 93% of pts disch by 10am were discharged home, 37% were discharged from MS2. Action:
Room turnaround time <120 minutes (Measured as average minutes for all shifts)	CCH: Ed Richards FH: Jeff Sullivan	Goal: Benchmark:	Jan Feb Mar Apr May Jun Jul Aug Sep Oct Nov Dec	99 99 98 100 86 91 86 86 89 87 89 86	Analysis: Goal continues to be met each month. Action: None required	Jan Feb Mar Apr May Jun Jul Aug Sep Oct Nov Dec	30 60 43 33 35 63 49 29 30 27 32 33	Analysis: Goal for 4Q2010 met. Action: None required.
		Goal: Benchmark:	Jan Feb Mar Apr May Jun Jul Aug Sep Oct Nov Dec			Jan Feb Mar Apr May Jun Jul Aug Sep Oct Nov Dec		
Surgery								
First case started on time	CCH: Robin Grace, RN Lawrence Novak, MD Jeff Spillane, MD FH: Periop Process Improvement Team: Doug Mann MD Mark Kamp MD Jeanne Rocheleau RN	Goal: 65% With 5" grace period : 75th = 72% 50th = 62% 25th = 49%	Jan Feb Mar Apr May Jun Jul Aug Sep Oct Nov Dec	57% 59% 55% 63% 60% 63% 69% 73% 69% 78% 71% 69%	Analysis: Exceeding goal in Q3 & Q4 Action: PI team in place. Working with anesthesia, meets once per week. Anesthesiologists and physicians have set expectations to start on time. Bylaws allow 15 min delay	Jan Feb Mar Apr May Jun Jul Aug Sep Oct Nov Dec	67% 67% 67% 68% 57% 66% 61% 54% 57% 53% 80% 77%	Analysis: January through August stats reflect FH elimination of the 5" grace to be uniform in reporting with CCH Goal Not Met for Sept & Oct due to ineffective process and planning. Action: Improved compliance towards goal achieved Nov and Dec due to increased surgeon/anesthesia support and effective surgical procedure planning.

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OR turnover - patient out to patient in (average minutes)	CCH: Robin Grace, RN Lawrence Novak, MD Jeff Spillane, MD FH: Periop Process Improvement Team: Doug Mann, MD Mark Kamp, MD Jeanne Rocheleau, RN	Goal: 28 Minutes Benchmark: 75th 22" 50th 27" 25th 32"	Jan Feb Mar Apr May Jun Jul Aug Sep Oct Nov Dec	31 30 31 29 31 30 30 30 30 29 31 30	Analysis: Close to meeting goal. Has come to within 2-3 minutes. Action: PI continues w staff education, continued monitoring & reporting to OR Committee	Jan Feb Mar Apr May Jun Jul Aug Sep Oct Nov Dec	27 27 28 28 30 31 31 30 31 31 29 28	Analysis: Goal Not Met. May 2010 thru November 2010 due to absence of management within Perioperative Svcs. and ineffective processes. Action: PI Committee initiatives will include creation of "turnover team," clearly defined roles for turnovers and standardized work.
Day of surgery cancellations	CCH: Robin Grace, RN Barbara Clancy, RN Lawrence Novak, MD FH: Periop Process Improvement Team: Doug Mann MD Mark Kamp MD Jeanne Rocheleau, RN	Goal: Per Compass benchmark Benchmark: Best Practice 3-4% within 24 hrs	Jan Feb Mar Apr May Jun Jul Aug Sep Oct Nov Dec	3.5 5.8 4.1 4.3 3.6 3.8 4.2 4.1 4.3 4.8 2.5 4.1	Analysis: Close to best practice rate of 3-4%. Action: PI plan in place to achieve the desired goal. Close to goal.	Jan Feb Mar Apr May Jun Jul Aug Sep Oct Nov Dec	6% 3% 3% 3% 2% 2% 3% 2% 2% 4% 4% 3%	Analysis: Goal Met Action: None required.
WHO Surgical safety checklist	CCH: Robin Grace, RN Jeff Spillane, MD Lawrence Novak, MD FH: Jeanne Rocheleau, RN Patrick Flynn, MD	Goal: 100% Benchmark: 100%	Jan Feb Mar Apr May Jun Jul Aug Sep Oct Nov Dec	98% 98% 98% 98% 98% 100% 100% 100% 100% 90% 98% 100%	Analysis: New indicator with rapid upward trend (79-99%) since adopted 4/09. Drop in Oct w recovery. Action: Physician champion was key to improved compliance. Continue monitoring of approx 50 cases/month to ensure continued improvement and compliance.	Jan Feb Mar Apr May Jun Jul Aug Sep Oct Nov Dec	100% 100% 100% 100% 100% 100% 100% 100% 100% 100% 100% 100%	Analysis: Goal Met Action: None required.
% Unscheduled return to the operating room during same inpatient admission related to the prior procedure. (% of total inpatient surgeries)	CCH: Robin Grace, RN Lawrence Novak, MD Michele McGennis, RN FH: Chief of Surgery	Goal: 0 Benchmark: Trend	Jan Feb Mar Apr May Jun Jul Aug Sep Oct Nov Dec	0.85 0.70 0.93 2.80 1.90 2.08 1.80 3.40 0.90 1.45 1.30 2.49	Analysis: Rare Occurrences, Subset of above. Monitored for trends. Reported to BoRM & referred for peer review. Action: Continue to review all returns to OR for analysis, BoRM reporting & Peer Review as needed.	Jan Feb Mar Apr May Jun Jul Aug Sep Oct Nov Dec	1.94 2.16 1.35 3.45 0.75 1.86 1.28 1.54 1.44 0.77 0.68 1.80	Analysis: Surgical intervention appropriate in all cases reviewed; all cases complex in nature due to medical comorbidities as well as for surgical issues. Control chart for the last 24 months indicates process is in control (in terms of the rate) and there are no periods of special cause variation. Action: Request discontinuance of collecting data for this measure.

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Cath Lab						
First case starts on time	CCH: Joanie Drusella, RN FH: Diana Molloy, RN	Goal: 90% Benchmark: Best Practice 3-4% within 24 hrs	Jan 19% Feb 35% Mar 23% Apr 31% May 22% Jun 25% Jul 31% Aug 20% Sep 21% Oct 55% Nov 48% Dec 76%	Analysis: Goral for on time start measure has been changed to only include scheduled cases. The PI progress has been significant with this goal. Action: A PI team remains in place. Schedule changes, process flow changes, and accountability have been addressed and progress is evident over the last quarter.	Jan 21.1% Feb 60.0% Mar 42.1% Apr 33.3% May 37.5% Jun 46.7% Jul Aug Sep Oct 64.7% Nov 74.1% Dec	Analysis: 100% of delays are attributable to MD arriving in room late. Average delay time from patient in room to start time is 3-4 minutes for all first starts without any consistent identifiable delays in steps in process from arrival to MD in room. Action: CCH has discontinued monitoring of this process so FH will consider discontinuing and choosing another issue to replace for 01/2011.
Door to balloon time (minutes) for STEMI patients	CCH: Joanie Drusella, RN Pauline Philie, RN FH: N/A	Goal: < 90 min (CCH goal) Benchmark: < 90 minutes (ACC national benchmark)	Jan 72 Feb 49.1 Mar 36 Apr 58 May 38 Jun 38 Jul 51.7 Aug 56.1 Sep 89.8 Oct 34.8 Nov 76.1 Dec 60.0	Analysis: Outstanding results, far exceeding national and DPH goal of DBT <90. Action: Continue to review data with interventional MDs and AMI team on a quarterly basis	Jan Feb Mar Apr May Jun Jul Aug Sep Oct Nov Dec NA	
		Goal: Benchmark:	Jan Feb Mar Apr May Jun Jul Aug Sep Oct Nov Dec		Jan Feb Mar Apr May Jun Jul Aug Sep Oct Nov Dec	
Patient Access						
Outpatients registered within 10 minutes of arrival	CCH: Stacy McGlame FH: Kathleen Frostholm	Goal: 90.0% Benchmark:	Jan 80.45% Feb 83.00% Mar 87.00% Apr 90.00% May Jun 77.00% Jul 90.00% Aug 90.00% Sep 91.72% Oct 92.70% Nov 91.60% Dec 94.58%	Analysis: Rate of patients that wait less than 10 minutes has shown steady improvement for Q4, 2010. The rate has been sustained consecutively for 6 months. Action: Staff work flow has changed to meet times of increased volume. Staff redesigned patient sign in sheet to eliminate back log. Staff hours changed to be available for high volume times.	Jan 63% Feb 80% Mar 90% Apr 84% May 94% Jun 89% Jul 79% Aug 79% Sep 80% Oct 84% Nov 79% Dec 81%	Analysis: Last spring we randomly audited wait times documentation; several process changes were made including sending US & MRI patients directly to Radiology for registraton. Volume increases during the summer, Registration managing many staffing challenges and both the lead and manager were on medical leave resulting in wait times not being monitored on a regular basis. Action: All preregistered ACU treatment patients will report directly to point of service. We will be piloting this same process with other ACU procedures over the next month.

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OP Radiology-Outpatients registered within 10 minutes of arrival	CCH: Cheryl Crupi, RT FH: Joanne Smith, RT	Goal: Benchmark:	Jan Feb Mar Apr May Jun Jul Aug Sep Oct Nov Dec	P E N D I N G		Jan Feb Mar Apr May Jun Jul Aug Sep Oct Nov Dec	P E N D I N G	Analysis: Action:
Breast care center- Outpatients registered within 10 minutes of arrival	CCH: Pat Ryan-Blanchard, RN	Goal: Benchmark:	Jan Feb Mar Apr May Jun Jul Aug Sep Oct Nov Dec	P E N D I N G		Jan Feb Mar Apr May Jun Jul Aug Sep Oct Nov Dec	NA	
Outpt Rehab (Falmouth - time of a patient's scheduled appointment compared to the time they are actually started.) (CCH-% of on-time starts)	CCH: Julie Drake FH: Kendallyn Cavanaugh	Goal: Pt seen w/ 5 min of scheduled appt time for 30 appts, and 10 min for 45-60 min appts.	Jan Feb Mar Apr May Jun Jul Aug Sep Oct Nov Dec	98.0% 99.0% 100.0% 100.0% 100.0% 100.0% 100.0% 99.0% 100.0% 99% 99% 100%	Analysis: Rehab rate of patients that wait less than 5 minutes for Q4 remain between 99 - 100% Action: Sustain goal	Jan Feb Mar Apr May Jun Jul Aug Sep Oct Nov Dec	93.9% 94.0% 91.2% 93.6% 100.0% 94.4% 94.3% 88.0% 90.6% 91.7% 89.0% 93.0%	Analysis: A control chart indicates a steady, continuous rate of compliance with a mean for the year of 94%. In order to improve the rate of compliance, something in the process will need to be changed. Action: Sustain compliance and continue to review delays immediately, provide corrective treatment.
Outpt Rehab Bourne- time of a patient's scheduled appointment compared to the time they are actually started.	CCH: Julie Drake FH: Kendallyn Cavanaugh	Goal: Pt seen w/ 5 min of scheduled appt time for 30 appts, and 10 min for 45-60 min appts.		NA		Jan Feb Mar Apr May Jun Jul Aug Sep Oct Nov Dec	87.6% 98.6% 91.9% 95.1% 90.0% 92.3% 88.3% 84.3% 93.2% 92.0% 93.3% 94.6%	Analysis: A control chart indicates a steady, continuous rate of compliance with a mean for the year of 92%. In order to improve the rate of compliance, something in the process will need to be changed. Action: Sustain compliance and continue to review delays immediately, provide corrective treatment.

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Oncology - Rate of patients that wait to be seen will be <= 10 minutes 95% of the time	CCH: John Ponte	Goal:95% Benchmark:	Jan Feb Mar Apr May Jun Jul Aug Sep Oct Nov Dec	73.0% 80.0% 82.0% 80.0% NA 88.0% 87.0% 93.0% 90.0% 91.0% 94.0%	Analysis: Wait times continue to improve, 95% goal UNMET. Action: Physician assistant hired and started Oct. 2010, the plan is that physician schedule will be alleviated with the addition of a PA. Patient quick access time has been built into the PA schedule to also help alleviate wait times for walk in patients and add on patients.	Jan Feb Mar Apr May Jun Jul Aug Sep Oct Nov Dec	NA	
Appointments available for outpatient testing within 24 hours of request	CCH: Sally Pyne FH: Kathleen Frostholm	Goal: Benchmark:	Jan Feb Mar Apr May Jun Jul Aug Sep Oct Nov Dec	100% 100% 100% 100% 100% 100% 100% 100% 100%	Analysis: Goal met Action: Continue process for sustained success.	Jan Feb Mar Apr May Jun Jul Aug Sep Oct Nov Dec	100% 100% 100% 100% 100% 100% 100% 100% 100% 100% 100%	Analysis: Analysis: Includes monitoring availability (within 24 hrs if requested) for CT, US, Nuclear, and diagnostic mammograms. Dx Mammography increased its availability while Nuc. Med and Ultrasound declined. These percentages are based on scheduled tests that were booked in 24 hrs as "needed" tests. Action: Recommend to OP Service Line Team to include both measures on the Dashboard to more accurately reflect appointment status and availability.
Nursing								
Discharge instructions for HF completed more than 95% of time (Core Measure) excludes medication instructions	CCH: Deb Robinson, RN FH: Chief of Medicine Nursing Mgrs	Goal: 95th Percentile (100%) Benchmark: CDB Aggregate Score 87.7%	Jan Feb Mar Apr May Jun Jul Aug Sep Oct Nov Dec	92% 89% 95% 90% 93% 86% 96% 94% 98%	Analysis: 100% goal UN MET for the nursing measure of discharge instructions. Improvement noted, Overall nursing score 96 compared to 89 Q3. Overall discharge instructions including medication instructions UNMET - Jul = 93, Aug. = 70 and Sep = 85 Action: There were 2 corrective action plans; a the 11 7 nurse at time of 24 hour checks review all patients initial assessment and update the PMH for CHF if applicable, the second CAP started in Sept.; discharge check list for core measures implemented. Timely review of failures with the Nurse Mger.	Jan Feb Mar Apr May Jun Jul Aug Sep Oct Nov Dec	100.0% 100.0% 83.3% 75.0% 92.9% 88.9% 90.9% 90.9% 92.3% 92.3% 83.3% 100%	Analysis: There are three 4Q2010 variances; the denominator has declined in the last several months and contributed to the lower rates. Lack of nursing discharge assessment or failure to identify pts with HF contribute the compliance rate. Action: Clinical Decision Specialists working with Nursing are beginning disch instructions by the 2nd day to initiate an improved process by discharge. A clinical coordinator involved STAAR and HF pt readms and should contribute to improvements.
Pneumococcal vaccination completed on 95% of patients with pneumonia (Core Measure)	CCH: Deb Robinson, RN FH: Chief of Medicine, Nursing Mgrs, Pharmacists	Goal: 95th Percentile (100%) Benchmark: CDB Aggregate Score 93%	Jan Feb Mar Apr May Jun Jul Aug Sep Oct Nov Dec	96% 100% 90% 82% 94% 100% 92% 92% 87%	Analysis: Goal of 100% UNMET Quarter 3, 2010 Action: Nursing PI Team identified 2 process barriers. Pharmacy was involved and process changes to decrease steps to vaccine orders and changing the order from a one time order to a daily order until given have been implemented January 2011.	Jan Feb Mar Apr May Jun Jul Aug Sep Oct Nov Dec	93.8% 92.9% 100.0% 100.0% 100.0% 90.0% 94.7% 100.0% 100.0% 100.0% 100.0%	Analysis: Sustained excellent performance , for 4Q10 all candidates received the vaccine. Action: Continue to support Nursing by frerquently updating graphs.

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Opportunity Statement	Reporting Party	Goal/ Benchmark	CCH 2010		CCH Analysis/Action Plan	FH 2010		FH Analysis/Action Plan
Smoking cessation counseling provided and documented AMI, CHF, PN (Core Measures)	CCH: Deb Robinson, RN FH: Chief of Medicine Eric Bauman, RT Nursing	Goal 95th Percentile (100%)	Jan	93%	Analysis: 2 cases observed Q3, both cases had conflicting information, MD documented that patient was a smoker, nurse documented pt. was a non smoker Action: Nursing managers are sent notification of failure to meet core measure best practice guidelines. Goal 2011 will be to add smoking cessation information to all discharge paperwork.	Jan	100.0%	Analysis: Composite score of AMI, HF, PN measures (sums of numerators divided by sums of denominators x 100). During 2Q2010, 2/11 smokers were not counseled, one admitted and discharged the next morning before RT saw the patient. Small number variation.
			Feb	70%		Feb	100.0%	
			Mar	82%		Mar	100.0%	
			Apr	100%		Apr	66.7%	
			May	92%		May	66.7%	
			Jun	100%		Jun	100.0%	
		Jul	100%	Jul		92.9%		
		Aug	91%	Aug		66.7%		
		Sep	94%	Sep		100.0%		
		Oct		Oct		90.0%		
		Nov		Nov		100.0%		
		Dec		Dec		98.0%		
Pain								
Pain assessment documented prior to administration of pain medication on adult nursing units	CCH: Deb Robinson, RN FH: Diana Molloy, RN	Goal: 90%	Jan	NA	Analysis: Goal met Action: PI with focus on evaluation of nursing understanding of process and clarification of documentation expectation.	Jan	84.6	Analysis: Monitoring process ineffective in terms of a) performing monitoring in minimal cases on all nursing units and b) in aggregating data in unit-based audit tool. Population not sufficient to statistically represent entire population. Feed back reports require all or non performance rather than providing a percentage for both initial and reassessment, does not provide time, location, nurse data elements needed to facilitate review.
			Feb	NA		Feb	87.5	
			Mar	NA		Mar	90.0	
			Apr	79%		Apr	100.0	
			May	86%		May	100.0	
			Jun	89.0		Jun	100.0	
		Jul	87.0	Jul		80.0		
		Aug	80.0	Aug		100.0		
		Sep	96.0	Sep		75.0%		
		Oct	99.0	Oct		77.6%		
		Nov	94.0	Nov		54.3%		
		Dec	96.0	Dec				
Pain reassessment documented post-administration of pain medication on adult nursing units	CCH: Deb Robinson, RN FH: Diana Molloy, RN	Goal: 90%	Jan	23%	Analysis: Goal unmet , improvement noted Action: Nurse Mger. completed a Read Learn & Sign education in Dec. for 100%of all RN's. Pain Reassessment exceeded goal of 90% in January of 2010.	Jan	66.7	Action: As of the end of 2010, Nursing Directors have redesigned data collection and metrics that are compliance based rather than all or none based, to a) reflect practice and b) to facilitate discussion and improvement.
			Feb	50%		Feb	83.3	
			Mar	40%		Mar	66.7	
			Apr	43%		Apr	66.7	
			May	56%		May	100.0	
			Jun	59%		Jun	100.0	
		Jul	53%	Jul		62.5		
		Aug	50%	Aug		50.0		
		Sep	66%	Sep		50.0		
		Oct	82.0	Oct		33.0		
		Nov	79.0	Nov		40.0		
		Dec	83.0	Dec				
		Goal:	Jan			Jan		
			Feb			Feb		
			Mar			Mar		
			Apr			Apr		
			May			May		
			Jun			Jun		
		Benchmark:	Jul			Jul		
			Aug			Aug		
			Sep			Sep		
			Oct			Oct		
			Nov			Nov		
			Dec			Dec		

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Outpatient wait times	Pat Cabana, MT	Goal: 95% - patients drawn within 15 mins. Benchmark:	Jan Feb Mar Apr May Jun Jul Aug Sep Oct Nov Dec	 95.4 94.2 89.4 86.8 94.1 80.0 89.0	Analysis: increase in wait times in July & August. Improvement noted in Sept. 95% goal UNMET. Barrier identified as lab orders are being entered incorrectly or missing lab orders barriers to timely outpatient lab draw times. Action: Q4 multidisciplinary Process Improvement Team to review issues, note barriers and formulate improvement plan.	Jan Feb Mar Apr May Jun Jul Aug Sep Oct Nov Dec	 P E N D I N G	
Critical value/critical test reporting	Deb Robinson, RN	Goal: 90% Benchmark:	Jan Feb Mar Apr May Jun Jul Aug Sep Oct Nov Dec	38.1 46.4 47.5 33.3 NA NA 56 79 95 92 94 88	Analysis: Continued Improved compliance noted Q4 Action: Critical Value reported to nursing ; 100% of documentation compliance is reviewed weekly Continue to measure compliance weekly	Jan Feb Mar Apr May Jun Jul Aug Sep Oct Nov Dec	100.00% 100.00% 88.00% 100.00% 100.00% 50.00% 94.00% 100.00% 91.00% 92.00%	Analysis: Average 3Q2010 = 95%; Goal Met Action: None required.
Facilities								
Temperature of food <i>(from Press Ganey)</i>	CCH: Scott Taylor FH: Garth Meyerhoff	Goal: 95th Benchmark:	Jan Feb Mar Apr May Jun Jul Aug Sep Oct Nov Dec	 47 35 66 56	Analysis: The temperature of the food trend is not met. The ranking dropped in Q4 from 66 to 56. Action: Room Service is being evaluated through a Process Improvement team. Food delivery time is being reviewed for improvement.	Jan Feb Mar Apr May Jun Jul Aug Sep Oct Nov Dec	 59 73 47.0 84.0 57.0 73.0 88.0 92.0 81.0 69.0	Analysis: Temperature of food rank improved to 37 from 59 from 4Q09 and the mean improved by 1.7% to 81.8%. Very good responses were 40.6% of respondents compared to 43.9 from our peer group. Measure is not included in the PG Internal Priority Index. Action: Continue monitoring delivery/interview process; attempt to identify issues in variable measure results.
Quality of food <i>(from Press Ganey)</i>	CCH: Scott Taylor FH: Garth Meyerhoff	Goal: 95th Benchmark:	Jan Feb Mar Apr May Jun Jul Aug Sep Oct Nov Dec	 47 59 76 77	Analysis: Slight upward trend of 77th rank as compared to previous quarter of 76th percentile ranking within the Press Ganey database. Action: The new "Room Service" model increases menu choices and food is prepared at time of order thus increasing the quality of the food.	Jan Feb Mar Apr May Jun Jul Aug Sep Oct Nov Dec	 53 66.0 63.0 61.0 52.0 92.0 82.0 91.0 81.0 55.0	Analysis: 3Q2010 Food Quality has increased by 8 percentile points from the same three month period last year due to staff awareness, some new equipment and support from other departments. In the past several months we have added several new pieces of equipment, and conducted training for the staff and managers on customer service reflected in our August score. Action: This quarter we will continue to train the staff and will add a new "Merry Chef" which is a type of microwave and we will begin to see the results of the new steamer that was installed in September

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Have all meals to patient within 15 minutes for correct delivery	CCH: Scott Taylor FH: Garth Meyerhoff	Goal: =>95%	Jan	NA		Jan	95	Analysis: 3Q2010 Goal Met. We have begun having the dietary staff passing the trays on the floor where ever possible. We should begin seeing results in the change in August and September. We also expect to temperature of the food scores increase further. 4Q monthly average is 94.0%. Action: None required.
		Benchmark:	Feb			100		
	Mar	95						
	Apr	95						
	May	95						
	Jun	85.0						
	Jul	90.0						
	Aug	95.0						
	Sep	95.0						
	Oct	92.0						
	Nov	90%						
	Dec	100%						
Deliver trays to patients within 45 minutes of order (Room service call)	CCH: Scott Taylor FH: Garth Meyerhoff	Goal: > 90%	Jan		Analysis: Measuring began in March 2010. Each month there is a steady improvement. Goal met two out of the three months in Q4, 2010. Action: Process Improvement in place with staff. Supervisor monitoring of the process is providing accountability and feedback for improvement	Jan	82%	Analysis: This is important to the select patient. The comment from the returns are very complimentary. These results are computer tracked and monitored. Action: Reminding the staff to scan when meals are delivered will improve this score.
		Benchmark:	Feb			83%		
	Mar	76%						
	Apr	86%						
	May	89%						
	Jun	88%						
	Jul	85%						
	Aug	86%						
	Sep	92%						
	Oct	91%						
	Nov	87%						
	Dec	89%						
Inpatient facility cleanliness (from Press Ganey)	CCH: Ed Richards FH: Garth Meyerhoff	Goal:95%	Jan		Analysis: Goal Met Action: Continue to monitor with weekly rounding with the Environmental service team. Oversight and staff accountability in place.	Jan		Analysis: 3Q2010 There has been a 12 percentile increase for the latest 3 month period vs. the same period last year. We have also improved by 9 percentile points for YTD Through August from the same period last year. Action: Room renovations, when completed, will give the appearance of cleaner rooms. We may adjust housekeeping staff schedules to find the correct person for each area.
		Benchmark:	Feb			99		
	Mar							
	Apr	99						
	May							
	Jun							
	Jul							
	Aug	98						
	Sep							
	Oct							
	Nov	99						
	Dec							
Inpatient facility noise reduction (from Press Ganey)	CCH: Ed Richards FH: Garth Meyerhoff	Goal: 95%	Jan		Analysis: Trend continues in the 60+ percentile each quarter through the year with little or no improvement. Action: New PI team is recommended to re-evaluate noise levels and identify improvement strategies. This is a priority in 2011	Jan		Analysis: 3Q2010 Noise Level rank increased 14 percentiles from Q2 and overall improved 5 percentiles for YTD 2010 over the 2009 period. Many methods have been implemented recently, ie changing wheels on carts, yacker tracer, etc. Action: This period we will look at quieting an air handler, and installing noise attenuating floors in patient rooms awaiting renovation.
		Benchmark:	Feb			65		
	Mar							
	Apr	69						
	May							
	Jun							
	Jul							
	Sep	67						
	Oct							
	Nov	61						
	Dec							

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Service Line - Medicine								
# Rapid Response Calls per month (RRT)	CCH: Lori Jewett, RN FH: Jonathan Costa, MD Deb Byrne, RN	<i>Goal: 15 (CCH) 10 (FH) calls/month (source: VHA suggested goal)</i>	Jan	17	Analysis: Met, 54% of RRT pts stay in their rooms, 29% were trans to higher level of care. Action: Continue to trend and monitor.	Jan	10	Analysis: Goal for 4Q2010 frequency not met. Inpatient volume and ALOS flat for 2010 Action: RRT, Nursing and Education are finalizing the plans and process for family initiated RRT calls.
			Feb	23		Feb	04	
			Mar	25		Mar	14	
			Apr	13		Apr	11	
			May	16		May	9	
			Jun	10		Jun	11	
			Jul	24		Jul	6	
			Aug	16		Aug	9	
			Sep	12		Sep	4	
			Oct	16		Oct	7	
			Nov	22		Nov	5	
			Dec	21		Dec	5	
			<i>Benchmark:</i>					
		Jan			Jan			
		Feb			Feb			
		Mar			Mar			
		Apr			Apr			
		May			May			
		Jun			Jun			
		Jul			Jul			
		Aug			Aug			
		Sep			Sep			
		Oct			Oct			
		Nov			Nov			
		Dec			Dec			
		<i>Goal:</i>	Jan		Jan			
			Feb		Feb			
			Mar		Mar			
			Apr		Apr			
			May		May			
			Jun		Jun			
		<i>Benchmark:</i>	Jul		Jul			
			Aug		Aug			
			Sep		Sep			
			Oct		Oct			
			Nov		Nov			
			Dec		Dec			
Pay for Performance								
Acute Myocardial Infarction (AMI) All-or-None Score = % of patients who met all applicable measures, or "perfect care"	CCH: Cardiovasc. Quality Council FH: Bruce Levy, MD Deb Byrne, RN	<i>Goal: 95th percentile (100%)</i>	Jan	88.0	Analysis: 3 variances from 84 cases. 2 for no B-Blocker at d/c without documented reason. 1 for ASA at d/c, pt was discharged by general surg following abd surgery. No documented reason for not prescribing ASA at discharge. Action: Data was sent to the Dept of Cardiology for further analysis & follow-up	Jan	100	Analysis: Sustained excellent performance. Action: Information regarding new Statin measures effective 4/1/11 distributed.
			Feb	92.0		Feb	100	
			Mar	89.3		Mar	100	
			Apr	95.8		Apr	100	
			May	92.6		May	91.2	
			Jun	100.0		Jun	88.9	
			Jul	96.0		Jul	100	
			Aug	96.0		Aug	100	
			Sep	96.0		Sep	100	
			Oct			Oct	100	
			Nov			Nov	100	
			Dec			Dec	100	
			<i>Benchmark: P4P Measures Q3'10: Midas 50th percentile=98.2%</i>					

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Children's Asthma Care All-or-None Score = % of patients who met all applicable measures, or "perfect care"	CCH: ECS.L. FH: Greg Parkinson, MD Stephanie Whalen, RN	Goal: 95th percentile (100%) Benchmark: Q3 '10: Midas 50th percentile = 66.7%	Jan	33.3	Analysis: Data represents 2 cases. One MassHealth pt met 100% of all measures. The second case was lacking documentation of receiving a portion of d/c instructions addressing environment/triggers and a plan of rescue. Action: A specific d/c instruction sheet was implemented during Q2 to address all measures pertaining to Pediatric Asthma d/c instructions.	Jan	100	Analysis: Sustained excellent performance. Small N. Action: None required.
			Feb	no patients		Feb	100	
			Mar	50.0		Mar	100	
			Apr	no patients		Apr	no patients	
			May	50.0		May	100	
			Jun	no patients		Jun	no patients	
			Jul	0.0		Jul	0	
			Aug	no patients		Aug	0	
			Sep	100.0		Sep	66.7	
			Oct			Oct	no patients	
			Nov			Nov	100	
			Dec			Dec	no patients	
Heart Failure All-or-None Score = % of patients who met all applicable measures, or "perfect care"	CCH: Lawrence McAuliffe, MD Mary Lynch, RN FH: Bruce Levy, MD Deb Byrne, RN	Goal: 95th percentile (100%) Benchmark: P4P Measures Q3 '10: Midas 50th percentile=93.9%	Jan	84.6	Analysis: 11 of 46 encounters did not meet the documentation requirements for HF1 discharge instructions. Need for more education identified. 6 of 24 encounters did not meet documentation req. for not prescribing an ace/arb for LVSD Action: Mtgs with Nsg and Perf Improvement on-going to improve the process. Perf Improvement providing more frequent reports/feedback. Letters to providers for OFI variances.	Jan	100.0	Analysis: 2Q10- 29th percentile in DV comparative data base. All but one variance (smoking cessation) were attributable to discharge instructions. Small numbers variation. 3Q10, seven variances involving four measures. Action: Continue to send variance notices and data to units and providers.
			Feb	81.5		Feb	96.0	
			Mar	88.0		Mar	90.0	
			Apr	75.0		Apr	76.2	
			May	83.3		May	95.2	
			Jun	72.0		Jun	91.7	
			Jul	88.0		Jul	88.9	
			Aug	61.5		Aug	94.1%	
			Sep	83.3		Sep	84.6%	
			Oct			Oct	96.0%	
			Nov			Nov	90.0%	
			Dec			Dec	95.6%	
Pneumonia All-or-None Score = % of patients who met all applicable measures, or "perfect care"	CCH: Alan Sugar, MD Nurse Mgrs; Kevin Bresnahan, MD Deb Robinson, RN FH: Jonathan Costa, MD Rob Davis, MD	Goal: 95th percentile (100%) Benchmark: P4P Measures Q3 '10: Midas 50th percentile=91.9%	Jan	90.9	Analysis: 113 PN cases. The all-or-none bundle not met due to 5 pts not receiving PN vaccine. 7 pts did not get blood cultures drawn before abx administered, 1 pt did not get abx within 6hrs of arrival and 1 did not receive recommended abx for PN. Action: OFI letters are sent to physician reminding them of recommended abx selection, timing and blood culture criteria. Each case pertaining to EC is reviewed by EC Mgr and Physician. Physician Director of infectious disease reviews all cases out of compliance for abx selection and notifies physicians involved. PN vac. letters are sent to mgrs of each nsg floor for those cases falling out of compliance. D/C envelop core measure checklist includes PN and FLU Vaccine.	Jan	80.0%	Analysis: Vaccination scores improved in 4th quarter. Small N variations. Action: Feedback provided to providers and units.
			Feb	73.9		Feb	90.0%	
			Mar	71.4		Mar	87.5%	
			Apr	83.3		Apr	100.0%	
			May	84.6		May	100.0%	
			Jun	85.8		Jun	93.7%	
			Jul	89.7		Jul	85.7%	
			Aug	79.3		Aug	94.10%	
			Sep	76.7		Sep	88.90%	
			Oct			Oct	85.70%	
			Nov			Nov	84.60%	
			Dec			Dec	89.70%	
Surgical Infection Prevention Project (SCIP) All-or-None Score = % of patients who met all applicable measures, or "perfect care" for All Measures	CCH: Jeff Spillane, M.D. FH: Chief of Surgery, SCIP Team	Goal: 95th percentile (98.25%) Benchmark: P4P Measures Q3 '10: Midas 50th percentile=88.9%	Jan	85.6	Analysis: Overall specific areas for improvement are: Foley Cath D/C, post-op abx discontinued, Beta Blocker 2 card surg, post-op glucose control. Ortho surg has highest scores. Card Surg. Identified for improvement. Action: RN from card surg now on SCIP task force. Freq of interim reporting increased. ICU Nsg. Mgr. copied on SCIP data.	Jan	93.4%	Analysis: Small N variation. Action: None Required.
			Feb	92.0		Feb	90.9%	
			Mar	88.9		Mar	96.4%	
			Apr	87.3		Apr	96.5%	
			May	89.6		May	94.6%	
			Jun	88.3		Jun	98.3%	
			Jul	95.9		Jul	94.6%	
			Aug	88.2		Aug	97.8%	
			Sep	87.6		Sep	97.8%	
			Oct			Oct	100.0%	
			Nov			Nov	96.1%	
			Dec			Dec	97.7%	

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Hospital Outpatient (HOP) AMI/Chest Pain (includes only ER patients who are transferred from the ER to an Acute Care Facility) **NC = No Cases	CCH: Kevin Bresnahan, MD FH: Bruce Levy, MD Rob Davis, MD	Goal: 95th Percentile (100%) Benchmark: P4P Measures Q3 '10: Midas 50th percentile= 100%	Jan	50.0	Analysis: Few cases in study. Measure only applies to pts who are transferred to other facilities. Action: None required. Small numerator/denominator	Jan	100.0	Analysis: 2Q >95th percentile, 100%. This is a compliance score for ASA. Goal met for AMI and Chest pain patients. 4Q10 5/6 encounters met criteria. Action: Small N, none required.
			Feb	100.0		Feb	100.0	
			Mar	100.0		Mar	100.0	
			Apr	100.0		Apr	100.0	
			May	no patients		May	100.0	
			Jun	100.0		Jun	100.0	
			Jul	no patients		Jul	100.0	
			Aug	no patients		Aug	100.0	
			Sep			Sep	100.0	
			Oct			Oct	66.7	
			Nov			Nov	100.0	
			Dec			Dec	100.0	
Hospital Outpatient (HOP) Surgery	CCH: Lawrence Novak, MD Robin Grace, RN FH: Chief of Surgery, SCIP Team	Goal: 95th Percentile (100%) Benchmark: P4P Measures Q3 '10: Midas 50th percentile=97.09% for timing, 96.97% for selection	Jan	100.0	Analysis: Very few encounters qualify. Measure only applies to patients who are transferred to other facilities. Most encounters at CCH are admitted. Action: Abx order sets developed. Letters sent to providers w variances since Q1 09. Data sent to Dept of Cardiology for analysis.	Jan	100.0	Analysis: Small N. No variances for eight months. Action: Small N, none required.
			Feb	98.1		Feb	100.0	
			Mar	100.0		Mar	100.0	
			Apr	88.7		Apr	88.3	
			May	80.9		May	100.0	
			Jun	90.0		Jun	100.0	
			Jul	92.9		Jul	100.0	
			Aug	96.2		Aug	100.0	
			Sep			Sep	100.0	
			Oct			Oct	100.0	
			Nov			Nov	100.0	
			Dec			Dec	100.0	
Intrapartum antibiotic prophylaxis for group B streptococcus	CCH: David Elmer, MD Richard Angelo, MD Dian Birch, RN FH: Chief of Obstetrics/Gynecology	Goal: 100% Benchmark:	Jan	66.7	Analysis: Q3 represents two out of five patients that had incomplete documentation of antibiotic administration Action: Cases reviewed by Dept of OB and OB Quality mting. PI implemented. OB nurse to daily review patient charges identified as GBS positive. Audit tool was put in place in October to track documentation compliance.	Jan	100	Analysis: 2Q 10 One of two patients sis not receive GBS antibiotics. Action: Variance notices to be developed and sent for MassHealth encounters.
			Feb	100.0		Feb	100	
			Mar	100.0		Mar	100	
			Apr	80.0		Apr	50	
			May	100.0		May	no patients	
			Jun	100.0		Jun	no patients	
			Jul	60.0		Jul	100	
			Aug	100.0		Aug	100	
			Sep	100.0		Sep	100	
			Oct			Oct	50.0	
			Nov			Nov	100.0	
			Dec			Dec	no patients	
Perioperative antibiotic administration for C-section	CCH: David Elmer, MD Richard Angelo, MD Dian Birch, RN FH: Chief of Obstetrics/Gynecology Chief of Anesthesia	Goal: 100% Benchmark:	Jan	75	Analysis: Q3-10 represents one patient that did not receive antibiotic within 60 min of incision time. Action: PI instituted in Sept. to include antibiotic admin. Check and documentn completed by anesthesia as part of the surgical time out procedure before the start of each C-Section.	Jan	66.7	Analysis: 4Q 10 One of two patients sis not receive GBS antibiotics. Action: Variance notice sent for MassHealth encounters.
			Feb	100		Feb	100	
			Mar	100		Mar	100	
			Apr	100		Apr	100	
			May	100		May	100	
			Jun	100		Jun	100	
			Jul	100		Jul	100	
			Aug	75		Aug	100	
			Sep	100		Sep	100	
			Oct			Oct	100	
			Nov			Nov	100	
			Dec			Dec	100	

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Opportunity Statement	Reporting Party	Goal/ Benchmark	CCH 2010		CCH Analysis/Action Plan	FH 2010		FH Analysis/Action Plan
Healthcare Associated Infections								
Central Line Associated Bloodstream Infections (CLA-BSI) / 1000 Central Line Days-ICU	Georgia Dash, RN, MS, CIC	Goal: Zero Benchmark: CDC National Healthcare Safety Network (NHSN) Mean Med/Surg ICU-1.5 (pub 12/09) 2009 FH ICU- 0.2 (2/937) 2009 CCH ICU-0 (0/1260)	Jan	0 (0/57)	12/31/10 Analysis: Sustain goal of zero central line associated bloodstream infection.	Jan	0 (0/74)	12/31/10 Analysis: Below national benchmarks. Continue to strive for zero CLABSI.
			Feb	0 (0/51)		Feb	0 (0/56)	
			Mar	0 (0/82)		Mar	0 (0/65)	
			Apr	0 (0/91)		Apr	0 (0/80)	
			May	7.0 (1/143)		May	0 (0/72)	
			Jun	0 (0/107)		Jun	0 (0/69)	
			Jul	0 (0/98)		Jul	0 (0/96)	
			Aug	0 (0/111)		Aug	0 (0/75)	
			Sep	0 (0/96)		Sep	0 (0/36)	
			Oct	0 (0/129)		Oct	11.8 (1/85)	
			Nov	0 (0/60)		Nov	0 (0/104)	
			Dec	0 (0/45)		Dec	0 (0/135)	
			Ventilator Associated Pneumonia (VAP) / 1000 Ventilator Days - ICU	Georgia Dash, RN, MS, CIC		Goal: Zero Benchmark: CDC NHSN Mean Med/Surg ICU - 2.2 (pub 12/09) 2009 FH ICU - 0 (0/780) 2009 CCH ICU- 0 (0/1398)	Jan	
Feb	0 (0/58)	Feb			0 (0/30)			
Mar	0 (0/95)	Mar			0 (0/76)			
Apr	0 (0/126)	Apr			0 (0/39)			
May	0 (0/159)	May			0 (0/37)			
Jun	0 (0/78)	Jun			0 (0/58)			
Jul	0 (0/124)	Jul			0 (0/78)			
Aug	5.6 (1/180)	Aug			0 (0/51)			
Sep	0 (0/98)	Sep			0 (0/25)			
Oct	0 (0/133)	Oct			0 (0/59)			
Nov	0 (0/31)	Nov			13.0 (1/77)			
Dec	0 (0/45)	Dec			0 (0/79)			
Surgical Site Infection Coronary Artery Bypass Graft	Georgia Dash, RN, MS, CIC	Goal: Zero Benchmark: CDC NHSN All Risk Categories Combined Mean - 2.55 (pub 12/09) FH 2009 Mean - CCH 2009 Mean- 0 (0/17)			Jan		0 (0/8)	12/31/10 Action: One SSI in CABG for 2010. All SCIP measures followed. Continue to strive for zero.
			Feb	0 (0/6)	Feb			
			Mar	0 (0/10)	Mar			
			Apr	0 (0/8)	Apr			
			May	0 (0/5)	May			
			Jun	0 (0/10)	Jun			
			Jul	0 (0/13)	Jul			
			Aug	0 (0/9)	Aug			
			Sep	0 (0/7)	Sep			
			Oct	0 (0/10)	Oct			
			Nov	7.7 (1/13)	Nov			
			Dec	0 (0/11)	Dec			
			Surgical Site Infection in Total Hip Replacement	Georgia Dash, RN, MS, CIC	Goal: Zero Benchmark: CDC NHSN All Risk Categories Combined Mean - 1.3 (pub 12/09) FH 2009 Mean - 1.4 (2/142) CCH 2009 Mean-0.4 (1/226)	Jan	0 (0/23)	
Feb	8.0 (2/25)	Feb				0 (0/10)		
Mar	3.0 (1/38)	Mar				0 (0/19)		
Apr	0 (0/24)	Apr				0 (0/10)		
May	3.3 (1/30)	May				0 (0/15)		
Jun	0 (0/35)	Jun				0 (0/21)		
Jul	0 (0/15)	Jul				7.7(1/13)		
Aug	0 (0/11)	Aug				0 (0/10)		
Sep	11.1 (3/27)	Sep				0 (0/10)		
Oct	5.9 (1/17)	Oct				0 (0/10)		
Nov	0 (0/12)	Nov				0 (0/15)		
Dec	4.8 (1/21)	Dec				0 (0/7)		

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Surgical Site Infection in Total Knee Replacement	Georgia Dash, RN, MS, CIC	Goal: Zero	Jan	0 (0/27)	12/31/10 One SSI for 2010. Continue to strive for zero.	Jan	3.8 (1/26)	12/31/10 Analysis: Four SSIs in 2010. Two were superficial and two were deep. All cases reviewed with surgeons. Antiseptic impregnated dressing undergoing trial.
			Feb	0 (0/30)		Feb	5.8 (1/17)	
			Mar	0 (0/24)		Mar	4.0 (1/27)	
			Apr	0 (0/20)		Apr	0 (0/17)	
			May	0 (0/21)		May	0 (0/21)	
			Jun	0 (0/13)		Jun	0 (0/19)	
			Jul	4.2 (1/24)		Jul	0 (0/19)	
			Aug	0 (0/12)		Aug	0 (0/21)	
			Sep	0 (0/17)		Sep	4.3 (1/23)	
			Oct	0 (0/24)		Oct	0 (0/16)	
			Nov	0 (0/24)		Nov	0 (0/23)	
			Dec	0 (0/15)		Dec	0 (0/15)	
				Benchmark: CDC NHSN All Risk Categories Combined Mean - 0.9 (pub 12/09) CCH 2009 Mean- 1.2 (3/254) FH 2009 Mean- 3.2 (8/250)				
Hand Hygiene Before Patient Contact	Georgia Dash, RN, MS, CIC	Goal: 100%	Jan		12/31/10 Analysis: 4th Qtr showed improved performance.	Jan		12/31/10 Analysis: Improvement in overall performance.
			Feb			Feb		
			Mar	74.0%		Mar	72.0%	
			Apr			Apr		
			May			May		
			Jun	68.0%		Jun	80.0%	
			Jul			Jul		
			Aug			Aug		
			Sep	72.0%		Sep	84.0%	
			Oct			Oct		
			Nov			Nov		
			Dec	73.0%		Dec	84.0%	
				Benchmark: Massachusetts General Hospital (MGH) - greater than 90%				
Hand Hygiene After Patient Contact	Georgia Dash, RN, MS, CIC	Goal: 100%	Jan		12/31/10 Analysis: Hand hygiene performance declined. Considering purchase of electronic staff monitoring system.	Jan		12/31/10 Analysis: 4th Qtr showed 3% decline to 87%. Continue monitoring.
			Feb			Feb		
			Mar	89.0%		Mar	88.0%	
			Apr			Apr		
			May			May		
			Jun	87.0%		Jun	90.0%	
			Jul			Jul		
			Aug			Aug		
			Sep	90.0%		Sep	90.0%	
			Oct			Oct		
			Nov			Nov		
			Dec	82.0%		Dec	87.0%	
				Benchmark: Massachusetts General Hospital (MGH)-greater than 90%				
Mortality								
Overall Inpatient Average Length of Stay (LOS) (Overall arithmetic mean)	CCH: Molly Nadeau, RN FH: Pamela Kendrick, RN	Goal: 4.0	Jan	3.90	Analysis: Goal met, stable trend Action: Continue to monitor.	Jan	3.90	Analysis: Goal not met for last two months of Q1 10 ALOS for quarter = 4.1. 2Q 10 ALOS = 3.91, 3Q10 ALOS =3.86, 4Q10 ALOS = 4.20. Action: 65% of acute care inpatients were greater than age 64 with an ALOS for 2010 of 4.39. IQ and 4Q ALOS for this group exceeded 4.5 days.
			Feb	3.90		Feb	4.10	
			Mar	4.20		Mar	4.28	
			Apr	3.90		Apr	3.96	
			May	3.90		May	3.92	
			Jun	3.69		Jun	3.86	
			Jul	3.85		Jul	3.79	
			Aug	4.06		Aug	3.99	
			Sep	3.97		Sep	3.65	
			Oct	3.86		Oct	4.10	
			Nov	4.05		Nov	4.20	
			Dec	3.87		Dec	4.30	
				Benchmark: Midas '10 4.63 Midas '09 4.65 CCH '09 3.96 FH '09 4.07				

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Opportunity Statement	Reporting Party	Goal/ Benchmark	CCH 2010		CCH Analysis/Action Plan	FH 2010		FH Analysis/Action Plan
Overall Inpatient Mortality Rate	CCH: James Butterick, MD FH: Chief of Surgery Chief of Medicine	<i>Goal:</i> <i>Benchmark:</i> Midas '10-1.92 Midas '09-1.97 CCH '09- 2.18 FH '09 -1.92	Jan Feb Mar Apr May Jun Jul Aug Sep Oct Nov Dec	1.97 2.59 2.81 1.74 2.12 1.92 2.35 2.14 2.36 1.66 2.28 1.57	Analysis: Mortality rate in Q4, 2010 ranges between 1.66 and 2.28 in Nov. Two out of three months trended down below goal of 2.0. Action: All mortality is reviewed by Senior nurse analyst. Peer review is performed on all cases that meet criteria. Opportunities for improvement have been identified and a target focus on Sepsis management is in progress.	Jan Feb Mar Apr May Jun Jul Aug Sep Oct Nov Dec	1.91 1.89 0.69 1.15 2.12 0.99 0.93 0.91 0.91 1.75 1.74 1.64	Analysis: 4Q2010- Overall mortality rate 1.76 compared to 1.42 for 3Q10. The last 8 quarters were in the 5th percentile in Midas CDB. Action: None required, low rate continues.
AMI 30-Day Mortality (CMS) Qualitative Report Annual	CCH: James Butterick, MD FH: Herbert Gray, MD	<i>Goal: Better than U.S. National Rate</i> <i>Benchmark:</i> HQA (Hospital Quality Alliance)	Jan Feb Mar Apr May Jun Jul Aug Sep Oct Nov Dec	Better than U.S. National Rate	HQA data 4Q 08 - Q3 09	Jan Feb Mar Apr May Jun Jul Aug Sep Oct Nov Dec	No Different than U.S. National Rate	HQA Reported 4Q09 data for year ending 3Q09
Heart Failure 30-Day Mortality (CMS) Qualitative Report Quarterly	CCH: Lawrence McAuliffe, MD FH: NA	<i>Goal: Better than U.S. National Rate</i> <i>Benchmark:</i> HQA (Hospital Quality Alliance)	Jan Feb Mar Apr May Jun Jul Aug Sep Oct Nov Dec	No Different than U.S. National Rate	HQA data 4Q 08 - Q3 09	Jan Feb Mar Apr May Jun Jul Aug Sep Oct Nov Dec	No Different than U.S. National Rate	HQA Reported 4Q09 data for year ending 3Q09
Pneumonia 30-Day Mortality (CMS) Qualitative Report Annual	CCH: Alan Sugar, MD FH: NA	<i>Goal: Better than U.S. National Rate</i> <i>Benchmark:</i> HQA (Hospital Quality Alliance)	Jan Feb Mar Apr May Jun Jul Aug Sep Oct Nov Dec	No Different than U.S. National Rate	HQA data 4Q 08 - Q3 09	Jan Feb Mar Apr May Jun Jul Aug Sep Oct Nov Dec	Better than U.S. National Rate	HQA Reported 4Q09 data for year ending 3Q09

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Medicare Case Mix Index	CCH: James Butterick, MD Molly Nadeau, RN FH: Rob Davis, MD Pamela Kendrick, RN	Goal: 1.51 CCH Benchmark: Midas '10 1.66 Midas '09 1.64	Jan Feb Mar Apr May Jun Jul Aug Sep Oct Nov Dec	1.52 1.53 1.59 1.51 1.51 1.50 1.50 1.63 1.58 1.49 1.56 1.49	Analysis: Close to goal in October and December. Goal exceeded in November. Quarter average goal met. Action: Continue to strive for >90% review of all Medicare cases and 100% review of all Medicare Surgical Cases	Jan Feb Mar Apr May Jun Jul Aug Sep Oct Nov Dec	1.43 1.44 1.43 1.42 1.44 1.43 1.42 1.42 1.42 1.45 1.42 1.45	Analysis: Steady improvement in CMI due to improved medical staff documentation in the record facilitated by the Clinical Documentation Specialists. Source=JATA Database Action: Performance is exceptional, no action plan required.
Total Risk Events Reported per 1000 patient days (Includes inpatient, outpatient, observation and ER) <i>*measure under review</i>	CCH: Lisa Tager, JD, LICSW, MSW FH: Melinda Dunne, RN	Goal: TBD Benchmark:	Jan Feb Mar Apr May Jun Jul Aug Sep Oct Nov Dec	19.0 26.0 28.0 32.0 36.0 31.0 29.0 39.0 27.0 22.3 32.3 24.4	Analysis: Event reporting activities have remained high - laboratory staff have made a concerted effort to complete reports on lost/mislabeled specimens. Action: Sustain event reporting activities by continuing to educate staff and provide f/u to reported events	Jan Feb Mar Apr May Jun Jul Aug Sep Oct Nov Dec	12.8 16.7 16.8 9.1 9.4 9.0 6.2 7.2 10.1 8.2 11.4 8.0	Analysis: YTD 98.3% of risk events reported via EIR, 31.5% are medication errors, 80.3% are inpatient and 94.1% are Level I & 2. Over time (from 1/09) the number of events is trending upward. Action: Attempt to analyze the rate of medication error reporting. Attempt to determine whether increased medication event reporting can be achieved.
Hospital Acquired Conditions								
Unintended retention of a foreign object in a patient after surgery or other procedure per 1000 inpatient admissions (ICD-10 coding definition change effective 10/1/08)		Goal: 0.0 Benchmark: Midas '10 0.04 Midas '09 0.03 CCH '09 0.12 FH 09 0.00	Jan Feb Mar Apr May Jun Jul Aug Sep Oct Nov Dec	0.0 0.0 0.0 0.0 0.0 0.0 0.0 0.0 0.0 0.0 1/ 0.76 0.0	Analysis: Goal not met for November with the rate rising to 0.8. Action: Case reviewed for Root Cause. Our goal is to continue to strive for zero cases of unintended foreign objects.	Jan Feb Mar Apr May Jun Jul Aug Sep Oct Nov Dec	0.0 0.0 0.0 0.0 0.0 0.0 1/1.56 0.0 0.0 0.0 0.0 0.0	Analysis: Sustained excellent performance. July '10, a single case with broken drill bit left in bone. Action: None required. Continue to provide feedback.
Patient death or serious disability associated with intravascular air embolism that occurs while being cared for in a healthcare facility per 1000 inpatient admissions		Goal: 0.0 Benchmark: Midas '10 0.0 Midas '09 0.0 CCH '09 0.0 FH '09 0.0	Jan Feb Mar Apr May Jun Jul Aug Sep Oct Nov Dec	0.0 0.0 0.0 0.0 0.0 0.0 0.0 0.0 0.0 0.0 0.0 0.0	Analysis: Sustained excellent performance. Action: None required. Continue to provide feedback.	Jan Feb Mar Apr May Jun Jul Aug Sep Oct Nov Dec	0.0 0.0 0.0 0.0 0.0 0.0 0.0 0.0 0.0 0.0 0.0 0.0	Analysis: Sustained excellent performance. Action: None required. Continue to provide feedback.

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Opportunity Statement	Reporting Party	Goal/ Benchmark	CCH 2010		CCH Analysis/Action Plan	FH 2010		FH Analysis/Action Plan
Patient death or serious disability associated with a hemolytic reaction (abnormal breakdown of red blood cells) due to the administration of ABO/HLA (Blood Incompatibility) per 1000 inpatient admissions		Goal: 0.0	Jan	0.0	Analysis: Sustained excellent performance. Action: None required. Continue to provide feedback.	Jan	0.0	Analysis: Sustained excellent performance. Action: None required. Continue to provide feedback.
		Feb	0.0	Feb		0.0		
		Mar	0.0	Mar		0.0		
		Apr	0.0	Apr		0.0		
		May	0.0	May		0.0		
		Jun	0.0	Jun		0.0		
		Jul	0.0	Jul		0.0		
		Aug	0.0	Aug		0.0		
		Sep	0.0	Sep		0.0		
		Oct	0.0	Oct		0.0		
		Nov	0.0	Nov		0.0		
		Dec	0.0	Dec		0.0		
		Benchmark: Midas '10 0.0 Midas '09 0.0 CCH '09 0.0 FH '09 0.0						
Stage 3 or 4 pressure ulcers acquired after admission (Midas ICD-10 coding to be updated 10/17/08)	CCH: Nursing FH: Nursing	Goal: 0.0	Jan	0.0	Analysis: 2 cases observed Q4, Both pts had extended LOS, both were on skin care protocol and had approp. wound care consults Action: Continue to monitor and review cases for improvement opportunities	Jan	0.0	Analysis: Sustained excellent performance. Action: None required. Continue to provide feedback.
		Feb	0.0	Feb		0.0		
		Mar	0.0	Mar		0.0		
		Apr	0.0	Apr		0.0		
		May	0.0	May		0.0		
		Jun	0.0	Jun		0.0		
		Jul	1/0.65	Jul		0.0		
		Aug	1/0.67	Aug		0.0		
		Sep	0.0	Sep		0.0		
		Oct	1/0.72	Oct		0.0		
		Nov	1/0.76	Nov		0.0		
		Dec	0.00	Dec		0.0		
		Benchmark: Midas '10 0.12 Midas '09 0.15 CCH '09 0.0 FH '09 0.15						
Falls & Trauma includes electric shock, intracranial injuries, fracture, dislocations, crush injuries, and burns per 1000 inpatient admissions	CCH: Joan Martinelli, RN FH: Melinda Dunne, RN	Goal: 0.0	Jan	1/0.71	Analysis: Goal of zero met for all months except January and July 2010. Action: Falls prevention bundle revised. Emphasis on hourly rounding with monitoring of compliance has been in place and is making a difference in our falls injury prevention.	Jan	1/1.74	Analysis: An intra-operative closed fracture of shaft of femur during revision for loose prosthesis; Action: Continue to review cases immediately, do corrective treatment and develop plan for prevention.
		Feb	0.0	Feb		0.00		
		Mar	0.0	Mar		0.00		
		Apr	0.0	Apr		0.0		
		May	0.0	May		0.0		
		Jun	0.0	Jun		0.0		
		Jul	1/0.65	Jul		0.0		
		Aug	0.0	Aug		0.0		
		Sep	0.0	Sep		0.0		
		Oct	0.0	Oct		0.0		
		Nov	0.0	Nov		0.0		
		Dec	0.0	Dec		0.0		
		Benchmark: Midas '10 0.36 Midas '09 0.40 CCH '09 0.70 FH '09 0.75						
Catheter-Associated Urinary Tract Infection per 1000 inpatient admissions		Goal: 0.0	Jan	0.0	CDC NHSN recommends not using ICD 9 codes to identify catheter associated urinary tract infection because of inaccuracy of coded data in identification of UTI Action: Sustain 0 infections.	Jan	1/1.74	Analysis: Based on ICD Coding. One case of inpatient UTI-1Q10. Action: None Required
		Feb	0.0	Feb		0.0		
		Mar	0.0	Mar		0.0		
		Apr	1/0.73	Apr		0.0		
		May	0.0	May		0.0		
		Jun	0.0	Jun		0.0		
		Jul	0.0	Jul		0.0		
		Aug	0.0	Aug		0.0		
		Sep	0.0	Sep		0.0		
		Oct	1/0.72	Oct		0.0		
		Nov	0.0	Nov		0.0		
		Dec	0.0	Dec		0.0		
		Benchmark: Midas '10 0.30 Midas '09 0.34 CCH '09 0.17 FH '09 0.30						

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Vascular Catheter-Associated Infection per 1000 inpatient admissions		Goal: 0.0	Jan	0.0	CDC NHSN recommends not using ICD 9 codes to identify catheter associated urinary tract infection because of inaccuracy of coded data in identification of UTI Action: Sustain 0 infections.	Jan	0.0	Analysis: Based on ICD coding, not surveillance. Beginning 10/1/09, measure will include all CLA-BSI infections for all locations. No trend. Action: Cases reviewed in collaboration with Infection Control to make a clinical determination versus coding rules prior to billing.
			Feb	1/0.84		Feb	0.0	
			Mar	0.0		Mar	0.0	
			Apr	1/0.73		Apr	0.0	
			May	0.0		May	0.0	
			Jun	1/0.66		Jun	0.0	
		Benchmark: Midas '10 0.74 Midas '09 0.78 CCH '09 0.23 FH '09 0.60	Jul	0.0		Jul	0.0	
			Aug	0.0		Aug	0.0	
			Sep	0.0		Sep	0.0	
			Oct	0.0		Oct	0.0	
			Nov	0.0		Nov	0.0	
			Dec	0.0		Dec	0.0	
			Dec	0.0		Dec	0.0	
Surgical Site Infection Following: Orthopedic Procedures (spine, neck, shoulder, elbow)		Goal: 0.0	Jan	0.0	Analysis: Sustained excellent performance. Action: None required. Continue to provide feedback.	Jan	0.0	Analysis: Sustained excellent performance. Action: None required. Continue to provide feedback.
			Feb	0.0		Feb	0.0	
			Mar	0.0		Mar	0.0	
			Apr	0.0		Apr	0.0	
			May	0.0		May	0.0	
			Jun	0.0		Jun	0.0	
		Benchmark: Midas '10 0.03 Midas '09 0.03 CCH '09 0.06 FH '09 0.00	Jul	0.0		Jul	0.0	
			Aug	0.0		Aug	0.0	
			Sep	0.0		Sep	0.0	
			Oct	0.0		Oct	0.0	
			Nov	0.0		Nov	0.0	
			Dec	0.0		Dec	0.0	
			Dec	1/0.75		Dec	0.0	
Deep Vein Thrombosis (DVT)/Pulmonary Embolism (PE) following: Total Knee Replacement Hip Replacement		Goal: 0.0	Jan	0.0	Analysis: No Occurrences, Stable Action: None required. Continue to provide feedback.	Jan	0.0	Analysis: Sustained excellent performance. Action: None required. Continue to provide feedback.
			Feb	0.0		Feb	0.0	
			Mar	0.0		Mar	0.0	
			Apr	0.0		Apr	0.0	
			May	0.0		May	0.0	
			Jun	0.0		Jun	0.0	
		Benchmark: Midas '10 0.19 Midas '09 0.18 CCH '09 0.00 FH '09 0.15	Jul	0.0		Jul	0.0	
			Aug	0.0		Aug	0.0	
			Sep	0.0		Sep	0.0	
			Oct	0.0		Oct	0.0	
			Nov	0.0		Nov	0.0	
			Dec	0.0		Dec	0.0	
			Dec	0.0		Dec	0.0	
Manifestations of poor glycemic control		Goal: 0.0	Jan	0.0	Analysis: Goal not met in November with rate of 0.759 Action: Case reviewed.	Jan	0.0	Analysis: Sustained excellent performance. 4Q10 1 encounter of elderly male with DKA in setting of multiple comorbid conditions. Action: None required. Continue to provide feedback.
			Feb	0.0		Feb	0.0	
			Mar	0.0		Mar	0.0	
			Apr	0.0		Apr	0.0	
			May	0.0		May	0.0	
			Jun	0.0		Jun	0.0	
		Benchmark: Midas '10 0.06 Midas '09 0.05 CCH '09 0.06 FH '09 0.15	Jul	0.0		Jul	0.0	
			Aug	0.0		Aug	0.0	
			Sep	0.0		Sep	0.0	
			Oct	0.0		Oct	0.0	
			Nov	1/0.76		Nov	0.0	
			Dec	0.0		Dec	1 / 1.83	
			Dec	0.0		Dec	0.0	

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Surgical Site Infection, mediastinitis, following coronary artery bypass graft (CABG)		Goal: 0.0	Jan	0.0	Analysis: Sustained excellent performance. Action: None required. Continue to provide feedback.	Jan	NA		
		Feb	0.0	Feb					
		Mar	0.0	Mar					
		Apr	0.0	Apr					
		May	0.0	May					
		Jun	0.0	Jun					
		Jul	0.0	Jul					
		Aug	0.0	Aug					
		Sep	0.0	Sep					
		Oct	0.0	Oct					
		Nov	0.0	Nov					
		Dec	0.0	Dec					
Patient Satisfaction									
Press Ganey Overall Inpatient Rank	CCH: Dept. Managers Nursing Managers FH: Sue Wing	Goal: Top 5% of equivalent bed-sized facility (95th percentile)	Jan	96	Goal Met - Continue to strive for excellence with a focus in 2011 on improving HCAPS	Jan	52	Analysis: Comparison to 50-100 beds, Increase from 12/09 at 47th percentile. 1Q10 N=566, an increase in volume of responses from 4Q09. Up to the 64th %ile by end of 3Q10. 4th Quarter percentile is the 61st	
		Feb	96	Feb					
		Mar	96	Mar					
		Apr	96	Apr					
		May	96	May					
		Jun	96	Jun					
	Benchmark: 95th percentile	Jul	95	Jul		58			Action: Inpatient Service Line is working on the priority index to improve.
	Aug	95	Aug						
	Sep	95	Sep						
	Oct	95	Oct						
	Nov	96	Nov						
	Dec	96	Dec						
Patient Satisfaction-Press Ganey Overall Outpatient Rank (report quarterly)	CCH: Cheryl Crupi Julie Drake Diane Marino FH: Sue Wing	Goal: Top 5% of all facilities (95th percentile)	Jan	44	Analysis: CCH comparison to 100K-500K- N=281 gradual increase in rank score but remains well below goal. Action: All outpatient sites working with FH on a PI program to improve scores. Best practices are shared.	Jan	51	Analysis: Comparison 100K-150K, increase from 4Q09 score of 45% to 57th percentile in 4Q10.	
		Feb	44	Feb					
		Mar	25	Mar					
		Apr	25	Apr					
		May	25	May					
		Jun	25	Jun					
	Benchmark: 95th percentile	Jul	33	Jul		61			Action:
	Aug	33	Aug						
	Sep	33	Sep						
	Oct	33	Oct						
	Nov	46	Nov						
	Dec	46	Dec						
Patient Satisfaction - Press Ganey Overall ER Rank (report quarterly)	CCH: Kevin Bresnahan, MD Deb Robinson, RN FH: Rob Davis, MD Carole Kibner, RN	Goal: Top 5% of equivalent visits: (95th percentile)	Jan	99	Peer group = Goal met at 96th percentile ranking. Action: Sustain patient satisfaction	Jan	99	Analysis: Comparison 35K-50K, increase from 4Q09 score of 89th percentile, score in top 5% nationally compared to 4Q10 at the 99th percentile.	
		Feb	99	Feb					
		Mar	99	Mar					
		Apr	96	Apr					
		May	96	May					
		Jun	96	Jun					
	Benchmark: 95th percentile	Jul	94	Jul		99			Action: ED Service is working to maintain the gains.
	Aug	94	Aug						
	Sep	94	Sep						
	Oct	94	Oct						
	Nov	96	Nov						
	Dec	96	Dec						

These reports, findings and information are hereby designated as proceedings, records and reports of a medical peer review committee, are deemed confidential to the extent allowable and are not subject to subpoena, discovery or introduction into evidence. (M.G.L., c.111, s.204)

Cape Cod Healthcare
Quality and Safety Dashboard as of February 22, 2011
Core Measure Data through Quarter 3 2010

Opportunity Statement	Reporting Party	Goal/ Benchmark	CCH 2010		CCH Analysis/Action Plan	FH 2010		FH Analysis/Action Plan
Patient Satisfaction - Press Ganey Overall Oncology Rank (report quarterly)	CCH: John Ponte Kailen Ryan	Goal: Top 25% of(75th percentile)	Jan	73	Analysis: Press Ganey Rank Unmet Action: The CCH Cancer Center currently has 3 ongoing PI teams; patient education for Chemo side effects and Medical Oncology expectations, New patient scheduling and 1 for improvement of transition from inpatient to outpatient radiation therapy.	Jan		NA
			Feb					
			Mar					
			Apr					
			May					
			Jun					
		Benchmark: 95th percentile	Jul	66		Jul		
			Aug					
			Sep					
			Oct					
			Nov					
			Dec			37		
Feb								
Mar								
Apr								
May								
Jun	59	Jul						
Aug								
Sep								
Oct								
Nov								
Dec								