Dignity Health Quality Transparency Dashboard

Methodist Hospital of Sacramento

At Dignity Health Methodist Hospital of Sacramento, our mission is to provide high quality compassionate health care for all who seek it, and we strive for the best, safest care for our patients. We're participating in the Hospital Quality Transparency Dashboard project to enable consumers to make informed choices about their health care through publicly available data about our hospital, and we encourage others to do the same. Below are our recent results for five outcome measures out of hundreds that we track, showing how we compare to other hospitals in California and across the U.S. ***Remember, lower numbers indicate better patient care for that specific measure.***

OUTCOME MEASURES

Lower is better	CLABSI	Colon SSI	NTSV	Sepsis Mortality	30-day Readmission
Methodist Hospital of Sacramento	1.21	N/A	28.33	8.59	11.79
Measure Period	1/1/2023 – 12/31/2023				
California State Level	0.80	0.89	23.40	15.61	14.75
Measure Period	4/1/2022 – 3/31/2023		7/1/2022 – 6/30/2023	1/1/2022 – 12/31/2022	7/1/2021 – 6/30/2022
National Level	0.78	0.89	26.30	15.00	14.60
Measure Period	4/1/2022 – 3/31/2023		7/1/2022 – 6/30/2023	1/1/2022 – 12/31/2022	7/1/2021 – 6/30/2022

PROGRAM STATUS

■ **Yes** ☐ **Deliveries are not available at this hospital**	**Maternity Safety Program (Program Status Measure)** This hospital has a Maternity Safety Program in place. A maternity safety program provides a coordinated approach and emergency response to risks associated with pregnancy and childbirth.
■ **Yes**	**Sepsis Protocol (Program Status Measure)** This hospital has a Sepsis Protocol in place. A sepsis protocol provides guidance for a coordinated approach to identification and treatment of an infection and inflammatory response which is present throughout the body.
■ **Yes**	**Respiratory Monitoring Program (Program Status Measure)** This hospital has a Respiratory Monitoring program in place. Respiratory monitoring provides guidance for assessment of risk of respiratory depression, and includes continuous monitoring of breathing and functioning of the lungs and circulatory system when indicated.

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OUTCOME MEASURE DEFINITIONS

CLABSI – CENTRAL LINE-ASSOCIATED BLOOD STREAM INFECTION

A central line-associated blood stream infection is a serious infection that occurs when bacteria or germs enter the bloodstream through an IV called a central line. A central line allows access to a major vein close to the heart and can stay in place for weeks or months. It is mainly used for medication delivery and blood draws. Central line infections are measured using the Centers for Disease Control and Prevention Standardized Infection Ratio (SIR). This ratio is the observed number of infections divided by the number of expected infections. Values less than 1.00 show that the number of observed infections was lower than expected. Values more than 1.00 show that the number of infections was higher than expected. N/A means the scoring related to predicted infections is not available.

COLON SSI – SURGICAL SITE INFECTION FROM COLON SURGERY

A surgical site infection occurs after surgery and is caused by bacteria or germs in the part of the body where the surgery took place. Surgical site infections for colon surgery are measured using the Centers for Disease Control and Prevention Standardized Infection Ratio (SIR). This ratio is the observed number of infections divided by the number of expected infections. Values less than 1.00 show that the number of observed infections was lower than expected. Values more than 1.00 show that the number of infections was higher than expected. N/A means the scoring related to predicted infections is not available.

NTSV – NULLIPAROUS, TERM, SINGLETON, VERTEX CESAREAN BIRTH RATE

The percentage of cesarean (surgical) births among first-time mothers who are at least 37 weeks pregnant with one baby in a head down position (not breech or transverse). Lower values indicate that fewer cesareans were performed in the hospital among primarily low risk, first-time mothers.

SEPSIS MORTALITY

Sepsis or septic shock is the body's extreme response to an infection. It is a life-threatening medical emergency that is a risk for patients admitted to an emergency department or hospital care setting. Without timely treatment, sepsis can lead to tissue damage, organ failure (e.g., kidney, lungs, liver, etc.), and death. Sepsis infection is measured by the percent of patients who die in the hospital. A lower number shows a better outcome.

30-DAY READMISSION – HOSPITAL-WIDE ALL-CAUSE 30-DAY UNPLANNED READMISSION RATE

The percentage of patients who were unexpectedly readmitted within 30 days of discharge from the hospital for any reason. Lower values indicate that fewer cases were unexpectedly readmitted after discharge.

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NATIONAL INITIATIVES

CLABSI – prevention efforts include but are not limited to:

- Adopt vascular access policies that highlight appropriate device selection criteria and maintenance criteria
- Implement daily justification of central lines by providers
- Provide daily chlorhexidine bathing in critical care to reduce bioburden
- Eliminate unnecessary vascular access devices to limit portals of entry
- Utilization of checklist for inserting, managing and device needs

COLON SSI – prevention efforts include but are not limited to:

- Adopt an evidenced based colorectal bundle that focuses on prevention efforts before, during, and after the surgical procedure
- Perform Audits of instrument handling from point of use to storage, utilizing an evidenced based sterilization audit checklist
- Perform active surveillance to identify commonalities and trends with associated action plans

NTSV – prevention efforts include but are not limited to:

- Provide feedback to physicians by providing Cesarean Birth data reports
- Create a multidisciplinary perinatal quality and safety improvement team to create action plans
- Educate physicians, clinical staff, patients and their families on the risk and benefits on cesarean birth
- Provide recommendations to physicians and clinical staff on labor management of low risk women

SEPSIS MORTALITY – prevention efforts include but are not limited to:

- Adopt the evidence based sepsis guidelines that focus on the management of the severe sepsis and septic shock patient
- Review mortality cases for opportunities, develop action plans and discuss within the facilities multidisciplinary team
- Monitor for SEP-1 bundle compliance and opportunities for improvement
- Adopt tracking and hand off process to ensure bundle compliance is completed
- Provide patient/family education on sepsis

30-DAY READMISSION – prevention efforts include but are not limited to:

- Adopt evidence based practices to reduce readmissions
- Convene a multidisciplinary readmission improvement team focused on developing improvement strategies and utilizing data to drive initiatives
- Refer patients to the most appropriate post-acute setting
- Identification of patients at high risk for readmissions and align the intensity of discharge planning to their readmission risk
    - Begin discharge planning upon admission
    - Provide individualized patient discharge education
    - Medication reconciliation prior to discharge with “Med to Bed” programs
    - Prior to discharge, schedule the patient’s post-discharge visit with their primary care provider
    - Discharge phone calls

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Assurance of Safety through Monitoring and Prevention of Serious Safety Event

Methodist Hospital of Sacramento identifies, monitors and acts on to prevent serious safety events through various quality and safety interventions. Table below shows how Methodist hospital is doing on the various serious safety events identified by the National Quality Forum.

Category	Event Name	2022	2023	2024
Surgical or Invasive Procedure Events	Surgery or other invasive procedure performed on the wrong site	0	0	0
	Surgery or other invasive procedure performed on the wrong patient	0	0	0
	Wrong surgical or other invasive procedure performed on a patient	0	0	0
	Unintended retention of a foreign object in a patient after surgery or other invasive procedure	1	0	1
	Intraoperative or immediately postoperative/postprocedure death in an ASA Class 1 patient	0	0	0
Product or Device Events	Patient death or serious injury associated with the use of contaminated drugs, devices, or biologics provided by the healthcare setting	0	0	0
	Patient death or serious injury associated with the use or function of a device in patient care, in which the device is used or functions other than as intended	0	0	0
	Patient death or serious injury associated with intravascular air embolism that occurs while being cared for in a healthcare setting	0	0	0
Patient Protection Events	Discharge or release of a patient/resident of any age, who is unable to make decisions, to other than an authorized person	0	0	0
	Patient death or serious injury associated with patient elopement (disappearance)	0	0	0
	Patient suicide, attempted suicide, or self-harm that results in serious injury, while being cared for in a healthcare setting	0	0	0
Care Management Events	Patient death or serious injury associated with a medication error (e.g., errors involving the wrong drug, wrong dose, wrong patient, wrong time, wrong rate, wrong preparation, or wrong route of administration)	0	0	0
	Patient death or serious injury associated with unsafe administration of blood products	0	0	0
	Maternal death or serious injury associated with labor or delivery in a low-risk pregnancy while being cared for in a healthcare setting	0	0	0
	Death or serious injury of a neonate associated with labor or delivery in a low-risk pregnancy	0	0	0
	Patient death or serious injury associated with a fall while being cared for in a healthcare setting	0	0	0
	Any Stage 3, Stage 4, and unstageable pressure ulcers acquired after admission/presentation to a healthcare setting	1	2	1
	Artificial insemination with the wrong donor sperm or wrong egg	0	0	0
	Patient death or serious injury resulting from the irretrievable loss of an irreplaceable biological specimen	0	0	0

Category	Event Name	2022	2023	2024
	Patient death or serious injury resulting from failure to follow up or communicate laboratory, pathology, or radiology test results	0	0	0
Environmental Events	Patient or staff death or serious injury associated with an electric shock in the course of a patient care process in a healthcare setting	0	0	0
	Any incident in which systems designated for oxygen or other gas to be delivered to a patient contains no gas, the wrong gas, or are contaminated by toxic substances	0	0	0
	Patient or staff death or serious injury associated with a burn incurred from any source in the course of a patient care process in a healthcare setting	0	0	0
	Patient death or serious injury associated with the use of physical restraints or bed rails while being cared for in a healthcare setting	0	0	0
Radiologic Events	Death or serious injury of a patient or staff associated with the introduction of a metallic object into the MRI area	0	0	0
Potential Criminal Events	Any instance of care ordered by or provided by someone impersonating a physician, nurse, pharmacist, or other licensed healthcare provider	0	0	0
	Abduction of a patient/resident of any age	0	0	0
	Sexual abuse/assault on a patient or staff member within or on the grounds of a healthcare setting	0	0	0
	Death or serious injury of a patient or staff member resulting from a physical assault (i.e., battery) that occurs within or on the grounds of a healthcare setting	0	0	0

Summary of Data in the Table:

For Calendar Year 2024, Methodist Hospital sustained excellent results in the prevention of serious safety events as evident in the table above. There were no events that resulted in the death or serious disability of a patient.

Efforts Taken By Methodist Hospital to Improve Safety and Quality:

1. Identify these events through a robust surveillance program that includes self reporting, medical record reviews, and review of outcomes.
2. Review of each event by a multidisciplinary team to identify factors that led to occurrence of the event.
3. Evaluation of current prevention practices to identify any gaps in the system by conducting a comparison with evidence based practices.
4. Planning an implementation of action items to resolve all gaps in prevention practices that were identified.
5. Ongoing monitoring to ensure that the improvement activities are sustained.

Definitions:

Serious Safety Event: An event that is preventable, serious, adverse, indicative of a problem in a healthcare setting;s safety systems, and is important for public credibility or public accountability (1).

National Quality Forum (NQF): A not-for-profit organization that supports efforts to improve healthcare. The NQF publishes a list of harmful clinical events that are largely preventable. to help healthcare facilities assess, measure and report performance in providing safe care.