OREGON OFFICE of RURAL HEALTH

39th Annual Oregon
Rural Health Conference

OPPORTUNITY Just knock.

Presents

Care Compare Methodology Changes & Response for Agile Improvement

Speakers:

Meg Linza, MSN, RN, CPHQ, CPHRM - Director of Quality, Risk, Clinical Education, & Employee Health

Brett Byers, BSN, RN, CPHQ - Quality Nurse Specialist

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Care Compare Methodology Changes & Response for Agile Improvement

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Quality Nurse Specialist

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10/12/22

Neither presenter has any conflicts of interest to disclose.

Intent of Star Ratings on Care Compare

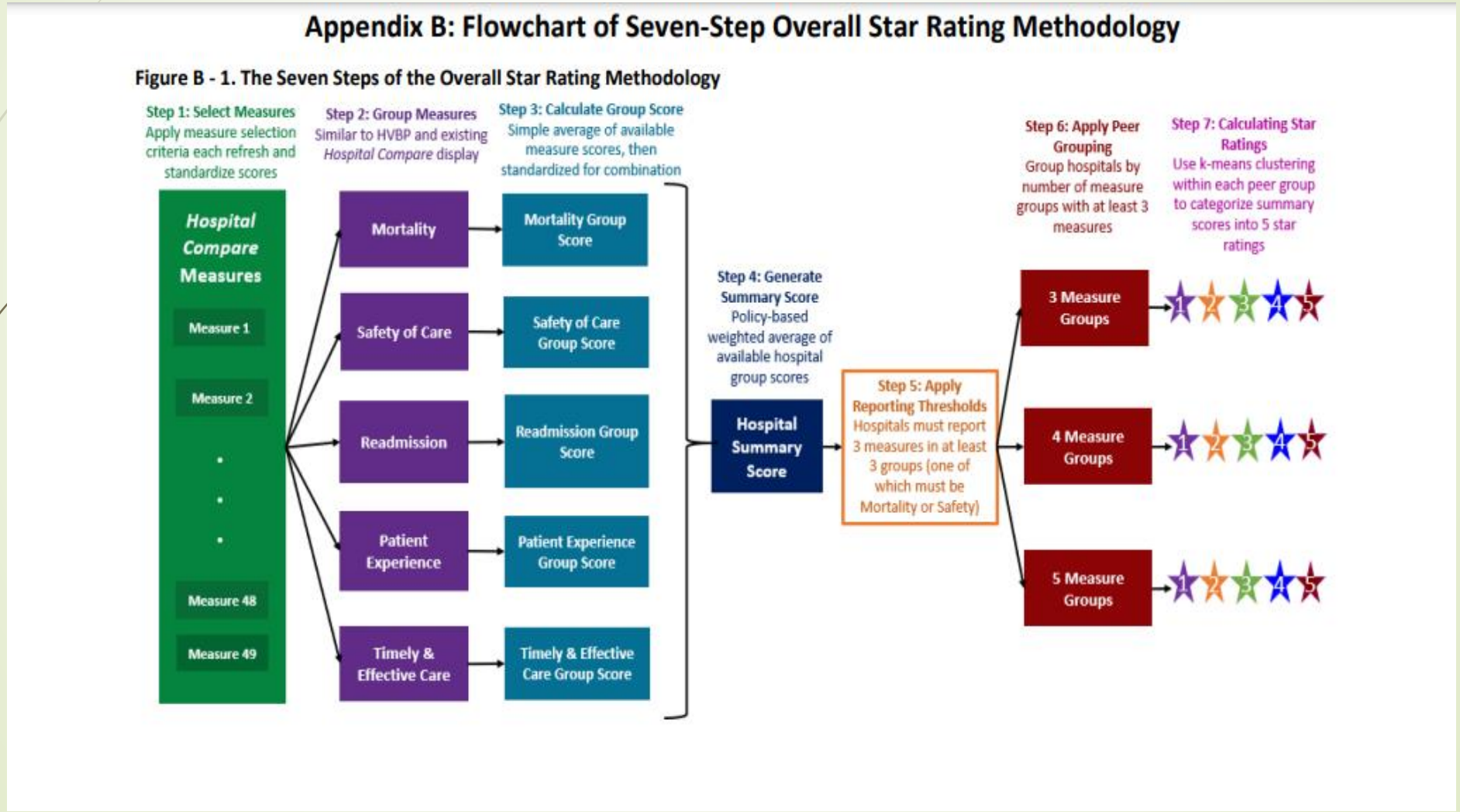
- A provocative discussion of whether Care Compare Ratings are meeting the intent of the Star Ratings for healthcare consumers.
- Data may be up to 2 years old, difficult to affect change.
- Changes in Healthcare in the US, especially during the Pandemic
- Changes in methodology on top of changes in what measures matter. Recommendation: Change methodology then allow for opportunity for improvement before posting results in a star rating in the future.
- Discourages reporting if measures score low due to overall low “n”.
- Concern over consumer confidence when choices are few for hospital/clinic choices in rural communities.

Our Response to Understand

- Months of Chart Reviews and questions to CMS. Review of findings with governing bodies/boards.
- Questions with Cerner partners on Claims-based and process reporting abstracts.
- Many OR and WA hospitals chose to not publish (CAHs have the ability to opt-out of publishing star ratings on Care Compare)
- When hospitals choose to withhold it defeats the intent of Care Compare.
- In 2021 (WA State CAH 17/38 reported. OR CAH 17/24 reported-11 OR) Our CAH fell w/in the #4 Measure Grouping
- Consult with CAH colleagues and OHSU partners to learn from their experience.

Review of Methodology Changes

- V4.1



Safety or Mortality as Process Measures required and weighted 22%

- No credit for HAI success of no reportable findings
- HAIs are challenging for CAHs-low “n”, and Predicted score < 1
- In our case Safety of Care-reflective only of C-diff cases/and clinical review proved only 2 were potentially HAI
  ** Review cases and educate on the timing of testing. Your IP is critical for these surveillance cases.

Story of C-diff and HAI Continued:

Measure Name [c]	Your Hospital's Measure Result [d]	Measure Performance Category [e]	Measure's National Mean of Scores [f]	Measure's Standard Deviation Across Hospitals [g]	Your Hospital's Standardized Measure Score [h]	Measure Weight [i]	Measure Score	Measure Group Score [d] from Table 2
Central-Line Associated Bloodstream Infection (CLABSI)	N/A	N/A	0.692	0.63	N/A	0.0%		
Catheter-Associated Urinary Tract Infection (CAUTI)	N/A	N/A	0.719	0.58	N/A	0.0%		
Surgical Site Infection from Colon Surgery (SSI-colon)	N/A	N/A	0.812	0.66	N/A	0.0%		
Surgical Site Infection from Abdominal Hysterectomy (SSI-abdominal hysterectomy)	N/A	N/A	0.927	0.89	N/A	0.0%		
MRSA Bacteremia	N/A	N/A	0.813	0.66	N/A	0.0%		(1.98)
Clostridium Difficile (C.difficile)	2.519	Same	0.584	0.47	-4.08	50.0%	(2.04)	
Hospital-Level Risk-Standardized Complication Rate (RSCR) Following Elective Primary Total Hip Arthroplasty (THA) and Total Knee Arthroplasty (TKA)	2.4%	Same	2.5%	0.005	0.11	50.0%	0.06	
Patient Safety and Adverse Events Composite	N/A	N/A	0.99	0.19	N/A	0.0%		

Q. How would CMS calculate an Overall Star Rating for a small hospital with few measures on Care Compare?

A. If the hospital meets the minimum threshold requirements (three measure groups with three measures per group, one of which must specifically be Mortality or Safety of Care), then the Overall Star Rating will be reported using the same methodology used for hospitals with many measures. If the hospital does not meet the minimum requirement, then it will not receive an Overall Star Rating.

2021 Range Summary

Star Classification

Table 9 shows the range of summary scores for each star category within each peer group.

Table 9. K-means Overall Star Rating summary score ranges for April 2021, by peer group*

Rating	3-measure group peer group (n=337)	4-measure group peer group (n=553)	5-measure group peer group (n=2,465)
1 Star	-2.69, -0.73	-2.85, -0.69	-2.21, -0.87
2 Star	-0.71, -0.21	-0.67, -0.03	-0.87, -0.41
3 Star	-0.19, 0.24	-0.02, 0.42	-0.41, -0.04
4 Star	0.25, 0.69	0.43, 0.89	-0.04, 0.34
5 Star	0.72, 2.40	0.91, 1.91	0.35, 1.39

*Shows results for the 3,355 hospitals that met the reporting criteria.

Key Takeaways:

- Know your data and where it is extracted from Claims or Process-EHR data.
- Work closely with IT/Business Intelligence partners.
- Create a year-over-year comparison to highlight the areas where the organization can impact the results.
- Share this information to encourage efforts and motivate your teams. (It takes a village)
- Begin now to track and with continuous process improvement will see results in 2-3 years when the data will catch up.

3. Key Take away

Methodology Change

a.) Peer Group reduced from ~3700 hospitals to 553 hospitals-narrowing the room for error and making the middle-high performance more competitive

b.) In prior methodology, some measures would have carried a more significant load than others based on various factors. Current methodology weights all measures in a measure group the same using a simple average. Difficult with small numbers and when predicted value <1 where measure no longer counts towards overall weight, as in Safety Measures (HAI).

References/Resources

Q Net

https://qualitynet.cms.gov/inpatient/public-reporting/overall-ratings

Measure Dates

https://data.cms.gov/provider-data/dataset/4j6d-yzce

IQR Webinars

https://qualitynet.cms.gov/inpatient/iqr/webinars

Compare Data Dictionary

https://data.cms.gov/provider-data/topics/hospitals

Quality Reporting Center

https://www.qualityreportingcenter.com/en/contact-us/

Methodology Questions

https://cmsqualitysupport.servicenowservices.com/qnet_qa?id=ask_a_question

QualityNet Help Desk

qnetsupport@hcqis.org

Questions?
Comments?

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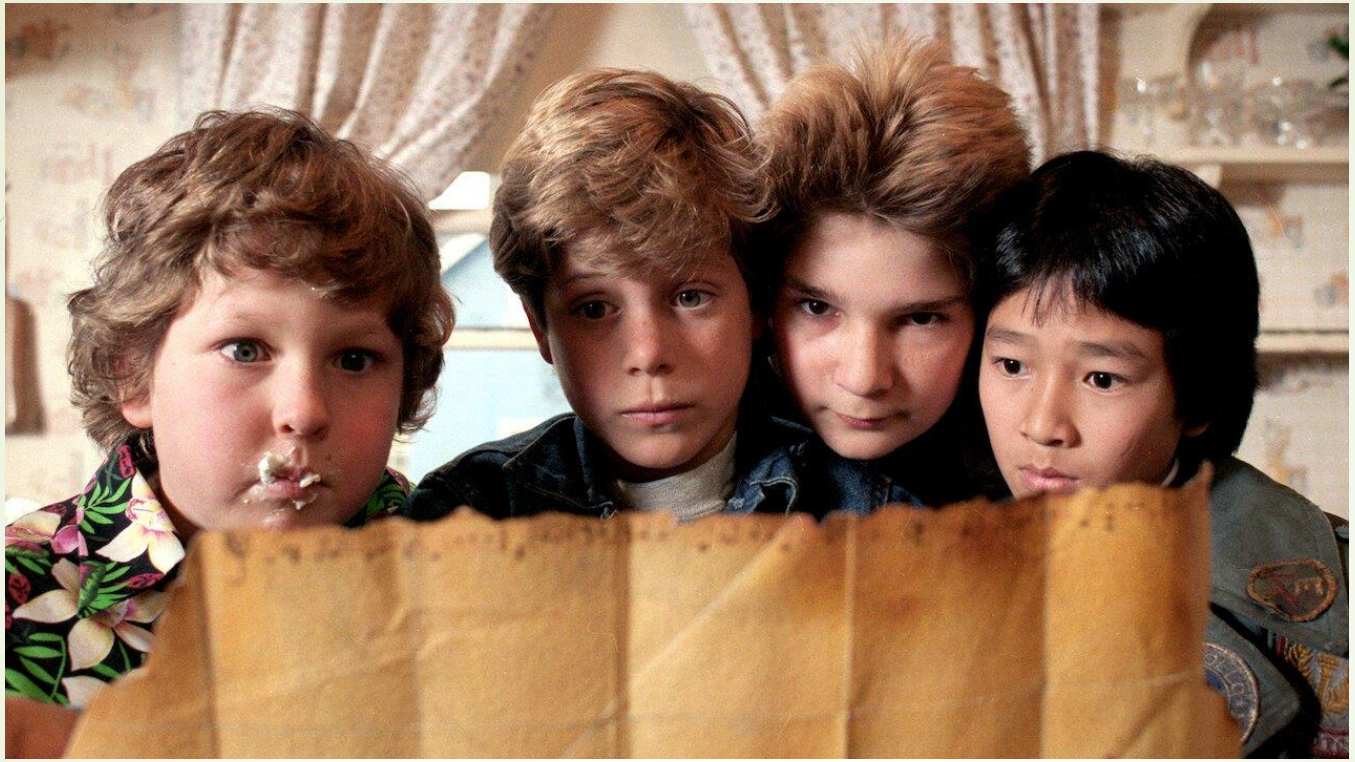

How did we respond?

5 stages of grief- Denial, Anger, Bargaining, Depression, Acceptance!

How do we get there?

Charting the course for data monitoring and performance improvement

Creating tools

Use your tools. Make new tools. EHR, CMS, tracker, Vendors, etc

Measure	April 2021 w/ data collection period Benchmarks s=state, n=national		July 2021 preview report w data collection period. Benchmarks s=state, n=national		October 2021 Preview Report w/ data collection period Benchmarks s=state, n=national		January 2022 Preview Report w/ data collection period Benchmarks s=state, n=national		July 2022 Preview Report w/ data collection period Benchmarks s=state, n=national		October 2022 Preview Report w/ data collection period Benchmarks s=state, n=national		Quality Improvement Actions	Links for more detailed information
OP-18b Median Time from ED Arrival to ED Departure for Discharged ED Patients *(Lower is better)*	124 mins (s=119, n=113) (380 pts)	Q1 (2019) - Q4 (2019)	133 mins (s=121, n=115) (193 pts)	Q4 (2019) - Q3 (2020)	131 mins (s=126, n=129) (197 pts)	Q3 (2020) - Q4 (2020)	134 mins (s=133, n=125) (291 pts)	Q3 (2020) - Q1 (2021)	134 mins (s=162, n=155) (388 pts)	Q4 (2020)- Q3 (2021)	134 mins (s=137, n= 155) (389 pts)	Q1 (2021)- Q4 (2021)		https://qualitynet.cms.gov/files/61ae3ce537d7ec0022baddd5?filename=1d_ED_Throughput_set_v15.0a.pdf
OP-18c Median Time from ED Arrival to ED Departure for Discharged ED Patients - Psychiatric/Mental Health Patients *(Lower is better)*	151 mins (s=159, n=179) (28 pts)	Q1 (2019) - Q4 (2019)	141 mins (s=166, n=181) (12 pts)	Q4 (2019) - Q3 (2020)	134 mins (s=184, n=186) (8 pts)	Q3 (2020) - Q4 (2020)	164 mins (s=216, n=248) (14 pts)	Q3 (2020) - Q1 (2021)	164 mins (s=250, n=254) (22 pts)	Q4 (2020)- Q3 (2021)	153 mins (s=204, n=204) (23 pts)	Q1 (2021)- Q4 (2021)		https://qualitynet.cms.gov/files/61ae3ce537d7ec0022baddd5?filename=1d_ED_Throughput_set_v15.0a.pdf
OP-22 Left Without Being Seen *(Lower is better)*	1% (s=2%, n=2%) (14,161 pts)	Q1 (2019) - Q4 (2019)	1% (s=2%, n=2%) (14,665 pts)	Q1 (2019) - Q4 (2019)	1% (s=2%, n=2%) (14,665 pts)	Q1 (2019) - Q4 (2019)	1% (s=2%, n=2%) (12,126 pts)	Q1 (2020) - Q4 (2020)	1% (s=2%, n=2%) (12,126 pts)	Q1 (2020) - Q4 (2020)	1% (s=2%, n=2%) (12,126 pts)	Q1 (2020) - Q4 (2020)		https://qualitynet.cms.gov/files/61ae3ce537d7ec0022baddd5?filename=1d_ED_Throughput_set_v15.0a.pdf
OP-23 Head CT or MRI Scan Results for Acute Ischemic Stroke or Hemorrhagic Stroke Patients who Received Head CT or MRI Scan Interpretation Within 45 Minutes of ED Arrival *(higher is better)*	40% (s=64%, n=72%) (15 pts)	Q1 (2019) - Q4 (2019)	25% (s=66%, n=72%) (8 pts)	Q4 (2019) - Q3 (2020)	11% (s=68%, n=72%) (9 pts)	Q3 (2020) - Q4 (2020)	18% (s=67%, n=72%) (11 pts)	Q3 (2020) - Q1 (2021)	38% (s=67%, n=71%) (8 pts)	Q4 (2020)- Q3 (2021)	57% (s=66%, n=70%) (7pts)	Q1 (2021)- Q4 (2021)	Debbi O shared data with Dr Gena (ED). Quality RNs changed measure validation process (10/21). Plans to create workgroup consisting of ED mgr, ED Med Director, Quality, and Imaging mgr to correct this issue (5/22)	https://qualitynet.cms.gov/files/61ae3cfc30ffbc00229c3629?filename=1f_Stroke_set_v15.0a.pdf
Healthcare Personnel Vaccination														
IMM-3 Infuenza Vaccination Coverage among Healthcare Personnel *(higher is better)*	n/a	Q4 (2019) - Q1 (2020)	n/a	Q4 (2019) - Q1	89% (s=71%, n=86%)	Q4 (2020) - Q1 (2021)	89% (s=71%, n=86%)	Q4 (2020) - Q1 (2021)	89% (s=71%, n=86%)	Q4 (2020) - Q1 (2021)	81% (s=66%, n=80%)	Q4 (2021)- Q1 (2022)		https://cmit.cms.gov/CMIT_public/ReportMeasure?measureId=2577
HCP-COVID-19 Covid-19 Vaccination Coverage Among Helathcare Personnel *(higher is better)*											n/a		new for 2022. Not required for CAHs at this time	
Perinatal Care														
PC-01 Early Elective Delivery 37-39 weeks *(lower is better)*	0% (s=2%, n=2%) (21 pts)	Q1 (2019) - Q4 (2019)	12% (s=1%, n=3%) (8 pts)	Q4 (2019) - Q3 (2020)	12% (s=1%, n=3%) (8 pts)	Q3 (2020) - Q4 (2020)	8% (s=1%, n=3%) (12 pts)	Q3 (2020) - Q1 (2021)	17% (s=2%, n=2%) (18 pts)	Q4 (2020)- Q3 (2021)	19% (s=2%, n=2%) (16pts)	Q1 (2021)- Q4 (2021)	Brett B. presented at Nov.2021 MCC meeting. Offered education to providers about alternative dx codes when applicable	https://cmit.cms.gov/CMIT_public/ViewMeasure?MeasureId=5893
Cardiac Care														
OP-2 Fibrinolytic Therapy Received Within 30 Minutes of ED Arrival *(higher is better)*	60% (s=30%, n=58%) (5 pts)	Q1 (2019) - Q4 (2019)	50% (s=25%, n=54%) (2 pts)	Q4 (2019) - Q3 (2020)	0% (s=31%, n=52%) (2 pts)	Q3 (2020) - Q4 (2020)	0% (s=25%, n=52%) (2 pts)	Q3 (2020) - Q1 (2021)	0% (s=26%, n-53%) (2pts)	Q4 (2020) - Q3 (2021)	n/a (0pts)	Q1 (2021)- Q4 (2021)		https://qualitynet.cms.gov/files/61ae3cd037d7ec0022baddd2?filename=1b_AMI_set_v15.0a.pdf
OP-3b Median Time to Transfer to Another Facility for Acute Coronary Intervention - Reporting Rate *(lower is better)*	247 mins (s=51, n=58) (1 pts)	Q1 (2019) - Q4 (2019)	186 mins (s=49, n=58) (2 pts)	Q4 (2019) - Q3 (2020)	124 mins (s=58, n=61) (1 pts)	Q3 (2020) - Q4 (2020)	124 mins (s=57, n=61) (1 pts)	Q3 (2020) - Q1 (2021)	0 cases	Q4 (2020) - Q3 (2021)	172 mins (s=60, n=62) (1 pt)	Q1 (2021)- Q4 (2021)		https://qualitynet.cms.gov/files/61ae3cd037d7ec0022baddd2?filename=1b_AMI_set_v15.0a.pdf
Cancer Care														

Measure *(nb= national benchmark 'mean' provided by Medisolv from over 200 hospitals. As of January 2022 there are no federally published benchmarks)*	Q1 2020	Q2 2020	Q3 2020	Q4 2020	Q1 2021	Q2 2021	Q3 2021	Q4 2021	Q1 2022	Q2 2022	Q3 2022	Q4 2022	Quality Improvement Actions	Links for more detailed information
Stroke														
STK-2 Ischemic stroke patients prescribed or continuing to take antithrombotic therapy at hospital discharge *(higher is better)*	75% (4 pts)	100% (5 pts)	100% (6 pts)	83% (6 pts)	80% (nb=78%) (6 pts)	100% (nb=82%) (2 pts)	100% (nb=79%) (9 pts)	100% (8 pts)	100% (7pts)	100% (6 pts)				https://ecqi.healthit.gov/ecqm/eh/2022/cms104v10
STK-3 Ischemic stroke patients with atrial fibrillation/flutter who are prescribed or continuing to take anticoagulation therapy at hospital discharge *(higher is better)*	50% (2 pts)	N/A (0 pts)	100% (1 pts)	50% (2 pts)	100% (nb=51%) (1 pts)	N/A (nb=41%) (0 pts)	0% (nb=44%) (1 pts)	0% (1 pts)	100% (1pt)	50% (1/2pts)				https://ecqi.healthit.gov/ecqm/eh/2022/cms071v11
STK-5 Ischemic stroke patients administered antithrombotic therapy by the end of hospital day 2 *(higher is better)*	100% (4 pts)	80% (5 pts)	67% (3 pts)	100% (5 pts)	100% (nb=80%) (3 pts)	N/A (nb=84%) (0 pts)	100% (nb=82%) (6 pts)	83% (6 pts)	100% (8pts)	100% (5/5pts)				https://ecqi.healthit.gov/ecqm/eh/2022/cms072v10
STK-6 Ischemic stroke patients who are prescribed or continuing to take statin medication at hospital discharge *(higher is better)*	75% (4 pts)	100% (5 pts)	100% (6 pts)	83% (6 pts)	80% (nb=76%) (5 pts)	100% (nb=78%) (2 pts)	100% (nb=76%) (9 pts)	100% (8 pts)	85.7% (6/7 pts)	66.7% (4/6pts)				https://ecqi.healthit.gov/ecqm/eh/2022/cms105v10
VTE Prophylaxis														
VTE-1 This measure assesses the number of patients who received VTE prophylaxis or have documentation why no VTE prophylaxis was given the day of or the day after hospital admission or surgery end date for surgeries that start the day of or the day after hospital admission *(higher is better)*	65% (166 pts)	72% (104 pts)	77% (127 pts)	59% (136 pts)	64% (nb=85%) (123 pts)	60% (nb=85%) (128 pts)	73% (nb=86%) (178 pts)	77% (127 pts)	71.1 % (135 pts)	75.4% (122 pts)			Presentation given to ACS supervisor on 1.10.22 re: eCQM data and areas for improvement. Will f/u in Q2 2022 re: Quality Improvement Projects for VTE prophylaxis measures. June '22- Brett B and Emily C presented to ACS retreats x4. July '22- Brett B presented to Dr. Durrani, lead Hospitalist	https://ecqi.healthit.gov/ecqm/eh/2022/cms108v10
VTE-2 This measure assesses the number of patients who received VTE prophylaxis or have documentation why no VTE prophylaxis was given the day of or the day after the initial admission (or transfer) to the Intensive Care Unit (ICU) or surgery end date for surgeries that start the day of or the day after ICU admission (or transfer) *(higher is better)*	89% (72 pts)	74% (50 pts)	79% (58 pts)	78% (60 pts)	73% (nb=79%) (66 pts)	68% (nb=80%) (53 pts)	74% (nb=76%) (73 pts)	79% (58 pts)	73.1% (52 pts)	76.3% (86 pts)				https://ecqi.healthit.gov/ecqm/eh/2022/cms190v10
Safe Use of Opioids														
n/a Proportion of inpatient hospitalizations for patients 18 years of age and older prescribed, or continued on, two or more opioids or an opioid and benzodiazepine concurrently at discharge *(lower is better)*	measure was new in 2021				10.3% (nb=22%) (117 pts)	11.6% (nb=21%) (138 pts)	16.4% (nb=20%) (128 pts)	14.5% (124 pts)	13.4% (134 pts)	10.3% (126 pts)				https://ecqi.healthit.gov/ecqm/eh/2022/cms506v4

Measure	Q1 2020 S= state benchmark	Q2 2020 S= state benchmark	Q3 2020 S= state benchmark	Q4 2020 S= state benchmark	Q1 2021 S= state benchmark	Q2 2021 S= state benchmark	Q3 2021 S= state benchmark	Q4 2021 S= state benchmark	Q1 2022 S= state benchmark	Q2 2022 S= state benchmark	Q3 2022 S= state benchmark	Q4 2022 S= state benchmark	Quality Improvement Actions	Links for more detailed information
Measures on Quality Dashboard														
Hemorrhage Risk Assessment on Admission Did the mother have hemorrhage risk assessments - with risk level assigned - performed on admission to labor and delivery and on admission to postpartum? This is in alignment with the Joint Commission Maternal Safety Standards for Hemorrhage. *(higher is better)*	70.80% (s=97%) (65 pts)	64.50% (s=97%) (76 pts)	81.50% (s=97%) (81 pts)	78.70% (s=42%) (61 pts)	5% (s=94%) (61 pts)	0% (s=93%) (0/57 pts)	6.80% (s=94%) (4/59 pts)	15.10% (s=94%) (8/53 pts)	26.30% (s=95%) (15/57 pts)	56.90% (29/51 pts)			Brett B. presented at Nov. MCC meeting. FBC nurses to implement new workflow Jan 2022	https://safehealthcareforeverywoman.org/aim/patient-safety-bundles/maternal-safety-bundles/obstetric-hemorrahage-patient-safety-bundle-2/
PC-01 Early Elective Delivery Elective vaginal or cesarean deliveries among 37/38 week deliveries (excluding cases with complications) *(lower is better)*	0% (s=1.9%) (3 pts)	0% (s=3.7%) (6pts)	25% (s=3.2%) (4pts)	0% (s=2.3%) (4 pts)	0% (s=4.0%) (4pts)	50% (s=4.4%) (4 pts)	16.70% (s=6.8%) (6 pts)	0% (s=3.6%) (2 pts)	0% (s=5.6%) (3 pts)	0% (5 pts)			Brett B. presented at Nov. MCC meeting. Offered education to providers about alternative dx codes when applicable	https://qualitynet.cms.gov/files/61ae3cd037d7e0022baddd2?filename=1b_AMI_set_v15.0a.pdf
Cesarean After Labor Induction Induced deliveries that resulted in a cesarean (regardless of the reason for the cesarean). Formerly named "Failed Inductions" *(lower is better)*	11.80% (s=19.6%) (17 pts)	19.40% (s=20.6%) (31 pts)	9.80% (s=19.1%) (41 pts)	14.30% (s=19.6%) (28 pts)	19.20% (s=19.6%) (26pts)	10.70% (s=19.3%) (28 pts)	3.60% (s=20.6%) (28 pts)	20.80% (s=20.5%) (24pts)	15.40% (s=20.6%) (4/26 pts)	18.50% (5/27 pts)				
Cesarean Delivery Measures														
Cesarean Birth: Overall This is the most basic of all cesarean measures but is not endorsed by any quality organization. It mixes mothers with very different issues--notably mothers with prior cesarean births (who have a 90% rate of repeat cesarean) and mothers who are at much lower risk (including those with prior vaginal deliveries and no risk factors). Also known as the the "Total Cesarean Rate".	21.50% (s=21.9%) (65 pts)	31.60% (s=30.3%) (76 pts)	22.20% (s=29.6%) (81 pts)	21.30% (s=28.9%) (61 pts)	24.60% (s=28.8%) (61 pts)	28.10% (s=29.9%) (57 pts	16.9% (s=30.2%) (59 pts)	32.1% (s=30.6%) (17/53pts)	26.30% (s=29.6%) (15/57 pts)	33.30% (17/51 pts)				
Cesarean Birth: Primary Cesarean deliveries among all deliveries without a prior cesarean. While the Primary Cesarean rate is an improvement over the Overall (Total) Cesarean rate, it is not endorsed by any quality organization, nor are there any established targets for this measure.	17.70% (s=20.6%) (62 pts)	22.70% (s= 21.5%) (66 pts)	17.30% (s=20.9%) (75 pts)	15.80% (s=19.9%) (57 pts)	16.40% (s=20.2%) (55 pts)	19.60% (s=22.2%) (51 pts)	10.90% (s=21.4%) (55 pts)	28% (s=21.9%) (14/50 pts)	16% (s=21.4%) (8/50 pts)	22.70% (10/44 pts)				
Cesarean Birth: NTSV Cesarean births among Nulliparous, Term, Singleton, Vertex (NTSV) deliveries. The PC-02-Current version uses the most current Joint Commission (TJC) PC-02 measure specifications retrospectively applied to all prior time periods. This allows for accurate trending, even as the TJC specifications have changed over time.	18.50% (s=25.1%) (27 pts)	31.30% (s=25.6%) (32 pts)	25.70% (s=24.9%) (35 pts)	29.20% (s=24.8%) (24 pts)	21.20% (s=24.4%) (33 pts)	20.00% (s=25.6%) (20 pts)	16.70% (s=25.3%) (24 pts)	28.60% (s=27%) (6/21 pts)	21.70% (s=24.3% (5/23 pts)	25% (5/20 pts)				
Vaginal Delivery Measures														
Episiotomy Rate Episiotomy procedures among all vaginal deliveries without shoulder dystocia See more details. This measure is endorsed by NQF and the Leapfrog Group, which recommends a **target episiotomy rate of <5%** based on population studies. While statewide episiotomy rates have fallen rapidly in the last decade, there is still wide variation among hospitals (0.3% to 35%)--suggesting opportunities for improvement. *(lower is better)*	2% (s=3.2%) (49 pts)	0% (s=3.4%) (52 pts)	1.70% (s=2.9%) (59 pts)	0% (s=2.9%) (48 pts)	0% (s=2.8%) (46 pts)	0% (s=2.5%) (41 pts)	4.30% (s=2.4%) (47 pts)	0% (s=2.5%) (36 pts)	0% (s=2.4%) (0/41 pts)	0% (0/32 pts)				
	16.90%	23.70%	24.70%	31.10%	29.50%	26.30%	35.60%	24.50%	15.80%	21.60%				

Measure	Q1 2020 S= state benchmark	Q2 2020 S= state benchmark	Q3 2020 S= state benchmark	Q4 2020 S= state benchmark	Q1 2021 S= state benchmark	Q2 2021 S= state benchmark	Q3 2021 S= state benchmark	Q4 2021 S= state benchmark	Q1 2022 S= state benchmark	Q2 2022 S= state benchmark	Q3 2022 S= state benchmark	Q4 2022 S= state benchmark
Adverse Drug Events												
Anticoagulation Safety Excessive Anticoagulation with Warfarin-Inpatients. Number of patient events with an INR > 5 after any warfarin administration for patients cared for in an inpatient area. A patient that has multiple elevated INRs will be counted as sone event until it drops below 3.5 and rises above 5 again. *(lower is better)*	18.75% 3/16 pts	0% 0/12 pts	0% 0/9 pts	4.76% 1/21 pts	10% 2/20 pts	4.76% 1/21 pts	16.67% 2/12 pts	10% 1/10 pts	0% 0/19 pts	0% 0/9 pts		
Glycemic Safety Percent of inpatients receiving a glycemic agent with blood glucose < 50. Number of patient BG levels < 50 mg/dl after any hpoglycemic agent adminstration for patients cared for in an inpatient area. *(lower is better)*	1.43% 1/70 pts	0% 0/42 pts	0% 0/50 pts	1.23% 0/81 pts	5.55% 6/110 pts	0% 0/91 pts	5.49% 5/91 pts	0% 0/93 pts	5.63% 4/71 pts	0% 0/81 pts		
Opioid Safety Percent of inpatients receiving Naloxone after Opioid Administration. Number of patients cared for in an inpatient area who received naloxone < 24 hours after any opioid administration related to over sedation. *(lower is better)*	0.81% 2/246 pts	0.60% 1/166 pts	0% 0/224 pts	0.78% 2/257 pts	0% 0/235 pts	0.37% 1/270 pts	0.63% 2/315 pts	0% 0/268 pts	0% 0/259 pts	0% 0/224 pts		
Patient Safety Indicators												
VTE Peri-Operative Pulmonary Embolism (PE) or Deep Vein Thrombosis (DVT) Rate, per 1000 surgical discharges. Discharges, among cases meeting the inclusion and exclusion rules for the denominator, with a secondary ICD-10-CM diagnosis code for proximal deep vein thrombosis (DEEPVIB *) or a secondary ICD-10-CM diagnosis code for pulmonary embolism (PULMOID *). *(lower is better)*	0% 69 pts	0% 8 pts	0% 11 pts	0% 48 pts	0% 66 pts	0% 65 pts	0% 53 pts	0% 51 pts	0% 0/57 pts	0% 0/61 pts		
Pressure Ulcer Hospital Acquired Pressure Injury Rate. Discharges, among cases meeting the inclusion and exclusion rules for the donominator, with any secondary ICD-10-CM diagnosis codes for pressure ulcer and any secondary ICD-10-CM diagnosis codes for pressure ulcer stage III or IV (or unstageable) (DECUBVD *). *(lower is better)*	0% 24 pts	0% 9 pts	0% 16 pts	0% 110 pts	0% 134 pts	0% 145 pts	0% 162 pts	0% 114 pts	0% 0/117 pts	0% 0/105 pts		
Sepsis and Septic Shock Rate Mortatlity rate among patients with sepsis and septic shock. Number of inpatient hospital deaths, among cases meeting the inclusion and exclusion rules for the denominator. *(lower is better)*	0% 2 pts	0% 0 pts	0% 3 pts	0% 5 pts	0% 4 pts	0% 6 pts	0% 7 pts	0% 9 pts	0% 0/5 pts	0% 0/2 pts		

Anticipation

Waiting for the next report to drop

Not a magic tool.

This is me when the Tracker didn't solve all the world's problems

Celebrate the wins!

Close relationship with C-Suite and Board

Quarterly reports to BoT

Quality Directors in Oregon CAHs

Brighter days ahead!

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OPPORTUNITY Just knock.

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