Southern California Patient Safety Collaborative
Progress Report
Quarter 1, 2007 - Quarter 3, 2009

California Joint Summit
Preventing Hospital-Acquired Infections
March 1, 2010
SCPSC Track I Measures

- Adult ICU VAP rate per 1,000 ventilator days
- Adult ICU CL BSI rate per 1,000 central line days
- MRSA Laboratory-confirmed Bloodstream Infection rate per 1,000 patient days
- Hospital Acquired Pressure Ulcers (HAPU) Stage 2 or above from CalNoc quarterly prevalence study
- Mortality from severe sepsis/septic shock
Ven0lator
Associated Pneumonia

SCPSC Quarterly Percentile Run
Number of Ventilator-Associated Pneumonias per 1,000 Ventilator Days
January 2007 - September 2009

Mean = 2.10, Median = 0, N=26
Central Line BSI

SCPSC Quarterly Percentile Run
CL BSI Rate per 1,000 Central Line Days
January 2007 - September 2009

Mean = 1.65, Median = 0.8, N=57
MRSA BSI

Mean = 0.18, Median = 0.05, N=26
Pressure Ulcer Variation

SCPSC Comparative
Percentage (%) of Patients with Hospital-Acquired Pressure Ulcers (HAPU), Stage 2 or Above
Sepsis (Severe/Shock) Mortality

Mean = 27%, Median = 24%, N=19,
Actual Risk Reduction = 5%, Relative Risk Reduction = 17%

New mean of aggregate showing risk reduction of 5%
used to calculate Lives Saved

680 Lives Saved
Southern California Patient Safety Collaborative 2010

- Part of statewide initiative funded by Anthem Blue Cross

*Patient Safety First...a California Partnership for Health*
- 3 year’s of funding: 2010-2012
- No charge to HASC member hospitals
The 2010-2012 SCPSC will focus on the following clinical topics and be delivered in 3 Tracks:

• **Track I:**
  – *Hospital Acquired Infections in the ICU Setting:* focus on the reduction of incidence of (VAP) ventilator-associated pneumonia, (CLBSI) central line blood stream infections, and (CAUTI) catheter-associated urinary track infections, and (MRSA) methicillin-resistance blood stream infections.
  – *Sepsis:* reduction of incidence and mortality.
  – *Surgical Care Improvement Project (SCIP):* focus on improving compliance with each of the 10 measures, and reducing the incidence of surgical infections.

• **Track II:**
  – *Pressure Ulcers:* reducing the incidence of facility-acquired pressure ulcers
    • Hospitals will participate with representatives from local nursing homes with leadership from Health Services Advisory Group.

• **Track III:**
  – *Perinatal Care:* reduction of elective deliveries prior to thirty-nine (39) weeks gestation, and reduction of birth trauma.
Southern California Patient Safety Collaborative 2010

• Continue existing partnership with California’s QIO – Health Services Advisory Group
  – SCIP, MRSA, and Pressure Ulcers (with nursing homes)
• Premier’s Performance Improvement Portal
  – SCPSC Community
  – One license to each committed hospital.
  – New website and the one location for meeting registration, meeting materials, Q &A with documentation, and clinical content from SCPSC and 1,000 hospitals.
Welcome new user to the Performance Improvement Portal!

Evidence Based Care Sprint: SCIP-VTE 2 (Appropriate VTE prophylaxis in surg pts)

What’s Hot

- QUEST Sepsis Learning Collaborative Meeting Agenda 12.10.09
  Go
- Multidisciplinary Approach to Care of the Severely Septic Patient (CAMC, 2009) Go
- National Palliative Care Registry for 2009
  Go

New advice by favorite people (0)
New answers to my questions (0)
New answers watched questions (0)

Welcome Leslie

SC HQT Category
by: Leslie Schultz
The South Carolina Healthcare Quality Trust (SC HQT) category was designed with the 4 system aims for Every Patient Counts (EPC) in mind.

Please share your success stories and lessons learned!...

Southern California Patient Safety Collaborative and logo here

Customized “Site Message”
Only SC HQT users see this
Discharge Process Improvement

by: Marci Jackson
last update: 08/26/2009
A Case Study by Barnes-Jewish Hospital of St. Louis:

Discharging a patient is an activity common to every hospital – small, large, community, inner-city, teaching or non-teaching. The discharge process can have an impact on numerous factors, such as patient satisfaction, bed availability, timely tests and procedures needed for discharge, home health equipment and service availability, social worker and therapist coordination, transportation, and nursing home arrangements. No matter what type of patient is being discharged (maternity, medicine, orthopedic, neurologic) numerous activities must be completed for each before the patient can be released. This work toward discharge day should begin upon admission.

See link below for complete study.
Contributed via the Innovations in Systems website.
http://www.iier.com

Usefulness: 7  
Reviews: 116

Categorization: General > Patient Throughput, Operations Improvement - General > Six Sigma/Lean, Toolbox > White Papers, Toolbox > PE/PP/PWG Resources > Assessment Tools

Provide Feedback!

D. Russell  
05/17/2009

Discharge Timeout

This is a great idea. I have been tossing something similar to aid our Heart Failure discharge compliance with education and instructions. It is nice to see a plan than had already been established. It gives me some guidance.
## A Snapshot of Measures

<table>
<thead>
<tr>
<th>Structure</th>
<th>Process</th>
<th>Clinical Outcomes</th>
<th>Financial Outcomes</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Perinatal Care</strong></td>
<td>• # of participating hospitals • AHRQ Culture of Safety Survey</td>
<td>• Percentage of elective deliveries at &lt;39 weeks gestational age</td>
<td>• Birth trauma rate per 1,000 live births • Percentage of NICU admissions where there was elective delivery prior to 39 weeks</td>
</tr>
<tr>
<td><strong>Sepsis</strong></td>
<td>• # of participating hospitals</td>
<td></td>
<td>• Sepsis mortality rate</td>
</tr>
<tr>
<td><strong>Hospital Acquired Infections</strong>  • VAP  • CLBSI  • CAUTI  • MRSA (HSAG)</td>
<td>• # of participating hospitals</td>
<td>• CLBSI rate per 1,000 central line days • VAP rate per 1,000 ventilator days • CAUTI rate per 1,000 patient days • MRSA Laboratory confirmed Bloodstream Infection rate per 1,000 patient days</td>
<td>• ROI</td>
</tr>
<tr>
<td><strong>Hospital Acquired Pressure Ulcers (HSAG)</strong></td>
<td>• # of participating hospitals</td>
<td>• Hospital Acquired Pressure Ulcers (HAPU) Stage 2 or above from CalNoc quarterly prevalence study (CHART)</td>
<td></td>
</tr>
</tbody>
</table>

VAP = ventilator-associated pneumonia  
MRSA = Methicillin Resistant Staphylococcus Aureas  
CLBSI = central line blood stream infections  
CAUTI = catheter-acquired urinary tract infections
CMS National Patient Safety Initiative

- **SCIP Measures**
  - Submit data to HSAG Quality Improvement Specialist

- **Healthcare-Associated MRSA Infections**
  - CDC National Healthcare Safety Network and the new Multi-Drug Resistant Organism (MDRO) Module

- **Hospital-Acquired Pressure Ulcers**
  - Encourage submission of data to CAL-NOC
Patient Safety Surveys

- AHRQ Hospital Survey on Patient Safety Culture
- Hospital Leadership & Quality Assessment Tool (HLQAT)
  - Reassessment 6 months after baseline, before April 30, 2011.
  - HSAG will assist hospitals in administering the surveys, analyzing results and planning interventions.
SCPSC Contact Information:

Website: www.SoCalPatientSafety.org

Catherine Carson, Hospital Association of Southern California
  CCarson@hasc.org

Karen Arriaga, Hospital Association of Southern California
  Karriaga@hasc.org

Mia Arias, National Health Foundation
  Marias@nhfca.org

Mary Fermazin, MD, Health Services Advisory Group
  Mfermazin@hsag.com

Tammy Wallace, Health Services Advisory Group
  TWallace@hsag.com  Fax: 818-409-0835