AMERICA'S ESSENTIAL HOSPITALS

Essential Hospitals Engagement Network (EHEN)
2014 Best Practice Survey: Highlights and Responses

Leadership &

Patient and Family Engagement

Background

- In May 2014, EHEN asked its hospitals to complete a survey of the interventions and practices they have implemented or plan to implement as part of their quality improvement efforts.
- Response rate: 12 of 22 hospitals responded (55 percent).

Report Information

- This report is not intended to recommend any one intervention or practice, nor is it intended to prove causation between interventions and outcomes.
- Hospitals were not necessarily able to answer every question.
- The report is a full breakdown of responses to each question from the survey.
- For questions, please contact your improvement coach or e-mail EHEN@essentialhospitals.org.

Essential Hospitals Engagement Network (EHEN)

Best Practices Survey 2014 - Leadership

Red Numbers Represent Responses (n=12)

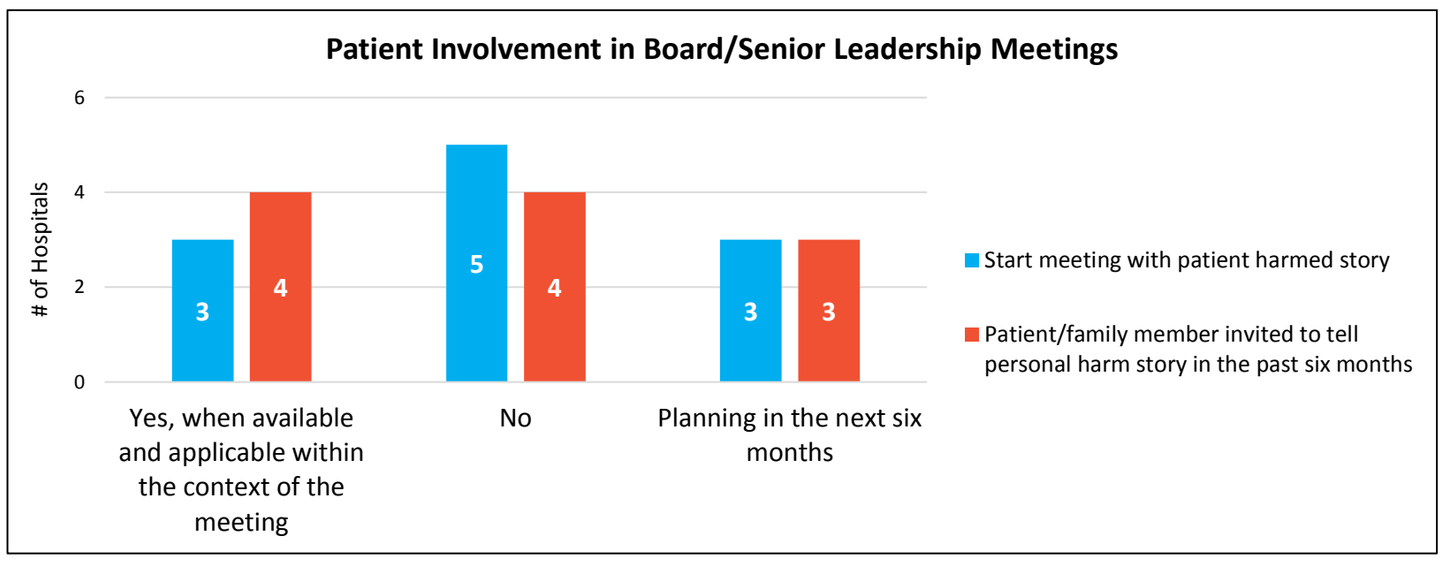
1. **The Partnership for Patients has created four measures used across all hospital engagement networks (HENs) to understand and benchmark leadership practices. Please indicate which apply to your organization. Check all that apply.**

9	Hospital has regular quality review aligned with the Partnership for Patients goals.
9	Hospital has a public commitment to safety improvement with transparency in sharing more than CORE measurement data with the public.
10	Hospital staff, all or nearly all, has a role or perceived goal in patient safety (e.g., explicit in HR goals, a group bonus based on a patient safety target).
11	Hospital board of trustees has a quality committee established and regularly reviews patient safety data, including review and analysis of risk events.

2. **Do board or senior leadership meetings start with a story about a patient who has been harmed (The patient is not present at the meeting)?**

0	Yes, every meeting
3	Yes, when available and applicable within the context of the meeting
5	No
3	No, but plans are in process to try this within the next six months

3. **Has a patient or family member been invited to a board or senior leadership meeting to tell their personal story of harm at least once in the past six months?**



4. **Which answer best describes your hospital's current application of the safety practice known as the "Housewide Daily Safety Huddle" (also called "Daily Safety Briefing")?**

1	We are unaware of this practice.
2	We are aware of this leadership practice but haven't tried it.
6	We are aware of this leadership practice and are planning to try it.
2	We have tried this practice but do not do it regularly.
1	This is an established practice

5. **If you answered D or E to question 4, please tell us about the structure of your huddles. Check all that apply.**

2	The huddles are led by either the CEO or the highest ranking leader present in the hospital.
0	Huddles are held once a day.
1	Huddles are held twice a day.
0	Huddles are held five days a week.
1	Huddles are held seven days a week.
1	The huddles follow a scripted set of questions.
1	Key operational leaders and department leaders are expected to attend the huddles.
3	There is a process in place to follow up on all issues.
0	Other:

6. Which answer best describes the current practice of your hospital's leadership with regard to transparency and learning from adverse events?

0	Staff do not share or discuss things that go wrong, because they fear being blamed or punished.
0	Staff would be willing to discuss things that go wrong, but legal counsel does not allow them to talk about adverse events, unless risk management is present (e.g., a risk management committee meeting where the discussion is legally protected from discovery).
7	Throughout the organization, we are open about things that go wrong in our care. Data on harm events, such as infections and complications, are available to all staff and discussed regularly as part of the process of learning and improvement. However, **it is not shared with patients, families, or the general public.**
5	Throughout the organization, we are open about things that go wrong in our care. Data on harm events, such as infections and complications, are available to all staff and discussed regularly as part of the process of learning and improvement. **We voluntarily make our data on harm events available to the public, whether it's posted in patient areas in the hospital, on our website, or some other easily accessible forum.**

7. Which answers best describe your hospital's leadership practice of "Reality Rounding" (scripted, regular rounds on clinical units by leaders, focusing on discovering and fixing operational barriers to safety practices)?

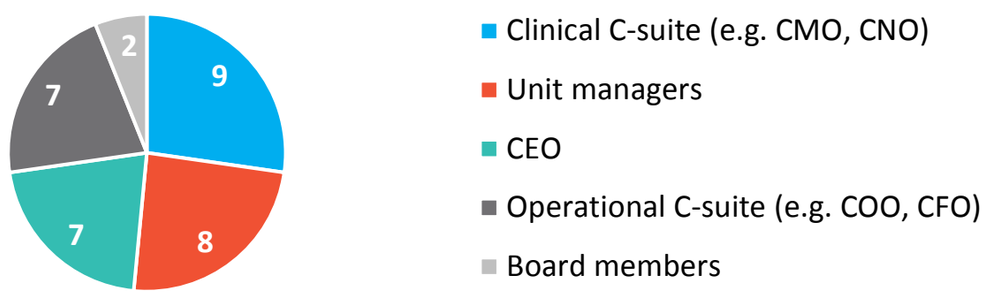
Frequency:

0	Never
6	Seldom
6	Often

Barriers discussed: (Check all that apply)

9	Operational (e.g. supplies, equipment)
8	Non-operational (e.g. culture)
9	Clinical (e.g. bundle compliance, care coordination)

Reality Rounding Participants



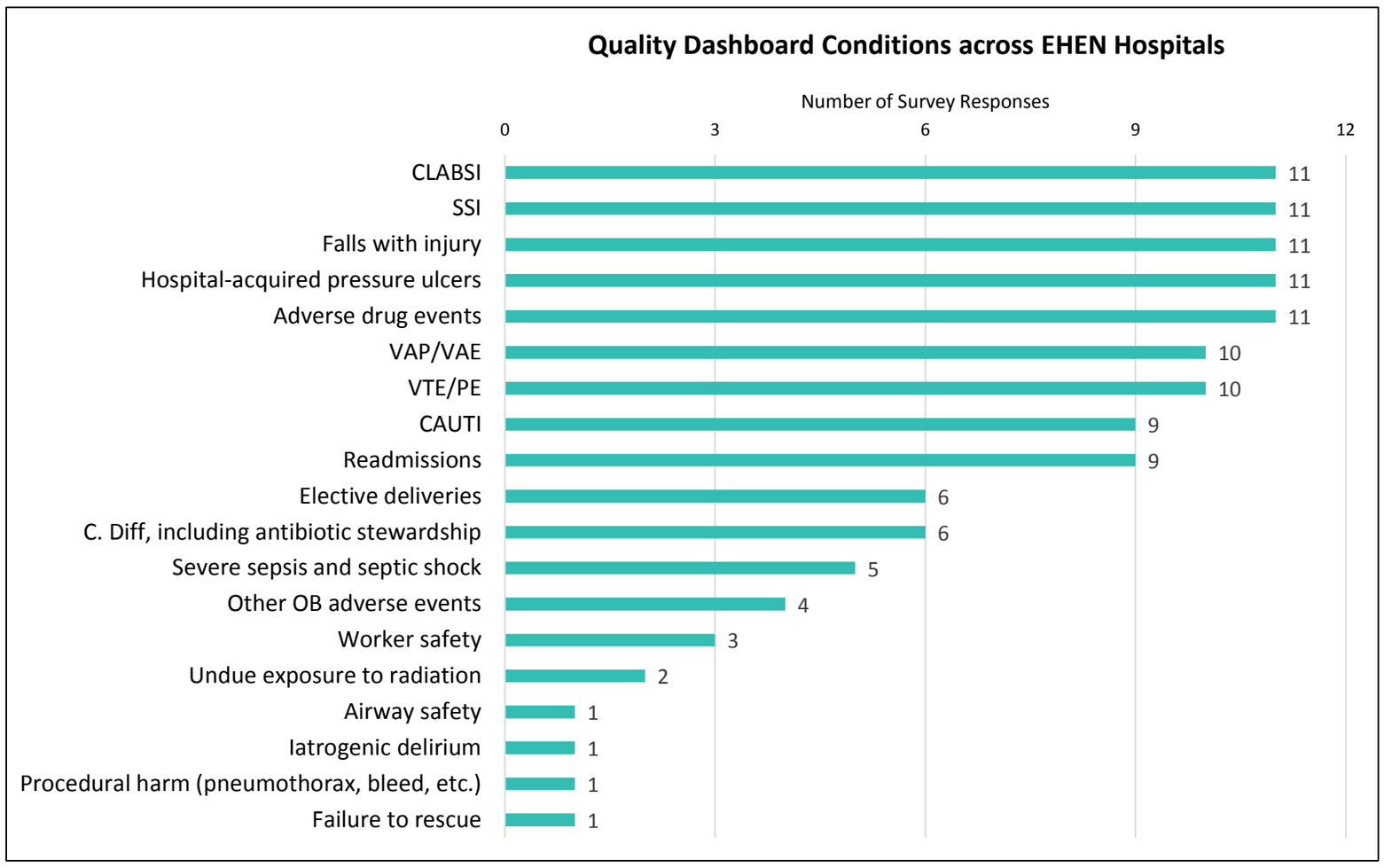
8. Which answer describes your hospital's approach to data display about safety?

0	Our safety reports are fairly technical displays of rates of events per 1,000 device days or per 100 cases. These data are discussed by safety experts and medical staff, but staff on the units or floors are basically unaware of them.
6	The safety committee and other experts sees both technical data on harm rates and simple data on the number of patients who have experienced harm, but these data aren't shared in any widely accessible way with staff on each unit.
6	Each unit has clear, simple displays in hallways and work areas that show the number of patients who have been harmed in that unit and that are regularly updated with current information.

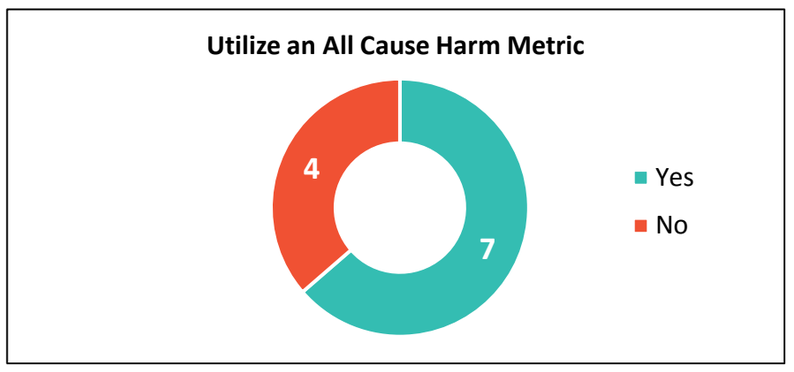
9. Is the Partnership for Patients/EHEN initiative part of your organization's current strategic/quality plan to improve care?

10	Yes
2	No

10. Does your strategic plan/quality board dashboard focus on reducing harm in many of the Partnership for Patients conditions? Please check all that are included as organizational priorities in your current strategic plan/quality board dashboard:



11. It is an emerging best practice to track "harm across the board" or "all cause harm," which is a composite measure of various types of harm events (the measure may include any of the above types of harm and any other type of harm that the hospital chooses). Does your hospital have an all cause harm metric?



Hospital	Metric Description
SFGH	CAUTI, CLABSI, VAP/VAE, SSI, Falls w/injury, HAPU, VTE/PE, ADE, Readmissions, Elective Deliveries, Sepsis, C.Diff and antibiotic stewardship
Rancho Los Amigos	All patient harm events from UHC's Safety Intelligence System
MetroHealth	SSI, Falls, HAPU, ADE, VTE, EED
Harbor-UCLA	Medication errors, Falls, HAPU, SSI, CLABSI, CAUTI, VAP
Regional One	All incident reports reviewed weekly Risk Management/Quality. Quality portion of the Board is updated Quarterly on various safety issues noted from the Incident Tracking System. Current focus is on ADE related to our recent go live with scanning.
San Mateo	Medication errors, CLABSI, CAUTI (ICU ONLY), HAPU, Falls with injury, SSI, VTE
Contra Costa	IHI Global Trigger Tool Measurement, IHI Perinatal Trigger Tool Measurement

12. Our staff last took the Hospital Culture of Safety Survey in (please provide the year):

2011	2012	2013	2014
1	**4**	**5**	**1**

13. How has your organization used the results from your Hospital Culture of Safety Survey? Check all that apply.

10	To diagnose the current status of our organizations safety culture
9	To raise awareness about patient safety issues to senior leadership
7	To examine the effectiveness of specific patient safety interventions
6	To fulfill organization and/or regulatory requirements
7	To conduct internal and external benchmarking
9	To track change over time
0	Not applicable
1	Other: SFGH:"To get feedback from front line staff"

Essential Hospitals Engagement Network (EHEN)

Best Practices Survey 2014 - Patient and Family Engagement

Red Numbers Represent Responses (n=12)

Section 3: Patient and Family Engagement (PFE)

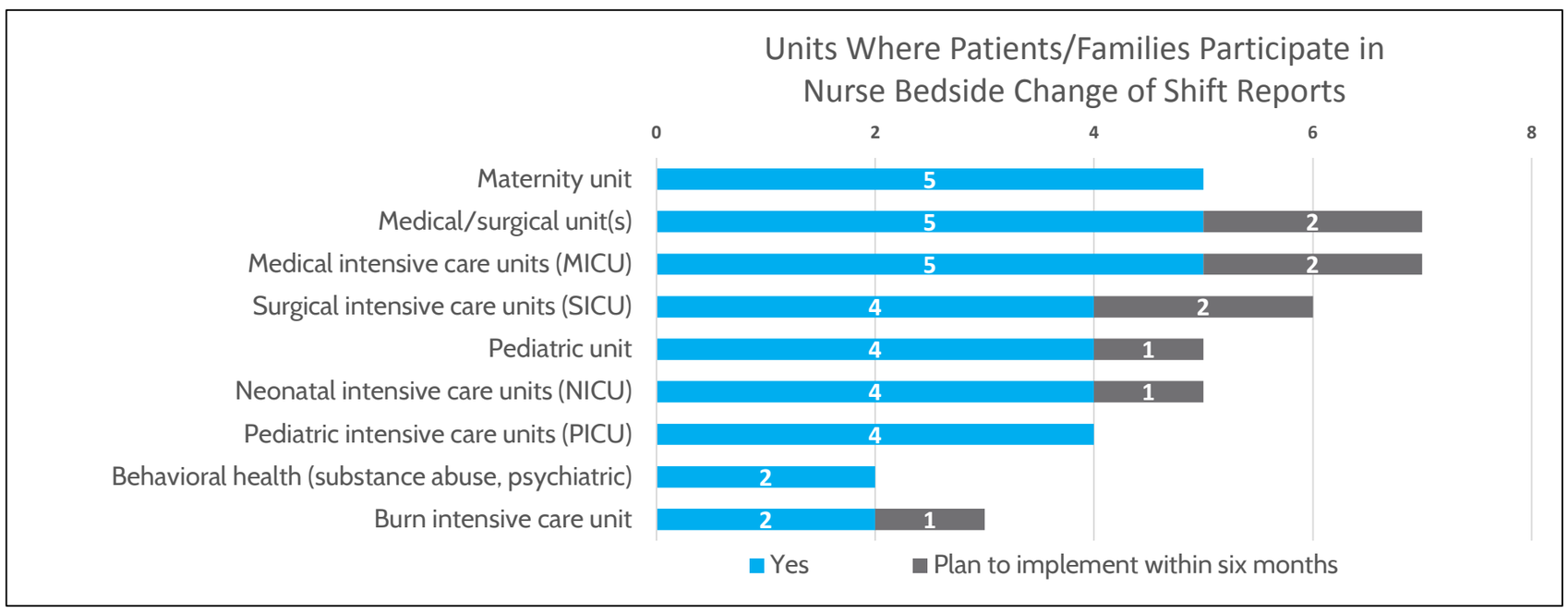
1. **Before every scheduled admission, does hospital staff provide and discuss with the patient and family a planning checklist similar to CMS' Discharge Planning Checklist, and elicit questions or comments from the patient or family?**

2	Yes
9	No
	Plans are in process to have in next six months

2. **When feasible, does your hospital conduct shift-change huddles and bedside reporting in the presence of patients and family members?**

1	Yes, across all units
8	Yes, across some units or planning to implement (If selected, see question 2A.)
3	No, not in any hospital unit

2A. If answering "Yes, across some units or planning" above, for each unit listed below please indicate whether patients and/or family members are encouraged to participate in the nurse bedside change of shift report.



3. **Does your hospital have a person or functional area, which may also operate within other roles in the hospital, dedicated to and proactively responsible for PFE and that systematically evaluates PFE activities (e.g. open chart policy, PFE trainings, and establishing and disseminating PFE goals)?**

6	Yes
5	No
	Plans are in process to have in next six months

4. **Does your hospital have an active PFE committee or at least one former patient who serves on a patient safety or quality improvement committee or team?**

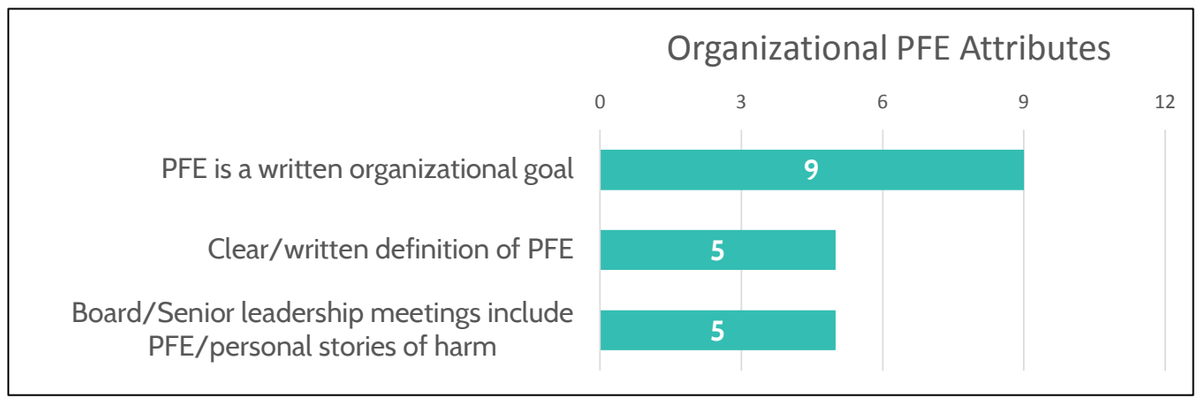
6	Yes
6	No
	Plans are in process to have in next six months

5. **Does your hospital have at least one patient who, acting as a patient representative, serves on a governing and/or leadership board?**

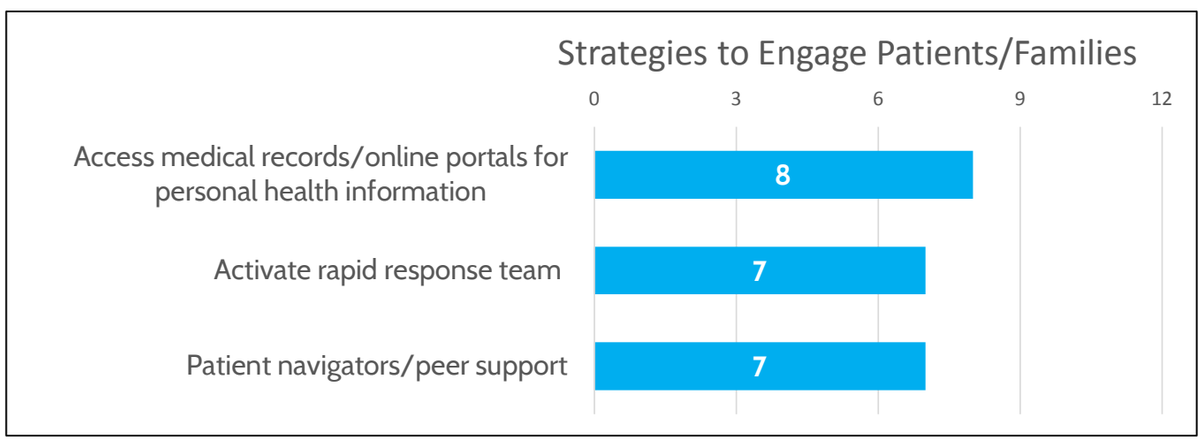
5	Yes
7	No
	Plans are in process to have in next six months

Section 3: Patient and Family Engagement (PFE)

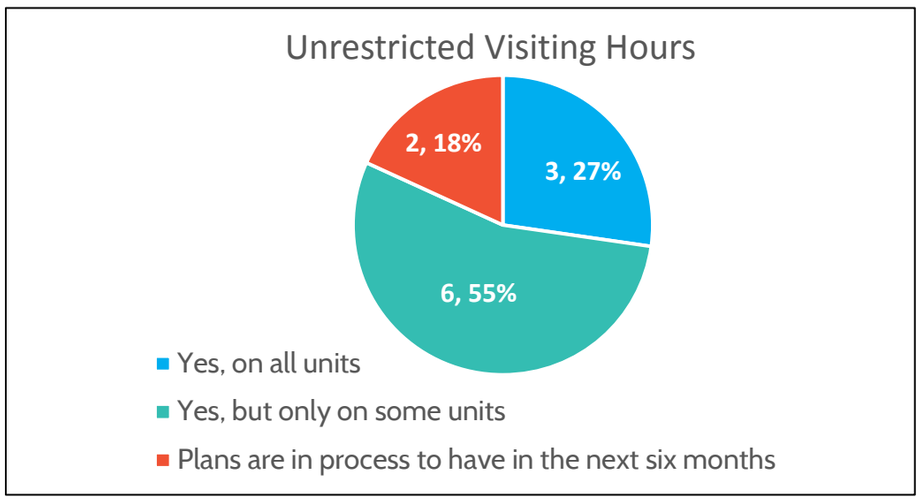
6. Which of the following are true regarding PFE and leadership in your organization? Check all that apply.



7. Which of the following strategies does your hospital use to engage patients and their families in care? Check all that apply.



8. Are visiting hours unrestricted and families welcomed at all hours?



Essential Hospitals Engagement Network (EHEN)
2014 Best Practice Survey: Highlights and Responses

Hospital-Acquired Infections (HAI)

Catheter-Associated Urinary Tract Infections (CAUTI)
Central Line-Associated Blood Stream Infections (CLABSI)
Surgical Site Infections (SSI)
Ventilator-Associated Events/Pneumonia (VAE/VAP)

Background

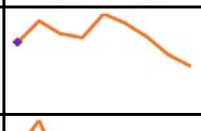
- In May 2014, EHEN asked its hospitals to complete a survey of the interventions and practices they have implemented or plan to implement as part of their quality improvement efforts.
- Response rate: 12 of 22 hospitals responded (55 percent).

Report Information

- This report is not intended to recommend any one intervention or practice, nor is it intended to prove causation between interventions and outcomes.
- Hospitals were not necessarily able to answer every question.
- The highlight section provides comparisons between conditions and associations with relevant outcome data. The outcome data was collected though the National Healthcare Safety Network (NHSN) or UHC's clinical database (CDB/CDB-lite). The remainder of the report is a full breakdown of responses to each question from the survey.
- For questions, please contact your improvement coach or e-mail EHEN@essentialhospitals.org.

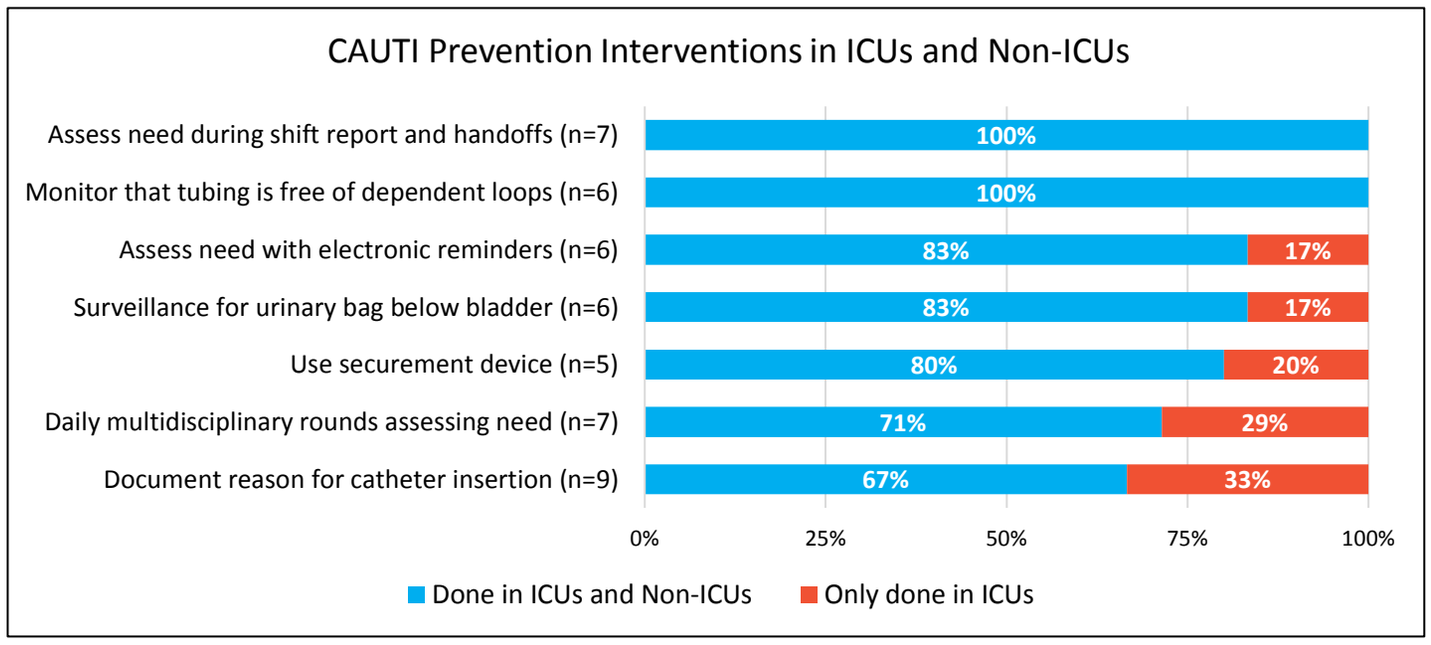
CAUTI: Best Practice Survey Highlights

In their own words... Top three effective CAUTI prevention strategies in the past 18 months from top performers.

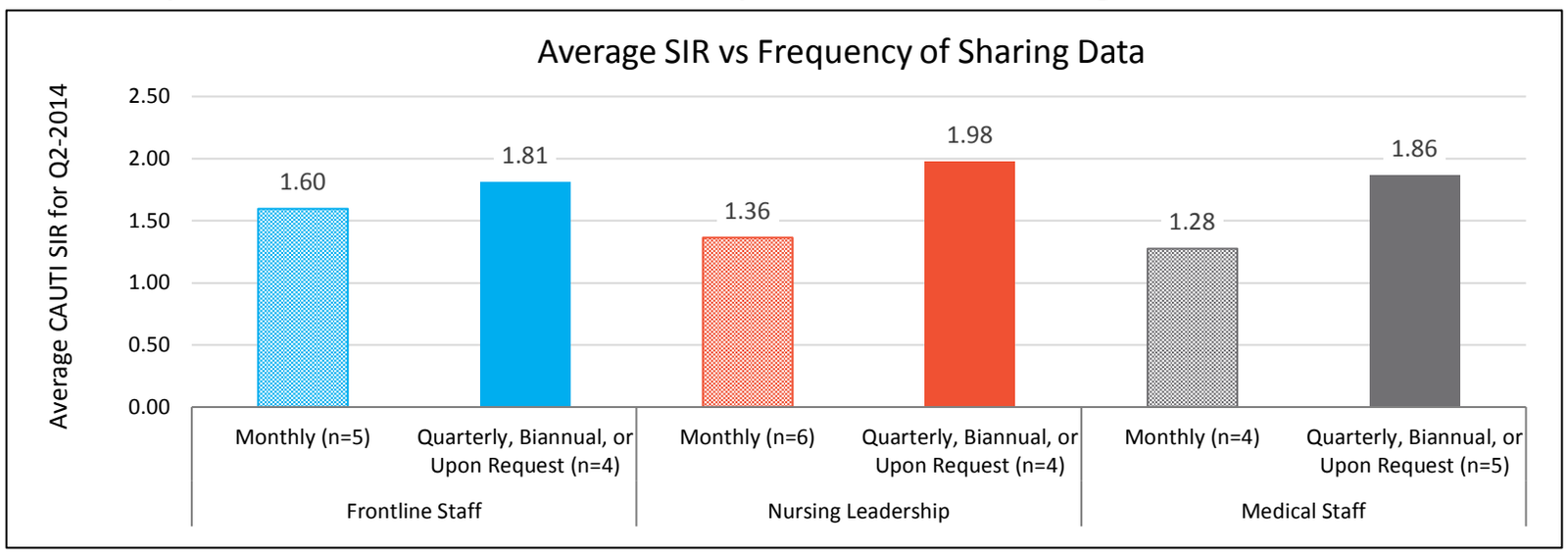
			Top Three Effective Strategies (Identified by the Hospital)		
	% Improvement	Sparkline	#1	#2	#3
Contra Costa Regional Medical Center	-52.8		Electronic MD reminders to remove foley	Change to new catheter insertion tray with reminders and booklets for patients and families	
San Francisco General Hospital and Trauma Center	-37		Remove Foleys when discharged from ICU	Development of standard indications	Added to daily rounding
John H. Stroger Hospital of Cook County	-32		Securement devices	Closed system insertion kits	Staff education
Regional One Health	-15.8		Daily Rounds	White communication boards	Data sharing

Notes: Performance based on overall NHSN CAUTI Standardized Infection Ratio (SIR). For all, the baseline is Q1-Q2'12 and the performance period is Q2'14. Sparklines show trend over time from baseline to Q2'14.

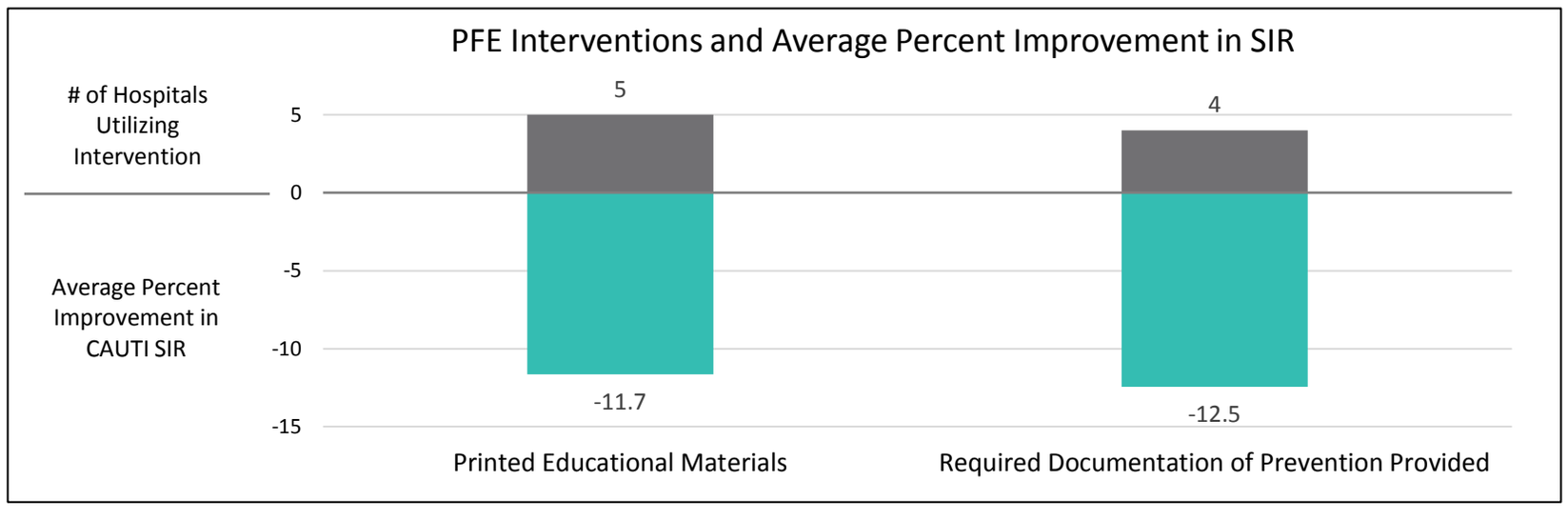
Going beyond the ICU... When implemented in the ICU, several interventions are spread to Non-ICU units.



Utilizing data... Hospitals that share data on a monthly basis have on average a lower Standardized Infection Ratio (SIR).

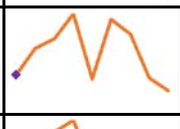
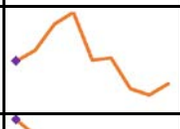


Engaging patients & families... On average, patient and family engagement (PFE) interventions are associated with improvement in SIR.



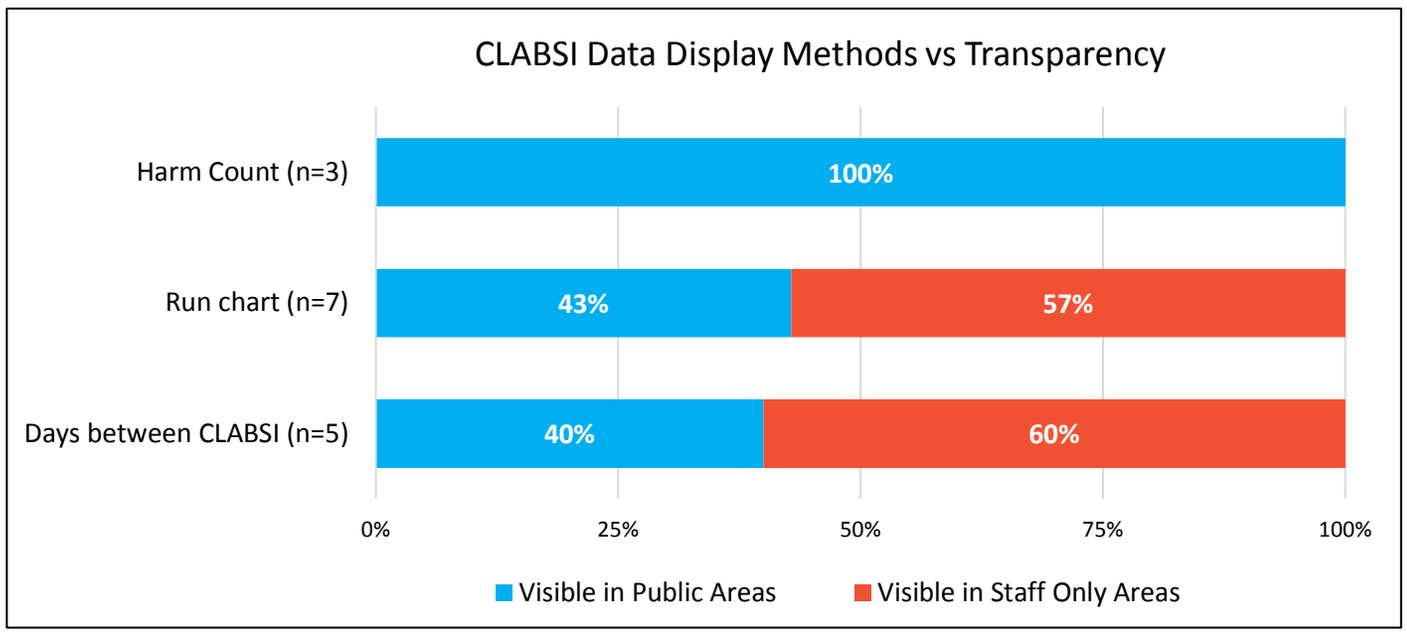
CLABSI: Best Practice Survey Highlights

In their own words... Top three effective CLABSI prevention strategies in the past 18 months from top performers.

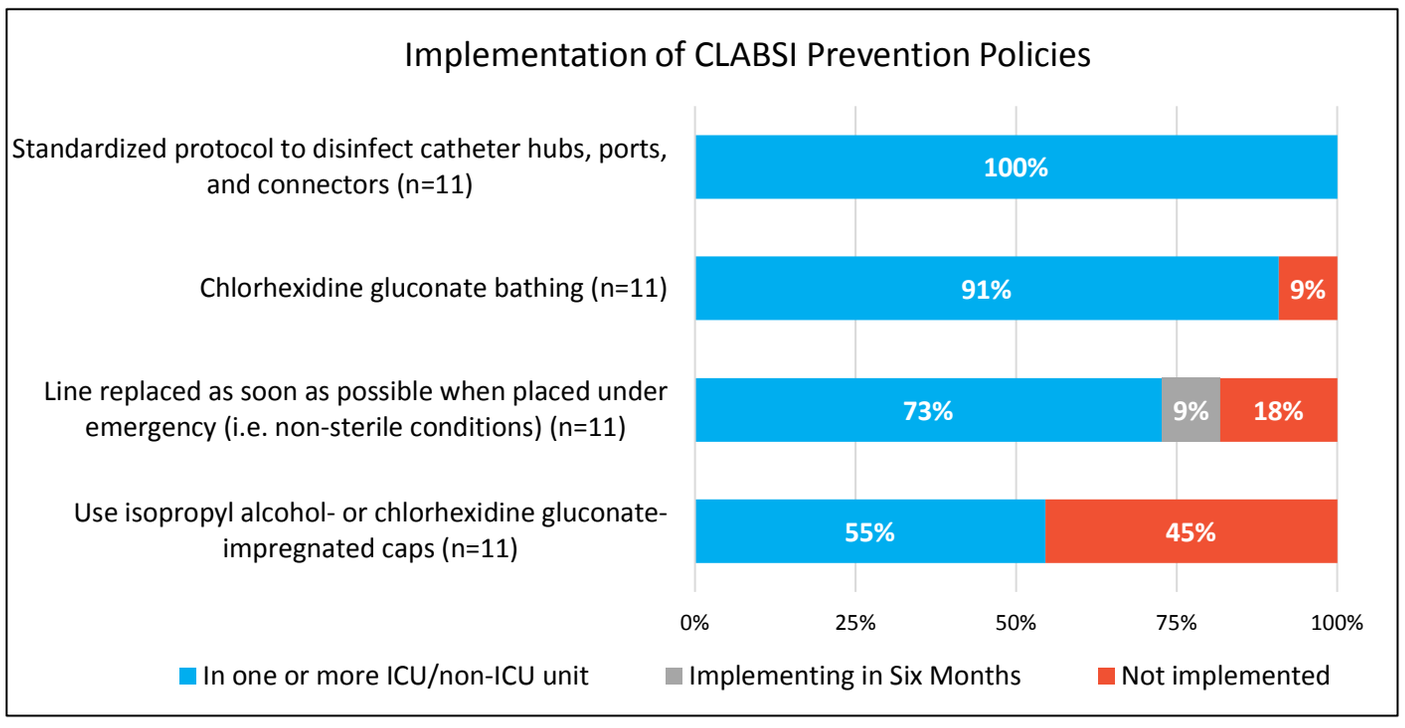
			Top Three Effective Strategies (Identified by the Hospital)		
	% Improvement	Sparkline	#1	#2	#3
San Francisco General Hospital and Trauma Center	-100		Regular line care audits	Daily line necessity and prompt removal	Documentation tool to assist with decision support
Maricopa Integrated Health System	-52.5		Universal decolonization	Line maintenance team rounding weekly on all patients with central lines	Curos devices (port protectors, for Tego, and for male luer tips)
Regional One Health	-51.9		Standardization of dressing change trays	Data sharing	Daily rounds
Truman Medical Centers-Hospital Hill	-44.3		Impregnated chlorhexidine caps	PICC insertion lists	

Notes: Performance based on overall NHSN CLABSI Standardized Infection Ratio (SIR). For all, the baseline is Q1-Q2'12 and the performance period is Q2'14. Sparklines show trend over time from baseline to Q2'14.

Toward transparency... When data is displayed using these methods, it is often shown in public areas.

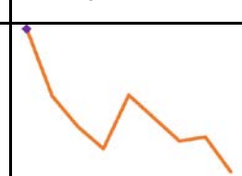
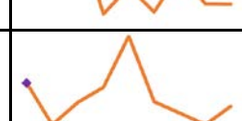


Regarding policies... Using impregnated caps is one of the least widely adopted CLABSI prevention policies.



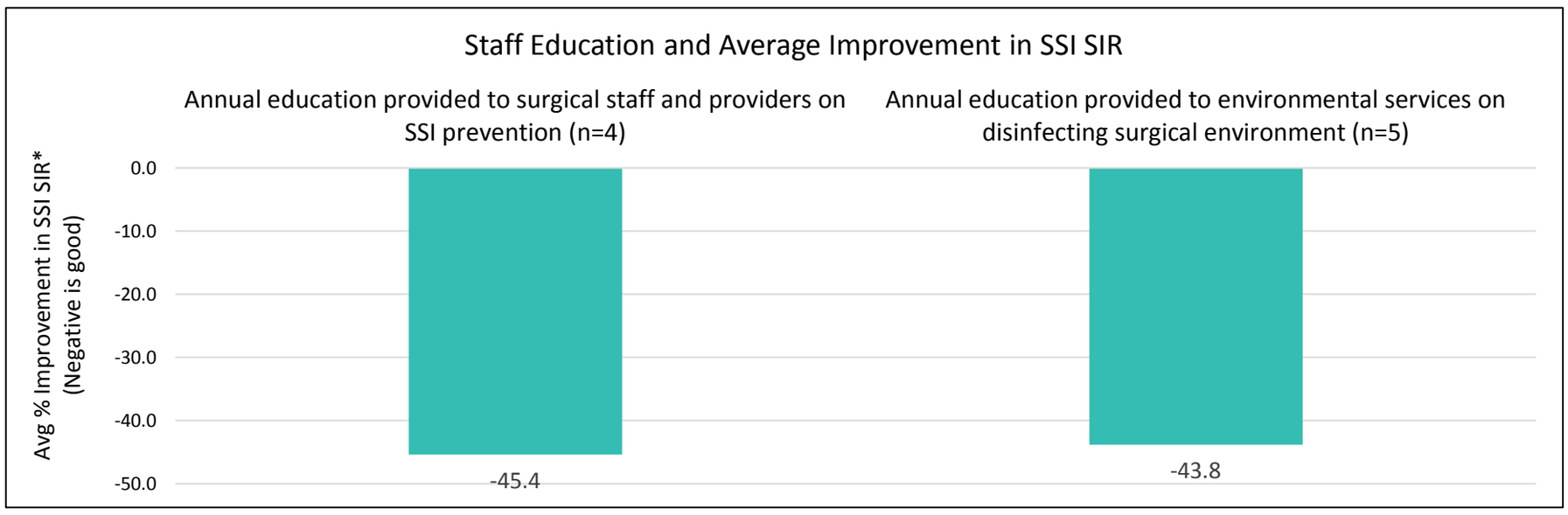
SSI: Best Practice Survey Highlights

In their own words... Top three effective SSI prevention strategies in the past 18 months from top performers.

			Top Three Effective Strategies (Identified by the Hospital)		
	% Improvement	**Sparkline**	**#1**	**#2**	**#3**
Maricopa Integrated Health System	-100		Installed retractable straps on the outer doors of the ORs to decrease the frequency of them opening during surgery	Stopped exchanging linen carts in order to decrease the amount of dust/dirt particles coming into the department	Monthly review of ATP Audits (cleanliness of the environment) which are shared with staff and reviewed with EVS staff monthly
San Mateo Medical Center	-69.2		HgbA1c monitoring	Chlorhexidine bathing	One on one education with surgeons
Regional One Health	-55.6		Centralization of high level disinfection	Rounding	Surgical attire education
San Francisco General Hospital	-47.7		SSI included on harm dashboard	Chlorhexidine bathing in the ICU	

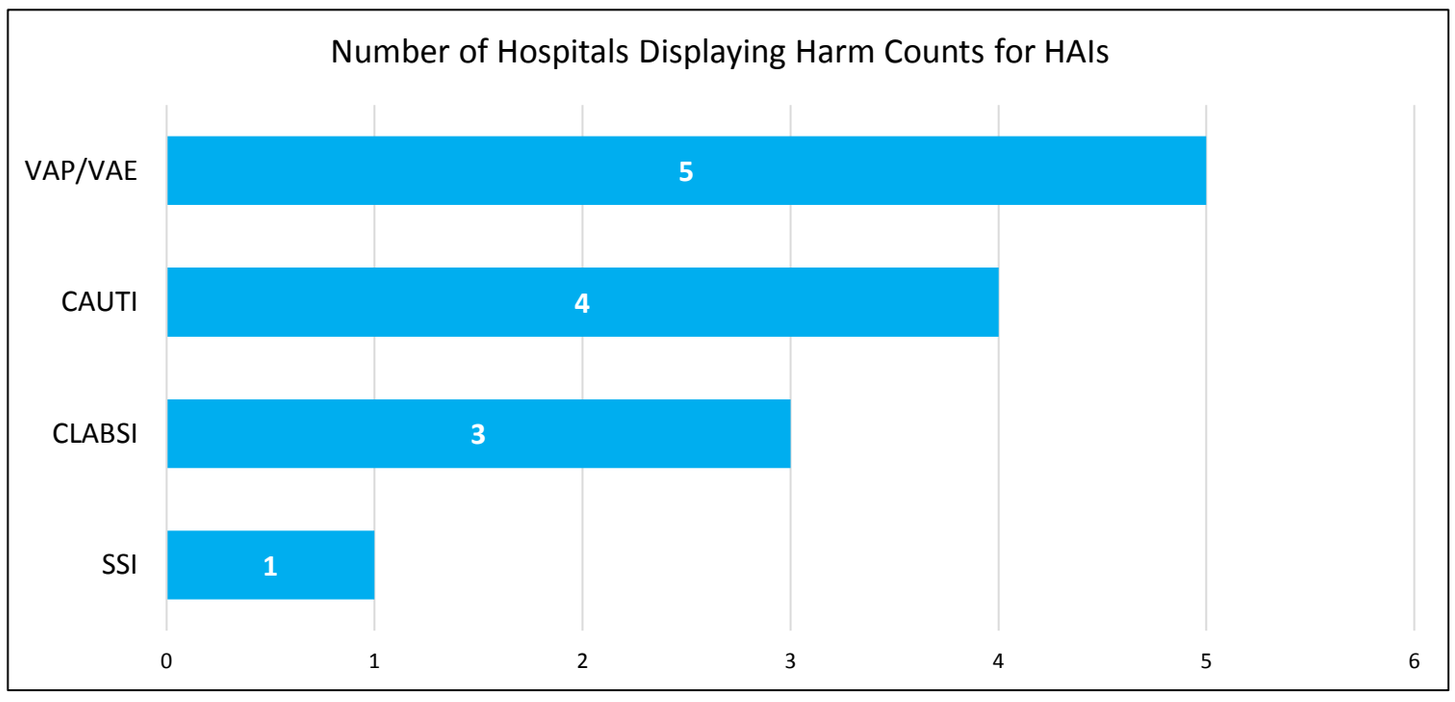
Notes: Performance based on NHSN All SSI Standardized Infection Ratio (SIR). For all, the baseline is Q1-Q2'12 and the performance period is Q2'14. Sparklines show trend over time from baseline to Q2'14.

Alongside staff education... Hospitals providing annual education to staff have, on average, seen substantial improvement.



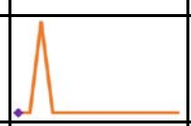
*- Improvement is based on a baseline of Q1-Q2'2012 and performance of Q2'2014

Displaying Harm Counts... Only one hospital displays harm counts for SSI as well as the other hospital-acquired infections.



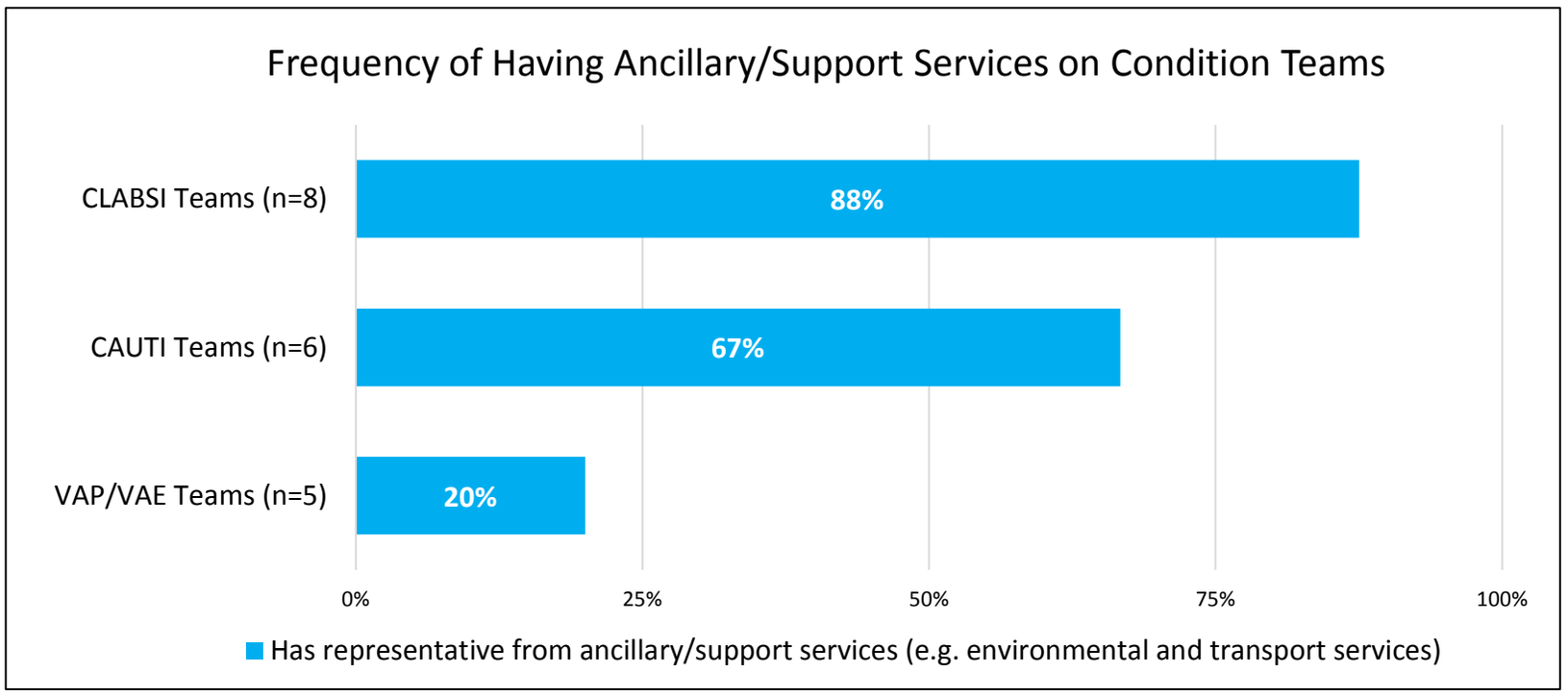
VAP: Best Practice Survey Highlights

In their own words... Top three effective VAP prevention strategies in the past 18 months from top performers.

			Top Three Effective Strategies (Identified by the Hospital)		
	% Improvement	Sparkline	#1	#2	#3
San Mateo Medical Center	Zero Harm		Improved documentation with mandatory fields	Decreased length of intubation	Multidisciplinary rounds in ICU
Rancho Los Amigos National Rehabilitation Center	Zero Harm		Query on medical record system to facilitate data gathering		
Regional One Health	-100		Use of complete mouth care kits	Rounding	Data sharing

Notes: Performance based on UHC-defined VAP, which was collected through UHC's CDB/CDB-lite. For all, the baseline is 2010 and the performance period is Q2'14. Sparklines show trend over time from baseline to Q2'14.

As for team composure... Unlike CAUTI and CLABSI, VAP/VAE teams often do not often have ancillary services represented.



Essential Hospitals Engagement Network (EHEN)

Best Practices Survey 2014 - Hospital-Acquired Infections (HAIs)

Red Numbers Represent Respones (n=12)

Section 4: Hospital-Acquired Infections (HAI)

Infection Prevention Practices

1. In the past two years, has your organization participated in a national, state/regional, grant-funded or systemwide initiative on the following topics?

	Yes	No	If Yes, name of initiative
Hand Hygiene	7	4	
CAUTI	10	1	
CLABSI	9	2	
VAP/VAE	6	3	
SSI	7	2	

2. What current practices are you using to support efforts to improve hand hygiene compliance in your hospital? Check all that apply.

10	Periodic direct observations/audits/secret shoppers
2	Product consumption devices
5	Self-reporting surveys
1	Smart technology (badges, dispenser transmissions, video, etc.)
4	Senior leadership rounds focused on handwashing compliance
2	Other, please specify: SFGH-"real time audits"; Contra Costa-"Med pass survey"
	None at this time

3. What is the total number of staff currently working in your infection prevention department who are certified in infection control?(Describe using FTE's)

SFGH- 3; MetroHealth- 1.8; Stroger- 4; Santa Clara- 2; San Mateo- 1

4. During senior leadership rounds, harm from the following conditions is included as a concern:

	Yes, in all applicable units	No	Yes, but only some applicable units	We do not do senior leadership rounds
CAUTI	3	1	2	4
CLABSI	2	1	2	4
VAP/VAE	2	2	2	4
SSI	2	2	2	4

5. Our hospital has the following processes in place to educate patients and families about preventing hospital-acquired infections. Check all that apply.

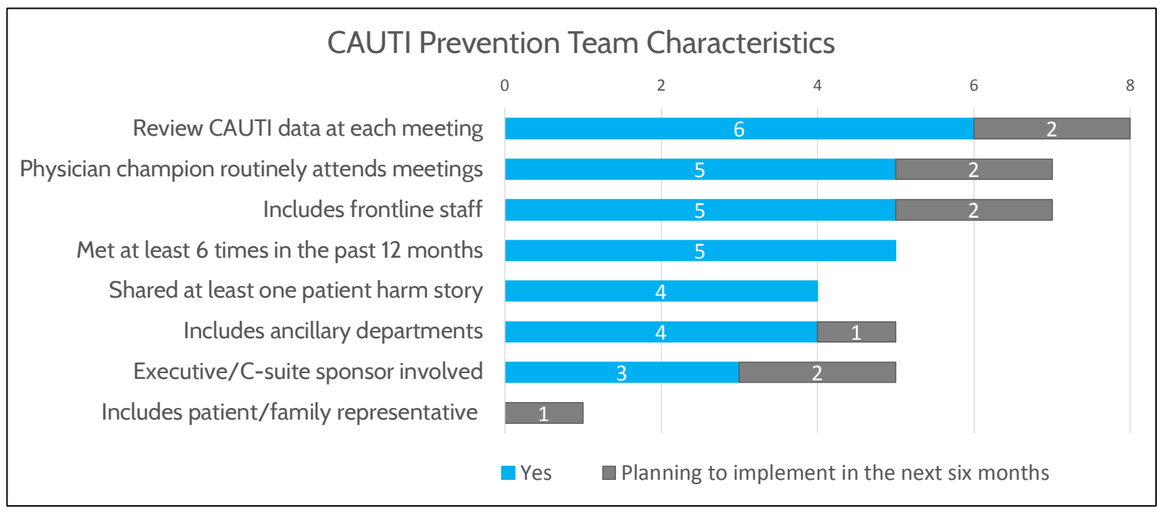
	Printed Educational Materials	Patient/Family Video	Teach-back Process	Required documentation of prevention provided to patient and family members	Other
CAUTI	4		2	4	
CLABSI	4		2	5	
VAP/VAE	4		2	4	
SSI	5		2	5	

Catheter-associated Urinary Tract Infections (CAUTI): Q6 - Q17

6. Does your hospital have a multidisciplinary team that stands alone or is part of an HAI committee *actively* working on CAUTI prevention?

8	Yes
4	No (Go to question 8)

7. Please answer the following questions for your CAUTI prevention team:

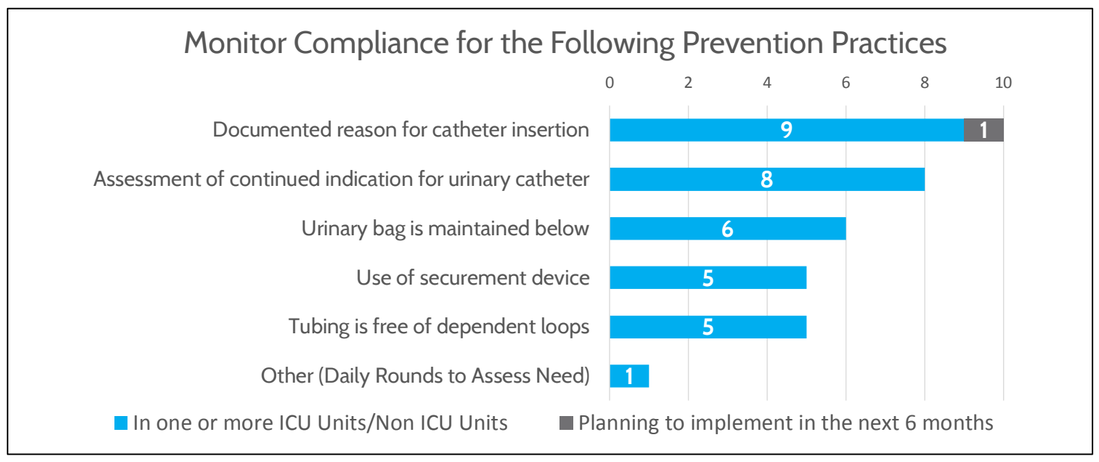


Section 4: Hospital-Acquired Infections (HAI)

8. Our hospital has evidence-based policies that include the following with respect to indwelling urinary catheters:

	Yes	No	Will adopt within six months
Appropriate indications for urinary catheter use	8		2
Automatic catheter removal when indication expires	3	4	3
Proper catheter insertion using sterile technique	9		1
Urinary catheter maintenance	9		1
Use of portable bladder ultrasounds to access urine volume	6	2	2
Indications and frequency for catheter changes	7	2	1

9. We have a method to routinely and consistently monitor compliance with the following practices to prevent CAUTI:



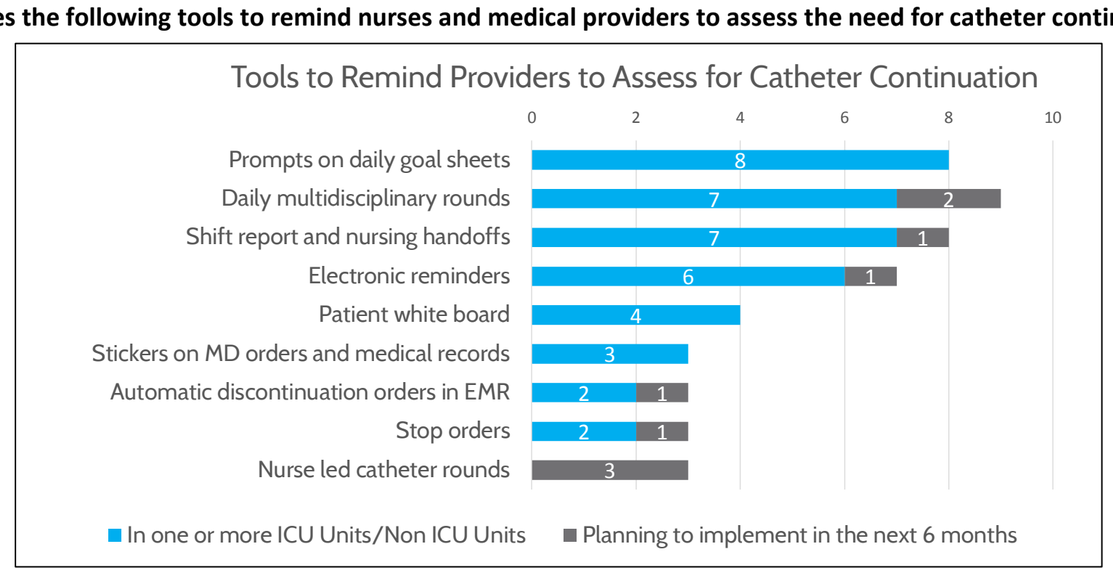
10. Has your hospital implemented a policy that allows nurse-initiated urinary catheter discontinuation (nurse driven protocol)? Check all that apply.

- 1 Yes, in one or more of our ICU units
- 2 Yes, in one or more non-ICU units
- 2 Working to implement within the next six months
- 6 Not at this time

11. What are valid indications for catheter insertion at your hospital? Check all that apply.

- 11 Peri-operative use for selected surgical procedures
- 10 Urine output monitoring in critically ill patients
- 10 Managing acute urinary retention and urinary obstruction
- 7 Assisting with pressure ulcer healing for incontinent patients
- 2 At patients' request to improve comfort
- 3 Other: Chronic use, end of life, unstable thoracic or lumbar spine & pelvic fx

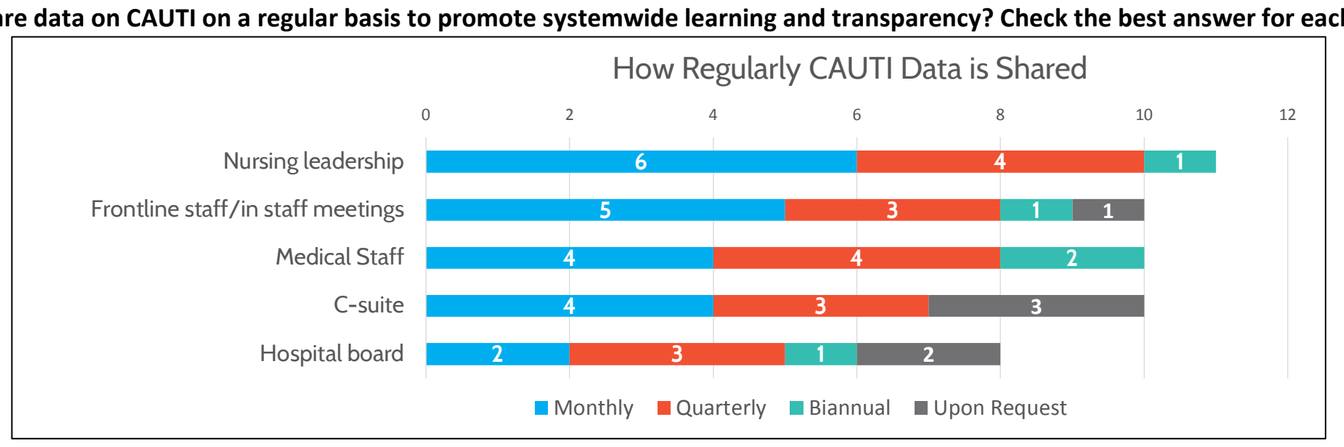
12. Our hospital uses the following tools to remind nurses and medical providers to assess the need for catheter continuation:



13. Does your hospital do a deep dive or root cause analysis to look for opportunities for improvement?

- 3 Yes, on all confirmed CAUTI cases housewide
- 2 Yes, on confirmed CAUTI cases, but only in selected units
- 6 We do not do in-depth reviews on CAUTI cases

14. How do you share data on CAUTI on a regular basis to promote systemwide learning and transparency? Check the best answer for each:



Section 4: Hospital-Acquired Infections (HAI)

15. Which methods are used to display CAUTI data on your clinical units?

	Staff-only accessible areas	Public areas such as hallways	Method is not used
Run charts	5	2	2
Control charts	1		5
Bar graphs/pie charts	2		6
Harm counts	1	3	4
Days between CAUTI	3	2	5
Other:			

16. Effectiveness is defined as the degree to which a tool or strategy produced the desired result or impact on the intended goal. Using this definition, please list the three most effective interventions/strategies for reducing CAUTI you have implemented in the past 18 months.

17. When do you provide education to nursing staff on indwelling urinary catheter indication and maintenance? Check all that apply.

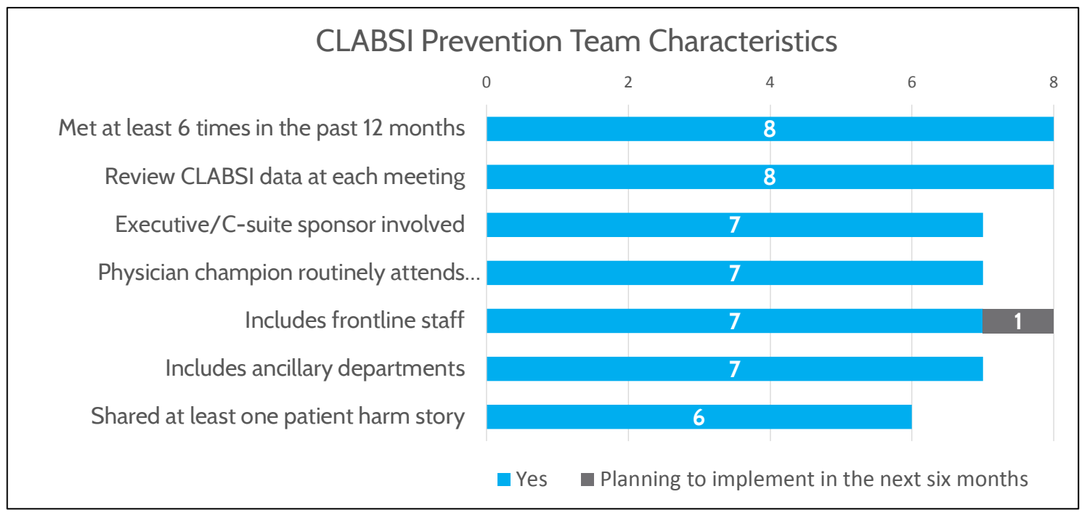
- 9 During new employee orientation
- 8 Annually
- 3 Other:

Central Line-Associated Blood Stream Infections (CLABSI): Q18 - Q33

18. Does your hospital have a multidisciplinary team that stands alone or is part of an HAI committee *actively* working on CLABSI prevention?

- 8 Yes
- 4 No (Go to question 20)

19. Please answer the following questions for your CLABSI prevention team:



20. Are healthcare providers at all levels empowered to stop the central line insertion (i.e. stop the line protocol) if a breach in sterile technique is observed?

- 11 Yes
- No
- Working to implement within the next six months

21. Our hospital has evidence-based policies that include the use of a central line insertion checklist.

- 11 Yes
- No
- Working to implement within the next six months

22. We have a method to routinely and consistently monitor compliance with the following practices to prevent CLABSI:

	In one or more ICU units	In one or more non-ICU units	Not at this time	Will adopt within six months
Hand hygiene at insertion	9	8	2	
Maximal barrier precautions	9	7	2	
Chlorhexidine skin prep at insertion	10	9	1	
Optimal catheter site selection	10	9	1	
Checking line daily for necessity	11	10		
Other: "Scrub the hub"	1			

23. Has your hospital implemented a policy that directs the replacement as soon as possible of central lines placed under emergency (non-sterile) conditions? Check all that apply

- 8 Yes, in one or more of our ICU units
- 6 Yes, in one or more non-ICU units
- 1 Working to implement within the next six months
- 2 Not at this time

Section 4: Hospital-Acquired Infections (HAI)

24. Has your hospital implemented a policy that directs the use of a standardized protocol (e.g. scrub the hub) used to disinfect catheter hubs, injection ports and needleless connectors with 70% alcohol or an iodophor prior to accessing the port? Check all that apply.

11	Yes, in one or more of our ICU units
11	Yes, in one or more of our non-ICU units
	Working to implement within the next six months
	Not at this time

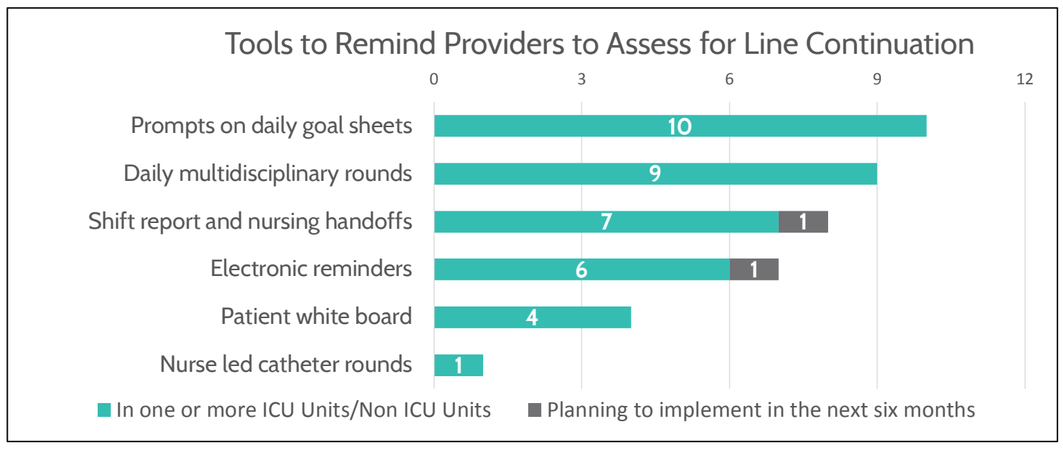
25. Has your hospital implemented a policy that directs the use of isopropyl alcohol- or chlorhexidine gluconate-impregnated caps to prevent intraluminal contamination? Check all that apply.

6	Yes, in one or more of our ICU units
6	Yes, in one or more of our non-ICU units
	Working to implement within the next six months
5	Not at this time

26. Has your hospital implemented a policy that directs chlorhexidine gluconate bathing to reduce bloodstream infections? Check all that apply.

10	Yes, in one or more of our ICU units
3	Yes, in one or more of our non-ICU units
1	Working to implement within the next six months
1	Not at this time

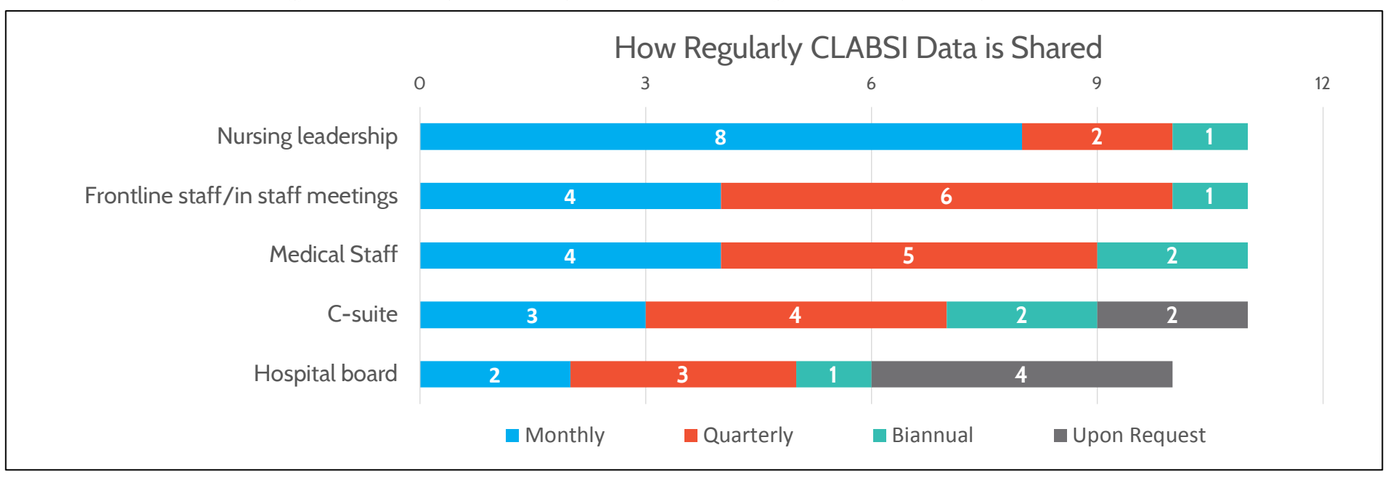
27. Our hospital uses the following tools to remind nurses and medical providers to assess the need for central line continuation:



28. Does your hospital do a deep dive or root cause analysis to look for opportunities for improvement?

5	Yes, on all confirmed CLABSI cases housewide
4	Yes, on all confirmed CLABSI cases, but only in selected units
2	We do not do in-depth reviews on CLABSI cases

29. How do you share data on CLABSI on a regular basis to promote systemwide learning and transparency? Select the best answer for each.



30. Which methods are used to display CLABSI data on your clinical units?

	Staff-only accessible areas	Public areas such as hallways	Method is not used
Run charts	4	3	2
Control charts	2		3
Bar graphs/pie charts	4		3
Harm counts		3	4
Days between CLABSI	3	2	4
Other:			

31. Effectiveness is defined as the degree to which a tool or strategy produced the desired result or impact on the intended goal. Using this definition, please list the three most effective interventions/strategies for reducing CLABSI you have implemented in the past 18 months.

32. When do you provide education to nursing staff on central line insertion and maintenance? Check all that apply.

10	During new employee orientation
9	Annually
3	Other: "Staff Meetings"; "Periodically"

Section 4: Hospital-Acquired Infections (HAI)

33. When do you provide education to medical staff on central line insertion and maintenance? Check all that apply.

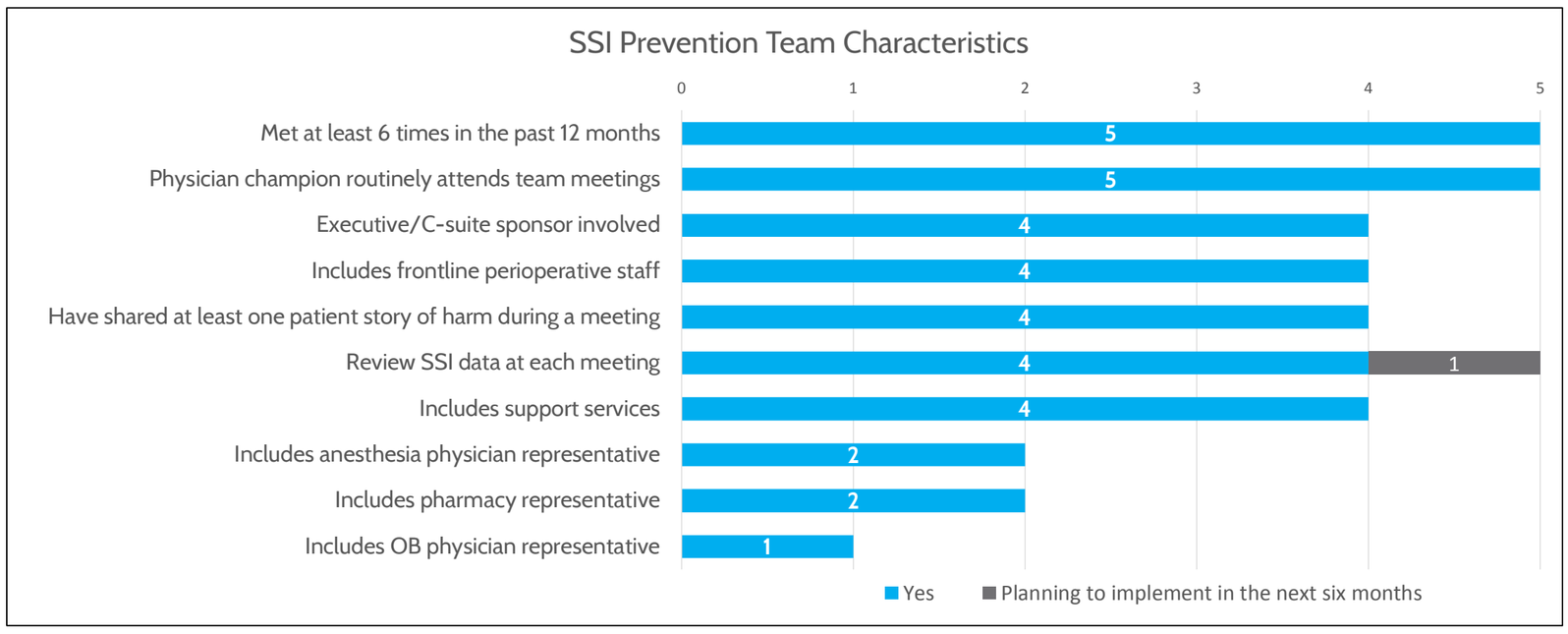
5 During credentialing orientation
4 Annually
5 Other: "As directed by the CLABSI Committee"; "Resident Orientation"; "Routinely via vascular access champions. Quality and Vascular Access classes held for staff 1-2 times per year"

Surgical Site Infections (SSI): Q34 - Q45

34. Does your hospital have a multidisciplinary team that stands alone is part of an HAI committee *actively* working on SSI prevention?

5 Yes
6 No (Go to Question 36)

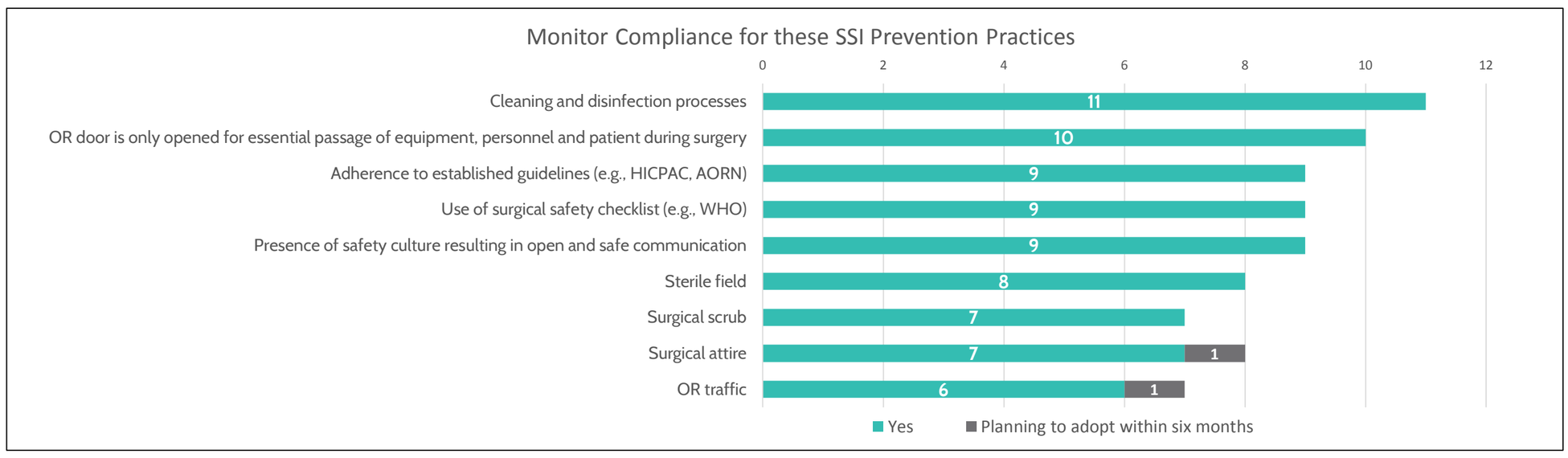
35. Please answer the following questions for your SSI prevention team:



36. Our hospital has evidence-based protocols or order sets that include the following with respect to preventing SSI:

	Yes	No	Will adopt within six months
Antibiotic dosing to include antibiotic selection, timing of administration, weight-based dosing, re-dosing (for prolonged procedures) and discontinuation	12		
Preoperative skin antisepsis using measures such as soap and water showers and chlorhexidine gluconate	10	1	1
Perioperative skin antisepsis practices utilizing the most appropriate skin antiseptic for the type of surgery performed	10	1	
Normothermia using a standardized process for all surgical patients	11	1	
Optimal glucose control for all surgical patients	11	1	
Screening/decolonizing selected patients with *Staphylococcus aureus*	3	7	2
Blood transfusion practices	7	3	1

37. We have a method to routinely and consistently monitor compliance with the following practices to prevent SSI:



38. Does your hospital do a deep dive or root cause analysis to look for opportunities for improvement? Check all that apply

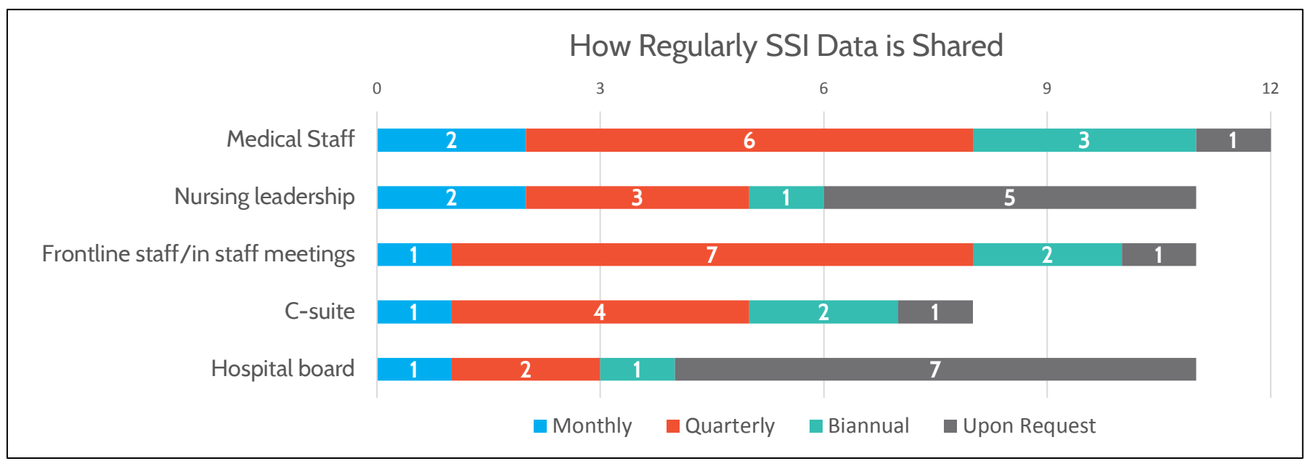
2 Yes, on all SSI housewide
3 Only on SSI for certain procedures
2 Only on SSI of certain severity
5 We do not do in-depth reviews on SSI cases

Section 4: Hospital-Acquired Infections (HAI)

39. Is incisional closure type (i.e., primary closure or delayed primary closure) a standard element in the perioperative record?

9	Yes
2	No

40. How do you share data on SSI on a regular basis to promote systemwide learning and transparency? Check the best answer for each:



41. Which methods are used to display SSI data on your clinical units?

Method	Perioperative areas		Inpatient unit(s)		
	Staff-only accessible areas	Public areas such as hallways	Staff-only accessible areas	Public areas such as hallways	Method not used
Run charts	2	1	2		7
Control charts	1				8
Bar graphs/pie charts	3		3		7
Harm counts		1	3		9
Days between SSIs					9
Other:					

42. Effectiveness is defined as the degree to which a tool or strategy produced the desired result or impact on the intended goal. Using this definition, please list the three most effective interventions/strategies for reducing SSI you have implemented in the past 18 months.

43. When do you provide education to surgical staff and providers on SSI prevention, such as on how to perform, document, and communicate SSI risk assessments results? Check all that apply.

8	During new employee orientation
4	Annually
3	Other: "As Needed"; "During Quality classes held for staff at least annually"

44. When do you provide environmental services staff training, including competency assessments related to cleaning and disinfecting the surgical environment? Check all that apply.

8	During new employee orientation
5	Annually
4	Other: "As Needed"; "Periodic"

45. Do discharge instructions include SSI prevention strategies at home when applicable?

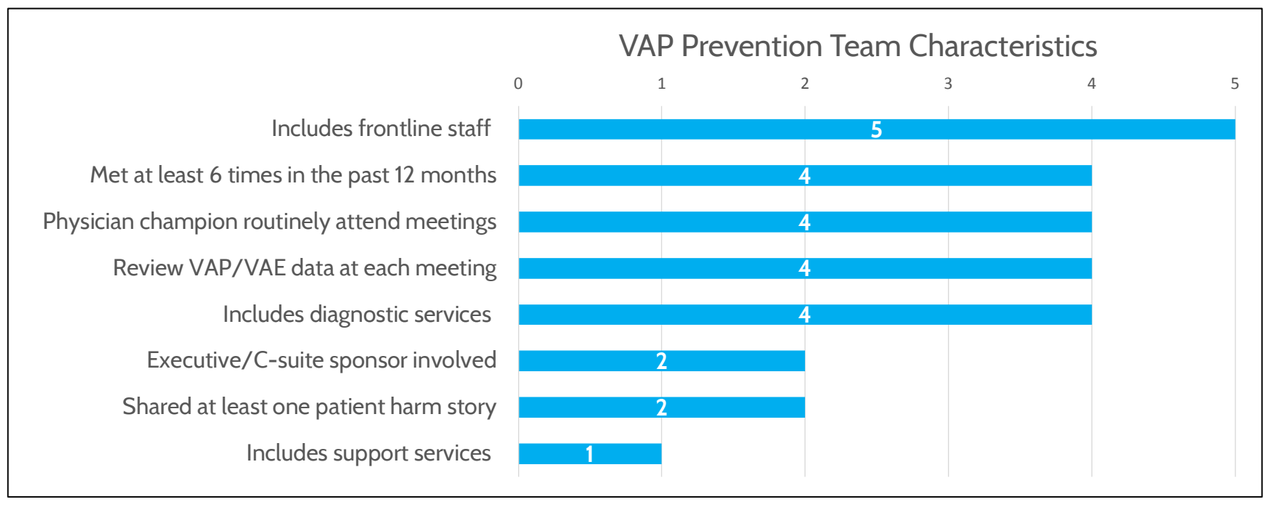
11	Yes
	No
1	Plan to implement within six months

Ventilator-Associated Pneumonia/ Ventilator-Associated Events (VAP/VAE): Q46 - Q56

46. Does your hospital have a multidisciplinary team that stands alone or is part of an HAI committee *actively* working on VAP/VAE prevention?

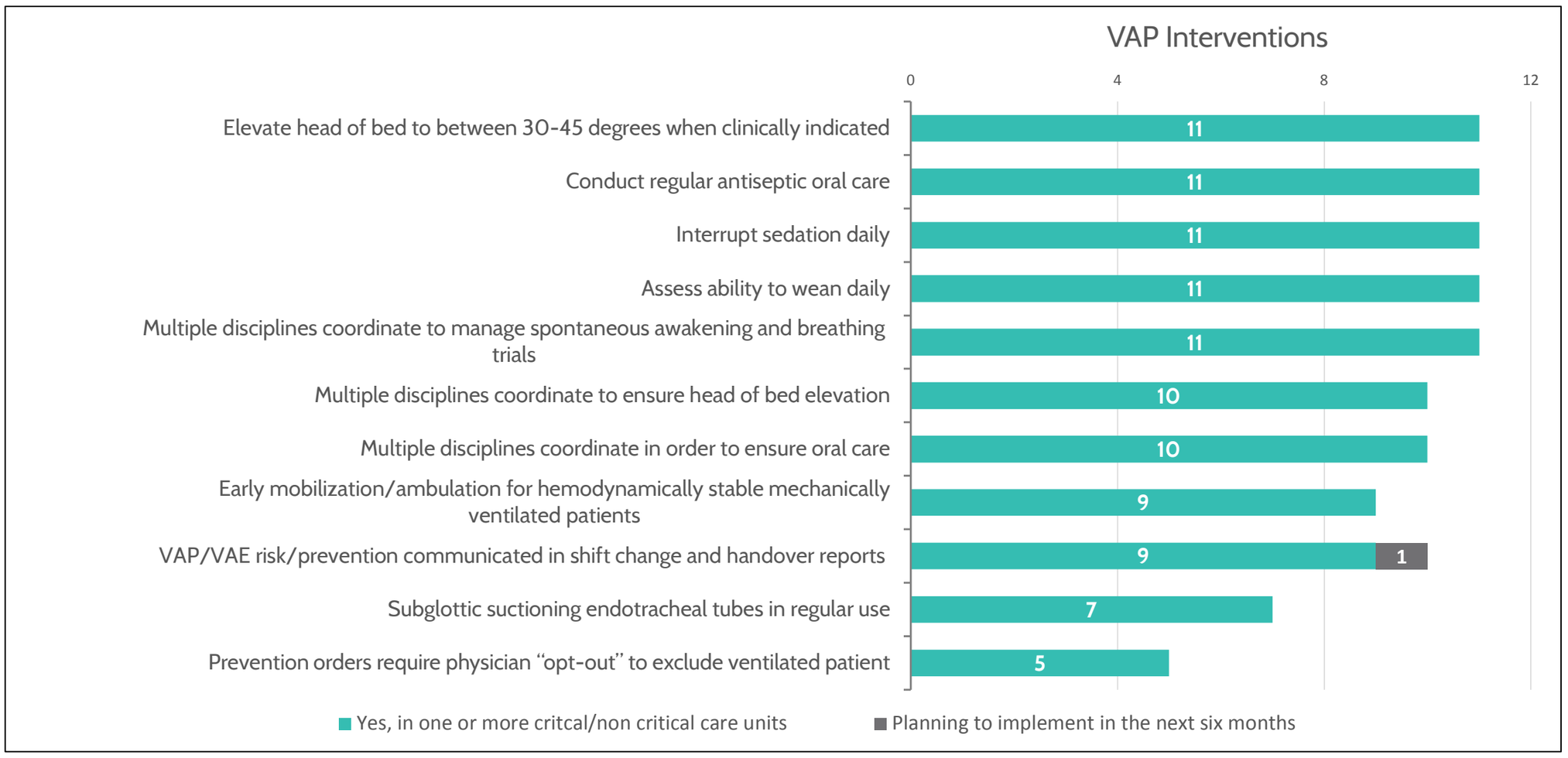
5	Yes
6	No (Go to question 48)

47. Please answer the following questions for your VAP/VAE prevention team:



Section 4: Hospital-Acquired Infections (HAI)

48. Our hospital has evidence-based policies aimed at preventing VAP/VAE. Check all that apply:



49. Do you use any of the following sedation scales to maximize weaning opportunities? Check all that apply.

7	Richmond Agitation and Sedation Scale (RASS)
2	Riker Sedation-Agitation Scale (SAS)
3	Modified Ramsay Score
1	Other: "Ramsey"
	Plan to implement in next six months
	No plans to implement

50. Do you monitor and manage delirium using any of the following scales? Check all that apply.

8	Confusion Assessment Method for the ICU (CAM-ICU)
	Intensive Care Delirium Screening Checklist (ICDSC)
	Nursing Delirium Screening Scale (NU-DESC)
	Delirium Detection Score (DDS)
1	Other: "Modified Ramsay Score"
	Plan to implement in next six months
1	No plans to implement

51. Indicate in which of the following non-ICU areas mechanically ventilated patients' head of bed elevation is reliably maintained as tolerated. Check all that apply.

4	Emergency Department
6	During transport within the hospital
2	During transport (e.g. ambulance, helicopter) between hospitals

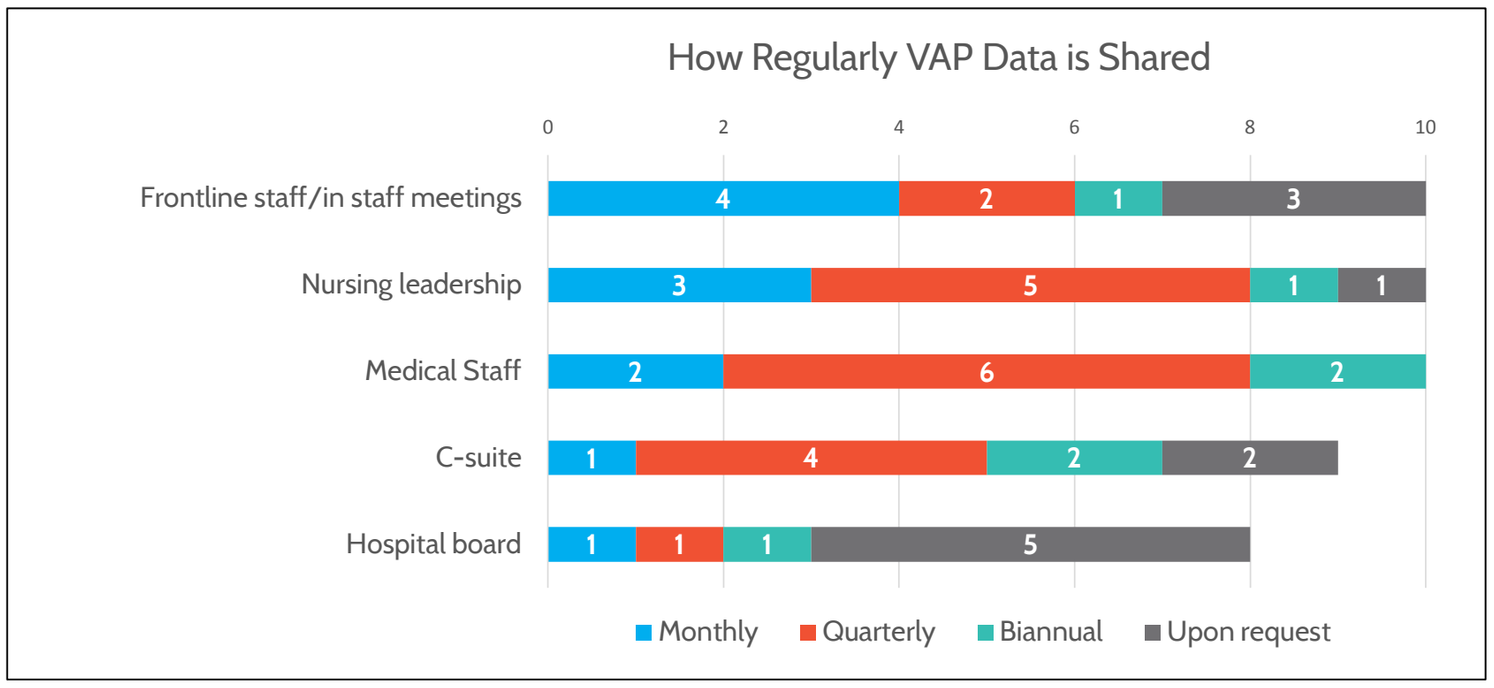
52. Do you do a deep dive or root cause analysis on any of the following categories to look for opportunities for improvement?

	Yes, on all cases	Yes, on cases meeting certain criteria	Planning to implement in the next six months	Intervention not used; no plans to implement
VAC	3	2		5
IVAC	2	2	1	5
Possible VAP	5	2	1	3
Probable VAP	5	2	1	2

53. Effectiveness is defined as the degree to which a tool or strategy produced the desired result or impact on the intended goal. Using this definition, please list the three most effective interventions/strategies for reducing VAP/VAE you have implemented in the past 18 months.

Section 4: Hospital-Acquired Infections (HAI)

54. How do you share data on VAP/VAE on a regular basis to promote systemwide learning and transparency? Select the best answer for each.



55. Which methods are used to display VAP/VAE data on your clinical units?

Method	ICU unit(s)		Medical/surgical unit(s)		
	Staff-only accessible areas	Public areas such as hallways	Staff-only accessible areas	Public areas such as hallways	Method not used
Run charts	3	3	2		3
Control charts	1				4
Bar graphs/pie charts	4		1		3
Harm counts	1	3	1		3
Days between VAP/VAEs		2		1	4
Other:	1		1		

56. When do you provide education to nursing staff on VAP/VAE prevention? Check all that apply.

10 During new employee orientation
6 Annually
1 Other: " As needed"

Essential Hospitals Engagement Network (EHEN)
2014 Best Practice Survey: Highlights and Responses

Hospital-Acquired Conditions (HAC)

Hospital-Acquired Pressure Ulcers (HAPU)
Adverse Drug Events (ADE)
Venous Thromboembolism (VTE)
Falls

Background

- In May 2014, EHEN asked its hospitals to complete a survey of the interventions and practices they have implemented or plan to implement as part of their quality improvement efforts.
- Response rate: 12 of 22 hospitals responded (55 percent).

Report Information

- This report is not intended to recommend any one intervention or practice, nor is it intended to prove causation between interventions and outcomes.
- Hospitals were not necessarily able to answer every question.
- The highlight section provides comparisons between conditions and associations with relevant outcome data. The outcome data was collected though UHC's clinical database (CDB/CDB-lite) and UHC's Web Data Entry Portal. The remainder of the report is a full breakdown of responses to each question from the survey.
- For questions, please contact your improvement coach or e-mail EHEN@essentialhospitals.org.

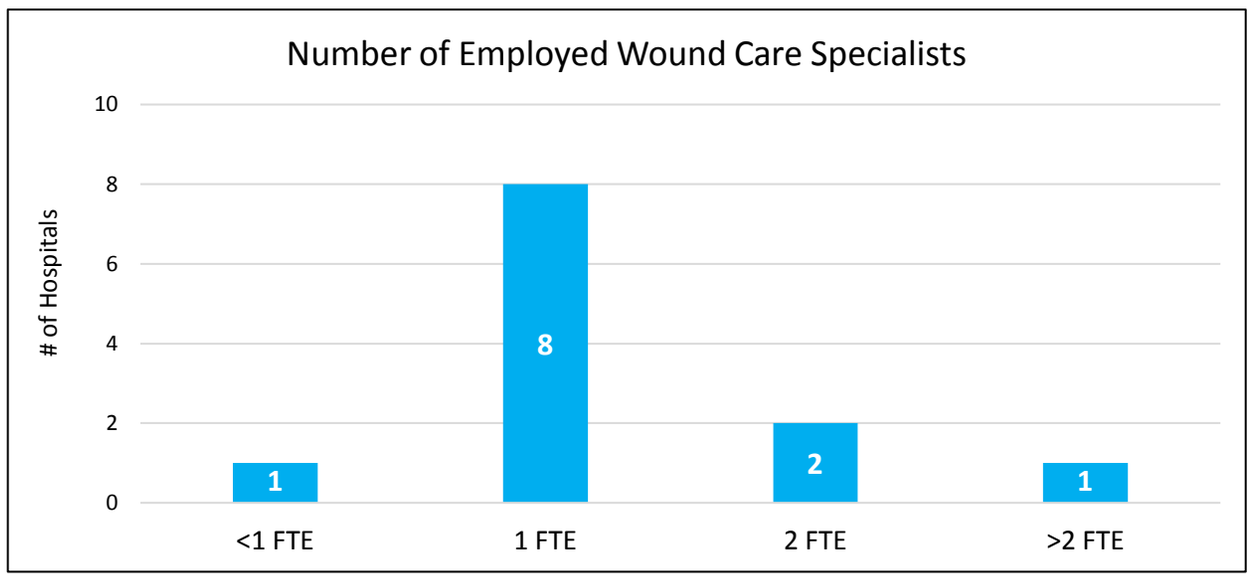
HAPU: Best Practice Survey Highlights

In their own words... Top three effective HAPU reduction strategies in the past 18 months from top performers.

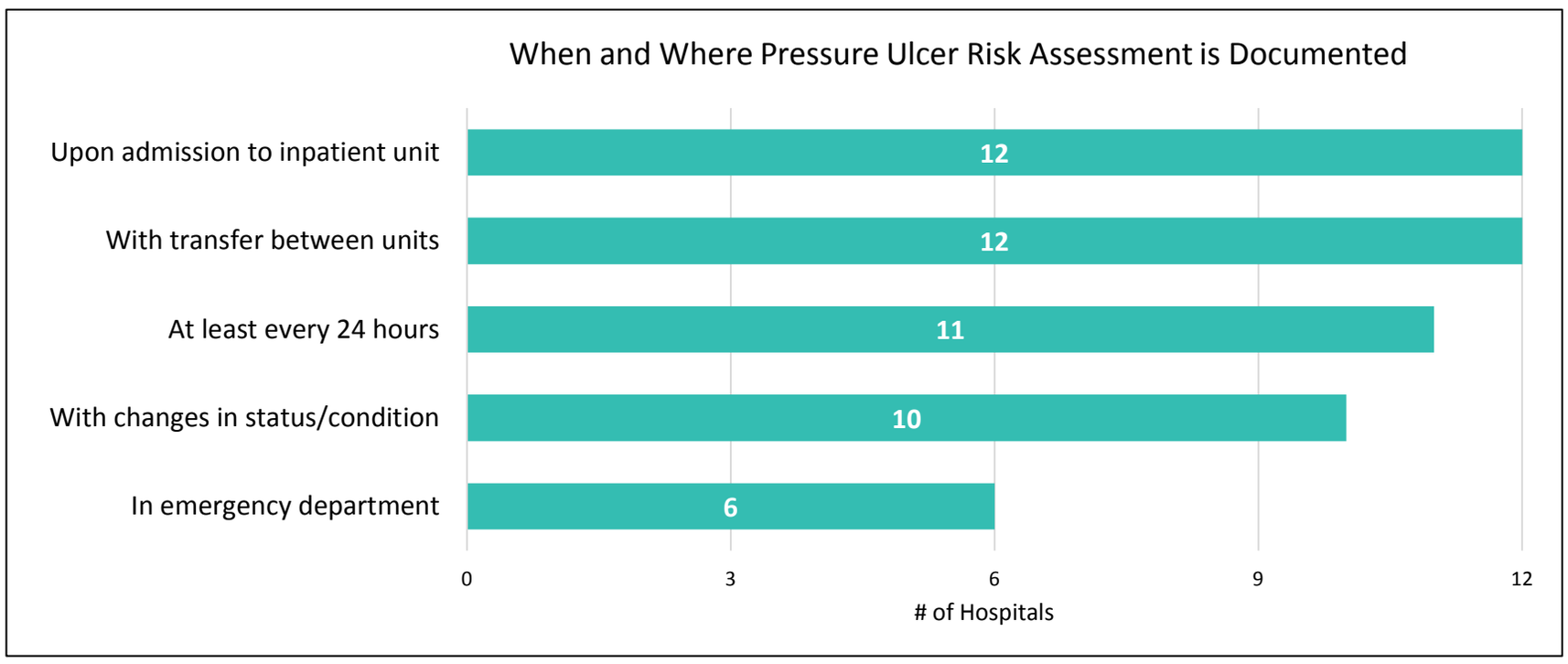
			Top Three Effective Strategies (Identified by the Hospital)		
	% Improvement	**Sparkline**	**#1**	**#2**	**#3**
Contra Costa Regional Medical Center	Maintained Zero		4 Eye Skin Assessments beginning in the ED for patients with a Braden Score of 18 or less	Every admission from the previous 24 hours is reviewed to make sure skin assessments were done. If PU found, interventions are initiated.	Intentional hourly rounding on patients at high risk for pressure ulcers
Alameda Health System - Highland Campus	-100		Education of MDs and RNs on a variety of topics	Implementation of a dedicated mobility (turn) team	Standardization of effective wound care products
Santa Clara Valley Medical Center	-100		Skin Care Champions responsible for education, classes, inservices, and competency day	HAPU Leadership Committee	PU Tracking Tool
Maricopa Integrated Health System	-100		Skin Champion Team with purpose to educate nursing units on Wound Ostomy Prevention	Turn Team with goal to identify high risk patients to routinely turn and do a skin and linen assessment every 2 hours	Ensuring patient/staff/family aware of risk through patient care notes printed prior to patient discharge

Notes: Performance based on AHRQ PSI-3 collected through UHC CDB/CDB-lite. The baseline is 2010 for all, except Contra Costa, which has a baseline of Q3'12 to Q2'13. The performance period is Q2'14 for all. Sparklines show trend over time from baseline to Q2'14.

With limited staffing... The majority surveyed have one or less full-time equivalent (FTE) certified wound care specialist.



Beyond once... Risk is assessed at numerous points of care and for half of those surveyed in the emergency department.



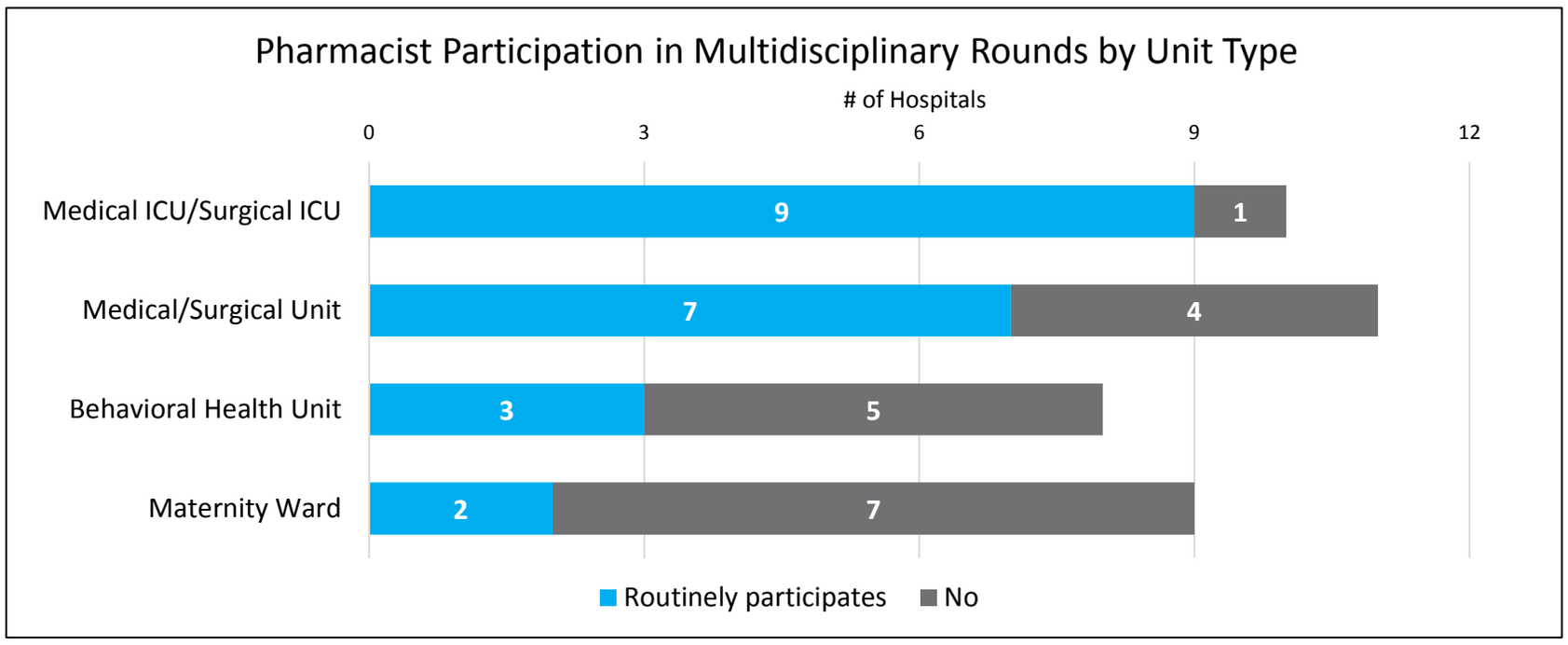
ADE: Best Practice Survey Highlights

In their own words... Top three effective ADE prevention strategies in the past 18 months from top performers.

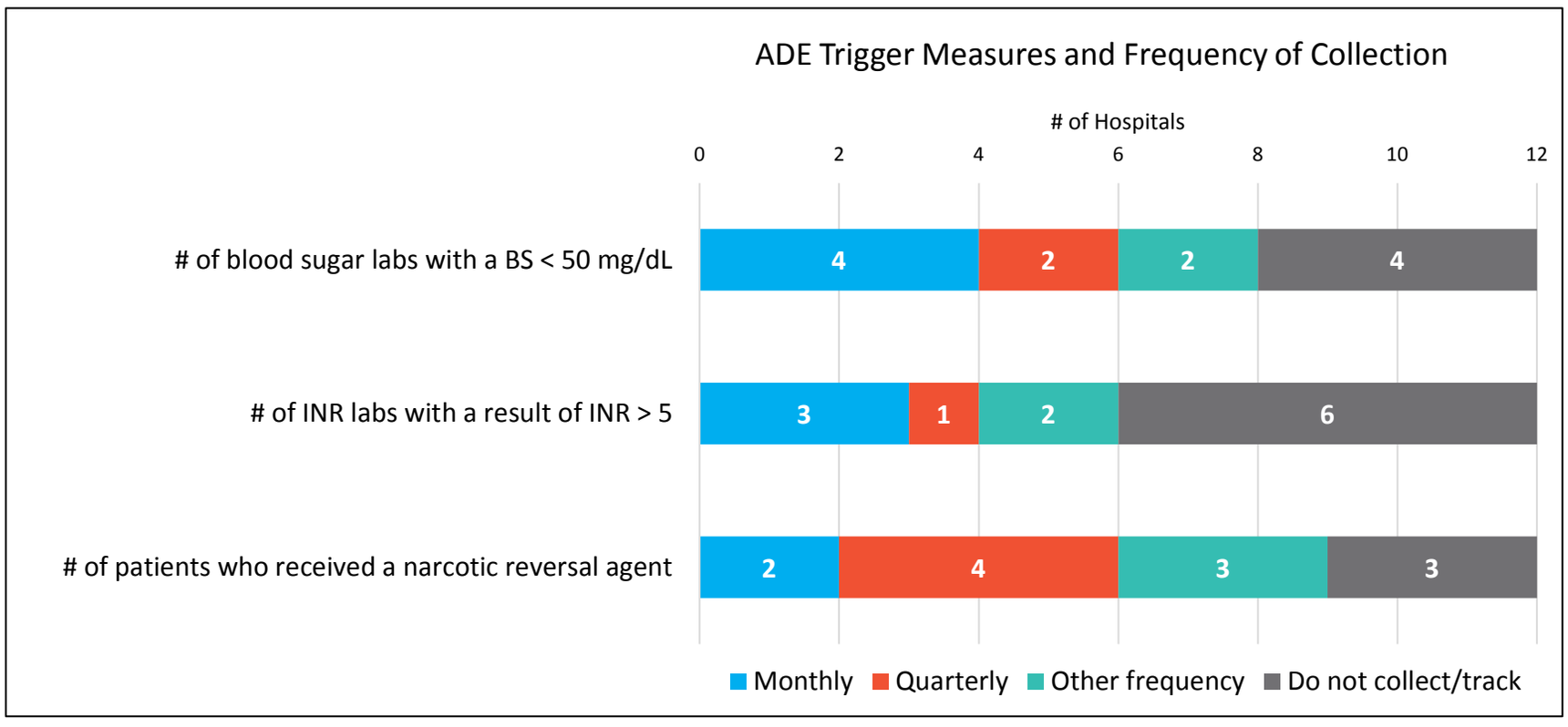
			Top Three Effective Strategies (Identified by the Hospital)		
	% Improvement	**Sparkline**	**#1**	**#2**	**#3**
San Francisco General Hospital and Trauma Center	-50		Implemented metric unit as standard measurement	Policy and procedure for safe use of fentanyl patches implemented	Electronic medication reconciliation module and ePDP/Discharge module implementation
Maricopa Integrated Health System	-28.8		Implemented pop-up alerts for any time certain medications are administered (e.g. reversal agents alert state "if in response to ADE enter report")	Started asking students/residents to query during round "any ADEs to report"	
Truman Medical Centers-Hospital Hill	-9.3		Lower doses of narcotics	Daily INR monitoring by pharmacy	Bar coding technology
MetroHealth System	0		Minimize choice of pain medication per pain range	Opioid conversion chart placed in EPIC as a resource	Double checks for high risk medications with a sign off in EPIC

Notes: Performance based on All ADE data received through the Web Portal. The baseline is the first six months of reported data, and the performance period for all is Q2'14. Sparklines show trend over time from baseline to Q2'14.

With regards to collaboration... Clinical pharmacists do not as routinely participate in multidisciplinary rounds in behavioral and maternity units compared to others.

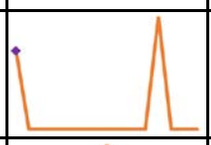


Because of data challenges... Only two hospitals collect and report all three ADE trigger measures on a monthly basis.



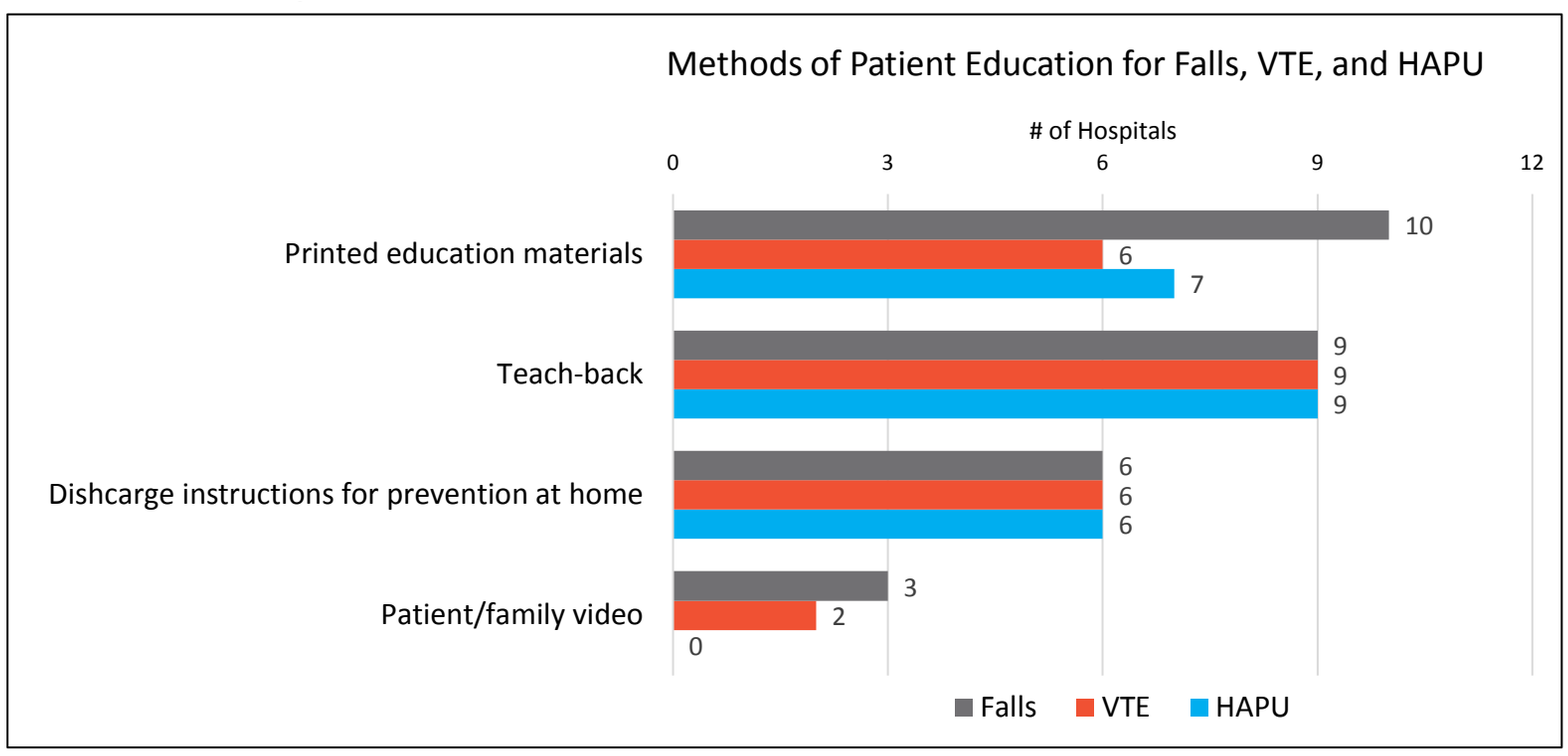
VTE: Best Practice Survey Highlights

In their own words... Top three effective VTE prevention strategies in the past 18 months from top performers.

			Top Three Effective Strategies (Identified by the Hospital)		
	% Improvement	Sparkline	#1	#2	#3
San Mateo Medical Center	-100		Mandatory documentation	Automatic orders	Communication at meetings
Contra Costa Regional Medical Center	-100		Tripling the number of available sequential compression devices for inpatients	Daily auditing for compliance of DVT prophylaxis	
Rancho Los Amigos National Rehabilitation Center	-27		Uniform admission order set	Appropriate prophylaxis option list	Part of admission sign outs

Notes: Performance based on modified AHRQ PSI-12 data gathered from UHC's CDB/CDB-lite. The baseline is 2010 for all, except Contra Costa, which has a Q3'12-Q2'13 baseline. The performance period for all is Q2'14. Sparklines show trend over time from baseline to Q2'14.

About educating patients and families... Printed materials, teach-back, and discharge instructions for prevention at home are as common for VTE as they are for HAPU and Falls.



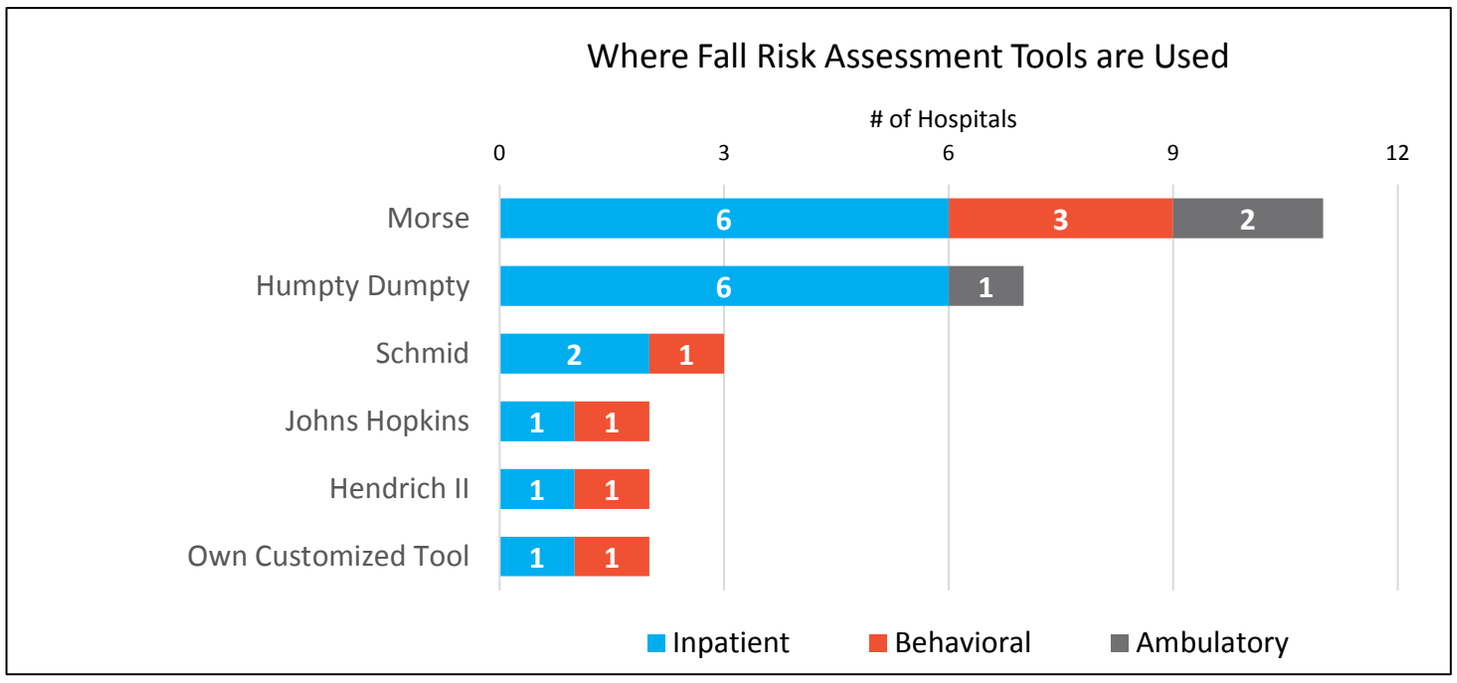
Falls: Best Practice Survey Highlights

In their own words... Top three effective Falls prevention strategies in the past 18 months from top performers.

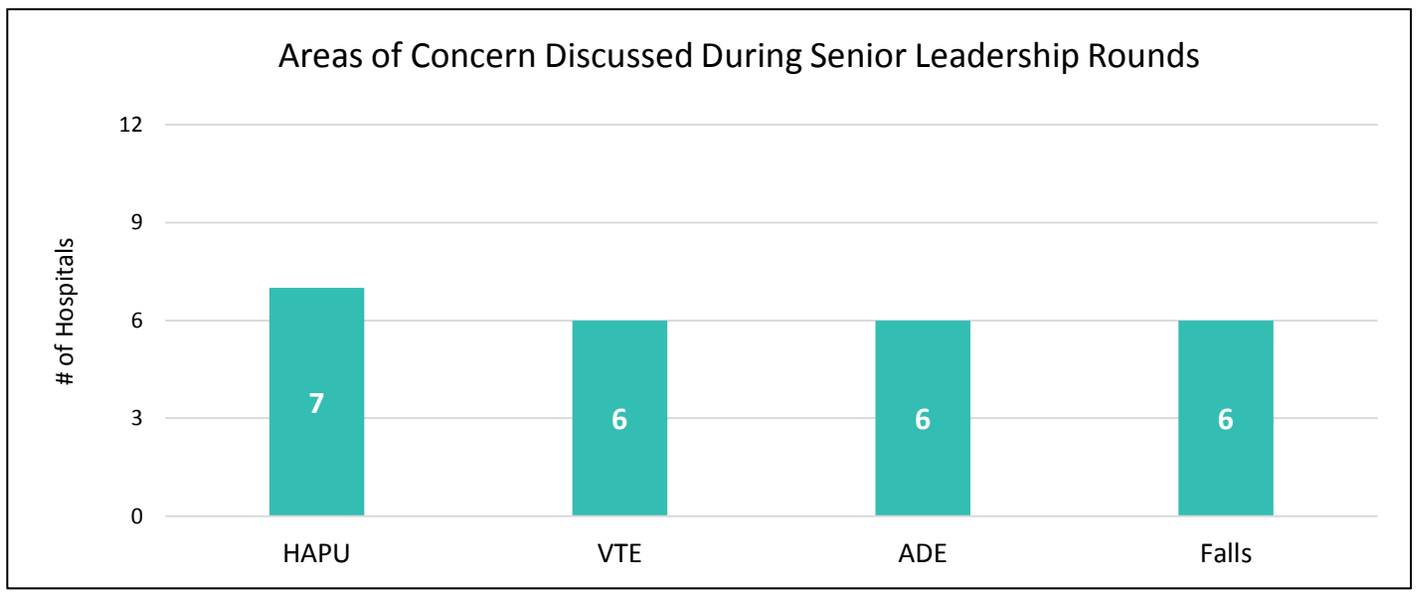
			Top Three Effective Strategies (Identified by the Hospital)		
	% Improvement	Sparkline	#1	#2	#3
Rancho Los Amigos National Rehabilitation Center	-16.3		The safe zone	Post fall huddle	Supervision while toileting
Harbor-UCLA Medical Center	-15.8		Hourly rounding	Fall debriefing after every fall	Quality & safety boards on each unit with that unit's total monthly falls and lessons learned
Regional One Health	-5		Rounding for the 3 P's (pain, position, and potty)	Utilizing patient sitters or encouraging family to stay	Obtaining bed alarms

Notes: Performance based on All Fall Rate data collected through the Web Portal. The baseline is six months of data, and the performance period is Q2'14 for all. Sparklines show trend over time from baseline to Q2'14.

Out of many risk assessment tools... Morse and Humpty Dumpty stand out as the most predominately used.



Of equal concern to leaders... Falls is discussed on senior leadership rounds as often as VTE, ADE, and HAPU.



Essential Hospitals Engagement Network (EHEN)

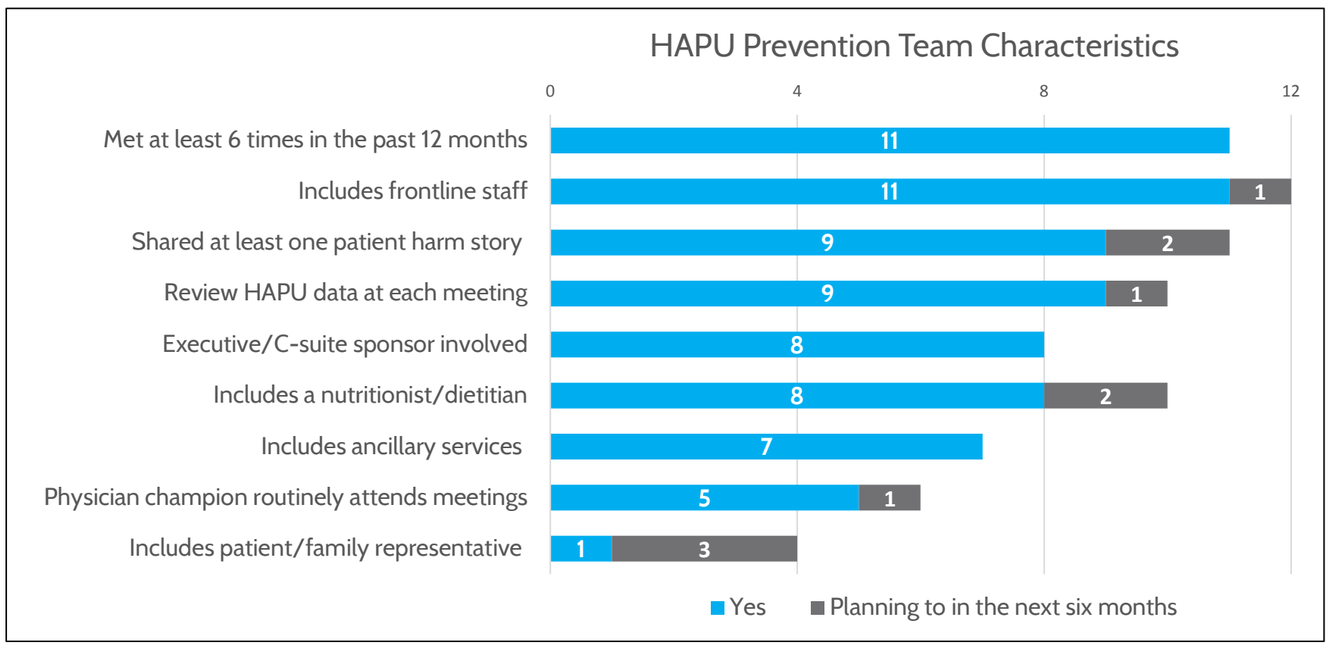
Best Practices Survey 2014 - Hospital-Acquired Pressure Ulcers (HAPU)

Red Numbers Represent Response (n=12)

1. **Does your facility have a multidisciplinary team (can be an existing committee/team) *actively* working on hospital-acquired pressure ulcer (HAPU) prevention?**

12 Yes
No (Go to Question 3)

2. **Please answer the following for your HAPU prevention team:**



3. **In the past two years, has your organization participated in a state/regional, national, grant-funded or hospitalwide HAPU prevention initiative?**

8 Yes
Name of the initiative: "PFP, EHEN, CALNOC, CALNOC, DSRIP"
4 No

4. **Do you report pressure ulcer data to any benchmarking organization?**

Organization:	Yes	No
NDNQI	**5**	**3**
CALNOC	**6**	**2**
Leapfrog	**3**	**5**

5. **How many certified wound care specialists does your hospital currently employ (number of FTEs)?**

Report .5 FTE	Report 1 FTE	Report 2 FTE	Report >2 FTE
1	**8**	**2**	**1**

6. Do you require and have a designated place to routinely document a skin assessment on patients? Check all that apply.

Practice:	Yes	No
Within six hours of admission to an inpatient unit	9	3
In the emergency department	8	3
At least every 24 hours	12	
With transfer between units	12	
Once per shift	11	1
In the operating room	10	2
In the recovery room	10	2
Return from special procedures (radiology, imaging, etc.)	6	6

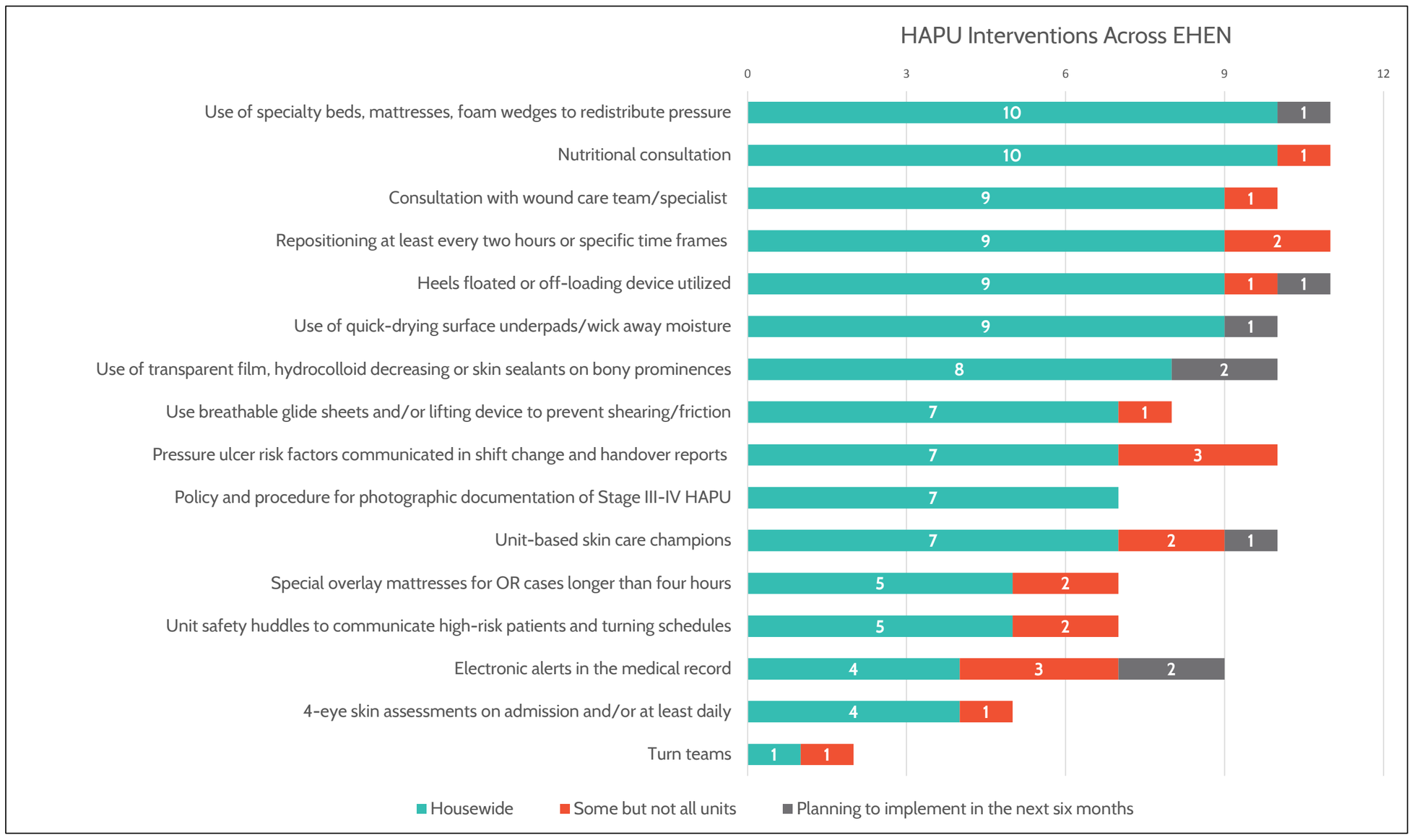
7. Which standardized pressure ulcer risk assessment tool do you use to determine which patients are more likely to develop a pressure ulcer? Check all that apply.

12	Braden
6	Braden Q
	Norton
	Waterlow
1	Hospital-developed tool
	Other:
	We don't use a standardized tool

8. If you use a standardized pressure ulcer risk assessment tool, does your hospital require and have a designated place to document pressure ulcer risk assessment in the medical record/EMR? Check all that apply.

Practice:		Yes	No	Plan to do within next six months
Upon admission to inpatient unit		12		
In emergency department		6	4	
At least every 24 hours		11	1	
With transfer between units		12		
With changes in status/condition		10	2	
Other:	"High risk for entire LOS"; "Every 3-4 hrs on some units"; "Upon transfer to another facility"	3		

9. Pressure ulcer prevention protocols are implemented based on a risk score. For patients assessed as being *at risk* , do you routinely and consistently activate the following interventions? Check all that apply.



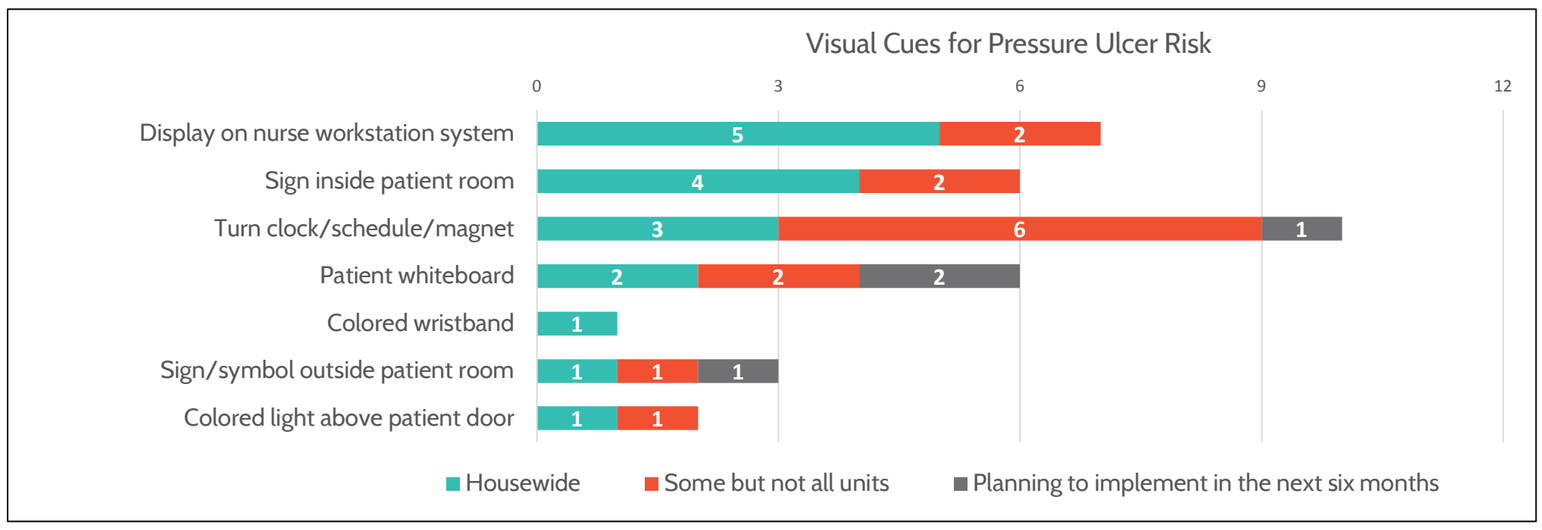
10. When do you complete a skin assessment and/or pressure ulcer risk assessment on surgical patients? Check all that apply.

10	On admission to the operating room
7	At discharge to the recovery room
7	Periodically in the OR for operations lasting more than four hours
8	At discharge to the inpatient unit/critical care unit
1	Other: "In PACU prior to going to OR"

11. Do you do a deep dive or root cause analysis to look for opportunities for improvement? Please check answer.

2	Yes, on all HAPU stage II or greater housewide
5	Yes, on all HAPU stage III, IV, and unstageable housewide
1	Only on HAPU, stage II or greater on selected units
1	Only on HAPU stage III, IV, and unstageable on selected units
2	We do not do RCA/in-depth reviews of HAPU

12. Which of the following visual cues do you use to communicate pressure ulcer risk to patients, families, and staff?



13. Do you complete device-related skin assessments at least every 24 hours?

Unit	Unit Does Not Exist in This Hospital	Device-related skin assessments are completed at least every 24 hours: Yes	Device-related skin assessments are completed at least every 24 hours: No
Medical unit(s)		10	
Surgical unit(s)		10	
Other (non-ICU) specialty units	1	9	
Medical intensive care units (MICU)	1	9	
Surgical intensive care units (SICU)	1	9	
NICU	3	7	
Emergency Department	1	6	3
Other: "Rehab"		1	

14. Is the development of new/hospital-acquired pressure ulcers included as an area of concern during senior leadership rounds?

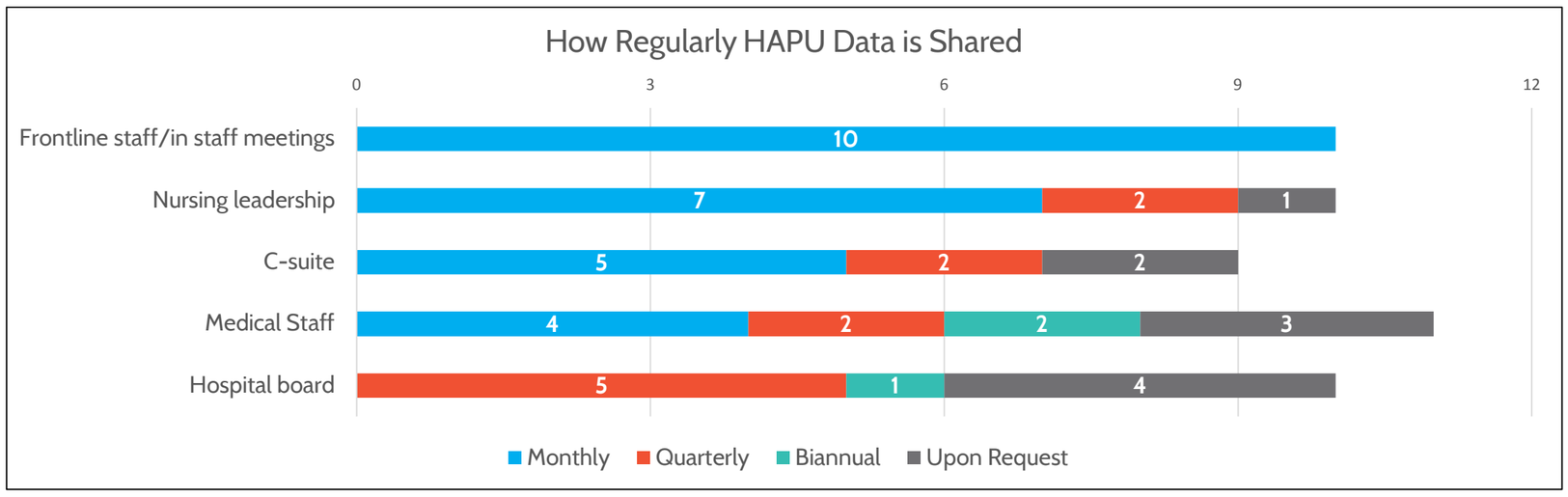
5	Yes
2	No
2	Yes, but only on some units
2	We do not do senior leadership rounds

15. Effectiveness is defined as the degree to which a tool or strategy produced the desired result or impact on the intended goal. Using this definition, please list the three top interventions/strategies for reducing HAPU you have implemented in the past 18 months

Section 8: Hospital-Acquired Pressure Ulcers (HAPU)

Return to Quick Link Navigation

16. How do you share data on hospital-acquired pressure ulcers on a regular basis to promote systemwide learning and transparency? Check the best answer for each.



17. Which methods do you use to display HAPU data in your hospital?

Method	ICU unit(s)		Medical/surgical unit(s)		Method not used
	Staff-only accessible areas	Public areas such as hallways	Staff-only accessible areas	Public areas such as hallways	
Run charts	3	4	4	3	4
Control charts	1	2	1	2	7
Bar graphs/pie charts	4	4	4	3	3
Harm counts	1	2	1	3	5
Days between HAPUs	1	1	1	2	5
Other: "Months since last HAPU"; "Line Graphs"	1	1	2	2	

18. How do you educate patients and families about the pressure ulcer risks and prevention measures? Please check all that apply.

- 7 Printed education materials
- 0 Patient/family video
- 9 Teach-back process
- 8 Designated place for and required documentation of pressure ulcer prevention education we provided to patients and family members
- 6 Discharge instructions include pressure ulcer prevention strategies at home
- 2 Other: "We encourage all patients to take their waffle mattresses/cushions home"; "WCOCN/Nurses provide patient education"

19. When do you provide education to nursing staff on HAPU prevention, such as how to perform, document, and communicate pressure ulcer risk assessment results? Check all that apply.

- 11 During new employee orientation
- 8 Annually
- 5 Other: "Depends on Unit need"; "Quarterly"; "Monthly"; "Skills fair and competencies"

Essential Hospitals Engagement Network (EHEN)

Best Practices Survey 2014 - Adverse Drug Events

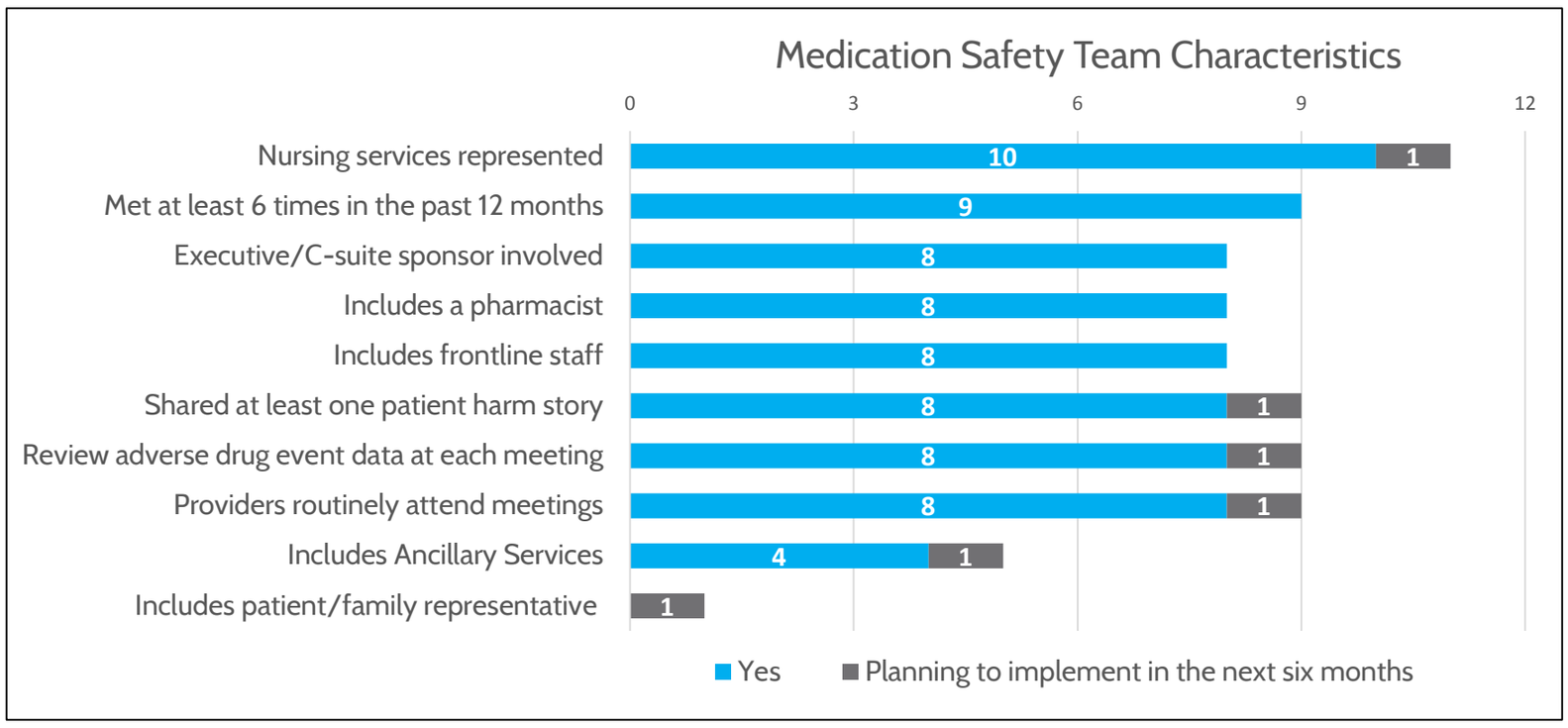
Red Numbers Represent Responses (n=12)

Section 5: Adverse Drug Events (ADE)

1. **Does your facility have a multidisciplinary team (can be an existing committee/team) *actively* working to address medication safety?**

10	Yes
2	No (Go to Question 3)

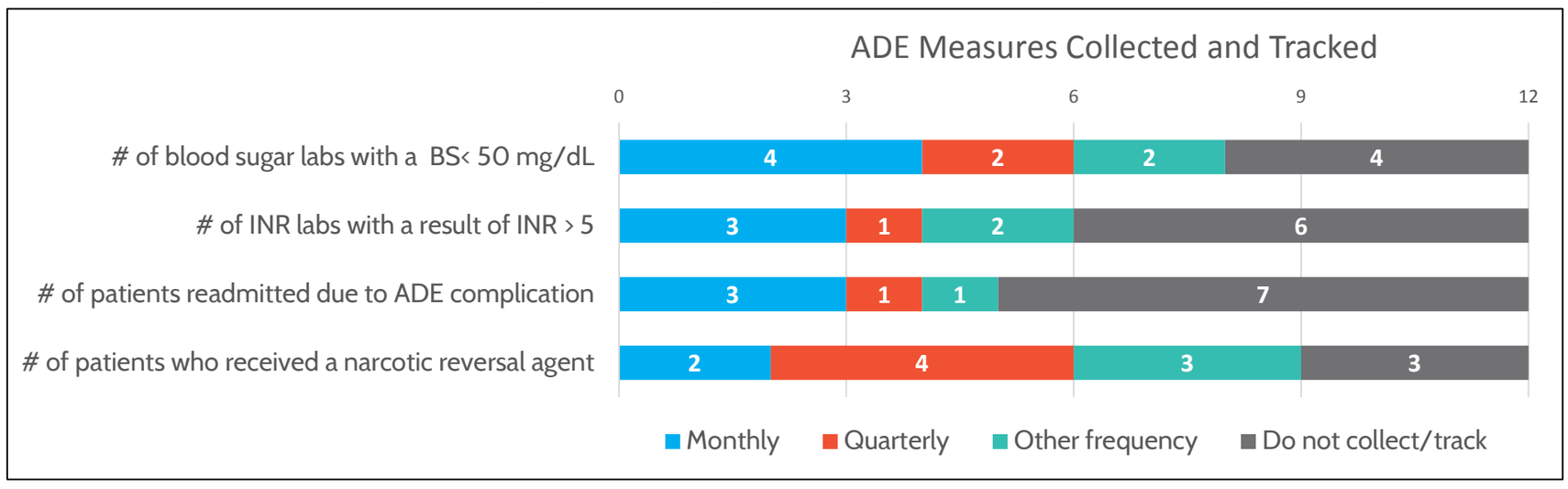
2. **Please answer the following for your medication safety team:**



3. **In the past two years, has your organization participated in a state/regional, national, grant-funded or hospitalwide medication safety initiative?**

8	Yes
	Name of the initiative:
3	No

4. **Our hospital collects and tracks data on the following adverse drug events on a routine basis. Check all that apply.**

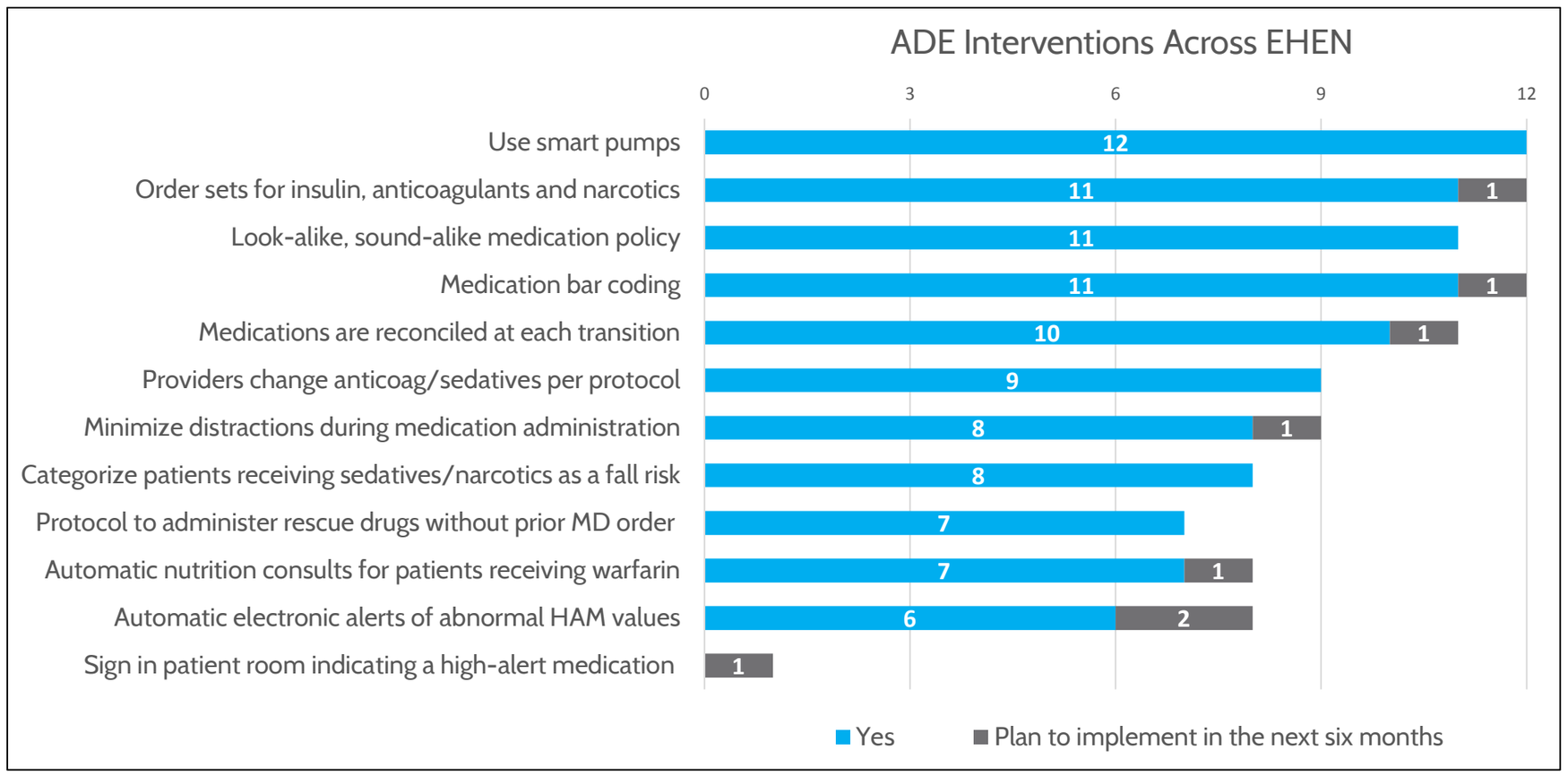


5. **Do you do a deep dive or root cause analysis to look for opportunities for improvement? Please check answer.**

4	Yes, on all adverse drug events, housewide
7	Only on selected adverse drug events, housewide
1	Only on selected adverse drug events on specific units
	We do not do RCA/in-depth reviews of ADEs

Section 5: Adverse Drug Events (ADE)

6. High-alert medications (HAMs) are associated with harm. Our hospital has implemented the following practices to prevent HAM-related ADEs.



7. Our hospital uses the following methods to enhance organizational awareness of adverse drug events: (check all that apply)

- 8 The Institute for Safe Medication Practices (ISMP) Medication Safety Self-Assessment at least annually
- 6 Medication trigger tool
- 10 Reports for medication errors/near misses
- Other:

8. For each unit, please indicate if a clinical pharmacist routinely participates in multidisciplinary rounds:

		Clinical pharmacist participates in rounds		
Unit	**Unit does not exist in this hospital**	**Yes**		**No**
Behavioral health (substance abuse, mental health, psychiatric)	3	3		5
Medical unit(s)		7		4
Surgical unit(s)		5		6
Other (non-ICU) specialty units	2	6		2
Medical intensive care units (MICU)	1	9		1
Surgical intensive care units (SICU)	2	8		1
Maternity ward(s)	1	2		7
Other: Stroger-NICU, Contra Costa-Palliative Care rounds		3		1

Section 5: Adverse Drug Events (ADE)

9. Our hospital uses the following strategies to prevent *Clostridium difficile* (CDI):

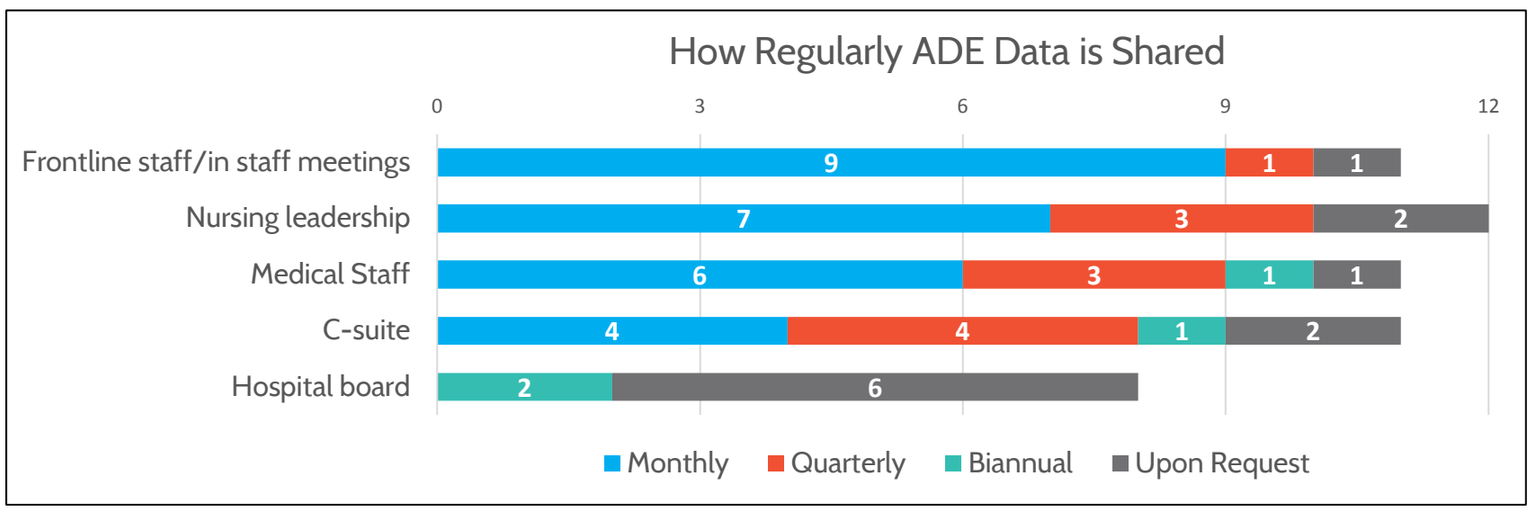
Interventions	Yes	No	Planning to implement in the next six months	Intervention not used; no plans to implement
Nurses are trained to recognize signs/symptoms of CDI	8		1	
Contact precautions implemented	9			
Antibiotic stewardship for CDI	10			
Chlorine-containing or other sporicidal product/technology is used for daily	6		1	
Hand hygiene, gloves, and gown required for all health care workers and visitors entering room	9			
Use dedicated equipment for CDI patients	5	1		
Nursing and environmental services staffs receive regular training on appropriate disinfection and cleaning techniques for CDI	7	1		
Private room for CDI patient or cohorting if private room unavailable	8			
Review all cases of CDI for improvement	4	1		1
Electronic alerts in the medical record	2	3	1	
CDI included in nurse shift handoff	7			
Patient and family education is provided on CDI	6			

10. Is harm from adverse drug events included as an area of concern during senior leadership rounds?

- 6 Yes
- 2 No
- 4 We do not do senior leadership rounds

11. Effectiveness is defined as the degree to which a tool or strategy produced the desired result or impact on the intended goal. Using this definition, please list the three most effective interventions/strategies for reducing adverse drug events you have implemented in the past 18 months.

12. ADE data are shared on a regular basis to promote systemwide learning and transparency. Select the best answer for each.



13. How do you educate patients and families about potential adverse drug events? Check all that apply.

- 10 Printed education materials
- 2 Patient/family video
- 6 Teach-back process
- 5 We have a designated place for and required documentation of ADE education we provide to patients and family members

Section 5: Adverse Drug Events (ADE)

14. When do you provide education to health care personnel on ADEs for high-alert medications? Check all that apply.

12	During new employee orientation
6	During new physician/resident orientation
3	Annually
9	When new relevant information is available
	Other:

Essential Hospitals Engagement Network (EHEN)

Best Practices Survey 2014 - Venous Thromboembolism

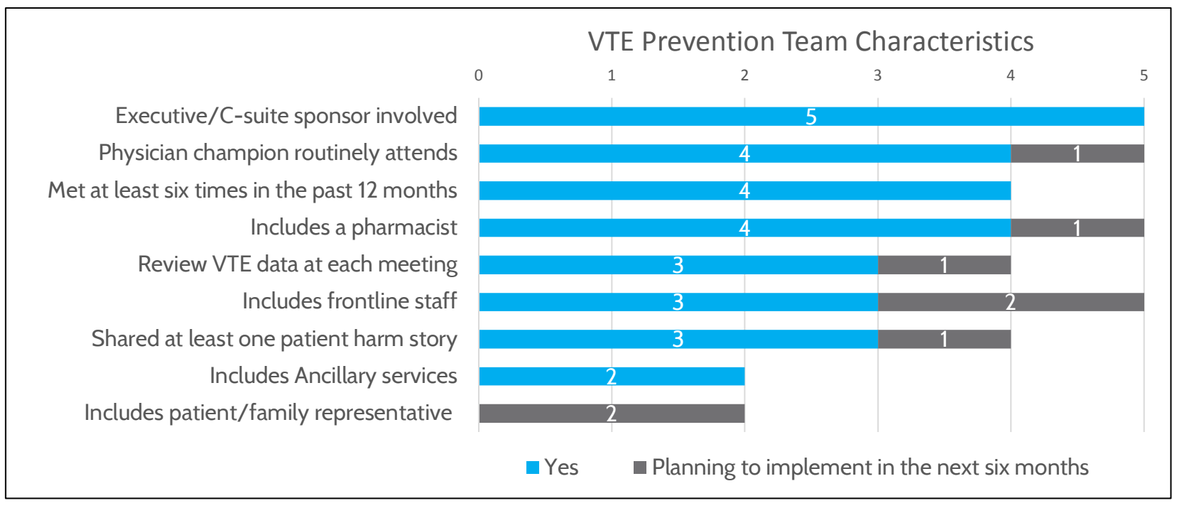
Red Numbers Represent Responses (n=12)

Section 7: Venous Thromboembolism (VTE)

1. Does your facility have a multidisciplinary team (can be an existing committee/team) *actively* working on hospital-acquired venous thromboembolism (VTE) prevention?

5	Yes
6	No (Go to Question 3)

2. Please answer the following for your VTE prevention team:



3. In the past two years, has your organization participated in a state/regional, national, grant-funded or hospitalwide VTE prevention initiative?

4	Yes, name of initiative: "DSRIP"
6	No

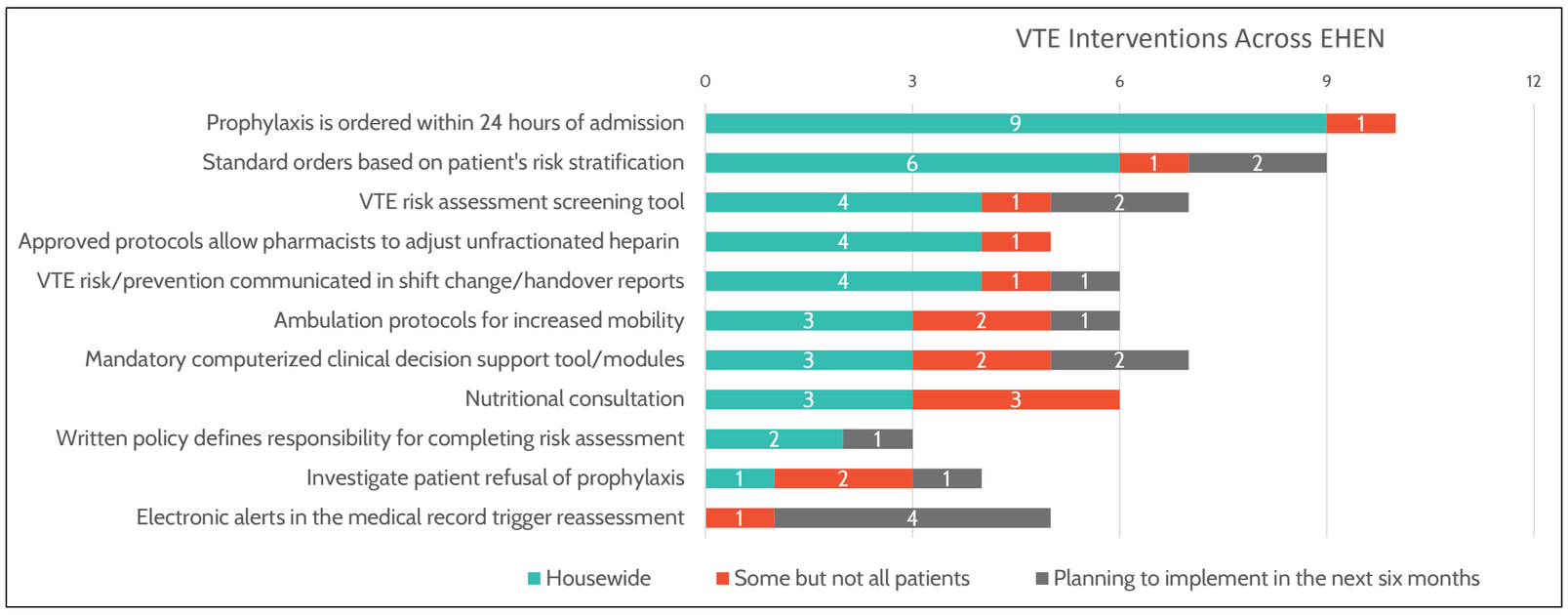
4. Do you require and have a designated place in the medical record to routinely document a VTE risk assessment?

Practice	All Adult Patients	Only Service-Specific Patients	No
Upon hospital admission	**6**	**1**	**3**
At change in level of care	**4**		**6**
Re-assessed within 24 hours of admission	**3**		**7**
Post-surgical procedures	**4**	**1**	**5**

5. Our VTE protocol includes the following: Check all that apply

7	A standardized risk assessment
8	Menu of appropriate pharmacologic prophylaxis options based on risk
7	Method to determine contraindications to pharmacologic VTE prophylaxis
10	Mechanical prophylaxis options
	Other:
	We do not have a VTE protocol

6. Interventions aimed at preventing hospital-acquired VTE are routinely and consistently activated. Select the best response for each intervention.



7. Does VTE prophylaxis begin in the Emergency Department for boarded patients awaiting bed placement?

5	Yes
3	No
1	Working to implement within the next six months

Section 7: Venous Thromboembolism (VTE)

8. Do you do a deep dive or root cause analysis to look for opportunities for improvement?

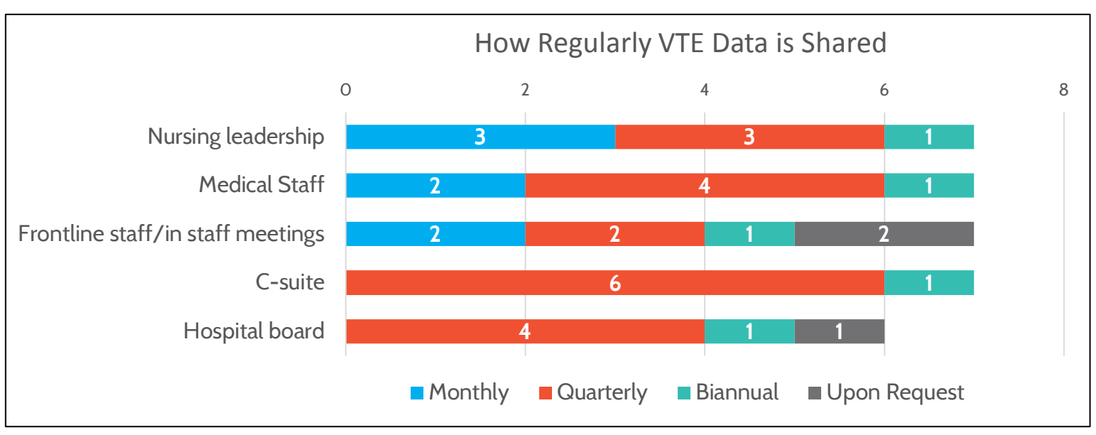
3	Yes, on all hospital-acquired VTEs, housewide
4	Only on targeted post-surgical cases
1	We do not do RCA/in-depth reviews of VTE

9. Is the development of hospital-acquired VTE included as an area of concern during senior leadership rounds?

2	Yes, all units
4	Yes, but only on some units
	No
3	We do not do senior leadership rounds

10. Effectiveness is defined as the degree to which a tool or strategy produced the desired result or impact on the intended goal. Using this definition, please list the three most effective interventions/strategies for reducing hospital-acquired VTE you have implemented in the past 18 months.

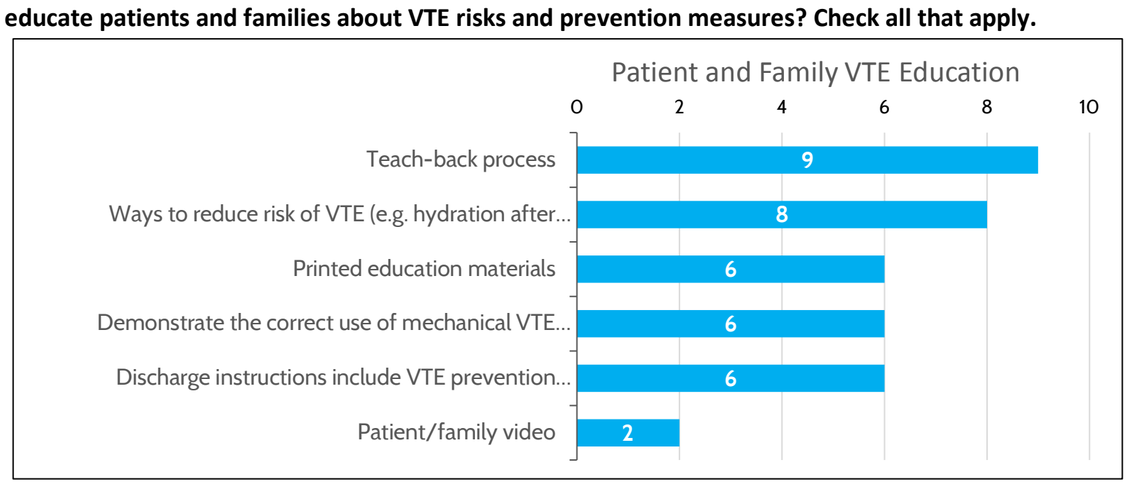
11. How do you share data on hospital-acquired VTE on a regular basis to promote systemwide learning and transparency? Select the best answer for each.



12. Which methods do you use to display VTE data in your hospital? Select all that apply.

Method	ICU unit(s)		Medical/surgical unit(s)		Method not used
	Staff-only accessible areas	Public areas (e.g. hallways)	Staff-only accessible areas	Public areas (e.g. hallways)	
Run charts	1		1		5
Control charts					7
Bar graphs/pie charts	1		1		7
Harm counts		2		2	5
Days between falls					5
Other: Regional One- Chart that is a daily drill down on all patients receiveing heparin; data includes bolus information and rate changes	1		1		

13. How do you educate patients and families about VTE risks and prevention measures? Check all that apply.



14. When do you provide education to nursing staff on VTE prevention? Check all that apply.

7	During new employee orientation
3	Annually
3	Other: "As needed"; "Unit council meetings"

Essential Hospitals Engagement Network (EHEN)

Best Practices Survey 2014 - Falls

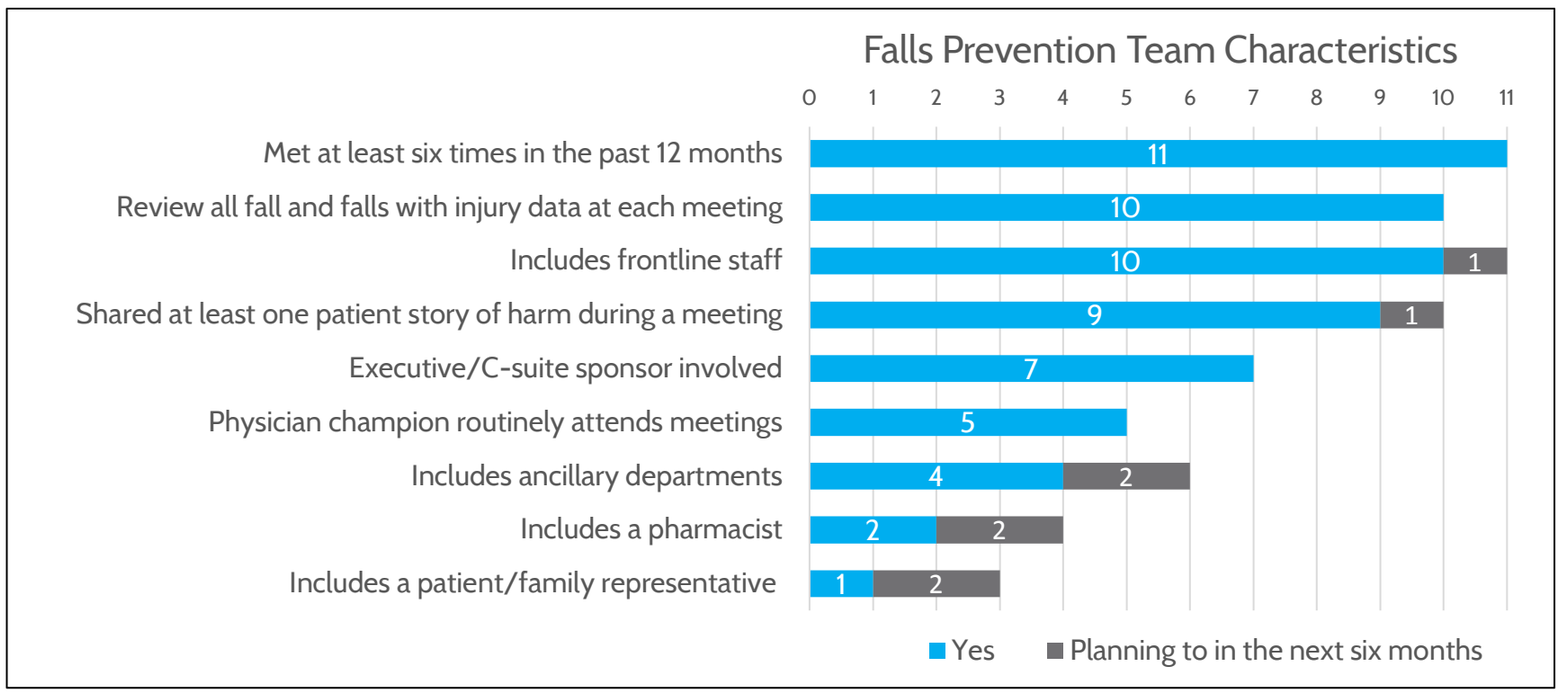
Red Numbers Represent Responses (n=12)

Section 6: Falls

1. Does your facility have a multidisciplinary team (can be an existing committee/team) *actively* working on falls prevention?

11	Yes
1	No (Go to Question 3)

2. Please answer the following for your falls prevention team:



3. Do you report falls/falls with injury data to any benchmarking organization?

Organization:	All Falls	Falls with Injury
NDNQI	**6**	**4**
CALNOC	**4**	**2**
Other	**2**	**2**

4. In the past two years, has your organization participated in a state/regional, national, grant-funded or hospitalwide falls prevention initiative?

8	Yes
	Name of the initiative:
4	No

5. Which standardized falls risk assessment tool do you use in your organization?

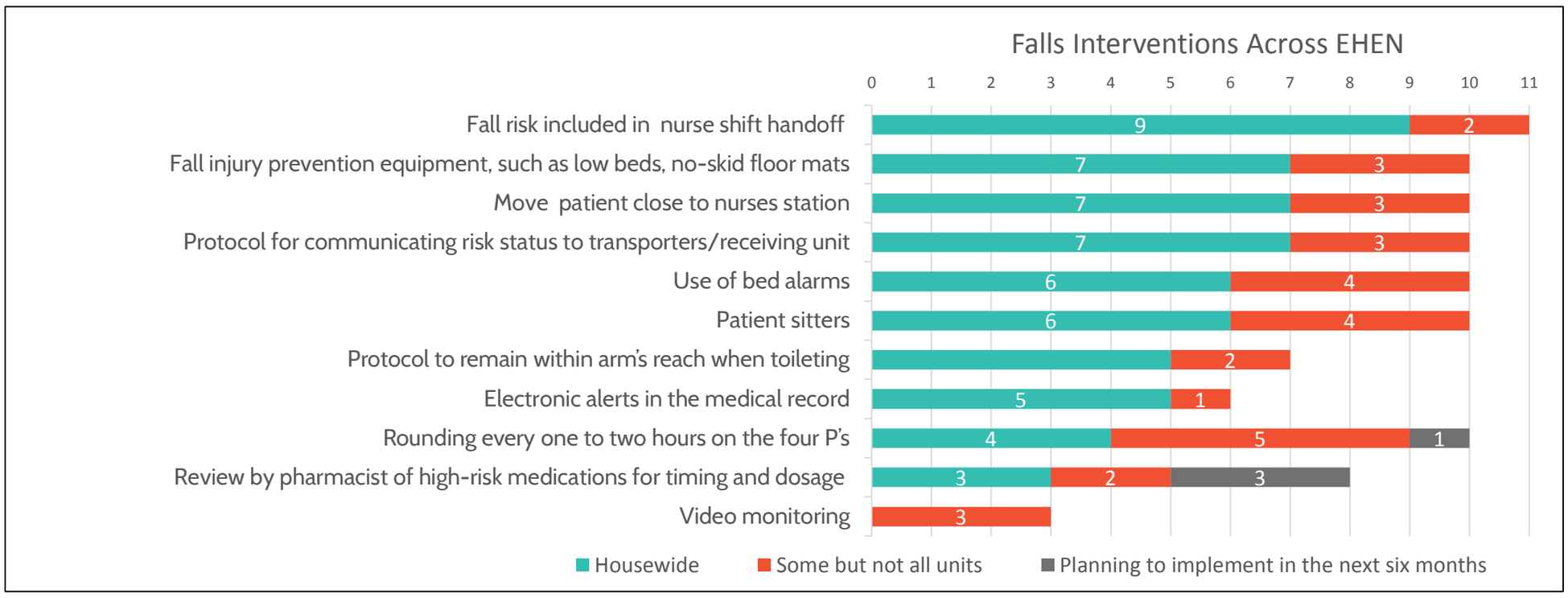
	Location Type		
Fall Risk Assessment	**Inpatient Units**	**Ambulatory Settings**	**Behavioral Health**
Morse	**6**	**2**	**3**
Hendrich II	**1**		**1**
Schmid	**2**		**1**
Get Up and Go/Timed			
STRATIFY			
Johns Hopkins	**1**		**1**
Humpty Dumpty	**6**	**1**	
Our own customized tool	**1**		**1**
Other: Regional One-"Modified Morse Scale"	**1**	**2**	

Section 6: Falls

6. Do you require and have a designated place to document screening/rescreening of patient fall risk?

Practice:	Yes	No
Upon admission to an inpatient unit	11	
In the emergency department	8	1
At least every 24 hours	10	1
With transfer between units	11	
With changes in status/condition (e.g. post-procedure, high-risk medication changes)	11	
Post-fall	11	

7. For patients assessed as high-risk for falls, do you routinely and consistently activate the following interventions? Check all that apply.



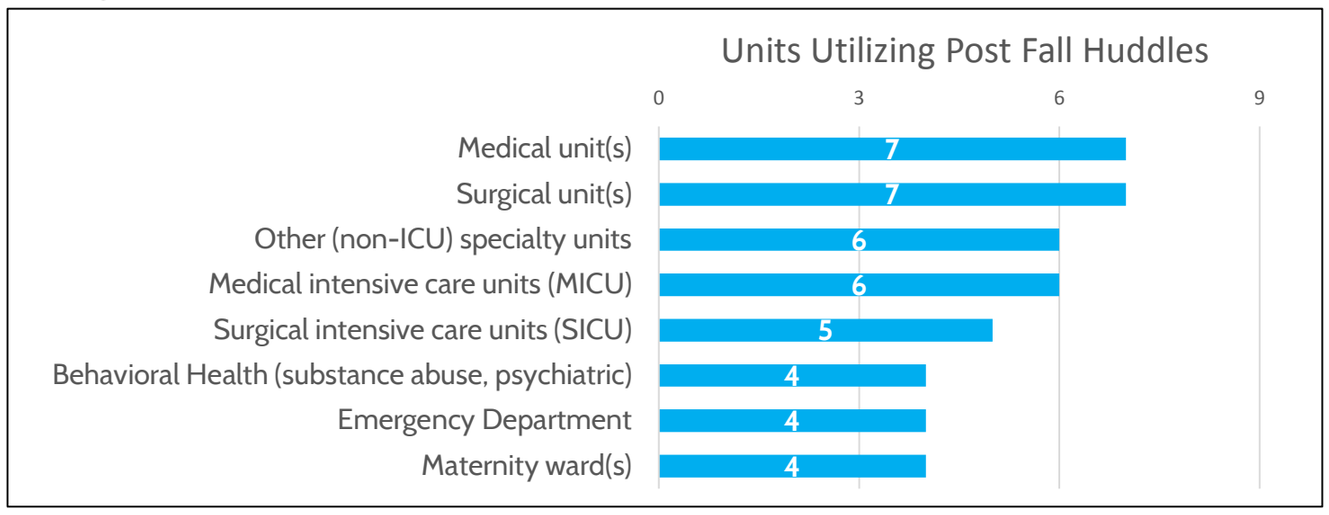
8. Do you do a deep dive or root cause analysis to look for opportunities for improvement? Please check answer.

3	Yes, on all falls housewide
2	Only falls on selected units
2	Only falls with injury, housewide
3	Only falls with injury, on selected units
1	We do not do RCA/in-depth reviews of falls

9. Do you have a process in place to conduct a post-fall safety huddle after a fall occurs?

8	Yes, all falls
1	Yes, but only falls with injury
	Plan to implement in the next six months
2	No

10. If you answered yes for all falls or only falls with injury on Question 9, for each unit please indicate if post-fall huddles occur immediately after an event:



Section 6: Falls

11. Which visual cues do you use to communicate falls risk to patients, families, and staff?

Visual cue	Housewide	Some but not all units	Planning to implement in the next 6 months	Intervention not used; no plans to implement
Wristband	6	3		1
Colored socks	3	1		6
Sign outside patient room (e.g. falling star)	9			2
Sign inside patient room	8	2		1
Colored gown		2		8
Display on nurse workstation system	2	1	1	6
Colored light above patient door	1	1		8
Other:				

12. Is harm from falls included as an area of concern during senior leadership rounds?

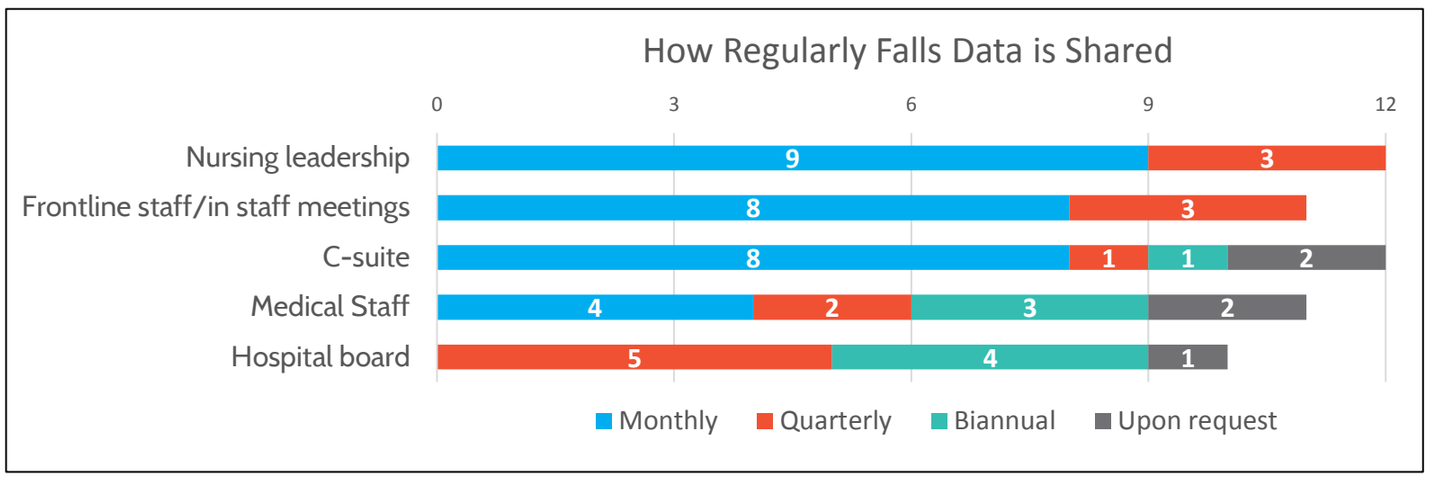
6	Yes
2	No
	Yes, but only on some units
3	We do not do senior leadership rounds

13. Has your hospital implemented a "No Pass Zone" initiative, where all employees are expected to respond to patient call lights?

1	Yes
1	Plans are in place to implement in the next six months
9	No

14. Effectiveness is defined as the degree to which a tool or strategy produced the desired result or impact on the intended goal. Using this definition, please list the three most effective interventions/strategies for reducing falls/falls with injury you have implemented in the past 18 months.

15. How do you share data on falls/falls with injury on a regular basis to promote systemwide learning and transparency? Select the best answer for each.

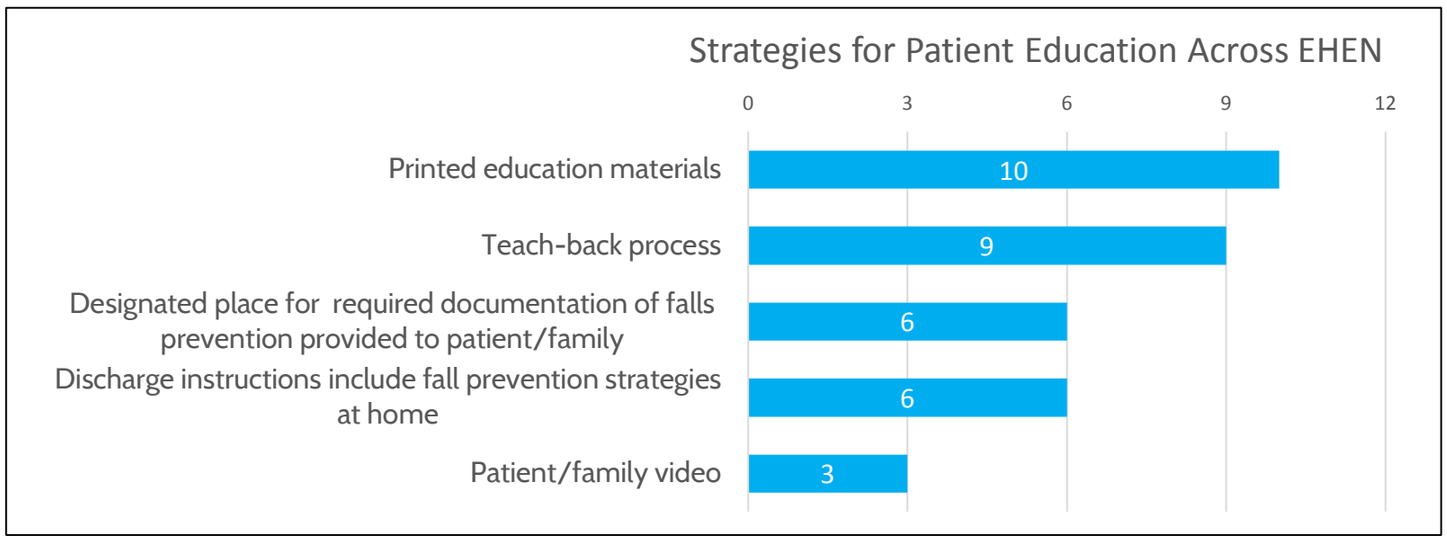


16. Which methods are used to display falls or falls with injury data in your hospital? Check all that apply.

Method	ICU unit(s)		Medical/surgical unit(s)		Method not used
	Staff-only accessible areas	Public areas (e.g. hallways)	Staff-only accessible areas	Public areas (e.g. hallways)	
Run charts	2	3	3	3	5
Control charts	1	2	1	2	6
Bar graphs/pie charts	2	1	2	2	2
Harm counts	2	5	1	4	3
Days between falls	1	3	1	2	4
Other:	1	2	1	2	

Section 6: Falls

17. How do you educate patients and families about fall risks and prevention measures? Please check all that apply.



18. When do you provide education to nursing staff on falls prevention, such as on how to perform, document, and communicate fall risk assessments results? Check all that apply.

12 During new employee orientation
7 Annually
5 Other: Rancho Los Amigos-"DHS and Orientation manual, hospital wide inservice education"
Maricopa-"During unit huddle when implementing some of the new interventions"
Harbor UCLA-"Skills Fair, DHS competencies"
Truman Medical Centers-"skills verification"
San Mateo-"Staff meetings and inservices"

Essential Hospitals Engagement Network (EHEN)
2014 Best Practice Survey: Highlights and Responses

Adverse OB & Early Elective Deliveries (EED)

Background

- In May 2014, EHEN asked its hospitals to complete a survey of the interventions and practices they have implemented or plan to implement as part of their quality improvement efforts.
- Response rate: 10 of 17 hospitals with OB services responded (59 percent).

Report Information

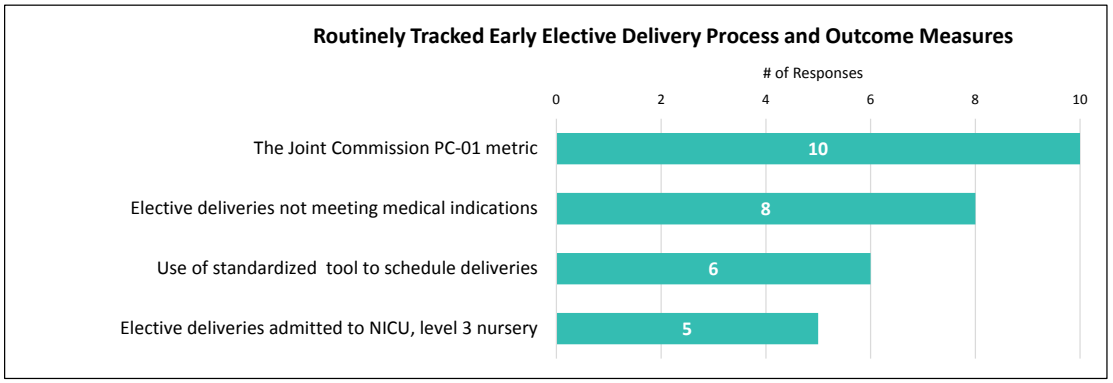
- This report is not intended to recommend any one intervention or practice, nor is it intended to prove causation between interventions and outcomes.
- Hospitals were not necessarily able to answer every question.
- The highlight section provides comparisons between conditions and associations with relevant outcome data. The outcome data was collected though UHC's Web Data Entry Portal. The remainder of the report is a full breakdown of responses to each question from the survey.
- For questions, please contact your improvement coach or e-mail EHEN@essentialhospitals.org.

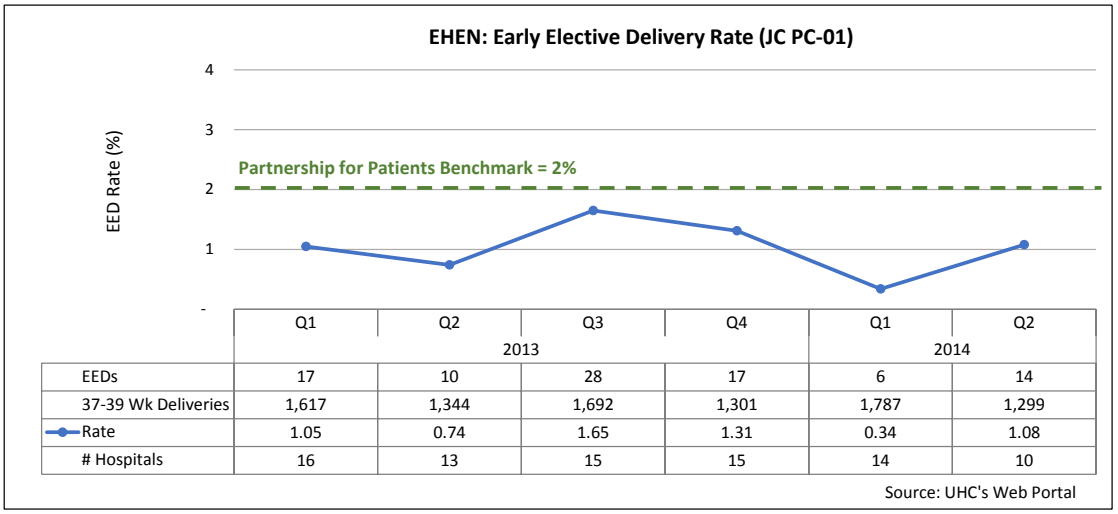
Adverse OB: Best Practice Survey Highlights

In their own words... Top three effective strategies for assessing and managing hypertensive emergencies.

	Top Three Effective Strategies (Identified by the Hospital)		
	#1	**#2**	**#3**
Maricopa Integrated Health System	Development of a protocol to standardize treatment of several elevated blood pressures (aligned with ACOG guidelines)	OB skills fair in March, 2013, and continuing education regarding preeclampsia in October 2013	Provider Ascom phones, specifically to use for hypertensive crisis or hemorrhage
MetroHealth System	Resident didactics	Maternal fetal medicine (MFM) covering L&D	MFM on back-up call for nights and weekends
Regional One Health	Skills fairs for both MD's and RN's	Twice daily huddles attended by entire Women's Services staff (consistently since 2008)	Patient Safety Rounds held every shift with MD's, RN's, Safety RN, and Charge RN
Santa Clara Valley Medical Center	Revised EHR order sets	Increased staff education (RN & MD) via Grand Rounds and materials	

In regard to early elective deliveries... Hospitals in large part took up the challenge by the Partnership for Patients to reduce early elective deliveries (EED) by making it a priority and tracking their processes.





	Q1	Q2	Q3	Q4	Q1	Q2
	2013				2014	
EEDs	17	10	28	17	6	14
37-39 Wk Deliveries	1,617	1,344	1,692	1,301	1,787	1,299
Rate	1.05	0.74	1.65	1.31	0.34	1.08
# Hospitals	16	13	15	15	14	10

Source: UHC's Web Portal

Essential Hospitals Engagement Network (EHEN)

Best Practices Survey 2014 - Adverse OB Events/Early Elective Deliveries

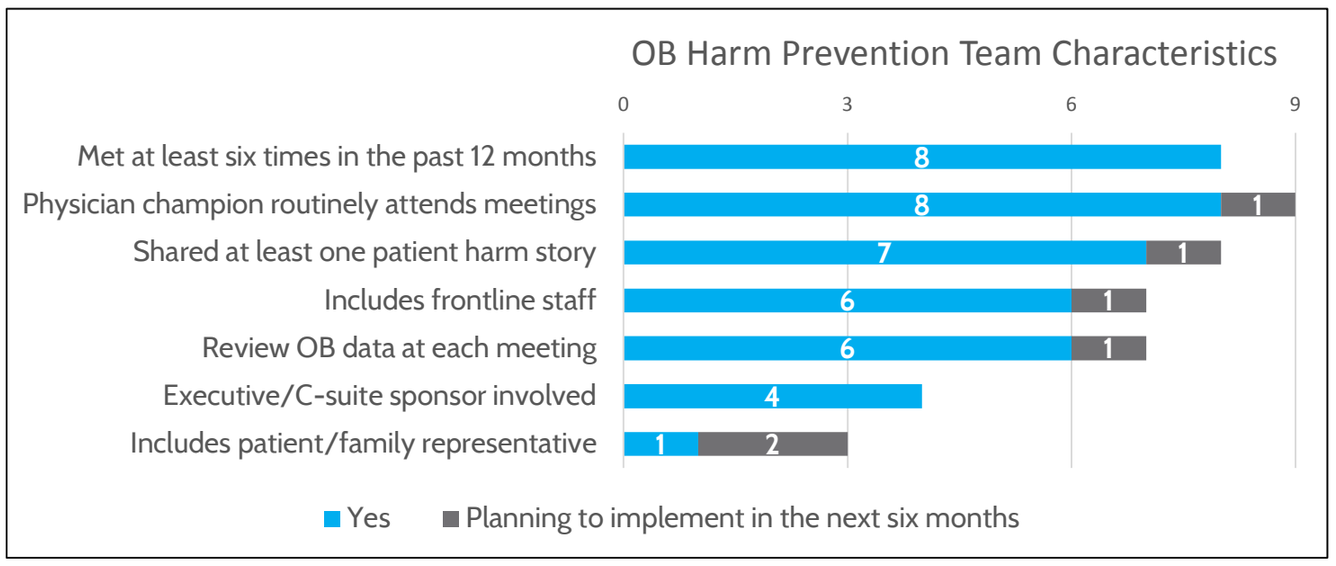
Red Numbers Represent Responses (n=10; Excludes hospitals with no OB services)

Adverse OB Events/EED

1. **Does your facility have a multidisciplinary committee/team (can be an existing committee/team) *actively* working on improving safety and reducing harm from OB/perinatal adverse events?**

9	Yes
0	No (Go to Question 3)

2. **Please answer the following for your OB/perinatal committee/team:**



3. **Which events are your OB/perinatal committee/team actively working to reduce/routinely monitor? Please check all that apply.**

8	Elective deliveries between 37 and 39 weeks gestation/PC-01
9	C-section rates/PC-02
8	Episiotomy rates
9	Maternal hemorrhage
8	Hypertensive emergencies
6	Newborn birth trauma
2	Other: Santa Clara- Maternal Length of Stay

Questions 4-8 pertain to elective deliveries <39/0 weeks gestation

4. **In the past two years, has your organization participated in a state/regional, national, grant-funded or systemwide initiative to reduce elective deliveries < 39 weeks?**

6	Yes, name of the initiative:
3	No

5. **Is reducing elective deliveries a current organizational priority? Check all that apply.**

6	Part of our organizational strategic plan
5	A metric (event count or rate) is included on our senior leadership and/or board reports
9	Part of our quality improvement committee metrics
1	No, not at this time

6. **For process and outcome data related to elective deliveries, does your organization routinely track:**

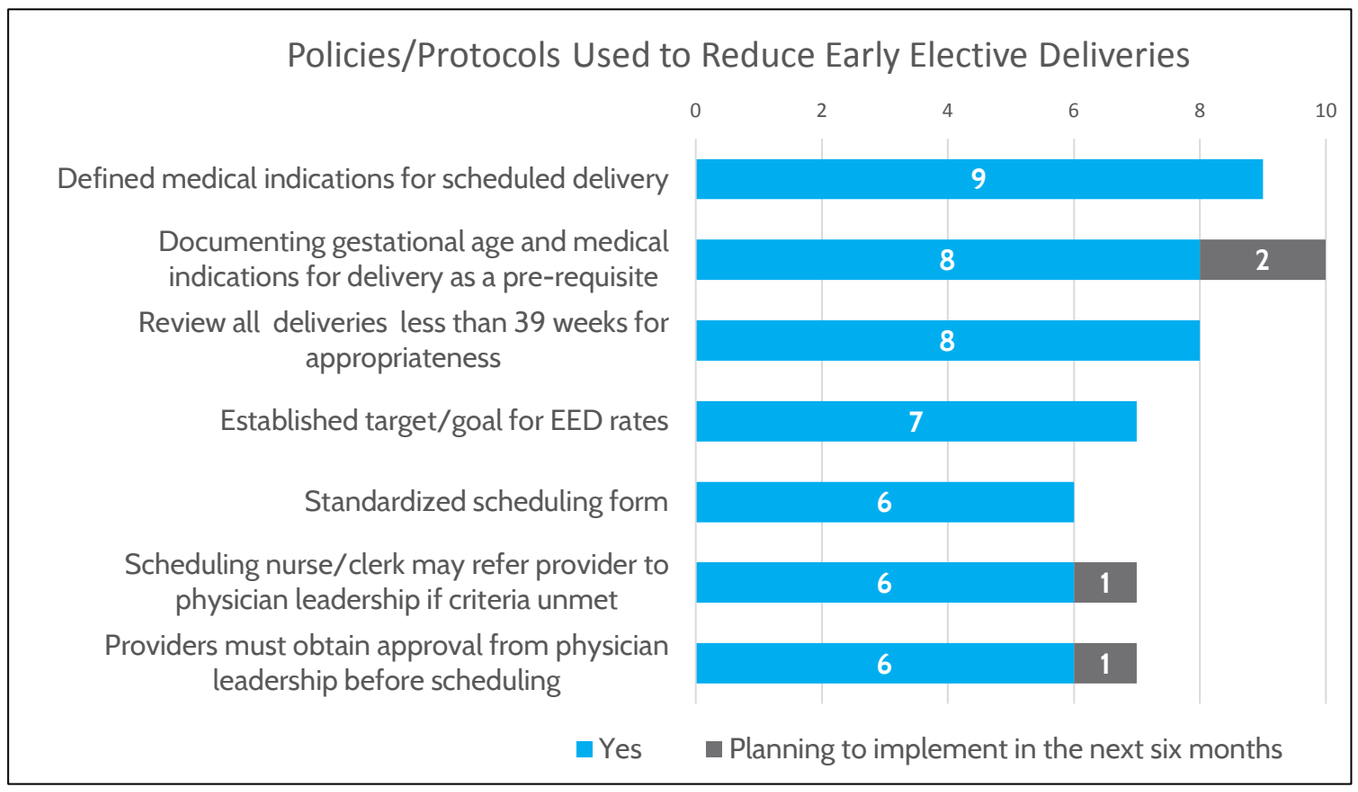
Process and Outcomes	Yes	No
Use of standardized tool to schedule deliveries	**6**	**2**
Elective deliveries not meeting medical indications	**8**	**1**
The Joint Commission PC-01 metric	**10**	
Elective deliveries admitted to NICU, level 3 nursery	**5**	**4**

Adverse OB Events/EED

7. Does your organization have a hard stop policy in place to prevent elective deliveries <39/0 weeks without medical indication?

7	Yes
1	No
1	Not at this time, but we will have in the next six months

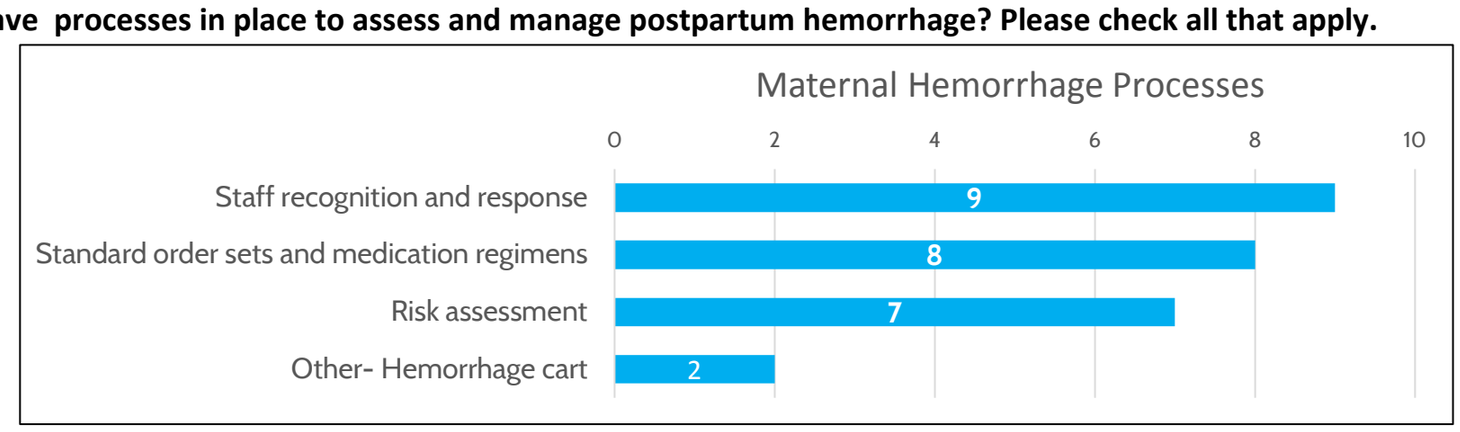
8. Has your organization implemented the following evidence-based policies/protocols to reduce non-medically indicated elective deliveries?



Questions 9-14 pertain to OB adverse events.

9. Effectiveness is defined as the degree to which a tool or strategy produced the desired result or impact on the intended goal. Using this definition, please list the three most effective interventions/strategies for assessing and managing hypertensive emergencies you have implemented in the past 18 months

10. Do you have processes in place to assess and manage postpartum hemorrhage? Please check all that apply.



11. For which hemorrhage measures do you routinely collect and analyze data? Please check all that apply.

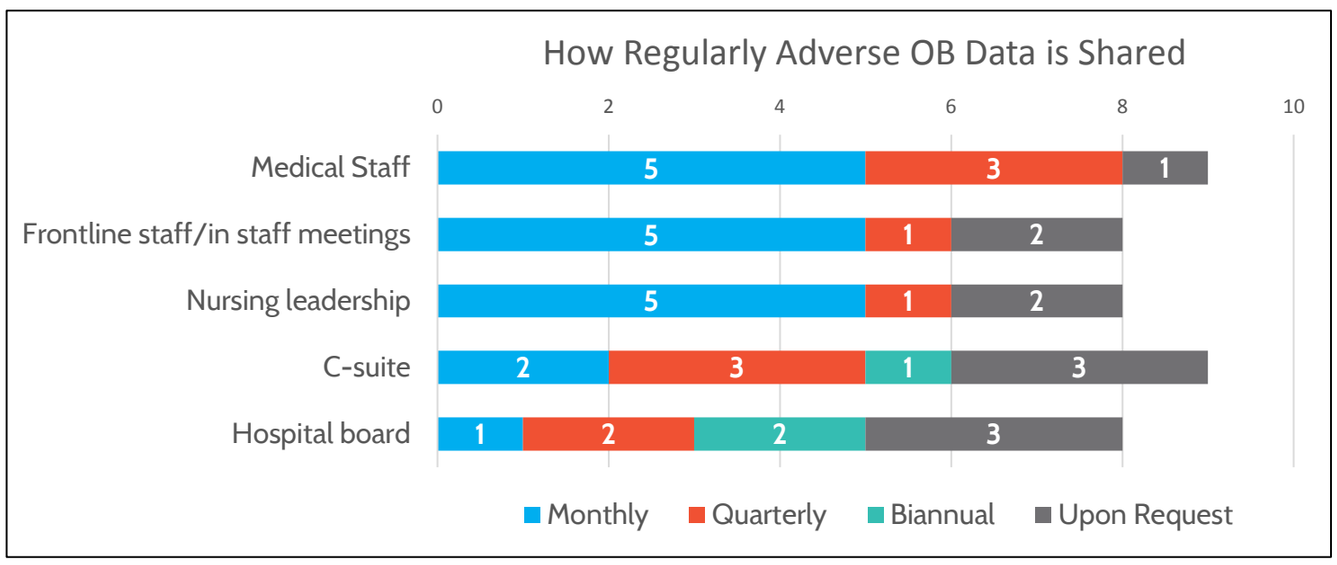
3	Number of women admitted to the labor and delivery unit whose risk of OB hemorrhage has been assessed and recorded in the medical record
6	Number of women who have given birth who were transfused with >4 units of any blood product
3	Other: Santa Clara- Women with EBL>2,000cc ; Contra Costa- Women with excessive blood loss (>500 ml vaginally, > 1,000 ml surgically) Maricopa - Women transfused for postpartum hemorrhage and patients that had a Cesarean Hysterectomy.

12. Our facility provides periodic education/certification on maternal/newborn crisis issues

Topic	Providers	Nurses	Other staff	Education/certification not provided
Shoulder dystocia	**8**	**7**	**4**	**1**
Postpartum hemorrhage	**9**	**9**	**4**	**0**
Hypertensive emergency	**8**	**8**	**1**	**0**
Newborn resuscitation	**9**	**8**	**1**	**0**
Electronic fetal monitoring using NICHD common language	**8**	**7**	**1**	**0**

Adverse OB Events/EED

13. How do you share data on OB adverse events on a regular basis to promote systemwide learning and transparency? Select the best answer for each.



14. Which patient/family engagement strategies are in place in your OB unit(s)? Check all that apply.

7	Routine leadership rounds
4	Patient/family involved in leadership rounds
3	Other: Harbor- Baby Friendly; Regional One- Pt. Safety Rounds

AMERICA'S ESSENTIAL HOSPITALS

Essential Hospitals Engagement Network (EHEN)
2014 Best Practice Survey: Highlights and Responses

Readmissions

Background

- In May 2014, EHEN asked its hospitals to complete a survey of the interventions and practices they have implemented or plan to implement as part of their quality improvement efforts.
- Response rate: 12 of 22 hospitals responded (55 percent).

Report Information

- This report is not intended to recommend any one intervention or practice, nor is it intended to prove causation between interventions and outcomes.
- Hospitals were not necessarily able to answer every question.
- The highlight section provides comparisons between conditions and associations with relevant outcome data. The outcome data was collected though UHC's clinical database (CDB/CDB-lite). The remainder of the report is a full breakdown of responses to each question from the survey.
- For questions, please contact your improvement coach or e-mail EHEN@essentialhospitals.org.

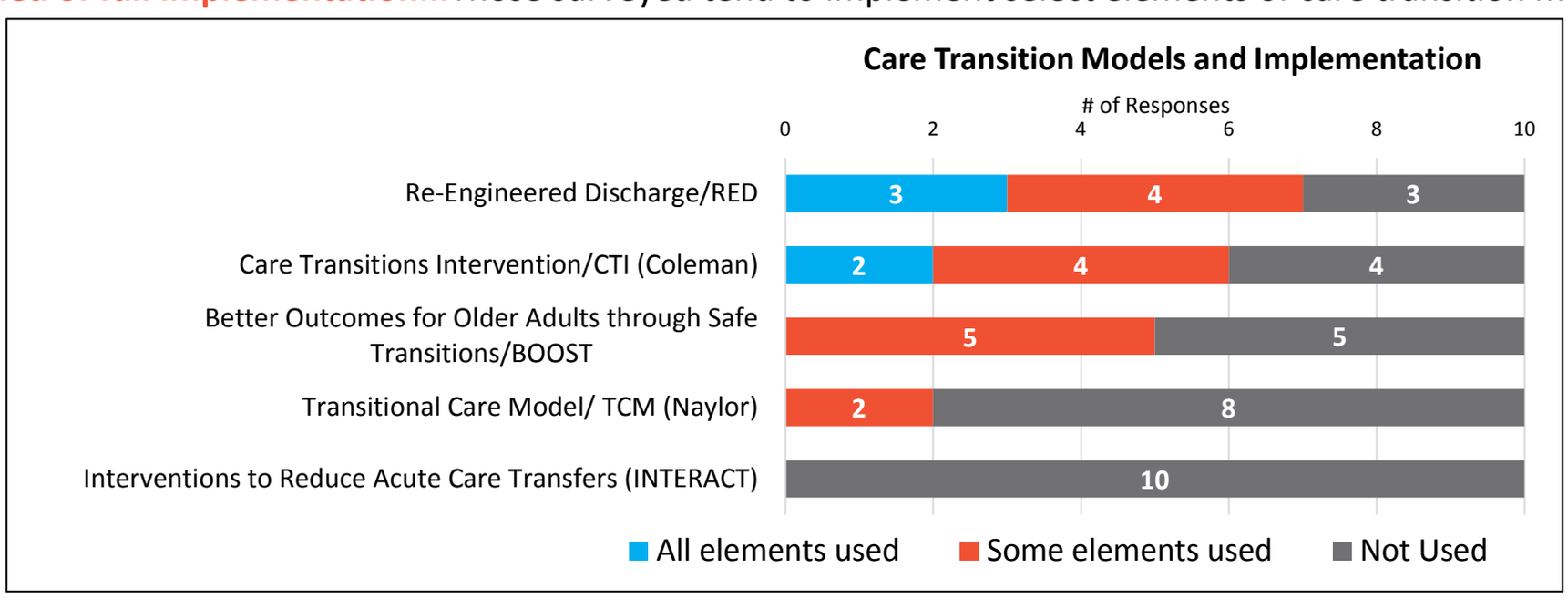
Readmissions: Best Practice Survey Highlights

In their own words... Top three effective Readmissions reduction strategies in the past 18 months from top performers.

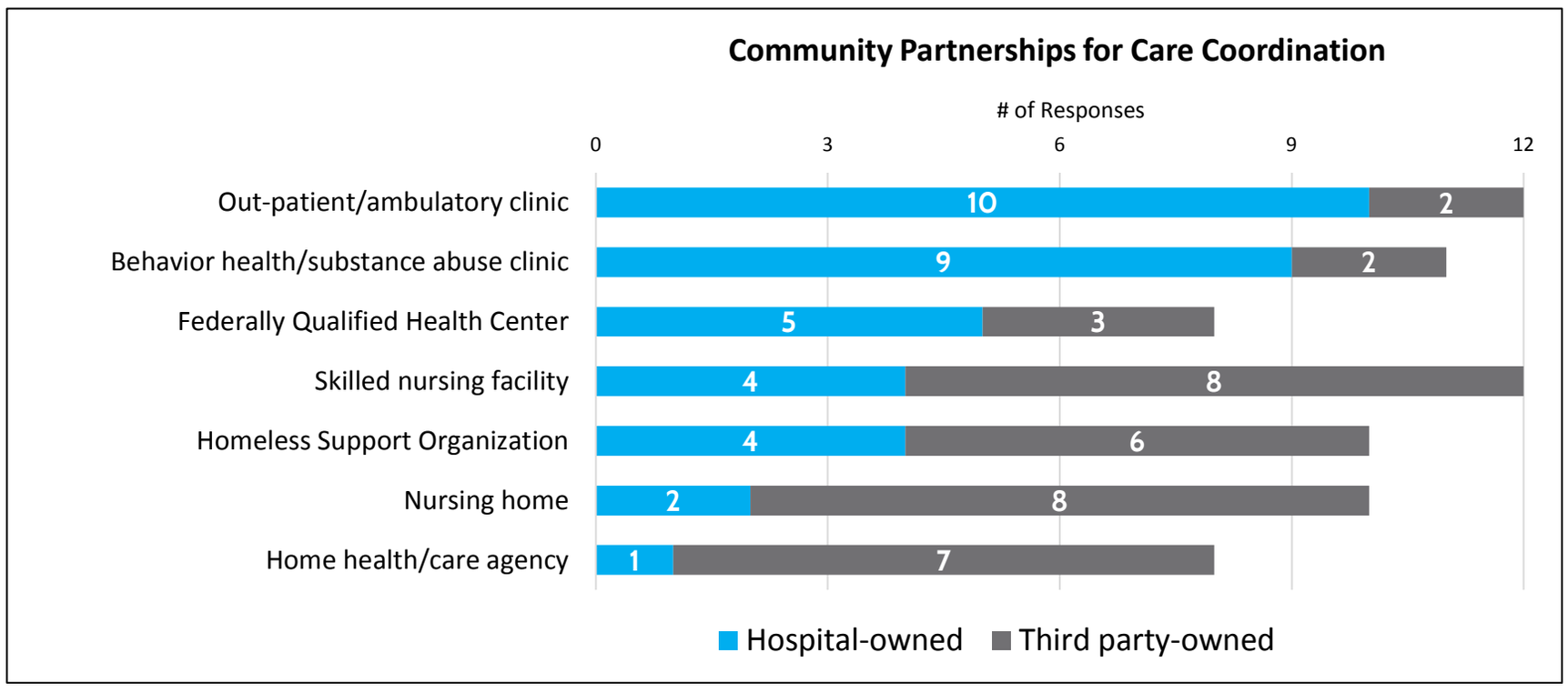
			Top Three Effective Strategies (Identified by the Hospital)		
	% Improvement	**Sparkline**	**#1**	**#2**	**#3**
Maricopa Integrated Health System	-17.3		Post discharge follow-up phone calls by hospital unit coordinators, which help determine patient compliance post discharge	Electronic risk assessment tool through EPIC that helps nursing assign appropriate score and trigger consult to care management when high risk.	Steps were recently outlined for ED physicians to make appointments for patients in the Transition Clinic. Hospital Unit Coordinators will be integrated into referral process.
MetroHealth System	-10.3		ACO care coordination/care navigation	Care Management/Social Work/Clinical Team discharge rounds	Transitional Care Program
Contra Costa Regional Medical Center	-5.5		SNF Care Managers	Pharmacy medication reconciliation and education prior to discharge	Structured follow-up phone calls within 72 hrs of discharge, and for select patients, a home visit and phone calls for 30 days after discharge.
Truman Medical Centers-Hospital Hill	-4.5		Outpatient infusions chairs for patients	Patients bringing all home meds with them to ED and/or outpatient clinic appointments	Follow-up appointments with next provider within 7-10 days post discharge

Notes: Performance based on 30-day All-Cause, All-Payer Readmissions data collected through UHC's CDB/CDB-lite. The baseline is 2010 for all, except Contra Costa, whose baseline is Q3'12-Q2'13). The performance period is Q2'14 for all, except MetroHealth, whose performance period is Q4'13). Sparklines show trend over time.

In lieu of full implementation... Those surveyed tend to implement select elements of care transition models.



Through partnerships... Hospitals surveyed can not make meaningful reductions in readmissions acting alone.



Essential Hospitals Engagement Network (EHEN)

Best Practices Survey 2014 - Readmissions/Care Transitions (CT)

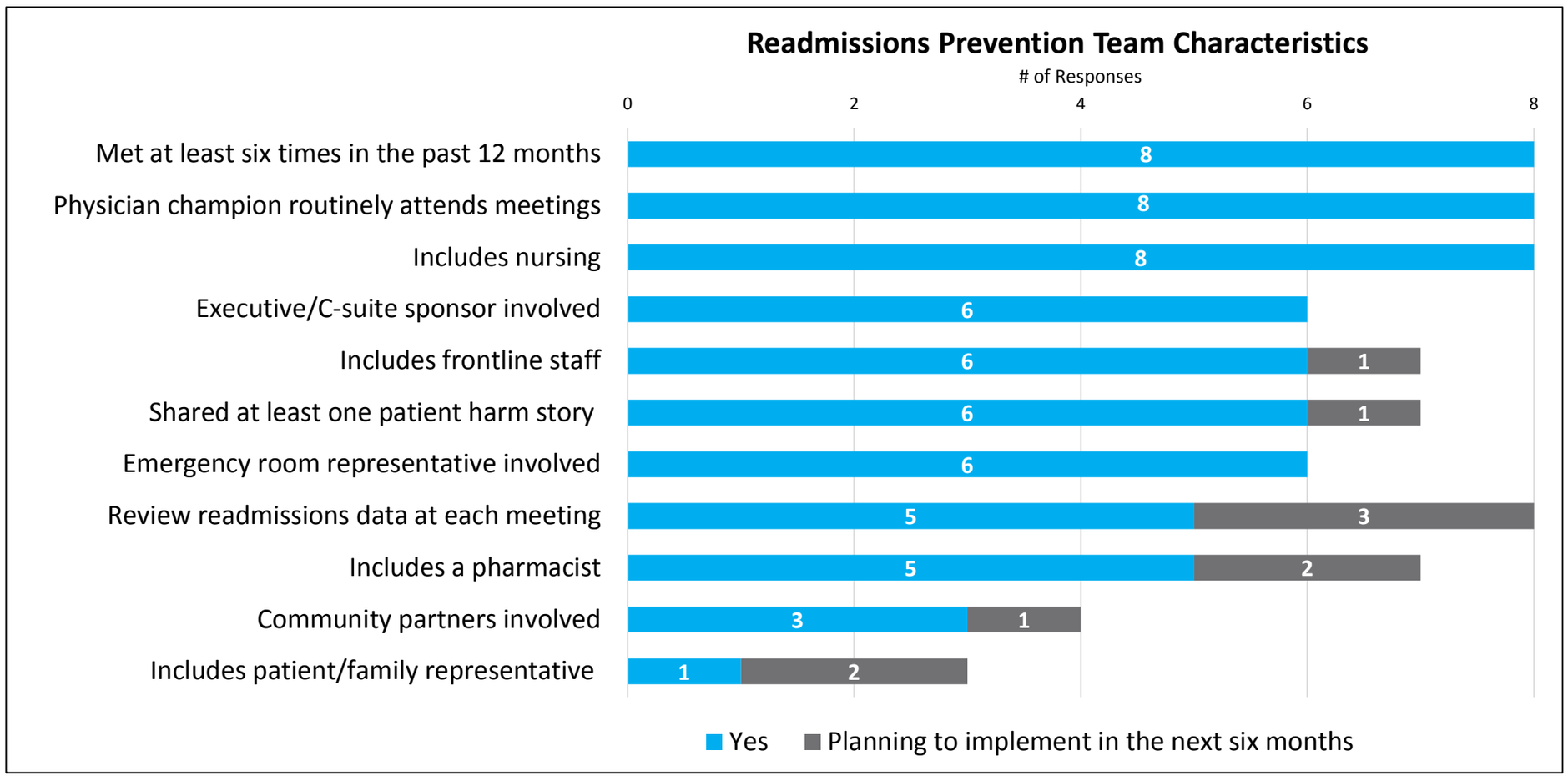
Red Numbers Represent Responses (n=12)

Section 10: Readmissions/Care Transitions (CT)

1. Does your facility have a multidisciplinary team *actively* working to reduce readmissions/improve CT?

8	Yes
3	No (Go to question 3)

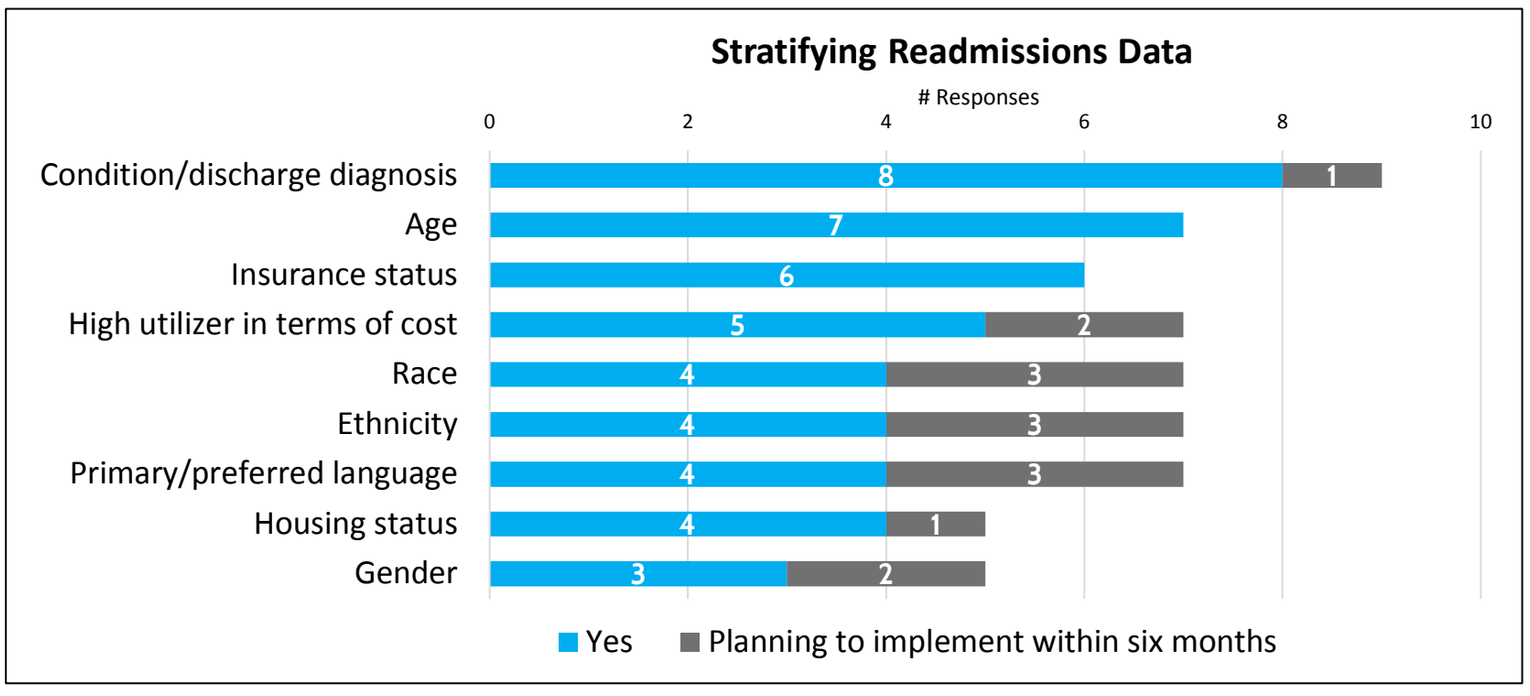
2. Please answer the following for your readmissions/CT team:



3. We have done an inventory of all internal and external initiatives/projects/programs currently working to reduce readmissions/improve CT within our hospital system.

4	Yes
5	Currently in process
2	No

4. Readmissions data are routinely stratified by which of the following patient characteristics:



Section 10: Readmissions/Care Transitions (CT)

5. Does your readmissions/CT committee routinely track and review the following outcomes data? Select the best response.

Outcome measures	All discharges	Only specific discharge diagnoses	Do not track
Seven days or less post discharge readmissions	4	2	3
15 days post discharge readmissions	3	2	3
30 days post discharge readmissions	8	2	
60-90 day post discharge readmissions	5	2	1
Return to the emergency room visits within seven days post discharge	1	5	2
Readmissions related to adverse drug events		3	5
Other: CCRMC- 30 day return to ED	1		

6. Do you routinely collect and monitor data on the following process measures for discharged patients? Select the best response.

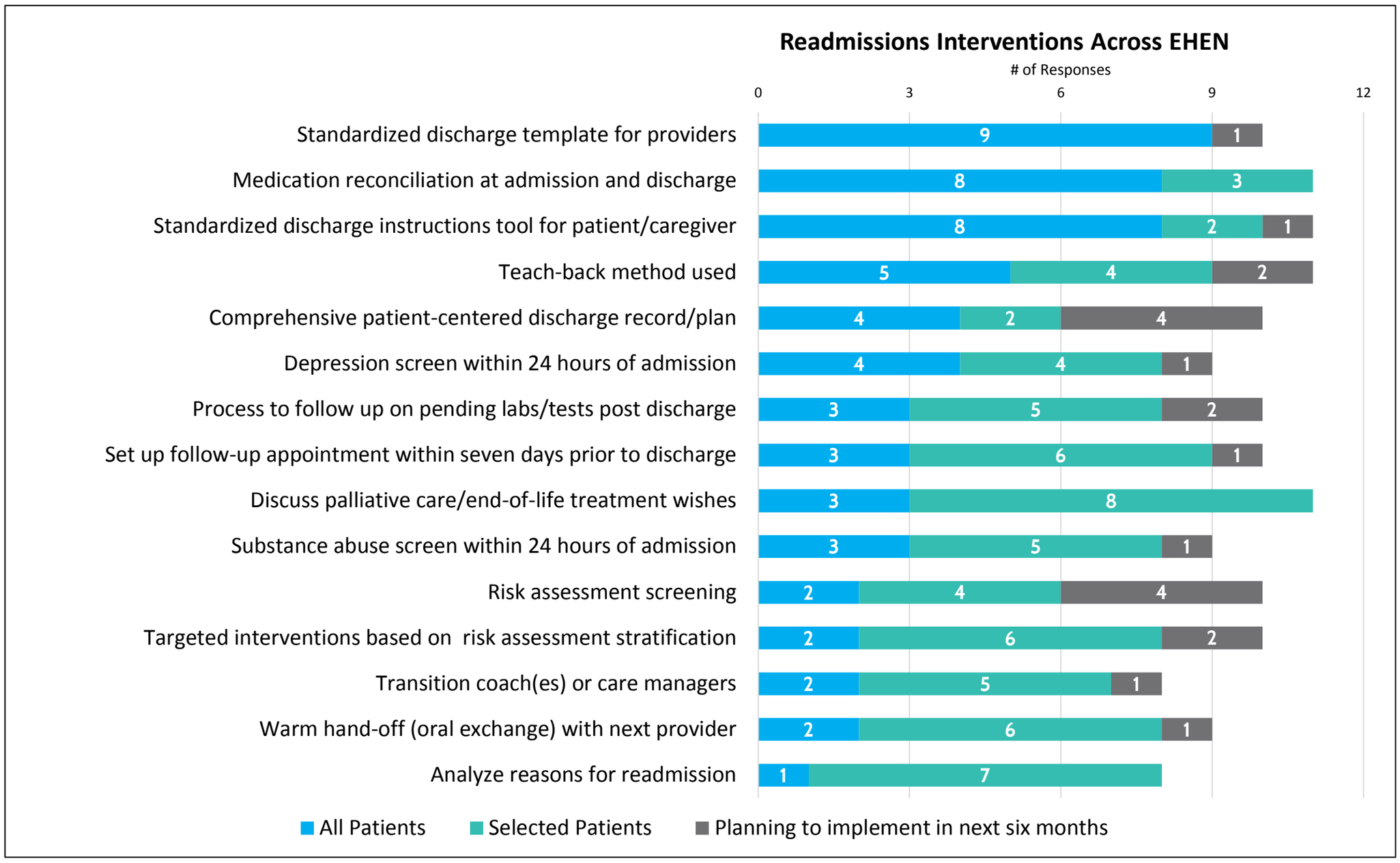
Practice	All discharges	Only selected discharges	Plan to do within next six months
Number of cases with completed discharge summary transmitted/made available to post care provider within 72 hours post discharge	4	4	2
Number of cases with documented follow-up appointment with post care provider within seven days post discharge	5	3	2
Number of cases with documented follow-up phone call within 72 hours of discharge	4	2	3
Number of cases for which defined and separate lists of discontinued, new, and continued medications are present in the medical record	5	1	3
Other: Rancho- F/U Medical Appt		1	

7. In the past 12 months, for which populations have you tried to improve CT/reduce readmissions? Check all that apply.

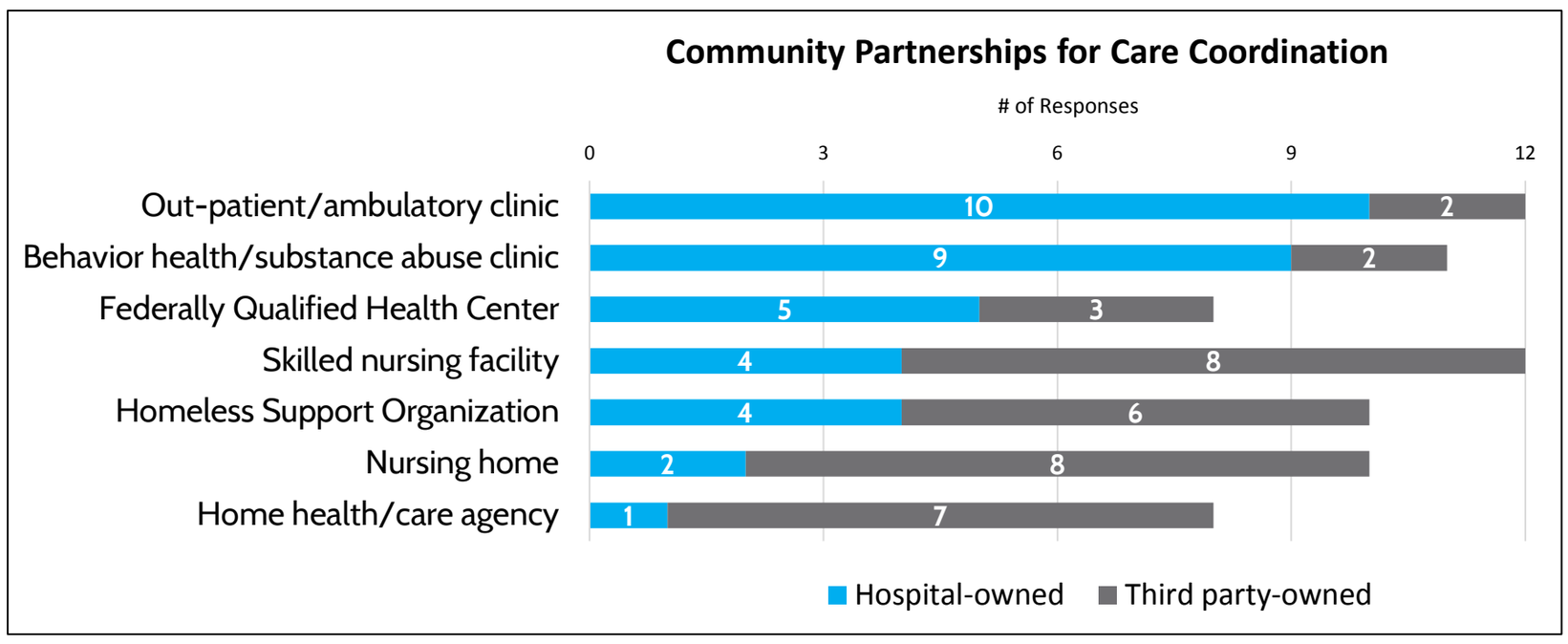
- 6 Specific patient diagnostic groups (e.g., heart failure, AMI, pneumonia, COPD, etc.)
- 7 All-cause, all-payer readmissions
- 5 Patients with behavioral health issues (e.g., mental health, substance abuse)
- 3 Other: MetroHealth- Uninsured, Patients on Waiver and ACO Medicare FFS; Alameda- Frequent Fliers; CCRMC- All Med/Surg excluding Psych and Perinatal

Section 10: Readmissions/Care Transitions (CT)

8. **Common interventions have been shown to positively impact care transitions and lead to a reduction in readmissions. Which of the following do you routinely and consistently use? Select the best response.**



9. **Do you have active partnerships with community organizations/post-care providers to improve care coordination? Check all that apply.**



10. **Effectiveness is defined as the degree to which a tool or strategy produced the desired result or impact on the intended goal. Using this definition, please list the three top interventions/strategies for reducing readmissions/improving care transitions you have implemented in the past 18 months**

Section 10: Readmissions/Care Transitions (CT)

11. Which multidimensional models do you use improve care transitions? Select the best response.

Models to improve transitional care	All elements	Some elements but not all	Have not used this model
Care Transitions Intervention/CTI (Coleman)	2	4	4
Transitional Care Model/ TCM (Naylor)		2	8
Better Outcomes for Older Adults through Safe Transitions/BOOST		5	5
Re-Engineered Discharge/RED	3	4	4
Interventions to Reduce Acute Care Transfers (INTERACT)			10

12. Does your hospital have a process for post discharge phone calls as part of follow-up care? Check all that apply.

- 6 Calls are made within 24-72 hours of discharge
- 2 Calls are made through a call center
- 4 Calls are made by a nurse, care manager, or pharmacist
- 7 A scripted interview tool is used and includes re-enforcement of discharge plan
- 5 All medications are discussed
- 6 We have a protocol/process for following up with medical issues identified on the call
- 3 We do not make post discharge phone calls

13. Which of the following post discharge interventions does your care transitions/readmissions program include? Check all that apply.

- 3 Dedicated full-time transition coach/care manager/social worker
- 10 Medication reconciliation
- 7 Transportation to/from follow-up appointments
- 11 Inclusion of family/caregivers in transition care plan
- 9 Reminder call(s) for follow-up appointments
- 7 Home visit(s)
- 7 Post-discharge follow-up clinic/provider access for patients without a PCP
- 2 Telehealth or telemonitoring program
- 9 Referral to behavioral health and/or substance abuse services

14. Which tool(s) do you use to identify individuals most at risk for returning to the hospital? Check all that apply.

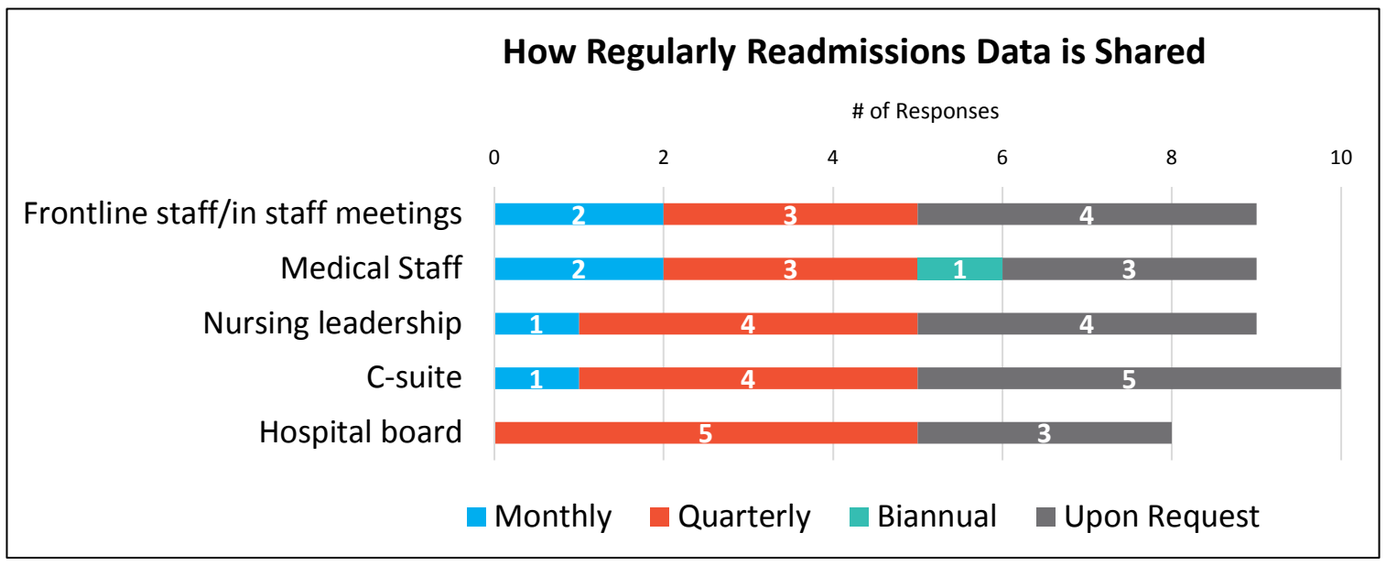
- 3 LACE/Modified LACE tool
- 3 BOOST 8Ps
- 0 CORE Readmission Risk Calculator
- 4 Chart review
- 5 Electronic Health Record
- 3 Predictive modeling
- 2 Registry
- 2 Transitional Care Model Discharge screen for high-risk older adults
- 1 Other: Rancho: PHQ2

15. How do you support patient attainment of prescriptions/medications at time of discharge? Check all that apply.

- 6 Medications delivered to/ Prescriptions filled for patient prior to discharge 7 days/week
- 4 Medications delivered to/ Prescriptions filled for patient prior to discharge 5 days/week
- 6 Electronic transmission directly to pharmacy
- 7 Prescriptions are faxed to or called into to pharmacy
- 10 Patients receive a hard copy prior to discharge
- 8 Provisions for interim medication supply
- 8 Co-pay support/low cost alternatives for medications
- Other:

Section 10: Readmissions/Care Transitions (CT)

16. How do you share data on hospital readmissions on a regular basis to promote system wide learning and transparency? Select the best response.



17. Which methods do you use to display readmission data in your hospital?

Method	Method used	Method *not* used
Run charts	**5**	**3**
Control charts	**2**	**6**
Bar graphs/pie charts	**4**	**4**
Harm counts	**2**	**5**
Days between readmissions	**2**	**5**
Other:		