Mobilizing the Health Workforce to Reduce Hospital-Acquired Conditions

1st Meeting of the Patient Safety 2014 Quarterly Meeting Series
Supporting the Partnership for Patients

convened by the
NATIONAL QUALITY FORUM

January 29, 2014

9th Floor Conference Center
1030 15th Street NW, Washington, D.C. 20005

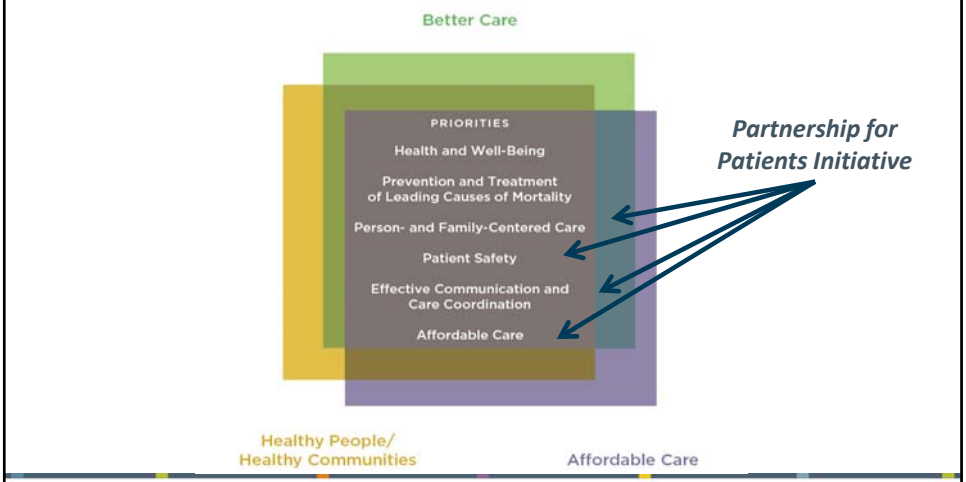
Welcome and Introductions

Norman Kahn, MD
Executive VP and CEO
Council of Medical Specialty Societies
Meeting Chair

The National Quality Strategy

NATIONAL QUALITY FORUM 3

The National Quality Strategy



NATIONAL QUALITY FORUM

Partnership for Patients

GOALS:

40% **Reduction in Preventable Hospital-Acquired Conditions**
1.8 Million Fewer Injuries | 60,000 Lives Saved

20% **Reduction in 30-Day Readmissions**
1.6 Million Patients Recover without Readmission

Working together to implement the patient safety priority area of the National Quality Strategy

2014 National Quality Forum Meeting Series

A series of four meetings over the year. Topics include:

1. **Engaging the workforce --**
2. Engaging purchasers and payers --
3. Leveraging accreditation efforts --
4. Taking action in person-centered care --

-- To accelerate the Partnership for Patients goals of reducing hospital acquired conditions and readmissions.

Today's Meeting Objectives

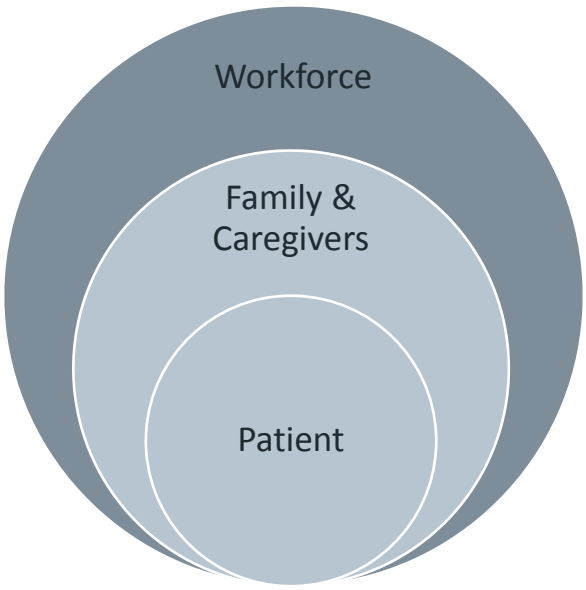
1. Identify the most effective best practices to mobilize the health workforce in meeting the Partnership for Patients goals.
2. Identify concrete steps for achieving results through these best practices.
3. Enable participants to take immediate action in their organizations and membership bases.

Attendees today

Workforce Definition:

"All people engaged in actions whose primary intent is to enhance health"

– World Health Organization



Today's Agenda

Overview of Partnership for Patients
Where are we now?

Experience the Culture of Safety from a new perspective
Audience activity

Embracing a Culture of Safety
Success stories from the field

Taking action
Facilitated discussion

Welcome and Introductions

Neal Comstock
Vice President, Membership
National Quality Forum

Table Introductions

Please take a moment to introduce yourselves at your round table

Partnership for Patients: Where Are We Now?

Dennis Wagner and Paul McGann
Partnership for Patients Co-Directors

CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES
CENTER FOR MEDICARE & MEDICAID INNOVATION

National Quality Forum (NQF)

Patient Safety Quarterly Meeting Series:
The "Yin" and "Yang" of Current Results and
Mobilizing the Health Workforce to Reduce Hospital-Acquired Conditions

January 29, 2014

Dennis Wagner & Paul McGann, M.D.
Co-Directors, Partnership for Patients

U.S. Department of Health & Human Services
CMS Center for Medicare & Medicaid Innovation

Thank You

- For the hard work you are doing to improve our nation's healthcare system.
- For your active commitment to improve the care of patients and clients.
- For your leadership and history of commitment and success on health care improvement, innovation and spread.

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Our Challenge to Leaders in the Room

Use today to generate your "to do" list of items to accelerate progress in pursuit of reduced harm and 30 day readmissions:

1.
2.
3.
4.
5.

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Our Requests to Each of You

- Choose to Stand for Better Care, Better Health at Lower Cost…for Our Patients, Your Profession, Our Nation
- Use Your Platforms to Make This Happen
- Do More of What is Already Working…Everywhere
- Lead in Enrolling Others
- Stand Together in Serving As Catalysts for Change

We can achieve our Bold Aims.

Questions to Run On

- Where are we with the Partnership for Patients (PfP) today?
  - What are our results so far?
  - What areas need increased action and attention?
- How do we leverage the PfP to mobilize the health workforce?
- How can the health workforce support this safety culture change, and improve patient care?
- ***What can NQF members and key stakeholders do to further contribute to reduce harm to patients and un-necessary readmissions?***

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Partnership for Patients Focused on 2 Breakthrough Aims

GOALS:

40% **Reduction in Preventable Hospital-Acquired Conditions**

1.8 Million Fewer Injuries | 60,000 Lives Saved

20% **Reduction in 30-Day Readmissions**

1.6 Million Patients Recover without Readmission

partnershipforpatients.cms.gov

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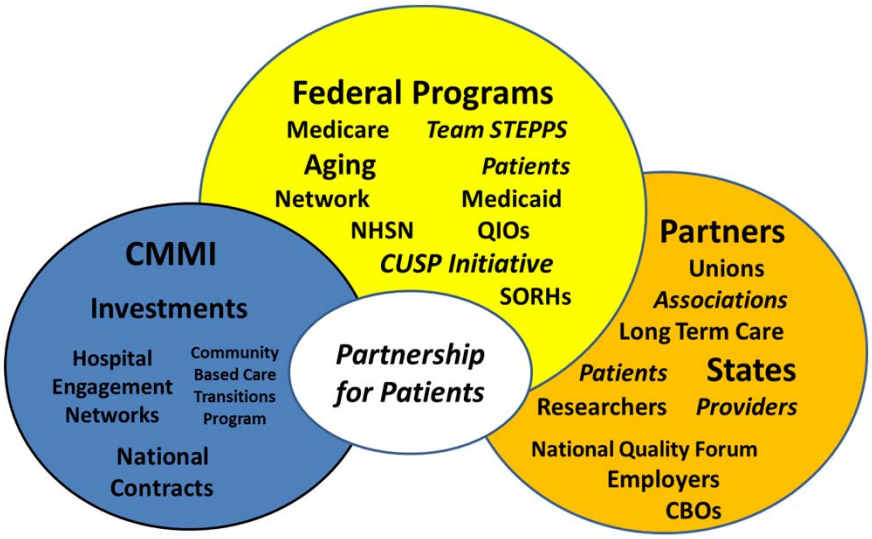
Partnership for Patients Achieves Results Through "3 Engines"



Exemplary Actions

- ***What are some of the examples of work by Partners to achieve action and results on the PfP aims?***
- ***What actions can we take to call attention to, celebrate, and spread these kinds of results?***

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Partners Contribute in Many Diverse & Significant Ways

- NQF Maternity Action Team, March of Dimes, ACOG, LeapFrog and others team to achieve major national reductions in Early Elective Deliveries.
- US OPM work to align Federal Employee Health Benefit plans with the Partnership for Patients Aims.
- "Buying Value" initiative to align purchasing with PfP Aims by large employers, unions, NBGH and many others.
- Johnson & Johnson incentives to employees discharged from hospitals who call for guidance on health care follow-up.

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11 Priority Areas of Focus

"No Patient wants a hospital that is only good at preventing 3 types of harm."

Hospital Engagement Networks are required to address ten areas of focus:

1. Adverse Drug Events
2. Catheter-Associated Urinary Tract Infections
3. Central Line Associated Blood Stream Infections
4. Injuries from Falls and Immobility
5. Obstetrical Adverse Events, including Eclampsia and Serious Maternal Hemorrhage
6. Reducing Early Elective Deliveries
7. Pressure Ulcers
8. Surgical Site Infections
9. Venous Thromboembolism
10. Ventilator-Associated Pneumonia
11. Reducing Readmissions

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Leading Edge Advanced Practice Topics (LEAPT) Program

- Severe Sepsis and Septic Shock (mandatory)
- Clostridium Difficile (c-diff), including antibiotic stewardship
- Hospital Acquired Acute Renal Failure
- Airway Safety
- Iatrogenic Delirium
- Procedural Harm (Pneumothorax, Bleed, etc.)
- Undue Exposure to Radiation
- Failure to Rescue
- Hospital Culture of Safety that fully integrates patient safety with worker safety
- Cost savings calculations for HACs (core and/or above), especially using "actual" cost and volume data (as compared with "projected")

Results Come From Many Contributors and Partnerships

- National Quality Strategy
- **National Priorities Partnership and Many Private Partners**
- American Nursing Association NDNQI
- NQF Maternity Action Team, American College of Obstetricians and Gynecologists, March of Dimes and Others Focused on Strong Start
- AHRQ Measurement Tools
- OASH HAI Action Plan
- HRSA Rural Health Programs
- Quality Improvement Organizations
- US OPM Federal Employee Health Benefit Plans
- ACL Aging Services Networks
- Reporting Programs
- Payment Penalties
- Hospital Engagement Networks
- Indian Health Service
- Community Based Care Transitions Program
- …and many others

Partnership for Patients Results: We Are Moving in the Right Direction!

- ***National Support and Management System*** **for Reducing HACs and Readmissions is in Place for 3700+ Hospitals**
- **Progress on *Patient and Family Engagement* is Accelerating**
- **Dramatic *Progress on EEDs* in Multiple Networks and Hundreds of Hospitals; Further Rapid Improvement Expected**
- **LEAPT is Launched and in the Field**
- **Initial Estimates Show Significant, Regular Decreases in Medicare 30-Day Readmissions in 2012**
- **2011 & Early 2012 AHRQ Independent National Scorecard Results Show Trends Are Positive and Moving in the Right Direction**

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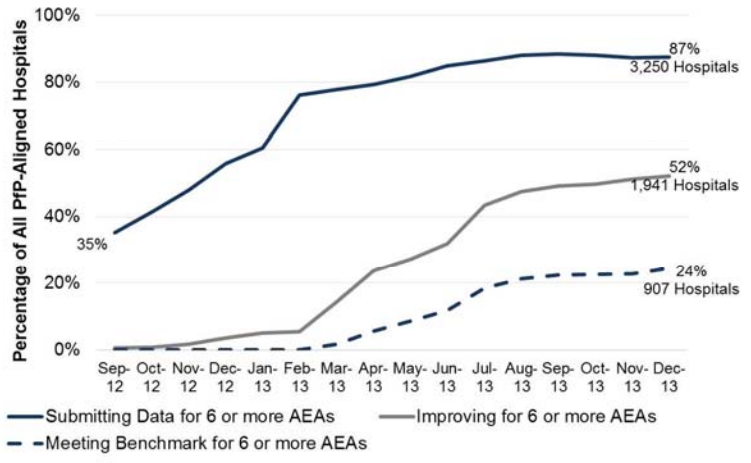
National Support & Management System Is Showing Increased Reporting, Improvement and Benchmark Status on 6+ HACs Over Time

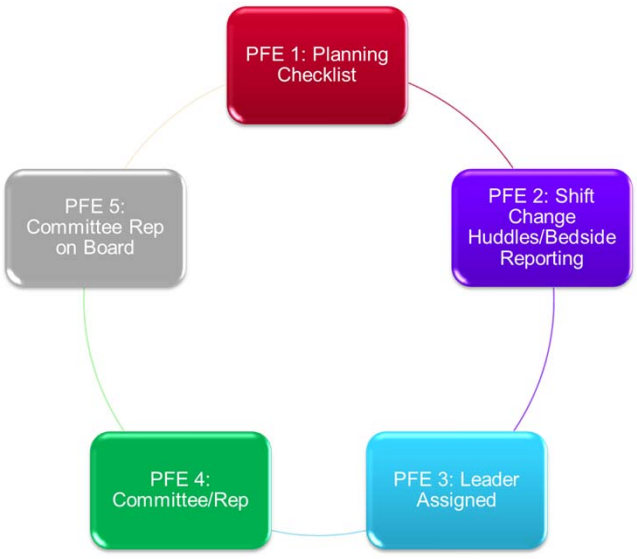


Source: Monthly Z-5 Spreadsheets submitted by HENs..

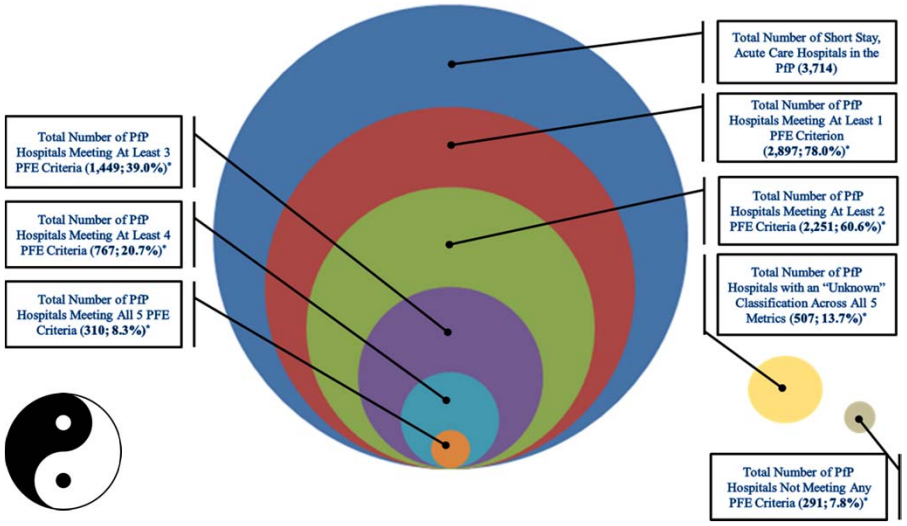
Partnership for Patients
Work on Patient & Family Engagement (PFE)

- **Authentically engage** patients in our work: model and create momentum
- **Identify** organizations that reflect best practices
- **Replicate** and spread effective practices
- **Track** progress on PFE across hospitals and increase transparency. Tracking on 5 PFE areas.
- **Team** with and support others involved in and leading this work

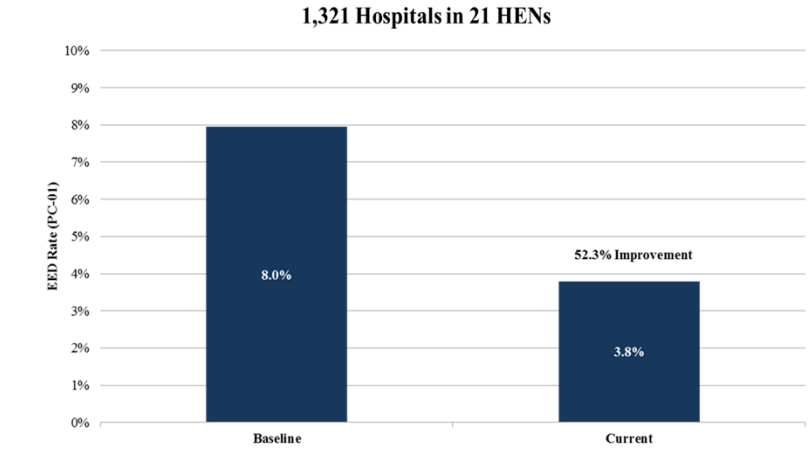
Tracking on 5 Dimensions of Patient and Family Engagement



Numbers of PfP Hospitals Meeting Patient and Family Engagement Criteria, December 2013

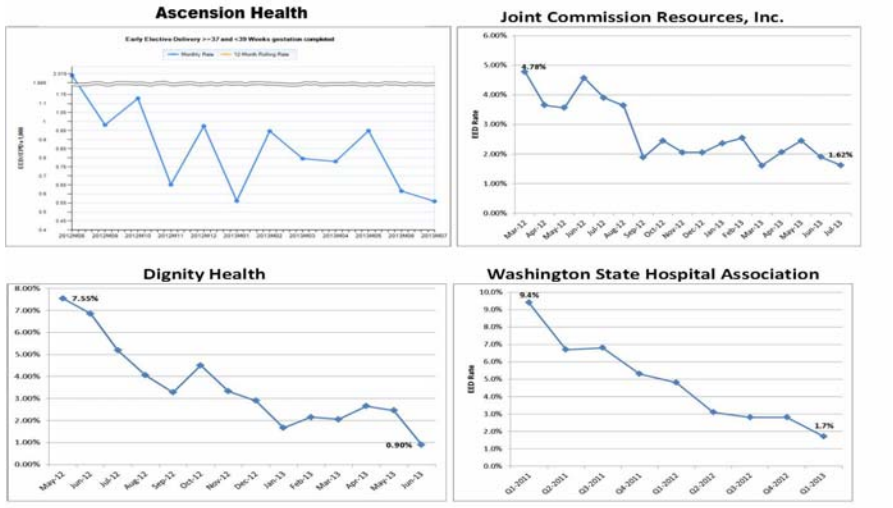


Dramatic Reductions in Early Elective Deliveries for 1300+ Hospitals Using PC-01 Measure

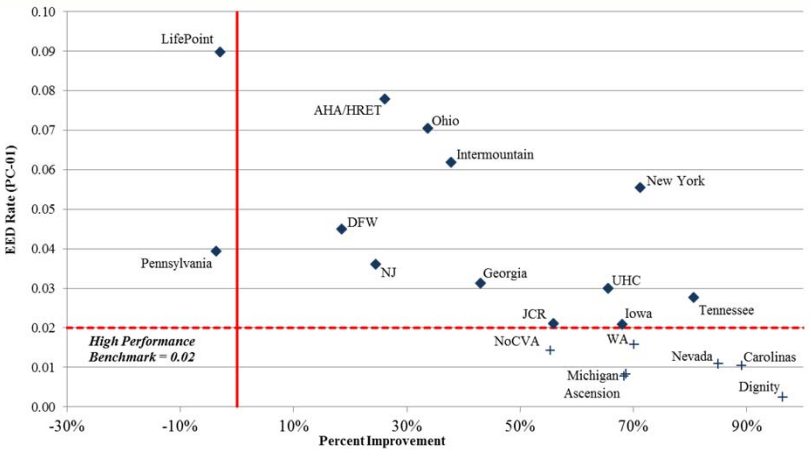


Source: HEN-reported data submitted December 2013.
Notes: Baseline and current periods vary by HEN. The HENs (and therefore number of hospitals) included in the run chart differ from those in this bar chart for two reasons: (1) quarterly data submitters were not included in the run chart, which shows the monthly trend, and (2) not having enough complete data during some of the months shown in the run chart. Baseline and current period rates are rounded for presentation, while the percent improvement is calculated using unrounded data.

4 Examples of Many HEN-Wide Results in Reduction of Early Elective Deliveries



Early Elective Delivery (EED) (PC-01), Current Rate and Percent Improvement by HEN



Source: HEN-reported data submitted November 2013.
Notes: Progress is seen as movement towards the bottom right corner of the figure, indicating both reduction in harm and low current event rate. The graph depicts measure improvement and levels only for those HENs that chose to report this measure, and at least 60 percent of the aligned hospitals are represented in the data. Baseline and current periods vary by HEN. Pennsylvania and LifePoint have later baselines than other HENs (Q4 2012 and Q1 2013, respectively), so data showing worsening is based only on the two data points with sufficient data to date.
+ Indicates HEN met High Performance Benchmark

We Need to Generate Further Progress and Results on Reducing EEDs

Seeking Improvement!

Some Examples Where Further EED Results Are Needed

- PR 17%
- KY 19%
- OK 13%
- NM 6%
- MT, ID, CT – low overall reporting

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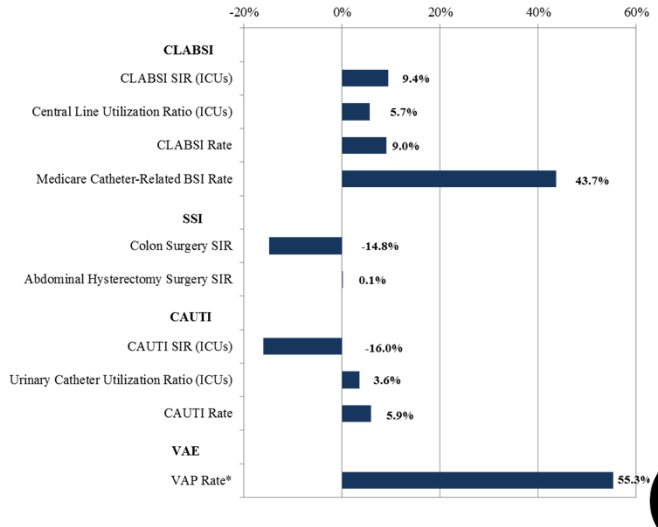
Improvement from Baseline in Leading Indicators with at least 500 Hospitals Reporting

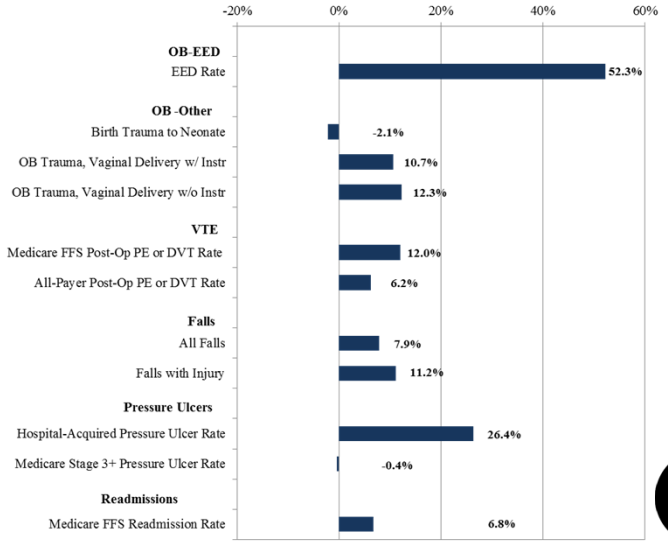


*Concerns have been raised about the measure specifications for this measure.

HSAG HEALTH SERVICES ADVISORY GROUP

MATHEMATICA Policy Research

Improvement from Baseline in Leading Indicators with at least 500 Hospitals Reporting



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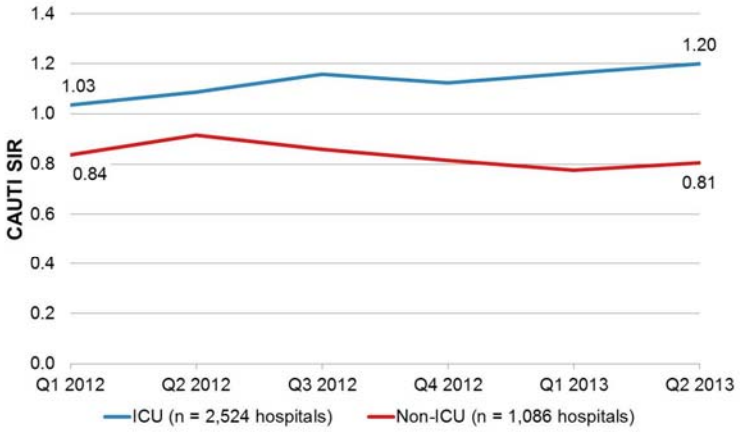
NHSN CAUTI Standardized Infection Ratio (SIR), HEN-Aligned Hospitals, by Unit Type



Source: NHSN (n = 2,524 to 2,584 HEN-aligned hospitals in ICU data, depending on the quarter, and 983 to 1,093 HEN-aligned hospitals reporting non-ICU data, depending on the quarter).

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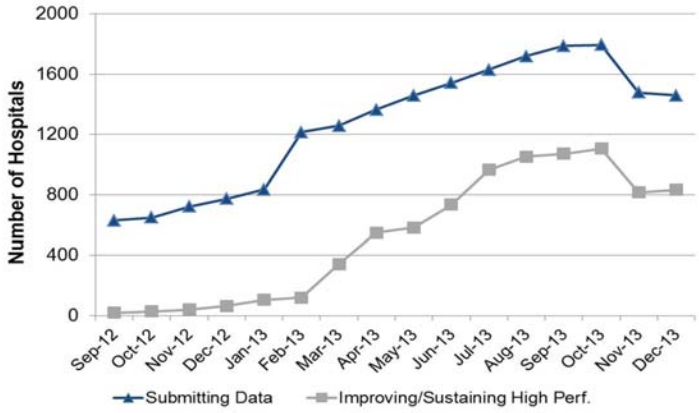
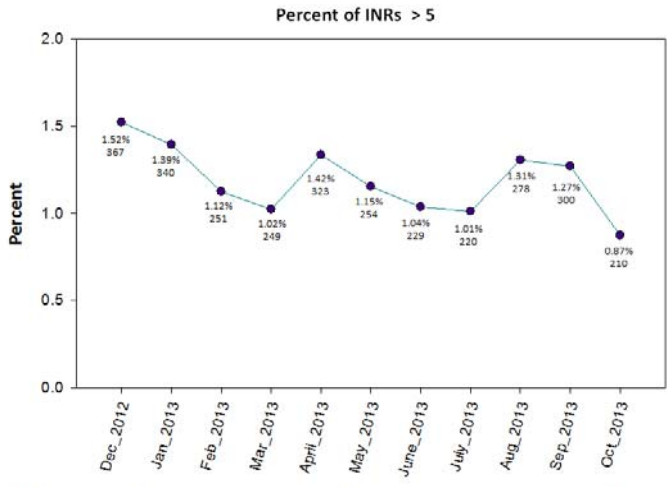
Number of Hospitals Measuring Adverse Drug Events



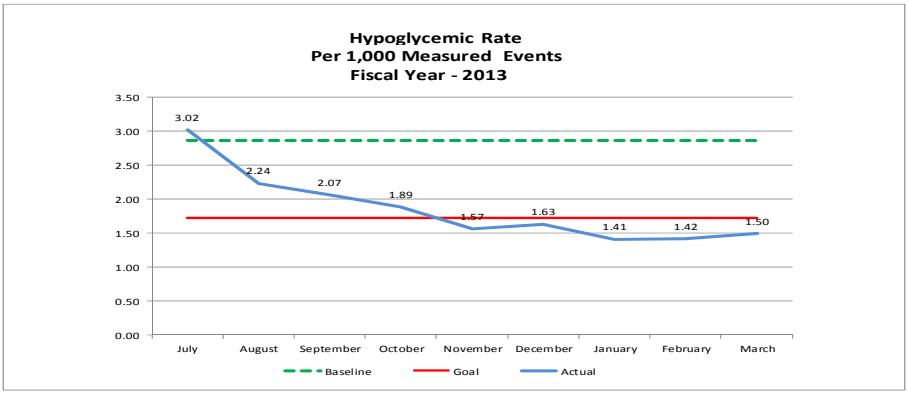
Note: Source is Z-5 spreadsheets. The November/December dip is due to a PfP decision to disallow use of the measure "Manifestations of Poor Glycemic Control" to qualify hospitals for reporting and improvement. This measure, while easy to obtain, is so rare that most hospitals would expect zero events in most reporting periods.

Ascension Health INR >5 Progress



# of lab test	24,133	24,402	22,325	22,547	22,702	22,018	22,084	21,756	21,296	23,626	24,014
# of hospitals	50	48	55	54	55	55	55	56	54	60	63

Dignity Health: Progress in Reducing Rate of Hypoglycemia



	Baseline	12-Jul	12-Aug	12-Sep	12-Oct	12-Nov	12-Dec	13-Jan	13-Feb	13-Mar
Numerator	8,709	598	447	405	382	322	343	331	296	324
Denominator (Total POC Results)	3,067,407	197,915	199,960	195,670	201,919	205,596	209,882	234,646	208,707	216,104
Number of Hospitals	35	35	35	35	35	35	35	35	35	35

100% Hospital Participation (35)

*FYTD 2013 (July 2012-March 2013)[41]

Safety Across the Board in the Dignity Hospital Engagement Network

Dignity 35 aligned hospitals, 100% of applicable hospitals are in each trend		**ADE**: 65% decrease in hypoglycemic rate (POC results<40 mg/dl)	**CAUTI**: 45.3% decrease in CAUTI per 1,000 catheter days (house-wide)
CLABSI: 34.5% decrease in CLABSI per 1,000 central line days	**Falls**: 35.8% decrease in falls with injury (NDNQI definition)	**EED**: 96.4% decrease in EED rate (PC-01); sustaining rate <1%	**PrU**: 50% decrease in rate of HAPU (all stages)
SSI: 35.7% decrease in SSI/100 targeted procedures	**VAP**: 60.4% decrease in VAP per 1,000 vent days	**VTE**: Sustaining low (benchmark)VTE rate (PSI-12)for the Medicare population	**Readm**: 9.6% reduction in Medicare FFS readmissions

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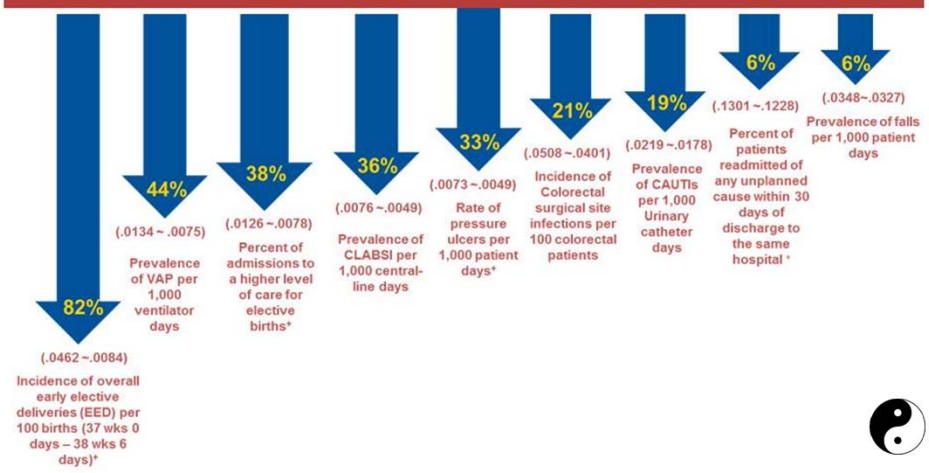
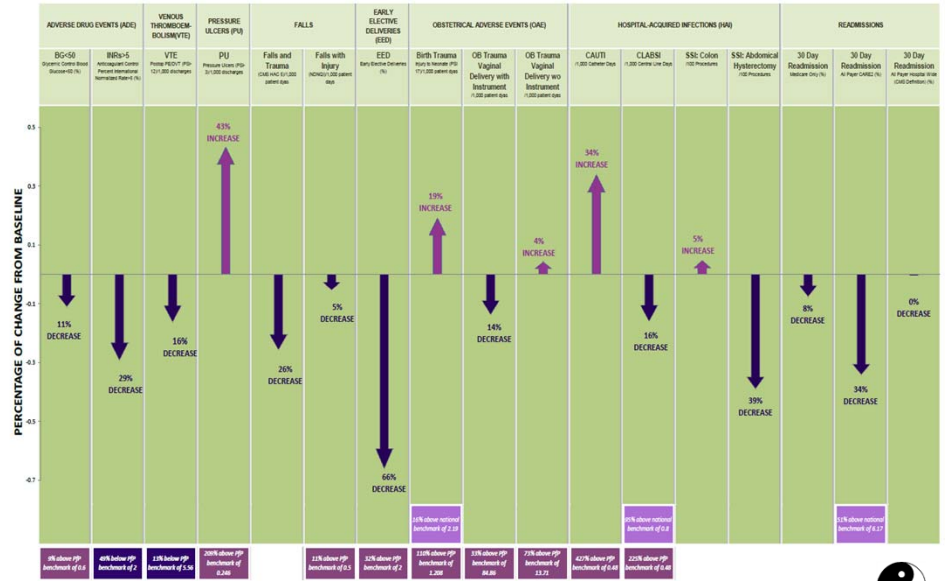
MHA Keystone Center HEN Improvement*



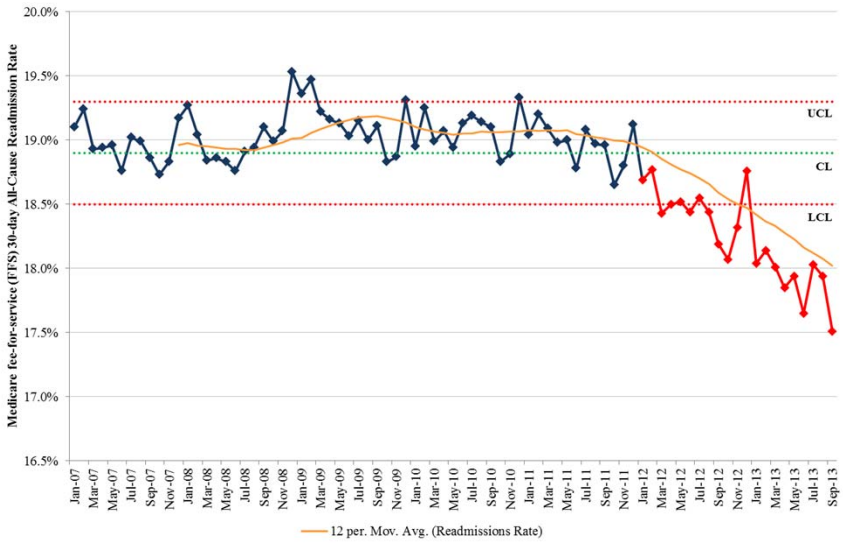
*MHA Keystone HEN improvement was calculated by analyzing the percent difference between the corresponding measures baseline and the June –August 2013 data. MHA Keystone HEN Baseline data was calculated using CY2010 data if available. If CY 2010 data was not available, a baseline was calculated using the first 3 months of data for the corresponding measure starting in October 2011.
+EED data through December 2012, pressure ulcers baseline is May-July 2012, readmissions data is recent as of April-June 2013, percent of admissions to a higher level of care for elective births is recent as of April 2013 – June 2013.

Georgia HEN Health
Harm Across the Board Progress Toward Goals



Leading Indicators Data

Medicare Fee-for-Service (FFS) 30-day All-Cause Readmissions



AHRQ National Scorecard Shows Modest Improvement in Overall Harm Reduction in 2011, Compared to 2010 Baseline

	CY 2010	CY 2011	Difference
PFP Measured HACs	4,745,000	4,614,000	-131,000
PFP Measured HACs per 1,000 discharges	145	142	-3
All-payer 30d readmission rate	14.4% 32.9M admissions	14.4% 32.7M admissions	200k less hospital admissions

- AHRQ Estimated Costs Saved from Harm Reduction in 2011 vs. 2010: **$870,000,000**
- AHRQ Estimated Deaths Averted from Harm Reduction in 2011 vs. 2010: **3,215**

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We Know How to Achieve the Results We Seek

- High performing hospitals…
- Entire systems of hospitals…
- And hospitals across entire states…

…have figured out how to achieve the results we seek, including rapid progress on "Safety Across the Board".

The challenge is spread

Our Challenge to Leaders in the Room

Use today to generate your "to do" list of items to accelerate progress in pursuit of reduced harm and 30 day readmissions:

1. **Call attention to effective methods of Infection Preventionists & Nurses in Dignity…to millions of others in the national workforce**
2. **Call attention to effective methods of pharmacists in Ascension and Dignity…to millions of others in the national workforce**
3. **Work aggressively to mobilize hospitals, OB-GYNs, patients and others in places with still-high EED rates**
4.
5.

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Questions to Run On

- Where are we with the Partnership for Patients (PfP) today?
  - What are our results so far?
  - What areas need increased action and attention?
- How do we leverage the PfP to mobilize the health workforce?
- How can the health workforce support this safety culture change, and improve patient care?
- ***What can NQF members and key stakeholders do to further contribute to reduce harm to patients and un-necessary readmissions?***

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Morning Break (15 minutes)

Embracing the Culture of Safety From Multiple Perspectives

Norman Kahn, Meeting Chair

Table Activity

NQF staff will pass out templates and short narratives on various stakeholder perspectives to each table

Table Activity Discussion

- What perspectives are represented in this story? Whose perspective is missing (if any)?
- From your own perspective (as the part of the workforce you represent), what elements of a Culture of Safety are present? Which are missing?
- Taking on another perspective (for example, a nurse might take on the perspective of specialist, or a pharmacist might take on the perspective of a patient), what elements of a culture of safety are present? Which are missing?
- As an outsider looking in, what would you "prescribe" to the workforce in this narrative to enable a Culture of Safety?

Table Activity Report Out

Each table reports back on key insights

Networking Lunch (45 minutes)

Creating Culture for Excellent Patient Outcomes

Barbara Pelletreau
Senior Vice President, Patient Safety

Wendy Kaler
Manager of Infection Prevention,
Saint Francis Memorial Hospital

January 29, 2013

Dignity Health.

Overview

- Overview of Dignity Health
- A Comprehensive Approach
  - ❑ Structure / Leadership Engagement
  - ❑ Accountability and Transparency
  - ❑ Strategies for Making Change "Stick"
- From a Hospital's Perspective
- Audience Checklist
  - ❑ Homework

Dignity Health

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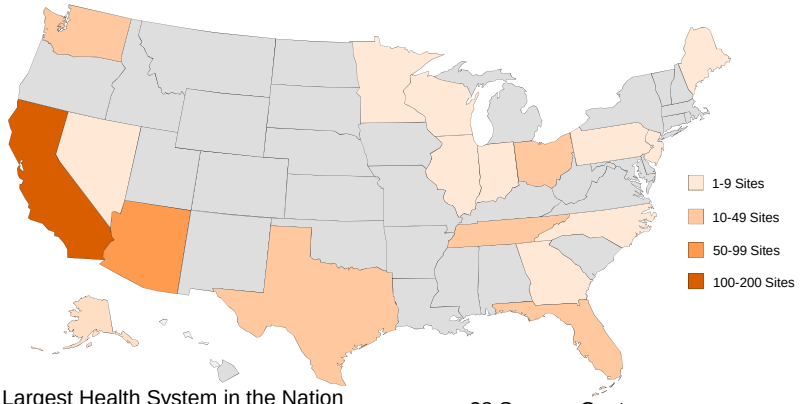
Dignity Health - Who We Are



5th Largest Health System in the Nation
$14 Billion in Assets
39 Hospitals (33 in California, 3 in Arizona, 3 in Nevada)
243 Clinics
47 Imaging Centers

28 Surgery Centers
10,000 Affiliated Physicians
4 Health Plans with 511,000 Members
18 State Network
56,000 Employees
590 Medical Foundation Physicians

As of January, 2013

Dignity Health

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Mission and Values in Action

Mission ~ *Delivering* compassionate, high quality, affordable health services while *Serving* and advocating for our brothers and sisters who are poor and disenfranchised; and *Partnering* with others in the community to improve the quality of life

Values ~

- Dignity
- Collaboration
- Justice
- Stewardship
- Excellence

Dignity Health

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We know that Culture Matters

HSR Health Services Research

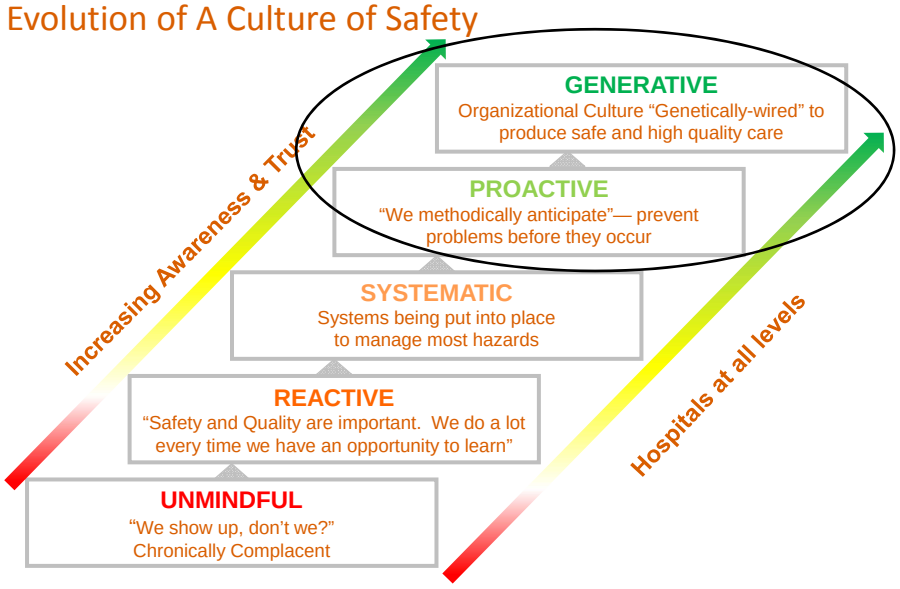
© Health Research and Educational Trust
DOI: 10.1111/j.1475-6773.2010.01204.x
RESEARCH ARTICLE

Perceptions of Hospital Safety Climate and Incidence of Readmission

Luke O. Hansen, Mark V. Williams, and Sara J. Singer

Objective. To define the relationship between hospital patient safety climate (a measure of hospitals' organizational culture as related to patient safety) and hospitals' rates of rehospitalization within 30 days of discharge.
Data Sources. A safety climate survey administered to a random sample of hospital employees ($n = 36{,}375$) in 2006–2007 and risk-standardized hospital readmission rates from 2008.
Study Design. Cross-sectional study of 67 hospitals.
Data Collection. Robust multiple regressions used 30-day risk-standardized readmission rates as dependent variables in separate disease-specific models (acute myocardial infarction [AMI], heart failure [HF], pneumonia), and measures of safety climate as independent variables. We estimated separate models for all hospital staff as well as physicians, nurses, hospital senior managers, and frontline staff.
Principal Findings. There was a significant positive association between lower safety climate and higher readmission rates for AMI and HF ($p \leq .05$ for both models). Frontline staff perceptions of safety climate were associated with readmission rates ($p \leq .01$), but senior management perceptions were not. Physician and nurse perceptions related to AMI and HF readmissions, respectively.
Conclusions. Our findings indicate that hospital patient safety climate is associated with readmission outcomes for AMI and HF and those associations were management level and discipline specific.

Evolution of A Culture of Safety



Structure / Leadership Engagement

Operating Company with Strong Local Leadership

- Focus on communities, not hospitals
- Fosters clinical enterprise focus
- Enables streamlined decision making
- Creates greater accountability for outcomes
- Responsive to community needs

Leadership Engagement ~ Starts at the Top

Bay Area Medicine Man

Fortune profiles Lloyd Dean, CEO of San Francisco-based Dignity Health, noting he has become one of the most connected Bay Area CEO's in the nation. Dean is well regarded by national and local constituencies, as well as his own employees. He has been an ardent supporter of Obamacare, despite being a CEO of a hospital corporation. Kathleen Sebelius, the U.S. Secretary of Health and Human Services, says Dean is in the constellation of 10 health care leaders she relies on our bounces ideas off of. The profile includes a look at Dean's upbringing and his career path.

Dignity Health

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Systematic Approach to a Culture of Safety

- Setting meaningful metrics
- Providing complete toolkits
- Coordinating with hospitals' leads
- Establishing a timeline
- Providing results/interpretation

System Leadership

- Providing access/results to units
- Identifying high/low performers
- Interpreting results
- Monitoring engagement
- Assuring strong leadership

Hospital/Department Engagement

Dignity Health

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Accountability and Transparency

Dignity Health

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OFFICIAL REPORTING PERIOD

Area of Focus	Achieved Target	Baseline	Target	CYTD Actual	CYTD Level of Progess to Goal	CYTD % Change From Baseline
#1 Hypoglycemic Rate	↑	0.29%	0.17%	0.12%	▦	58.60%
#2 Catheter Associated Urinary Tract Infections	↑	1.89	1.13	0.97	▦	48.51%
#3 Central Line Associated Blood Stream Infections	↓	0.81	0.49	0.58	△	28.95%
#4 Falls	↓	0.11	0.06	0.08	●	22.01%
#5 Perinatal Safety - Early Elective Deliveries	↑	7%	0.01	0.3%	▦	94.95%
#5 Perinatal Safety - Oxytocin	↑	63.0%	85.0%	85.6%	▦	35.93%
#6 Hospital Acquired Pressure Ulcers	↓	2.13	1.28	1.28	✓	39.66%
#7 Surgical Site Infections	↓	0.84	0.50	0.80	●	5.09%
#8 Venous Thromboembolism & Pulmonary Embolism	↓	4.24	2.54	3.97	●	6.30%
#9 Ventilator Associated Pneumonia	↑	1.63	0.98	0.82	▦	49.31%
#10 Readmissions within 30 Days	↓	7.33%	5.86%	7.04%	●	4.02%
#11 ED Holds and Facility Decompression	↓	394	295	383	●	2.65%
#12 Culture of Safety - Just Culture	↑	43%	80%	82%	▦	90.64%
#12 Culture of Safety - Safety Attitude Questionnaire	↓	65	72	64	△	-1.14%

No Harm Campaign – Cost Savings Report

No Harm Campaign as of November 30, 2013	January 1, 2012 to November 30, 2013					
	Numerator	Denominator	Rate	Numerator Variance From Baseline	# Events Saved	Cost Saving
#1 Hypoglycemic Rate	8,799	4,752,242	0.19%	-1	4,983	$5,909,838
#2 Catheter Associated Urinary Tract Infections	837	731,498	1.14	-176	553	$476,686
#3 Central Line Associated Blood Stream Infections	397	571,622	0.69	-135	60	$1,020,000
#4 Falls	243	3,003,595	0.08	-58	57	$1,108,080
#5 Perinatal Safety - Early Elective Deliveries	195	26,623	0.73%	160	1,621	$1,180,088
#6 Hospital Acquired Pressure Ulcers	788	549,523	1.43	-123	366	$6,148,800
#7 Surgical Site Infections	456	58,587	0.78	-271	36	$427,464
#8 Venous Thromboembolism & Pulmonary Embolism	2,156	550,157	3.92	-828	155	$1,597,430
#9 Ventilator Associated Pneumonia	164	158,665	1.03	-42	90	$1,766,970
#10 Readmissions within 30 Days	56,811	802,567	7.08%	-23,732	2,017	$19,363,200
TOTALS	$70,846	$11,205,079		-25,206	9,938	$38,998,556

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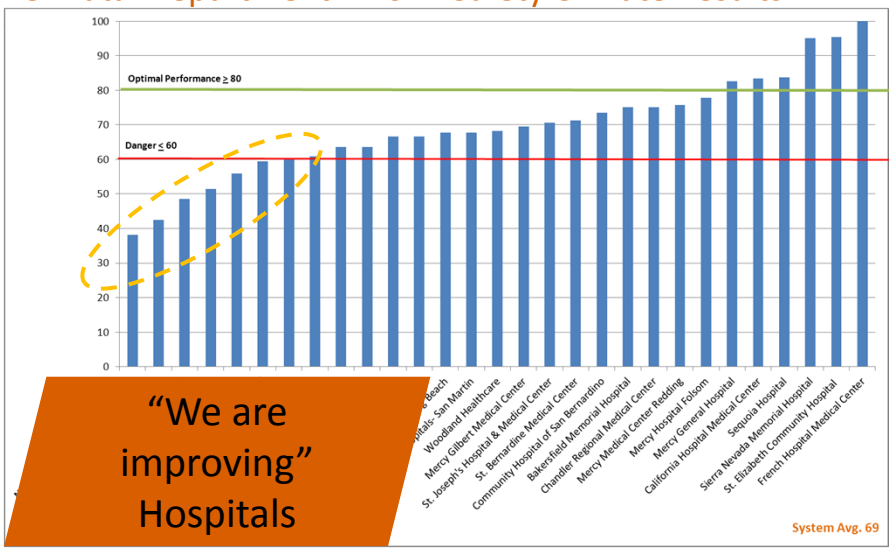
Perinatal Department – 2012 Safety Climate Results



"We are improving" Hospitals

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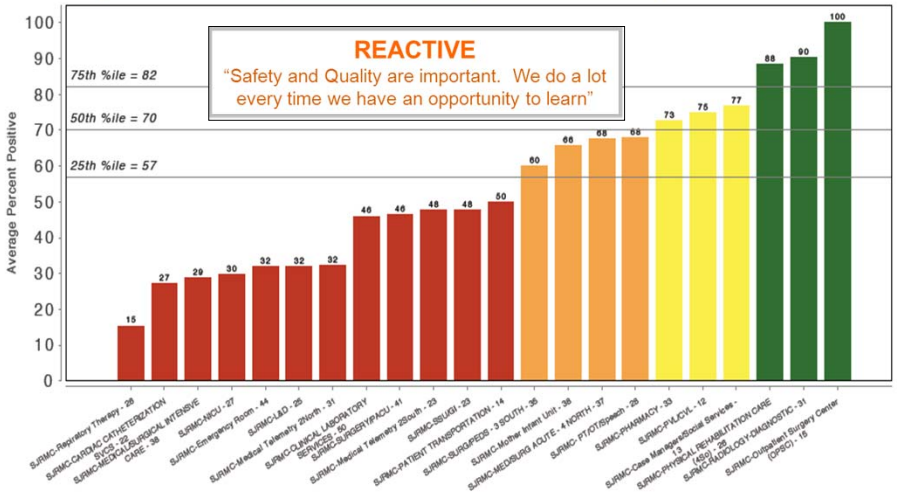
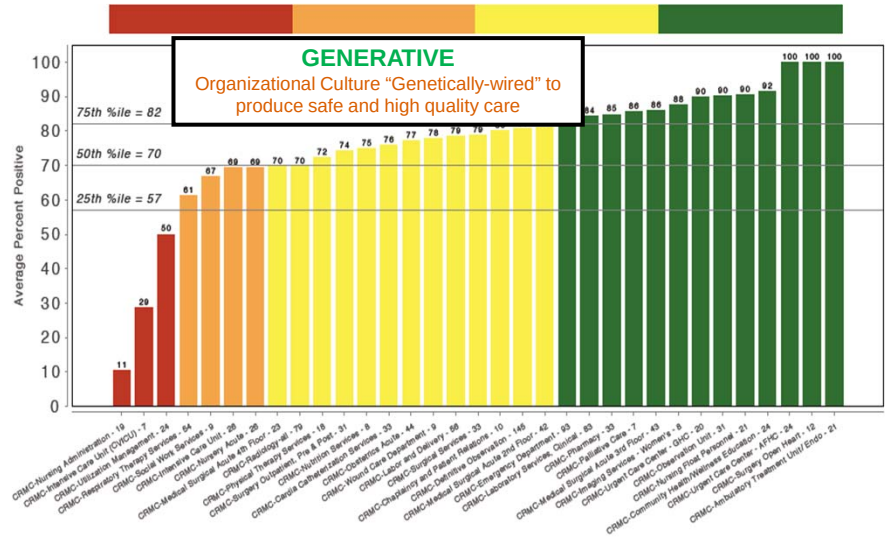
Safety Climate "WE ARE IN THE PROCESS OF IMPROVING" Hospital

Note: Use the multicolored bars to see how you fit with the benchmark archive. If you have less red and more green than the benchmark, you are more positive than the benchmark. If the colors all match up, you are about the same as the benchmark.

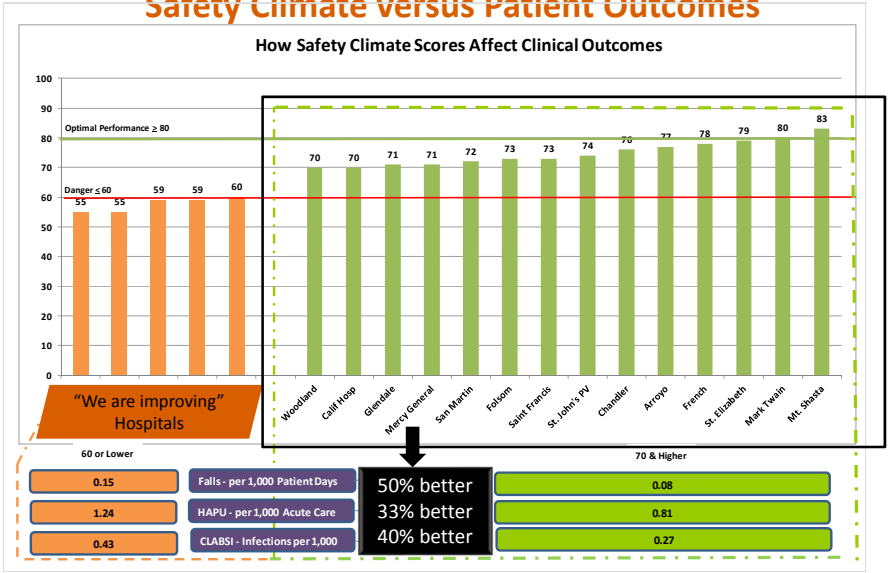


Safety Climate "WE JUST FOCUS ON WHAT IS RIGHT" HOSPITAL

Note: Use the multicolored bars to see how you fit with the benchmark archive. If you have less red and more green than the benchmark, you are more positive than the benchmark. If the colors all match up, you are about the same as the benchmark.



Safety Climate versus Patient Outcomes



Good results but do patients benefit?

Perinatal Safety Initiatives – System-Wide Outcomes

- Successfully reduced non-indicated EEDs to < 1%
- Reduced NICU admissions for term infants by 3.8%
- No change in stillbirths or primary C/S rate
- Reduced percentage of Operative Vaginal Delivery by 17.5%
- Reduced incidence of Shoulder Dystocia by 21.6%
- Reduced birth trauma by 21.1%
- Reduced utilization of blood and peripartum hysterectomy

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Strategies to Make Change Stick

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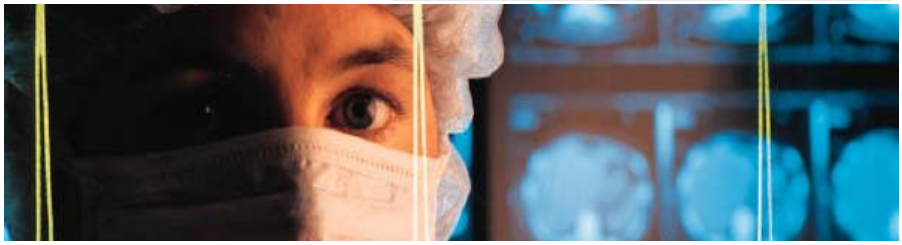
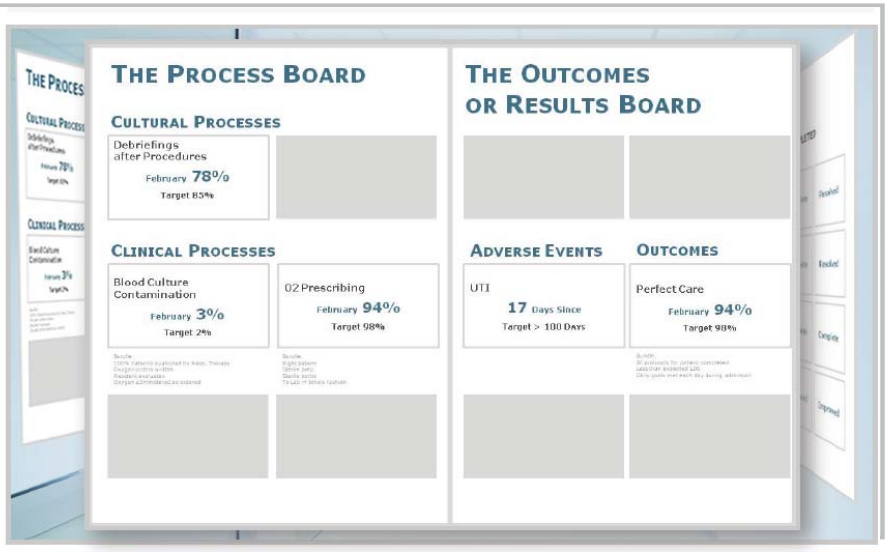
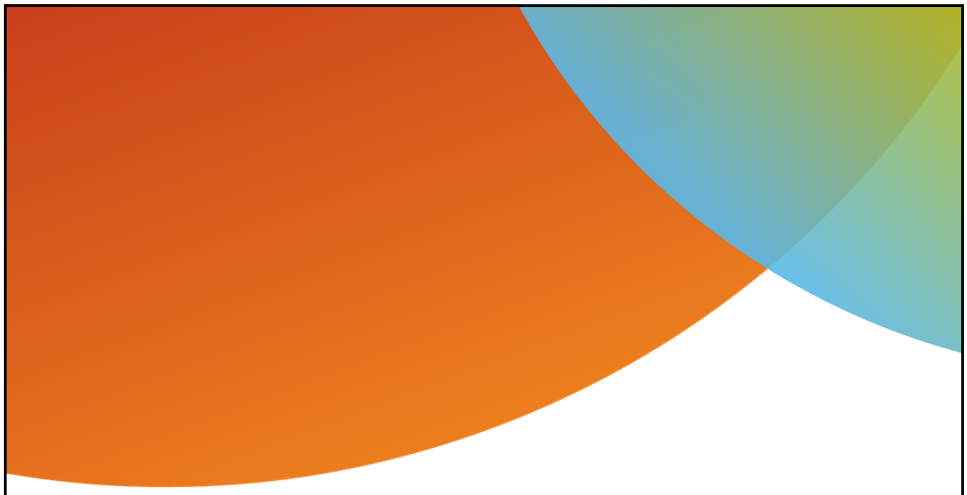
Strategies for Making It Stick

	The associated behaviors:
Leadership embraces it	Present to leadership, work a plan, set the vision
Roll out system wide adoption	Key stakeholders, monthly calls, toolkits, favorable budget, and incorporated into current infrastructure. Including EHR
Patients and caregivers benefit	Internal or external evidence supports better results, engaged employees/unit leadership support
Integrate with existing actions	Identify high/low performing units, right leaders, Just Culture, Lean/Six Sigma, patient outcomes



Other Tactics - Learning is Visible in Healthy Work Areas





From a Hospital's Perspective

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It is about people and building relationships

- Engage them Early… and Often
  - Nursing/Medical School curriculum
- Focused New Hire Orientation of Bedside Staff—
  - Make it personal
  - Nursing, Environmental Services, Therapies
  - Annual competencies
- Employ Champions - Choose the right people
  - Provide stewardship, verify compliance until new norm is achieved
  - Have difficult conversations at the bedside using O-I-L-S
  - Ensure compliance and intervene in real-time with MeasureVentionists
  - Increase performance improvement role with Infection Preventionists
  - Expect physician champions to actively round

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The right people might be outside the usual job categories

The right people are …

- ✓Collaborative
- ✓Creative
- ✓Focused
- ✓Unflappable
- ✓Accountable
- ✓Tenacious
- ✓Cheerleaders
- ✓Change agents

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Give the right people the right tools

- Give staff the equipment they need to make it easy to do the right thing
- Save staff time, provide options and alternatives that promote critical thinking of what's best for that patient
- Work with vendors to support implementation and improve designs of products that make it easier for bedside staff to do the right thing.



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In Summary
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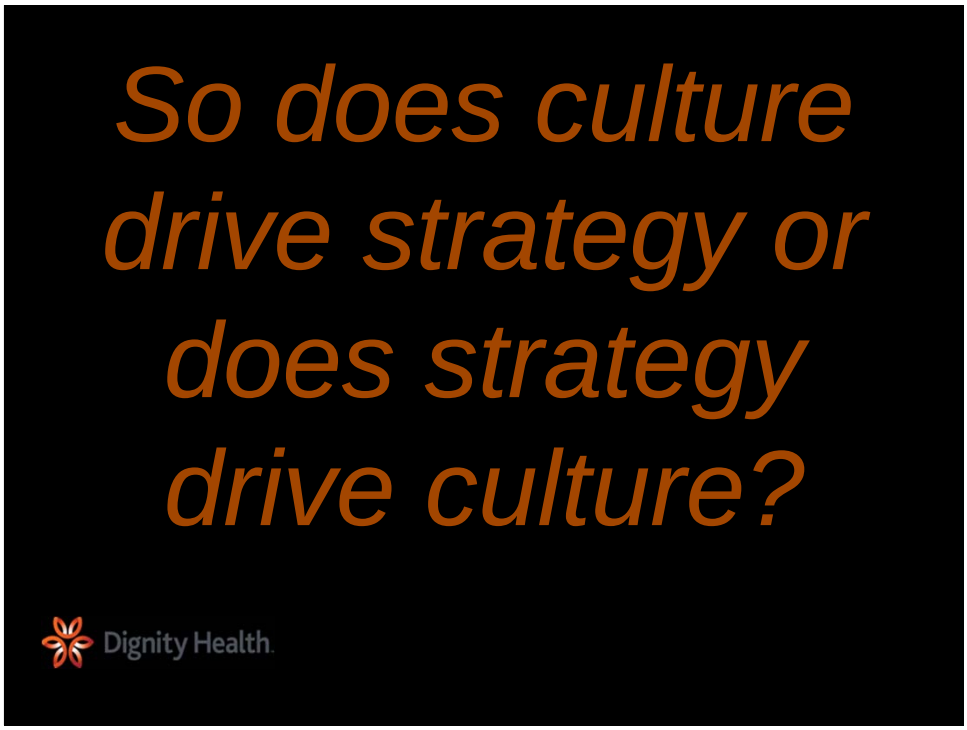
So does culture drive strategy or does strategy drive culture?
Dignity Health.

"Culture eats strategy for lunch."

Culture, Strategy and Accountability dine together.

Dignity Health.

A Checklist for Culture of Safety, Quality Care & Patient Results

- ❑ 1. Does your leadership round daily at the bedside and units?
- ❑ 2. Can each of your senior leaders articulate the top ten safety and quality goals across your system?
- ❑ 3. Are your results available by hospital, easy to access and presented real time across all hospitals?
- ❑ 4. Can your organization easily identify the low performers and dedicated additional resources for improvement?
- ❑ 5. Does your hospital adopted evidence based practices (or create proven practices to share)?
- ❑ 6. Does your hospital support accountable and effective leaders at a department level?
- ❑ 7. Does your hospital engage councils, leadership groups, physicians, champions to implement and drive change?
- ❑ 8. Does your EHR team align with your clinical, safety and quality leaders?
- ❑ 9. Does your hospital adopt proven strategies from other learning organizations to improve outcomes?
- ❑ 10. Does your hospital drill down and share your adverse events?

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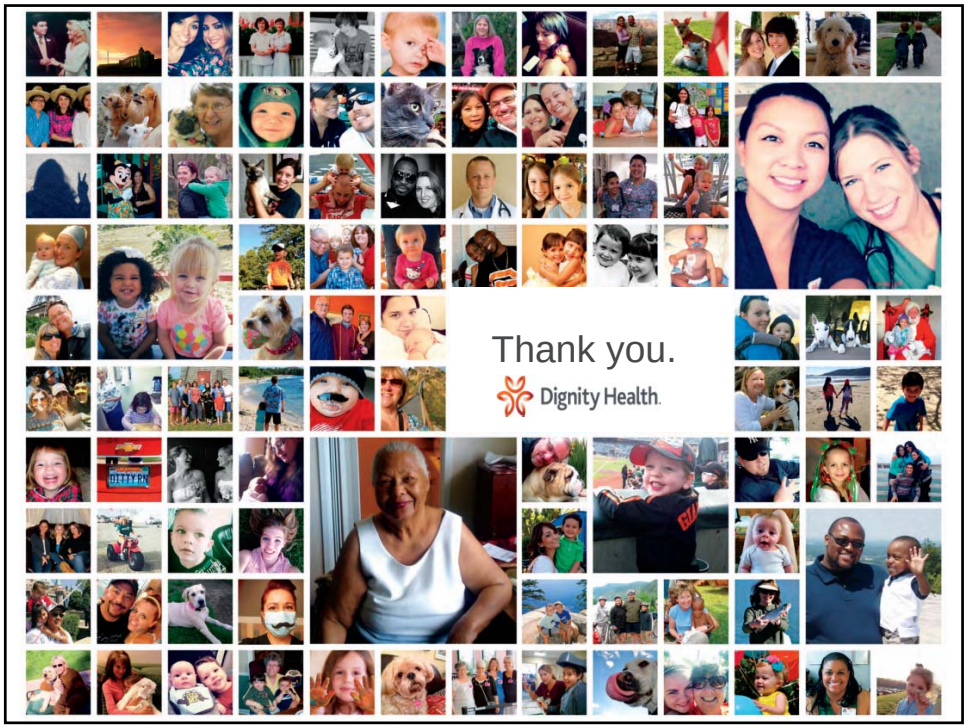


Embracing the Culture of Safety

Charisse Coulombe, AHA/HRET

NQF Mobilizing the Health Workforce to Reduce Hospital Acquired Conditions

January 29, 2014

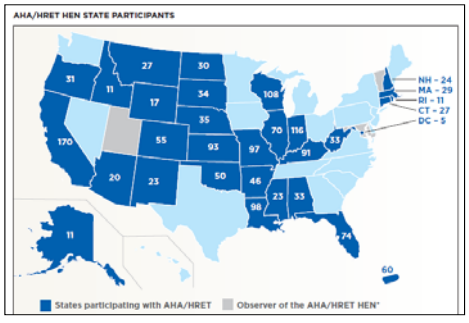
hospitals in pursuit of excellence

TRANSFORMING HEALTH CARE THROUGH RESEARCH AND EDUCATION

HRET HEALTH RESEARCH & EDUCATIONAL TRUST In Partnership with AHA

Background

- Over 1,600 hospitals in the AHA/HRET Hospital Engagement Network (HEN) project
- 31 State Hospital Associations
- 46% of hospitals are rural
- 33% of hospitals are CAH



HRET HEALTH RESEARCH & EDUCATIONAL TRUST In Partnership with AHA

Culture Challenge

- Each hospital has a unique culture
- Working with each of the hospitals through the state hospital association to better understand challenges and similarities
- Metrics are needed as a concrete way of measuring progress to eliminate harm

Culture Requires

- Leadership
- Multiple Strategies
- Measurement (difficult but necessary)

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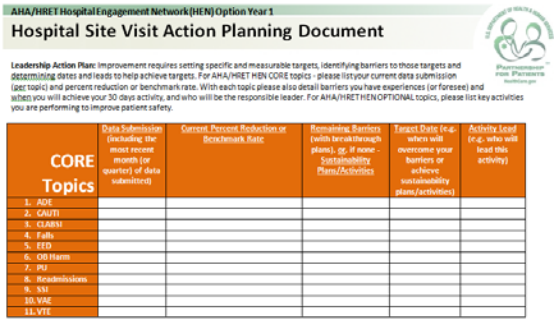
Specific Best Practices to Create Culture Change

- Leadership Education includes
  - Governance Video Series
  - Improvement Leader Fellowship
  - Site Visits



AHA/HRET Hospital Engagement Network (HEN) Option Year 1

Hospital Site Visit Action Planning Document

Leadership Action Plan: Improvement requires setting specific and measurable targets, identifying barriers to those targets and determining dates and leads to help achieve targets. For AHA/HRET HEN CORE topics - please list your current data submission (per topic) and percent reduction or benchmark rate. With each topic please also detail barriers you have experiences (or foresee) and when you will achieve your 30 days activity, and who will be the responsible leader. For AHA/HRET HEN OPTIONAL topics, please list key activities you are performing to improve patient safety.

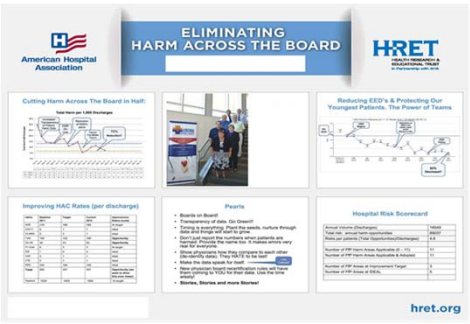
CORE Topics	Data Submission (including the most recent month (or quarter) of data submitted)	Current Percent Reduction or Benchmark Rate	Remaining Barriers (with breakthrough plans), or, if none - Sustainability Plans/Activities	Target Date (e.g. when will overcome your barriers or achieve sustainability plans/activities)	Activity Lead (e.g. who will lead this activity)
1. ADE					
2. CAUTI					
3. CLABSI					
4. Falls					
5. FED					
6. OB Harm					
7. PU					
8. Readmissions					
9. SSI					
10. VAE					
11. VTE					

Specific Best Practices to Create Culture Change

- Multiple Strategies include
  - Focus on key Patient and Family Engagement activities
  - Site Visits with specific action planning and follow-up
  - Allowing hospitals to share their successes and failures with each other via LISTSERVs® and case studies
  - Providing resources and tools such as TeamSTEPPS for the key areas

Specific Best Practices to Create Culture Change

- Measurement include
  - Real-time data reports for CEO and front line team to assess progress
  - Eliminating Harm Across the Board Storyboards



Results of Culture Change Intervention

- Through the end of the base period

HARMS PREVENTED WITH COST SAVINGS – PROJECTIONS THROUGH END OF BASE PERIOD

Topic	Harms Prevented	Cost Savings
CAUTI	2,806 patients who did not have a CAUTI	$ 1,221,600
CLABSI	611 patients who did not have a CLABSI	$ 8,452,600
EED	13,340 babies who were not electively delivered before 39 weeks (640 babies who did not have to go to the NICU)	$ 3,132,200
Readmissions	50,442 All Cause 30-Day Readmissions Prevented	$166,311,600
Pressure Ulcers	96 Stage III/IV Pressure Ulcers Prevented	$ 933,400
SSI	1,337 patients who had a SSI prevented	$ 15,056,000
VAP	368 patients who did not have a VAP	$ 6,430,100
VTE	72 patients who did not have a Post-Operative PE or DVT	$ 210,200
Estimated Total	69,072 patients who had a harm prevented	$201,811,600

Data Source: Comprehensive Data System (10/28/2013)

Results of Culture Change Intervention

- Lessons Learned
  - Collecting harm data is a challenge but becomes a powerful driver for change
  - Engagement at all levels of the organization is critical and sharing successes and barriers with other hospitals is key
    - "The answer is somewhere in the [virtual] room"
  - Culture change is hard but all types of hospitals in our HEN have been able to achieve success

Three Requests to Achieve Safety Across the Board

- Leaders need to be committed to change
- Understand that this change is not "cookie-cutter" so multiple strategies must be considered
- Need to have consistent messaging and monitoring of data to prove change has occurred

Getting to Zero Harm

The High Reliability Journey

Connecticut
Hospital Association

Mary Reich Cooper, MD, JD
Chief Quality Officer
Presentation to NQF Patient Safety Meeting
January 29, 2014

We start with a story…

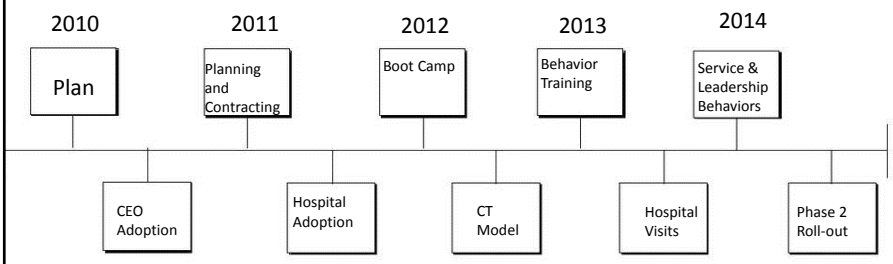
Safety Starts With Me

CHA Safe Care Leading Together

"The number one priority for Connecticut hospitals is **ensuring patient safety while delivering the highest quality of care**.

Patients and their families depend on our hospitals to deliver outstanding care under the ***safest possible conditions***."

Timeline



High Reliability: Leadership Engagement

Senior leader engagement

Safety huddles across the state

CHA High ***Reliability*** Leadership Methods

Set the Tone of Safety as a Core Value

Leaders show the way by setting expectations and setting good examples. Leaders model, inspire, train and encourage team members to keep themselves and others safe each and every day.

- Safety First in Every Meeting
- Safety First in Decisions – What's best for the Patient?
- Encourage Error, Problem and Event Reporting
- Thank those who Voice Safety Concerns
- Communicate Lessons from Safety Events
- Educate for Safety Every Day

Find and Fix System Causes

Leaders remove barriers that impede team members from performing effectively and take active steps to find and fix the holes in the Swiss Cheese before they lead to patient or employee harm.

- Daily Safety Check-in
- Start the Clock on Safety Critical Issues
- Top 10 Lists with Action Plans
- Pre-Task and After-Action Huddles
- Leadership workgroups
- Unit Top 2 & Patient Communication Boards

Build and Reinforce Accountability

Leaders make reliability a reality by building a culture of collegial teamwork where sound practice habits are adopted by all to reduce human error. Leaders reinforce good habits, correct poor ones, never punish honest mistakes, yet are not afraid to hand out fair consequences to those who choose to adopt reckless behaviors.

- Rounding to Influence with 5:1 Feedback
- Fair and Just Accountability using the Performance Management Decision Guide
- Red Rules to Communicate Safety Absolutes
- Safety Coaches

HPI

Slide 1

CHA Safe Care Leading Together

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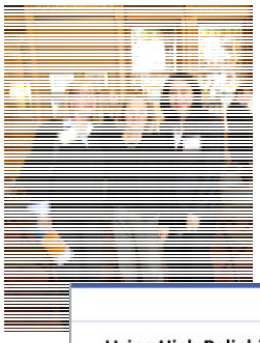
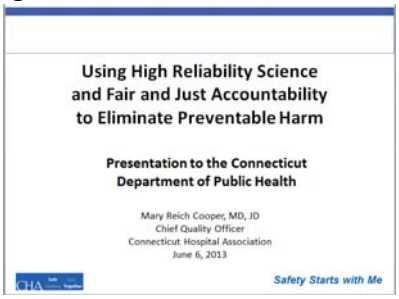
High Reliability: Modeling The Behaviors



- Metrics at Quality Committee of Board
- Updates to the Board
- Discussion with leadership
- Safety stories to staff
- Training CHA staff
- Spreading the word

Using High Reliability Science to Monitor the Use of Restraint and Seclusion

Mary Reich Cooper, MD, JD
Chief Quality Officer
May 2, 2013



Using High Reliability Science and Fair and Just Accountability to Eliminate Preventable Harm

Presentation to the Connecticut Department of Public Health

Mary Reich Cooper, MD, JD
Chief Quality Officer
Connecticut Hospital Association
June 6, 2013

Safety Starts with Me

CHA Safe Care Leading Together

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High Reliability: Training The Hospitals

- 4,000 people trained at CHA
- 400 trainers certified by CHA
- Thousands of staff trained at the hospitals
- Medical staff trained via multimedia

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High Reliability: Endorsing Hospital Behaviors

Safety Starts with Me

C Communicate Clearly
- Repeat Backs / Read Backs with Clarifying Questions
- Phonetic and Numeric Clarifications

H Handoff Effectively
- SBAR

A Attention to Detail
- Self-check using STAR

M Mentor Each Other – 200% Accountability
- Cross-Check and Coach teammates
- Speak up for Safety: ARCC it up – "I have a Concern"

P Practice and Accept a Questioning Attitude
- Validate and Verify
- Stop the Line – "I need clarity!"

Be a safety "CHAMP" for our patients

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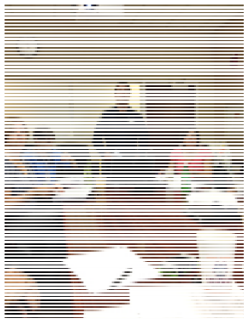
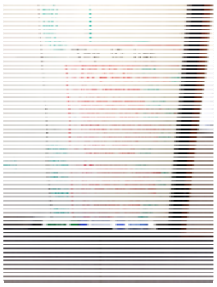
High Reliability: Site Visits and High-Touch

- Introductory visits to every hospital in the state
- Advance planning and schedules
- Structured rollout
- Fall Harvest visits

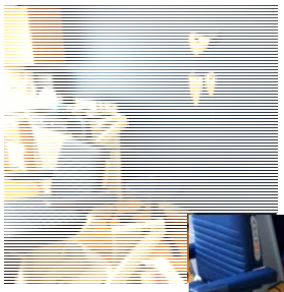


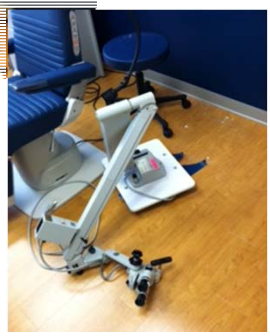


CHA Safe Care Leading Together

High Reliability: Using Media To Make The Point

- Website with more than 200 users
- Safety stories daily
- Safety tweets and twitter chats
- Webinars added to safety training





CHA Safe Care Leading Together

Partnership for Patients: Additional Value

- ADE: $3000 per case
- CAUTI: $750 per case
- CLABSI: $19,000 per case
- Falls: $11,250 per case
- OB and EED rates: N/A
- HAPU: $43,180 per case
- SSI: $20,000 per case
- VTE: $10,000 per case
- VAP/VAE: $43,000 per case
- Readmissions: $9600 per case

Source: CMS (HRET Harm Calculator)

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Partnership for Patients: Leveraging High Reliability

- Level 1
  - Participate in a PfP HEN
  - Data Reports monthly
- Level 2
  - Level 1 PLUS
  - Collect Safety Events
  - Commit to Reduce Harm to Zero
- Level 3
  - Level 2 PLUS
  - Commit to train all staff
  - Commit to train medical staff
  - Commit to daily safety huddles
  - Commit to leadership and staff safety behaviors

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Connecticut Savings:

More than $30 million thus far

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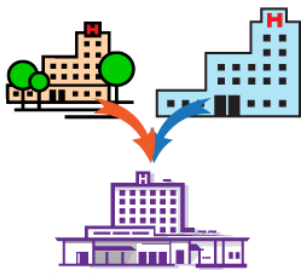
Competing Priorities



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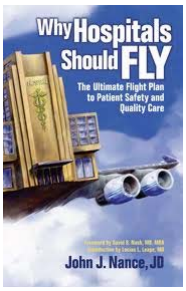
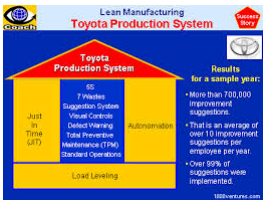
Flavor of the Day, Week, Month….

PLANETREE





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High Reliability: Next Steps

- Integrate Patient and Family Engagement
- Expand Level 3 participation
  - 24/28 hospitals
- Strengthen safety and leadership behaviors
- Increase utilization of media for reinforcement
- Measure performance and patient impact

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QUESTIONS?

Afternoon Break (15 minutes)

Moving to Action: How Will You Create Safety Across the Board at Your Organization?

Norman Kahn, Meeting Chair

Accelerating Action to get Results: Next Steps

Evaluation of the Day

Survey Monkey link will be sent to you after today's meeting

Please respond by **Friday, February 7**

Meeting Materials Available Online

- Meeting materials will be available on www.qualityforum.org shortly, including:
  - Today's presentation
  - A recording of today's meeting
  - A meeting summary

Thank You