AMERICA'S ESSENTIAL HOSPITALS

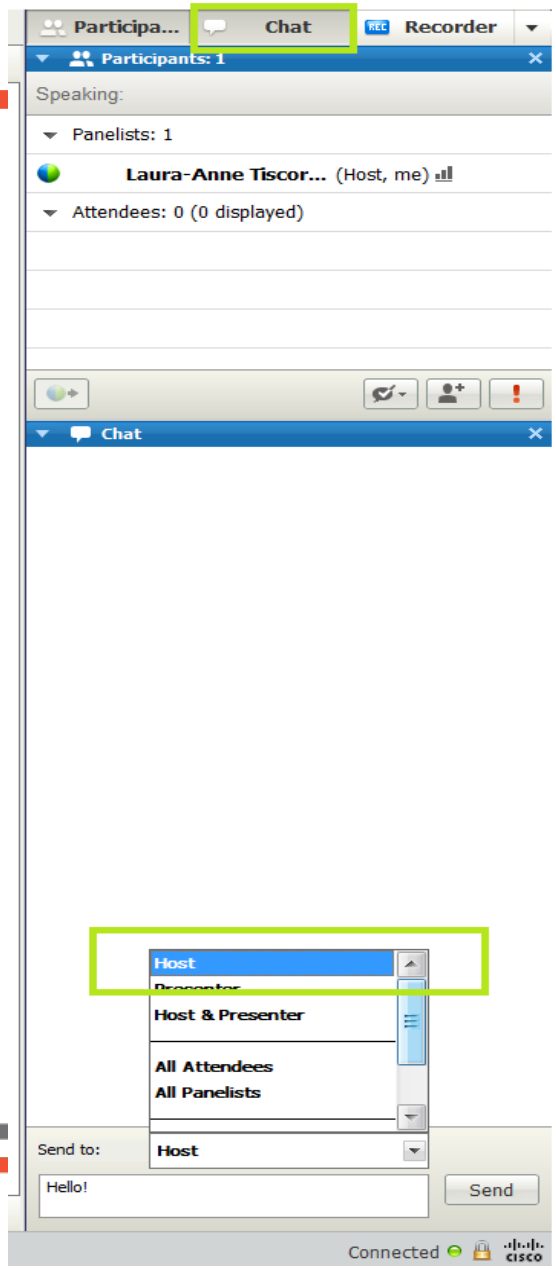
Leadership for Safety: Transparency

Essential Hospitals Engagement Network

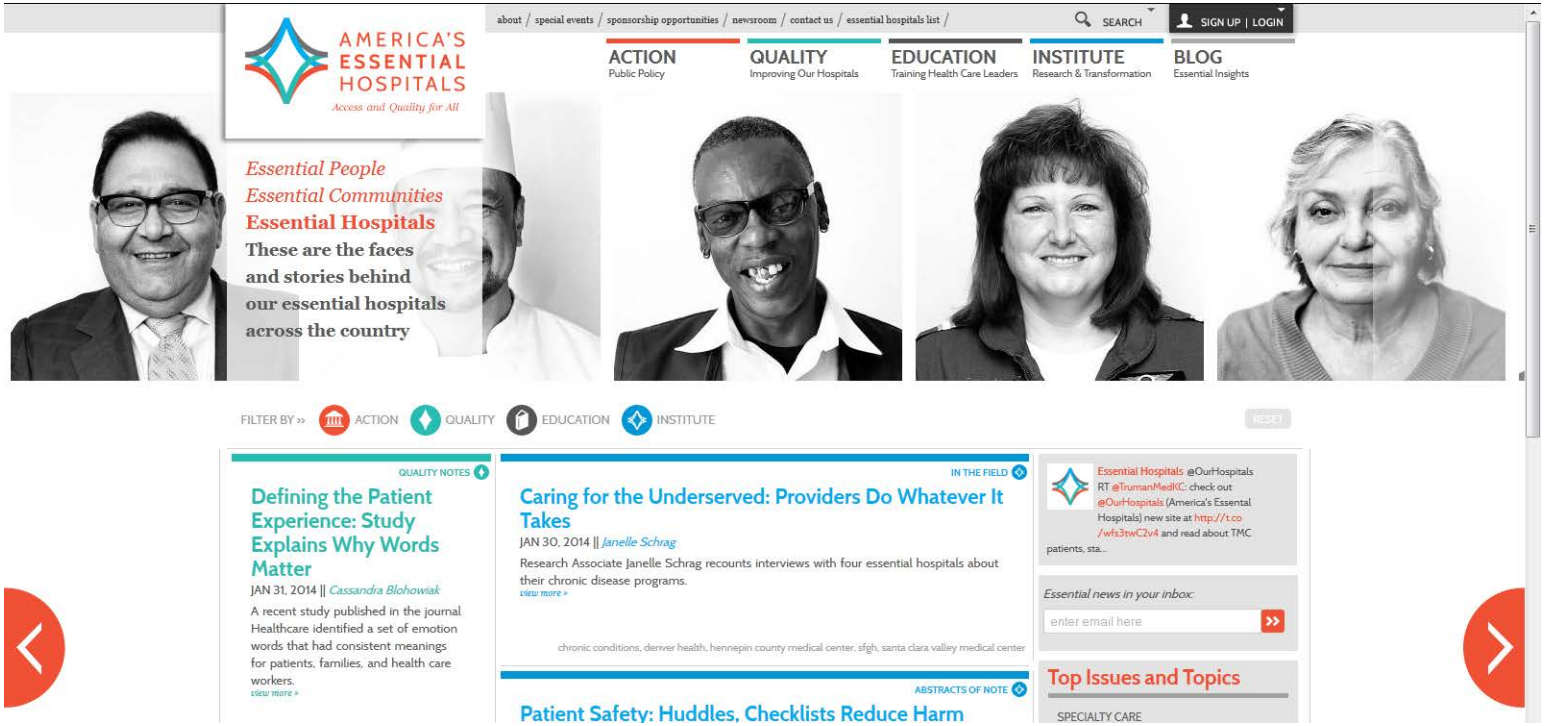
May 15, 2014

CHAT FEATURE

The chat tool is available to ask questions or comments at any time during this event.



ENGAGE AT OUR NEW WEBSITE!



Network with peers, learn how essential hospitals are changing lives
Now live at essentialhospitals.org

2014 PARTNERSHIP FOR PATIENTS

Partnership for Patients (PfP)

- CMS-funded
- Reduce nine hospital-acquired conditions by 40 percent
- Reduce readmissions by 20 percent

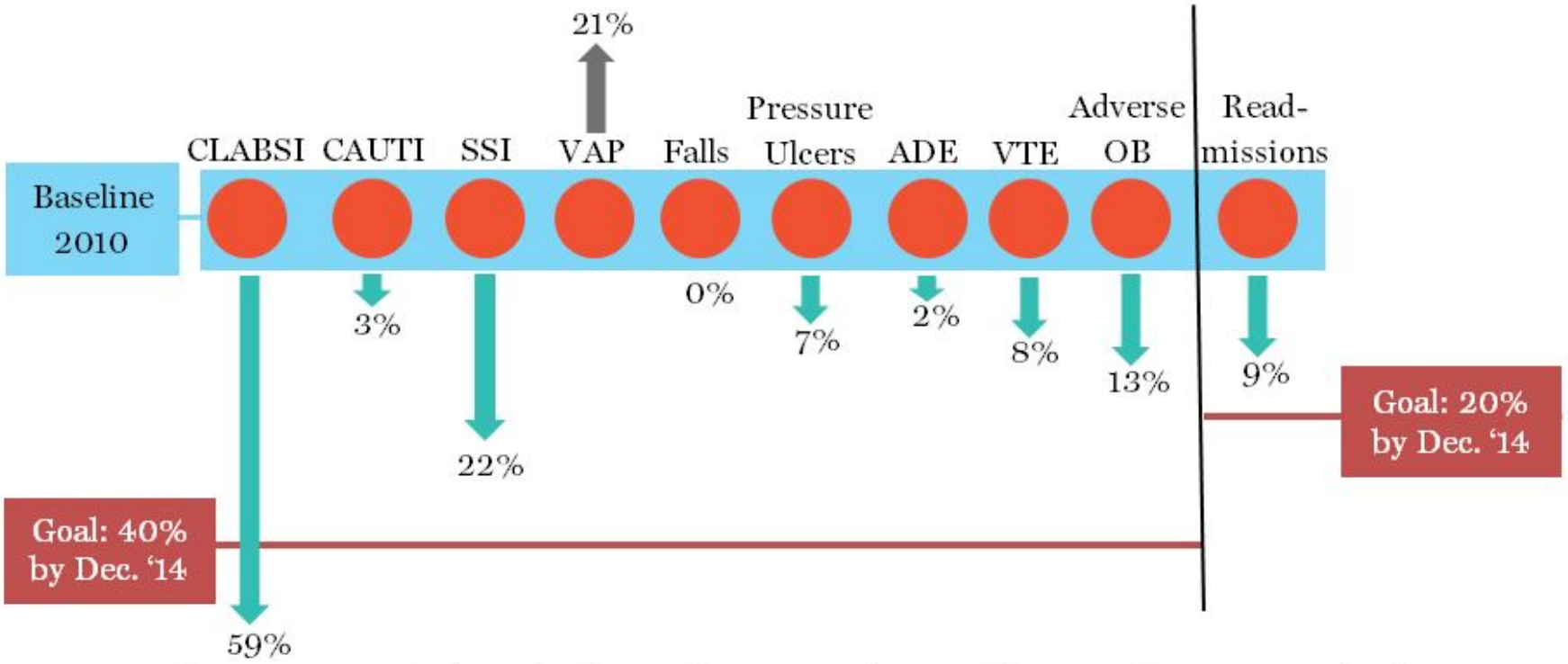
Hospital Engagement Networks (HENs)

- 27 contracted organizations
- 3,700 U.S. hospitals

Essential Hospitals Engagement Network (EHEN)

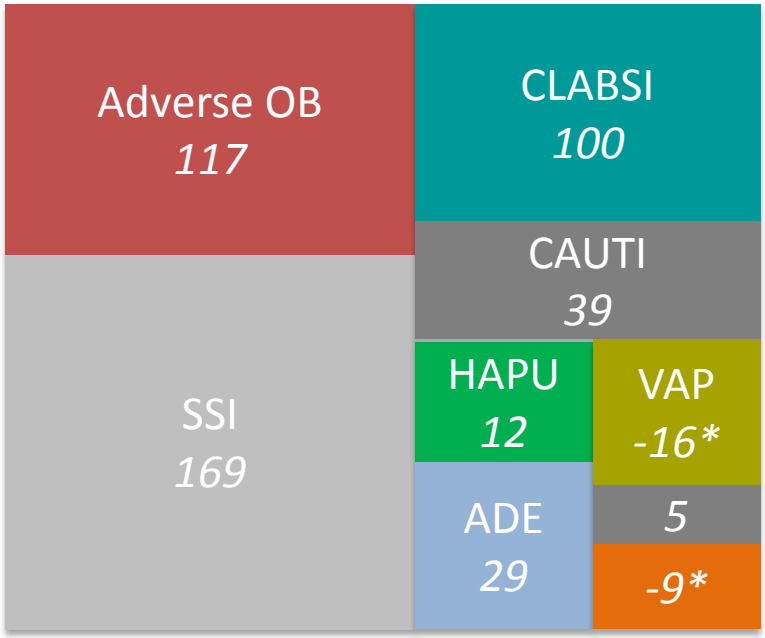
- 22 hospitals nationwide
- Only essential hospital-focused HEN
- Special focus on health equity

EHEN Progress Towards PfP Goals as of Oct'13-Dec'13 Performance Period



Note: For all measures, UHC's claims database is the source and >85% of the network is represented. Adverse OB is episiotomy. Percent change is based on rates.

HARM AVOIDED THROUGH THE EHEN



Falls

VTE

\+

Readmissions
2,124

= *2,570*

harm events avoided

**The EHEN has avoided events in eight of ten harm areas*

Transparency:

America's Essential Hospitals Leadership for Safety Webinar Series

James L. Reinertsen, M.D.

jim@reinertsengroup.com

307.353.2299

Leadership for Safety: Action Planning Checklist

Leadership Behaviors and Tools	Actions Planned
Take personal ownership of safety in your organization	
Eliminate the denominator: How many patients did we harm last year?	
Be transparent: wall displays, open discussion of serious safety events…	
Start every meeting with a patient story	
Frame safety aims in reference to the theoretical ideal	
Do “reality rounding” on key safety practices	
Executive visits to safety teams	
Daily safety huddle	
Make hard decisions that change the culture—on both values and technical performance!	

If you're going to be naked in public, it's good to be buff.

Tapscott and Ticoll
The Naked Corporation

Let’s hear your field reports

- What safety data do you see when you walk through units?
- What have you done “organization-wide” to communicate your efforts to reduce harm to patients?
- If we went on your website, what safety data would we find? Would it be “just the good stuff” or would we see everything, whether good, bad, or ugly?

Transparency Journey
San Francisco General Hospital and Trauma Center

Anh Pham, MPH
Janet Kosewic, MSN, RN, CNL

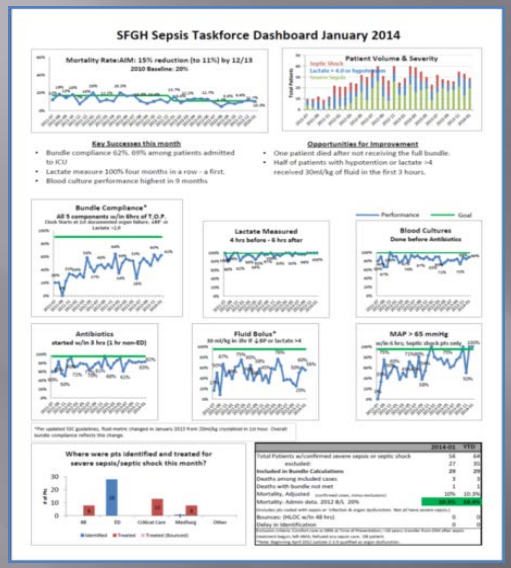
Background

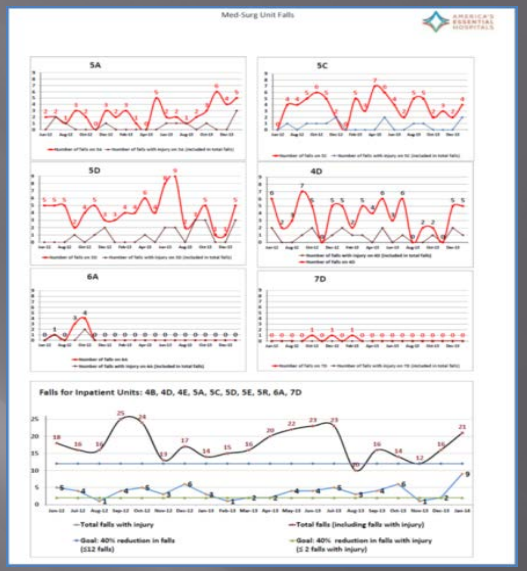
- Prior to January 2013:
  - Data dissemination and display varied
  - Some quality data dashboards existed for PI teams
- America's Essential Hospitals site visit in January 2013:
  - Data was not visible on units
  - Staff could not speak to quality outcome measures

Weekly Patient Safety Huddles

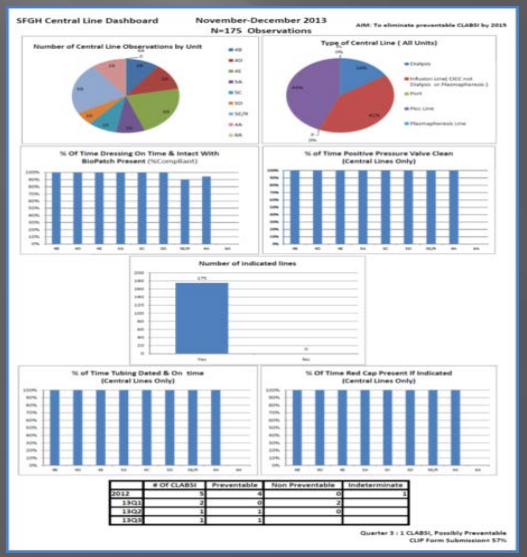
- Starting in February 2013
  - Posted standardized PI dashboards in designated areas on each unit
  - Huddled staff and provided an overview of the dashboards
  - Ensured information passed on to the next shift
  - Feedback and staff suggestions were used for small tests of change to improve format and staff understanding

Dashboards


SFGH Sepsis Taskforce Dashboard January 2014
Mortality Rate:AIM: 15% reduction (to 11%) by 12/13
2010 Baseline: 20%
Patient Volume & Severity
Key Successes this month
Bundle compliance 62%, 69% among patients admitted to ICU
Lactate measure 100% four months in a row - a first.
Blood culture performance highest in 9 months
Opportunities for Improvement
One patient died after not receiving the full bundle.
Half of patients with hypotention or lactate >4 received 30ml/kg of fluid in the first 3 hours.
Bundle Compliance*
All 5 components w/in 6hrs of T.O.P.
Lactate Measured
4 hrs before - 6 hrs after
Blood Cultures
Done before Antibiotics
Performance
Goal
Antibiotics
started w/in 3 hrs (1 hr non-ED)
Fluid Bolus*
30 ml/kg in 3hr if ↓BP or lactate >4
MAP > 65 mmHg
Where were pts identified and treated for severe sepsis/septic shock this month?
2014-01
YTD


Med-Surg Unit Falls
5A
5C
5D
4D
6A
7D
Falls for Inpatient Units: 4B, 4D, 4E, 5A, 5C, 5D, 5E, 5R, 6A, 7D
Total falls with injury
Total falls (including falls with injury)
Goal: 40% reduction in falls (≤12 falls)
Goal: 40% reduction in falls with injury (≤ 2 falls with injury)

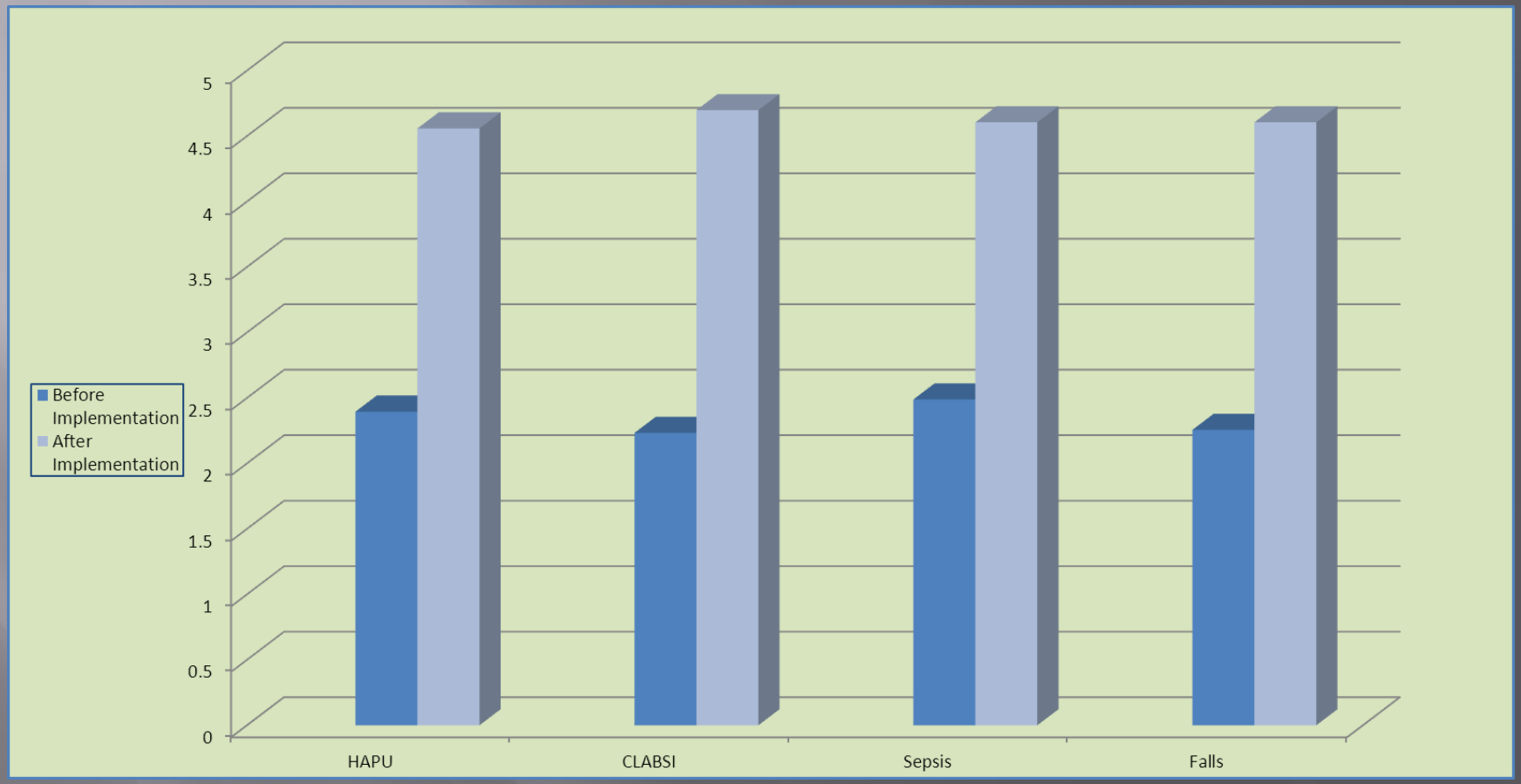

On the Way to Zero
Reported HAPIs per unit, 01/2013 - YTD


SFGH Central Line Dashboard
November-December 2013
N=175 Observations
AIM: To eliminate preventable CLABSI by 2015
Number of Central Line Observations by Unit
Type of Central Line (All Units)
% Of Time Dressing On Time & Intact With BioPatch Present (%Compliant)
% of Time Positive Pressure Valve Clean (Central Lines Only)
Number of indicated lines
% of Time Tubing Dated & On time (Central Lines Only)
% Of Time Red Cap Present If Indicated (Central Lines Only)
# Of CLABSI
Preventable
Non Preventable
Indeterminate
Quarter 3 : 1 CLABSI, Possibly Preventable
CLIP Form Submissionin 57%

Unannounced CMS Survey

- September 2013
  - CMS conducted an unannounced 3 day "Patient Safety Initiative" survey to test pilot a surveyor tool
  - Survey focused on:
    - Quality Improvement
    - Infection Control
    - Discharge Planning
  - Front line staff interviewed in every unit of the hospital
  - 100% of the units were able to interpret the hospital and unit PI dashboard for the surveyor

Internal Dashboard Evaluation



Dashboard Format Changes

- Inspiration for change:
  - Sue Currin (CEO), along with other hospital executives, attended the June 2013 NAPH conference in Hollywood, Florida
- Began developing a Patient Safety Dashboard that includes 9 measures of harm:
  - CAUTI
  - CLABSI
  - C-Diff
  - Falls with Injuries
  - SSI
  - HAPU
  - VAP
  - Med Errors
  - Sentinel Events

- Replaced 4 PI Dashboards with 1 overall hospital wide patient safety dashboard

Data Center Collaboration

- Agreed on standardized definitions for measures
  - National Healthcare Safety Network (NHSN)
  - Centers for Medicare/Medicaid (CMS)
  - Joint Commission core measure
  - National Database of Nursing Quality Indicators (NDNQI)
- Both hospital and unit dashboard formats are user friendly
- Unit specific dashboards personalize harm outcomes

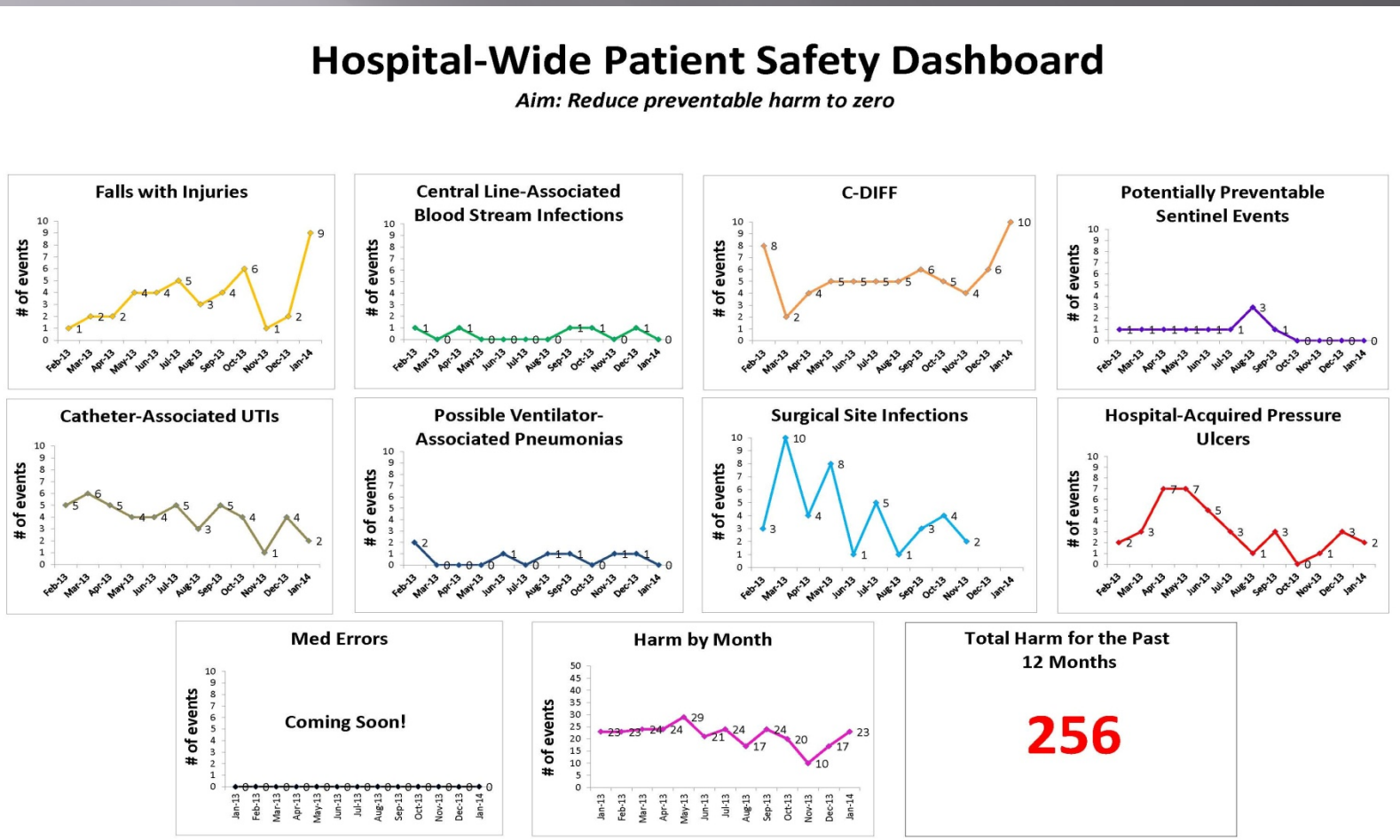
Standardized Definitions

Hospital-Wide Patient Safety Dashboard

Aim: Reduce preventable harm to zero

FALL (Collaborative Alliance for Nursing Outcomes-CALNOC/National Database of Nursing Quality Indicators-NDNQI)
-Falls with any injury
-Inpatient acute care units 4B 4D 4E 5A, 5C, 5D, 5E/5R, 6A
HAPU (Centers for Medicare & Medicaid Services-CMS reportable database)
-Hospital acquired pressure ulcers that meet CMS requirements (includes mucosal)
-Inpatient acute care units 4B, 4D, 4E, 5A, 5C, 5D, 5E/5R, 6A
SSI (National Healthcare Safety Network-NHSN)
-Superficial Incisional SSI:
Superficial Incisional Primary (SIP) is identified in the primary incision in a patient that has had an operation with one or more incisions (e.g., C-section incision or chest incision for Coronary Artery Bypass Graft [CABG])
Superficial Incisional Secondary (SIS) is identified in the secondary incision in a patient that has had an operation with more than one incision (e.g., donor site [leg] incision for CABG)
-Deep Incisional SSI:
Infection occurs within 30 or 90 days after operative procedure and involves deep tissues of the incision (e.g., fascial and muscle layers) and patient has at least one of the following:
a. Purulent drainage from the deep incision.
b. A deep incision that spontaneously dehisces or is deliberately opened by a surgeon and is culture-positive or not cultured and patient has at least one of the following signs or symptoms: fever (>38 C); localized pain or tenderness. A culture-negative finding does not meet this criterion.
c. An abscess or other evidence of infection involving the deep incision that is found on direct examination, during invasive procedure, or by histopathologic examination or imaging test
d. Diagnosis of a deep incisional SSI by a surgeon or attending physician
-Organ/Space SSI:
Infection occurs within 30 or 90 days after operative procedure and infection involves any part of the body, excluding the skin incision, fascia, or muscle layers, that is opened or manipulated during the operative procedure and patient had at least one of the following:
a. purulent drainage from a drain that is placed into the organ/space
b. organisms isolated from an aseptically-obtained culture of fluid or tissue in the organ/space
c. an abscess or other evidence of infection involving the organ/space that is found on direct examination, during invasive procedure, or by histopathologic examination or imaging test
d. Diagnosis of an organ/space SSI by a surgeon or attending physician and meets at least one criterion for a specific organ/space infection site listed in Table 4 of the SSI protocol
-Inpatient acute care units 4B, 4D, 4E, 5A, 5C, 5D, 5E/5R, 6A
C-DIFF (National Healthcare Safety Network-NHSN)
-Clostridium difficile Infection (LabID Event): A non-duplicate C. difficile toxin-positive laboratory result from unformed (i.e., conforming to the shape of the container) stool sample obtained on or after day 4
-Inpatient acute care units 4B, 4D, 4E, 5A, 5C, 5D, 5E/5R, 6A
CAUTI (National Healthcare Safety Network-NHSN)
-A UTI where an indwelling urinary catheter was in place for >2 calendar days when all elements of the UTI infection criterion were first present together, with day of device placement being Day 1, AND an indwelling urinary catheter was in place on the date of event or the day before. If an indwelling urinary catheter was in place for >2 calendar days and then removed, the UTI criteria must be fully met on the day of discontinuation or the next day
-Inpatient acute care units 4B, 4D, 4E, 5A, 5C, 5D, 5E/5R, 6A
CLABSI (National Healthcare Safety Network-NHSN)
- A central line-associated bloodstream infection (CLABSI) is a laboratory-confirmed primary bloodstream infection (LCBI) where central line (CL) or umbilical catheter (UC) was in place for >2 calendar days when all elements of the LCBI infection criterion were first present together, with day of device placement being Day 1, AND a CL or UC was in place on the date of event or the day before. If a CL or UC was in place for >2 calendar days and then removed, the LCBI criteria must be fully met on the day of device discontinuation or the next day. If the patient is admitted or transferred into a facility with a central line in place (e.g., tunneled or implanted central line), day of first access is considered Day 1
-Inpatient acute care units 4B, 4D, 4E, 5A, 5C, 5D, 5E/5R, 6A
VTE (Centers for Medicare/Medicaid Services-CMS/Joint Commission core measure)
-Adult patients who developed a VTE (Pulmonary Embolism or Deep Vein Thrombosis) and did not receive pharmacologic or mechanical VTE prophylaxis or have an appropriate contraindication to prophylaxis documented in the medical record prior to the VTE diagnosis
-Inpatient acute care units 4B, 4D, 4E, 5A, 5C, 5D, 5E/5R, 6A
VAP (National Healthcare Safety Network-NHSN)
- A possible PN where the pt. is on a ventilator for more than 2 days and meets VAP criteria pending infection control and lab confirmation within 90 days
-Inpatient acute care units 4E and 5E/5R (ICU only)
SENTINEL EVENTS (Joint Commission)
-A sentinel event is an unexpected occurrence involving death or serious physical or psychological injury or the risk thereof. Serious injury specifically includes loss of limb or function. The phrase "or the risk thereof" includes any process variation for which a recurrence would carry a significant chance of a serious adverse outcome. The event has resulted in an unanticipated death or major permanent loss of function, not related to the natural course of the patient's illness or underlying condition OR
-The event is one of the following: Suicide (within 24hrs after discharge), Med. Error, Procedural Complication, Wrong site surgery, Treatment delay, Restraint death, Elopement death, Assault/Rape/Homicide, Transfusion death, Patient abduction, Unanticipated death of full term infant, Unintended retention of foreign body, or Fall related
FOR MORE DETAIL PLEASE CONTACT THE PATIENT SAFETY TEAM. THANK YOU!

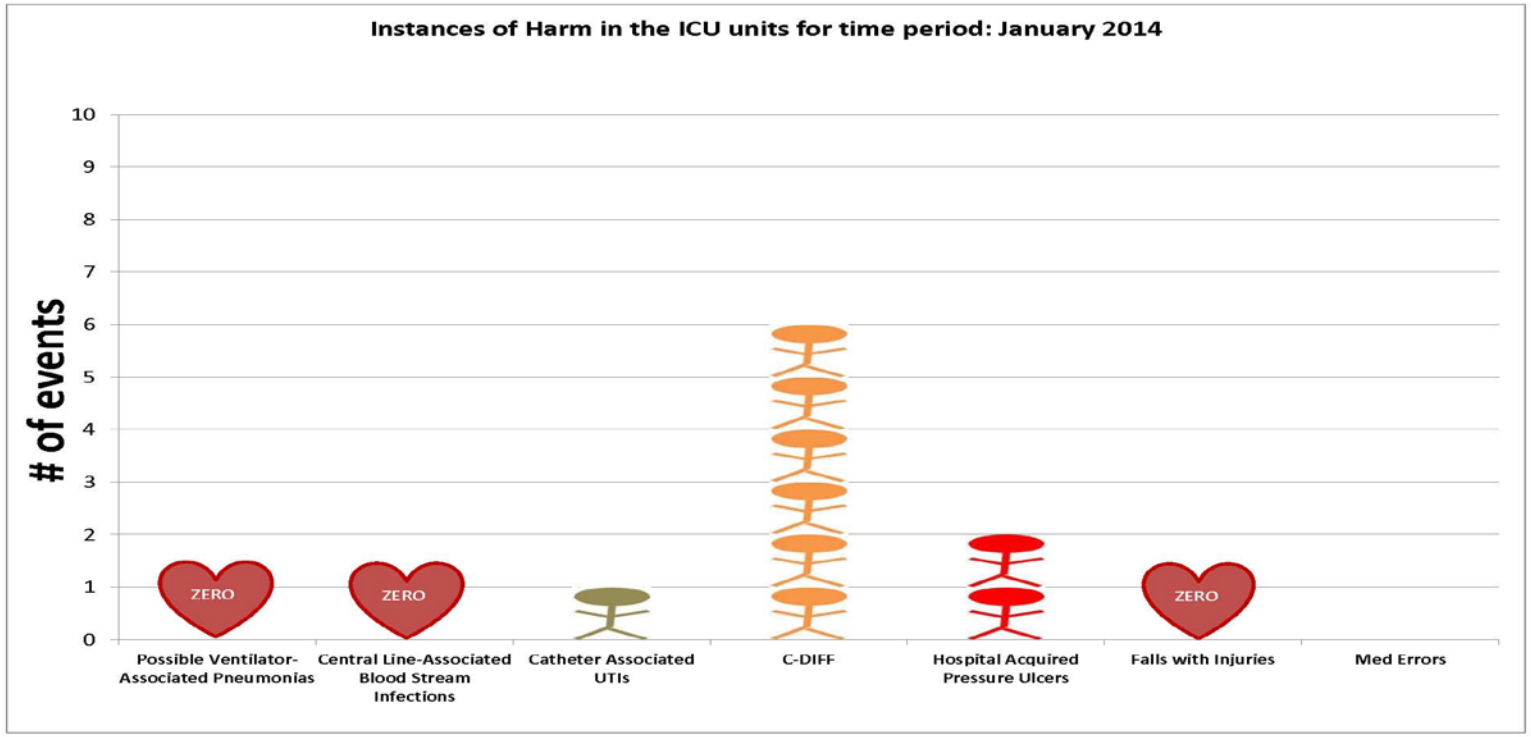
Latest Phase of the Patient Safety Dashboard



April 2014: Monthly Department Specific Dashboards

Patient Safety Dashboard

Aim: Reduce preventable harm to zero



Brought to you by the Quality Data Center: Informing, engaging, and transforming practice through clinical and operational data.

For Questions, please contact the Quality Data Center 415-206-4161

Challenges & Results

- Challenges:
  - Timely data
    - clinical evaluation and/or lab confirmation. Examples include:
      - Surgical site infection (SSI)
      - Central line Associated Bloodstream Infection (CLABSI)
  - Sensitivity to unit specific data
- Results:
  - Departments respond to the data with action
  - Increased staff awareness and engagement

Next Steps

- Incorporate one key process measure into each outcome graph
  - Catheter Associated Urinary Tract Infection (CAUTI)
    - Process measure: foley indication
- Post publicly outside of administration offices
- Purchase standardized display cabinets
- Include best practices to the dashboard
- Continue huddles

QUESTIONS?

How Transparent is Your Organization?

Level 1

Level 5

We don’t display or discuss any bad data to staff or public

We are completely transparent about everything, even if it shows poor performance

What does “Level 5” look like?

- Unit Level:
  - Data displays that show safety goals, unit performance vs. goals, how many patients have been harmed, in areas visible to public. The data displays are frequently used as a convening point for conversations about safety work.

What does “Level 5” look like?

- Organization level:
  - 8 minute video led by CEO and C-suite, widely distributed and viewed by all staff
  - “Last year we harmed ____ patients with hospital acquired infections, pressure ulcers and other mishaps. Zero is the only acceptable goal. Everyone plays a part in achieving that goal. We will update our progress monthly. Now, here are some specific aspects of the plan…”

What does “Level 5” look like?

http://www.healthleadersmedia.com/content/LED-304290/How-Making-Hospital-Quality-Data-Public-Affects-Providers##

- Community and Public
  - Teaching hospital posts 20,000 reviews of its doctors on website. (all except those that are libelous, profane, or violate patient privacy)
    - "One of the finest doctors I have ever dealt with … thorough in her examinations and is very careful to explain …" wrote one patient about a nephrologist.
    - This doctor "is the bomb! Very professional, gives you a clear understanding of what is going on, and what is to come," a patient wrote about a gynecologic surgeon.
    - And about an orthopedic surgeon, "Horrible patient care." And, "Worst physician I'd ever seen. He did not seem to have any interest … I felt like I was a number."

Summary

- Transparency is a extraordinarily important force for improvement.
- The “audience” for your transparency is internal. You go outside to get inside.
- Go public with data before you’re proud of it.
- Transparency takes courage, and must be led from the top.

What’s stopping you?

ASSIGNMENT FOR NEXT MONTH'S WEBINAR

- Go to the front lines of a clinic or hospital setting and watch the nurses and doctors use the EHR for one hour. Ask 5 front line clinicians this question: "Is the EHR making your patient care safer, or less safe? Explain."
- Read the IOM report on EHR safety (will be sent in follow-up email)

UPCOMING EVENTS

- **Save the Date**

  Sustainability Summit in Chicago, IL

  November 10

- **Next webinar:** Leadership for Safety: Safety and the EHR with special guest speaker David Classen, MD, MS, CMIO Pascal Metrics

  July 20| 12- 1 pm EST

THANK YOU FOR ATTENDING

- **Evaluation:** When you close out of WebEx following the webinar a evaluation will open in your browser. Please take a moment to complete. We greatly appreciate your feedback!

- **Check out the new EHEN Leadership for Safety Program website:** http://essentialhospitals.org/institute/ehen-leadership-safety-program/

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