# Foundation for Healthy Communities NH Partnership for Patients

## Hospital Engagement Network (HEN) 2.0

## Hospital National Healthcare Safety Network (NHSN) Workshop

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**Our charge is clear: reduce preventable harm by 40% and reduce preventable readmissions by 20% by 9/23/2016.**

# Objectives

1. Introductions
2. Review the HEN 2.0 project goals and timeframe – related to HAI
3. Orient to available resources
4. Share baseline performance
5. Solicit input for agendas/ priorities to focus on in next SIX months!!!

# Results

Interim estimates for 2014 show a sustained **17 percent** decline in hospital-acquired conditions (HACs) since 2010. A cumulative total of **2.1 million** fewer HACs were experienced by hospital patients over the 4 years (2011, 2012, 2013, and 2014) relative to the number of HACs that would have occurred if rates had remained steady at the 2010 level. The measured interim rate for 2014 held steady from 2013 at **121** HACs per 1,000 discharges, down from **145** in 2010. We estimate that nearly **87,000** fewer patients died in the hospital as a result of the reduction in HACs and that approximately **$19.8 billion** in health care costs were saved from 2010 to 2014.

# NH Results

- A cumulative total of 4873 fewer HACs were experienced by hospital patients over the 4 years (2011, 2012, 2013, and 2014) relative to the number of HACs that would have occurred if rates had remained steady at the 2010 level.
- Approximately **$40.2 million** in health care costs were saved / averted from 2010 to 2014.

# New Hampshire

- All 26 acute care hospitals are committed to work on Partnership for Patients with FHC, through AHA HRET
- Will align with work of NH Health Care QA Commission, State of NH Programs (HAI, Adverse Events, Opioid Drug Task Force, etc.), QIN/QIO and others

# HEN 2.0 Project Goals

## Reduce Harm by 40%
## Reduce Preventable Readmissions by 20%
## …by September 23, 2016

| Core Adverse Event Areas (AEAs): Must report on all applicable AEAs | |
|---|---|
| • Adverse Drug Events (ADE) | • Injuries from Falls and Immobility |
| • Central Line-Associated Blood Stream Infections (CLABSI) | • Catheter-Associated Urinary Tract Infection (CAUTI) |
| • Ventilator Associated Events (VAP) | • Venous Thromboembolism (VTE) |
| • Pressure Ulcers (PrU) | • Surgical Site Infections |
| • Obstetrical (OB) Harm and Early Elective Deliveries (EED) | • Readmissions |

# Additional Harm Areas

## Reduce Harm by 40%

| Additional AEAs: | |
|---|---|
| • Airway Safety | • Clostridium difficile (C. diff.), including antibiotic stewardship* |
| • Culture of Safety, fully integrates patient safety with worker safety** | • Failure to Rescue** |
| • Iatrogenic Delirium | • Undue Exposure to Radiation |
| • Severe Sepsis and Septic Shock* | |
| * HRET focus: Sepsis, C. diff. and two other **measures for NH | |

# Raising the Bar in HEN 2.0

Expectations:

- Work on all applicable topic areas including the 10 core topics, additional four topics and operational metrics
  - Submit data for at least four additional, applicable AEAs, including Sepsis and C. difficile
  - 3 operational metric categories: 1) patient and family engagement, 2) health care disparities 3) engaging leadership and governance
- Submit required data on all applicable topics, including needs assessment, baseline data and monitoring data
- Commit to collaboration – participate in and share success stories and lessons learned with other HEN hospitals and participate in site visits.

# Data Submission

- Timeframe of baseline varies by measure
- Monitoring data to be entered monthly, beginning with October 2015 data
- NHSN data uploaded directly to CDS
- Other data predominately claims based, AHRQ PSI
- Pursuing perfection…should not stand in way of data collection

**“It is hard to drive your car looking in the rear view mirror”**

***"Patients and their families are essential partners in the effort to improve the quality and safety of health care."***

- **Tanya Lord** PhD, MPH is available through Partnership for Patients and the FHC to assist New Hampshire hospitals to develop or enhance their patient engagement programs.
- She offers expertise as a professional in patient safety and patient engagement as well as a patient/family member who experienced the death of her son due to medical error.
- Her unique perspective allows her to effectively communicate and work with both healthcare professionals and patients.

# National HEN 2.0 Topic Resources

- Website, with a searchable resource library: www.hret-hen.org and YouTube channel with recorded webinars and meetings
- Change packages and checklists
- Educational opportunities
- LISTSERVs http://www.hret-hen.org/inc/dhtml/listserv.dhtml
  - ❑ **Infections** - includes Catheter-Associated Urinary Tract Infection (CAUTI), Clostridium difficile Infection (CDI), Central Line-Associated Blood Stream Infection (CLABSI), Surgical Site Infection (SSI) and Ventilator-Associated Event (VAE)
  - ❑ **Sepsis**

# Change packages and checklists

- Available Now: 2016 change packages have been updated to include:
  - Up-to-date harm definition and resources
  - Relevant updates in best practices and change ideas
  - An easy-to-use, streamlined structure
  - Additional background on how to use the driver diagrams

- We encourage you to review opportunities in your facility to drive change in harm prevention and patient safety by downloading the new resources for:
  - Pressure Ulcers
  - Sepsis
  - Falls
  - Readmissions
  - CDI
  - Airway Safety
  - CLABSI

# Surgical Site Infection (SSI)

## Surgical Site Infection (SSI) Risk Reduction

**Published: February 9, 2016**

If you want to learn more about ways to decrease patient risk for surgical site infections, take a look at this webinar. Here you will find strategies discussed by Cynosure Health Improvement Advisors and the St. Mary's Regional Medical Center team in Russelville, AR share their hospital success story.
The HRET data team will also provide an update on surgical site infection process and outcomes measures including national percent reporting and percent reduction to date.

## NHSN SSI Surveillance with Case Studies - 2015

**Published: December 18, 2015 by Centers for Disease Control and Prevention**

Recorded National Healthcare Safety Network (NHSN) SSI training includes review of definitions and SSI 2015 changes, how to identify SSI, complete SSI Event Form and link an SSI event to a procedure.

## Surgical Site Infections (SSI) Webinar

**Published: November 23, 2015**

During this webinar, improvement advisors review tried and true recommended strategies to reduce surgical site infections and  also discuss emerging approaches to reduce SSI.

# CAUTI

## HEN 2.0 CAUTI Webinar

**Published: November 4, 2015**

This webinar features Dr. Jennifer Meddings from the University of Michigan Medical School and Linda Milillo Wilson from Jupiter Medical Center. Dr. Meddings reviews the problem of unecessary Foley catheter use and reviews how Foley indication lists are used in interventions to decrease unnecessary catheter use. She also reviews the current guidance for Foley catheter use from the 2009 Healthcare Infection Practices Advisory Committee. Linda provides a hospital story of how Jupiter Medical Center reduced CAUTI by empowering certified nursing assistants.

# CLABSI

## HEN 2.0 CLABSI Webinar Nailing CLABSI Prevention!

**Published: February 18, 2016**

**Are your Central Line-associated Blood Stream Infection (CLABSI) rates up or are you interested in ways to reduce CLABSI? If so take a look at this webinar, the Kern Medical team in Bakersfield, California share their hospital success story to reduce CLABSI, specifically focusing on maintenance bundle. Cynosure Health Improvement Advisors discuss recommended and emerging maintenance strategies for CLABSI prevention and explore what will keep CLABSI prevention efforts going. The HRET data team will review the required CLABSI process and outcome measures for the HEN 2.0 project and HEN level progress on reducing CLABSI**

## NHSN HAI CLABSI, Secondary BSI Training 2015

**Published: December 18, 2015**

Recorded National Healthcare Safety Network (NHSN) HAI CLABSI and Secondary BSI training includes review of definitions, how to collect central line and patient day data, review of Secondary BSI Guide, case studies and pathogen assignment.

# C. Difficile

## Preventing and Diagnosing C. Difficile Infections

**Published: January 13, 2016**

Our first webinar of the year on the most challenging topic, C difficile. The presenters spoke and shared information that was challenging but informative for audiences who have been seeking answers on the following:

• Preserve: how to get started with or enhance your antibiotic stewardship program to improve your organization's microbial resistance patterns.
• Predict: how to make a clinical diagnosis of C difficile disease, using not just testing tools, but also using pre-test probability based on the specific patient's clinical characteristics.
• Prevent: how human factors and drift destroy our best efforts to prevent transmission, and tips from the experts on the best and simplest ways to kill the spores.

## Clostridium difficile Boot Camp Part 1

**Published: March 10, 2014**

Facilitated by Barb DeBaun, RN, MSN, CIC and Katrina Trivedi, MD, the Part 1 webinar provides an overview of C. difficile and antimicrobial stewardship and discusses C. difficile infection prevention and antimicrobial stewardship in community hospitals.

## Clostridium difficile Boot Camp Part 2

**Published: March 11, 2014**

Facilitated by Barb DeBaun, RN, MSN, CIC and Katrina Trivedi, MD, the Part 2 webinar identifies opportunities for community partnership to reduce CDI, reviews treatment options and highlights ways to engage patient and families in CDI prevention.

# VAE

## VAE Prevention: Getting to the Next Level

**Published: March 6, 2014**

This webinar identifies ways to incorporate VAE surveillance into daily workflow and reviews methods to test and implement each of the ABCDE bundle elements. The webinar was held on March 6, 2014 and facilitated by Cheryl Ruble, MS, RN, CNS, Cynosure Health Improvement Advisor.

## NHASN VAE, and PNEU/VAP Training 2015

**Published: December 18, 2015 by Centers for Disease Control and Prevention**

Recorded National Healthcare Safety Network (NHSN) VAE and PNEU/VAP training includes review of definitions, surveillance and changes made to surveillance in 2015.

# Sepsis

## HEN 2.0 Sepsis Webinar

**Published: November 5, 2015**

During the first sepsis webinar of HEN 2.0, we prioritized strategies to create success in your Sepsis Mortality Reduction Program and touched upon the new Surviving Sepsis Campaign guidelines. Additionally, we highlighted Union Hospital's story as they share the critical elements that prompted a 40 percent reduction in sepsis mortality. The webinar concluded with an active demonstration of the use of the Plan-Do-Study-Act (PDSA) cycle to hardwire improvement in sepsis screening.

## Sepsis Mortality Reduction Boot Camp Part 1

**Published: March 17, 2014 by**

This webinar utilizes hospital stories and subject matter experts to outline strategies for early identification, implementation of the three and six hour bundles, and suggestions for measurement in multiple hospital settings to address sepsis.

## Sepsis Mortality Reduction Boot Camp Part 2

**Published: March 18, 2014**

This webinar utilizes hospital stories and subject matter experts to outline strategies for early identification, implementation of the three and six hour bundles, and suggestions for measurement in multiple hospital settings to address sepsis.

# Fellowship

- ***Experienced HEN Fellow Action Leader Series***
- ***Foundational HEN Fellow Action Leader Series***

What we provide:

- Monthly webinars and in-person meetings
- Coaching on Action Learning Projects (ALPs), highlighting individual or hospital progress toward HEN project goals
- Certificate of completion (upon ALP submission)

What we expect:

- Attendance during monthly webinars and other events
- One ALP per Fellow
- Networking and peer-sharing

# National Upcoming HEN 2.0 Events

- http://www.hret-hen.org/
- CEU / CME credits offered for live participation
- Evaluation post webinar

- NO COST 

# State HEN 2.0 Events

- Based on needs assessments & site visits
  - 100% of NH hospitals
- Sepsis Meeting – held October 30th
- Under Consideration / Planning –

  **SSI / Safe Surgery*** – Nancy Chobin

  **CAUTI** -

  **Pressure Ulcers*** – Peter Nolette

  **Falls*** – Pat Quigley

  ADEs

  OB Harm – NNEPQIN

  Patient & Family Engagement – Tanya Lord

# Readmissions – Linking Initiatives

- Community Partners
- Huddle for Care http://huddleforcare.org/
- QIN Transition work & CMS data
- Falls – Community Programs
- Socio-economic factors – i.e.. Housing, transportation
- NH Medication Bridge Program
- EMS Mobile Integrated Healthcare
- NH COPD Plan – Breathe NH
  - My COPD Action Plan
- Healthcare Decision Making – POLST, Advance Directives, Palliative Care

# Questions?