Turning On The High Beams

The Case for Staying the Course: Hospital Patient Safety Improvement Stories

California Readmission Summit
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The California Hospital Engagement Network (CalHEN)

• A Partnership for Patient’s initiative supported by the Centers for Medicare and Medicaid (CMS) to hospitals in 2012 and 2013.

• CalHEN is subcontracted with the Health Research, Education and Trust (HRET), a subsidiary of the American Hospital Association (AHA).
  – AHA is contracted with CMS.
Goals

• 1\textsuperscript{st} Goal:
  ○ Engage hospitals to commitment to reducing hospital acquired conditions by 40% and preventable readmissions by 20% by December 31, 2013 in order to attain CMS goals.

• 2\textsuperscript{nd} Goal:
  ○ Accelerate and spread patient safety strategies systematic with different implementation models across the United States. CMS funded 26 Hospital Engagement Networks (HENs).
Project Overview: Harm Topics

Hospital Acquired Conditions (HACs)

1) Adverse Drug Events (ADE)
2) Catheter Associate Urinary Tract Infections (CAUTI)
3) Central Line Associated Blood Stream Infection (CLABSI)
4) Early Elective Delivery (EED)
5) FALLS- with and without injury (FALLS)
6) OB Harm (OB)
7) Pressure Ulcers (PU)
8) Surgical Site Infections (SSI)
9) Ventilator Acquired Pneumonia (VAP)
10) Venous Thromboembolism (VTE)

11) Elective Readmissions (READ)
The CalHEN Model

• Six Network Facilitators

• Supports geographic defined area to provide:
  
  o **Technical support, coaching and consulting:**
    o Principles and tools of process improvement
    o Test of change and spreading successful strategies
    o Evidence based strategies and tactics using HRET harm topic change packages
  
  o **Encourage and facilitate hospitals to share** their lessons learned and success stories to others to support their improvement
  
  o **Collaboration** with state, county, federal and private organizations to affect hospital improvement to achieve patient safety goals
Opportunities To Discover, Learn, Share and Spread Improvement Success

• HRET
  o **Collaborative** in person and virtual education and hospital sharing calls
  o **Listserv** networking
  o Process Improvement **Fellow Leadership training**
  o **CEO and Medical Leadership** opportunities
  o **Affinity Groups** conference calls - rural/critical access, psy, LTC, OB and readmission and medication management
  o Hospital **Progress Improvement Reports**
  o Hospital Progress and CEO Dashboard **Reports on Progress**

• CalHEN
  o **Webinars** on harm topics, PI principles and tools and patient and leadership engagement
  o **Weekly Updates**
  o **Sharing Success Stories**, cross pollination across the state
  o **Community meeting collaboration** with HSAG and Regional Hospital Associations
  o Small hospital **group sharing calls** targeted to discuss topic measure they are struggling with a hospital that has been successful reducing harm
  o Hospital PI Team **site visits and conference calls**
  o **Progress/AIM Reports**
Types of Hospitals Participating

- General Medical / Surgical: 106
- Rural*: 33
- Long-Term Care: 11
- Sub Acute: 9
- Long Term Acute Care: 8
- Psychiatric: 3
- Rehab and Surgical: 1
- Cancer Specialty: 1
Hospitals Reporting By Harm Area and Readmission

* Represents reporting for December 2012 and September 2013

Diagram showing reporting percentages for various harm areas:
- ADE: 35%
- VTE: 43%
- PU: 46%
- EED: 56%
- OB: 71%
- Falls: 73%
- VAP: 74%
- CAUTI: 77%
- CLABSI: 96%
- SSI: 98%
- Readmits: 100%

Legend:
- Blue: Outcome Measures Only
- Red: All Measures
Percent of Hospitals Who Have Achieved PfP Goals (September 2013)

Level of Progress
- # of Hospitals submitting data with zero at baseline, zero for last 6 to 11/23 or 12/24 months
- >40%
- 15%-19%
- 30%-39%

California Hospital Engagement Network
Working to reduce patient harm by 40 percent and readmissions by 20 percent by the end of 2013.
Percent of Hospitals Sustaining PfP Goals (September 2013)

• Zero (0) incident reporting:
  - ADE - 8% of hospitals (6 to 11 months or 6-23 months)
  - CAUTI - 30% of hospitals (12 to 24 months)
  - CLABSI - 32% of hospitals (12 to 24 months)
  - Pressure Ulcers - 32% of hospitals (6 to 11 months or 6 to 23 months)
  - Ventilator Acquired Pneumonia - 33% of hospitals (24 months)
Achievements in Level of Progress Over Time (September 2013)
Patient Harm Avoid

- Cases Averted 5,733 patients (Est.)
QUESTIONS
Introductions

Harm Across the Board Hospital
Success Stories

An Interactive Experience
Readmission Reduction Within 30 Days (All Cause)

Chino Valley Medical Center
Chino, California

Presented by

Sue Montoya-Bell, LCSW
Case Management Director

and

Donna Young, RN
Process Improvement Director
Readmission Reduction: Disease Specific Acute Myocardial Infarction, Heart Failure and Pneumonia

Garfield Medical Center
Monterey Park, California

Presented by

Kathleen Connors, BS PT, MHA
Director of Patient Experience
Readmission Reduction: Within 30 Days (All Cause): Utilizing a Discharge “Time Out”

Hazel Hawkins Memorial Hospital
Hollister, California

Presented by

Marilouise Salsiccia, RN, CPHQ, HACP
Director Quality Resource
Readmission Reduction: Within 30 Days (All Cause)

Henry Mayo Newhall Hospital Medical Center
Valencia, California

Presented by

Elizabeth Cravitz, RN, MSN
Director, Case Management
Readmission Reduction: Managing Medications to Reduce 30-Day (All-Cause)

Mammoth Hospital, Mammoth Lakes, California

Presented by

Natalie Sanders, RN, BSN
Manager for Case Management and Utilization Review
Keeping Patients Safe Across All Harm Areas

Marshall Medical Center
Placerville, California

Presented by

Kassie Waters, BSN, CPHQ, MPA
Director of Quality
Keeping Patients Safe Across All Harm Areas

MemorialCare Health System
Fountain Valley, California

Presented by

Helen Macfie, Pharm.D, F.A.B.C.
Chief Transformation Officer