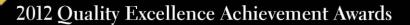
2012 Quality Excellence Achievement Awards Compendium

Recognizing Illinois Hospitals and Health Systems Leading in Quality and Transformative Health Care







OVERVIEW

The Illinois Hospital Association's (IHA) Institute for Innovations in Care and Quality (The Institute) second annual Quality Excellence Achievement Awards recognizes and celebrates the achievements of Illinois hospitals that are committed to transforming Illinois health care through innovative approaches and best practices.

From 67 submissions representing 40 hospitals, awards were presented to a total of eight hospitals in two categories: urban and rural/critical access. The two award recipients and six finalists, who were honored at IHA's annual Leadership Summit, were selected by a panel of 30 nationally-recognized quality improvement leaders based on their achievement and progress in advancing one or more elements of the Institute of Medicine's six aims for improvement:

- Safety
- Effectiveness
- Timeliness
- Efficiency
- Equity
- Patient-centered care

To share these initiatives among members, The Institute has published this compendium that provides a synopsis of all award entries along with contact information for additional details. The compendium receives national exposure by being featured annually on the Hospitals in Pursuit of Excellence (HPOE), an AHA affiliate, website.





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2012 Quality Excellence Achievement Awards

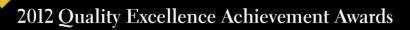


Call for Entries May 2013 Be sure to

watch for this opportunity to be recognized and celebrated for your hospital's achievements in advancing patient care.





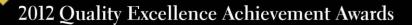




Award Recipients









AWARD RECIPIENTS

Award category—Rural/Critical Access

Katherine Shaw Bethea Hospital, Dixon

Streamlining the Intake Process of Cardiac Patients in the Emergency Department

Award category—Urban

OSF Healthcare System, Peoria

Improving Obstetrical Care Through Organizational Collaboration

The following pages contain summaries of the award recipients' projects.





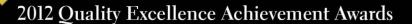
2012 Quality Excellence Achievement Awards



Award Finalists









AWARD FINALISTS

Rural/Critical Access category

Gibson Area Hospital & Health Services, Gibson City

Reduce Medication Errors Through the Implementation of Computerized Physician Order Entry (CPOE), Medication Bar Coding and Smart Pump Technology

Graham Health System, Canton

Intensive Care Management

St. Mary's Hospital, Centralia

Reducing Readmissions CQI+ Team-Implementing Change Through the IHA Project RED Collaborative

Urban category

Advocate Hope Children's Hospital, Oak Lawn

Utilization of an Interdisciplinary Team Approach for the Care of Infants with Hypoplastic Left Heart Syndrome (HLHS)—The Ideal Quality Improvement Collaboration

Alexian Brothers Health System, Arlington Heights

Improvement in Patient Safety and Quality of Inpatient Care Through Appropriate Blood Product Management

Holy Family Medical Center, Des Plaines

Collaborative Approach to Reduce Health Care-Acquired Clostridium difficile Infection Rate in a Long-Term Acute Care Hospital (LTACH)

The following pages contain summaries of the award finalists' projects.









Process Improvement-Non-Clinical

Hospital/System: Memorial Medical Center, Springfield

Contact: Charles D. Callahan, PhD, MBA, FACHE

Vice President of Quality & Operations

217-788-3433

callahan.chuck@mhsil.com

Project Title: Enhancing Hospital Safety Culture Through Use of Defect

Huddle Incident Management System

Summary: Data from the AHRQ Safety Culture Survey indicated the

need to improve mechanisms for incident capture, analysis, prioritization, and action. Based on Lean/Six Sigma methodology, the Defect Huddle was designed. It is a weekly 30-minute multidisciplinary team meeting where safety events, including near misses, medication errors, harm events, complaints/grievances, sentinel and/or regulatory issues, are presented and rated on a

harm scale.

The resulting summary score indicates the improvement response: (1) localized departmental Plan-Do-Study-Act;

(2) Multidisciplinary Failure Mode Effects Analysis

(FMEA); or (3) formal Root Cause Analysis. The Defect Huddle also serves as a tracking repository of safety

improvement efforts through conclusion.

Data from the first six months of Defect Huddle indicate that 97 safety events were reviewed, with 62% triaged as appropriate for FMEA, 31% for department PDSA "just do it" corrections and 7% for formal root cause analysis.

Website: https://www.memorialmedical.com



