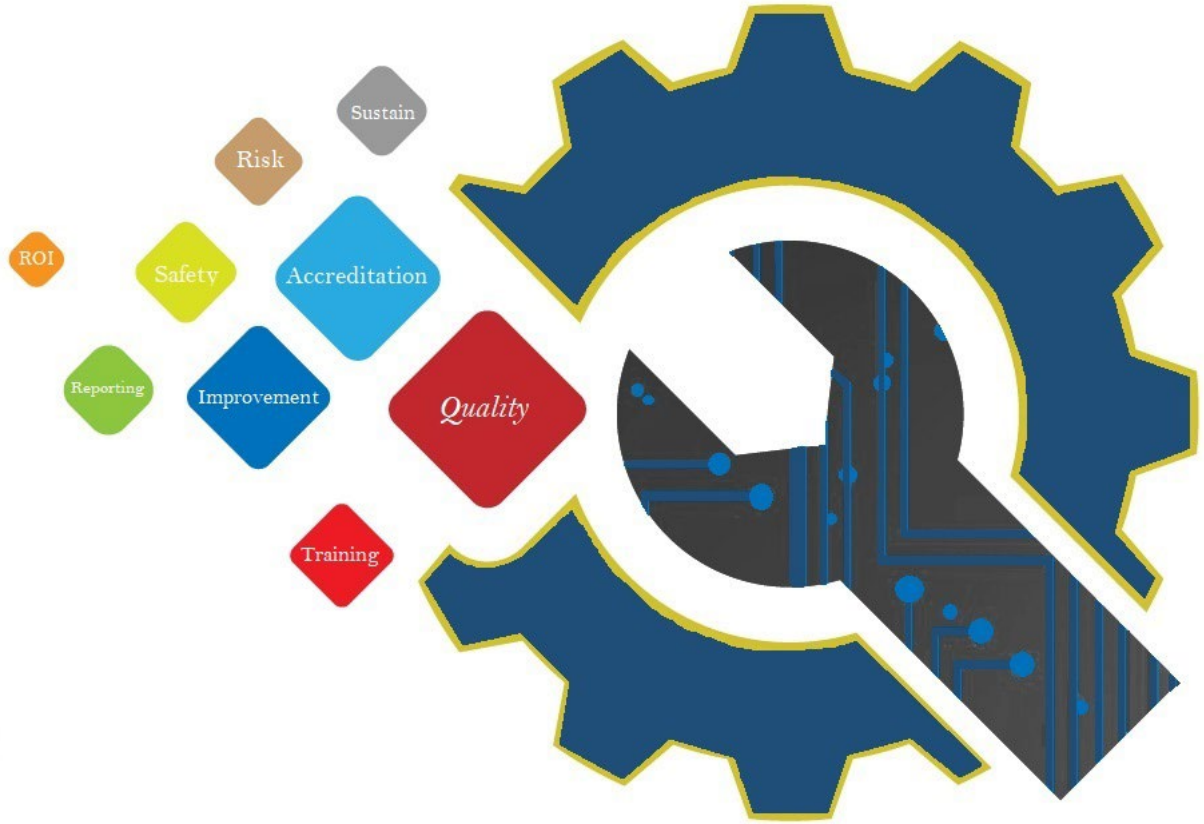
From Data to Action:

Leveraging Quality Metrics for Better Patient Care



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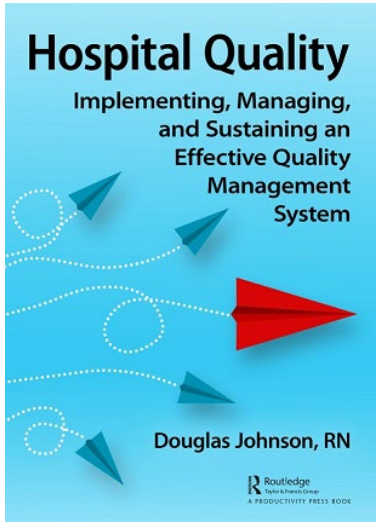
September 2025

Learning Objectives

- ✓ **Understand the Role of Measurement in Healthcare Quality** – Recognize how data-driven metrics support patient care improvements and quality oversight.
- ✓ **Apply the DIKW Framework** – Learn how to interpret and utilize data effectively, moving from raw information to actionable knowledge.
- ✓ **Identify Key Quality Metrics** – Discover which measurements are most relevant, timely, and impactful for continuous improvement.
- ✓ **Utilize Analytics Techniques** – Explore methods for monitoring, managing, and enhancing healthcare quality through data analysis.
- ✓ **Implement Meaningful Quality Improvement Strategies** – Gain practical insights on selecting the right measures at the right time for the right stakeholders.

Quality Management Program



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Quality Measurement and Analytics

Joint Commission:

LD.03.02.01 EP 4: For hospitals that use Joint Commission accreditation for deemed status purposes: The quality assessment and performance improvement program incorporates **quality indicator data**, including patient care data and other relevant data such as that submitted to or received from Medicare quality reporting and **quality performance programs** (for example, data related to hospital readmissions and hospital-acquired conditions).

LD.03.03.01: Leaders use hospital wide planning to establish structures and processes that **focus on safety and quality.**
EP 2 Planning is hospital wide, systematic, and involves **designated individuals** and information sources.

DNV:

QM1 SR1: The organization shall develop, implement, and maintain an ongoing **system for managing quality and patient safety.**

QM4 SR1: A **management representative shall be identified** by senior leadership and shall have the responsibility and authority, in conjunction with senior leadership, for ensuring that the requirements of the QMS are determined, implemented and maintained.

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Quality Measurement and Analytics

Accreditation Key Words related to Measurement and Analytics:

Techniques to **Analyze** and Display **Data** (PI.02.01.01)

Analyzes Data Collected (PI.02.01.01)

Uses the Results of **Data Analysis** (PI.02.01.01)

Planning…Information Sources (LD.03.03.01)

Collects **Data** to Monitor its Performance (PI.01.01.01)

Evaluate Culture of Safety and Quality (LD.03.01.01)

Provides Incidence **Data** (PI.02.01.01)

Data and Information Used Throughout the Hospital (LD.03.02.01)

Evaluate the Effectiveness (LD.03.05.01)

Reviews and **Analyzes** (PI.02.01.01)

Hospital **Analyzes** and Uses Information (LD.03.09.01)

Analyzes and Compares Internal Data Over Time (PI.02.01.01)

Quality Indicator **Data** (LD.03.02.01)

Identify the Frequency of **Data** Collection (PI.01.01.01)

Hospital Collects **Data**… (PI.01.01.01)

Patterns, Trends, or Variations in its Performance (PI.02.01.01)

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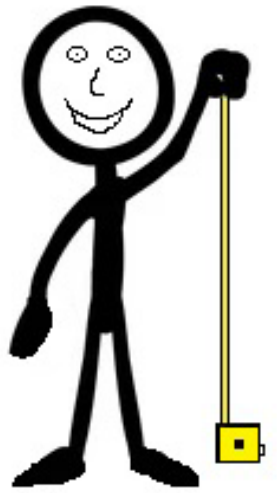
Quality **Role** in Measurement and Analytics



"If you can not measure it, you cannot improve it."

~William Thomson~

"Measurement is the first step that leads to control and eventually improvement. If you can't measure something, you can't understand it. If you can't understand it, you can't control it. If you can't control it, you can't improve it"

~H. James Harrington~

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BECKER'S
HOSPITAL REVIEW

Sharp drop in patient safety, infection control amid pandemic: 3 new findings

Gabrielle Masson - Monday, February 14th, 2022 Print | Email

Since the COVID-19 pandemic began, metrics tracking healthcare-associated infections and other complications of care indicate significant deterioration of multiple patient safety measures, according to an analysis published Feb. 12 by *The New England Journal of Medicine.*

Central line-associated bloodstream infections: 60 percent increase

Methicillin-resistant Staphylococcus aureus: 44 percent increase

Catheter-associated urinary tract infections: 43 percent increase

Reminder for Quality **Role** in Measurement and Analytics

Your role in quality is to turn & utilize data to move your organization up the Data-Information-Knowledge-Wisdom (DIKW) pyramid making it transparent to the entire organization.

Raw symbols, has no significance beyond its existence, it does not have meaning of itself

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Quality Measurement

Exercise:

Your organization is striving to achieve 5-Star CMS status. When you look at the measures that contribute to 5-Star, you identify your mortality measure for AMI is greater than expected:

Measure	Benchmark	50%tile	75%tile	Jan-20	Feb-20	Mar-20	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Total/YTD
Acute Myocardial Infarction (AMI) Mortality	5.0%	4.0%	2.7%	9.00%	9.00%	9.00%	15.30%	11.00%	10.60%	8.20%	9.80%	10.20%	10.29%	11.50%	12.80%	9.2%

You run a report of all AMI Mortalities from your data system – see data handout.

What do you do with this data?

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Quality Measurement

Engage clinicians and stakeholders

- What do they see as contributing reasons for the increased rate?
- What areas would they investigate to find root cause?

Obtain electronic information where available

- Based on the information available, what analysis can you perform?

Once background information is obtained, initiate a PDSA event

Quality Measurement – Turning Data into Information

What did we discover from the data set in our exercise?

ID	MRN	Age	Sex	Enc Start	Enc End	Proc Completed	Date of death	Present to LMC/HH ED	POV/EMS	OOH arrest	Intra-Op mortality	Transfer?	Transferring facility	Transfer hospital procedure
1	1000001	83	Male	1/12/2018	1/14/2018	PCI	1/14/2018	Yes	EMS	No	No	No	X	X
2	1000002	83	Female	1/24/2018	1/27/2018	CABG x3	1/27/2018	No	EMS	No	No	Yes	St. Vincent	coronary angiograph
3	1000003	56	Male	1/15/2018	1/20/2018	LHC	1/19/2018	Yes	EMS	Yes	No	No	X	X

Example questions that could be answered by the data:

- What ages consist of the most mortalities for AMI?
- Are there differences in mortality based on gender?
- Do some months have greater mortality than others? Days of the week?
- Is there a correlation between the procedure(s) performed and mortality?
- Does the arrival method have any significance?
- Do transfers to the facility from another facility have any significance?
- Do the notes outline any information that should be grouped together?

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Quality Measurement – Turning Data into Information

Data found in electronic systems does not provide all the information for finding the Root Cause or opportunities for improvement.

What data does do, if analyzed correctly, is eliminate subjective inferences about the causes.

- For Example:
  - "It is because of delays in transfers to our facilities from other hospitals so there is nothing we can do about it."
  - "Most are train wrecks, and they arrest outside of our facility."
  - "If patients would call EMS instead of driving themselves in, we would have better success."
  - "Our patients are the sickest of the sick so we can't be compared to other facility AMI rates."

Answering some of these questions before a PDSA can significantly increase your chances of moving towards real solutions.

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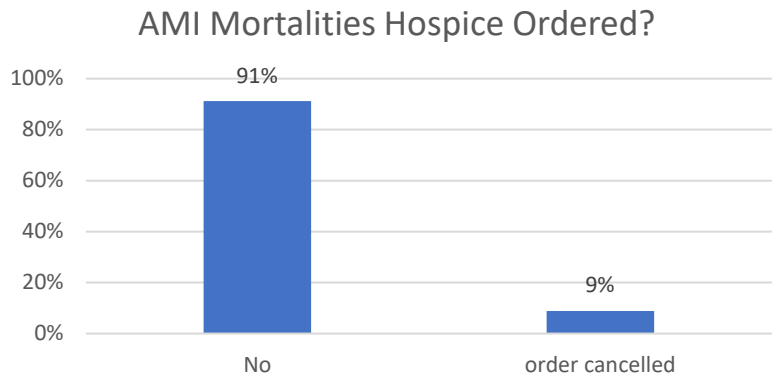
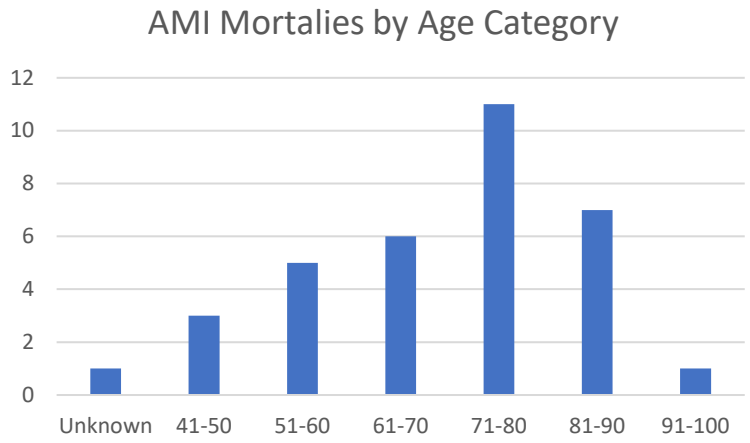
Quality Measurement – Turning Data into Information

Examples of questions that can be answered through our dataset:



"These patients should have been classified as hospice so they would not impact our inpatient mortality rate."

Data may support this statement



"What ages are these mortalities?"

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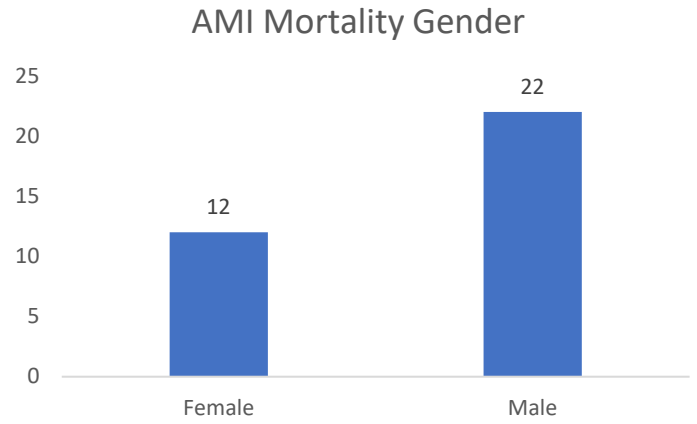
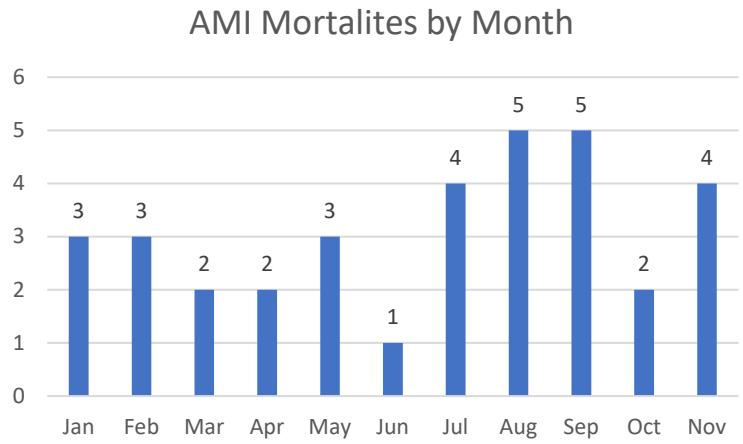
Quality Measurement – Turning Data into Information

Examples of questions that can be answered through our dataset:



"Is our mortality rate impacted more by women or men? Women tend to have more obscure symptoms for AMI"

65% are Men



"What time frame did these occur? Were they worse in May when we had part of the Cath lab down for remodel"

There is not a significant increase in May

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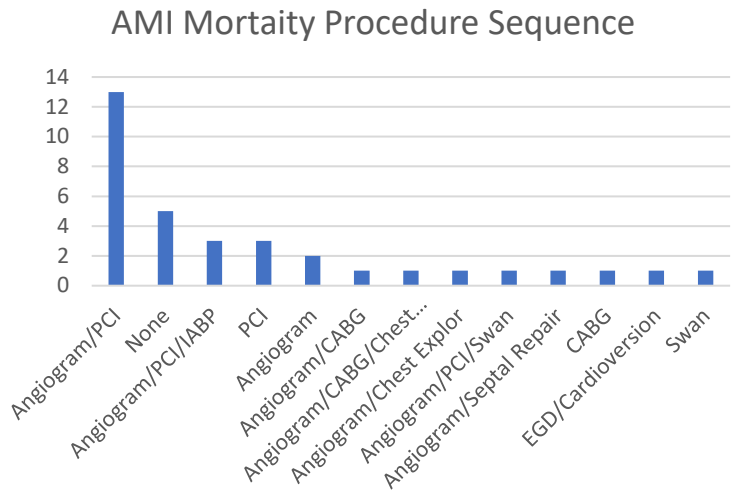
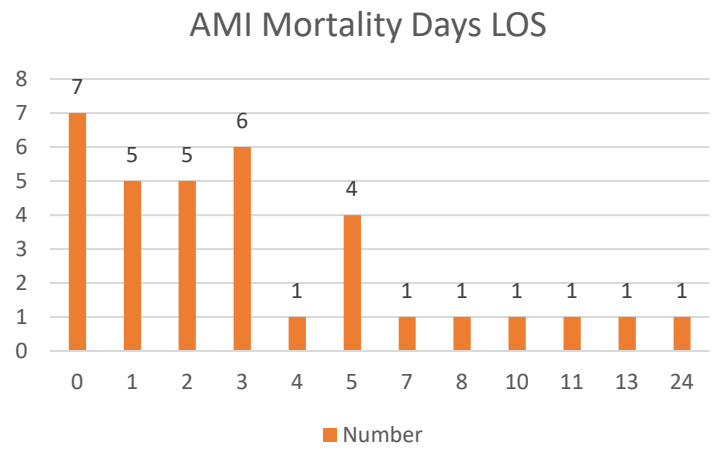
Quality Measurement – Turning Data into Information

Examples of questions that can be answered through our dataset:



"What procedures were most related to those that had a mortality?"

Highest procedure is PCI which you would expect for AMI



"Most come in very sick and there is little we can do about it - What was their inpatient LOS before expiring? "

35% occur in the first day, however 65% do not

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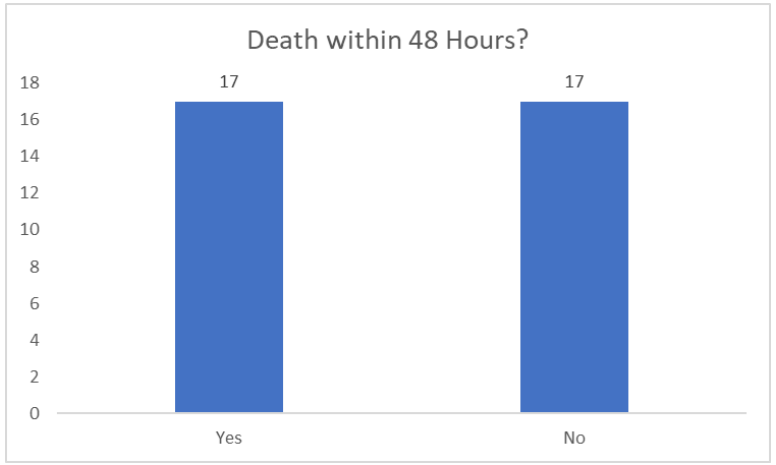
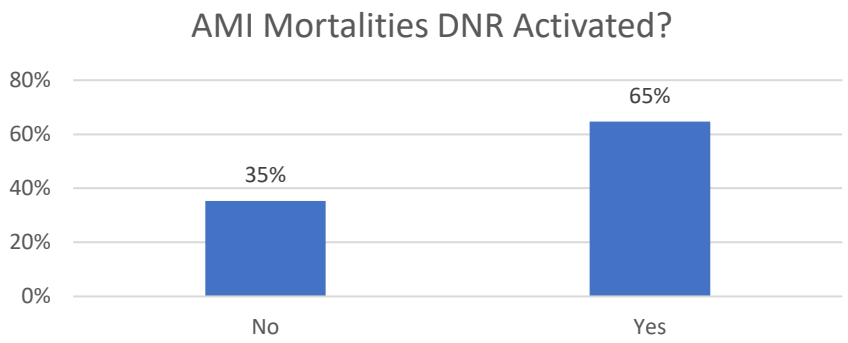
Quality Measurement – Turning Data into Information

Examples of questions that can be answered through our dataset:



"Most come in very sick and there is little we can do about it"

Half died within 48 hours



"They are all probably DNR"

Many are, but 35% are not

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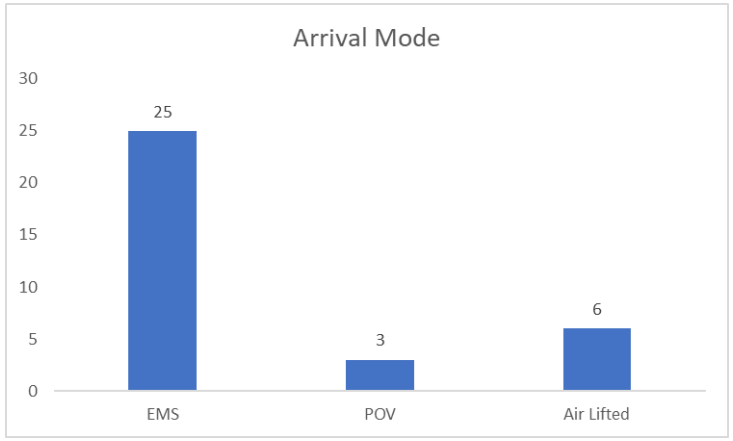
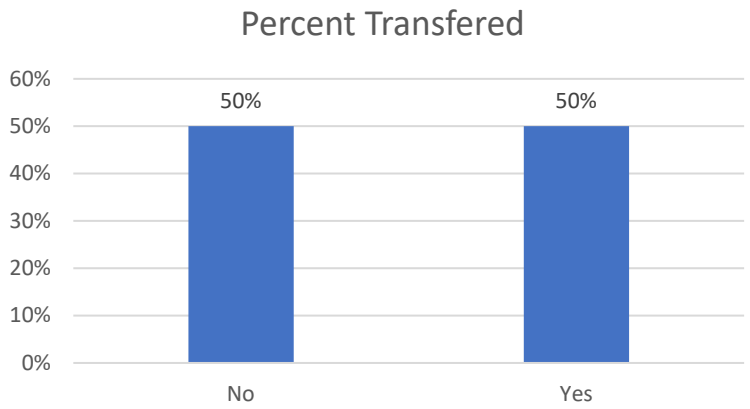
Quality Measurement – Turning Data into Information

Examples of questions that can be answered through our dataset:



"If patients would call EMS instead of driving themselves in, we would have better success."

Only 3 patients came by POV



"It is because of delays in transfers to our facilities from other hospitals so there is nothing we can do about it."

Only half were transfers

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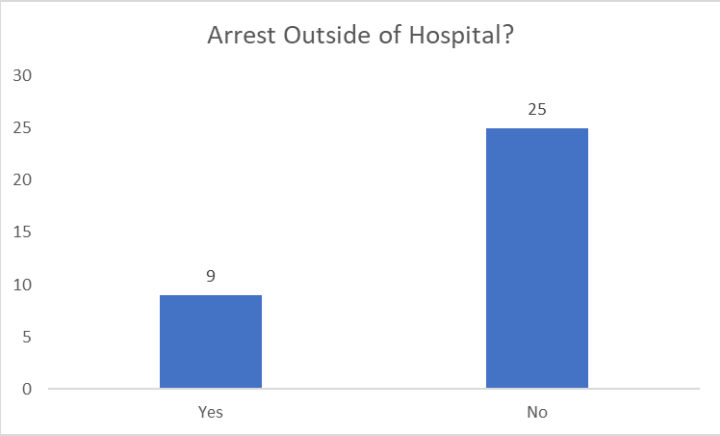
Quality Measurement – Turning Data into Information

Examples of questions that can be answered through our dataset:



"Most are train wrecks, and they arrest outside of our facility."

Only 26% arrested outside of the hospital

Discuss methods to respond to this statement

"It's just coding – these patients should not have been classified as AMI."

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Quality Measurement – Summary

Always engage clinicians and stakeholders preferable before doing your analysis to discover the analysis focus and anticipate the assumptions they have.

Utilize all available data sources:

- Electronic medical record
- Data registries
- Risk management systems and quality management systems

Methods for utilizing your analysis will be discussed in the Plan-Do-Study-Act (PDSA) training course.

Outcome vs In Process Measures

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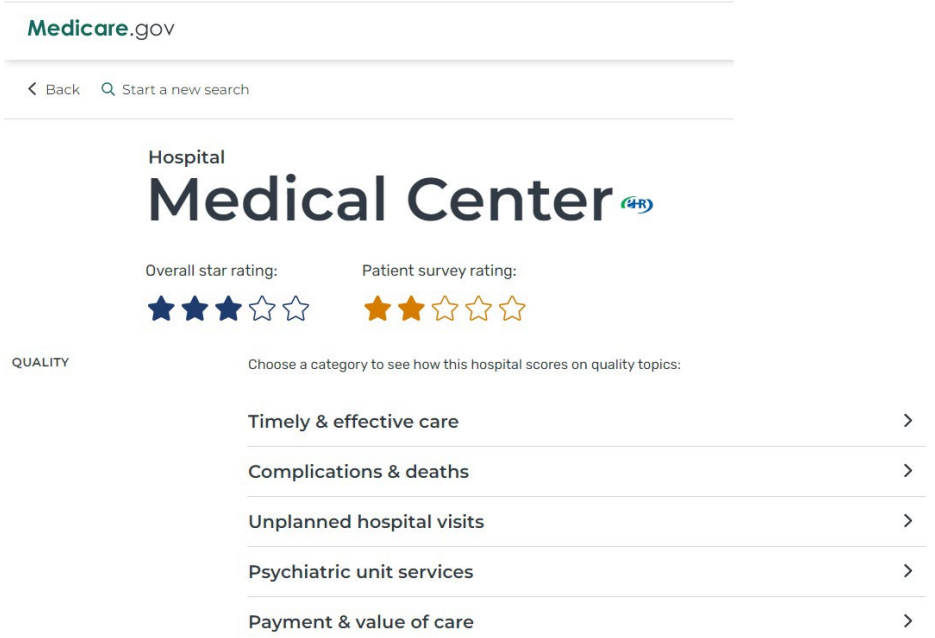
Outcome Metrics

These are the high-level clinical or financial outcomes that concern healthcare organizations. They are the quality and cost targets you are targeting for improvement. These measures are often reported to government and commercial payers.

Examples:

- Mortality Rates
- Readmission Rates
- Hospital Acquired Conditions
- Surgical Site Infections
- Patient Safety Indicators
- Length of Stay



AKA “Lagging Indicator”

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In Process Metrics

These measures are the specific steps in a process that lead — either positively or negatively — to a particular outcome metric.

In Process measures are predictive – that is they help to predict what the outcome will be.

AKA “Leading Indicator”

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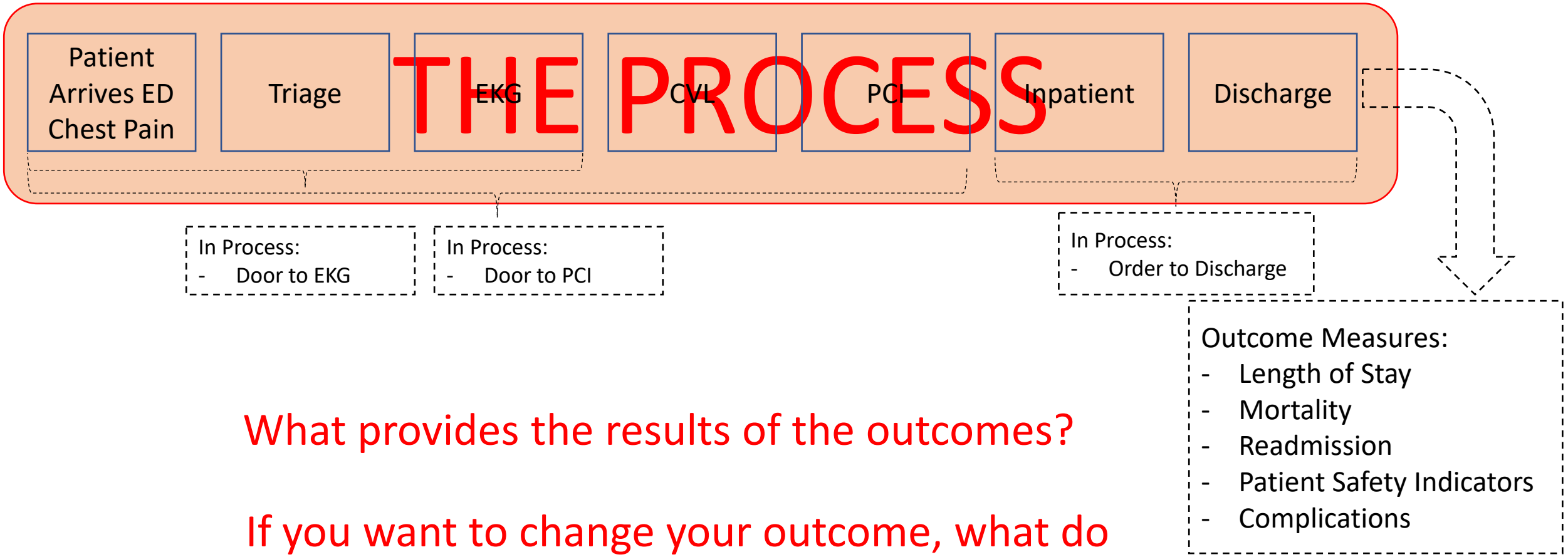
Outcome vs. In Process Metrics



What provides the results of the outcomes?

If you want to change your outcome, what do you apply the change to?

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Outcome vs. In Process Metrics

“Every system is **perfectly designed** to get the results it gets.”

~ Paul Batalden ~

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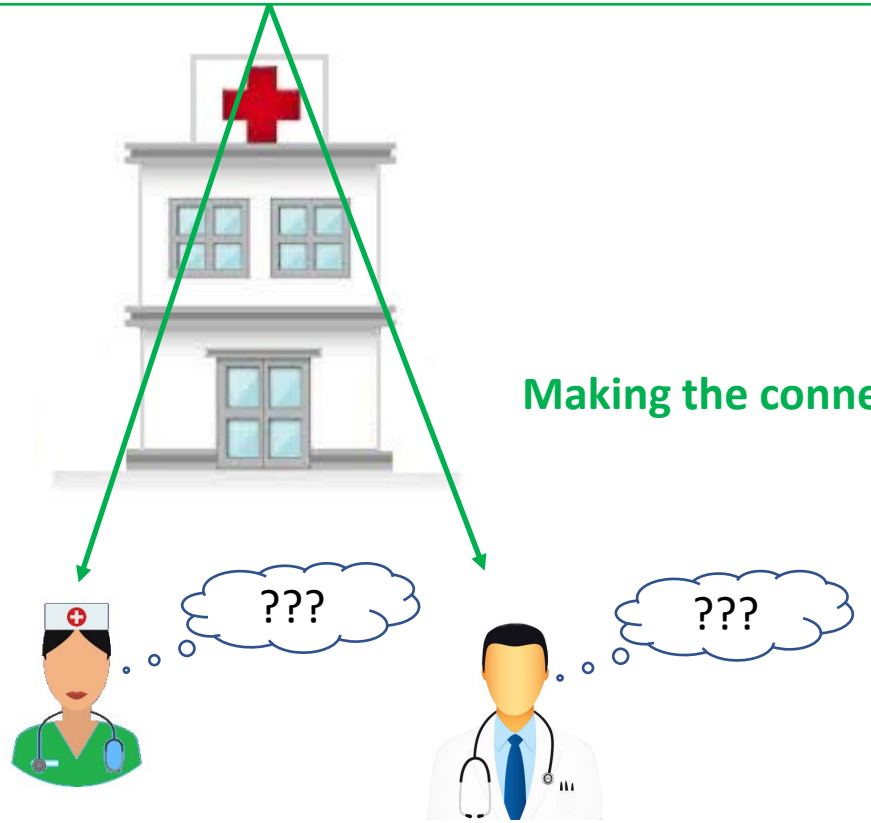
Cascade Measures

Cascade Measures

Strategy example:
Our organization strives to achieve a CMS 5-Star rating by January 2024



Making the connections to the front line

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Cascade Measures

Strategy example:
Our organization strives to achieve a CMS 5-Star rating by January 2027

- What measures define the 5-Star Criteria?
- How are we currently performing in those measures?
- What would our measures need to be to achieve 5-Star?

Cascade Measures – Understand the Gaps

Measure		Goal	Benchmark	Current
Person and Community Engagement Domain (HCAHPS)				
Communication with Nurses		80.00%	87.36%	74.0%
Communication with Doctors		80.00%	88.10%	76.2%
Responsiveness of Hospital Staff		70.00%	81.00%	61.4%
Communication about Medicines		60.00%	74.75%	57.6%
Cleanliness of Hospital Environment		80.00%	79.58%	71.6%
Quietness of Hospital Environment		70.00%	79.58%	51.9%
Discharge Information		80.00%	92.17%	82.3%
Care Transition		70.00%	63.32%	47.2%
Overall Rating of Hospital		80.00%	85.67%	70.0%
Safety Domain		**Goal**	**Benchmark**	**Current**
HAC CAUTI		0.554	0.000	0.000
HAC CLABSI		0.468	0.000	0.000
HAC C-DIFF		0.526	0.067	0.433
HAC MRSA		0.569	0.000	0.000
SSI Abdominal Hysterectomy		0.379	0.000	0.000
SSI Colon		0.590	0.000	0.000
CMS Patient Safety Indicator (PSI) 90	**Nat Avg**	**50%tile**	**75%tile**	**Current**
PSI 03 Pressure Ulcer	0.603	0.470	0.200	1.2
PSI 06 Iatrogenic Pneumothorax	0.253	0.140	0.000	0.0
PSI 08 In-Hospital Fall with Hip Fracture	0.108	0.000	0.000	0.0
PSI 09 PeriOp Hemorrhage or Hematoma	1.613	1.860	0.930	2.5
PSI 10 PO Acute Kidney Injury Requiring Dialysis	1.355	0.450	0.000	0.0
PSI 11 PO Respiratory Failure	6.135	2.970	1.550	0.0
PSI 12 PeriOp PE or DVT	3.759	2.700	1.850	1.1
PSI 13 PO Sepsis	4.785	3.290	1.400	1.2
PSI 14 PO Wound Dehiscence	0.913	0.000	0.000	0.0
PSI 15 Unrecognized Abdominopelvic Accidental Punct/Lac	1.261	0.850	0.000	0.0
Mortality	**Benchmark**	**50%tile**	**75%tile**	**Current**
Acute Myocardial Infarction (AMI) Mortality	12.0%	4.0%	2.7%	1.39%
Chronic Obstructive Pulmonary Disease (COPD) Mortality	8.6%	2.1%	1.2%	0.00%
Heart Failure (HF) Mortality	10.9%	2.2%	1.5%	4.41%
Pneumonia, Adult Mortality	15.0%	4.0%	2.9%	4.65%
Coronary Artery Bypass Graft (CABG) Mortality (Graft Only)		3.7%	0.0%	0.00%
Stroke Mortality, Ischemic		2.6%	1.3%	0.00%
Hospital Readmissions	**Nat Avg**	**50%tile**	**75%tile**	**Current**
Acute Myocardial Infarction (AMI)	15.7%	8.5%	6.5%	10.94%
Chronic Obstructive Pulmonary Disease (COPD)	19.6%	15.6%	12.7%	10.00%
Heart Failure (HF)	21.7%	16.7%	14.2%	23.33%
Pneumonia, Adult	16.6%	12.1%	10.2%	9.21%
Coronary Artery Bypass Graft (CABG)	12.6%	8.2%	6.2%	5.00%
Total Hip/Knee (THA/TKA)	3.9%	2.3%	1.6%	1.64%
Stroke		7.2%	4.2%	0.00%
Hospital Wide Readmission (HWR)		10.5%	9.1%	10.66%

Responsiveness of Hospital Staff
Communication about Medicines
Quietness of Hospital Environment
Care Transition
PSI 03 Pressure Ulcer
PSI 09 PeriOp Hemorrhage or Hematoma
Heart Failure (HF) Mortality
Pneumonia, Adult Mortality
Readmit Acute Myocardial Infarction (AMI)
Readmit Heart Failure (HF)

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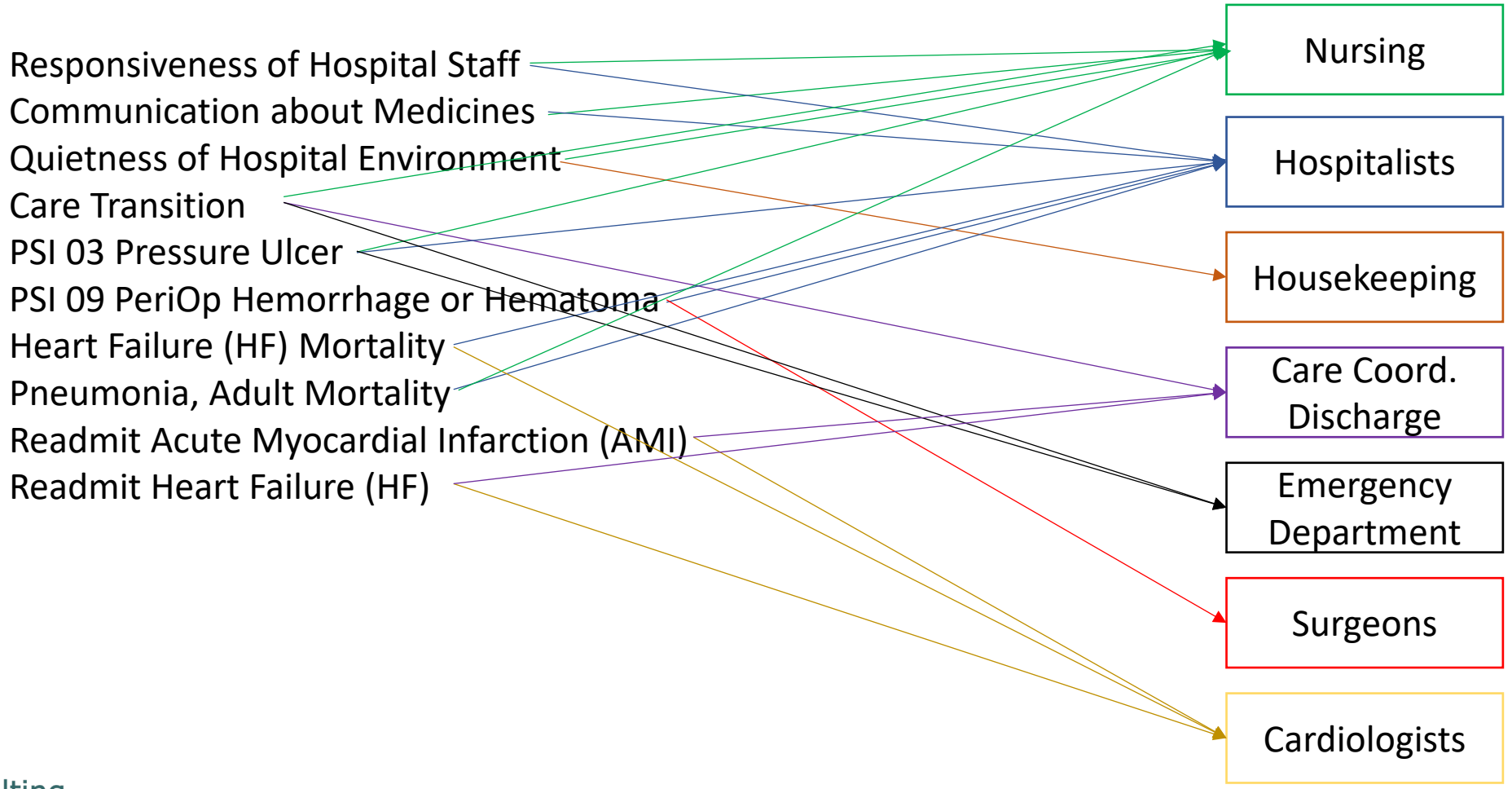
Cascade Measures – Identify Appropriate Caregivers



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Cascade Measures – Engage Appropriate Caregivers

- Share the organizational strategy – group discussions best, 1:1 interviews acceptable
- Share the data
- Open discussion
    - What are the things that we do that contribute to these results?
    - Is there evidenced based practice around procedures leading to these outcomes that we can investigate?
    - What things can we try to work toward an improvement?

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Cascade Measures – Create the Measurement System

Strategy example:
Our organization strives to achieve a CMS 5-Star rating by January 2024

Nursing	Hospitalists	Housekeeping	Care Coord. Discharge	Emergency Department	Surgeons	Cardiologists
• Responsiveness of Hospital Staff • Communication about Medicines • Quietness of Hospital Environment • PSI 03 Pressure Ulcer	• Responsiveness of Hospital Staff • Communication about Medicines • Heart Failure (HF) Mortality • Pneumonia, Adult Mortality	• Quietness of Hospital Environment	• Care Transition • Readmit Acute Myocardial Infarction (AMI) • Readmit Heart Failure (HF)	• PSI 03 Pressure Ulcer	• PSI 09 PeriOp Hemorrhage or Hematoma	• Heart Failure (HF) Mortality • Readmit Acute Myocardial Infarction (AMI) • Readmit Heart Failure (HF)

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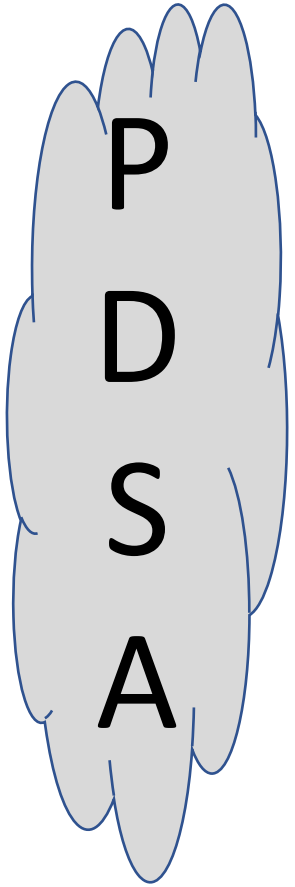
Cascade Measures – Moving from Outcome to In Process Measurement

Outcome Measure

i.e., Pressure Injury



In Process Measure

i.e.,
Skin assessments within 4 hours of admission
Nutrition consults for high-risk patients
Appropriate mattress for high-risk patients
Reposition every 2 hours

PDSA Covered in Module 5

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Tools for Managing Measurement – The Quality Oversight Scorecard

2025 Quality Oversight Scorecard	
XYZ Hospital	YOUR COMPANY TAGLINE IS HERE
Year:	2024
Executive Quality Oversight:	Jane Doe
Quality Director:	John Smith
Version:	2.6
Note: This document should not contain patient identifiable information (PHI). Please do not add patient identifiable information in notes or comments.	
Description	
The quality oversight scorecard is used to continuously evaluate the metrics and performance for each department and program for XYZ. Each scorecard is specifically tailored to monitor the metrics related to patient care in that specific area while addressing specific DNV criteria. These measures are reviewed and monitored at the monthly Quality and Patient Safety Council.	
Departments:	
Strategic Scorecard	Medical Staff
Anesthesia	Medical Unit
Behavioral Health	Medical 4T
Biomed	Neuro/Ortho
Cancer Center	Oncology
Heart Center/Cardiac Unit	Operating Department/Periop
Hospitalists	Operating Dept Pre/Post OR
Cardiovascular Lab	Pathology
Childrens	Pharmacy
Coronary Care Unit	Plant Operations/Facilities
Diagnostic Imaging	Readmissions
Dietary Services	Rehab
Emergency Department	Rehab, Inpatient Unit
Environmental Services	Respiratory Therapy
HIM	Risk
Hospice	Safety/Security
ICU	Supply Chain
IMC	Surgical Unit
Infection Control	Utilization Review/Discharge
Information Technology	Women's
Lab	
Other:	
Scorecard Status	Hospital 1 Quality Committee
DNV Cross-Reference	Hospital 2 Quality Committee
Update Schedule	Hospital 3 Quality Committee
Board Quality & Safety	Version Control

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The Quality Oversight Scorecard

Strategic Dashboard

Pillar	Organizational Vision	Breakthrough Objectives (3-5 year)	Annual Objectives	Activities/Measures Owner(s)	Service Lines/Groups Impacting Objective
Service	Provider of Choice	90%tile HCAPS		CNO	Admitting, Case Management, Dietary, Lab, Transport, EVS, Nursing, Physicians, Pharmacy
Service	Provider of Choice	1. Customer Engagement Target 3% increase annually 2. Net Promoter Score = 3% increase annually	Improved Customer Satisfaction (YOY)/ Standardized SLT Rounding	CNO	
Service	Best Place to Be Cared For	Employee Engagement of: 80% by year 5 with incremental increases yearly Employee Satisfaction of: 80% by year 5 with incremental increases yearly	Standard work for: Employee Engagement, Recognition, Celebrating Successes, Thinking Systemically.	CNO	
Service	Best Place to Be Cared For	Improved patient engagement/satifaction by 5% annually HCAHPS/ NPS Score: 2% Improvement, every 6 months	Standard work for: Bedside shift report, service recovery, service excellence, physician rounding.	CMO	

Pillar	Organizational Vision	Breakthrough Objectives (3-5 year)	Annual Objectives	Activities/Measures Owner(s)	Service Lines/Groups Impacting Objective
Financial	Ensure The Long Term Financial Health of the Institution	Achieve 15% or better margins		CEO	Entire Organization (all service lines and contractors)
Financial	Ensure The Long Term Financial Health of the Institution	Manage to MONTHLY/ANNUAL budget, not to exceed +/- 3% variance	1. Average LOS <=4.5 2. Adjusted EBITDAR = X	CFO	
Financial	Efficiency/ Process Improvement	Manage to MONTHLY/ANNUAL budget, not to exceed +/- 3% variance	Optimization of Labor and Supply Chain Directors/Managers to identify and implement at least 1 cost savings/ optimization initiative each quarter	CFO	
Financial	Efficiency/ Process Improvement	Hardwired Efficiencies in Labor and Inventory. Decrease OT by 5% each year. Supply Chain Savings of 5% each year.	Standard work for: Census Management Kanban Systems LOS Management	CFO	

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The Quality Oversight Scorecard

Strategic Dashboard

Pillar	Organizational Vision	Breakthrough Objectives (3-5 year)	Annual Objectives	Activities/Measures Owner(s)	Service Lines/Groups Impacting Objective
Growth	Greater Access and Efficiency	Journey to 700 Surgeries per Month		CEO	Marketing, Healthplan, Physicians, LMG Providers, EMS, Anesthesiology Group, Surgical Services
Growth		2% Growth YoY	Implementation of new service, service line or specialty	COO	
Growth		Improve capacity by maintaining ___ % load leveling for CMI		COO	
Growth		Improved patient throughput by 5%		COO	

Pillar	Organizational Vision	Breakthrough Objectives (3-5 year)	Annual Objectives	Activities/Measures Owner(s)	Service Lines/Groups Impacting Objective
Quality	Nationally Ranked Healthcare Provider in Quality and Safety	Achieve 5-Star rating		CEO	Nursing, Physicians, Pharmacy, Transport, EVS,
Quality	Nationally Ranked Healthcare Provider in Quality and Safety	Achieve 5-Star rating	2. Thrombectomy Accreditation 3. Hospital Acquired Conditions	CQO	
Quality	5-Star Rating (CMS)	Improved scorecard data, 5% annually in top 5 selected for each year	1. Operational Excellence Program Deployment with Standard Work for consistent display of Principle Based Behaviors and Systemic Thinking	CQO	
Quality	5-Star Rating (CMS)	Hardwired Patient Safety Focus - Maintain HAC rating. Reduction/Prevention of Falls and Pus by 5% annually	Standard work for: Prevention of Pressure Ulcers, Patient Falls Culture of Safety, PDCA	CQO	

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The Quality Oversight Scorecard

Quality Scorecard:	ICU

Department Description:	ICU	Hospital 1
	Executive Owner:	TK
	Department Owner:	RK
	Manager:	KR
Date Updated:	7/22/2025	

				Hospital 1												
Measure	**Description**	**DNV Criteria**	**Target**	**Jan-25**	**Feb-25**	**Mar-25**	**Apr-25**	**May-25**	**Jun-25**	**Jul-25**	**Aug-25**	**Sep-25**	**Oct-25**	**Nov-25**	**Dec-25**	**Total/CYTD**
Customer Experience																
HCAHPS - Doctor Explain	During this hospital stay, how often did doctors explain things in a way you could understand? Would you say: Never/Sometimes/Usually/Always	QM7 SR4k	63.0%	57.10%	44.40%	71.40%	80.00%	88.90%								75.00%
HCAHPS - Overall Safety	Overall, would you rate the level of safety you felt while in the hosptial as: Excellent/Very Good/Good/Fair/Poor	QM7 SR4k	52.2%	50.00%	55.60%	50.00%	60.00%	62.50%								83.30%
Infection Prevention																
CAUTI	Catheter associated urinary tract infection rate	QM7 SR4h(1)	0	0	1	0	0	0	1	0						2
CLABSI	Central line associated blood stream infection	QM7 SR4h(1)		1	0	0	0	0	0	0						1
C-Diff	Clostridioides difficile hospital aquired	QM7 SR4h(1)		0	0	0	0	0	0	0						0
MRSA	Hospital aquired MRSA	QM7 SR4h(1)		0	0	0	0	0	0	0						0
Hand Hygiene	Hand Hygiene Compliance Rate	QM7 SR4p	90%	96.7%	90.2%	88.3%	95.0%	95.0%	92.5%							557.7%
Patient Safety																
Falls	Number of Patient Falls with or without injury	QM7 SR4a	0	1	1	0	0	1								3
PSI03 Pressure Injury	Hospital acquired stage 3, 4, Unstageable PI	QM7 SR4a		1	0	0	0	0	0							1
Pressure Injury	Any hospital acquired pressure injury	QM7 SR4a		5	0	7	3	5								
Bar Code Scanning	Bedside bar code scanning rate	QM7 SR2	98%	98.5%	98.9%	98.3%	98.5%	98.4%	98.2%							
Quality Incidents	Quality incidents related to department classified as Serious Safety Events (SSE1-SSE5)	QM7 SR4n	0	0	0	0	0	0								0

Selecting a department, allows you to add the measures for each month under each quarter

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The Quality Oversight Scorecard

Quality Scorecard:	Hospitalist

Department Description:	Hospitalist	Hospital 1	Hospital 2
	Executive Owner:	EL	PS
	Department Owner:	MB	NC
Date Updated:	7/22/2025		

Hospital 1																
Measure	Description	DNV Criteria	Target	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Total/CYTD
Customer Experience Hospitalist Specific																
Overall Rating of Hospital	Using any number from 0-10, where "0" is the "Worst Hospital Possible" and "10" is the "Best Hospital Possible," what number would you use to rate this hospital during your stay? 0-10	QM7 SR4k	58.12%	53.70%	63.00%	50.90%	60.00%	64.00%								57.62%
MD Communication Percent	Composite of all doctor/provider-specific communication questions below.	QM7 SR4k	74.63%	71.68%	74.54%	72.12%	73.89%	81.41%								74.13%
Doctors treat with courtesy/respect	During this hospital stay, how often did doctors treat you with courtesy and respect? Would you say: Always/Usually/Sometimes/Never	QM7 SR4k	82.69%	79.30%	84.30%	80.90%	81.10%	87.80%								82.19%
Doctors listen carefully to you	During this hospital stay, how often did doctors listen carefully to you? Always/Usually/Sometimes/Never	QM7 SR4k	72.93%	68.40%	71.20%	70.00%	73.20%	83.80%								72.43%
Doctors expl in way you understand	During this hospital stay, how often did doctors explain things in a way you could understand? Would you say: Always/Usually/Sometimes/Never	QM7 SR4k	68.28%	67.40%	68.20%	65.50%	66.70%	72.60%								67.78%
HCAPS Number Respond	Number of Surveys *Sample sizes won't always match as some patients decline to answer some questions.*	QM7 SR4k	Informational	135	110	110	111	73								545
Infection Prevention																
HAC C-Diff	Hospital Acquired C-Diff Infection	QM7 SR4h(1)	0	0	1	1	0	1	1	0						4
HAC MRSA	Hospital Acquired MRSA infection	QM7 SR4h(1)		0	0	0	0	1	0	0						1
HAC CAUTI	Hospital acquired CAUTI infection	QM7 SR4h(1)		1	1	1	3	3	3	0						12
HAC CLABSI	Hospital acquired CLABSI infection	QM7 SR4h(1)		1	0	0	0	2	0	0						3
SSI - Colon	Surgical Site Infection for Colon Procedures	QM7 SR4h(1)		0	0	0	0	1	0	0						1
SSI Hip	Surgical site infection	QM7 SR4h(1)		0	0	0	0	0	0	0						0
SSI Knee	Surgical site infection	QM7 SR4h(1)		0	1	0	0	0	0	0						1
SSI - Hyst	Surgical Site Infections for Hysterectomies	QM7 SR4h(1)		0	1	0	0	0	0	0						1
Patient Safety																
Falls	Number of patient falls	QM7 SR4a	0	40	46	51	48	41								226
Fall With Injury	Fall with injury	QM7 SR4a		8	8	5	7	8								36
PSI 03- Stage 3, 4, Unstageable Pressure Injury	Hospital acquired stage 3, 4 or Unstageable PI	QM7 SR4a		1	1	2	1	0	0							5
Sentinel Events	Sentinel Events	QM7 SR4a														0
Quality - Process Indicators																
Sepsis 3 Hour Bundle	Severe sepsis 3 hour bundle compliance	QM7 SR4s	79.0%	50.0%	81.8%	40.0%	45.5%									
Venous Thromboembolism Prophylaxis	eVTE-1 Venous Thromboembolism Prophylaxis	QM7 SR4s	100.0%	57.3%	57.1%	53.5%	48.8%									
8 Condition Readmissions	8 Condition Readmission Rate (one month behind)	QM7 SR4i(1)	8.31%	8.61%	7.53%	9.03%	12.88%									7.44%
6 Condition Mortality	6 Condition Mortality Rate (Hospital 2)	QM7 SR4m	1.0	7.8%	5.3%	2.4%	1.5%									
Medical Management																
Length of Stay	Overall Hospital Length of Stay (LOS)	QM7 SR4p		6.26	6.85	6.37										
Discharge Order by 10AM	Percentage of discharges with a discharge Home Order by 10AM	QM7 SR4p	Informational	66%	68%	68%										
Observation LOS	Observation Length of Stay (Hours)	QM7 SR4p														
Patient Days	Patient Days (inpatient units)	QM7 SR4p	Informational	8988	8482	9022	9139									
Case Mix Index	Case Mix Index Overall	QM7 SR4p	Informational													

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The Quality Oversight Scorecard

Benefits of the Quality Oversight Scorecard:

- ✓ One centralized location for all areas of the business
- ✓ Allows for automation of measures where available (i.e., hand hygiene audits done in one department will automatically update that unit's scorecard)
- ✓ Once measures are cascaded from the strategy to the front line, provides a clear roadmap and aggregation at those levels
- ✓ Allows access and update collaboration between all areas of the organization (i.e., the manager of the ED can update their own measures)
- ✓ Standard tool used in report-outs such as daily huddle, quality council, medical executive committee, and the board
- ✓ History of quality progress utilized in accreditation surveys
- ✓ Method of communicating what is important to the organization
- ✓ Customizable approach allowing for the addition and subtraction of relevant measures for your organization

Paying for Quality Initiatives

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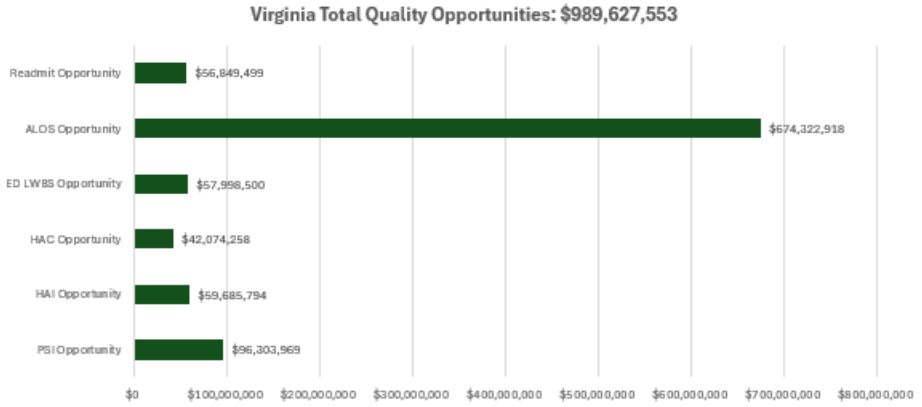
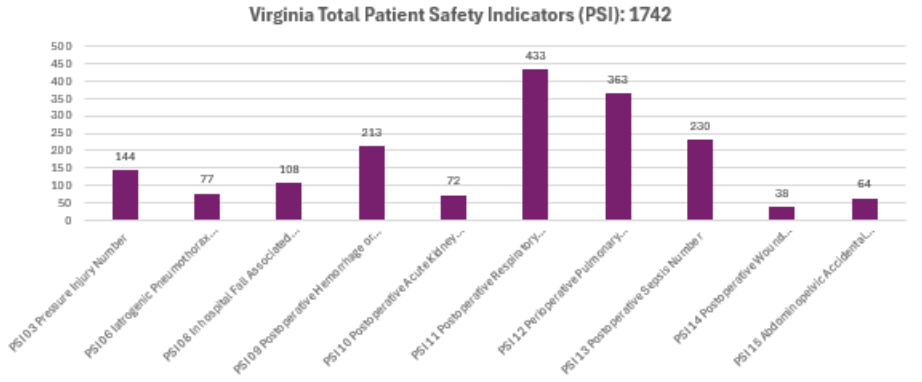
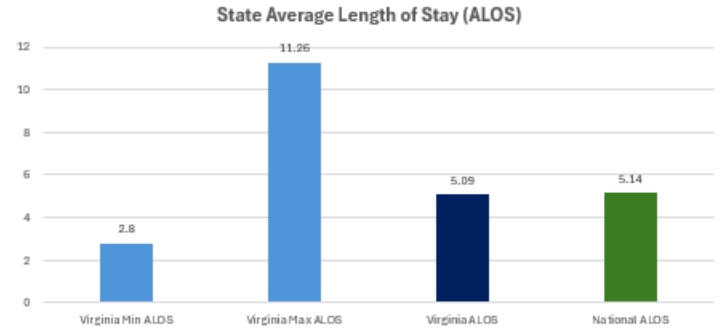
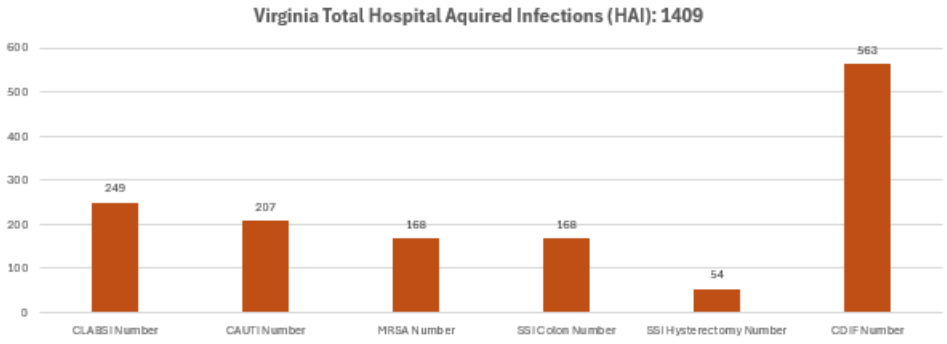
How to Pay for Your Quality Initiatives

Reporting Period	CMS 2025
State	Virginia
Hospitals in Summary	85
Inpatient Charges	$54,252,633,720
Total ROI Opportunity	**$989,627,553**
PSI Opportunity	$96,303,969
HAI Opportunity	$59,685,794
HAC Opportunity	$42,074,258
ED LWBS Opportunity	$57,998,500
ALOS Opportunity	$674,322,918
Readmit Opportunity	$56,849,499
Legal Costs	$85,696,500
Hospitals With HAC Penalty	11
Hospitals With Readmit Penalty	60
Virginia Min ALOS	2.8
Virginia Max ALOS	11.26
Virginia ALOS	5.09
National ALOS	5.14
Min ED LWBS Percent	0.00%
Max ED LWBS Percent	6.00%
PSI 03 Pressure Injury Number	144
PSI 06 Iatrogenic Pneumothorax Number	77
PSI 08 In hospital Fall Associated fracture Number	108
PSI 09 Postoperative Hemorrhage or Hematoma Number	213
PSI 10 Postoperative Acute Kidney Injury Requiring Dialysis Number	72
PSI 11 Postoperative Respiratory Failure Number	433
PSI 12 Perioperative Pulmonary Embolism or Deep Vein Thrombosis Number	363
PSI 13 Postoperative Sepsis Number	230
PSI 14 Postoperative Wound Dehiscence Number	38
PSI 15 Abdominopelvic Accidental Puncture or Laceration Number	64
CLABSI Number	249
CAUTI Number	207
MRSA Number	168
SSI Colon Number	168
SSI Hysterectomy Number	54
CDIF Number	563
Update Date	6/4/2025









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Virginia 2025

Quality Star Rating and Cost Due to Poor Quality

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How to Pay for Your Quality Initiatives

Quality-Cost Optimization Assessment

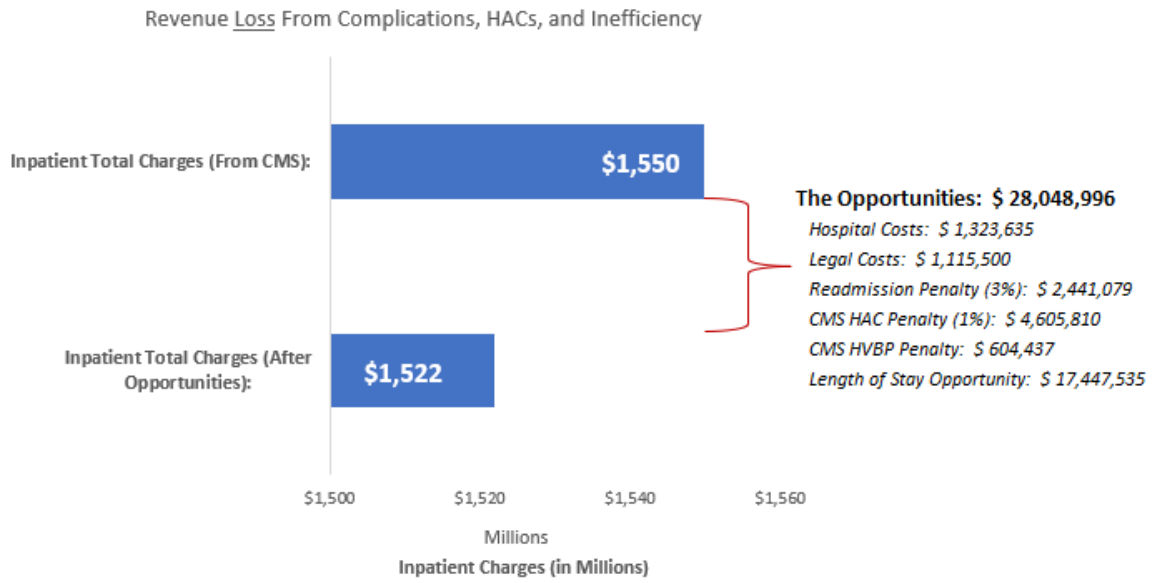
presented to:

XYZ Medical Center

Complications and HACs Costs		
Hospital Costs:	$	1,323,635
Legal Costs:	$	1,115,500
Penalties and Other Costs Based on Performance		
Readmission Penalty (3%):	$	2,441,079
CMS HAC Penalty (1%):	$	4,605,810
CMS HVBP Penalty:	$	604,437
Length of Stay Opportunity:	$	17,447,535
Left Without Being Seen Opportunity:	$	511,000

Total Opportunity Costs:	**$**	**28,048,996**

Outcomes Data		% Hospitals Worse Than You
CMS Star Rate	3	60%
CMS Patient Sat Star Rate	2	26%
LeapFrog Score	B	68%



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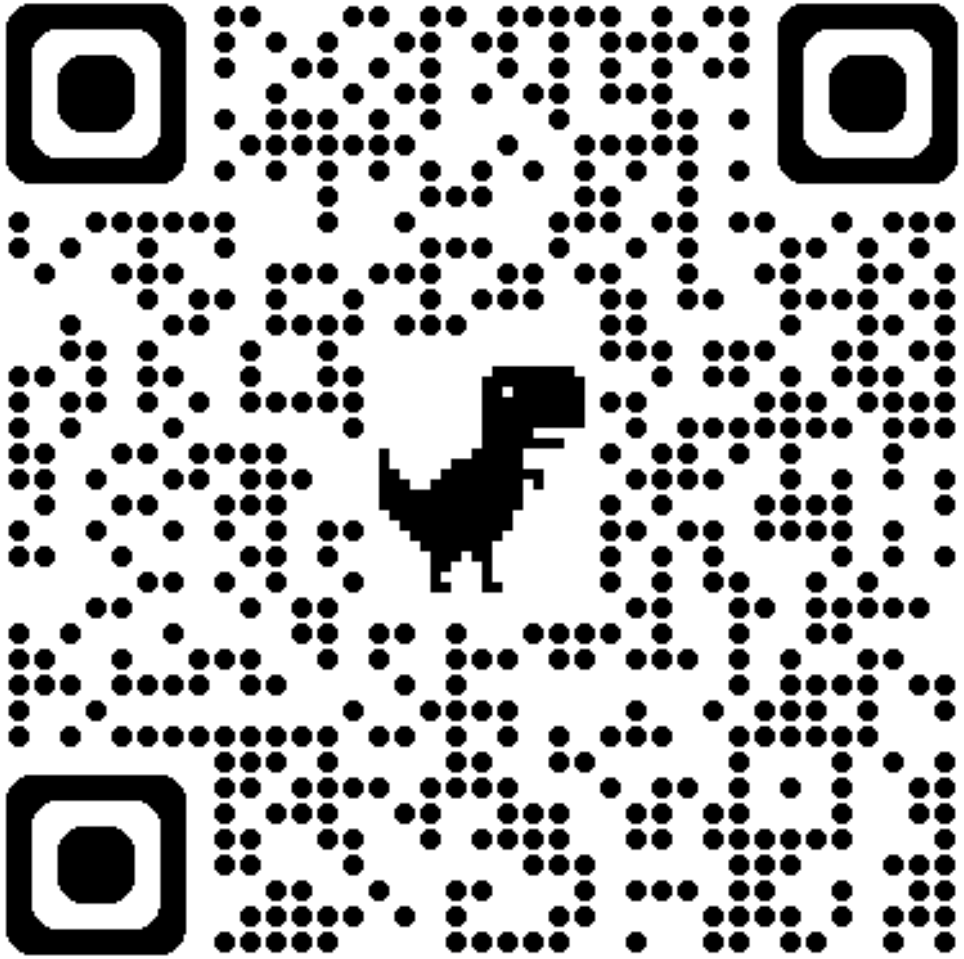

For your hospital's specific summary

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Discussion

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