

Minutes of the meeting of the Quality and Patient Safety Committee of the Board of Directors of the Cook County Health and Hospitals System held Tuesday, November 24, 2009 at the hour of 12:00 P.M. at John H. Stroger, Jr. Hospital of Cook County, 1901 W. Harrison Street, in the fifth floor conference room, Chicago, Illinois.

## **I. Attendance/Call to Order**

Chairman Ansell called the meeting to order at 12:00 P.M.

Present: Chairman David Ansell, MD, MPH and Directors Hon. Jerry Butler and Luis Muñoz, MD, MPH (3)  
Mary Driscoll, Lois Elia and Pat Merryweather (Non-Director Members)

Absent: None (0)

Additional attendees and/or presenters were:

Homer Abiad, MD  
Angela Butler  
Patrick T. Driscoll, Jr.  
William T. Foley  
David Goldberg, MD  
Aaron Hamb, MD  
Martina Harrison  
Avery Hart, MD

Randolph Johnston  
Sue Klein  
Mark Krause, MD  
Maurice Lemon, MD, MPH  
Roz Lennon  
Charlene Luchsinger  
Stephen Martin, PhD, MPH  
Michael Puisis, MD

John Raba, MD  
Elizabeth Reidy  
Lula Roberson  
Deborah Santana  
Anthony J. Tedeschi, MD,  
MPH, MBA  
Michael Vernon, MD  
Sharon Welbel, MD

## **II. Public Speakers**

Chairman Ansell asked the Secretary to call upon the registered speakers.

The Secretary responded that there were none.

## **III. Committee Report**

### **A. Minutes of the Quality and Patient Safety Committee Meeting, October 21, 2009**

Director Butler, seconded by Director Muñoz, moved to accept the minutes of the Quality and Patient Safety Committee Meeting of October 21, 2009. THE MOTION CARRIED UNANIMOUSLY.

## **IV. Recommendations, Discussion/Information Items**

### **A. Quarterly quality report from Provident Hospital of Cook County**

Lula Roberson presented the quarterly quality report from Provident Hospital of Cook County (Attachment #1). Martina Harrison provided additional information. The Committee reviewed and discussed the information.

After the presentation, Chairman Ansell noted that a discussion needs to be held on the subject of “how are we getting mortality data by service lines and complication rates?” He added that this discussion would include Stroger, Provident and Oak Forest Hospitals.

**IV. Recommendations, Discussion/Information Items (continued)**

**B. Proposed 2010 Quality and Patient Safety Committee meeting dates (Attachment #2)**

Director Butler, seconded by Director Muñoz, moved to approve the proposed 2010 Quality and Patient Safety Committee meeting dates. THE MOTION CARRIED UNANIMOUSLY.

**C. Update on infectious control/hospital acquired infections**

Dr. Sharon Welbel, of the Division of Infectious Diseases, presented an update on infectious control/hospital acquired infections (Attachment #3). The Committee reviewed and discussed the information.

**D. 2010 Quality Plans (System and Affiliates) and Structure**

Dr. Jack Raba, System Interim Chief Medical Officer, presented the 2010 Quality Plans (System and Affiliates) and Quality Structure (Attachment #4). He added that the affiliate initiatives are included in the information. The Committee reviewed and discussed the information. Chairman Ansell noted that the Joint Commission will be coming to Stroger Hospital; he suggested that the organizational structure of Quality for the individual affiliates be included in their plans.

Director Butler, seconded by Director Muñoz, moved to accept the 2010 Quality Plans for the System and its affiliates, and the Quality Structure. THE MOTION CARRIED UNANIMOUSLY.

**E. Cook County Department of Public Health 2008 Annual Report (Attachment #5)**

Director Butler, seconded by Director Muñoz, moved to receive and file the Cook County Department of Public Health 2008 Annual Report. THE MOTION CARRIED UNANIMOUSLY.

**F. Cook County Department of Health Annual Tuberculosis Surveillance Report (Attachment #6)**

Dr. Michael Vernon, of the Cook County Department of Public Health, presented additional information on the report.

Director Butler, seconded by Director Muñoz, moved to receive and file the Cook County Department of Public Health Annual Tuberculosis Surveillance Report. THE MOTION CARRIED UNANIMOUSLY.

**G. Miscellaneous**

Chairman Ansell provided an overview of the new Illinois Department of Public Health's website for hospital report cards at <http://www.healthcarereportcard.illinois.gov/>.

**V. Action Items**

**A. Any items listed under Sections III, IV and VI**

**VI. Closed Session Discussion/Information Items**

**A. Update on status of preparations for Cermak re-accreditation**

**B. Reports from the Medical Staff Executive Committees**

- i. Oak Forest Hospital of Cook County
- ii. Provident Hospital of Cook County
- iii. John H. Stroger, Jr. Hospital of Cook County

**C. Medical Staff Appointments/Re-appointments/Changes**

**D. Reports on the following:**

- i. Sentinel events or near misses
- ii. Patient grievance reports
- iii. "Never" events
- iv. Recent regulatory visits

**E. Report on performance pertinent to accreditation standards for John H. Stroger, Jr. Hospital of Cook County**

Director Butler, seconded by Director Muñoz, moved to recess the regular session and convene into closed session, pursuant to the following exceptions to the Illinois Open Meetings Act: 5 ILCS 120/2(c)(17), which permits closed meetings for consideration of "the recruitment, credentialing, discipline or formal peer review of physicians or other health care professionals for a hospital, or other institution providing medical care, that is operated by the public body," and 5 ILCS 120/2(c)(11), regarding "litigation, when an action against, affecting or on behalf of the particular body has been filed and is pending before a court or administrative tribunal, or when the public body finds that an action is probable or imminent, in which case the basis for the finding shall be recorded and entered into the minutes of the closed meeting." THE MOTION CARRIED UNANIMOUSLY.

Director Butler, seconded by Chairman Ansell, moved to adjourn the closed session and reconvene into regular session. THE MOTION CARRIED UNANIMOUSLY.

Director Butler, seconded by Chairman Ansell, moved to approve the Medical Staff Appointments/Re-appointments/Changes (Attachment #7). THE MOTION CARRIED UNANIMOUSLY.

**VII. Adjourn**

Director Butler, seconded by Chairman Ansell, moved to adjourn. THE MOTION CARRIED UNANIMOUSLY and the meeting adjourned.

Respectfully submitted,  
Quality and Patient Safety Committee of the  
Board of Directors of the  
Cook County Health and Hospitals System

XXXXXXXXXXXXXXXXXXXXXXXXXXXX  
David Ansell, MD, MPH, Chairman

Attest:

XXXXXXXXXXXXXXXXXXXXXXXXXXXX  
Deborah Santana, Secretary

Cook County Health and Hospitals System  
Minutes of the Quality and Patient Safety Committee Meeting  
November 24, 2009

ATTACHMENT #1

# Provident Hospital of Cook County

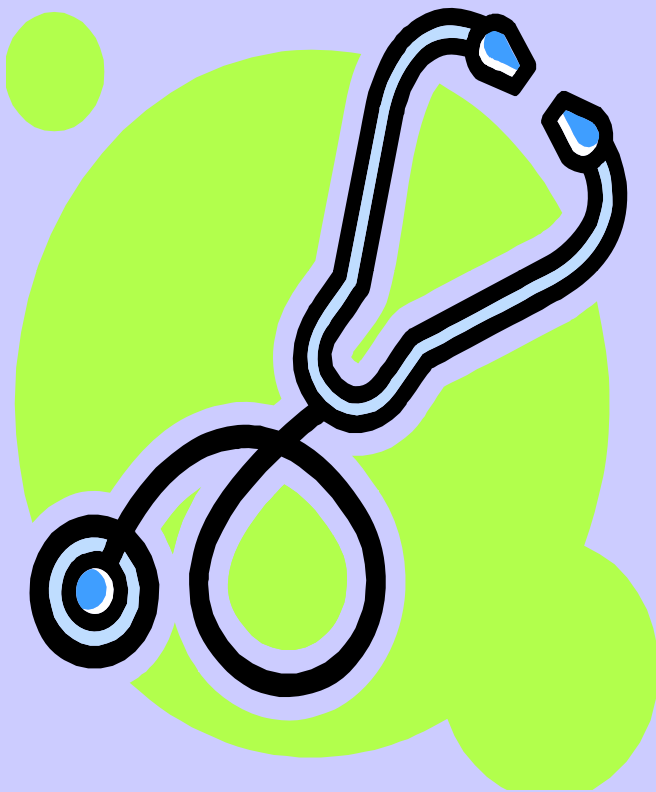


## THIRD QUARTER 2009 SUMMARY OF QUALITY & PERFORMANCE IMPROVEMENT INITIATIVES

# INTRODUCTION

- Provide Status of Concurrent Core Measures Outcomes.
- Provide Status of Departmental Indicators
- Highlight performance improvement accomplishments.
- Identify Opportunities for further improvement.
- Identify planned interventions for improvement.
- Provide External Regulatory Updates.

# CORE MEASURES



A set of diagnosed based criteria adopted by CMS and Joint Commission to improve patient outcomes. Core Measures are called ORYX by Joint Commission. The rationale for these National Core Measures is to improve patient care outcomes for Acute Myocardial Infarction (AMI) Heart Failure (HF), Community Acquired Pneumonia (CAP), and Surgical Care Improvement Project (SCIP).

A multi-disciplinary team comprised of a physician team leader/champion, nursing, medical staff, and ancillary support services, has been addressing this ongoing project.

# 2009 SCIP MEASUREMENT OUTCOMES

		2008 Aggregate Score	2009 (CY) Quarter 1	2009 (CY) Quarter 2	2009 (CY) Quarter 3	2009 Aggregate Score	Target IL. Avg.	Target Nat'l Avg.
SCIP INF 1	Prophylactic Antibiotic Received Within One Hour Prior to Surgical Incision.	88% of 56 patients	100% of 12 patients	83.3% of 12 patients	100% of 9 patients	91% of 33 patients	87%	88%
SCIP INF.2	Prophylactic Antibiotic Selections for Surgical Patient	98 of 55 patients	100% of patients 12	100% of 12 patients	100% of 9 patients	100% of 33 patients	93%	92%
SCIP INF. 3	Prophylactic Antibiotic Discontinued Within 24 hours After Surgery End Time	92% of 49 patients	100% of 12 patients	91% of 11 patients	100% of 9 patients	97% of 32 patients	81%	84%
SCIP INF.4	Cardiac Surgery Patients with Controlled 6 A.M. Post-operative Serum Glucose	-	-	-	-	-	89%	85%
SCIP INF. 6	Surgery Patients with Appropriate Hair Removal.	83% of 96 patients	81% of 16 patients	100% of 19 patients	100% of 13 patients	92% of 48 patients	95%	95%
SCIP INF VTE1	Surgery Patients with Recommended Venous Thromboembolism Prophylaxis Ordered.	89% of 63 patients	100% of 5 patients	100% of 6 patients	100% of 5 patients	100% of 16 patients	85%	84%
SCIP INF.VTE2	Surgery Patient Who Received Appropriate Venous Thromboembolism Prophylaxis Within 24 hours Prior to Surgery to 24 Hours After Surgery	89% of 63 patients	100% of 5 patients	100% of 6 patients	100% of 5 patients	100% of 16 patients	81%	81%



# 2009 ACUTE MYOCARDIAL (AM.I.) MEASUREMENT OUTCOMES

		2008 Aggregate Rate	2009 (CY) Quarter 1	2009 (CY) Quarter 2	2009 (CY) Quarter 3	2009 Aggregate Rate	Target IL. Avg.	Target Nat'l Avg.
AMI-1	Aspirin at Arrival	95% of 21 patients	100% of 1 patient	100% of 4 patients	100% of 7 patients	100% of 12 patients	93%	94%
AMI-2	Aspirin Prescribed at Discharge	75% of 12 patients	0/0 patients	100% of 2 patients	100% of 3 patients	100% of 5 patients	91%	92%
AMI -3	ACEI or ARB Left Ventricular Dysfunction	100% of 1 patient	100% of 1 patient	100% of 2 patients	100% of 2 patients	100% of 5 patients	86%	90%
AMI-4	Adult Smoking Cessation Advice/Counseling	33% of 3 patients	100% of 2 patients	100% of 1 patient	100% of 4 patients	100% of 7 patients	91%	94%
AMI-5	Beta Blocker Prescribed at Discharge	67% of 12 patients	100% of 2 patients	100% of 2 patients	100% of 6 patients	100% of 10 patients	93%	93%
AMI-7	Fibrinolytic Therapy Received Within 30 Mnutes of Hospital Arrival	-	-		-	-	28%	40%
AMI-8a	Primary PCI Received Within 90 Minutes of Hospital Arrival	-	-		-	-	67%	72%

# 2009 OUTCOMES FOR HEART FAILURE (HF) MEASUREMENT

		2008 Aggregate Rate	2009 (CY) Quarter 1	2009 (CY) Quarter 2	2009 (CY) Quarter 3	2009 Aggregate Rate	Target IL. Avg.	Target Nat'l Avg.
HF -1	Discharge Instructions	79% of 366 patients	79% of 89 patients	95% of 106 patients	89% of 75 patients	87% of 270 patients	78%	73%
HF-2	Evaluation of Left Ventricular Function (LVS)	97% of 370 patients	100% of 91 patients	100% of 102 patients	100% of 90 patients	100% of 283 patients	92%	88%
HF-3	ACEI or ARB for LVSD	96% of 164 patients	99% of 83 patients	98% of 97 patients	100% of 72 patients	99% of 252 patients	88%	88%
HF-4	Adult Smoking Cessation Advice/Counseling	98% of 177 patients	100% of 43 patients	100% of 52 patients	100% of 41 patients	100% of 136 patients	92%	90%

# 2009 OUTCOMES FOR PNEUMONIA MEASUREMENT

		2008 Aggregate Score	2009 (CY) Quarter 1	2009 (CY) Quarter 2	2009 (CY) Quarter 3	2009 Aggregate Rate	Target IL. Avg.	Target Nat'l Avg.
PN-1	Oxygenation Assessment	100% OF 292 patients	100% of 60 patients	Retired by CMS	Retired by CMS	Retired by CMS	99%	99%
PN-2	Pneumococcal Vaccination	41% of 78 patients	57% of 7 patients	100% of 13patients	88% of 8 patients	82% of 28 patients	79%	81%
PN-3b	Blood Cultures Performed in the Emergency Department Prior to Initial Antibiotic Received in the Hospital	75% of 265 patients	78% of 49patients	86% of 44 patients	79% of 29 patients	81% of 122 patients	91%	90%
PN-4	Adult Smoking Cessation Advice/Smoking	99 of 203 patients	100% of 33 patients	100% of 35 patients	100% of 22 patients	100 % of 90patients	87%	87%
PN-5c	Initial Antibiotic Received Within 6 Hours of Hospital Arrival	73% of 287 patients	82% of 49 patients	86% of 44 patients	83% of 29 patients	84% of 122 patients	93%	93%
PN-6	Initial Antibiotic Selection for CAP in Immunocompetent Patient	86% of 227 patients	91% of 34 patients	97% of 33 patients	94% of 18 patients	94% of 85 patients	87%	87%
PN-7	Influenza Vaccination	63% of 38 patients	N/A	N/A	NA/	-	77%	77%

# **BARRIERS TO IMPROVEMENT OF PNEUMONIA OUTCOMES**

- Downsizing of inpatient beds=extended wait time ED..
- Patients presenting initially without symptoms of PN.
- Physicians and nurses deviating from PN protocol.
- Agency staff

## **INTERVENTIONS FOR IMPROVEMENT**

- Continue review of all pneumonia cases within 24-48 hours.
- Continue procedure for expediting chest xray tests and results.
- Continue monthly internal review to
  - -identify deficiencies
  - -and utilize quality tools to analyze root causes.
- Re-inservicing Nursing Staff, including, agency staff regarding the necessity for documenting correct times when blood cultures are obtained. Implement progressive disciplinary for non-compliant staff.

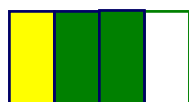
# DEPARTMENTAL INDICATORS

# PROVIDENT HOSPITAL OF COOK COUNTY

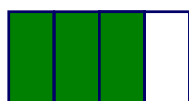
## DIVISION OF PROFESSIONAL SERVICES INDICATORS – THIRD CALENDAR QUARTER 2009

### Cardiac Diagnostic

Echocardiogram  
Read Time Inpt. &  
outpt. (48 hrs)



Complete Inpt.  
Stress Tests  
(48 hrs)



### Clinical Lab

STAT Lab  
Turnaround Time



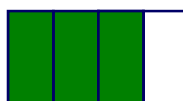
Proficiency  
Test Scores



Blood Culture  
Contamination Rate



Patient  
Satisfaction



### Employee Health

Tuberculin  
Skin Testing



Decrease Needlestick  
Injuries in Healthcare  
Workers



### Human Resources

Performance  
Evaluation  
Completion



### Infection Control

Hand washing  
Compliance



Surgical Site \*  
Infection Rate



0% 1.6% 0%

\*=Herniorraphy only included.  
Benchmark: 0.8-3.94

Central Line  
Associated BSI  
Rate



0% 0% 0%  
Benchmark: 2.9

### Physical Therapy

Outpatient  
Appointment  
Availability



Response Turn-  
around Time (TAT)



### Occupational Therapy (OT)

Turn-around Time for  
Initial O.T.  
Assessment



Patient  
Satisfaction with  
Outpatient O.T.



**Key:** Green : Targeted Goal of 90-100 is met  
Yellow: Targeted goal is not met; outcomes are 80-89%  
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## CORRECTIVE ACTION PLANS FOR VARIANCES

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- Clinical Laboratory: Turn-around Time of STAT Tests – The goal of 100% was not met due to staffing shortages and inconsistent monitoring by the Managers. The action plan implemented during the Fourth Quarter involves the analysis of the data to identify the individual technicians who are not performing and holding the Department Managers accountable. At the November 6, 2009 meeting of the Hospital-wide Quality and Performance Improvement Committee, it was unanimously approved that the October data outcomes must be provided at the December meeting and subsequently reported monthly.
- PT: Outpatient Wait Time – The wait time goal is less than two weeks. The variances are due to lack of staffing. The wait time of four weeks was maintained in spite of an increase in volume as compared with Third Quarter 2008 volume (40% higher). The wait goal during the Third Quarter 2008 was 5.58 as compared to four weeks this Third Quarter utilizing the same number of staff. Action Plan: The Department Director will continue to utilize partial or full coverage from contract staff for staff vacations and occasionally for additional short-term staffing to try to decrease wait times. Staff will continue to overbook outpatient evaluations when possible to account for no shows/cancellations of initial evaluation appointments and minimize unused appointment slots.

Response to PT Evaluation Requests within 24 hours: Analysis of variances reflect that the causes are inadequate coverage to lack of clear communication and notification of requests not being received in a timely manner. Action Plan: Department Director will ensure that coverage for inpatient evaluations is arranged during staff absences and clearly communicated to all staff. Department is working with IT to ensure consistent printing out of PT requisitions in the department. Staff have also been cross-checking the printed requisitions and the computerized task lists to ensure that all requisitions are received timely.

- OT: Treatments not completed due to the patient not being available or patient refusal are beyond staff/department control. Staff try to make a second attempt to see the patient if they are unavailable due to a test or other appointment. No treatments were missed due to lack of staff availability during this reporting period.

At the November 6, 2009 meeting of the Hospital-wide Quality and Performance Improvement Committee, it was unanimously approved that the October data outcomes must be provided at the December meeting and subsequently reported monthly

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PROVIDENT HOSPITAL OF COOK COUNTY  
DIVISION OF PROFESSIONAL SERVICES – THIRD CALENDAR QUARTER 2009

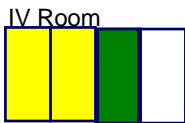
**Pharmacy**

**Radiology**

IV Hood  
Cleaning



Appropriate Garb



Check Pre-Mix (IV Room)

Expiration Dates



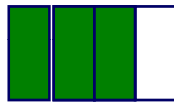
No Reconstituted items-24 hr.  
Expiration Date



**Indication for Lovenox**



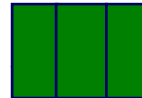
Appropriate Lovenox Dosing



Film Reject Rate



Inventory of Lead  
Aprons



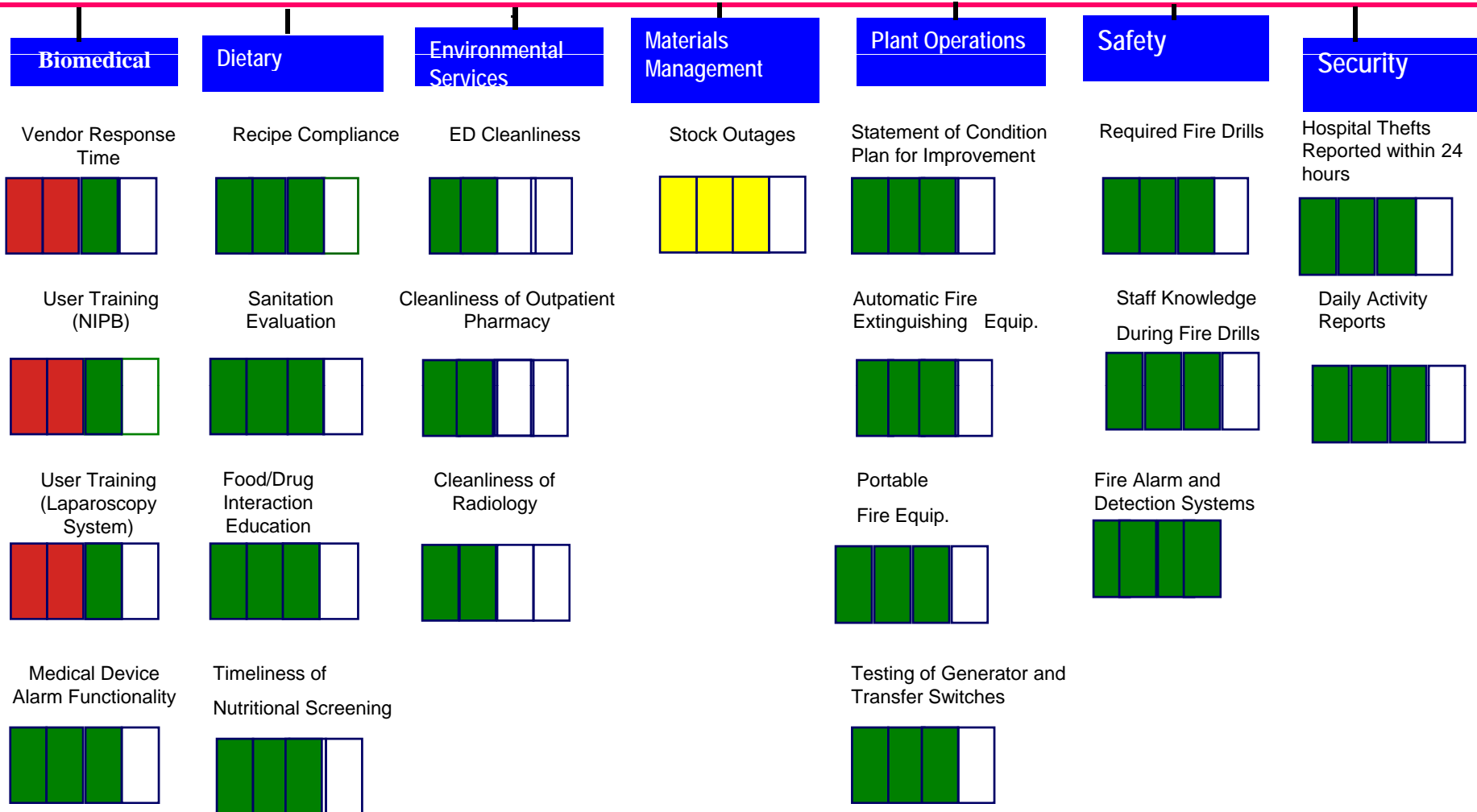
Drug Appropriateness Review  
(IV Contrast Media)



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Yellow: Targeted goal is not met; outcomes are 80-89%  
Red: Targeted Goal is not met; outcomes are 70-79% •

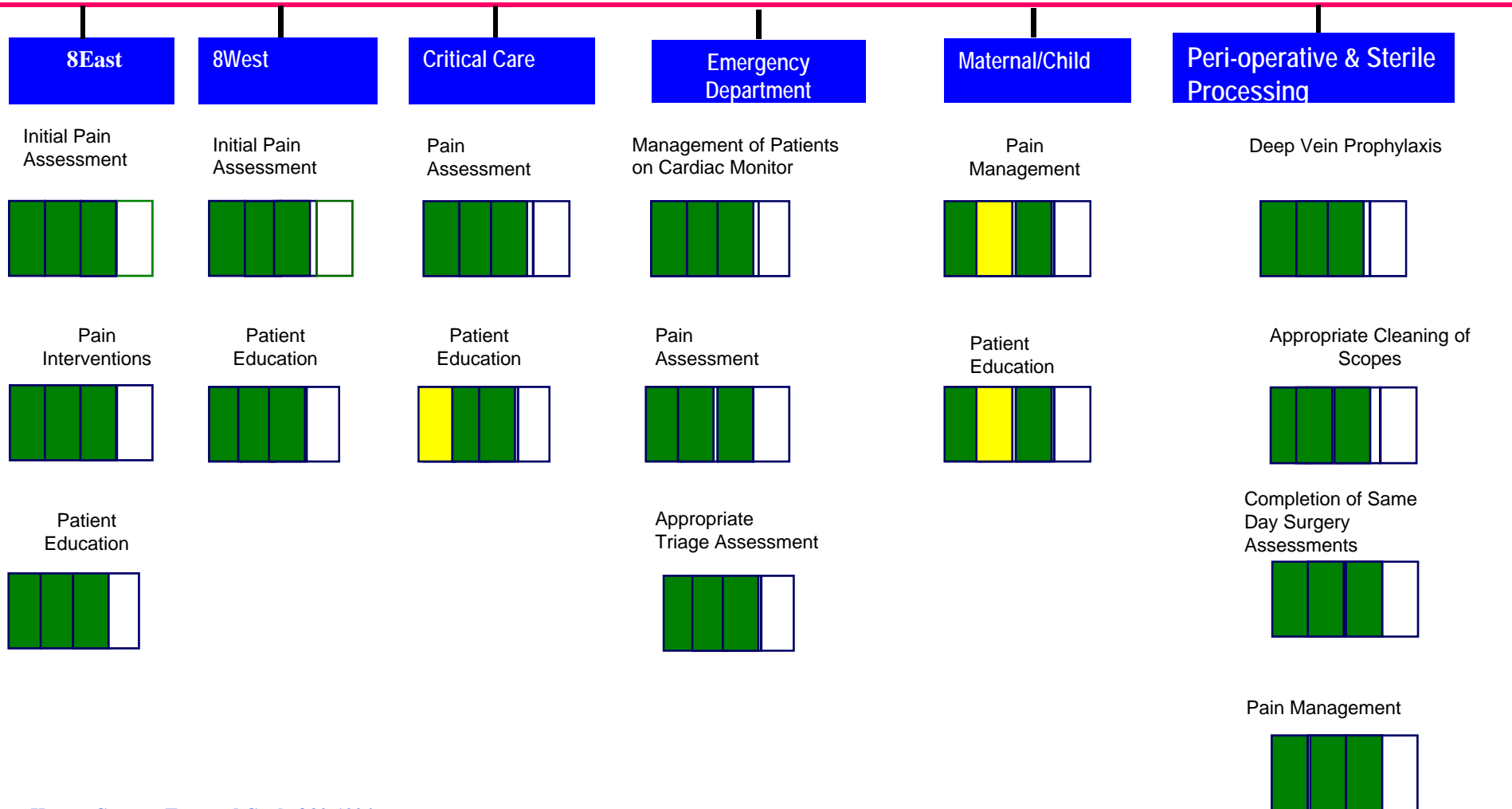


**PROVIDENT HOSPITAL OF COOK COUNTY**  
**DIVISION OF SUPPORT SERVICES QUALITY INDICATORS – THIRD CALENDAR QUARTER 2009**



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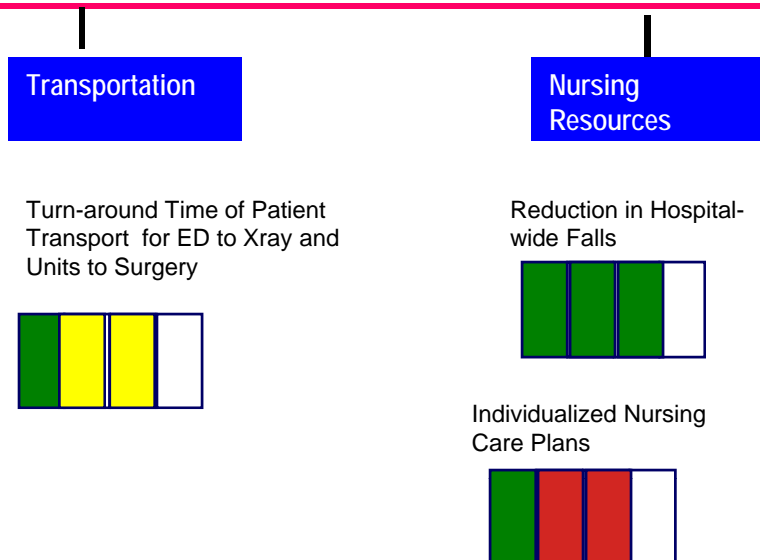
**PROVIDENT HOSPITAL OF COOK COUNTY**  
**DIVISION OF NURSING SERVICES QUALITY INDICATORS – THIRD CALENDAR QUARTER 2009**



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# PROVIDENT HOSPITAL OF COOK COUNTY

## DIVISION OF NURSING SERVICES QUALITY INDICATORS – THIRD CALENDAR QUARTER 2009



**Action Plan for Individualized Nursing Care Plans:** The Nurse Managers and Educators will concurrently provide 1:1 counseling to responsible staff regarding deficiencies in documentation; streamline the current process by developing an integrated 24 hours plan flow sheet. The revised flowsheet incorporates Problem, Intervention, and Evaluation documentation as well as resolution of individualized problems. This revised process will minimize the number of care plan forms required for documentation. Full implementation of the revised process is January 1, 2010.

**Action Plan For Timely Transport of Patients:** The analysis of data reflected the reasons for delays are (1) patients not ready, (2) inadequate staff to cover during lunch breaks or when staff is off ill. Department Director revised staffing patterns to overlapping shifts to compensate for lack of staff. For the issue of patient(s) not being ready (ED) due to treatments or procedures, the Director of ED Nursing has advised the staff not to request the transporter until the patient is ready for transport. The QPI Committee has requested that monthly reports regarding this measurement be provided.

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**PROVIDENT HOSPITAL OF COOK COUNTY**  
**DIVISION OF FINANCE QUALITY INDICATORS – FIRST AND SECOND CALENDAR QUARTER 2009**

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**Health & Information  
Records**

Coding Accuracy



Delinquent Medical Records



**Social Services**

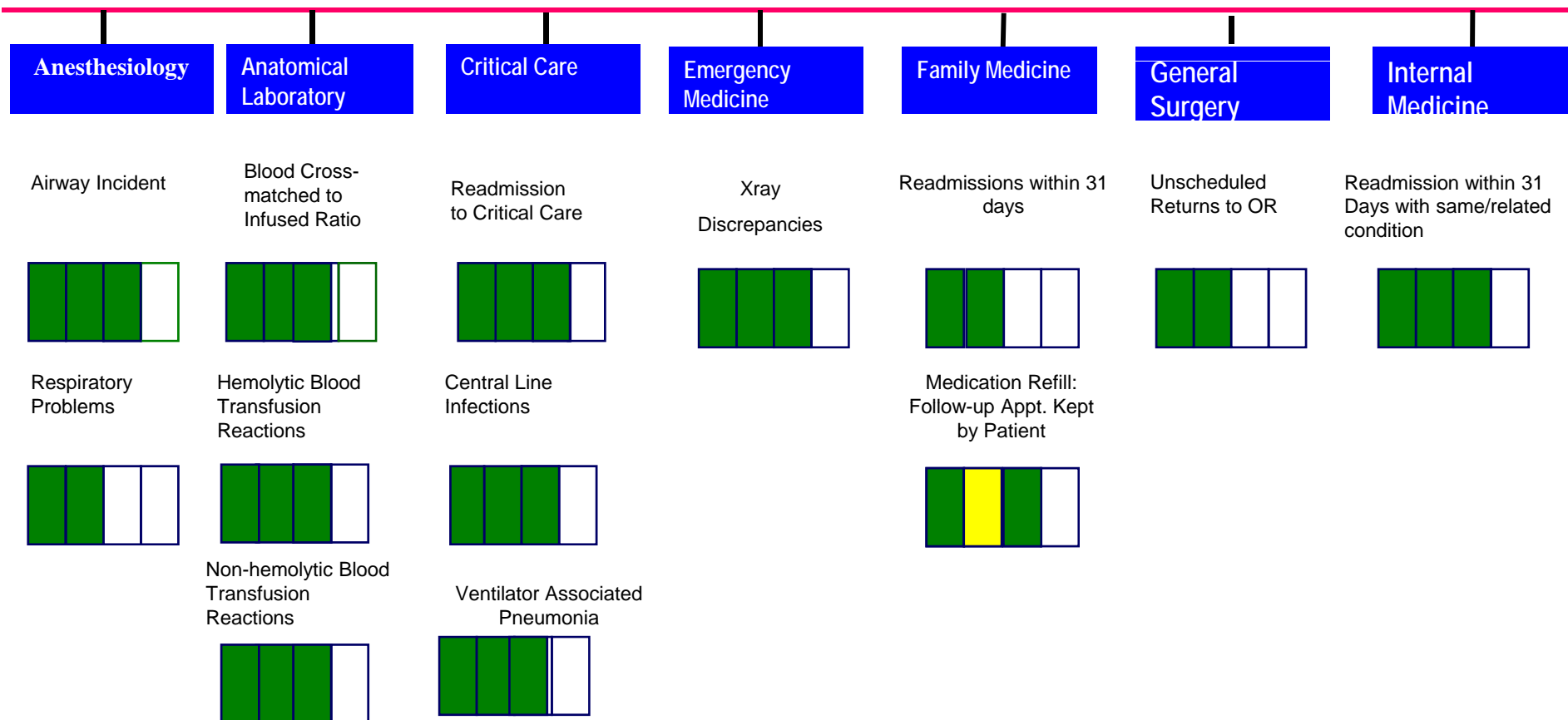
Timeliness of Intervention



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# PROVIDENT HOSPITAL OF COOK COUNTY

## DIVISION OF MEDICAL STAFF INDICATORS – THIRD CALENDAR QUARTER 2009



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Yellow: Targeted goal is not met; outcomes are 80-89%

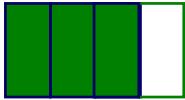
Red: Targeted Goal is not met; outcomes are 70-79% .

PROVIDENT HOSPITAL OF COOK COUNTY  
DIVISION OF MEDICAL STAFF SERVICES – THIRD CALENDAR QUARTER 2009

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Obstetrics/Gynecology

Primary C-Section Rate



Repeat C-Section Rate



Pediatrics

Neonatal Mortality



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Red: Targeted Goal is not met; outcomes are 70-79%

# NATIONAL PATIENT SAFETY GOALS

NPSG	STATUS OF IMPLEMENTATION	COMPLIANCE (Measure of Success )
<b>Goal 1:</b> Improve the accuracy of patient identification.	Policy and procedure in place. Staff inservices completed.	During 2009, compliance was assessed via patient observation and safety reports. 90% compliance as of Third Quarter 2009.
<b>Goal 2 :</b> Improve the effectiveness of communication among care givers.	Policies and Procedures have been developed and distributed.	Compliance assessed via observation and patient safety reports Compliance is 90% as of Third Quarter.
<b>Goal 7:</b> Reduce the risk of health care acquired infections. <b>7a:</b> Comply with current CDC hand hygiene guidelines . <b>7b:</b> Manage as sentinel events all identified cases of unanticipated death or major permanent loss of function associated with healthcare acquired infections.		Hand Hygiene : 100% compliance.  No occurrences of sentinel events due to health acquired infections.





# REGULATORY ACCOMPLISHMENTS

- Cook County Department of Public Health -Compliant
- Chicago Department of Public Health - Compliant
- Department of Regulations - Compliant
- College of American Pathologists – Accredited.

Cook County Health and Hospitals System  
Minutes of the Quality and Patient Safety Committee Meeting  
November 24, 2009

ATTACHMENT #2

## **Draft - 2010 Quality and Patient Safety Committee Meeting Dates**

### **Time: 12:00 – 2:00 P.M.**

Tuesday, January 19, 2010

Tuesday, February 16, 2010

Tuesday, March 16, 2010

Tuesday, April 20, 2010

Tuesday, May 18, 2010

Tuesday, June 15, 2010

Tuesday, July 20, 2010

Tuesday, August 17, 2010

Tuesday, September 21, 2010

Tuesday, October 19, 2010

Tuesday, November 16, 2010

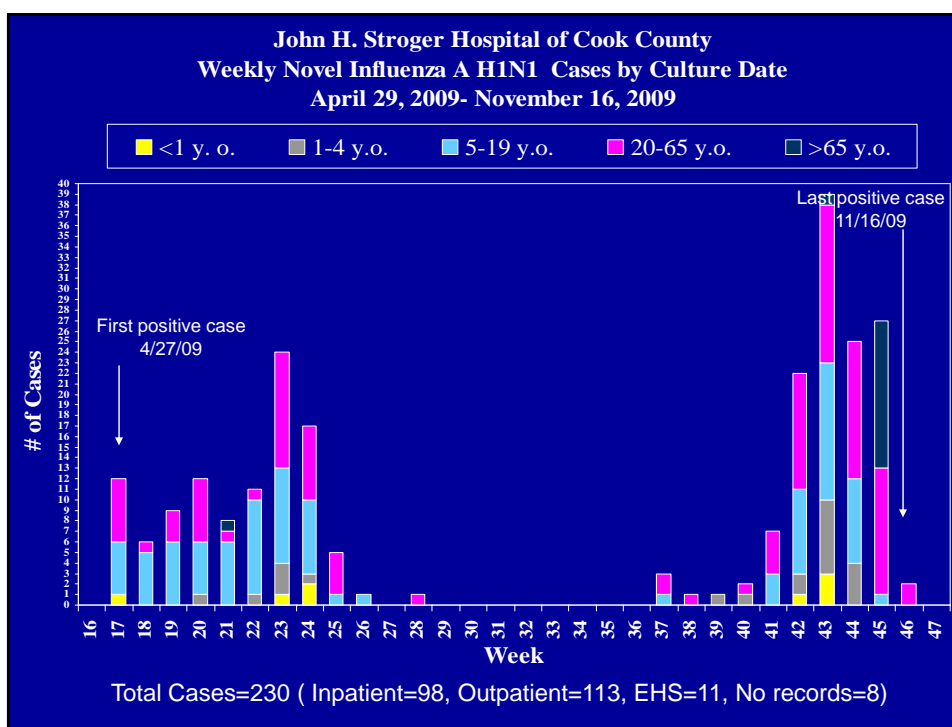
Tuesday, December 21, 2010

Cook County Health and Hospitals System  
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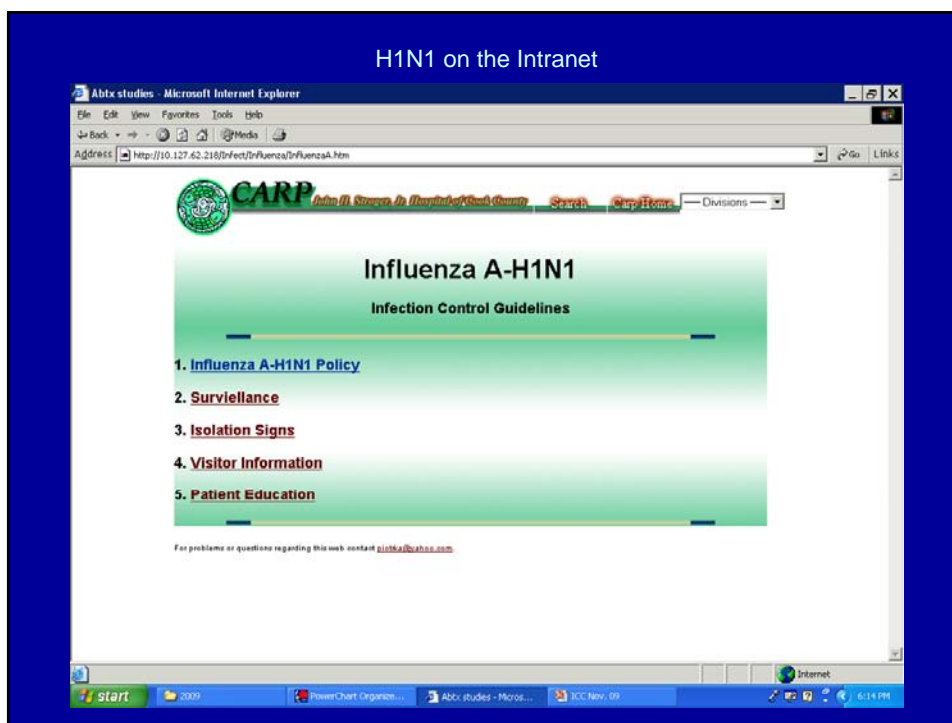
ATTACHMENT #3

# Healthcare Associated Infections CCHHS

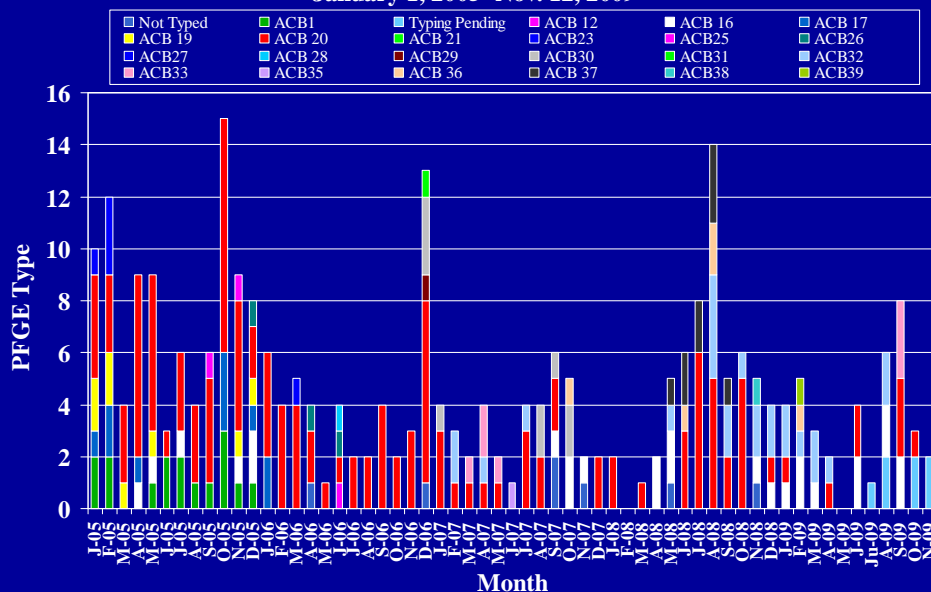
Sharon F. Welbel, M.D.

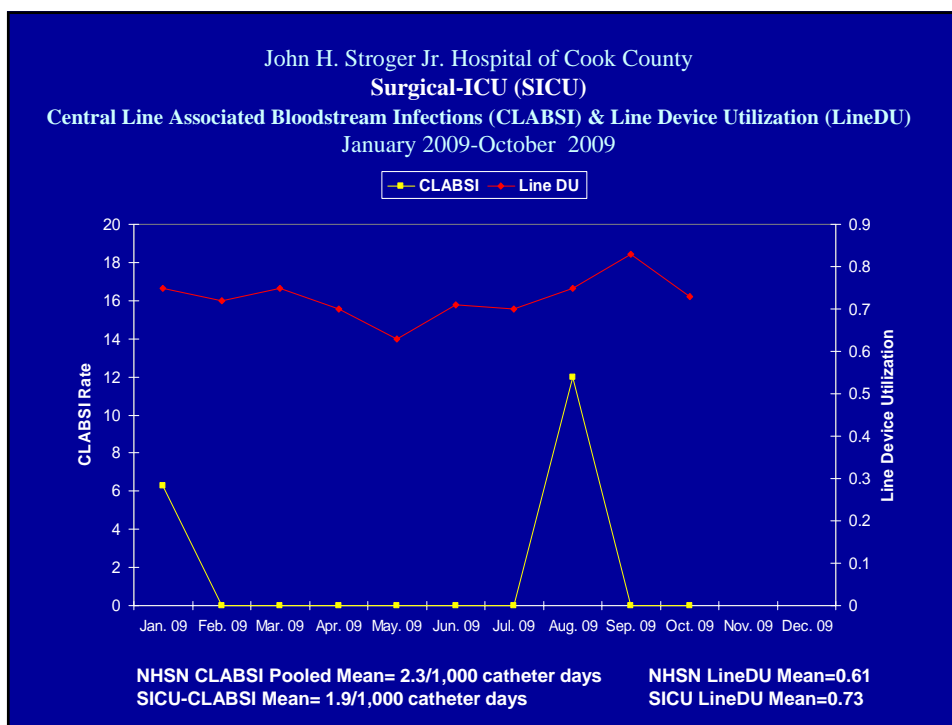
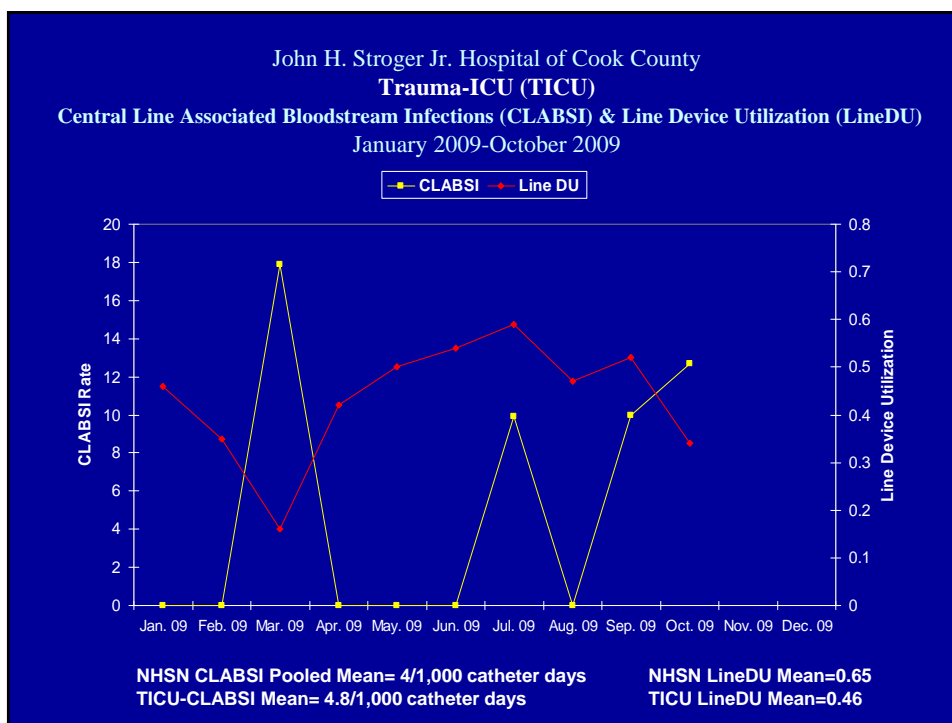


## H1N1 on the Intranet

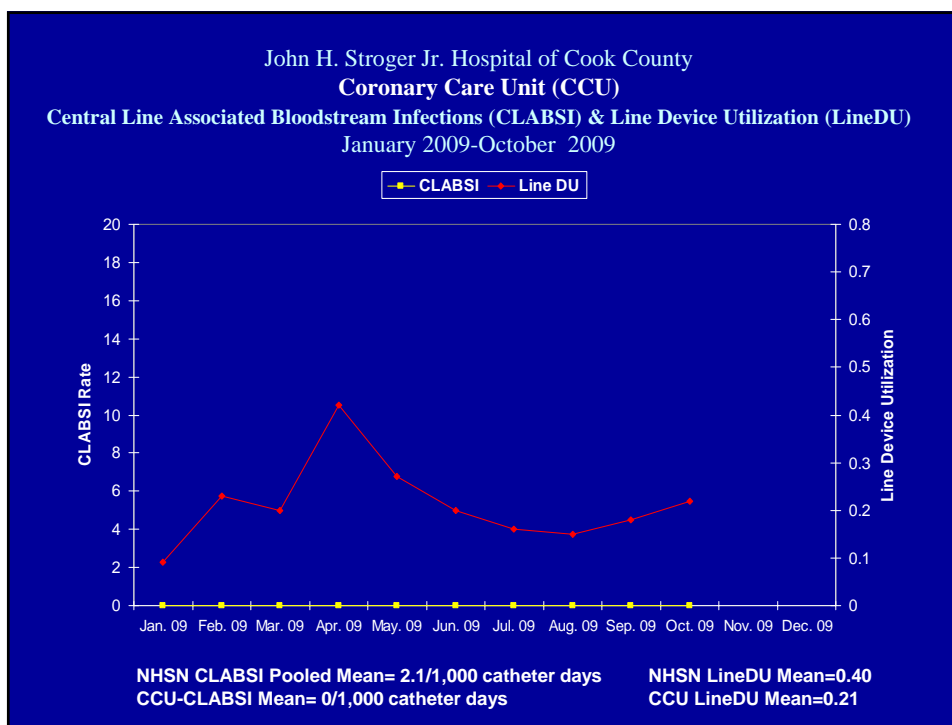
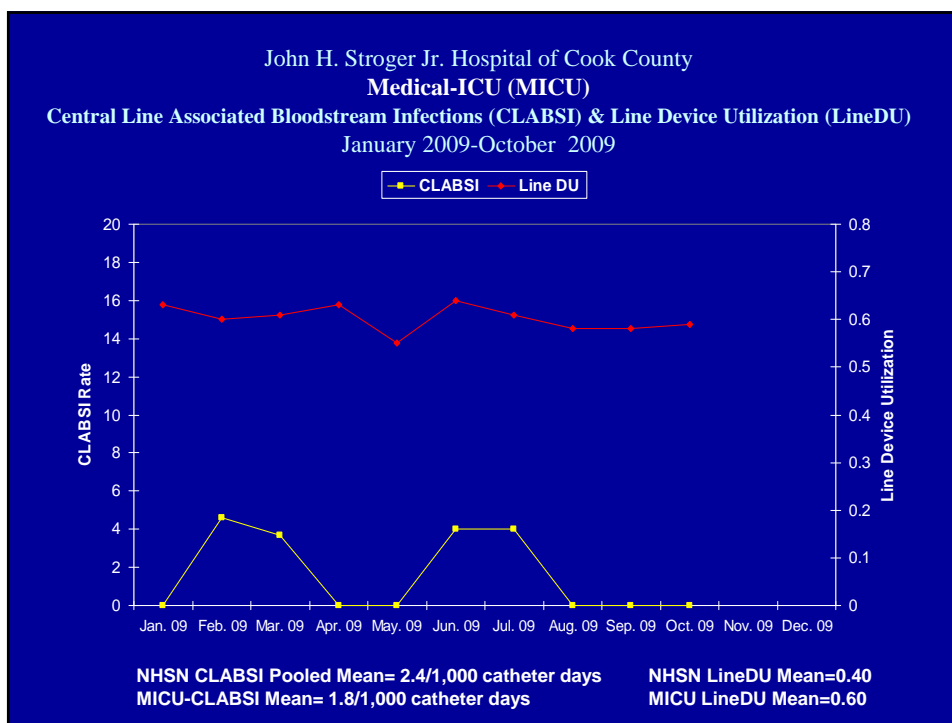


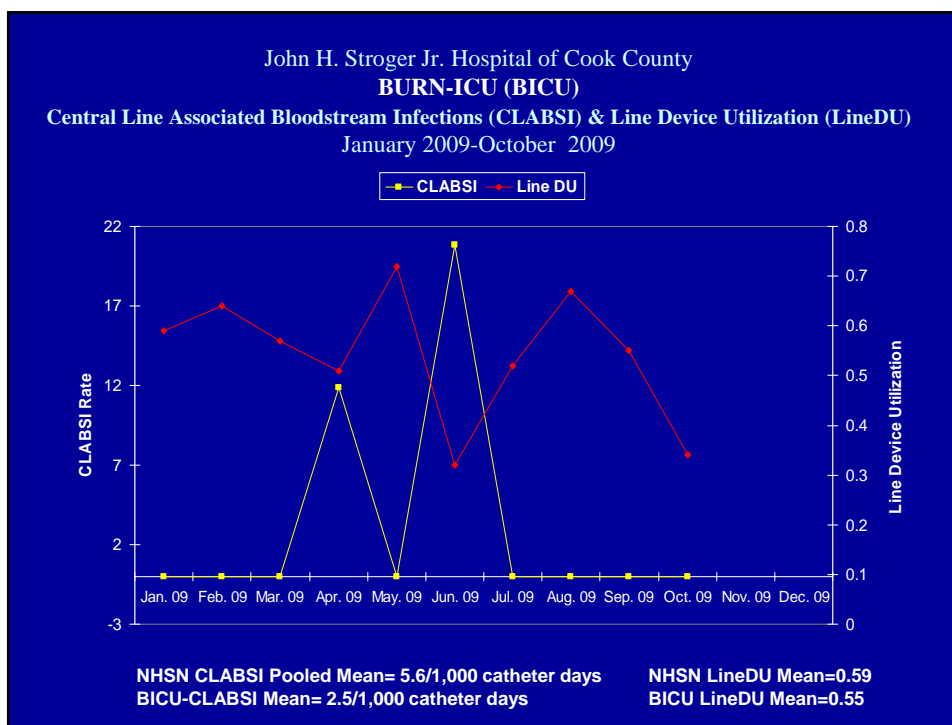
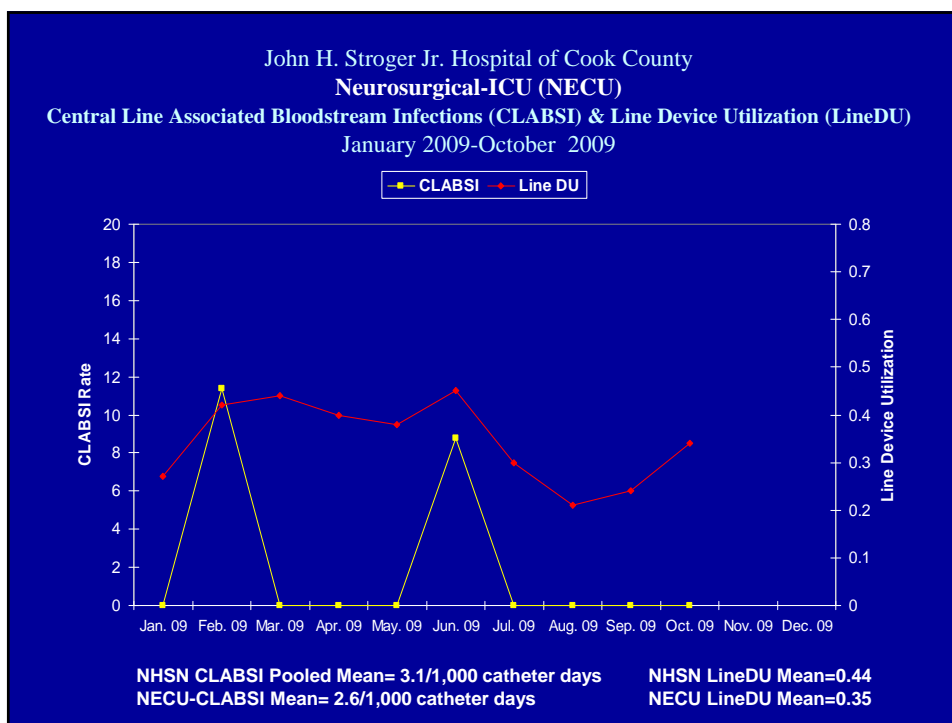
John H. Stroger Hospital of Cook County  
*Acinetobacter baumannii* Onset by PFGE Type  
 January 1, 2005- Nov. 12, 2009

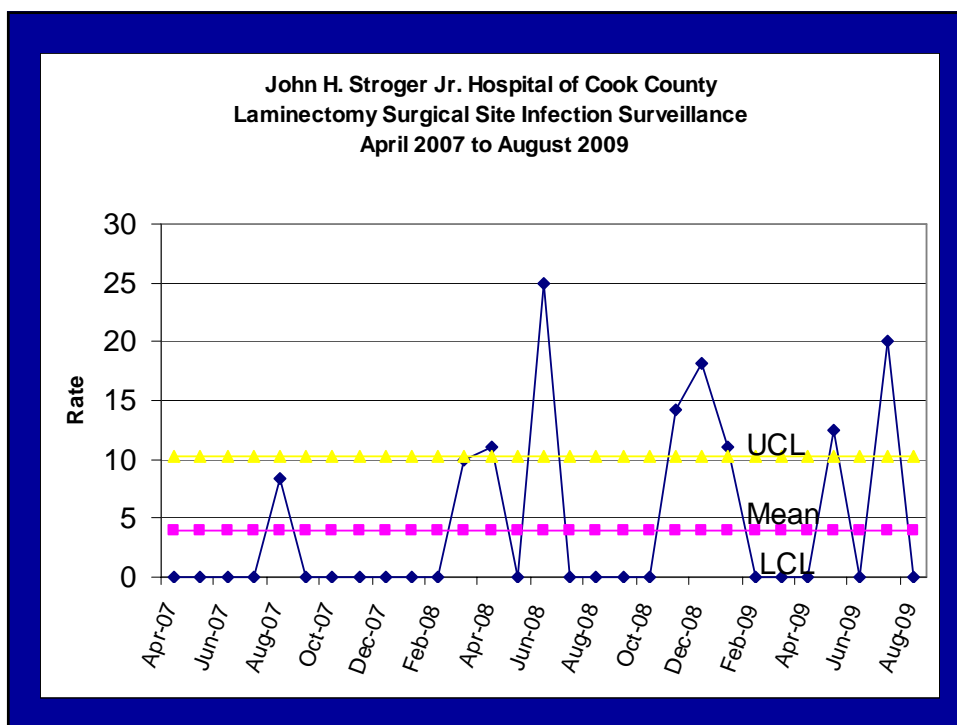
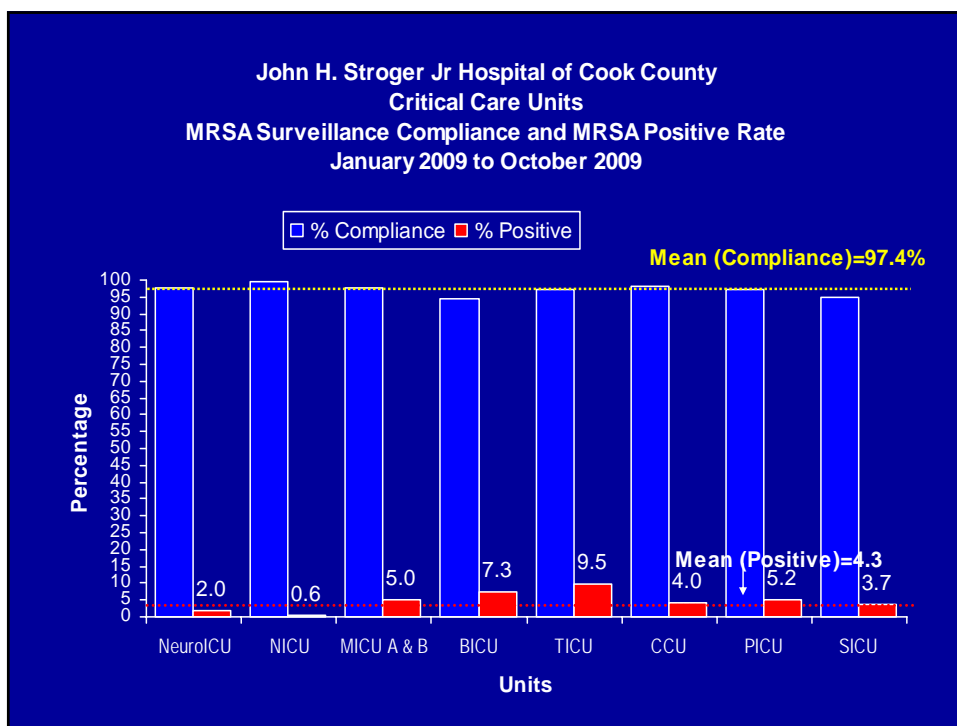












**John H. Stroger, Jr. Hospital of Cook County**  
**Outpatient Dialysis Incidents Summary**  
**January 2009 to December 2009**

Month	Total # of Out-patients (1st two days of month)	Number of Vascular Access Infections	Vascular Access Associated Infection per 100 Patient-months	Cuffed Catheter Associated Bacteremia per 100 Patient Months	Fistula Associated Bacteremia per 100 Patient Months	Graft	Fistula	Temporary Catheter	Permacath
January 2009	57	1	1.8	1.9	0	1	3	0	53
February 2009	62	2	3.2	3.4	0	1	3	0	58
March 2009	67	1	1.5	1.6	0	1	4	0	62
April 2009	60	3	5.0	5.4	0	1	4	0	55
May 2009	61	0	0	0	0	1	3	0	57
June 2009	52	1	1.9	2.1	0	2	3	0	47
July 2009	56	3	5.3	6.1	0	2	5	0	49
August 2009	61	2	3.3	3.6	0	2	4	0	55
September 2009									
October 2009									
November 2009									
December 2009									
Total	476	13	2.7	3.0	0	11	29	0	436

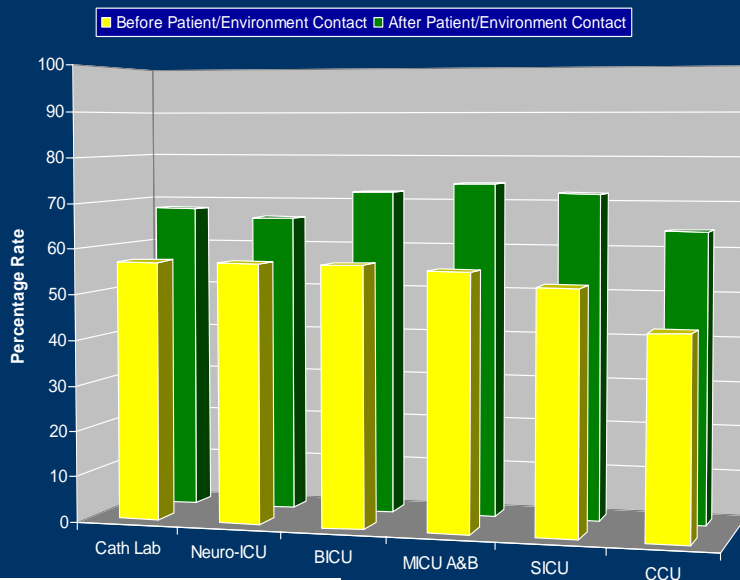
DSN Data: (Tokars, J., Miller, E., Stein, G. AJIC, 30 (5), 288-295).

Fistula vascular access rate= 0.56 (local access-0.30, access associated bacteremia-0.25)

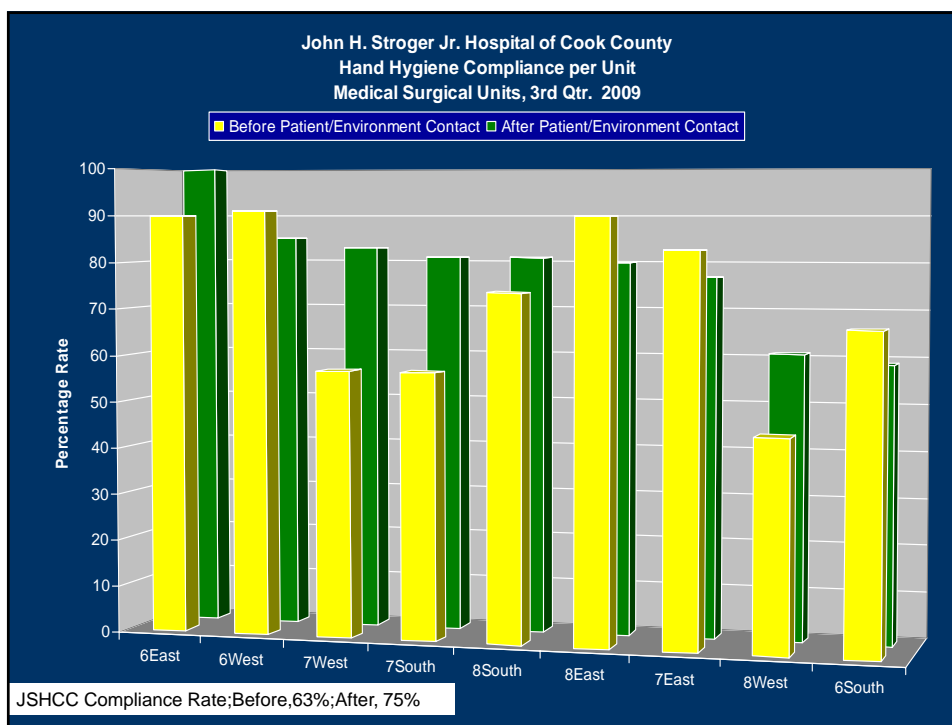
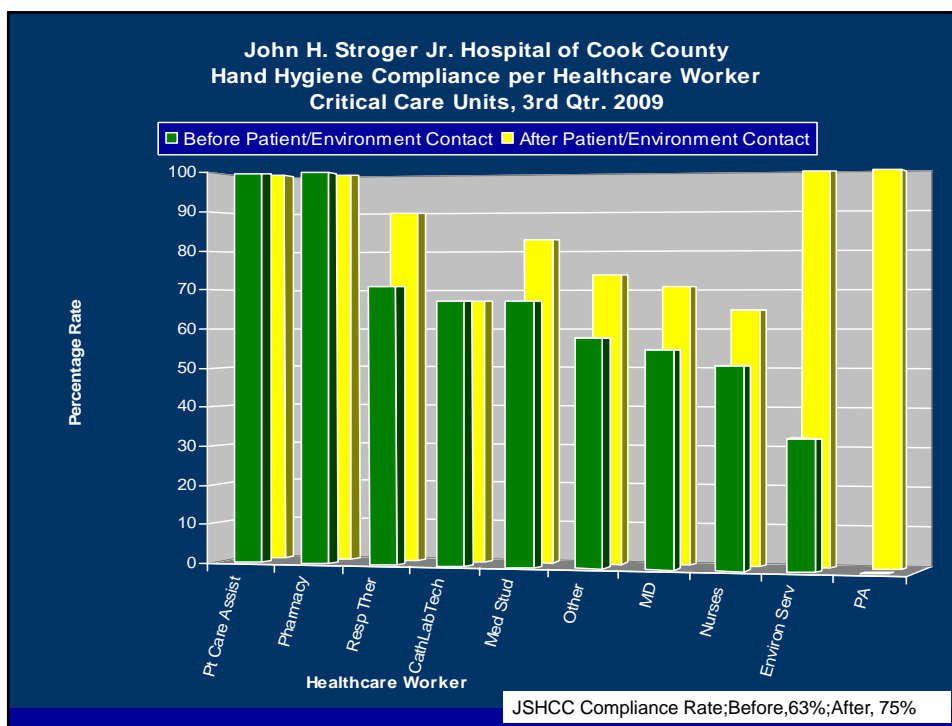
Cuffed Catheter= 8.42 (local access-3.58, access associated bacteremia-4.84)

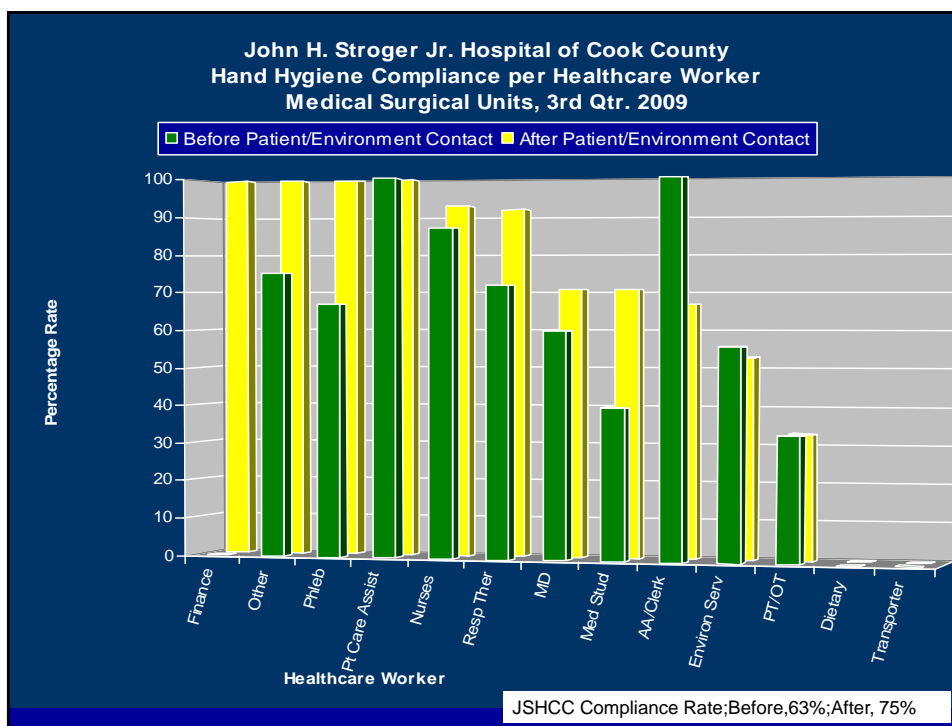
All access= 3.22 (local access 1.43, access associated bacteremia- 1.78)

**John H. Stroger Jr. Hospital of Cook County**  
**Hand Hygiene Compliance per Unit**  
**Critical Care Units, 3rd Qtr. 2009**

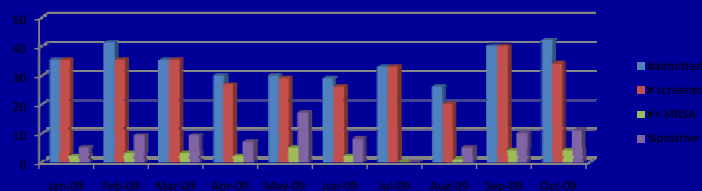


JSHCC Compliance Rate; Before, 63%; After, 75%





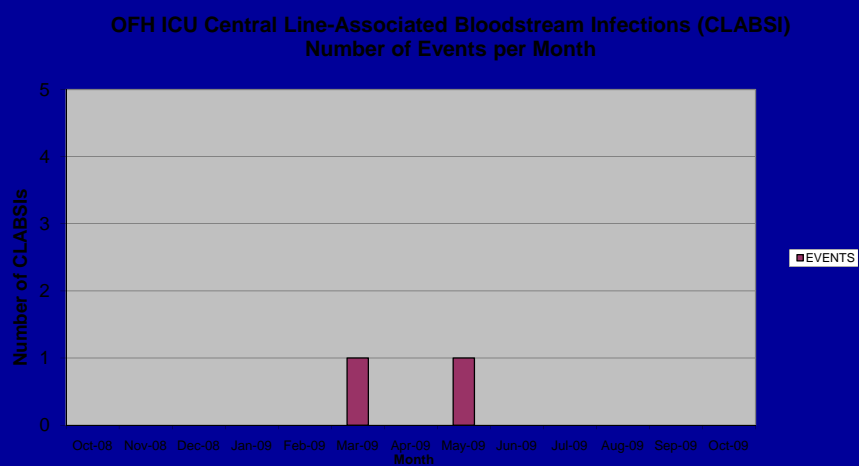
## MRSA Screening in the CCU

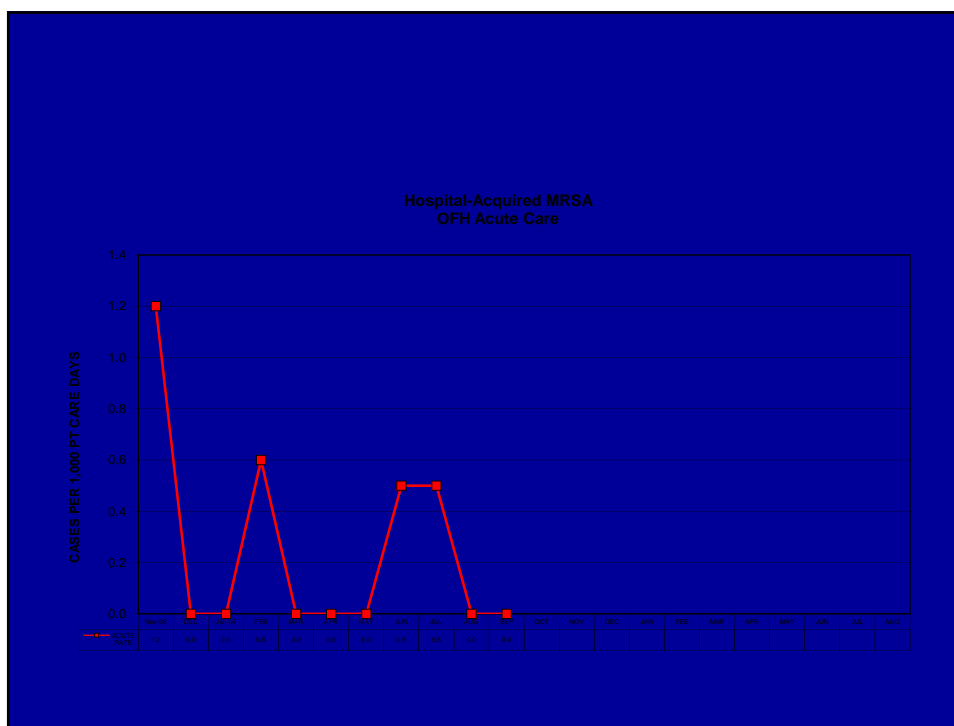


month	#admitted	# screened	#+ MRSA	%positive
Jan-09	35	35	2	5
Feb-09	41	35	3	9
Mar-09	35	35	3	9
Apr-09	30	27	2	7
May-09	30	29	5	17
Jun-09	29	26	2	8
Jul-09	33	33	0	0
Aug-09	26	20	1	5
Sep-09	40	40	4	10
Oct-09	42	34	4	11

## CA- BSI

Month/Year	# Infections	# Catheter Days	Rate	NHANE mean	Historical Mean
Jan-09	0	85	0	2.9	2.1
Feb-09	0	81	0	2.9	1.9
Mar-09	0	139	0	2.9	2.0
Apr-09	0	113	0	2.9	2.0
May-09	0	169	0	2.9	2.0
Jun-09	0	55	0	2.9	1.9
Jul-09	0		0	2.9	1.9
Aug-09	0	105	0	2.9	1.8
Sep-09	0	60	0	2.9	1.8
Oct-09	0	79	0	2.9	1.8







Cook County Health and Hospitals System  
Minutes of the Quality and Patient Safety Committee Meeting  
November 24, 2009

ATTACHMENT #4

Item IV(D) – Quality Plans (System and Affiliates) and Structure

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<u>Ruth M. Rothstein CORE Center</u>	<u>Page 22</u>
<u>John H. Stroger, Jr. Hospital of Cook County</u>	<u>Page 23</u>
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<u>Provident Hospital of Cook County</u>	<u>Page 26</u>

# **COOK COUNTY HEALTH & HOSPITALS SYSTEM**

## **2010 Quality Plan**

### **I. FOUNDATION OF THE CCHHS QUALITY**

The Cook County Health & Hospitals System (CCHHS) Quality Plan and related quality improvement activities are created and developed based on the mission and vision of the CCHHS.

#### **MISSION**

To deliver integrated health services with dignity and respect regardless of the patient's ability to pay; foster partnerships with other health care providers and communities to enhance the health of the public; and advocate for policies which promote and protect physical, mental, and social well-being of the people of Cook County.

#### **VISION**

In support of its public health mission, CCHHS will be recognized, locally, regionally, and nationally – and by patients and employees – as a progressively evolving model for an accessible, integrated, patient-centered, and fiscally responsible health care system focused on assuring high-quality care and improving the health of the residents of Cook County.

The CCHHS Board and all of its employees are fully committed to providing the highest quality of care to patients of Cook County in an environment that focuses on patient safety and fosters a system-wide focus on ongoing quality improvement. National and regional benchmarks, evidence-based standards, and modern, constantly updated best health care practices will be used to support and monitor the excellence of the care delivered in the CCHHS.

### **II. PURPOSE OF THE QUALITY PLAN**

- To demonstrate evidence of the commitment of the CCHHS to the delivery of quality care.
- To outline the framework and structure for identification, implementation, and evaluation of improvements for all clinical and support services in the CCHHS.
- To establish the reporting and review frameworks that will be used by the Medical, Staff, Nursing, and Ancillary Services to systemically report and review the quality and appropriateness of care in the CCHHS.

In order to assure that the CCHHS is dynamically responding to the ongoing needs of its patients, staff, and health care delivery system, with the approval of the CCHHS leadership, the plan, frameworks, and structure of its quality program may need to be modified during the calendar year. The CCHHS Quality & Patient Safety Committee will be notified of any modifications.

### **III. GOALS AND OBJECTIVES OF THE CCHHS QUALITY PLAN**

To facilitate the mission of the CCHHS and to implement the CCHHS Board's goals and objectives in order to promote organizational and clinical excellence, maximize patient

## COOK COUNTY HEALTH & HOSPITALS SYSTEM

### 2010 Quality Plan

safety and access to care, and achieve high levels of patient and staff satisfaction the CCHHS Quality Plan is designed to:

- A. Coordinate improvement efforts and projects to ensure that capital, staff, facilities and technologies are aligned with strategic priorities for service improvement.
- B. Implement a system-wide quality program with performance priorities
- C. Enable processes and systems that identify and resolve issues and events that may adversely impact patient care and services throughout the System.
- D. Identify and implement best practices for the provision of safe, cost effective care and services. Benchmark the System's services against the best of class hospitals and health care delivery systems.
- E. Meet the expectations of our patients, staff, and other stakeholders to improve and maintain patient and staff satisfaction.
- F. Continually assess and monitor organizational performance.
- G. Meet accreditation and certification requirements.
- H. Support compliance with all regulatory and licensure requirements.
- I. Track, trend, and communicate patient care and organizational outcomes.
- J. Establish a schedule for reporting of quality measurements, patient care statistics, and improvement projects.
- K. Create an organizational atmosphere of blameless and non-punitive, sustainable quality improvement.
- L. Foster the use of interdisciplinary problem solving throughout the CCHHS.
- M. Assure the involvement of the CCHHS Board of Directors and other facility leadership in quality improvement.

The Quality Plan will have the following inherent qualities and values (IOM, 2001):

- **Safe** – avoiding injuries to patients from the care that is intended to help them;
- **Effective** – providing services based on scientific knowledge to those who would benefit, and refraining from providing services to those not likely to benefit;
- **Patient Centered** – providing care that is respectful of, and responsive to, individual patient preferences, needs, and values and ensuring that patient values guide all clinical decisions;
- **Timely** – reducing waits and potential harmful delays;
- **Efficient** – avoiding waste, including waste of equipment, supplies, ideas, and energy; and
- **Equitable** – providing care that does not vary in quality because of personal characteristics such as gender, ethnicity, geographic location, and socioeconomic status

#### IV. SCOPE

To achieve the goal of delivering high quality care, all CCHHS employees are given the responsibility and authority to participate in the quality improvement program. The Quality Program includes the following activities:

## **COOK COUNTY HEALTH & HOSPITALS SYSTEM**

### **2010 Quality Plan**

Data related to the following are collected, analyzed and reported to the appropriate committees/departments/individuals:

- Operative and other invasive procedures
- Medication use and management
- Blood and blood component use
- Restraint and seclusion use
- Resuscitation and its outcomes
- Staffing Effectiveness
- Patient Satisfaction
- Core Measures
- Utilization Management
- Infection control surveillance and reporting
- Clinical Pertinence, appropriateness, and outcomes
- Autopsy results
- Moderate/deep sedation and anesthesia
- Morbidity and Mortality Review
- Organ Procurement Effectiveness
- National Patient Safety Goals where appropriate
- Quality Control related to Lab, Radiology, Dietary, Nuclear Medicine, and Radiation Oncology
- Performance measures related to the Environment of Care Management Plans
- Other measures as determined by the System and Affiliate Quality Councils and Committees

Data related to the required measures and patient safety is measured in a number of ways including: monitoring of indicators or processes, patient and staff surveys, reported events, root cause analysis, and other analyses.

The following quality and patient safety committees gather analyze and report on quality of care, treatment, services and patient safety in the CCHHS affiliates:

#### **John H. Stroger of Cook County Hospital**

Hospital Wide Quality Assessment  
& Improvement Committee  
Bioethics Committee  
Blood Bank and Transfusion  
Committee  
Cancer Committee  
Credentials Committee  
Critical Care Committee  
Departmental Quality Committees

Departmental Oversight Committees  
Drug & Formulary Committee  
Environment of Care Committee  
Hospital Oversight Committee  
Infection Control  
Medical Records Committee  
Operating Room Committee  
Patient Safety Committee  
Surgical Function Review Committee

**COOK COUNTY HEALTH & HOSPITALS SYSTEM**  
**2010 Quality Plan**

Utilization Management Committee

**Oak Forest Hospital**

Quality Oversight Committee

Medical Executive Committee

Blood Utilization Committee

Clinical Departmental Quality &

Performance Improvement Committees

Credentials Committee

Ethics Forum

Infection Control Committee

Intensive Care Committee

Medical Quality Council

Pharmacy and Therapeutics Committee

Surgical Case Review Committee

Utilization Review

Quality Council

Ancillary Department Quality &

Performance Improvement Committees

Core Measure Improvement Committee

Environment of Care Committee

Medication Safety Committee

Executive Patient Care Committee

Medical Records Committee

Nurse Executive Committee

Patient Safety Committee

**Provident Hospital**

Hospital Wide Quality & Performance Improvement Committee

Hospital Quality Forum

Nursing and Ancillary Support Services Quality & PI Sub-committees

Environment of Care Committee

Utilization Review

Medical Quality Forum

Credentials Committee

Infection Control Committee

Medical Department Quality & PI Committees

Medical Records Committee

Pharmacy & Therapeutics Committee

Patient Safety Committee

Surgical Case and Blood Utilization Committee

**Ambulatory & Community Health Network**

ACHN Quality Committee

Fantus Health Center-Stroger Specialty Center Quality Committee

**Cermak Health Services**

Quality Committee

Drug and Medication Utilization Committee

Mortality Committee

**CORE Center**

**COOK COUNTY HEALTH & HOSPITALS SYSTEM**  
**2010 Quality Plan**

Quality Improvement Committee

**Cook County Department of Public Health**  
Quality & Performance Improvement Committee

**V. PERFORMANCE IMPROVEMENT SELECTION**

Selection of opportunities for improvement may include one or more of the following mechanisms:

- incorporate goals or important functions of the CCHHS an/or affiliate
- evaluation of findings from root cause or failure mode effect analysis
- data, from internal or external sources, which indicate performance problems in a given process and affects a substantial proportion of patients or employees or represents a substantial risk
- risk management
- utilization management
- operational or quality committees
- external data or feedback from various customer or supplier groups related to the process
- data indicating performance or resource utilization problems from department quality improvement activities

Criteria for prioritization include:

- significant potential to improve patient safety
- significant potential to improve the quality of care
- significant potential to increase patient and staff satisfaction
- significant potential to impact efficiency
- significant potential to impact expense or revenue
- processes that cross multiple departments
- advances capabilities to do future improvement projects (such as pilot programs)
- significant potential to achieve strategic goals of system or affiliate

Should there be competition for resources, elective projects will be determined using a weighted matrix of risk and benefit.

**VI. METHODOLOGY**

The methodology utilized to improve is based on the type of project, goals, timeline and scope. The general method for quality improvement in the CCHHS is FOCUS-PDCA. The simplest improvement approach will be applied to a problem or issue, Rapid cycle improvement processes are encouraged when feasible and appropriate. The Quality Plan recognizes that more complex projects with a wide range of services and staff will require a more structured approach.

- **Find** a process to improve

## COOK COUNTY HEALTH & HOSPITALS SYSTEM

### 2010 Quality Plan

- Determined by either variation in data collection of key indicators or from an identified priority for improvement through the Quality Council/Committee using the selection criteria noted in V.
- **Organize** to improve the process
  - Assemble a team of staff who are knowledgeable of the process.
- **Clarify** current knowledge of the process
  - Gather and review the current data or data analysis. Be sure all members of the team understand the current process.
- **Understand** sources of process variation
  - Through qualitative and quantitative analysis and group discussion team should understand what the causes of variation in the current process may be.
- **Select** the process improvement
  - Based on above steps, use tools for performance improvement and re-engineering.
- **Plan** the implementation and the data collection as facilitated by the Quality Improvement staff.
- **Do** the improvement and data collection by making the change, implementing and then measuring the impact of the change (pilot test).
- **Check** the results of implementation through on-going data analysis by the PIC.
- **Act** to hold the gain and continue improvement
  - Actions should address the need for education, behavior change or system change. The plan of action will address who is responsible for implementation, the expected outcomes, timeframe for completion, when and how re-assessment is to occur.

#### VII. AUTHORITY OF THE BOARD OF DIRECTORS

The CCHHS Board of Directors shall have the authority for establishing, maintaining, and supporting a comprehensive and integrated system-wide quality improvement program. This includes an annual review of the CCHHS Quality Plan and program. The Board of Directors has delegated the authority for overseeing the effectiveness of the system's quality program to the Quality & Patient Safety Committee (QPSC) of the Board of Directors. The QPSC serves as the link between the Board of Directors and system's Quality Program and will report to the Board of Directors on the activities and outcomes of the system's quality program. The Board of Directors shall assign the responsibility for administering the quality plan to the CCHHS Quality Council, the system Chief Medical Officer, the system Chief Clinical Officer, the system Quality, Patient Safety, and Accreditation Director, and the affiliate CMOs, Quality Directors, Medical Executive Committees, CNOs, and ancillary leaders. The QPSC has also been delegated by the Board of Directors with the governing body's responsibility to review and approve the credentialing recommendations received from the medical staffs.

#### VIII. ROLE AND RESPONSIBILITY OF THE BOARD OF DIRECTORS IN QUALITY PROGRAM



## **COOK COUNTY HEALTH & HOSPITALS SYSTEM**

### **2010 Quality Plan**

The Cook County Health & Hospitals System Board of Directors assures that the required human and financial resources and processes are available to keep patients safe and to provide them with the highest standard of care in alignment with CCHHS' mission and vision. The Board reviews the summary reports on system and affiliate improvement activities and indicators that track the CCHHS' overall performance and reviews all periodic accreditation and regulatory audits. The Board will establish committees and subcommittees needed to fulfill its responsibility as the overseer of quality in the CCHHS.

#### **IX. ORGANIZATION AND STRUCTURE OF THE QUALITY PROGRAM OF THE CCHHS**

- 1. Board of Directors** receives and reviews regular summary reports from its Quality & Patient Safety Committee concerning quality and patient safety activities and projects, accreditation and regulatory audit visits, and key performance and outcome dashboards. The Board may also receive comprehensive system and affiliate reports and presentations as needed to enhance the Board's understanding and knowledge of especially important, demonstrative, or educational quality projects and outcomes.
- 2. Quality & Patient Safety Committee (QPSC) of the Board of Directors** is the committee of the CCHHS Board of Directors delegated with the responsibility of assuring the effectiveness of the CCHHS' quality program and and reviewing and approving all medical staff credentials and privilege applications in accordance with medical staff bylaws. The QPSC is comprised of three Directors of Board of Directors and other members with experience and expertise in the quality improvement and patient safety in health care delivery systems and organizations. The QPSC provides high level oversight of the effectiveness of quality and patient safety activities of the CCHHS. It approves the Annual Quality Plan, receives summary reports from the System Quality Council, trend reports, dashboards, and corrective action plans on core measures, national patient safety goals, sentinel, never, near miss events, mortalities, and patient and staff satisfaction surveys. The QPSC will also receive occasional comprehensive presentations concerning key system and affiliate quality improvement projects and outcomes.
- 3. System Quality Council (SQC)** critically analyzes quality reports received from system-wide quality taskforces, service lines, and performance improvement projects and minutes and quality reports from the seven affiliate quality councils/committees and the system nursing quality council. The SQC reviews and approves the annual system and affiliate quality plans and new system-wide quality initiatives recommended by the Annual Quality Initiatives and Planning Council. The SQC receives and provides input on reports and corrective action plans concerning core measures, national patient safety goals, sentinel, never, and near miss events, patient and staff satisfaction surveys, and regulatory and accreditation agencies. The SQC may request comprehensive presentations from

**COOK COUNTY HEALTH & HOSPITALS SYSTEM**  
**2010 Quality Plan**

affiliate and system quality committees, departments, and taskforces. The SQC is co-chaired by system CMO and the system Quality, Patient Safety, and Accreditation Director and its membership includes the system CCO, system COO, system CFO, system CMIO, system Inpatient Quality Director, the Assistant Pharmacy Director for Quality, at least one affiliate quality director, CMO, COO, CNO, President MEC, and at least one system or affiliate Department Chair, and one affiliate or system Division Chair.

4. **System Nursing Quality Council (SNQC)** aligns nursing and operations for assessment, monitoring, improvement, and sustainment of patient care processes to achieve patient-focused performance excellence. Membership of SNQC is comprised of representatives from CCHHS hospitals and affiliates.
5. **Annual Quality Initiatives and Planning Council (AQIPC)** is an ad hoc quality taskforce that meets in the Fall of each year to receive, review, select, and approve recommendations for new system quality initiatives received from the ambulatory and inpatient quality sub-councils. The recommendations for new system-wide quality initiatives would be submitted to the System Quality Council for incorporation in the next Annual Quality Plan. Membership of AQIPC will include the system and affiliate CMOs, CNOs, and Quality Directors, the system CMIO, CIO, COO, CFO, CCO.
6. **Affiliate Quality Council/Committee (AQC)** is the coordinating, oversight, and administrative committee for all quality and performance improvement activities in the affiliate. In affiliate hospitals, the quality council/committee collaborates with the Medical Staff Executive Committee in overseeing the clinical effectiveness of care. The President of Medical Staff Executive Committee or the affiliate CMO (in a non-hospital affiliate) or the affiliate CNO will chair or co-chair the affiliate quality council/committee. The membership of the AQC includes medical and nursing staff, senior affiliate leadership, clinical and ancillary department representatives, and clinical information staff. The AQC prepares and revises the affiliate's annual quality plan, identifies benchmarks, and keeps the affiliate current with established quality standards. The AQC receives scheduled quality reports concerning the affiliate's performance on core measures, national patient safety goals, untoward and sentinel events, accreditation and regulatory audits, system quality projects and clinical, ancillary, and financial department quality projects. The AQC monitors trends and progress on implementing corrective action plans. The AQC sends the minutes and reports of its meetings to the System Quality Council and presents its annual quality plan for approval to the System Quality Council.
7. **Affiliate Medical Staff Executive Committee (MSEC)**, as mandated by the Joint Commission, oversees the clinical quality of care delivered in an affiliate hospital. The Medical Staff Executive Committee provides leadership to the affiliate performance improvement activities to improve quality of care,

## **COOK COUNTY HEALTH & HOSPITALS SYSTEM**

### **2010 Quality Plan**

treatment, services, and patient safety. The MSEC participates in the identification of activities to measure and improve the clinical effectiveness, patient safety, quality, and efficiency of services provided in the affiliate hospital. The MSEC approves selection of medical staff members to serve on its standing medical care committees and receives and reviews reports from its standing committees. The leadership of the MSEC assists in the appointment of medical staff members to administrative quality performance improvement committees. The MSEC and its medical staff actively participate in ongoing quality activities and quality improvement projects of the Affiliate Quality Council/Committee. As part of its duty to promote quality and patient safety, the MSEC, as defined in its bylaws, assures that all providers are appropriately credentialed and privileged and their performance is monitored on an ongoing basis.

#### **X. Comparative Databases and Benchmarks**

The CCHHS utilizes comparative databases to incorporate a process for continuous assessment with similar organizations, standards, and best practices. This assessment can then lead to actions for improvement, as necessary. Databases that are utilized on an ongoing, routine basis include:

- Institute for Healthcare Improvement (IHI)
- Illinois Hospital Association (COMPdata)
- Press Ganey, Inc.
- Hospital Compare
- Quality Net
- Functional Independent Measurement System
- Agency for Healthcare Research and Quality (AHRQ)
- University HealthSystem Consortium Clinical Database (UHC)
- The Joint Commission
- Outpatient Prospective Payment System
- Inpatient Prospective Payment System
- Centers for Medicare & Medicaid Services
- Dartmouth Atlas Website
- National Surgical Quality Improvement Project (NSQIP)
- The Society of Thoracic Surgeons (STS)
- National Database of Nursing Quality Indicators (NDNQI)

#### **XI. Investigation**

The CCHHS recognizes the need for immediate investigation to be conducted when certain events occur. This investigation will not be effective in improving patient care if it is delayed to await any quality council's/committee's extension of authority at the committee's next scheduled meeting. To address the need for immediate investigation the quality committees will authorize certain individuals to act as investigators for the committee. These investigators shall pursue investigation as deemed appropriate by them prior to the next scheduled committee meeting. The investigator shall report to the committee at the next scheduled meeting and any materials and

**COOK COUNTY HEALTH & HOSPITALS SYSTEM**  
**2010 Quality Plan**

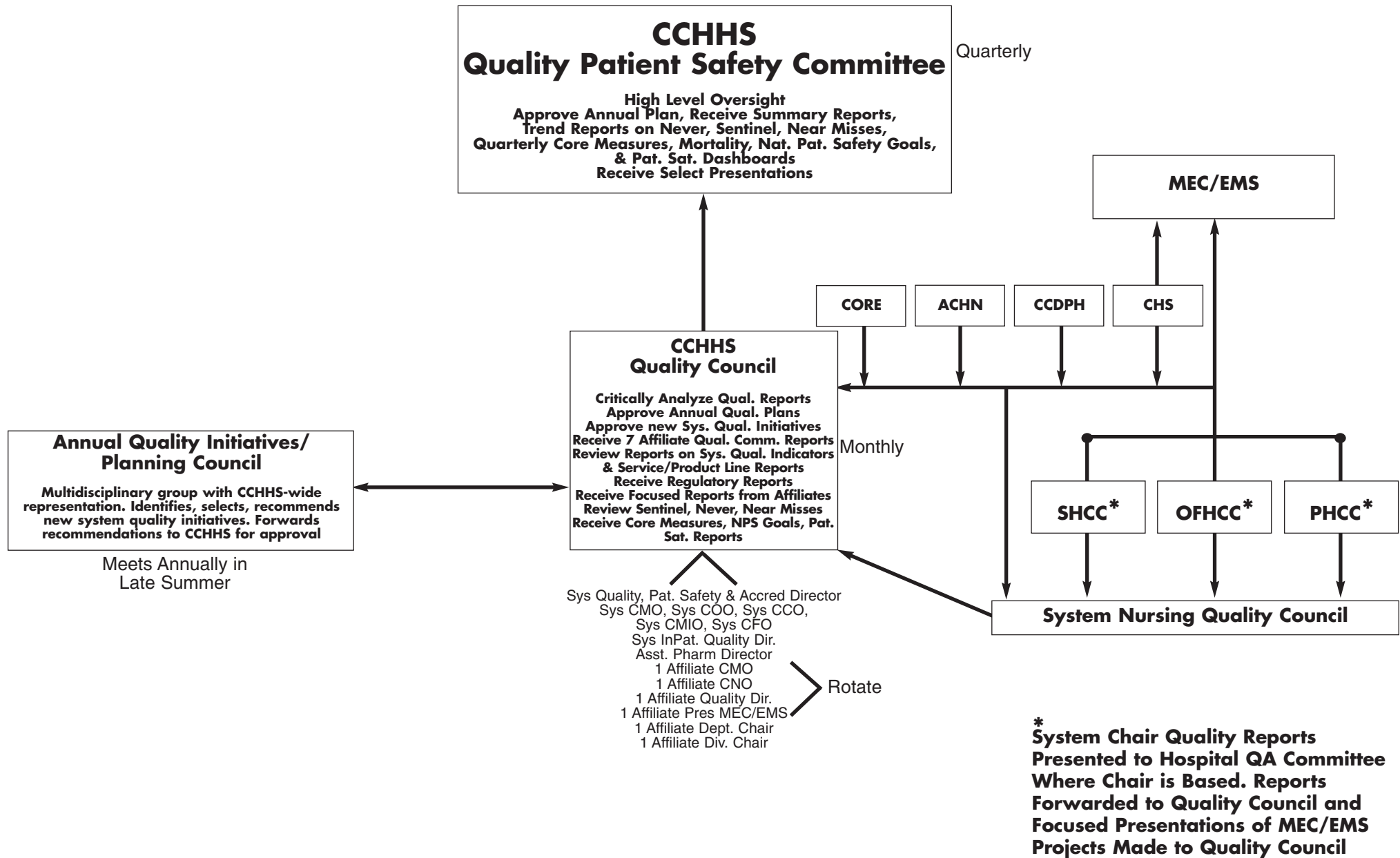
information gathered by the investigator shall be reported exclusively to the council/committee and maintained as confidential under the Medical Studies Act.

**XII. Confidentiality**

All information, reports, statements, or other data that serve or are the outcome of the quality improvement process shall be considered privileged and strictly confidential in their entirety. Such materials shall be used only for the evaluation and improvement of organizational processes and patient care. Such materials are not available for review by any individual outside of the quality improvement structure. The above fall within the privilege status under the Medical Studies Act of Illinois, which specifies that such information, is free from discovery and shall not be admissible as evidence.

# COOK COUNTY HEALTH & HOSPITALS SYSTEM

## System Quality Structure

DRAFT  
11-08-09

**Cook County Health & Hospitals System**  
**System-wide**  
**Quality Improvement Initiatives**  
**2010**

The 2010 Quality Plan for the CCHHS will approve by the CCHHS Quality & Patient Safety Committee and the CCHHS Board. The goals and objectives of the Quality Plan are aligned with the CCHHS Board's overall strategic and operational foci for 2010. Service excellence, patient safety, patient access to care, and patient/staff satisfaction are central to the CCHHS Boards' priorities

1. Achieve and/or Maintain Hospitals', Ambulatory & Community Health Network, Correctional Health Services (Cermak Health Services), and Laboratory accreditation.
2. Design and develop a customer service training initiative in 2010.
3. Design and develop a performance improvement education program that provides training at all organizational levels (Board, senior management, middle management, medical and nursing staffs and front line employees).
4. Develop and Implement no less than two system-wide, multi-disciplinary clinical performance improvement projects in 2010. These projects shall be implemented in the CCHHS inpatient units and, where applicable, integrated in the outpatient care setting.
5. Achieve and maintain top quartile for CORE measures and National Patient Safety goals (AMI, Pneumonia, CHF, and SCIP) at all three CCHHS hospitals.
6. Develop a system-wide Nursing quality structure that will determine key nursing performance indicators and establish mechanisms for measurement and improvement. .
7. Develop indicators and a dashboard for financial and supply chain management functions that documents improvement in the availability of supplies to the patients of the CCHHS.
8. Develop a clinical services dashboard that documents key service volumes and access data across the CCHHS.

## **ACHN 2010 Quality Improvement Projects**

- 1. ACHN continues to develop and refine structures and processes to improve Diabetes care.**  
Measurement: A1c and LDL  
Goal: To improve the % active patients at A1c target of “7%” and LDL target of < 100.
- 2. ACHN continues to develop and refine structures and processes to provide safe anticoagulation therapy.**  
Measurement: INR  
Goal: To improve the percentage of INR's in range to 50%, placing the Anticoagulation Clinic in the 30th percentile, (when compared to other anticoagulation clinics across the nation).
- 3. Improve Patient Satisfaction survey usefulness by obtaining valid peer group comparison.**  
Measurement: Press Ganey measures compared to peer group.  
Goal: To provide focused feedback to ACHN Clinical and Administrative Leadership for their action.
- 4. Excellent telephone access is key to patient satisfaction.**  
Measurement: Telephone global scoring (abandonment rate, wait time, etc)  
Goal: Increase monthly global score to 50 or greater for all clinics and overall.
- 5. Patient safety is a primary concern of both patients and the Ambulatory Network.**  
Goal: Achieve 100% compliance with Ambulatory National Patient Safety Goals through focused feedback and follow-up.  
Measurement: Monthly “spot check” of compliance to each goal in every clinic.
- 6. Ambulatory accreditation with the JCAHO is a commitment to quality care and service.**  
Goal: Complete a comprehensive Periodic Performance Review no later than March 15, 2010.  
Measurement: Acceptance of PPR by JCAHO.

## Cermak 2010 Quality Improvement Plan

In 2010, Cermak's Quality Improvement Plan will be the motor for driving change to achieve two primary goals:

- (1) NCCHC accreditation; and
- (2) Compliance with the US DOJ Agreed Order.

**Key changes** in the approach to QI in 2010 are:

- Total restructuring of the framework of quality improvement at the facility
  - A complete overhaul of Cermak's QI policy (*attached*)
  - Reorganization of QI efforts along multidisciplinary rather than departmental lines
  - Introduction of rigorous process mapping as the first step in process improvement
  - Incorporation of the concept of self-monitoring into all core processes
  - Identification, measurement, and reporting of metrics to measure core processes
- Direct involvement by top-level management in the QI effort;
- Involvement of all clinical providers as peer mentors and process monitors for chronic disease management
- Addition of an industrial engineer to process improvement efforts
- Allocation of resources to hire CCL (Cerner Control Language) programmers to automate the self-monitoring of key metrics

**Core processes** for improvement will continue to be those identified in 2009. Key metrics will now be measured and will include:

- Intake
  - Percentage of patients with serious medical illness missed at intake screening
  - Percentage of patients with serious mental illness missed at intake screening
- Sick call
  - Percentage of health service requests (HSRs) triaged within one day of submission
  - Percentage of patients with symptom-related HSRs seen within one day of triage
- Medication administration
  - Percentage of newly prescribed medications that are delivered or administered within 24 hours of the clinical encounter
  - Percentage of doses from standing prescriptions that are missed (days on which a scheduled dose pack or dose was not delivered or administered)
- Medical records
  - Percentage of progress notes that are entered into Cerner

**Quality indicators** for 11 common diseases and conditions are listed on the attachment.



<b>Disease or condition</b>	<b>Metric / Quality Indicator</b>
Diabetes	Percentage of patients with A1c measured within past 6 months, among persons incarcerated more than 90 days
	Percentage of A1c measurements performed more than 90 days after incarceration with A1c < 8.0
Hypertension	Percentage of diabetic patients with SBP < 130 or DBP < 85, among persons incarcerated more than 90 days
Hyperlipidemia	Percentage of diabetic patients with lipid profile measured within past 12 months, among persons incarcerated more than 90 days
	Percentage of LDL measurements performed more than 30 days after incarceration with LDL < 100
Heart failure	Percentage of patients with systolic heart failure on ACEI or ARB
Warfarin anticoagulation	Percentage of patients with therapeutic INR among persons on warfarin more than 2 weeks and incarcerated more than 2 weeks
HIV infection	Percentage of previously diagnosed patients for whom HAART is indicated that are on HAART, among persons incarcerated for more than 7 days
	Percentage of patients vaccinated for hepatitis, among persons incarcerated for more than 90 days
Asthma	Number of ER visits per unit time for asthma exacerbation, among persons incarcerated more than 30 days
Seizure disorder	Number of patients per unit time who experience a confirmed seizure, among persons incarcerated more than 7 days
Tuberculosis	Number of patients per unit time with intake CXR suspicious for TB who are not isolated within 24 hours of booking
Heroin addiction	Number of patients per unit time who are referred to ED for withdrawal symptoms, more than 24 hours after booking
Alcohol addiction	Number of patients per unit time with DT's

## **Cermak Policy A-06: Continuous Quality Improvement Program**

### **POLICY:**

Quality Improvement is part of every employee's job at Cermak. The Quality Improvement (QI) Program is the process by which Cermak employees monitor, evaluate, and improve the quality of care, eliminate waste, and improve efficiency.

The goals of the QI program are:

1. To ensure that high quality detainee care is delivered in a safe and appropriate manner.
2. To ensure compliance with recognized community standards of care and accreditation standards.
3. To provide care in a cost effective manner and to reduce waste in the system of care delivery.
4. To provide ongoing, systematic evaluation of both processes of detainee care and clinical or professional performance.

### **DEFINITIONS**

**Sentinel event** – A clinical event that results in an unanticipated death or major permanent loss of function, not related to the natural course of the patient's illness or underlying condition.

**Serious suicide attempt** – a suicide attempt that is considered to be either life-threatening or that required medical treatment for serious harm.

### **PROCEDURE**

#### **Quality Improvement Plan**

The Quality Improvement Committee (see below) will annually develop and propose a Quality Improvement Plan based on a program that identifies and prioritizes problems, opens channels of multidisciplinary communication, identifies metrics, and develops process improvement techniques to resolve identified concerns.

(1) The Plan will include the program's objectives for the year, scope, and desired metrics for evaluation of the process or problem in question. The plan will also include follow up measurements of previously executed projects. Selection of objectives will take the following points into consideration:

- a. The objective will be problem-focused, as evidenced by documented studies, documented analyses of processes, or other documented, objective methods.
- b. Identified problems will be prioritized objectively; those with the most serious effects upon detainee care will be dealt with first as determined by the Chief Operating Officer or Department Head.
- c. Quality improvement activities will follow accreditation requirements, requirements of any extant consent agreements, and needs of the facility.

(2) The Plan will be reviewed and approved annually by the Chief Operating Officer, Chief Medical Officer, and the Director of Quality Improvement.

(3) The Chief Operating Officer, Chief Medical Officer, and Quality Improvement Director will meet no less than annually with the Executive Director of CCDOC to advise him/her of the results of the past year's quality improvement activities and the Plan for the coming year.

(4) Additional quality improvement activities may be added to the Plan and previous activities may be reprioritized during the planned year as the need arises. Such changes may be directed by the Chief Operating Officer or proposed by the Quality Improvement Committee. In the latter case, they must be approved by the Chief Operating Officer.

### **Quality Improvement Committee**

*Selection of committee members.* The Chief Operating Officer will establish a Quality Improvement Committee composed of at least the facility Medical Director, Quality Improvement Director, Department Heads or designees, and Contract Vendor Representative, as applicable. A representative from nursing, medical records, mental health, dental, pharmacy, radiology, laboratory, other health care disciplines, or security will serve on the Committee or attend Committee meetings based on the agenda. A custody representative will be invited to all meetings. This person will be appointed by the Executive Director or Sheriff. Other clinical, administrative, and support staff will, at the discretion of the Chief Operating Officer or Quality Improvement Director, be requested to participate in Committee activities as they relate to identified needs, problems, or other detainee care issues.

*Committee chair.* The Director of Quality Improvement will be responsible for chairing monthly meetings of the QI Committee, maintaining minutes of those meetings, and accepting and maintaining required data collection. The Director of Quality Improvement will also be responsible for assisting various staff members and department heads in analyzing processes of care, developing metrics, and in developing methods of measuring outcomes. The Director of Quality Improvement will be responsible for development of the annual CQI plan.

*Committee meetings.* The CQI Committee will meet monthly in a standing time slot. Any cancellations must be approved by the Chief Operating Officer.

### **Process mapping**

Multidisciplinary project management teams will be formed to map, evaluate, and improve key processes of care within the organization. These groups will be determined by the Chief Operating Officer and will report their results to the Quality Improvement Committee.

For multi-department processes, the designated process improvement team leader will have final responsibility for ensuring that the specified process is mapped out. Every Department head ensure that department members, map out the processes of care in which that department participates, with multidisciplinary collaboration with other participating departments.

For single-department processes, each Department Head will be responsible for maintaining metrics for their key processes and reporting the results of those measurements to the Quality Improvement Committee on a monthly basis. Metrics in each area will represent outcome results.

The Quality Improvement Director and project managers will assist Department Heads in mapping out the process of care and metric for their area. Ongoing projects of measurement will be determined by staff, Department Heads or administrative leadership based on

## **Guidelines for Quality Improvement Projects**

In general, quality improvement teams will be multidisciplinary and will include any group of staff members. The process to monitor and evaluate care for a QI project will consist of the following steps:

1. Identify problem to be addressed
2. Describe process to be assessed;
3. Identify and convene staff members – typically multidisciplinary – to constitute a team;
4. Establish metrics that measure the key process;
5. Collect and organize data;
6. Evaluate data as it reflects on the quality of care;
7. Develop and implement a plan of action to improve care;
8. Assess the effectiveness of the corrective action;
9. Document the process noting improvements or changes resulting from the study; problem or process identification; metrics; plan of (corrective action); and follow-up.
10. Communicate relevant information to necessary individuals and departments.

Implementation of actions designed to correct problems will be reported to the Quality Improvement Committee. Following a reasonable period of implementation, the problem will be monitored to see if the desired results have been obtained by comparing current outcomes to previous outcomes. Key processes will have metrics which will be monitored continuously. For unique studies, if the desired results are obtained, the cycle will end. The program area will then be routinely monitored as required by this directive. If desired results are not obtained, the cycle will repeat itself to check problem identification, corrective actions, and implementation of corrective actions.

### **Data Stream**

The Quality Improvement Committee will receive a variety of data on an ongoing basis. These data will be used for purposes of identification of potential quality issues, statistical reporting, utilization review, and calculation of denominator-based rates. (See Cermak Policy A-04 for details of the data to be included in these reports.)

All reports will be submitted in electronic format. Due to the volume of material that must be reviewed each month, all reports will be due 10 business days before the regular meeting of the Quality Improvement Committee.

Reports for the data stream will include regular monthly statistical reports, QI project reports, occasional reports, monthly litigation review, and annual credentials review. For monthly reports, tabulation will include interval and cumulative (year-to-date) data. Once baselines have been established, monthly reports will also include the comparison year-to-date data from the previous year(s),

The list below includes basic metrics that will be monitored and reported to the QI Committee. The Chief Operating Officer will determine which additional metrics will be required to be reported to the QI Committee on a regular basis.

#### **MONTHLY STATISTICAL REPORTS**

##### *Utilization*

Number of health service requests submitted, cross-tabulated by:

Category of care (medical, dental, mental health); Division

Number of inmates receiving health services, cross tabulated by:

Category of care; Site of care (infirmery, ER, division, specialty clinic, etc.)

Referrals to specialists on and off campus, by clinical discipline

Hospital ER visits, by reason for referral, with subtotals for county hospital and nearest hospital

Hospital admissions, by discharge diagnosis

Hospital readmissions within 30 days and ER revisits within 30 days

*Unusual occurrences*

Critical-value lab reports

Deaths, serious morbidity, and sentinel events

*Infectious disease monitoring*

Suspect and active tuberculosis;

All CDPH-reportable diseases

Utilization of isolation rooms

Sanitation reports

*Patient satisfaction*

Grievances and complaints related to health care, cross-tabulated by:

Category of care (medical, dental, mental health); Division (see Cermak Policy A-11),

*Mental health*

Admissions and length of stay for psychiatric infirmery, by diagnosis

Programming hours for intermediate psychiatric patients, by Division

Serious suicide attempts,

Crisis watches

Restraints used and involuntary administration of psychotropics

*Any other regular reports required to fulfill accreditation requirements or consent agreements*

ANNUAL STATISTICAL REPORTS

Year-end data for all monthly reports listed above

Radiation safety and quality control activities for diagnostic services (see Cermak Policy D-03)

QI PROJECT REPORTS

Multidisciplinary projects

Departmental projects

OCCASIONAL REPORTS (by the month following the event)

Preparedness drills: disaster, mass casualty, man-down

Deficiencies related to health services as identified in safety and sanitation inspection reports from external agencies

MONTHLY LITIGATION REVIEW (by Director of QI)

Summary of new cases

Updates on open cases

ANNUAL CREDENTIALS REVIEW (by CMO; see Cermak Policy C-01)

## **Confidentiality**

Copies of minute and reports of monitoring, and evaluation activities, including status reports, detainee complaints, and other related quality improvement data will be maintained in a strictly confidential manner. The minutes of the Quality Improvement Committee will be marked "CONFIDENTIAL." Disclosure of quality improvement information is protected under Ill Rev Stat Ch 110, Para 8-2101.

Distribution of copies will be limited to:

- Chief Operating Officer;
- Deputy Chief Operating Officer
- Chief Medical Officer;
- Quality Improvement File.

To ensure the confidentiality of reports and minutes, the members or attendees of the Quality Improvement Committee meeting will review the minutes maintained in the Quality Improvement File and document that review by signature. Members of the health care staff will be advised of relevant activities and findings of quality improvement. This may be accomplished by staff review of the minutes on file documented by signature or some other demonstrable mechanism such as minutes of staff meetings.

Copies of minutes or access by others will be at the discretion of the Chief Operating Officer. Any questions regarding the appropriateness of release of confidential quality improvement materials will be directed to the Chief Operating Officer and State's Attorney for final resolution.

## **Privacy**

The privacy of patients and of staff members will be maintained. Reports of quality improvement projects will not include names, medical record numbers, or other unique identifiers of patients and staff members. Identifiers that are included in raw data tables will be stripped before presentation of the data.

*Revised: November 19, 2009*

## **Ruth M. Rothstein CORE Center 2010 Quality Improvement Projects**

### Quality of Care Indicators

- **Medical Record Review** (form attached) – CORE QIC is proposing changes in QA chart review to comply with JCAHO patient safety goals for 2010

### Interdepartmental projects:

- **Pap smear Initiative** Begun in 2008 initiative is to increase patient awareness of need for cervical screening, and increase the frequency with which Screenings are obtained for HIV+ women at CORE. Currently evaluating 2009 data to assess the level of awareness and measure effects of improvement efforts from 2008 to 2009
- **Customer Service Initiative** Task force completed evaluation of staff perceptions of customer service (CS). In process of adopting efforts to improve CS by raising staff awareness and accountability, implementing staff training, update and share the CORE Center's CS policy. Permanent Committee to take over from Task Force assessing and evaluating CS practices at CORE
- **Patient Retention Initiative** An ongoing initiative is in place to identify patients who are lost to follow-up for greater than 12 months. We are creating a mechanism and assigning a group of staff who will implement outreach efforts to locate and assess the client's reasons for leaving care, and coordinate with the necessary disciplines a plan to bring the client back into care and retain them. A federal SPNS grant was received by CORE to facilitate retention in care for women at high risk of loss to follow-up.
- **Pharmacy Cost Control Initiative** An ongoing effort to reduce cost in the CORE Center's pharmacy by enrolling patients in medication benefit programs for which they qualify (Medicaid, ADAP etc.). Reduces County drug acquisition costs by >\$50M annually and provides lifesaving medications to more than 5,000 HIV+ people treated at CORE.

### Departmental Projects:

- **Patient Satisfaction Survey** Results of departmental modules (Nursing, Registration, Pharmacy, Case management, Laboratory etc.) on annual patient satisfaction survey are being by managers and staff. Areas for improvement identified, improvement processes initiated as needed, and targeted patient surveys conducted in next few months.
- **Focused patient satisfaction surveys** to be conducted throughout 2010, to clarify specific consumer concerns identified in annual patient satisfaction survey and to obtain tracking data in response to attempts to improve services.

**John H. Stroger Hospital  
2010 Quality Improvement Projects  
Inpatient Initiatives**

**I. System Wide Projects (Indicators to be developed)**

Care of the Diabetic Patient  
Care of the Patient Requiring Anticoagulation

**II. Hospital**

**Ongoing Projects**

Acute Myocardial Infarction  
Heart Failure  
Pneumonia  
Surgical Care Improvement Project  
Hospital Consumer Assessment of Healthcare Providers and System Survey  
30-day risk standardized Mortality Rates (AMI, HF & Pneumonia)  
30-day risk standardized Readmission Rates (AMI, HF & Pneumonia)

**New Data Reporting (Starts 12/9/09)**

Agency for Healthcare Research and Quality (AHRQ) Measures)  
    Abdominal Aortic Aneurysm (AAA) Mortality Rate  
    Hip Fracture Mortality Rate  
    Mortality for Selected Surgical Procedures  
    Mortality for Selected Medical Conditions

Hospital Quality Data for Annual Payment Update (RHQDAPU) Measures

**2010 Hospital Performance Improvement Efforts Will Focus On**

- 1. PCI within 90 minutes of hospital arrival**
- 2. Surgical Care Improvement Project**
- 3. Smoking Cessation**
- 4. Restraint Use**
- 5. Various Measures of Patient Satisfaction**



## OAK FOREST HOSPITAL

### *2010 Quality Improvement Projects*

<b>System Measures</b>	<b>Indicator / Description</b>
Management of Diabetes Mellitus	<p><b>Enhances continuum of care between inpatient and outpatient levels</b></p> <p>Measurement of Hemoglobin A1C is recommended every 6 months for controlled diabetic patients (Hgb A1C 7.0 or less) and every 3 months when Hgb A1C is above 7.0.</p> <p>Department of Medicine will review all records or an adequate sample of discharged patients monthly to monitor compliance with above recommendations. Feedback will be given to individual physicians and to all physicians during monthly department meetings. This will also be reported regularly to QC and MQC.</p>
<p>Anticoagulation</p> <p>Inpatient Anticoagulation: Prevent excessively high INRs during hospitalization</p>	<p><b>Process Measure</b></p> <p>Percent of inpatient INR results exceeding predetermined levels (e.g., INR levels of 3.5 and 6 have been used, and there are published benchmarks for these).</p> <p>The desired outcome of reducing excessive INRs would be to prevent serious bleeding complications during inpatient anticoagulation.</p>
<b>Affiliate Measures (OFH)</b>	<b>Indicator /Description</b>
DVT Prophylaxis	<p><b>Process Measure</b></p> <p>Percent of inpatients with indications for DVT prophylaxis who received appropriate DVT prophylaxis (goal: 100%).</p>
Medication Reconciliation	<p><b>Process Measure affects Patient Outcome</b></p> <p>Improve inpatient and outpatient care within the system. Increase communication amongst affiliate care. Would encourage and enhance patient education and prevention /reduction of medication errors.</p> <p>Important to monitor even though goal was reconsidered by the Joint Commission.</p>

<p>Patient Satisfaction</p> <p>1) Discharge Instructions</p> <p>2) Communication with Providers (MDs/RNs)</p>	<p><b>Patient's Perception of Care</b></p> <p>Meet or exceed state and national benchmark. Results now show OFH below national average for both indicators. CORE measures data for discharge instructions also lower than expected.</p>
<p>CORE Measures</p>	<p><b>Patient Outcome Measures</b></p> <p>Achieve and maintain top quartile for CORE measures and National Patient Goals.</p>
<p><b>Departmental Measures</b></p>	<p><b>Indicators / Descriptions</b></p>
<p>Patient Throughput</p>	<p><b>Process and Patient Care Measure</b></p> <p>Emergency Department Triage &amp; Rehab Discharge Delays</p> <p>Impacts continuity of care, reduces turnaround times, and increases patient satisfaction. Long wait times in ER results in patients leaving without being seen. Discharge delays result in increased LOS – resulting in payment loss/denials.</p>
<p>Nursing Hand-off</p>	

**PROVIDENT HOSPITAL OF COOK COUNTY**  
**2010 QUALITY AND PERFORMANCE IMPROVEMENT PLAN**

**INTRODUCTION**

The following indicators and performance improvement initiatives will be facilitated by the use of the hospital's quality model: Plan, Do, Check, and Act Roadmap. Each individual indicator and those associated with the performance initiatives/storyboards will have a definition and formula. The frequency of data collection will be determined after baseline data is collected, but not less than quarterly.

The indicators and performance initiatives are inclusive in that they represent mandated external regulatory agencies' data collection requirements. For example, National Patient Safety Goals, Blood Utilization, Restraint Use, etc.

**SYSTEM-WIDE PROJECTS**

- Care of the Diabetic Patient
- Safe Administration of Anticoagulants
- Improve Core Measures Outcomes
  - Acute Myocardial Infarction
  - Heart Failure
  - Surgical Care Improvement
  - Community Acquired Pneumonia
- Customer Satisfaction
- Utilization of Direct Observation (Sitters) in the Hospital Setting

**HOSPITAL-WIDE PROJECTS**

- Improve Processes Involving Hybrid Medical Record. (SB)
- Improve Patient Thru-put (SB)
- Monitor Compliance to National Patient Safety Goals (I & SB)

**DEPARTMENTAL INDICATORS AND STORYBOARDS**

- **Anesthesia**
  - Air-way complications (I)
  - Moderate or Deep Sedation Complications(I)
  - Ongoing Professional Practice Evaluation
- **Intensive Care Medicine**
  - Improve Admission Process of Patients from the ED. (SB)
  - Institute Early Goal Directed Therapy for Sepsis. (I)
  - Ongoing Professional Practice Evaluation Indicators
- **Internal Medicine**
  - Improve Customer/Patient Satisfaction. (I & SB)
  - Decrease Number of Patients Leaving Against Medical Advise. (I)
  - Decrease Heart Failure Readmission Rate for Patient  $\geq$ Yrs. (SB)
  - Ongoing Professional Practice Evaluation

Key: I=Indicator

SB=Storyboard/Performance  
Improvement Initiative

**PROVIDENT HOSPITAL OF COOK COUNTY**  
**2010 QUALITY AND PERFORMANCE IMPROVEMENT PLAN**

**DEPARTMENTAL INDICATORS AND STORYBOARDS(contd.)**

- **Family Medicine**
  - Increase Training of All Attending and Resident Physicians in Management of Post-Partum Hemorrhage (I & SB)
  - Decrease Heart Failure Readmission Rate for Patient  $\geq$ Yrs. (SB)
  - Ongoing Professional Practice Evaluation Indicators
- **General Surgery**
  - Prophylaxis Antibiotics (SB)
  - VTE Prophylaxis (SB)
- **Obstetrics/Gynecology**
  - Prevention, Identification, Management of Post-Partum Hemorrhage (I&SB)
  - Improve Customer Service (I&SB)
  - Ongoing Professional Practice Evaluation Indicators
- **Nursing(contd)**
  - Identification, Prevention, and Management of Pressure Ulcers. (I&SB)
  - HCG Documentation (I&SB)
  - Pain Management (I)
  - Adverse Pregnancy Outcomes Reporting (I&SB)
  - First Case Start Time (I&SB)
  - Use of Restraints
  - Hand-off for Dialysis Patients (I)
  - Obtain Nutritional Consults for patients with the diagnoses of Coronary Artery Disease, Heart Failure, Diabetes, Cancer, Renal or G.I. Disease.
  - Height and Weight Communicated to Pharmacy
- **Cardio-diagnostics**
  - Decrease wait-time for Echocardiograms (I&SB)
  - Improve In-patient Stress Test Start Time (I)
- **Clinical and Anatomical Laboratory**
  - Turn-around Time of STAT Tests (I&SB)
  - Benchmark and Monitor Blood Contamination Rate(I)
  - Correlation Histology/Cytology (I)
  - Use of Blood and Blood Components (SB)
  - Confirmed Transfusion Reactions (I)
  - Significant Discrepancies between pre-operative and post-operative diagnoses
- **Health and Information Records**
  - Turn-around time of Completion of Operative Reports (I)
  - Timely Response to Release of Information Requests (I)
- **Human Resources**
  - Vacancy Rate
  - Turn-over Rate

Key: I=Indicator

SB=Storyboard/Performance  
Improvement Initiative

**PROVIDENT HOSPITAL OF COOK COUNTY**  
**2010 QUALITY AND PERFORMANCE IMPROVEMENT PLAN**

**DEPARTMENTAL INDICATORS AND STORYBOARDS(contd.)**

- **Human Resources**
  - Vacancy Rate
  - Turn-over Rate
- **Infection Control**
  - Benchmark and monitor Central Line Infection Rate
  - Benchmark and monitor Ventilator Acquired Pneumonia
  - Benchmark and monitor Surgical Infection Rate
- **Pharmacy**
  - Medication Errors (I)
  - Medication Usage (I)
  - Turn-around time of STAT Medications from order to administration (I&SB)
- **Physical/Occupational Therapy**
  - Completion of pertinent components of Physical Therapy Evaluations (I&SB)
  - Timely Scheduling of Outpatient Occupational Therapy Appointments
- **Radiology**
  - Benchmark and Monitor Biopsy Success Rate (I)
  - Benchmark and Monitor Screening Mammography Rate (I)
- **Safety**
  - Monitor Compliance to Environment of Care Plans (Safety and Security, Fire Safety, Hazardous Materials and Waste, Medical Equipment, Utilities).
  - Monitor Compliance to Emergency Management Plan
- **Social Services**
  - Evaluate competence of referral source in meeting the needs of the referred client. (I)
  - Improve communications related to the patients' needs. (SB)

Key: I=Indicator  
SB=Storyboard/Performance  
Improvement Initiative

Cook County Health and Hospitals System  
Minutes of the Quality and Patient Safety Committee Meeting  
November 24, 2009

ATTACHMENT #5



**Cook County  
Department of Public Health**  
**Cook County Health and Hospitals System**



The background of the page features a large, faint, circular seal of Cook County, Illinois. The seal contains the text "SEAL OF COOK COUNTY" around the perimeter and "JANUARY 1831" in the center. Inside the seal is a detailed illustration of a cityscape with a lighthouse, a ship, and a bridge.

## **Cook County Department of Public Health**

**Stephen A. Martin, Jr., PhD, MPH**  
Chief Operating Officer

### **Executive Staff**

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Director, Integrated Health Support Services

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Director, Environmental Health Services

Annual Report 2008

**[www.cookcountypublichealth.org](http://www.cookcountypublichealth.org)**

Annual Report Design Team

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#### **Graphic Designer**

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## **Introduction** Stephen A. Martin, Jr., PhD, MPH, Chief Operating Officer



The 2008 Annual Report highlights a year of continued collaboration. As a multi-faceted department, Cook County Department of Public Health (CCDPH) service units worked together and with community partners to bring essential public health programs and services to the residents of suburban Cook County. As an example, the department worked to support and enforce the Smoke-free Illinois Act that went into effect in 2008, banning smoking in public places; and coordinated emergency preparedness events to better prepare for a public health emergency.

Every day, our department strives to improve the quality of life for residents of suburban Cook County. Our dedicated staff work to prevent the spread of over 70 reportable communicable diseases, provide health promotion programs and enforce public health laws, rules and regulations. We are the state certified public health agency for suburban Cook County with the exception of Evanston, Skokie, Oak Park and Stickney Township. We are also one of seven operating units of the Cook County Health & Hospitals System. The other six operating units include the Ambulatory and Community Health Network of Cook County, Cermak Health Services of Cook County, The Ruth M. Rothstein CORE Center, John H. Stroger, Jr. Hospital, Oak Forest Hospital and Provident Hospital.

We are pleased to present this document to showcase programs and highlights of 2008. For additional information, please visit [www.cookcountypublichealth.org](http://www.cookcountypublichealth.org) or call 708-492-2000.

A handwritten signature in black ink that reads "Stephen A. Martin, Jr." followed by a large, stylized flourish.

## ***Integrated Health Support Services***

The Special Supplemental Nutrition Program for Women, Infants and Children (WIC) participated in the Farmer's Market Nutrition Program (FMNP) in 2008. The WIC program provides health care referrals and nutrition education and supplemental foods at no cost to low-income pregnant, breastfeeding and postpartum women, and to infants and children up to five years of age. The FMNP established by Congress in July 1992 provides fresh locally grown fruits and vegetables to WIC participants at the local farmer's market.

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In 2008, the CCDPH WIC program distributed 700 coupon booklets valued at more than \$10,000. Enrolled clients receiving a booklet were able to redeem the coupons at the Park Forest Farmers' Market. More than ten participating local farmers provided a wide variety of fresh fruit and vegetables to choose from for the women and children participating in suburban Cook County WIC.

Most fruits and vegetables are naturally low in calories and provide essential nutrients and dietary fiber. They may also play a role in preventing certain chronic diseases. Health organizations such as the American Cancer Society, American Diabetes Association, and the American Heart Association recommend five servings of fresh fruits and vegetables per day to prevent conditions such as diabetes, high blood pressure, cancer, and stroke.

Integrated Health Support Services Statistics

FAMILY CASE MANAGEMENT/DCFS  
MEDICAL CASE MANAGEMENT  
PROGRAM (MONTHLY)

Family Case Management	14,381
Targeted Intensive Prenatal Case Management	131
Delay of Subsequent Pregnancy	24
Healthy Families	37
Breast and Cervical Cancer Prevention	100

SERVICES (YEARLY)

Daycare Consultations	193
Vision Screenings	6,124
Hearing Screenings	6,340

WOMEN, INFANTS AND CHILDREN  
(WIC)

Monthly Caseload	23,422
Yearly Client Clinic Visits	86,067

CLIENT CLINIC VISITS (YEARLY)

Dental Health	6,011
Family Planning	6,638
HIV Screening	530
Immunizations	3,145
Prenatal Intake	3,498
Primary Care (Access to Care)	1,555
Sexually Transmitted Diseases (STDs)	8,653

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## ***Environmental Health Services***

The Environmental Health Services Unit is the regulatory arm of the Cook County Department of Public Health and is empowered to enforce Cook County and Illinois laws relating to environmental health issues. Environmental Health staff conduct routine, unannounced inspections at various facilities such as tanning parlors, retail food establishments and public swimming pools. Staff also investigate complaints received from residents and visitors in suburban Cook County.

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The Environmental Health Unit provides primary prevention through a combination of surveillance, education, enforcement and assessment programs designed to identify, prevent and abate the environmental conditions that adversely impact human health.

Environmental Health Services Statistics

<b>PRIVATE AND NON-COMMUNITY WATER SUPPLIES</b>	
<b>Water Samples Collected</b>	
Non-community	386
Private	56
<b>Abandoned Wells</b>	
Sealing Requests Received	310
Wells Sealed	209
<b>New Wells</b>	
Inspections Performed	150
Permits Issued	125
<b>Existing Non-Community Wells</b>	
Surveys Performed	139
Water Analysis Opinions Rendered	1,113
<b>PRIVATE SEWAGE DISPOSAL SYSTEMS</b>	
Installation Inspections Performed	48
Lot Surveys Performed	30
Plans Processed	30
Witnessed Percolation Tests Performed	6
<b>SEPTIC TANK CLEANERS</b>	
Permits Issued	75
Truck Inspections Performed	84

<b>WELL/SEPTIC SYSTEM MORTGAGE EVALUATIONS</b>	
Evaluations Processed	1
Inspections Performed	1
Water Samples Collected	1
<b>FOOD SERVICE ESTABLISHMENTS/ RETAIL FOOD STORES</b>	
<b>Intergovernmental Agreements</b>	
Inspections Performed	4,606
Plans Reviewed	73
<b>Unincorporated Areas</b>	
Inspections Performed	461
Licenses Issued	158
Plans Reviewed	10
<b>Food Complaints Received</b>	244
<b>HEALTHY HOMES</b>	
Inspections Performed	6
Presentations	12

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## ***Environmental Health Services Statistics*** continued

### **LEAD ABATEMENT**

Initial Inspections Performed	103
Compliance Letters Initiated	68
Follow-Up Inspections Performed	72
Clearance Inspections Performed	79
Enforcement Actions	3

### **MOBILE HOME PARKS**

Inspections Performed	68
Licenses Issued	33
Complaints Received	26

### **TOBACCO CONTROL**

Licenses Issued	56
Licenses Suspended (30 Days)	0
Fines	1
Compliance Inspections Performed	76
Notices of Violations Issued	1

### **SMOKE-FREE ILLINOIS**

Violation Letters Initiated	394
Complaints Received	628
Inspections Performed	32
Fines	5

### **INDOOR AIR QUALITY**

Inspections Performed	40
Violation Letters Initiated	25

### **NUISANCES**

Sewage Complaints Received	19
Sewage Complaints Inspections Performed	127
Non-Sewage Complaints Received	101
Non-Sewage Complaints Inspections Performed	422
Enforcement Actions	21

### **SWIMMING POOLS AND SPAS**

Public Pool Inspections Performed	657
Private Pool/Spa Plans Approved	15

### **TANNING FACILITIES**

Inspections Performed	139
-----------------------	-----

### **VECTOR CONTROL**

Inspections Performed	66
Mosquito Trap Checks	731
Mosquito VEC Tests Performed	659
Dead Birds Collected for Testing	46
Mosquito Batches Processed for PCR Testing	659
Specimen Results Reported and Posted	659

### **CLIENT CONSULTATIONS**

Total Client Consultations Performed	7,519
--------------------------------------	-------

***Working Together for a Smoke Free Illinois***

The Smoke Free Illinois Act (SFIA) was signed into law in 2007 and went into effect on January 1, 2008. Cook County Department of Public Health was a member of a state-wide coalition that played an integral role in passing this important public health legislation. The legislation prohibited smoking in virtually all public places and workplaces, including offices, theaters, museums, libraries, schools, commercial establishments, enclosed shopping centers and retail stores, restaurants, bars, private clubs and gaming facilities.

The SFIA protects public health by reducing exposure to second hand smoke, encouraging smokers to quit and discouraging youth from starting. Once the law went into effect in 2008, multiple units within the Cook County Department of Public Health worked to support and enforce the act.

During the year, CCDPH units successfully advocated to maintain the law and worked with high school students to send 800 thank you letters to legislators urging them to continue supporting the act. Health educators conducted public education presentations and Environmental Health staff investigated 628 complaints, issued 594 violation letters and performed 32 on-site inspections. Five establishments were fined for failing to comply with the SFIA.

## ***Policy Development and Communications***

The Policy Development and Communications Service Unit (PDCU) researches and analyzes public health policies, advocates for the adoption of science-based public health laws, rules and regulations and provides accurate and timely communications to suburban Cook County. PDCU staff play an important leadership role in formulating and enacting significant public health legislative initiatives in the areas of communicable disease control, environmental health, and chronic disease prevention.

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### **Emergency Pharmaceutical Dispensing Site Legislation SB2690**

**(Sen. Maloney - Rep. Yarbrough)** Since 2001, CCDPH has worked to develop a network of emergency pharmaceutical distribution sites for the purpose of dispensing mass prophylaxis during a public health emergency. The locations, referred to as “Point of Dispensing Sites” (PODS), are geographically distributed throughout suburban Cook County and are a critical component of the department’s emergency response plan. In 2008, PDCU drafted and introduced legislation (SB2690) requiring public community colleges to make their facilities available to local public health departments in the event of a public health emergency. On October 3, 2008, the governor signed the legislation into law (Public Act 95-0997) and community colleges are now an important part of the department’s POD network.



## **Food Pantry Recall Legislation HB5242 (Rep. Hernandez - Sen. Trotter)**

In 2008, a higher number of recalls of contaminated food products made national headlines. Local health departments are required to notify food service establishments of the recalls so the contaminated food item can be removed in a timely manner. With the increase in food recalls, CCDPH Environmental Health staff identified the need to have a registry of food banks and food pantries so that they may receive notification of food recalls. PDCU staff drafted and introduced HB5242 which required food banks, food pantries, soup kitchens and other related food relief stations to annually register with their certified local public health department. On August 14, 2008, the governor signed the legislation into law. (Public Act 95-0828)

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## ***Working Together for Emergency Preparedness***

Responding to a public health emergency takes planning, collaboration and preparation among many agencies. Cook County Department of Public Health Service Units including Community Preparedness and Coordination (CPCU), Communicable Disease (CD), Environmental Health (EH), Communications, Health Promotions (HPU), and more work together with community and agency partners from suburban Cook County and the surrounding collar counties to plan and prepare for public health emergencies.

***12***

In 2008, CCDPH coordinated a Cook County Pharmaceutical Stockpile Distribution plan exercise where more than 200 first responders from 25 municipalities from north suburban Cook County came together. The exercise aimed to enhance communication and coordination between Cook County government and suburban Cook County municipalities while activating Points of Dispensing sites.

Approximately 600 community volunteers practiced picking up medications during a public health emergency scenario. Planning exercises are vital to the safety and health of suburban Cook County residents in preparing for a public health emergency.

## ***Communicable Disease Prevention and Control Services***

The Communicable Disease Control Unit works to prevent and control the spread of infectious diseases within suburban Cook County. This responsibility is achieved through collaboration with those involved in the identification, diagnosis, treatment and legal, ethical and social management of communicable diseases.

### **Program Areas**

- General Communicable Disease Control
- Enhanced Surveillance
- HIV Surveillance and Prevention
- Infection Prevention and Outbreak Control
- Sexually Transmitted Diseases Surveillance and Prevention
- Tuberculosis Surveillance and Prevention
- Vaccine Preventable Diseases Surveillance and Prevention

### **Infection Prevention and Outbreak Control**

The Infection Prevention Program was established in 2008 in response to a growing number of outbreaks in out-of-hospital settings. The program provides guidance and oversight for infection prevention and control activities in all relevant settings within suburban Cook County including, long-term care facilities, dialysis centers and child care centers.

## ***Communicable Disease Prevention and Control Services (cont'd)***

The Infection Prevention Program's outbreak response activities include the control and prevention of potential infections that patients acquire while receiving treatment for medical conditions, known as healthcare-associated infections (HAIs). HAIs are among the leading causes of preventable death in the United States, accounting for an estimated 1.7 million infections and 99,000 associated deaths each year and it's estimated that they cause \$28 to \$33 billion in extra healthcare costs each year.

***14***

In order to contain these outbreaks, the Infection Prevention Program provides intensive hand hygiene education at the facilities, works with the staff to implement appropriate isolation precautions, promotes rigorous environmental cleaning practices, and encourages the use of alcohol-free, antiseptic wipes when appropriate. When these control measures are applied carefully, they often greatly reduce the number of healthcare-associated infections in a facility.

# Communicable Disease Statistics

## Vaccine Preventable Diseases

Diphtheria	0
Haemophilus Influenzae Type B	0
Hepatitis B	
Acute	66
Chronic	388
Measles	11
Mumps	19
Pertussis (Whooping Cough)	93
Rubella	0
Tetanus	0
Varicella (Chicken Pox)	245

## Selected Diseases

Cryptosporidiosis	13
E.Coli 0157:H7	11
Giardiasis	72
Haemophilus Influenzae (not B)	29
Hepatitis A	45
Hepatitis C	
Acute	0
Chronic	776
Histoplasmosis	19
Legionnaires' Disease	38
Listeria	10
Lyme Disease	9

Malaria	20
Meningococcal Infections	22
Meningitis, Listeria	10
West Nile Virus Neuroinvasive	3
Pneumococcal Invasive	32
Salmonellosis	287
Shigellosis	116
Streptococcal Invasive (Group A)	42
Typhoid Fever	5
Tuberculosis Disease	
Active	100
Latent	783

## Sexually Transmitted Diseases

Syphilis	88
Gonorrhea	2,499
Chlamydia	8,027
HIV (preliminary data)	*208
AIDS (preliminary data)	*103
Other	
Food-Borne Illness Complaints Received	25
Pediatric Influenza Deaths	1

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## ***Prevention Services***

The Prevention Services Unit (PSU) consists of five program areas that assist suburban Cook County communities in building and sustaining healthy environments. PSU program areas include:

- Chronic Disease Prevention
  - Health Promotion
  - Health Communications
  - Tobacco Prevention and Control
- Community Preparedness and Coordination
- Lead Poisoning Prevention
- Violence Prevention
- Epidemiology and Community Health Planning

PSU is an excellent resource to learn about the health status of a community. Trainings, educational materials and programs are available to support residents in their individual and group efforts to be healthy. Topics include nutrition, exercise, quitting smoking, preventing violence and more.

The Prevention Services Unit focused on strategic planning in 2008. This was its second year since reorganizing to better address violence, chronic disease and access to health care. These were the top three health concerns in suburban Cook County, according to data and input collected from community residents and leaders representing health, social service, government, faith-based, business and other sectors, involved in supporting public health.

In 2008, PSU implemented plans to strengthen the agency’s infrastructure and build capacity, and all prevention-services-related program areas are now under one umbrella for better planning, coordination and collaboration. PSU is strengthening a growing network of partnerships to address these and other priority health issues.

## ***Cook County Department of Public Health District Offices***

Administrative Office  
1010 Lake Street  
Oak Park, IL 60301  
708-492-2000  
708-492-2002 TDD

North District Office  
3rd District Courthouse  
2121 Euclid Avenue  
Room 250  
Rolling Meadows, IL 60008  
847-818-2860  
847-818-2023 TDD

West District Office  
Eisenhower Tower  
1701 S. First Avenue  
Room 102  
Maywood, IL 60153  
708-786-4000  
708-786-4002 TDD

Southwest District Office  
5th District Courthouse  
10220 S. 76th Avenue  
Room 250  
Bridgeview, IL 60455  
708-974-6160  
708-974-6043 TDD

South District Office  
6th District Courthouse  
16501 S. Kedzie Parkway  
Markham, IL 60426  
708-210-4500  
708-210-4010 TDD



## Cook County Board of Commissioners



**Todd H. Stroger**  
President

William M. Beavers

Jerry Butler

Forrest Claypool

Earlean Collins

John P. Daley

Mike Quigley

Elizabeth Ann Doody Gorman

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Joseph Mario Moreno

Joan Patricia Murphy

Anthony J. Peraica

Timothy O. Schneider

Peter N. Silvestri

Deborah Sims

Robert B. Steele

Larry Suffredin

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## **Cook County Health and Hospitals System Facilities**

Ambulatory and Community Health Network of  
Cook County  
627 S. Wood Street  
Chicago, IL 60612  
312-864-0719

Cermak Health Services of Cook County  
2800 S. California Avenue  
Chicago, IL 60608  
773-890-9300

Cook County Department of Public Health  
1010 Lake Street  
Oak Park, IL 60301  
708-492-2000

John H. Stroger, Jr. Hospital of Cook County  
1901 W. Harrison Street  
Chicago, IL 60612  
312-864-6000

Oak Forest Hospital of Cook County  
15900 S. Cicero Avenue  
Oak Forest, IL 60452  
708-687-7200

Provident Hospital of Cook County  
500 E. 51st Street  
Chicago, IL 60608  
312-572-2000

Ruth M. Rothstein CORE Center  
of Cook County  
2020 W. Harrison Street  
Chicago, IL 60612  
312-572-4500

Cook County Health and Hospitals System  
Minutes of the Quality and Patient Safety Committee Meeting  
November 24, 2009

ATTACHMENT #6



## **Cook County Health and Hospitals System**

# **Annual Tuberculosis Surveillance Report 2008**

Cook County Department of Public Health  
Protecting the Health and Environment of Suburban Cook County  
Affiliate, Cook County Health and Hospitals System  
Todd H. Stroger, Jr., President, Cook County Board of Commissioners

# COOK COUNTY DEPARTMENT OF PUBLIC HEALTH

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Cook County Department of Public Health  
Affiliate, Cook County Health and Hospitals System  
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Oak Park, IL 60301

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## OVERVIEW

### Suburban Cook County Tuberculosis Cases Declined in 2008

After several years with marked increases in active tuberculosis (TB) cases, reported TB cases declined 28% between 2007 (n=139) and 2008 (n=100). The number of cases reported in 2008 was the second lowest number reported in the past 10 years. In 2008, the rate of TB was 3.9 per 100,000 population compared to 5.7 per 100,000 in 2007.

### Cook County Department of Public Health (CCDPH) TB Control Activities, 2008

If untreated, a person with TB may infect as many as 10-15 others each year<sup>1</sup>. In order to prevent transmission of TB, the CCDPH TB Control and Prevention Program maintains constant vigilance in order to identify TB cases rapidly, to ensure that cases receive appropriate therapy and to screen contacts of TB cases to determine if they have been infected. To prevent and control TB in 2008, CCDPH staff conducted the following activities:

- Utilized an electronic database to monitor suspect and confirmed TB cases and to track all contacts to facilitate screening for TB infection.
- Administered 15,000 TB screening tests at the three CCDPH TB clinics located in Des Plaines, Forest Park and Harvey. As a result, 783 persons were identified as having latent TB infection (LTBI—see below) requiring treatment.
- Administered or assisted in 13 worksite and/or school-based skin testing programs.
- Reached out to more than 1,000 contacts to active TB cases.
- Provided direct care for 64 new, active TB cases through CCDPH clinics, including Directly Observed Therapy (DOT—see below).
- Gave 15 presentations and educational programs to diverse audiences:
  - ◊ Nursing homes or long-term care facilities (7)
  - ◊ Nursing staff, various organizations (3)
  - ◊ CEDA South Cook County (1)
  - ◊ Illinois Council on Tuberculosis (1)
  - ◊ South Suburban Head Start (1)
  - ◊ Head Start Health Advisory (1)
  - ◊ 2008 National Refugee and Immigration Conference (1)

### Tuberculosis Facts

Tuberculosis is an infection caused by the organism *Mycobacterium tuberculosis*, which spreads from person to person when a contagious individual sneezes, coughs, or speaks. Persons with pulmonary or laryngeal TB can infect others. TB bacilli form tiny particles (droplet nuclei) that can become suspended in air, sometimes for long periods, and cause infection when they are inhaled by others. Close contacts of TB cases, such as household members or others who spend considerable time together, can become infected.

Most infected persons have latent TB infection (LTBI) with no symptoms and are not infectious to others; the condition is found through a positive screening test (skin test or blood test). It is crucial, however, that persons with LTBI receive treatment, because without treatment about 10% will eventually develop active TB. Persons with LTBI and immunocompromising conditions progress to active TB more quickly, and are more likely to have serious outcomes. For example, HIV-infected persons develop active TB 50 times faster than individuals without HIV<sup>2</sup>. Without proper treatment, up to 90% of HIV-positive persons with TB will die within months of TB infection<sup>2</sup>. Consequently, identifying persons with HIV and TB coinfection is critical.

Active TB can be difficult to diagnose and treatment requires months of therapy. Although TB most commonly involves the lungs, it can infect any organ of the body. Active TB generally causes significant symptoms including night sweats, unexplained weight loss, fever, and chills. Without treatment, an estimated 60—70% of persons with active TB would die of this curable disease within a few years<sup>3</sup>.

Persons diagnosed with active TB are required to limit contact with others until they are no longer infectious and to follow an intensive antibiotic regimen lasting at least 6 months. Patients with active TB *must* adhere strictly to the prescribed treatment regimen in order to avoid the development of drug-resistant strains of TB. If a person develops drug-resistant (MDR) TB or acquires MRR-TB, therapy can take 18 months or longer, and drug regimens often require the use of more toxic antibiotics to treat TB effectively.

To ensure successful completion of the treatment regimen, and to minimize the prospect of drug-resistant TB, field staff from the CCDPH TB Control and Prevention Program watch persons with active TB take each dose of medication. This process is called directly observed therapy (DOT) and is a cornerstone of modern TB control and prevention. DOT is labor and resource intensive—and highly effective in curing TB.

### **Tuberculosis, a Global Challenge With Local Consequences**

Through aggressive TB case identification, effective treatment, and contact tracing efforts, transmission of TB within suburban Cook County has been largely controlled, mirroring national trends. But the control of TB requires a sustained commitment to screening and treatment of persons with LTBI. The majority of TB cases (66%) in 2008 were in persons born outside of the United States, many immigrating from many areas of the world where TB is common. These individuals, like most persons infected with TB, likely had LTBI which became active after they immigrated to the United States.

The World Health Organization estimates that one-third of the world's population, some 2 billion persons, currently have LTBI. Among this group, more than 9 million will develop active TB disease each year, and nearly 2 million, or 4,500 people per day, will die. The speed with which individuals can traverse the globe, together with dynamic immigration patterns to suburban Cook County, means that persons at risk of having LTBI are likely to reside within CCDPH jurisdiction. *Screening programs targeting these high risk populations can identify LTBI, a condition which can be treated before it progresses to active TB disease.*

During 2008, in addition to responding to identified cases of active TB, the CCDPH TB Prevention and Control Program utilized surveillance data to assist healthcare providers, schools, and other key partners to ensure that those most at risk of LTBI were screened. This critical step, as part of a strong, sustained private and public effort, is expected to prevent the development of active TB disease and greatly reduce the risk of potential transmission within the community.

---

1. WHO. Fact sheet on tuberculosis. Available at: <http://www.who.int/mediacentre/factsheets/fs104/en/index.html> (last accessed: 23 February 2009).

2. Stop TB Partnership. Talking Points—TB/HIV—June 2007. Available at: [http://www.stoptb.org/wg/tb\\_hiv/assets/documents/tbhivtalkingpoints.pdf](http://www.stoptb.org/wg/tb_hiv/assets/documents/tbhivtalkingpoints.pdf) (last accessed 23 February 2009).

3. Borgdorff Martien W., Floyd Katherine, Broekmans Jaap F.. Interventions to reduce tuberculosis mortality and transmission in low- and middle-income countries. *Bull World Health Organ*; 80(3): 217-227. Available at: [http://www.scielo.org/scielo.php?script=sci\\_arttext&pid=S0042-96862002000300008&lng=en&nrm=iso](http://www.scielo.org/scielo.php?script=sci_arttext&pid=S0042-96862002000300008&lng=en&nrm=iso).doi:10.1590/S0042-96862002000300008 (last accessed 24 February 2009).



## IMPORTANT TRENDS, 2008

### TB Case Rates

In 2008, 100 newly active cases of tuberculosis (TB) were identified in suburban Cook County. This represents a 28% decrease in the number of cases reported in 2007 (n=139). The rate of active TB disease in suburban Cook County in 2008 was 3.9 per 100,000 population, compared to 7.4 per 100,000 population in the City of Chicago.

### Place of Birth

Since 2000, the majority of TB cases in suburban Cook County occurred in persons born outside of the United States, in areas where TB is more common. In 2008, 66 (66%) of all TB cases were foreign-born. Countries ranking highest on the list of persons with TB in 2008 include the Philippines (n=16), Mexico (n=11), and India (n=10).

### Race/Ethnicity

There are marked differences in race/ethnicity by birthplace. In 2008, 76% of foreign-born TB cases were either Asian/Pacific Islanders or Hispanic or Latino. Among U.S.-born cases, 88% were either non-Hispanic white or non-Hispanic black. Among foreign-born TB cases in 2008, 56% were from Asia or the Pacific Islands and 20% were Hispanic or Latino; foreign-born non-Hispanic blacks and whites represented just 16% and 6%, respectively of reported TB cases. Among U.S.-born TB cases in 2008, 59% were non-Hispanic white and 29% were non-Hispanic black. Only 12% of U.S.-born cases were Hispanic. There were no U.S.-born TB cases of Asian descent in 2008.

### Age

Forty (40%) TB cases were aged 24-44 years in 2008; 30 (30%) were 45-64 years, and 22 (22%) were 65 years and older.

### TB and HIV/AIDS Coinfection

The proportion of TB cases tested for HIV increased from 25% in 2000 to 89% in 2008. Of the 89 persons tested for HIV, 8 (9%) were HIV positive.

### Multidrug-Resistant (MDR-TB) and Extensively Drug-Resistant (XDR-TB) Tuberculosis\*

Since 1999, suburban Cook County has averaged 1-2 multidrug-resistant TB (MDR-TB) cases each year. In 2008, there were no MDR-TB cases reported. Through 2008, there have been no cases of extensively drug-resistant TB (XDR-TB) reported in suburban Cook County.

### Site of Disease

Sixty-seven (67%) of all TB cases reported were pulmonary cases, 28 (28%) had extrapulmonary involvement, and 5 (5%) had both pulmonary and extrapulmonary involvement. These proportions have been consistent for the past 10 years.

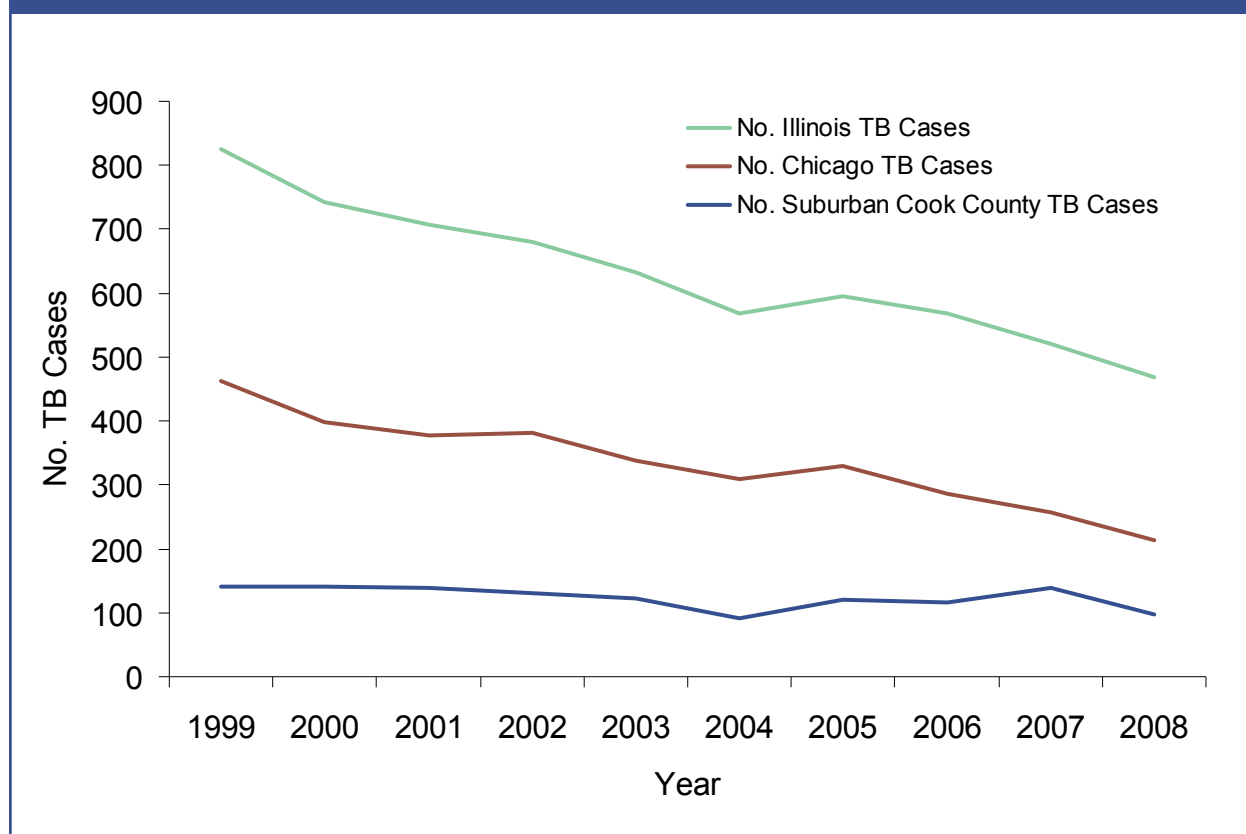
### Number of TB Cases and Case Rates by Municipality, 2008

A total of 52 TB cases (52%) lived in the North District during 2008. The North District represents approximately 44% of the general population of suburban Cook County, indicating a slightly larger than expected number of TB cases. Four of the top six municipalities with the largest number of TB cases were located in the North District: Evanston (n=6), Skokie (n=6), Des Plaines (n=5), and Morton Grove (n=5).

---

\*Multidrug-resistant TB (MDR-TB) is defined as TB resistant at least to isoniazid (INH) and rifampin (RIF). MDR TB treatment requires the use of second-line drugs that are less effective, more toxic, and more costly than first-line regimens. Extensively drug resistant TB (XDR-TB) is defined as resistance to INH, RIF, at least one fluoroquinolone and at least one of the injectable drugs (i.e., amikacin, kanamycin, or capreomycin).

Figure 1. Tuberculosis Cases by Selected Public Health Jurisdictions, 1999-2008



**Figure 1.** In suburban Cook County, tuberculosis (TB) cases declined steadily from an average of 140 cases per year between 1999-2001 to 91 cases in 2004, a decline of 35%. However, between 2004 and 2007, the trend reversed, and all of the previous gains were lost. From 2007 to 2008, cases declined 30%, from 139 in 2007 to 100 in 2008. Over the past 10 years, only the year 2004 had fewer cases ( $n=91$ ).

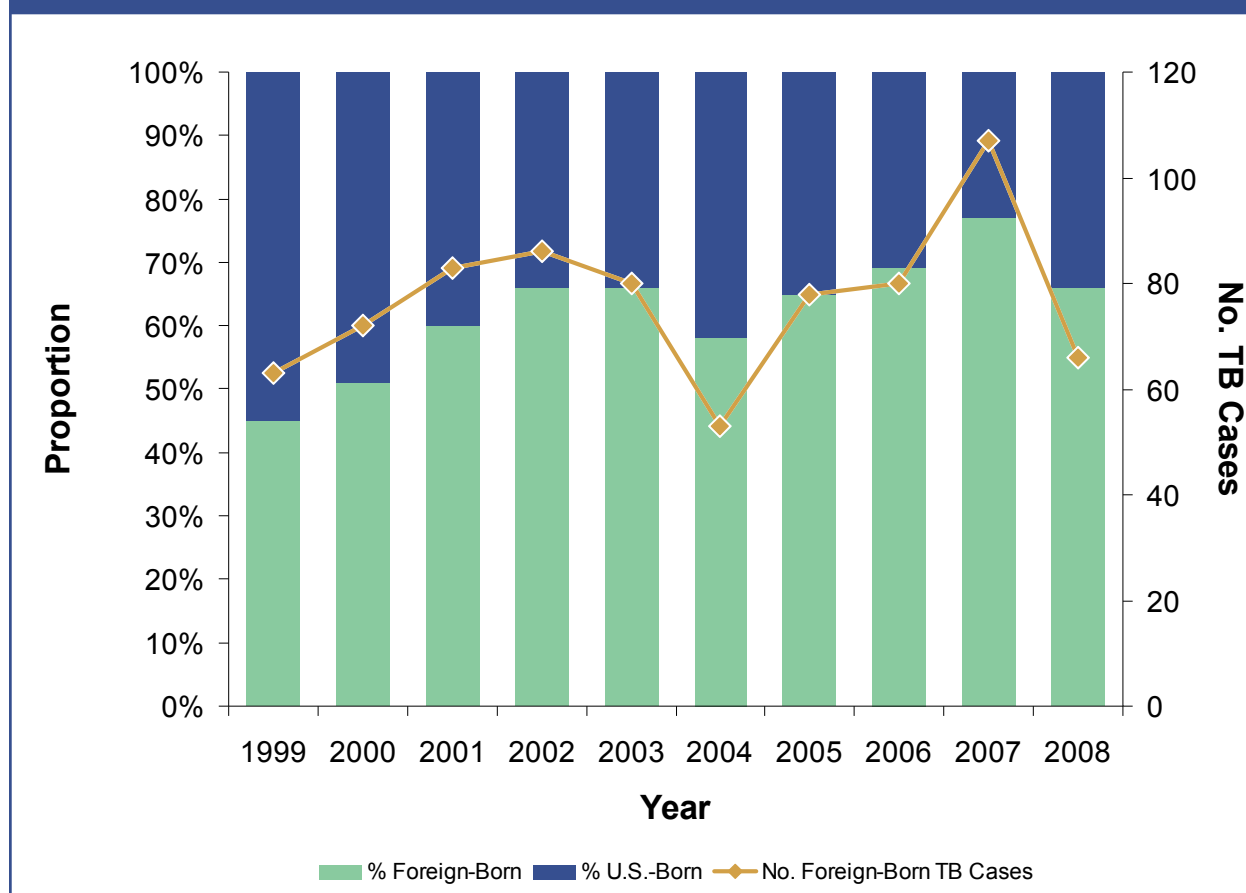
In the City of Chicago, and in Illinois overall, the trend in reported TB cases has been downward over the past 10 years. In Illinois, reported TB cases declined 43%, from 825 in 1999 to 569 in 2008. In Chicago, reported TB cases declined 54%, from 463 in 1998 to 214 in 2008.

**Table 1. Tuberculosis Cases and Percentages by Selected Characteristics, Suburban Cook County, 1999-2008**

Characteristic	1999		2000		2001		2002		2003		2004		2005		2006		2007		2008	
	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%
<b>Sex</b>																				
Male	77	55	75	53	74	53	72	55	70	57	53	58	57	48	64	55	73	53	58	58
Female	63	45	66	47	65	47	58	45	52	43	38	42	63	53	52	45	66	47	42	42
<b>Race/Ethnicity</b>																				
White, not Hispanic	51	36	31	22	34	24	28	22	28	23	23	25	21	18	19	16	26	19	24	24
Black, not Hispanic	22	16	43	30	32	23	22	17	30	25	19	21	30	25	19	16	16	12	20	20
Hispanic	20	14	20	14	26	19	25	19	19	16	21	23	24	20	25	22	29	21	17	17
Asian/Hawaiian/PI	38	27	45	32	46	33	55	42	45	37	28	31	45	38	53	46	68	49	38	38
Other/Unknown	9	6	2	1	1	1	0	0	0	0	0	0	0	0	0	0	0	0	1	1
<b>Age at Report</b>																				
Under 5	3	2	6	4	7	5	2	2	1	1	1	1	3	3	4	3	3	2	2	2
5-14	0	0	2	1	0	0	0	0	1	1	0	0	3	3	4	3	2	1	1	1
15-24	9	6	16	11	16	12	12	9	17	14	5	5	15	13	7	6	14	10	4	4
25-44	57	41	50	35	43	31	54	42	38	31	31	34	43	36	37	32	33	24	40	40
45-64	34	24	35	25	42	30	31	24	44	36	33	36	31	26	34	29	57	41	30	30
65+	37	26	32	23	31	22	31	24	21	17	21	23	25	21	30	26	30	22	23	23
<b>Total</b>	<b>140</b>	<b>100</b>	<b>141</b>	<b>100</b>	<b>139</b>	<b>100</b>	<b>130</b>	<b>100</b>	<b>122</b>	<b>100</b>	<b>91</b>	<b>100</b>	<b>120</b>	<b>100</b>	<b>116</b>	<b>100</b>	<b>139</b>	<b>100</b>	<b>100</b>	<b>100</b>

**Table 1. Sex:** In 2007 males accounted for 59 (59%) of all TB cases, a proportion that is somewhat higher than in previous years. **Age:** In 2008, 93 (93%) of all TB cases were 25 years or older. Persons aged 25-44 years accounted for the largest proportion of active TB cases, 40 (40%), followed by persons aged 45-64 years (30%). **Race/Ethnicity:** Asian/Pacific Islanders account for the largest proportion of TB cases—38%. The number of Asian/Pacific Islanders and Hispanics with active TB decreased 44% from 2007 to 2008.

Figure 2. Trends in Tuberculosis (TB) Cases by Place of Birth, Suburban Cook County, 1999-2008

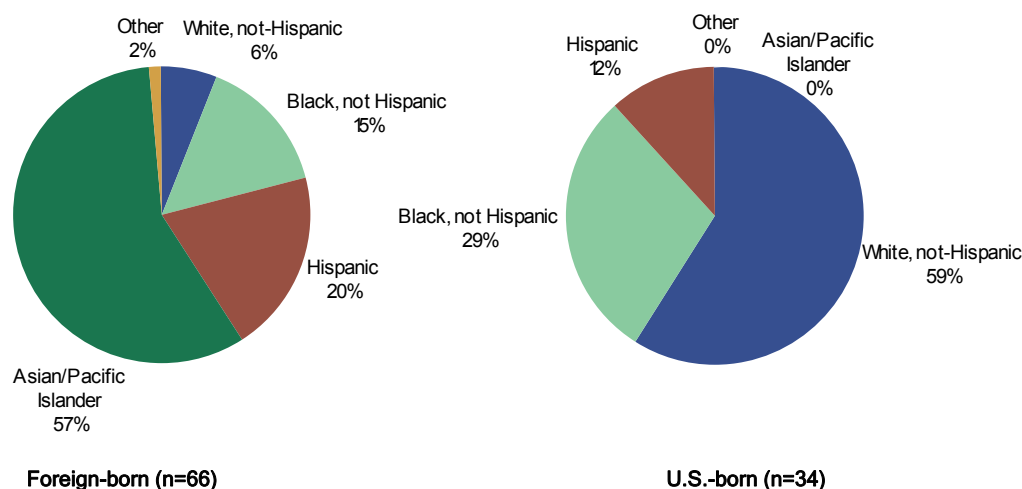


**Figure 2.** Between 1999 and 2007, the number of foreign-born TB cases increased 70%, from 63 in 2000 to 107 in 2007. Although the majority of cases in suburban Cook County were foreign-born in 2008, the proportion of foreign-born TB cases fell from 77% in 2007 to 66% in 2008. Similar increases were reported in Chicago (54% foreign-born, 2008)<sup>1</sup>, Illinois (60% foreign-born, 2008)<sup>2</sup>, and the U.S. (59% foreign born, 2008)<sup>3</sup>.

1. Eaglin M. Presentation, Chicago Technical Advisory Group Meeting. Chicago, IL, March 4, 2009.

2. Peter Ward, Personal Communication, 2009.

3. Centers for Disease Control and Prevention. *Reported Tuberculosis in the United States, 2008*. Atlanta, GA; U.S. Department of Health and Human Services, CDC: September, 2009.

**Figure 3. Percentage of Tuberculosis Cases by Place of Birth and Race/Ethnicity, Suburban Cook County, 2008**

**Figure 3.** Of the 100 cases of tuberculosis reported to Cook County Department of Public Health in 2008, 66 (66%) were foreign-born and 34 (34%) were U.S.-born. Among all TB cases reported in 2008, 100% of Asian/Pacific Islanders and 77% of Hispanics were foreign-born. Among foreign-born TB cases, 57% were Asian/Pacific Islanders and 20% were Hispanic. Among U.S.-born TB cases, 59% were non-Hispanic white and 29% were non-Hispanic black. Among all non-Hispanic whites, 83% were U.S. born; among all non-Hispanic blacks, 50% were U.S.-born.

**Table 2. Foreign-born Tuberculosis Cases by Top Countries of Birth\*, Suburban Cook County, 1999-2008**

Country	1999 No.	2000 No.	2001 No.	2002 No.	2003 No.	2004 No.	2005 No.	2006 No.	2007 No.	2008 No.
Philippines	5	9	6	7	13	10	12	16	21	16
Mexico	11	14	21	18	14	13	19	18	18	11
India	27	21	24	31	16	13	24	23	30	10
China	0	3	0	1	3	1	0	3	1	4
North Korea	0	0	0	0	1	0	0	0	1	3
Poland	1	6	6	4	3	3	2	1	4	2
Vietnam	2	0	3	1	3	0	1	2	1	2
Russia	2	1	0	0	1	0	1	0	1	2
South Korea	4	4	1	6	2	2	4	2	5	1
Pakistan	0	2	5	3	2	1	1	1	5	1
Nigeria	0	2	0	0	4	0	1	0	0	1
Romania	2	0	0	1	0	1	1	2	0	1
Burma	0	1	0	2	1	0	0	0	1	1
Greece	1	1	0	2	0	0	0	0	0	1
Thailand	1	1	2	0	1	0	0	1	1	0
Guatemala	0	0	1	1	1	1	0	0	2	0
Italy	1	0	0	1	1	0	1	0	2	0
Bosnia and Herzegovina	0	0	0	1	1	2	1	0	0	0
Haiti	0	0	0	0	3	0	1	0	1	0
Peru	0	0	0	0	1	1	1	0	2	0
Ukraine	0	1	0	0	1	1	0	0	2	0

\* Countries from which at least 5 TB cases were reported between 1999-2008

**Table 2.** Table 3 shows foreign-born TB cases by country of origin for countries in which at least 5 cases were reported over the past 10 years. The number of TB cases from the Philippines increased over the past decade, and in 2008 there were fewer TB cases reported among Mexicans and Indians compared with previous years.

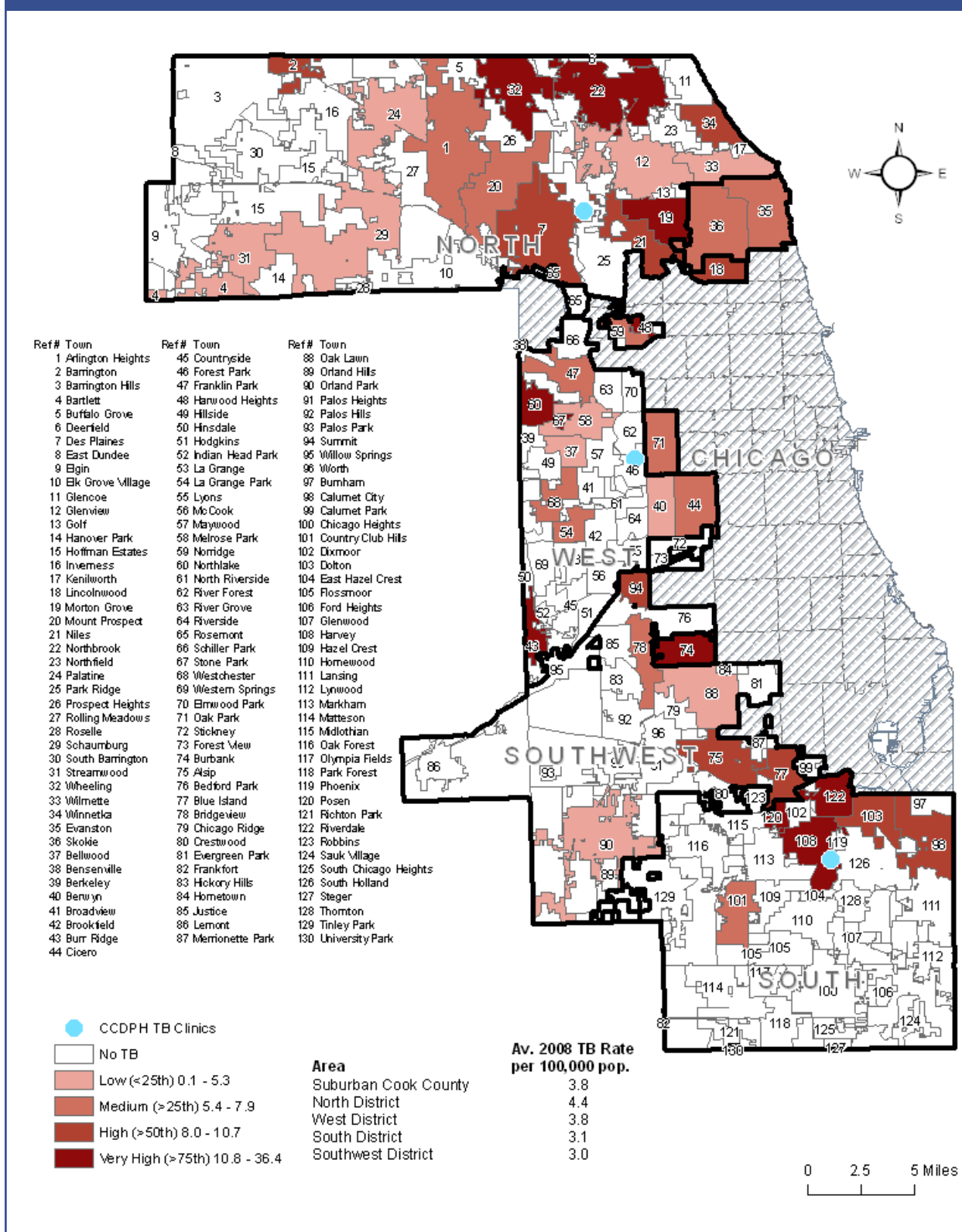
In 2008, foreign-born cases came from 15 different countries; however, the majority, 61%, came from just three: the Philippines (n=16), Mexico (n=11) and India (n=10). This has also been a stable trend over the past ten years.

**Table 3. Tuberculosis Cases, Number and Proportion of TB Cases Tested for HIV and Number and Proportion Coinfected with TB and HIV, Suburban Cook County, 2000-2008**

Year	Total Tuberculosis Cases No.	Tested for HIV		Coinfected with HIV	
		No.	%	No.	%
2000	141	35	25	5	14
2001	139	32	23	7	22
2002	130	72	55	5	7
2003	122	89	73	7	8
2004	91	75	82	4	5
2005	120	94	78	6	6
2006	116	85	73	2	2
2007	139	108	78	7	6
2008	100	89	89	8	9

**Table 3.** Between 2000 and 2008, the proportion of TB cases tested for HIV increased from 25% in 2000 to 89% in 2008. Of those with TB and HIV test results, approximately 9% were coinfectd in 2008.

**Figure 4. Tuberculosis Cases Rates per 100,000 Population by Municipality, Suburban Cook County, 2008**



**Table 4. Tuberculosis Cases and Rates (per 100,000 population) by Municipality for the North and West Districts, Suburban Cook County, 2006-2008**

NORTH							WEST						
City	2006		2007		2008		City	2006		2007		2008	
	No.	Rate	No.	Rate	No.	Rate		No.	Rate	No.	Rate	No.	Rate
Arlington Heights	2	2.7	3	4.0	4	5.4	Bellwood	0	0.0	1	5.1	1	5.2
Barrington	0	0.0	0	0.0	1	9.7	Berkeley	0	0.0	0	0.0	0	0.0
Barrington Hills	0	0.0	0	0.0	0	0.0	Benwyn	4	7.8	4	7.8	2	3.9
Bartlett	0	0.0	0	0.0	1	2.5	Broadview	1	12.7	0	0.0	0	0.0
Buffalo Grove	0	0.0	0	0.0	0	0.0	Brookfield	0	0.0	2	10.8	0	0.0
Des Plaines	2	3.5	11	19.5	5	8.8	Burr Ridge	0	0.0	0	0.0	2	18.0
Elgin	0	0.0	0	0.0	0	0.0	Cicero	7	8.5	6	7.2	4	4.9
Elk Grove Village	2	5.9	4	11.8	0	0.0	Countryside	0	0.0	0	0.0	0	0.0
Evanston	3	4.0	2	2.7	6	7.9	Elmwood Park	2	8.2	1	4.1	1	4.1
Glencoe	1	11.1	0	0.0	0	0.0	Forest Park	0	0.0	5	32.9	0	0.0
Glenview	3	6.5	4	8.7	2	4.3	Franklin Park	3	16.2	1	5.4	1	5.5
Golf	0	0.0	0	0.0	0	0.0	Harwood Heights	0	0.0	1	12.2	2	24.6
Hanover Park	0	0.0	1	2.7	0	0.0	Hillside	0	0.0	1	12.9	0	0.0
Hoffman Estates	2	3.8	6	11.5	0	0.0	Hinsdale	0	0.0	0	0.0	0	0.0
Inverness	0	0.0	0	0.0	0	0.0	Hodgkins	0	0.0	0	0.0	0	0.0
Kenilworth	0	0.0	0	0.0	0	0.0	Indian Head Park	0	0.0	0	0.0	0	0.0
Lincolnwood	0	0.0	2	16.6	1	8.4	La Grange	2	12.9	0	0.0	0	0.0
Morton Grove	4	18.0	2	9.0	5	22.3	La Grange Park	0	0.0	0	0.0	1	7.9
Mount Prospect	3	5.5	3	5.5	4	7.4	Lyons	0	0.0	1	9.6	0	0.0
Niles	2	6.8	5	17.0	3	10.3	Maywood	3	11.6	5	19.4	0	0.0
Norridge	0	0.0	0	0.0	1	7.1	Mccook	1	411.5	0	0.0	0	0.0
Northbrook	2	36.3	0	0.0	2	36.4	Melrose Park	5	22.2	1	4.4	1	4.5
Northfield	0	0.0	0	0.0	0	0.0	North Riverside	0	0.0	0	0.0	0	0.0
Palatine	3	4.5	4	5.9	1	1.5	Northlake	1	15.7	3	47.0	2	31.6
Park Ridge	0	0.0	0	0.0	0	0.0	Oak Park	0	0.0	1	2.0	3	6.0
Prospect Heights	4	24.4	2	12.2	0	0.0	River Forest	0	0.0	0	0.0	0	0.0
Rolling Meadows	1	4.2	2	8.4	0	0.0	River Grove	0	0.0	0	0.0	0	0.0
Roselle	0	0.0	0	0.0	0	0.0	Riverside	0	0.0	1	11.8	0	0.0
Schaumburg	2	2.7	7	9.6	3	4.1	Rosemont	0	0.0	0	0.0	0	0.0
Skokie	10	15.5	11	17.0	6	9.0	Schiller Park	1	8.6	1	8.6	0	0.0
South Barrington	0	0.0	0	0.0	0	0.0	Stone Park	2	40.8	0	0.0	1	20.6
Streamwood	2	5.4	2	5.4	1	2.7	Westchester	0	0.0	3	18.5	1	6.3
Wheeling	4	31.8	2	15.9	3	23.9	Western Springs	0	0.0	0	0.0	0	0.0
Wilmette	1	3.7	1	3.7	2	7.5							
Winnetka	0	0.0	1	8.0	1	8.0							
Total	53	4.6	75	6.6	52	4.5	Total	32	5.5	38	6.5	22	3.8

*Rates per 100,000 population per year.*

**Table 4. North District:** a total of 52 cases (52%) were living in the North District in 2008, which corresponds to a rate of 4.5 per 100,000 population. For the past three years, the North District has had the highest TB rates of the four Districts. Evanston (n=6), Skokie (n=6), Des Plaines (n=5) and Morton Grove (n=5) had the largest number of TB cases in the North District. Four of the top 5 municipalities with the largest number of TB cases were located in the North District.

**West District:** Twenty-two cases (22%) were reported from the West District, which corresponds to a rate of 3.8 per 100,000 population. Cicero (n=4) and Oak Park (n=3) had the largest number of reported TB cases in the West District.



**Table 5 . Tuberculosis Cases and Rates (per 100,000 population) by Municipality for the South and Southwest Districts, Suburban Cook County, 2006-2008**

SOUTH							SOUTHWEST						
City	2006		2007		2008		City	2006		2007		2008	
	No.	Rate	No.	Rate	No.	Rate		No.	Rate	No.	Rate	No.	Rate
Burnham	0	0.0	0	0.0	0	0.0	Alsip	0	0.0	2	10.5	2	10.6
Calumet City	2	5.3	2	5.3	4	10.7	Bedford Park	0	0.0	0	0.0	0	0.0
Chicago Heights	1	3.2	1	3.2	0	0.0	Blue Island	1	4.4	0	0.0	2	8.9
Country Club Hills	0	0.0	2	12.1	1	6.0	Bridgeview	1	6.7	0	0.0	1	6.7
Dixmoor	0	0.0	1	26.2	0	0.0	Burbank	0	0.0	2	7.2	3	10.8
Dolton	4	16.3	0	0.0	2	8.3	Calumet Park	0	0.0	0	0.0	0	0.0
East Hazel Crest	0	0.0	0	0.0	0	0.0	Chicago Ridge	0	0.0	0	0.0	0	0.0
Flossmoor	0	0.0	0	0.0	1	10.6	Crestwood	0	0.0	0	0.0	0	0.0
Ford Heights	0	0.0	0	0.0	0	0.0	Evergreen Park	1	5.0	0	0.0	0	0.0
Glenwood	1	11.5	1	11.5	0	0.0	Forest View	0	0.0	0	0.0	0	0.0
Harvey	3	10.4	2	7.0	4	14.0	Hickory Hills	0	0.0	0	0.0	0	0.0
Hazel Crest	0	0.0	0	0.0	0	0.0	Hometown	0	0.0	0	0.0	0	0.0
Homewood	1	5.3	0	0.0	0	0.0	Justice	0	0.0	0	0.0	0	0.0
Lansing	1	3.7	0	0.0	0	0.0	Lemont	0	0.0	0	0.0	0	0.0
Lynwood	0	0.0	0	0.0	0	0.0	Merrionette Park	0	0.0	0	0.0	0	0.0
Markham	0	0.0	0	0.0	0	0.0	Oak Lawn	0	0.0	2	3.7	1	1.9
Matteson	2	12.8	0	0.0	0	0.0	Orland Hills	0	0.0	0	0.0	0	0.0
Midlothian	1	7.2	1	7.2	0	0.0	Orland Park	2	3.6	3	5.4	1	1.8
Oak Forest	2	7.1	0	0.0	0	0.0	Palos Heights	0	0.0	0	0.0	0	0.0
Olympia Fields	0	0.0	0	0.0	0	0.0	Palos Hills	0	0.0	0	0.0	0	0.0
Park Forest	0	0.0	0	0.0	0	0.0	Palos Park	0	0.0	0	0.0	0	0.0
Phoenix	0	0.0	0	0.0	0	0.0	Stickney	0	0.0	0	0.0	0	0.0
Posen	0	0.0	0	0.0	1	20.2	Summit	0	0.0	0	0.0	1	9.7
Richton Park	0	0.0	2	15.4	0	0.0	Willow Springs	1	16.6	0	0.0	0	0.0
Riverdale	3	29.4	1	9.8	2	19.7	Worth	0	0.0	0	0.0	0	0.0
Robbins	0	0.0	0	0.0	0	0.0							
Sauk Village	0	0.0	0	0.0	0	0.0							
South Chicago Heights	0	0.0	0	0.0	0	0.0							
South Holland	0	0.0	0	0.0	0	0.0							
Steger	0	0.0	0	0.0	0	0.0							
Thornton	0	0.0	0	0.0	0	0.0							
Tinley Park	1	1.7	0	0.0	0	0.0							
Total	22	4.6	13	2.7	15	3.1	Total	6	1.6	9	2.4	11	3.0

*Rates per 100,000 population per year.*

**Table 5. South District:** a total of 15 cases (15%) were living in the North District in 2008, which corresponds to a rate of 3.1 per 100,000 population. Harvey (n=4) and Calumet City (n=4) had just over half of all the TB cases who were residents of the South District.

**Southwest District:** Eleven cases (11%) were reported from the West District, which corresponds to a rate of 3.0 per 100,000 population. Burbank (n=3), Alsip (n=2) and Blue Island (n=2) had the largest number of TB cases in 2008.

Cook County Health and Hospitals System  
Minutes of the Quality and Patient Safety Committee Meeting  
November 24, 2009

ATTACHMENT #7

# **JOHN H. STROGER, JR. HOSPITAL OF COOK COUNTY**

## **INITIAL APPOINTMENTS**

Mansour, Mohamed, MD Appointment Effective:	Correctional Health Service/Medicine November 24, 2009 through November 23, 2011	Active Physician
Margeta, Natasa L., MD Appointment Effective:	Medicine/Hospitalist November 24, 2009 through November 23, 2011	Active Physician
Pandey, Tanu S., MD Appointment Effective:	Medicine/General Medicine November 24, 2009 through November 23, 2011	Active Physician

## **Mid Level Practitioner**

Jordan, Shari M., CRNA Appointment Effective:	Anesthesiology November 24, 2009 through November 23, 2011	Certified Registered Nurse Anesthetist
Simmons, Zina M., CNP With Patricia Kelleher, MD Appointment Effective:	Medicine November 24, 2009 through November 23, 2011	Nurse Practitioner
Thomassie, Tracy C., CRNA Appointment Effective:	Anesthesiology November 24, 2009 through November 23, 2011	Certified Registered Nurse Anesthetist
Weiland, Sandra J., CRNA Appointment Effective:	Anesthesiology November 24, 2009 through November 23, 2011	Certified Registered Nurse Anesthetist

## **REAPPOINTMENT APPLICATIONS**

### **Department of Anesthesiology**

Ghaly, Ramsis, MD Reappointment Effective:	Anesthesia/Neurosurgery December 18, 2009 through December 17, 2011	Active Physician
Nasr, Ned, MD Reappointment Effective:	Anesthesia December 21, 2009 through December 20, 2011	Active Physician

### **Department of Correctional Health Services**

Carrington, David, MD Reappointment Effective:	Psychiatry November 24, 2009 through November 23, 2011	Voluntary Physician
Luke, Luckose, MD Reappointment Effective:	Psychiatry December 21, 2009 through December 20, 2011	Voluntary Physician
Ting, Andrew, MD Reappointment Effective:	Psychiatry December 18, 2009 through December 17, 2011	Active Physician

Item VI(C) – QPS Committee Agenda  
Medical Staff Appointments/Re-appointments/Changes

Page 1 of 5

**APPROVED**

**BY THE QUALITY AND PATIENT SAFETY COMMITTEE  
ON NOVEMBER 24, 2009**

**John H. Stroger, Jr. Hospital of Cook County**  
**Reappointment Applications (continued)**

**Department of Emergency Medicine**

Harter, David, MD	Emergency Medicine	Active Physician
Reappointment Effective:	December 16, 2009 through December 15, 2011	
Ross, Christopher, MD	Emergency Medicine	Active Physician
Reappointment Effective:	December 16, 2009 through December 15, 2011	
Straus, Helen, MD	Emergency Medicine	Active Physician
Reappointment Effective:	December 16, 2009 through December 15, 2011	

**Department of Medicine**

Bodnar, Ulana R., MD	Infectious Disease	Voluntary Physician
Reappointment Effective:	December 21, 2009 through December 20, 2011	
Borkowsky, Shane, MD	General Medicine	Active Physician
Reappointment Effective:	December 21, 2009 through December 20, 2011	
Chataut, Chandra P., MD	General Medicine	Active Physician
Reappointment Effective:	December 21, 2009 through December 20, 2011	
Ezike, Ngozi O., MD	General Medicine	Active Physician
Reappointment Effective:	December 21, 2009 through December 20, 2011	
Huhn, Gregory D., MD	Infectious Disease	Active Physician
Reappointment Effective:	November 24, 2009 through November 23, 2011	
Tchernodirnski, Stefan T., MD	General Medicine	Active Physician
Reappointment Effective:	December 18, 2009 through December 17, 2011	
Zimnowodzki, Simon, MD	Neurology	Consulting Physician
Reappointment Effective:	December 21, 2009 through December 20, 2011	

**Department of OB/Gyne**

Yordan, Edgardo, MD	Ob/Gyne/Gynecology	Active Physician
Reappointment Effective:	December 16, 2009 through December 15, 2011	

**Department of Pediatrics**

Kagan, Tatyana, MD	Peds/ER	Active Physician
Reappointment Effective:	December 21, 2009 through December 20, 2011	
Martinez, Jaime, MD	Adolescent Medicine	Active Physician
Reappointment Effective:	November 24, 2009 through November 23, 2011	



**John H. Stroger, Jr. Hospital of Cook County**  
**Reappointment Applications**  
**Department of Pediatrics (continued)**

Pildes, Rosita, MD	No clinical privileges	Honorary Physician
Reappointment Effective:	November 24, 2009 through November 23, 2011	

Rosado, Norell, MD	Child Protective Services	Active Physician
Reappointment Effective:	December 16, 2009 through December 15, 2011	

Soglin, David, MD	Pediatric Medicine	Active Physician
Reappointment Effective:	November 24, 2009 through November 23, 2011	

**Department of Surgery**

Gandi, Yogesh, MD	Neurosurgery	Active Physician
Reappointment Effective:	December 21, 2009 through December 20, 2011	

Patel, Urjeet, MD	Otolaryngology	Active Physician
Reappointment Effective:	December 16, 2009 through December 15, 2011	

**Department of Trauma**

Roxanne Roberts, MD – Renewal of Clinical Privileges	
Effective:	November 24, 2009 through June 18, 2010

**Mid-Level Practitioners Additional Clinical Privileges Request**

Brown, Barbara J., CNP	Medicine	Nurse Practitioner
With Sharon Irons, MD		

**Additional Clinical Privileges Requests**

Patel, Aiyub, MD	Medicine/General Medicine
Requesting Pulmonary and Critical Care Medicine	

Lazzaro, Gianluca, MD	Surgery/Surgical Oncology
Requesting General Surgery	

**Medical Staff Appointment From Provisional to Full Status**

Gopireddy, Dheeraj-Reddy, MD	Medicine/General Medicine	Voluntary Physician
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**CCHHS**  
**APPROVED**  
**BY THE QUALITY AND PATIENT SAFETY COMMITTEE**  
**ON NOVEMBER 24, 2009**



# **PROVIDENT HOSPITAL OF COOK COUNTY**

## **INITIAL APPOINTMENTS**

Chawla, Rashmi, MD Appointment Effective:	Internal Medicine/Pulmonary Critical Care November 24, 2009 through October 20, 2011	Affiliate Physician
Florens, Adrian, MD Appointment Effective:	Pediatrics November 24, 2009 through August 17, 2011	Affiliate Physician
Fogelfeld, Leon, MD Appointment Effective:	Internal Medicine/Endocrinology November 24, 2009 through November 23, 2011	Affiliate Physician

## **REAPPOINTMENT APPLICATIONS**

### **Department of Family Medicine**

Healy, Kristine, P.A. Reappointment Effective:	Family Medicine/ACHN November 20, 2009 through November 19, 2011	Physician Assistant
Nagaraj, Athihalli, MD Reappointment Effective:	Family Medicine November 30, 2009 through November 29, 2011	Ancillary Physician
Shaher, Ahmad, MD Reappointment Effective:	Family Medicine December 18, 2009 through December 17, 2011	Active Physician
Whitfield-Smith, Stephanie, MD Reappointment Effective:	Family Medicine November 24, 2009 through November 23, 2011	Active Physician

### **Department of Internal Medicine**

Brannegan, Richard T., MD Reappointment Effective:	Neurology December 17, 2009 through November 17, 2011	Affiliate Physician
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### **Department of Obstetrics & Gynecology**

Saffold, Carol, MD Reappointment Effective:	OB/Gyne November 24, 2009 through November 23, 2011	Ancillary Physician
Swift, Eddie, MD Reappointment Effective:	Maternal Fetal Medicine December 20, 2009 through December 19, 2011	Consulting Physician

### **Department of Pediatrics**

Siddiqui, Zaki, A., MD Reappointment Effective:	Pediatrics December 17, 2009 through December 16, 2011	Ancillary Physician
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### **Department of Radiology**

Holloway, Nathaniel, MD Reappointment Effective:	Radiation Oncology December 20, 2009 through July 26, 2011	Voluntary Physician
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# **OAK FOREST HOSPITAL OF COOK COUNTY**

## **MEDICAL STAFF APPOINTMENT**

<b><u>Name</u></b>	<b><u>Department</u></b>	<b><u>Status</u></b>
Muzaffar, Shirin, MD Appointment effective:	Medicine/Pulmonary Critical Care November 24, 2009 through August 18, 2011	Affiliate Physician

## **MEDICAL STAFF REAPPOINTMENT**

Schaider, Jeffrey, MD Reappointment effective:	Emergency Medicine November 24, 2009 through September 19, 2011	Affiliate Physician
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CCHHS

**APPROVED**

**BY THE QUALITY AND PATIENT SAFETY COMMITTEE  
ON NOVEMBER 24, 2009**

