

**Annual Evaluation  
Performance Improvement and Patient Safety Plan  
EHS Health System  
Fiscal Year 2007  
July 1, 2006-June 30, 2007**

Each year a formal review of the EHS Health System (EHS) Performance Improvement and Safety Plan is conducted to evaluate the strengths and limitations of the quality improvement efforts conducted throughout the previous year and to provide direction for the upcoming year.

The Performance Improvement Department of the EHS oversees the assessment, planning, implementation, and evaluation along with all disciplines and departments throughout the healthcare system to improve patient care and services. This report will summarize and highlight the accomplishments that have specifically impacted the EHS from July 2006 through June 2007.

Over the past two years, the Performance Improvement Department focused the quality strategy to hasten the transformation from a retrospective chart audit model to a proactive, real time process improvement model. There has been a greater collaboration between all entities and the community to improve the quality and safety of all individuals that are served by the EHS.

**Patient Safety**

The Radiation Safety Program

The EHS is committed to a Radiation Safety Program designed to maintain radiation exposures As Low As Reasonably Achievable (ALARA) and to ensure the impact of this hospital's use of radioactive materials and radiation-producing devices on personnel and the environment is minimized. Several highlights accomplished by the Radiation Safety Officer and Committee this year includes a change in service contract for maintenance of x-ray equipment from General Electric to Siemens Medical Systems. Both the EHS One Day Surgical Center program and the EHS Nuclear Medicine program were inspected by the State of New Hampshire and no deficiencies were identified during the inspections.

Quality Management Programs for Radiation Oncology and Nuclear Medicine provide annual reports to the Radiation Safety Committee and recently there is a formalized Quality Control Program to develop policies and procedures for enhancing and maintaining the highest quality images in Diagnostic Imaging. The Radiation Safety Officer developed a radiation safety-training program for the Clinical Engineering and facilities staff and trained all members of Nuclear Medicine and Physicists in radiation oncology on the proper shipping and handling for transporting radioactive materials within the EHS.

## **Infection Control**

House Bill 514, which was approved on June 21, 2005, established the New Hampshire Health Care Quality Assurance Commission. The Commission is made up of one representative from each acute care hospital and free standing ambulatory surgical centers and the designee of the Commissioner of the Department of Health and Human Services. The EHS and EHS One Day Surgicenter have been active participants in the Commission participating in multiple subgroups to impact change throughout the state. The major accomplishment of the Commission this year was the collection and reporting of statewide ventilator associated pneumonia (VAP) and central line bloodstream infection (CLBI) rates. The Commission worked collaboratively with the NH Infection Control Practitioners to identify an acceptable methodology for defining, collecting, and reporting these infections in the aggregate. EHS ICU Quality Team demonstrated best practice with a presentation to the Commission in March of this year.

The community has seen a rise in MRSA infections and VRE over the past year and so has the hospital. The hospital is participating in the IHI Save 5 Million Lives Campaign and has implemented the Reduction in MRSA Module. Part of the module is to proactively screen high-risk population. The EHS has begun screening all patients admitted from nursing homes and all patients admitted to the ICU. This way we can identify and provide the proper isolation necessary. The Commission is also addressing this statewide with a focus on hand hygiene, which is often cited as the primary prevention strategy for infections.

## **Technology**

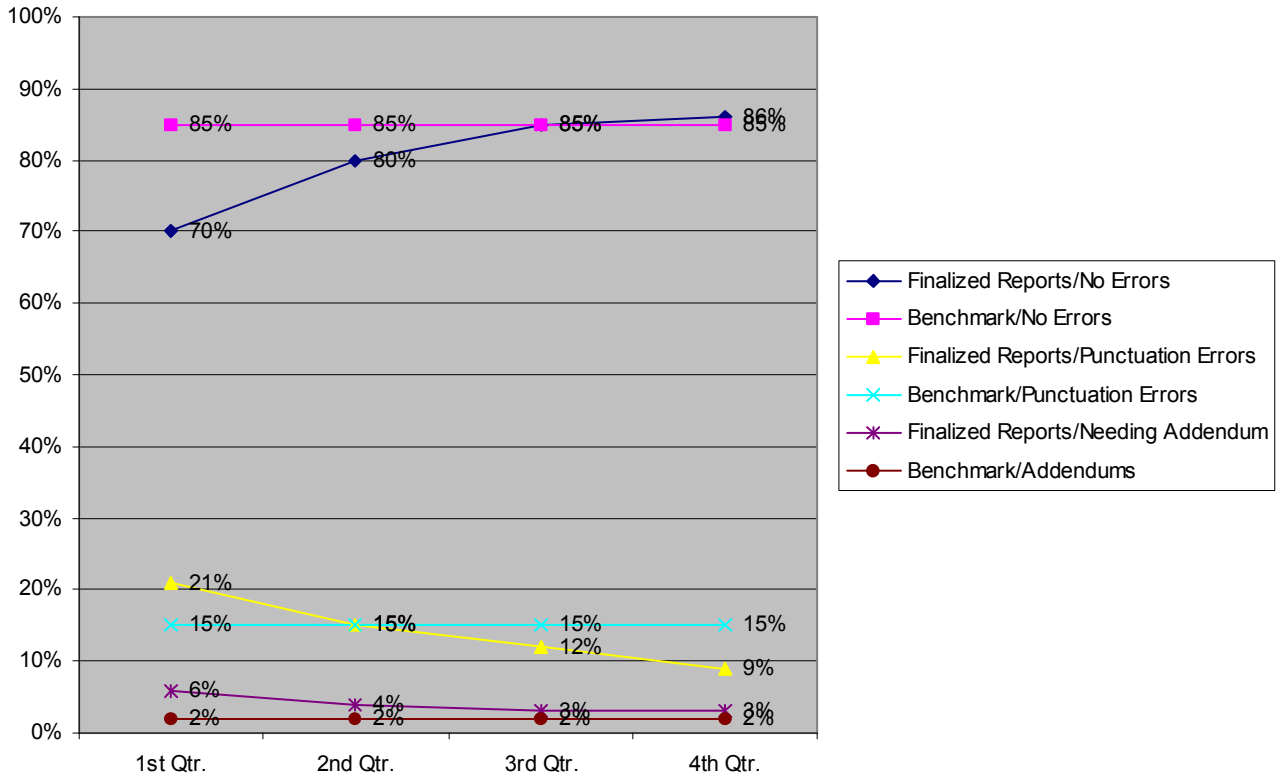
### EPIC

Clinical documentation Phase 1 went live in November with patient information gathered upon admission and patient discharge instructions. In December, MyEChart was launched at its first site. This allowed patients of EHS ambulatory physicians to access their medical record, book their own appointments and easily send messages and communicate with their physician for non-urgent matters. In March, Optime went live in the Operating Room which included OR scheduling, case tracking, procedure preference cards and billing. In May, the ability to access EKG tracings via a hyperlink in the patient's chart improved care by allowing clinicians to review a patient's cardiac history prior to surgery or other procedures. EPIC is improving the quality of care throughout the EHS.

### Voice Recognition Software in Radiology

Progress was made relative to the quality of radiology reports through the Voice Recognition software. The national benchmark for quality in radiology VR reports was exceeded by the 4<sup>th</sup> quarter for FY07.

### Voice Recognition Performance Improvement - FY07



## Risk Management

### Emergency Management Disaster Drills

The EHS's role within the community's emergency plan is coordinated with various agencies in accordance with the National Incident Management System (NIMS). This includes, but is not limited to departments of the municipality (City of Manchester), New Hampshire Office of Emergency Management, New Hampshire Department of Safety, the Federal Emergency Management Agency, Manchester Airport Authority, Manchester American Red Cross, Manchester Fire Department, Manchester Community Health, area EMS services, New Hampshire Hospital Association and various other community agencies and care providers. This integration is achieved through establishing relationships, frequent communication related to Emergency Management and participation in collaborative planning groups. The EHS is frequently viewed as a leader in emergency management readiness due to our experience with mock drills. A minimum of two (2) planned drills is executed each year. At least one of these exercises is designed to test the EHS's ability to manage an influx of patients using mock "victims" to simulate patients. Actual events may be considered as an "exercise" to meet this requirement.

### **Patient Satisfaction**

As part of a system wide Patient Access Re-design group, people who use the EHS, people who have never used the EHS and employees participated in focus groups held in October, November and December. There were a total of 4 sessions. These focus groups provided the EHS with rich information to re-design access and enhance patient care.

In an effort to boost our Press Ganey Patient Satisfaction Scores, the EHS invited Press Ganey Representatives to the EHS for a full day of information and education on how to improve overall satisfaction scores. A presentation was conducted on implementing Best Practices. Hands on demonstrations and learning labs taught the directors how to use the tremendous amount of information to motivate and educate their staff members.

### **The Joint Commission**

The EHS worked diligently throughout the fall to address the areas for improvement suggested by the Joint Commission in our June 2006 site visit. Our plan for improvement was accepted unconditionally and we met all the necessary requirements over the next four months. The hospital has incorporated a “readiness” culture and are prepped and prepared for any visit from any accrediting body. The Accreditation Leadership Team prepared for our PPR, which was held on July 16<sup>th</sup> and all of our action plans were clarified and accepted.

### **Hospital Performance Improvement Initiatives**

- Institute of Healthcare Improvement Participation
- New Hampshire Healthcare Quality Assurance Commission
- Centers for Medicare and Medicaid (CMS) Core Measures

### SAVE 100,000 LIVES CAMPAIGN

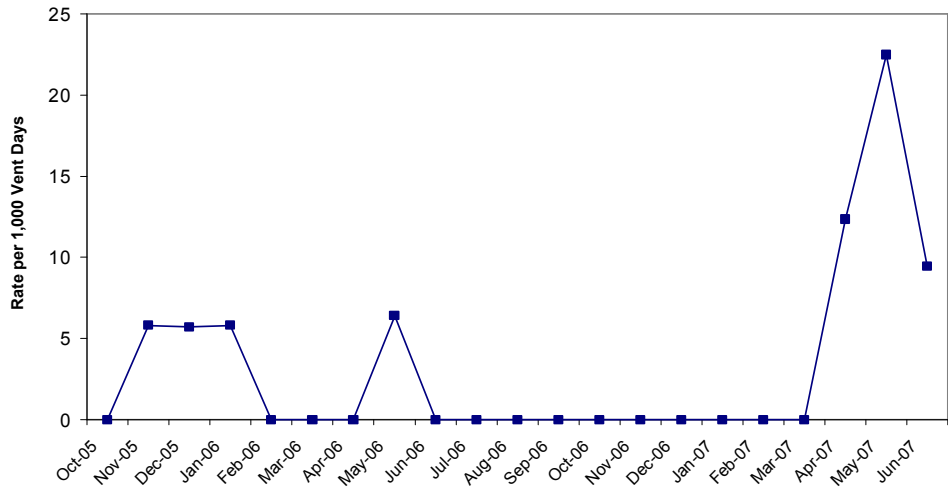
In October the 100,000 lives campaign, the brainchild of Dr. Donald Berwick of the Institute of Healthcare Improvement (IHI), to radically reduce morbidity and mortality in American healthcare officially ended. The EHS was successful in creating new processes with regards to surgical site infection prevention, acute myocardial infarct and implemented a rapid response team, called the CAT (Critical Assessment Team). The following information and data will demonstrate the success the EHS had initiating these initiatives.

In December senior leadership that included our CEO, President of the Board, Vice President Medical Affairs, Associate Medical Director, President Elect of the Medical Staff, Chief of Medicine, Vice President, Performance Improvement, and the Vice President of Support Services attended the Annual Conference for the Institute of Health Improvement. This conference offered leadership the ability to share information, learn from other hospitals and evaluate best practices across the world. As a result, our quality teams received ongoing and continuous support for implementation of VAP and Central Line Reduction processes, Surgical Site Prevention and Rapid Response Team implementation.

## VAP and CENTRAL LINE PROTOCOL IMPLEMENTATION

The ICU Quality Team focused diligently on the VAP and Central Line Infection Reduction programs throughout the year. A group of interdisciplinary individuals led by Dr. Thomas Wold, (intensivist) were successful in implementing consistent protocols and guidelines, which have reduced the infection rate in the intensive care unit. The goals for this project were to reduce central line and ventilator associated infections in the ICU, implement IHI Best Practice Bundles on managing ICU patients with central lines and on ventilators, gather meaningful and accurate data on central line and ventilator associated infection rates in the ICU and report central line and ventilator associated infection rates to New Hampshire Healthcare Quality Commission (NHHQC).

**ICU VAP Infection Rate per 1,000 Vent Days**  
10/1/05 - 6/30/07

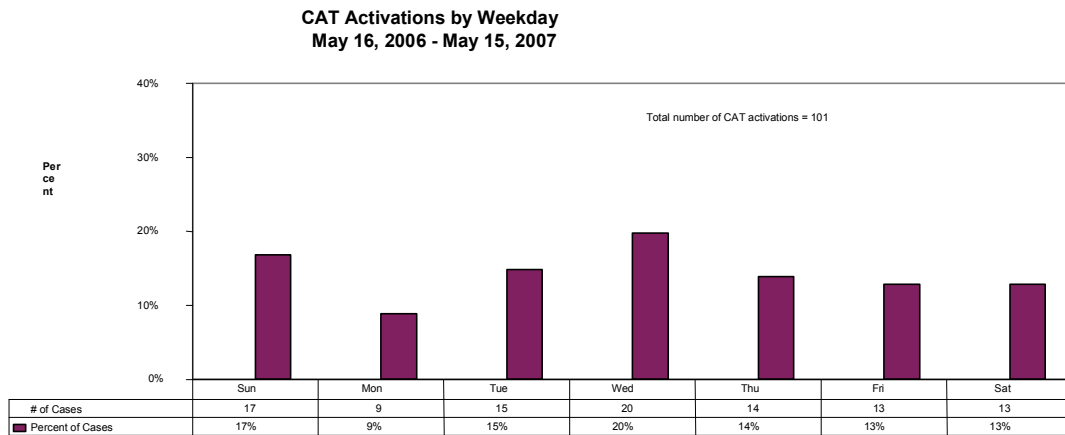


	Oct-05	Nov-05	Dec-05	Jan-06	Feb-06	Mar-06	Apr-06	May-06	Jun-06	Jul-06	Aug-06	Sep-06	Oct-06	Nov-06	Dec-06	Jan-07	Feb-07	Mar-07	Apr-07	May-07	Jun-07
VAP	0	1	1	1	0	0	0	1	0	0	0	0	0	0	0	0	0	0	1	2	1
Vent days	90	172	175	172	154	103	124	156	120	134	68	57	77	62	101	120	57	28	81	89	106
■ VAP Rate per 1,000 Vent Days	0.0	5.8	5.7	5.8	0.0	0.0	0.0	6.4	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	12.3	22.5	9.4

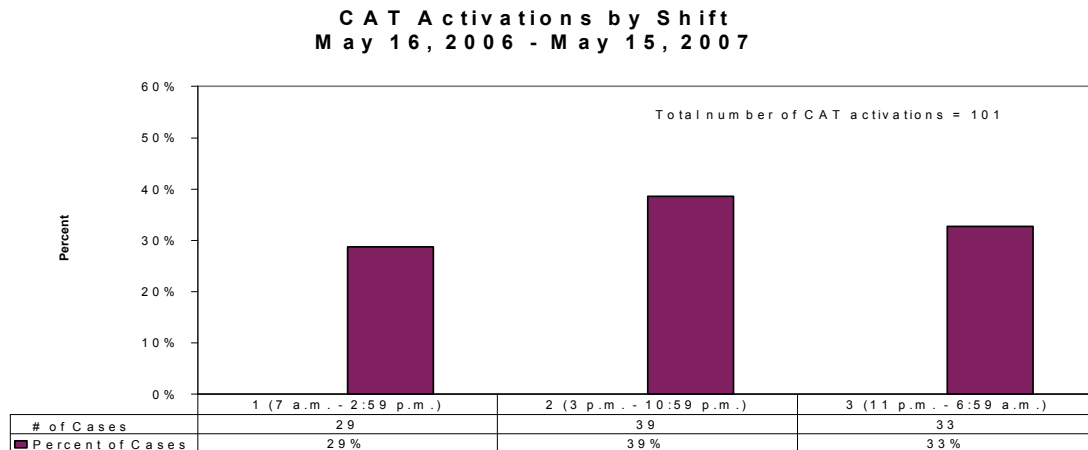
## RAPID RESPONSE TEAM (THE CAT!)

The CAT was let out of the bag on May 16, 2006 and every bedside nurse took the initiative to make the effort a major success. In one year, there were 101 activations of the team. ICU nurses and Respiratory Care Practitioners responded to the bedside nurse's call to activate a rapid patient assessment and effective communication process to enhance patient care outcomes. Physicians, pharmacists and nursing supervisors rounded out the patient care team when additional resources were required.

The team was utilized on all days of the week...

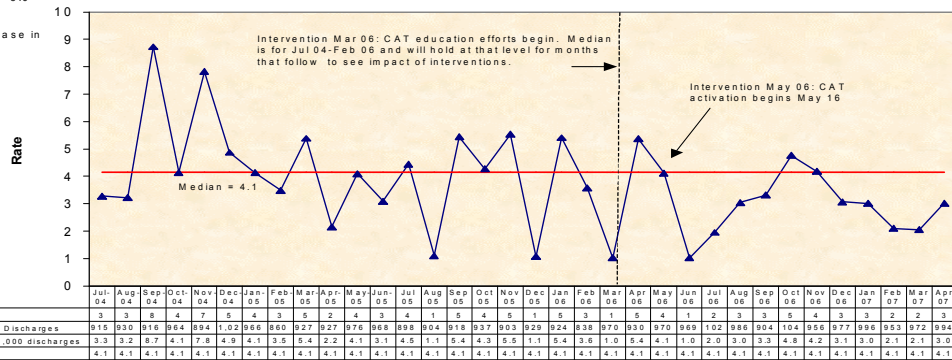


On all shifts...



### Code 9 Rate/1,000 Adult I/P Discharges July 2004 - April 2007

Code 9 Rate:  
Total rate (Jul04-Feb06) = 4.3  
Total rate (Mar06-Apr07) = 3.0  
% Change after CAT  
interventions = 30% decrease in  
Code 9's hospital-wide



Data source: HBO, Epic; Data based on Respiratory Therapy's procedure charge code 7800162 activity as Resp Ther responds to every Code 9 called and Procedure Charge Code 7800162 is charged to patient's account for every valid Code 9. Code 9's were calculated based on the month in which they occurred.  
Note: Due to renovations, PICU had no patients in Jan & Feb thereby reducing the denominator by approx. 42 discharges for those months, about 4% of total adult discharges.

Patients were transferred to a higher level of care in 49% of the cases. 96% of the CAT surveys have scored the team response as satisfied or very satisfied.

#### Benefits of the Program:

- The house wide Code 9 rate has decreased 30%
- The patient survival rate of resuscitation and survival to discharge after resuscitation revealed an overall improvement
- Greater emphasis on collaboration with staff and physicians
- Communication skills between physicians, nurses, and respiratory care practitioners have been enhanced with SBAR communication process

Thanks to everyone's clinical skill, intuition and experience, the EHS's first year with the CAT team was a SUCCESS!

#### SURGICAL CARE IMPROVEMENT PROJECT

The EHS and CMC staff collaborated on creating consistent forms to ease the confusion and burden of multiple forms being requested from the surgical offices. This was a successful and beneficial endeavor leading to a more efficient and effective process for a required CMS Core Measure.

#### Center for Medicare and Medicaid (CMS) Core Measures

Fiscal Year 2007 showed a tremendous improvement in the EHS's scores for acute myocardial infarction, congestive heart failure and pneumonia. All areas of the hospital joined together in creating system changes to provide sustainable improvements over the long term. The system improved from baseline scores in CY 4<sup>th</sup> quarter 2005 to CY 4<sup>th</sup> quarter 2006 scores in 19 out of 21 measurements, with one remaining the same at 100%.

**EHS  
CMS Core Measure  
Annual Evaluation**

Priority Focus Areas	Baseline Assessment Oct - Nov - Dec 2005	Q4 Oct – Nov - Dec 2006
<b>AMI 1: Aspirin on Arrival</b>	92.9%	100%
<b>AMI 2: Aspirin at Discharge</b>	92%	100%
<b>AMI 3: ACEI/ARB for LVSD</b>	50%	100%
<b>AMI 4: Adult Smoking Cessation</b>	100%	100%
<b>AMI 5: Beta Blocker at Discharge</b>	88.9%	100%
<b>AMI 6: Beta Blocker on Arrival</b>	90.9%	100%
<b>AMI 7: Median Time to Thrombolysis</b>	118 minutes (Mean Time)	85 min
<b>AMI 8: Median Time to PCI</b>		87 min
<b>AMI 9: PCI Received Within 120 Minutes of Hospital Arrival</b>	66.7%	75%
<b>AMI 10: Inpatient Mortality</b>	0.0%	3.3%
<b>PNE 1 Oxygen Assessment</b>	98.8%	100%
<b>PNE 2 Pneumococcal Vaccination</b>	46.9%	90%
<b>PNE 3: Blood Cultures Within 24 Hours of Arrival for ICU Admission</b>	88.9%	100%
<b>PNE 4: Blood Cultures Prior to Antibiotic Administration for ED Admits</b>	77.8%	95.8%
<b>PNE 5: Adult Smoking Cessation Counseling</b>	73.9%	100%
<b>PNE 6: Antibiotic Received Within 4 Hours of Hospital Arrival</b>	75.3%	89%

**EHS**  
**CMS Core Measure**  
**Annual Evaluation (Continued)**

Priority Focus Areas	Baseline Assessment Oct - Nov - Dec 2005	Q4 Oct – Nov - Dec 2006
<b>PNE 7: Antibiotic Selection/ Immunocompetent Patients</b>	89.4%	96.6%
<b>Influenza Vaccine</b>	45.7%	83.3%
<b>HF 1: Discharge Instructions</b>	48.0%	69%
<b>HF 2: Evaluation of LVS Function</b>	92.0%	100%
<b>HF 3: ACEI/ARB for LVSD</b>	88.9%	100%
<b>HF 4: Adult Smoking Cessation Counseling</b>	83.3%	100%

**Leadership**

The ongoing requirements for transparency of data, public reporting and overall patient satisfaction continues to be an area of highest concern for the EHS. There is much attention to state and federal mandates that impact not only the quality of care and safety but also the reimbursement strategies by CMS and third party payers. As we continue to strategize, the decision to strongly continue to partner with our physician champions in the performance improvement initiatives becomes critical to our ongoing success. We therefore have added physician leadership roles to work closely with the Performance Improvement Team in order to communicate and collaborate more effectively and efficiently throughout the system. Effective June 2007, Gavin Muir, MD accepted the role of Peer Review, Medical Director, Mark Myers, MD accepted the role of Physician Information, Medical Director, Anita Ritenauer, MD accepted the role of Medical Director for Hospital Quality Initiatives and Richard Friedman, MD remains in the role of EPN, Medical Director for Quality.

## **VNA Performance Improvement Initiatives**

### **Acute Care Hospitalization:**

This past year the VNA joined the ReACH (Reducing Acute Care Hospitalization) Collaborative. Working closely with the QIO and other homecare agencies across the nation (via conferences and teleconferencing) to develop Best Practices to reduce hospitalization.

A Clinical Nurse Specialist was hired, who is developing protocols for disease management. She works closely with the staff to review patient specific reasons for hospitalization and what could have been done to prevent it. We developed a high-risk tool to identify those clients on admission who were at risk for hospitalization. Once identified these clients have visits front loaded with specific interventions and teaching that will be completed in the first week. A telehealth nurse was hired and has implemented the telehealth program in appropriate client homes. This allows us to monitor those clients who are high risk for hospitalization on a daily visit.

A "Help Us Keep You Home" tool was developed and is reviewed with all clients at the time of admission to assist clients / families to determine who to call if a problem should arise. CHF guidelines, and patient teaching tools were developed and implemented.

VNA acute hospitalization rate is 31.24; in April '06 it was 33.42 The VNA target is 29.

### **Improvement in Surgical Wounds:**

The clinical nurse specialist works closely with the wound team. The wound team meets every other week to discuss difficult cases and to discuss the cases they have consulted on. The wound team has developed and implemented a protocol for nursing referrals to the team. A nutrition guide for healing wounds was developed and is distributed to clients and utilized as a teaching tool. The clinical nurse specialist will begin education this fall working towards her certification in wound care.

VNA Improvement in Surgical Wound rate is 74.69; in April '06 it was 70.78. The VNA target for this fiscal year is 78.37.

### **Improvement in Ambulatory Status:**

The Clinical Quality Improvement Committee developed a falls risk assessment to identify those clients at the time of admission, who are at risk for falls. Case conferences are held each week during the staff interdisciplinary team meeting to determine a plan of care and the need for rehabilitation services. Members of the rehab team presented an in-service to all staff on how to assess gait to ensure all staff were answering the oasis correctly.

VNA Improvement in Ambulatory Status is 36.14; in April '06 it was 28.55. The VNA target for this upcoming fiscal year is 39.

## **EHS Physician Network**

The EHS Physician Network Patient Care Committee (PCC) focused on its initial projects of diabetes care, mammography screening, well child visits, and lead screening by age 1 year. EPN performance, in several diabetes measures, continues to show improvement in performance at the network level. Certain practices have shown consistent performance improvement over the past year.

### **FY2007 QUALITY INITIATIVES**

The PCC identified several clinical projects as the focus of performance improvement for the fiscal year 2007 (July 2006-June 2007). These projects were delayed due to the difficulty in implementing new Health Maintenance (HM) and Best Practice Alerts in EPIC. Since we have completed the EPIC upgrade to the Spring 2007 environment, these problems have been resolved.

### **OSTEOPOROSIS SCREENING AND TREATMENT:**

Recently, we have been able to implement a process where all DEXA Scans done by Bedford Radiology will be scanned into EPIC by Bedford Radiology staff to an external order that has been created that will automatically satisfy the HM Topic and will be able to be included in reports. In addition, this process will be followed for all mammograms done by Bedford Radiology.

Operational reports for the office managers have been developed to identify women who have no documentation of having a DEXA Scan done so that their charts can be reviewed to identify missing data that can be entered into the HM Topic or be scheduled for their DEXA Scan. Performance reports for the EPN will be distributed in the coming months.

In-office finger stick HbA1c testing in Diabetic patients continues to be utilized successfully in several EPN practices with significant increases in the percentage of diabetic patients having at least 2 HbA1c tests in the past 12 months. In addition, physicians are finding that having the results available during the office visit has reduced office follow up time to make medication adjustments or inform patients of results.

**EPN Diabetic Patients with 2 HbA1c tests in the Past 12 Months; Goal >80%**

Practice	Jan-07	Feb-07	Mar-07	Apr-07	May-07	Jun-07	Jul-07
BRIARWOOD PRIMARY CARE	65%	66%	63%	63%	63%	66%	64%
DERRYFIELD MEDICAL GROUP	89%	89%	90%	92%	92%	93%	94%
ELLIOT FAMILY MEDICINE AT AMHERST	77%	77%	79%	78%	81%	80%	80%
ELLIOT FAMILY MEDICINE AT BEDFORD COMMON	70%	66%	71%	67%	66%	66%	69%
ELLIOT FAMILY MEDICINE AT BEDFORD VILLAG	79%	78%	79%	81%	80%	81%	79%
ELLIOT FAMILY MEDICINE AT GLEN LAKE	83%	86%	89%	89%	90%	88%	88%
ELLIOT FAMILY MEDICINE AT HOOKSETT	68%	60%	68%	71%	69%	74%	70%
ELLIOT FAMILY MEDICINE AT NEW BOSTON	79%	78%	76%	73%	79%	78%	80%
ELLIOT PEDIATRICS AND PRIMARY CARE AT RI	94%	94%	94%	96%	96%	95%	92%
ELLIOT PRIMARY CARE AT RAYMOND	77%	78%	81%	83%	81%	78%	79%
LON PRIM CARE PHYS	76%	75%	74%	72%	72%	73%	70%
SENIOR HEALTH PRIMARY CARE	81%	80%	83%	82%	85%	83%	84%
<b>EPN Average</b>	<b>78%</b>	<b>77%</b>	<b>78%</b>	<b>78%</b>	<b>79%</b>	<b>79%</b>	<b>78%</b>
<b>EPN Goal</b>	<b>80%</b>	<b>80%</b>	<b>80%</b>	<b>80%</b>	<b>80%</b>	<b>80%</b>	<b>80%</b>

**EPN Diabetic Patients with most recent HbA1c test < 7.0% (in the Past 12 Months); Goal >70%**

Practice	Jan-07	Feb-07	Mar-07	Apr-07	May-07	Jun-07	Jul-07
BRIARWOOD PRIMARY CARE	72%	74%	74%	71%	72%	72%	71%
DERRYFIELD MEDICAL GROUP	72%	75%	76%	76%	74%	74%	74%
ELLIOT FAMILY MEDICINE AT AMHERST	65%	69%	71%	68%	66%	72%	73%
ELLIOT FAMILY MEDICINE AT BEDFORD COMMON	50%	52%	47%	45%	47%	47%	47%
ELLIOT FAMILY MEDICINE AT BEDFORD VILLAG	66%	68%	62%	59%	63%	62%	65%
ELLIOT FAMILY MEDICINE AT GLEN LAKE	70%	67%	67%	66%	69%	71%	72%
ELLIOT FAMILY MEDICINE AT HOOKSETT	50%	50%	49%	51%	49%	48%	52%
ELLIOT FAMILY MEDICINE AT NEW BOSTON	53%	51%	51%	51%	54%	56%	59%
ELLIOT PEDIATRICS AND PRIMARY CARE AT RI	71%	69%	68%	71%	73%	73%	68%
ELLIOT PRIMARY CARE AT RAYMOND	73%	70%	75%	74%	77%	74%	74%
LON PRIM CARE PHYS	71%	70%	66%	64%	62%	63%	64%
SENIOR HEALTH PRIMARY CARE	71%	72%	73%	72%	74%	74%	74%
<b>EPN Average</b>	<b>66%</b>	<b>67%</b>	<b>66%</b>	<b>65%</b>	<b>66%</b>	<b>66%</b>	<b>66%</b>
<b>EPN Goal</b>	<b>60%</b>	<b>60%</b>	<b>60%</b>	<b>60%</b>	<b>60%</b>	<b>60%</b>	<b>70%</b>

**EPN Diabetic Patients with 2 Visits in the Past 12 Months; Goal >90%**

Practice	Jan-07	Feb-07	Mar-07	Apr-07	May-07	Jun-07	Jul-07
BRIARWOOD PRIMARY CARE	90%	90%	87%	90%	89%	89%	89%
DERRYFIELD MEDICAL GROUP	93%	93%	94%	95%	96%	96%	97%
ELLIOT FAMILY MEDICINE AT AMHERST	83%	83%	88%	88%	88%	90%	90%
ELLIOT FAMILY MEDICINE AT BEDFORD COMMON	89%	88%	87%	88%	90%	90%	91%
ELLIOT FAMILY MEDICINE AT BEDFORD VILLAG	92%	90%	90%	90%	90%	90%	90%
ELLIOT FAMILY MEDICINE AT GLEN LAKE	92%	98%	98%	97%	97%	97%	95%
ELLIOT FAMILY MEDICINE AT HOOKSETT	82%	78%	81%	81%	81%	84%	85%
ELLIOT FAMILY MEDICINE AT NEW BOSTON	87%	89%	86%	89%	89%	91%	89%
ELLIOT PEDIATRICS AND PRIMARY CARE AT RI	95%	95%	93%	96%	97%	96%	97%
ELLIOT PRIMARY CARE AT RAYMOND	89%	86%	90%	92%	91%	92%	91%
LON PRIM CARE PHYS	85%	83%	80%	79%	81%	82%	83%
SENIOR HEALTH PRIMARY CARE	93%	94%	94%	96%	95%	97%	96%
<b>EPN Average</b>	<b>89%</b>	<b>89%</b>	<b>89%</b>	<b>90%</b>	<b>91%</b>	<b>91%</b>	<b>91%</b>

**EPN Diabetic Patients with most recent HbA1c test > 8.5% (in the Past 12 Months); Goal <10%**

Practice	Jan-07	Feb-07	Mar-07	Apr-07	May-07	Jun-07	Jul-07
BRIARWOOD PRIMARY CARE	9%	8%	9%	8%	8%	8%	7%
DERRYFIELD MEDICAL GROUP	3%	2%	2%	2%	5%	5%	6%
ELLIOT FAMILY MEDICINE AT AMHERST	4%	5%	5%	5%	4%	3%	5%
ELLIOT FAMILY MEDICINE AT BEDFORD COMMON	15%	12%	12%	15%	15%	16%	16%
ELLIOT FAMILY MEDICINE AT BEDFORD VILLAG	12%	12%	11%	11%	11%	9%	9%
ELLIOT FAMILY MEDICINE AT GLEN LAKE	8%	10%	9%	10%	9%	7%	7%
ELLIOT FAMILY MEDICINE AT HOOKSETT	16%	15%	15%	15%	15%	15%	12%
ELLIOT FAMILY MEDICINE AT NEW BOSTON	19%	17%	16%	14%	14%	11%	13%
ELLIOT PEDIATRICS AND PRIMARY CARE AT RI	8%	9%	9%	7%	7%	7%	7%
ELLIOT PRIMARY CARE AT RAYMOND	6%	6%	6%	5%	6%	7%	7%
LON PRIM CARE PHYS	9%	11%	12%	13%	14%	13%	14%
SENIOR HEALTH PRIMARY CARE	3%	4%	3%	4%	5%	4%	4%
EPN Average	8%	8%	8%	9%	9%	9%	9%
EPN Goal	15%	15%	15%	15%	15%	15%	10%

**EPN Diabetic Patients with LDL in the Past 12 Months; Goal >85%**

Practice	Jan-07	Feb-07	Mar-07	Apr-07	May-07	Jun-07	Jul-07
BRIARWOOD PRIMARY CARE	82%	83%	84%	85%	87%	88%	87%
DERRYFIELD MEDICAL GROUP	83%	83%	84%	84%	81%	79%	82%
ELLIOT FAMILY MEDICINE AT AMHERST	81%	83%	87%	85%	84%	82%	80%
ELLIOT FAMILY MEDICINE AT BEDFORD COMMON	86%	87%	87%	87%	88%	88%	89%
ELLIOT FAMILY MEDICINE AT BEDFORD VILLAG	87%	88%	84%	83%	82%	84%	82%
ELLIOT FAMILY MEDICINE AT GLEN LAKE	85%	89%	89%	89%	90%	89%	89%
ELLIOT FAMILY MEDICINE AT HOOKSETT	77%	74%	78%	78%	75%	81%	78%
ELLIOT FAMILY MEDICINE AT NEW BOSTON	85%	85%	85%	86%	87%	87%	84%
ELLIOT PEDIATRICS AND PRIMARY CARE AT RI	87%	89%	89%	88%	86%	89%	90%
ELLIOT PRIMARY CARE AT RAYMOND	83%	82%	86%	88%	88%	89%	90%
LON PRIM CARE PHYS	87%	86%	88%	86%	87%	88%	88%
SENIOR HEALTH PRIMARY CARE	91%	92%	92%	93%	93%	93%	95%
EPN Average	85%	86%	87%	87%	87%	87%	87%
EPN Goal	85%	85%	85%	85%	85%	85%	85%

**EPN Diabetic Patients with most recent LDL <100 (in the Past 12 Months); Goal >70%**

Practice	Jan-07	Feb-07	Mar-07	Apr-07	May-07	Jun-07	Jul-07
BRIARWOOD PRIMARY CARE	54%	56%	54%	55%	52%	53%	54%
DERRYFIELD MEDICAL GROUP	59%	58%	61%	61%	61%	62%	62%
ELLIOT FAMILY MEDICINE AT AMHERST	74%	72%	72%	74%	80%	80%	79%
ELLIOT FAMILY MEDICINE AT BEDFORD COMMON	63%	64%	63%	61%	60%	60%	61%
ELLIOT FAMILY MEDICINE AT BEDFORD VILLAG	48%	52%	49%	46%	43%	41%	42%
ELLIOT FAMILY MEDICINE AT GLEN LAKE	65%	60%	61%	62%	68%	68%	67%
ELLIOT FAMILY MEDICINE AT HOOKSETT	54%	52%	55%	52%	53%	54%	57%
ELLIOT FAMILY MEDICINE AT NEW BOSTON	65%	63%	65%	66%	62%	67%	66%
ELLIOT PEDIATRICS AND PRIMARY CARE AT RI	65%	70%	68%	69%	68%	68%	70%
ELLIOT PRIMARY CARE AT RAYMOND	78%	79%	75%	74%	75%	78%	79%
LON PRIM CARE PHYS	59%	59%	59%	60%	61%	61%	61%
SENIOR HEALTH PRIMARY CARE	62%	66%	65%	66%	65%	66%	67%
EPN Average	62%	63%	62%	62%	62%	63%	64%
EPN Goal	TBD	TBD	TBD	TBD	TBD	TBD	70%

**EPN Diabetic Patients with Microalbumin or ACEI/ARB in the Past 12 Months**

Practice	Jan-07	Feb-07	Mar-07	Apr-07	May-07	Jun-07	Jul-07
BRIARWOOD PRIMARY CARE	85%	83%	84%	84%	84%	85%	84%
DERRYFIELD MEDICAL GROUP	76%	78%	80%	81%	80%	80%	81%
ELLIOT FAMILY MEDICINE AT AMHERST	80%	81%	82%	83%	83%	82%	83%
ELLIOT FAMILY MEDICINE AT BEDFORD COMMON	90%	88%	87%	86%	86%	86%	88%
ELLIOT FAMILY MEDICINE AT BEDFORD VILLAG	83%	84%	79%	78%	83%	82%	81%
ELLIOT FAMILY MEDICINE AT GLEN LAKE	85%	89%	88%	87%	88%	88%	88%
ELLIOT FAMILY MEDICINE AT HOOKSETT	61%	56%	69%	69%	62%	64%	65%
ELLIOT FAMILY MEDICINE AT NEW BOSTON	68%	68%	66%	64%	66%	67%	66%
ELLIOT PEDIATRICS AND PRIMARY CARE AT RI	92%	91%	92%	94%	95%	96%	97%
ELLIOT PRIMARY CARE AT RAYMOND	91%	88%	92%	92%	90%	90%	92%
LON PRIM CARE PHYS	87%	86%	87%	85%	84%	83%	85%
SENIOR HEALTH PRIMARY CARE	82%	83%	81%	80%	79%	80%	80%
<b>EPN Average</b>	<b>83%</b>	<b>82%</b>	<b>83%</b>	<b>83%</b>	<b>82%</b>	<b>83%</b>	<b>83%</b>

**EPN 12 Month Well Child Visit Rate – measured at 14 months: Goal >90%**

Well Child Visits - 12 Months	Jan-07	Feb-07	Mar-07	Apr-07	May-07	Jun-07	Jul-07
EPN Average	88%	88%	88%	89%	88%	88%	86%
EPN Goal	90%	90%	90%	90%	90%	90%	90%

**EPN 24 Month Well Child Visit Rate – measured at 30 months: Goal >90%**

Well Child Visits - 24 Months	Jan-07	Feb-07	Mar-07	Apr-07	May-07	Jun-07	Jul-07
EPN Average	92%	92%	92%	92%	92%	92%	91%
EPN Goal	90%	90%	90%	90%	90%	90%	90%

**EPN Lead Screening Rate – measured at 14 months: Goal >95%**

Lead Screening rate	Jan-07	Feb-07	Mar-07	Apr-07	May-07	Jun-07	Jul-07
EPN Average	77%	77%	78%	76%	76%	74%	74%
EPN Goal	95%	95%	95%	95%	95%	95%	95%

**EHS Awards Received:**

- EHS One Day Surgical Center – Press Ganey Award for Patient Satisfaction > 95% for 12 consecutive quarters. Only 8 surgery centers in the country received this award.
- Community Health Education received a Gold Circle School Partnership Award from the NH Partners in Education for our partnership with the Jewett Street School.
- Community Health Education-- Outstanding Achievement Award from the Governor’s Council on Physical Activity and Health for Fit & Healthy Teens.
- President’s Community Partner Award from the Campus Compact for New Hampshire for our partnership with NH Community Technical College in providing student-learning experiences

**EHS Quality Goals and Safety Strategies for Fiscal Year 2008**

Reduce Hospital Acquired Infections  
Prevent Medication Errors through Medication Reconciliation  
Improve Patient Care and safety Through Our EPIC Technology  
Improve the Use of Evidence Based Guidelines for Chronic Disease and Complex Medical Conditions  
Strengthen the Culture of Quality and Safety Across the Healthcare System  
Readiness for all National Patient Safety Goals and Joint Commission Standards  
Excellence in Demonstration of Disaster Readiness

In summary, the Quality and Safety Team will continue to pursue excellence to promote the well-being and safety of our community, our employees and all others who enter the EHS.

Respectfully submitted,

Mary Ann McEntee, MHA, BSN, RN  
Vice President, Performance Improvement  
September 8, 2007