Kansas Hospital Engagement Network

Virtual Meeting

Agenda

- Introductions
- Early Elective Delivery Prevention
  - Taking It To the Next Level
    - Dignity Health story
    - Statewide EED survey summary
    - 2015 Kansas EED/Obstetric Harm Collaborative
    - Resources
- Kansas HEN Data Update
  - 2014 Year-End Summary
  - Introduction to new hospital data reports
- Announcements & Upcoming Events
- Questions and Answers
Introductions

Presenters

Dignity Health

Special Guest:
Suzanne Wiesner, RN, MBA/HCM, C-EFM
Director, Maternal Child Health Services
Dignity Health
Sacramento, California

Kansas Healthcare Collaborative

Michele Clark, MBA, CPHQ, ABC
Program Director

Eric Cook-Wiens, MPH, PCMH
Measures and Data Manager

Comments or questions?

Please type your comments or questions into the chat window throughout the virtual meeting.

We will pause for telephone Q&A after EED presentation and at the end.

Or contact us after the webinar. Emails and phone numbers are provided on the last slide.
Reducing the Rate of Early Elective Delivery – Our Organization’s Journey

March 25, 2015

Suzanne Wiesner, RN, MBA/HCM, C-EFM
Director, Maternal Child Health Services

DISCLOSURE

Suzanne Wiesner has reported no relevant financial interest/relationships with commercial entities that may have ties to this presentation.
Session Objectives

- To review Dignity Health Perinatal Safety initiative to reduce the incidence of Early Elective Delivery
- To understand the commonalities and differences in the methods used for data collection and reporting
- To identify strategies for success in the reduction of Early Elective Delivery

Perinatal Services at Dignity Health

- 60,000+ deliveries per year
- 29 facilities with Birthing Units in California, Arizona and Nevada
- 21 NICU’s

Perinatal Safety Team includes:

- System-level Director, Manager and Medical Director
- Facility-level Perinatal Directors/Managers, Perinatal Safety Specialists and Physician Champions
Early Elective Delivery (EED) Initiative

Dignity Health Commits to the Reduction of EED

• Despite guidelines from organizations like ACOG, March of Dimes, and California Maternal Quality Care Collaborative (CMQCC), elective early term delivery was quite common.
• Early term delivery associated with increased Length-of-Stay in Labor and Delivery and increased admissions to the NICU, both associated with increasing health care costs and decreasing patient satisfaction.
• As part of a larger patient safety initiative, a system goal was established to reduce Early Elective Delivery across the organization.
Dignity Health Commits to the Reduction of EED

- Perinatal Safety initiative to reduce EED – system level initiative introduced September 2011
  - Standardized list of approved medical indications for delivery >37 weeks and < 39 weeks gestation
  - “Hard Stop” process for scheduling of Inductions and Cesarean Sections
  - Monthly chart audit / data collection by facility-based Perinatal Safety Specialist
  - System-level goal to reduce rate of EED to < 5%

System-level baseline = 6.82%

Dignity Health Commits to the Reduction of EED (cont.)

Common Attempts of “Indicated Deliveries” Not Meeting Criteria

1. Impending Preeclampsia
2. Impending Macrosomia
3. Previous C-Section (at 38 weeks)
4. Prolonged prodromal labor
5. Amniotic Fluid Index (AFI) < 7cm
6. Persistent uterine contractions without cervical change
7. Previous preterm birth
### Medical Indications for Delivery before 39 weeks Gestation

<table>
<thead>
<tr>
<th>Description</th>
<th>Clarification</th>
<th>TJC Criteria</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. HIV Disease</td>
<td>Delivery recommended at 38 weeks if viral load &gt;1000</td>
<td>Yes</td>
</tr>
<tr>
<td>2. Placenta previa</td>
<td></td>
<td>Yes</td>
</tr>
<tr>
<td>4. Vaginal bleeding</td>
<td></td>
<td>Yes</td>
</tr>
<tr>
<td>6a. Gestational hypertension</td>
<td>Persistent blood pressure &gt;140/90</td>
<td>Yes</td>
</tr>
<tr>
<td>6b. Chronic Hypertension</td>
<td>Persistent blood pressure &gt;140/90</td>
<td>Yes</td>
</tr>
<tr>
<td>7. Pre-eclampsia/Eclampsia</td>
<td></td>
<td>Yes</td>
</tr>
<tr>
<td>8. Renal disease</td>
<td>Documentation of worsening or compromising maternal health</td>
<td>Yes</td>
</tr>
<tr>
<td>9. Liver disease</td>
<td>Documentation of worsening or compromising maternal health</td>
<td>Yes</td>
</tr>
<tr>
<td>10. Diabetes</td>
<td>Poorly controlled or medication</td>
<td>Yes</td>
</tr>
<tr>
<td>11. Congenital defects</td>
<td></td>
<td>Yes</td>
</tr>
<tr>
<td>12. Unstable lie</td>
<td>Transverse or franking breech</td>
<td>Yes</td>
</tr>
<tr>
<td>13. Congenital abnormality of fetus or fetal abnormalities due to infection or other causes</td>
<td>Where the neonatal consultant request early delivery</td>
<td>Yes</td>
</tr>
<tr>
<td>14. Feto-maternal hemorrhage</td>
<td></td>
<td>Yes</td>
</tr>
<tr>
<td>15. Intrauterine growth restriction</td>
<td>&lt;5th percentile</td>
<td>Yes</td>
</tr>
<tr>
<td>16. Polyhydramnios</td>
<td>AF&lt;5 cm or LVP&lt;3 cm</td>
<td>Yes</td>
</tr>
<tr>
<td>17. Chorioamnionitis</td>
<td></td>
<td>Yes</td>
</tr>
<tr>
<td>18. Abnormal fetal heart rate</td>
<td></td>
<td>Yes</td>
</tr>
<tr>
<td>19. Vas previa</td>
<td></td>
<td>Yes</td>
</tr>
<tr>
<td>20. Poor obstetric history/prior stillbirth or neonatal death</td>
<td></td>
<td>Yes</td>
</tr>
<tr>
<td>21. Specialist Consultation/Recommendation</td>
<td>Documentation that supports why continuation of pregnancy until 39 weeks will have a detrimental effect on maternal and/or fetal/neonatal outcomes</td>
<td>No</td>
</tr>
</tbody>
</table>

**Exclusion**

- Spontaneous active labor
- Previous uterine rupture
- Previous myomectomy
- >3 prior cesarean sections
- Specialist Consultation/Recommendation

**NOTE** - Only singleton deliveries are counted.

---

### “Hard Stop” Process for Scheduling – Critical Elements

- Determination of Estimated Date of Confinement (EDC) and gestational age – per ACOG guidelines
- Documentation to support Medical Indication for Delivery
- Facility Leadership oversight of the scheduling process
- Physician Champion and escalation using the Chain of Command when conflicts occur
- Peer review process for non-medically indicated early delivery
SAMPLE
“Scheduling Form for Induction and Cesarean Sections”

Early Elective Deliveries – Monthly Chart Audits

• Perinatal Safety Specialists – audit charts and submit in Midas
  – Denominator = ALL deliveries 37 0/7 weeks to 38 6/7 weeks
  – Numerator = Deliveries without an approved medical indication
  – See Medical Indications for Elective Delivery Before 39 Weeks Gestation
    • Updated January 2013
    • Indications 1 through 32 – includes clarifying information and TJC criteria

NOTE: Dignity Health EED rate varies slightly from The Joint Commission (PC-01) Perinatal Care Measure.
### Exclusions - Medically Indicated Delivery

**Dignity Health vs. The Joint Commission**

<table>
<thead>
<tr>
<th>Criteria</th>
<th>Dignity Health</th>
<th>TJC</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>31. ≥ Three previous C/S</td>
<td>YES</td>
<td>NO</td>
<td>Dignity Health Policy based on increase rate of adverse neonatal outcomes may be higher at ≥ previous C/S.</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>• J Matern Fetal Neonatal Med. 2013 June.</td>
</tr>
<tr>
<td>32. Consultative Recommendation</td>
<td>YES</td>
<td>NO</td>
<td>Instances where guidelines could not be met but delivery is still indicated (i.e. initiation of chemotherapy, maternal surgery of another condition)</td>
</tr>
</tbody>
</table>
Dignity Health vs. The Joint Commission

• Dignity Health:

  All Elective Deliveries
  All Deliveries 37-38w6d

• The Joint Commission:

  All Elective Deliveries
  (All Deliveries 37-38w6d)-Exclusions

\[
\frac{3 \text{ EED}}{1000 \text{ (total 37-38w6d)}} = 0.3\%
\]

\[
\frac{3 \text{ EDD}}{1000-750 \text{ (labor, PROM, exclusions)}} = 1.2\%
\]
Dignity Health - Early Elective Deliveries
System-Level Results – 29 Facilities

- Aug-11 BASELINE: 6.82% (Annualized N=1,420)
- Cal Yr 12: 1.10% (N=150)
- Cal Yr 13: 0.34% (N=48)
- Cal Yr 14: 0.09% (N=13)

Dignity Health vs TJC - Early Elective Deliveries
System-Level Results – 29 Facilities

- Cal Yr 12: 1.10% PC-01
- Cal Yr 13: 0.34%
- Cal Yr 14: 0.09%

Measure PC-01
## Facilities with No Early Elective Deliveries for CY13 - CY14
### Dignity Health Methodology

- California Hospital
- Community Hospital San Bernardino
- French Hospital
- Marian Regional Medical Center
- Mercy Hospital of Folsom
- Mercy Hospital Bakersfield
- Mercy Medical Center, Mt. Shasta
- Mercy San Juan Medical Center
- Sierra Nevada Memorial Hospital
- St Bernardine Medical Center
- St Joseph’s Medical Center, Stockton
- St Mary Medical Center, Long Beach
- St Rose Dominican – Siena Campus

## Facilities with No Early Elective Deliveries for CY13 - CY14
### TJC Perinatal Core Measure (PC-01)

- Mercy Gilbert Medical Center
- Mercy Hospital Bakersfield
- Mercy Medical Center, Mt. Shasta
- Mercy San Juan Medical Center
- St Joseph’s Medical Center, Stockton
Tips for Success

• Medical Staff Engagement is key to success
• Hospital Leadership Engagement is key to success
• Data! Data! Data! Department and Provider-level data can be very valuable in monitoring progress
• Don’t be afraid to Celebrate Your Success!
Taking it to the next level: Kansas EED Prevention

• Background
• Highlights of statewide EED survey
• 2015-16 Kansas EED Collaborative

For more information contact:
Michele Clark
Program Director
Kansas Healthcare Collaborative
mclark@khconline.org
785-235-0763 x1321
**Background**

**Kansas Healthcare Collaborative:**
Designee by Kansas Hospital Association to administer the Kansas Hospital Engagement Network.

- Comprehensive, multi-faceted approach
- Leadership and collaboration
- Learn and share with others

**102 hospitals are in the Kansas HEN.** (74 are CAH.)
**52 are birthing hospitals.** (27 are CAH.)
Kansas has 15 more birthing hospitals. (10 were in other HENs).

---

**Kansas HEN Approach**

- State-level education and hospital-sharing
- Wesley Medical Center hospital improvement advisor
- State and national partnerships
- Distribution of March of Dimes EED Resource Kits to hospitals
- Resources by AHA/HRET HEN (2012-14)
  - See www.hret-hen.org
  - Change package, literature, resources
  - National experts, education, hospital-sharing
  - National collaboration, list-serve
EED Key Driver Diagram

AIM

Primary Driver

Secondary Driver

Reduce Demand

Reduce Early Elective Deliveries to <3% by December 31, 2014

Reduce Availability

Raise awareness of risks of EED for physicians, nurses and hospital staff.

Raise awareness of risks of EED for patients, families, and the community.

Create a hospital policy and procedure that guides scheduling and oversight for elective deliveries.

Develop mechanisms to support appropriate implementation and enforcement of policies and procedures.

EED Prevention in Kansas

Kansas HEN Approach

Standard EED Measures:

- Joint Commission PC-01
- Processes: Wesley Medical Center
  - Use of standardized tool for scheduling cesarean sections and induction of labor
  - Documentation of indication prior to induction of labor
  - Record review of scheduled cesarean sections and inductions of labor less than 39 weeks gestation

KHC’s Obstetric/EED web page:
www.khconline.org/patient-safety-focus-areas/147-obstetric-adverse-events
Key influencers to hospital adoption of EED hard-stop policy

- ACOG guidelines
- Hospital Engagement Network
- Blue Cross and Blue Shield of Kansas policy alignment
- Resolution by KHA Board of Directors encouraging Kansas hospitals to adopt policies against EEDs (June 2013)

### Resolution

Whereas, Kansas hospitals improve the health of their patients using evidence-based practices and national standards;  

Be it resolved that the Board of Directors of the Kansas Hospital Association recommends that its member hospitals develop a policy stating that unless a medical condition exists that necessitates an earlier delivery, the induction of labor will not be scheduled for women unless they have reached 39 completed weeks of gestation.

---

**Kansas HEN EED Progress**

January 2012 to December 2014

Elective deliveries at $>= 37$ Weeks and $< 39$ weeks (2012-2014)

Reduction from baseline: **70.5%**

Year-end EED rate: **4.6%** (Oct-Dec 2014)
Digging deeper into recent data

In 2014, 53 facilities submitted at least one month of EED data; the number of numerator events reported was:

123

38 facilities submitted EED data for entire 12 months.
- 15 had no EED events the whole year

51 facilities submitted ≥3 months of data in 2014
- 32 had a current EED rate of 0.0% (last 3 mo. of data)

Kansas EED Survey Highlights

KHC conducted online survey of all Kansas birthing hospitals in mid-February to mid-March 2015 to:

- Gain statewide snapshot of EED progress and perceived impact to date,
- Gather feedback on adoption of EED prevention processes and measures,
- Conduct environmental scan of HEN and NQF OB quality initiatives within the state.

68 of 69 birthing hospitals responded.
98.5% response rate
### Total hospital births

<table>
<thead>
<tr>
<th>Year</th>
<th>Total</th>
<th>Range</th>
<th>Median</th>
</tr>
</thead>
<tbody>
<tr>
<td>2014</td>
<td>38,386</td>
<td>7 - 6,049</td>
<td>177</td>
</tr>
<tr>
<td>2013</td>
<td>37,872</td>
<td>12 - 5,868</td>
<td>192</td>
</tr>
<tr>
<td>2012</td>
<td>37,953</td>
<td>10 - 6,266</td>
<td>179</td>
</tr>
</tbody>
</table>

66 of 69 Kansas birthing hospitals responding
Feb-Mar 2015

### EED measures adopted

(Click all that apply)

- Patients with elective vaginal deliveries or elective cesarean section at &gt;=37 and &lt;39 weeks gestation completed. (The Joint Commission PC-01) [Kansas HEN]
- Non-medically indicated elective deliveries before 39 weeks gestational age
- A measure similar to TJC PC-01 but using different medical indications
- We do not have an EED measure
- Other

14 hospitals (20.8%) track both.

67 of 69 Kansas birthing hospitals responding
Feb-Mar 2015
EED Hard-stop Policy Adoption

Kansas Birthing Hospitals

- Yes: 58 (86.6%)
- No: 9 (13.4%)
- No response: 67 of 69 Kansas birthing hospitals responding

Polling Question

What were the biggest influencers for your facility to adopt a hard-stop policy? (check all that apply)

- Medical guidelines and evidence
- Participation in EED collaborative
- KHA board resolution
- Hospital leadership
- Physician leadership
- Hospital medical, quality committees
- Hospital mission/values for patient safety
- Financial incentives
- Other
How would you generally characterize the acceptance of the hard-stop policy at your facility by the following stakeholders?

Physicians involved with obstetrical care:
- Strong acceptance: 34.5%
- Mild acceptance: 29.3%
- Neutral: 3.4%
- Mild resistance: 29.3%
- Strong resistance: 3.4%

Nursing staff involved with obstetrical care:
- Strong acceptance: 89.5%
- Mild acceptance: 8.8%
- Neutral: 0.0%
- Mild resistance: 1.8%
- Strong resistance: 0.0%

Other staff involved with obstetrical care:
- Strong acceptance: 70.7%
- Mild acceptance: 19.0%
- Neutral: 8.6%
- Mild resistance: 1.7%
- Strong resistance: 0.0%

Hospital administrators:
- Strong acceptance: 86.2%
- Mild acceptance: 5.2%
- Neutral: 8.6%
- Mild resistance: 0.0%
- Strong resistance: 0.0%

Birth mothers:
- Strong acceptance: 14.0%
- Mild acceptance: 38.6%
- Neutral: 19.3%
- Mild resistance: 26.3%
- Strong resistance: 22.8%

Families of birth mothers:
- Strong acceptance: 12.3%
- Mild acceptance: 33.3%
- Neutral: 29.8%
- Mild resistance: 22.8%
- Strong resistance: 1.8%

To what extent do you believe your facility’s hard-stop policy has made an impact on:

<table>
<thead>
<tr>
<th>Impact Area</th>
<th>Negative Impact</th>
<th>No Impact</th>
<th>Favorable Impact</th>
</tr>
</thead>
<tbody>
<tr>
<td>Your organization's ability to recruit and retain physicians to provide obstetrical care</td>
<td>2.3%</td>
<td>86.0%</td>
<td>11.6%</td>
</tr>
<tr>
<td>Where patients choose to deliver their baby</td>
<td>4.4%</td>
<td>76.7%</td>
<td>18.6%</td>
</tr>
<tr>
<td>The care experience for birth mothers and family members</td>
<td>52.4%</td>
<td>47.6%</td>
<td>55.8%</td>
</tr>
<tr>
<td>Hospital staff satisfaction and morale</td>
<td>7.0%</td>
<td>37.2%</td>
<td>55.8%</td>
</tr>
</tbody>
</table>
Characterize your facility’s current status in your efforts to prevent early elective deliveries:

Current Status in EED Prevention

- No response: 4.3%
- No structured efforts at this time: 4.3%
- Just getting started: 4.3%
- Implementing improvement but facing challenges: 21 hospitals (30.1%)
- Implementing improvements and progressing well: 29 hospitals (55.1%)
- Implementing improvements with positive, sustained results: 21 hospitals (30.4%)

66 of 69 Kansas birthing hospitals responding, Feb-Mar 2015

Scheduling process:
Use of a standardized tool for scheduling cesarean sections and induction of labor

- Adopted and implemented. Data confirms high reliability in its use (>99.5% of the time): 20 hospitals (30.3%)
- Adopted and implemented. No data, but believe high reliability in its use: 16 hospitals (24.2%)
- Adopted and implemented, but room for improvement in its use: 9 hospitals (13.6%)
- Our facility has not adopted a scheduling tool: 21 hospitals (31.8%)
- No response: 2.9%

66 of 69 Kansas birthing hospitals responding, Feb-Mar 2015
**Documentation process:**

Documentation of indication prior to induction of labor as part of induction bundle

- Facility has monitoring data that confirms our pre-induction checklist with medical documentation serves as a highly reliable hard-stop to EED.
- No data, but we believe our facility's pre-induction checklist serves as a highly reliable hard-stop to EED.
- Our pre-induction checklist calls for medical indication, but the documentation is not consistently provided or an enforced requirement.
- Our facility does not require documentation prior to induction of labor.
- No response

66 of 68 Kansas birthing hospitals responding, Feb-Mar 2015

**Medical Review Process:**

Record review of scheduled cesarean sections and inductions of labor less than 39 weeks gestation

- Our facility has implemented a reliable and effective process for medical review of scheduled early term deliveries.
- Our facility is developing a process for medical review of scheduled early term deliveries, but we have had challenges in implementation.
- Our facility does not have a process in place for medical review of all scheduled inductions or cesarean deliveries prior to 39 weeks gestation.
- No response

66 of 69 Kansas birthing hospitals responding, Feb-Mar 2015
### Neonatal Intensive Care Unit

**Does your hospital have a NICU?**

- **Yes**: 17 (26.6%)
- **No**: 47 (73.4%)
- **No response**: 0

<table>
<thead>
<tr>
<th>Year</th>
<th>Total</th>
<th>Range</th>
<th>Median</th>
<th># of NICU hospitals responding</th>
</tr>
</thead>
<tbody>
<tr>
<td>2014</td>
<td>3,742</td>
<td>0 - 1,011</td>
<td>191</td>
<td>13</td>
</tr>
<tr>
<td>2013</td>
<td>3,691</td>
<td>0 - 957</td>
<td>205</td>
<td>12</td>
</tr>
<tr>
<td>2012</td>
<td>3,718</td>
<td>0 - 934</td>
<td>213</td>
<td>12</td>
</tr>
</tbody>
</table>

### Newborn Transfers to NICUs

**Does your hospital have a NICU?**

- **Yes**: 17 (26.6%)
- **No**: 47 (73.4%)
- **No response**: 0

<table>
<thead>
<tr>
<th>Year</th>
<th>Total</th>
<th>Range</th>
<th>Median</th>
<th># of non-NICU hospitals responding</th>
</tr>
</thead>
<tbody>
<tr>
<td>2014</td>
<td>194</td>
<td>0 - 54</td>
<td>2</td>
<td>34</td>
</tr>
<tr>
<td>2013</td>
<td>193</td>
<td>0 - 32</td>
<td>4</td>
<td>35</td>
</tr>
<tr>
<td>2012</td>
<td>160</td>
<td>0 - 34</td>
<td>2</td>
<td>34</td>
</tr>
</tbody>
</table>
To what extent is your facility currently engaged with the new OB measures recently introduced through the Partnership for Patients and the HEN?

Focus on Obstetrical Hemorrhage and Preeclampsia

![Bar chart showing engagement levels for obstetrical hemorrhage risk assessment upon admission, OB blood transfusions, and timely treatment for severe hypertension.](chart)


To what extent is your facility currently engaged with the 14 perinatal measures endorsed by the National Quality Forum?

Top 5 NQF Perinatal Measures in Kansas

![Bar chart showing engagement levels for various perinatal measures.](chart)

2015 Kansas EED Collaborative

- Goals
- Methods
- Let’s work together!

For more information contact:
Michele Clark
Program Director
Kansas Healthcare Collaborative
mclark@khc.online.org
785-235-0763 x1321

Kansas OB/EED Collaborative

The Collaborative is open to all Kansas hospitals that will:

1) Commit to taking it to the next level
2) Establish teams that will be highly engaged within the collaborative, and
3) Share experiences and successes in the spirit of all-teach, all-learn.
Goals and Methods

State goal:
Kansas birthing hospitals will collectively achieve benchmark performance (<2% EED rate) for TJC PC-01 measure by April 2016.

Methods:
- Facility-level goals and work plan
- Bi-monthly learning sessions (at least one in-person)
- Technical assistance, resources, support
- Virtual community, list-serv
- Partnerships
- Monthly data collected through QHi

Next Steps: Kansas OB/EED Collaborative

★ Send an email to express interest:
Kansas Healthcare Collaborative
Michele Clark, Program Director
mclark@khconline.org
or call 785-235-0763 ext. 1321

LET’S WORK TOGETHER!!

Taking it to the next level in EED and obstetric harm prevention.
OB Harm/EED Resources

- KHC Obstetrical Adverse Events web page
  www.khconline.org/patient-safety-focus-areas/147-obstetric-adverse-events
  - Education archive
  - Toolkits and Resources
  - Literature and Reports
  - Measures and data

- AHA/HRET Hospital Engagement Network
  www.hret-hen.org
  - See Obstetrical Adverse Event & Early Elective Deliveries section. Click on Resources and/or Event Archives in left menu. (Screen shot provided on next slide.)
Q&A / Discussion

Kansas HEN
Data and Measures Updates

• Results for 2014
• 2015 Data, Measures and Reports

Eric Cook-Wiens
Data and Measures Manager
Kansas Healthcare Collaborative
ewiens@khconline.org
785-235-0763 x1324
HEN Goals

Project Goal:
To reduce inpatient harm by 40 percent and readmissions by 20 percent by December 2014.

Secondary goal:
Participation by all hospitals in the network with a target of 80% of facilities reporting data for outcome measures.
Percent of hospitals submitting 8 or more data points

- Early Elective Delivery: 49%
- CAUTI Rate (non-CUSP): 87%
- Fall Rate (w/ or w/o injury): 93%
- CLABSI Rate: 93%
- Readmissions (all cause): 92%
- SSI (at least one*): 91%
- HF Readmissions (all cause): 81%
- Potentially Preventable VTE: 80%
- ADE (at least one*): 73%
- Stage 2 or Higher HAPU: 66%
- Massive OB Blood Transfusions: 62%
- Total OB Blood Transfusions: 62%
- Timely Tx. for Severe HTN: 34%

*Combined all outcome measures for reporting statistic

Reflects data through December 2014.
As of March 23, 2015
Great work!

**Significant Improvements**
- Meeting improvement targets for 5 measures
- Marked success in preventing CLABSI, CAUTI & EED
- Early success with OB measures
- Readmission going in the right direction
- Lots of individual hospital success stories

**Participation**
- Tremendous improvement in data collection
- 58 facilities joined our NHSN groups
- Learned some challenging new measures
- Quality improvement data is reaching senior leaders

Where to from here?

- Measure changes pending HEN 2.0
- Re-focus our reports on improvement (not just data submission)
  - Side-by-side reports will start again with HEN 2.0
    - Redesign to focus on performance
  - New format for detailed Kansas HEN data reports
    - “Beamer reports”
      - First version ready next week – to include data through December 2014
      - New distribution method:

*Email from KHC to Primary HEN Contact next week with link to download facility-level PDF report and share with quality improvement teams and hospital leadership.*
Sample of new report format:

PDF can be shown as full-screen presentation.

Summary of Kansas HEN Outcome Measures
Through December 2014

<table>
<thead>
<tr>
<th>Area</th>
<th>Outcome Measure</th>
<th>Most Recent</th>
<th>Months Submitted</th>
<th>Current Performance</th>
</tr>
</thead>
<tbody>
<tr>
<td>ADE</td>
<td>Balance administration</td>
<td>12/2014</td>
<td>24</td>
<td>Zero = same.</td>
</tr>
<tr>
<td></td>
<td>Excessive anticoagulation with Warfarin - Inpatient</td>
<td>12/2014</td>
<td>28</td>
<td>Zero = same.</td>
</tr>
<tr>
<td></td>
<td>Hypoglycemia in inpatient receiving insulin</td>
<td>12/2014</td>
<td>24</td>
<td>Most data</td>
</tr>
<tr>
<td>CAUTI</td>
<td>CAUTI rate per 1,000 catheter days</td>
<td>12/2014</td>
<td>23</td>
<td>Zero = same.</td>
</tr>
<tr>
<td>GLARIS</td>
<td>GLARIS rate per 1,000 central-line days</td>
<td>06/2012</td>
<td>6</td>
<td>Infl. data</td>
</tr>
<tr>
<td>Falls</td>
<td>Falls with or without injury</td>
<td>12/2014</td>
<td>30</td>
<td>Zero = same.</td>
</tr>
<tr>
<td>OB</td>
<td>Elective deliveries at ≤ 37 weeks and &lt; 30 weeks</td>
<td>12/2014</td>
<td>24 (22)</td>
<td>Zero = ≤ 3 min.</td>
</tr>
<tr>
<td></td>
<td>Total OB Blood Transfusions</td>
<td>12/2014</td>
<td>24</td>
<td>Most = same.</td>
</tr>
<tr>
<td></td>
<td>Tardy Treatment for Severe Hypertension</td>
<td>12/2014</td>
<td>24 (3)</td>
<td>SPE = same.</td>
</tr>
<tr>
<td>BAPU</td>
<td>Patients with at least one stage III or greater BAPU</td>
<td>12/2014</td>
<td>24</td>
<td>Zero = ≤ 3 min.</td>
</tr>
<tr>
<td></td>
<td>Patients with at least one stage II or greater BAPU</td>
<td>12/2014</td>
<td>24</td>
<td>Zero = ≤ 3 min.</td>
</tr>
<tr>
<td>Readmissions</td>
<td>Readmissions within 30 days (all cases)</td>
<td>12/2014</td>
<td>35</td>
<td>Zero = ≥ 80%.</td>
</tr>
<tr>
<td></td>
<td>Readmissions within 30 days (all cases)</td>
<td>12/2014</td>
<td>35 (31)</td>
<td>Zero = ≤ 80%.</td>
</tr>
<tr>
<td>SSI</td>
<td>SSI rate (within 30 days after procedure) for colon surgery procedures</td>
<td>11/2014</td>
<td>24</td>
<td>Zero = ≤ 5 mm.</td>
</tr>
<tr>
<td></td>
<td>SSI rate (within 30 days after procedure) for abdominal hysterectomy procedures</td>
<td>11/2014</td>
<td>24</td>
<td>Zero = ≤ 5 mm.</td>
</tr>
<tr>
<td></td>
<td>SSI rate (within 30 days after procedure) for all surgical procedures</td>
<td>-</td>
<td>0</td>
<td>No data</td>
</tr>
<tr>
<td>VAE</td>
<td>VAE rate - All units (CDC/NHS)</td>
<td>12/2014</td>
<td>0</td>
<td>No data</td>
</tr>
<tr>
<td>VTE</td>
<td>Potentially preventable VTE</td>
<td>12/2014</td>
<td>24 (3)</td>
<td>No data</td>
</tr>
</tbody>
</table>

NOTE: The number of months having a denominator greater than zero is indicated in parentheses. An empty summary is provided if at least 0 months of data were submitted. For the OB/ED and VTE outcome measures, a denominator of zero is considered valid.
How are cell colors determined?

**GREEN**
- Streak of at least 3 months with zero numerator events
- Reduction from baseline of 40% (20% for readmit.)
  (Either 2011 annual baseline or first 3 months of monitoring data)
- Meeting national benchmarks (current benchmarks set by CMS or HRET)

**Yellow**
- Reduction from baseline < 40% (20% for readmit.)

**Red**
- No reduction (note baseline rates of zero)

---

### National Benchmarks

<table>
<thead>
<tr>
<th>Measure</th>
<th>Benchmark</th>
<th>Source</th>
</tr>
</thead>
<tbody>
<tr>
<td>Elective deliveries at &gt;= 37 Weeks and &lt; 39 weeks</td>
<td>2%</td>
<td>CMS HEN Program</td>
</tr>
<tr>
<td>Patients with at least one stage II or greater HAPU</td>
<td>1.487%</td>
<td>CMS HEN Program</td>
</tr>
<tr>
<td>Patients with at least one stage III or greater HAPU</td>
<td>0.21%</td>
<td>HRET</td>
</tr>
<tr>
<td>Falls with or without injury</td>
<td>2.15 falls per 1,000 patient days</td>
<td>CMS HEN Program</td>
</tr>
<tr>
<td>CAUTI rate per 1,000 catheter days</td>
<td>0.48 infections per 1,000 device days</td>
<td>CMS HEN Program</td>
</tr>
<tr>
<td>CLABSI rate per 1,000 central-line days</td>
<td>0.18 infections per 1,000 central-line days</td>
<td>CMS HEN Program</td>
</tr>
<tr>
<td>Potentially preventable VTE</td>
<td>0.156%</td>
<td>HRET</td>
</tr>
<tr>
<td>Excessive anticoagulation with Warfarin - Inpatients</td>
<td>0%</td>
<td>CMS HEN Program</td>
</tr>
<tr>
<td>Hypoglycemia in inpatients receiving insulin</td>
<td>7%</td>
<td>CMS HEN Program</td>
</tr>
</tbody>
</table>

Source: HRET Improvement Calculator v3.03, July 2014
How are cell colors determined?

- **Grey**
  - No Data submitted
  - Insufficient data – fewer than 8 monthly data points submitted
  - Sparse data – data is sufficient, but not enough events to compare recent performance with baseline
- **N/A**
  - Inapplicable focus areas for certain facilities (eg, CLABSI, SSI, OB and VAE)
New Kansas HEN reports

- When reviewing your report, if you see data that needs to be updated or corrected, fix it in the appropriate data system (NHSN or QHi).
- Reports will not include historical data submitted through CareCounts.
- May need some iterations to find and fix issues with the new report format.
- If there is a problem or question(s) about the report, notify Eric at KHC.
Facility-level Kansas HEN Data Reports

- KHC plans to distribute the facility-level reports once per quarter.
- KHC will be able to produce updated reports for individual requests within 1-5 work days.
- Once our ‘cell color’ rules mature to reflect topic-specific progress, cells colors may be a component of next iteration of a de-identified, side-by-side “comparison report,” which will focus on performance toward HEN goals.

Announcements

- HEN 2.0
- PFAC Collaborative
- Upcoming Events
- Resources

For more information contact:
Michele Clark
Program Director
Kansas Healthcare Collaborative
mclark@khconline.org
785-235-0763 x1321
HEN 2.0 Update

- AHA/HRET will submit multi-state hospital association proposal to CMS by March 28.
  - **Kansas HEN will be included.**
- AHA/HRET anticipates CMS awards will start Summer 2015.
- KHC will keep you informed.

Kansas PFAC Collaborative

A statewide collaborative hosted by KHC with national faculty to help hospitals establish an effective Patient and Family Advisory Council or to improve upon an existing PFAC program.

<table>
<thead>
<tr>
<th>March/April</th>
<th>Sign-up Period</th>
</tr>
</thead>
<tbody>
<tr>
<td>April 16, 2015</td>
<td><strong>Kick-off Event, PFAC Training in Topeka</strong></td>
</tr>
<tr>
<td>May 18</td>
<td>Coaching Call</td>
</tr>
<tr>
<td>June 18</td>
<td>Learning Session (webinar)</td>
</tr>
<tr>
<td>July 16</td>
<td>Coaching Call</td>
</tr>
<tr>
<td>August 19</td>
<td>Learning Session (webinar)</td>
</tr>
<tr>
<td>September 11</td>
<td>Learning/Sharing Session (in-person at KHA Convention in Wichita)*</td>
</tr>
<tr>
<td>October 22</td>
<td>Coaching Call</td>
</tr>
<tr>
<td>November 12</td>
<td>Learning/Sharing Session (webinar?)</td>
</tr>
</tbody>
</table>

For recording of our February webinar and more information, visit: [www.khconline.org/patient-and-family-engagement](http://www.khconline.org/patient-and-family-engagement)
Kansas Healthcare Collaborative, www.khconline.org

Upcoming Events

Introduction to Lean in Healthcare Workshop
KMS/KaMMCO Conference Center
623 SW 10th Ave.
Topeka

Join us
March 26-27

Space is limited. Register today!

Now Full

Upcoming National Events:

April 14, 2015 • 11 am – 12 pm CT
On the CUSP: Stop CAUTI
April National Content Webinar

Topic:
Sustainability and Spread

Presenter:
Eugene Chu, MD, FHM
Director of Community Medicine
Boulder Community Hospital

To join, dial 877-410-5657, passcode 28128
Webinar link:
https://www.yourcall.com/webecho/?username=ON%20THE%20CUSP%20STOP%20HA!
Access archived CAUTI educational sessions at:
www.onthecuspstopcauti.org/educational-sessions/content.cab
# Dates to Remember

<table>
<thead>
<tr>
<th>Date</th>
<th>Event Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>April 16</td>
<td>Kansas PFAC Collaborative Kick-off Event (Topeka)</td>
</tr>
<tr>
<td>April 22</td>
<td>Kansas HEN Webinar</td>
</tr>
<tr>
<td>May 27</td>
<td>Kansas HEN Webinar</td>
</tr>
<tr>
<td>June 3</td>
<td>Kansas ICU CUSP/CAUTI Project Meeting (cohort 9) (Topeka)</td>
</tr>
<tr>
<td>June 24</td>
<td>Kansas HEN webinar</td>
</tr>
</tbody>
</table>

*Pre-register at [www.khconline.org](http://www.khconline.org)*  
*Plan to log into webinars 10-15 minutes early.*

---

# Kansas HEN Webinar Archive

Access recordings and handouts at [www.khconline.org](http://www.khconline.org)

See [General Education Archive](http://www.khconline.org).
Your KHC Team

Kendra Tinsley  
Executive Director  
ktdsley@khconline.org

Michele Clark  
Program Director  
mclark@khconline.org

Eric Cook-Wiens  
Data and Measurement Manager  
etriens@khconline.org

Rhonda Lassiter  
Executive Assistant  
rlasster@khconline.org

Janie Rutherford  
Communications Director  
jrutherford@khconline.org

785-235-0763

Q&A / Discussion